APPENDIX D. PROMISING COMPONENTS AND INTERVENTIONS TO REDUCE READMISSIONS

TABLE D-1. Promising Components and Interventions to Reduce Readmissions	
Comprehensive Discharge Planning	
Assess Transition Risks	• Screen patient for medical & social readmission risks. • Standardize risk assessment. • Query patient about prior post-discharge period. • Initiate planning to mitigate transition risks immediately. • Obtain information from primary & community care providers as needed.
Prepare the Patient	• Identify the primary learner (may be family or other third party). • Personalize education. • Teach patient regarding condition & recovery (self-monitoring, warning signs). • Use teach-back to assess comprehension. • Provide patient-centered information to patient & family at discharge for reference (discharge instructions including POC, medications, appointments, contact information). • Involve clinical pharmacist in pre-discharge education. • Utilize transition coaches & advocates. • Assess patient understanding of discharge POC.
Develop Post-Discharge Plan of Care (POC)	• Involve all disciplines (nursing, social work, clinical pharmacist, etc.). • Involve patient & family members. • Reconcile medications. • Incorporate care events & recovery milestones. • Counsel re palliative & end-of-life care as appropriate. • Electronically prescribe discharge medications directly to community pharmacy.
Post-Discharge Support and Care	
Prepare the Next Provider of Care	• Identify next provider of care. • Standardize format & content of communication to next provider of care. • Include post-discharge POC & medication reconciliation. • Assign responsibility for communication. • Communicate discharge summary to physician responsible for followup care. • Use patient as conduit of information to next provider (paper communication, patient-managed PHR). • Confirm receipt by next provider of care. • Verify common understanding with telephone call to next provider of care. • Involve the patient's physician in developing the discharge POC & home care. • Utilize a checklist for visits following discharge.
Ensure Post-Discharge Followup	• Arrange care for patients lacking a regular source of care. • Schedule appointments pre-discharge for followup clinician care & testing. • Arrange home care/visiting nurse. • Implement home care protocols for high-risk patients. • Front-load PCP/clinic visits. • Front-load home care. • Utilize APN with special training in population (CHF). • Provide transportation, free followup care (for uninsured). • Provide home visit(s) by NP, physician, or multidisciplinary team. • Verify visit and/or dispensing of discharge meds. • Provider continuity during the transition.

TABLE D-1 (*continued*)	
Ensure Post-Discharge Support	• Post-discharge telephone outreach (NP or clinical pharmacist). • Multiple telephone contacts. • Provide patient hotline. • Utilize transition coaches & advocates. • Engage community services. • Use tele-monitoring with electronic link to case manager and/or provider to monitor status & compliance.
SOURCE: Metzger J. Preparing for accountable care: Coordinated care. Falls Church, VA: Computer Sciences Solutions Global Institute for Emerging Healthcare Practices; 2012; WA12_0280 HCG.	

LONG-TERM AND POST-ACUTE CARE PROVIDERS ENGAGED IN HEALTH INFORMATION EXCHANGE: Final Report

Files Available for This Report

MAIN REPORT

Executive Summary	http://aspe.hhs.gov/daltcp/reports/2013/HIEengagees.shtml
HTML	http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml
PDF	http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.pdf

APPENDIX A. SELECTED PROGRAMS AND INITIATIVES THAT SUPPORT CARE COORDINATION AND INFORMATION EXCHANGE FOR PERSONS RECEIVING LTPAC/LTSS

HTML	http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendA
PDF	http://aspe.hhs.gov/daltcp/reports/2013/HIEengageA.pdf

APPENDIX B. FRAMEWORK TO CHARACTERIZE HEALTH INFORMATION EXCHANGE TO SUPPORT CARE COORDINATION FOR PERSONS RECEIVING LTPAC/LTSS

HTML	http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendB
PDF	http://aspe.hhs.gov/daltcp/reports/2013/HIEengageB.pdf

APPENDIX C. ENVIRONMENTAL SCAN AND LITERATURE REVIEW SOURCES

HTML	http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendC
PDF	http://aspe.hhs.gov/daltcp/reports/2013/HIEengageC.pdf

APPENDIX D. PROMISING COMPONENTS AND INTERVENTIONS TO REDUCE READMISSIONS

HTML	http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendD
PDF	http://aspe.hhs.gov/daltcp/reports/2013/HIEengageD.pdf

APPENDIX E. SUMMARY OF LITERATURE ON HEALTH INFORMATION EXCHANGE OUTCOMES AND RELATED MEASURES

HTML	http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendE
PDF	http://aspe.hhs.gov/daltcp/reports/2013/HIEengageE.pdf

APPENDIX F. EXAMPLES OF COMMUNITY-BASED CARE TRANSITION PROGRAM WITH LTPAC/LTSS PARTICIPATION

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendF
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageF.pdf

APPENDIX G. HEALTH INFORMATION EXCHANGE INTERVENTIONS AND ACTIVITIES IDENTIFIED THAT SUPPORT CARE COORDINATION FOR PERSONS RECEIVING LTPAC/LTSS

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendG
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageG.pdf

APPENDIX H. SITE VISIT SUMMARY: RUSH UNIVERSITY MEDICAL CENTER, CARE TRANSITIONS PROGRAM, BRIDGE PROGRAM

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendH
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageH.pdf

APPENDIX I. SITE VISIT SUMMARY: BEACHWOOD HOMES

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendI
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageI.pdf

APPENDIX J. SITE VISIT SUMMARY: EASTERN MAINE HEALTH SYSTEM, EASTERN MAINE HOME CARE

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendJ
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageJ.pdf

APPENDIX K. SUMMARY OF INFORMATION ROUTINELY EXCHANGED BY THE THREE SITES VISITED, BY CARE COORDINATION FUNCTION

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendK
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageK.pdf

APPENDIX L. STANDARDS AVAILABLE TO SUPPORT HEALTH INFORMATION EXCHANGE OF LONG-TERM AND POST-ACUTE CARE DATA

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendL
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageL.pdf

APPENDIX M. GLOSSARY

HTML http://aspe.hhs.gov/daltcp/reports/2013/HIEengage.shtml#appendM
PDF http://aspe.hhs.gov/daltcp/reports/2013/HIEengageM.pdf