Seven Essential Intervention Categories For Designing Transitions Strategies for Patients & Caregivers Across the Continuum

Patient & Identified Family Caregiver Engagement /Education

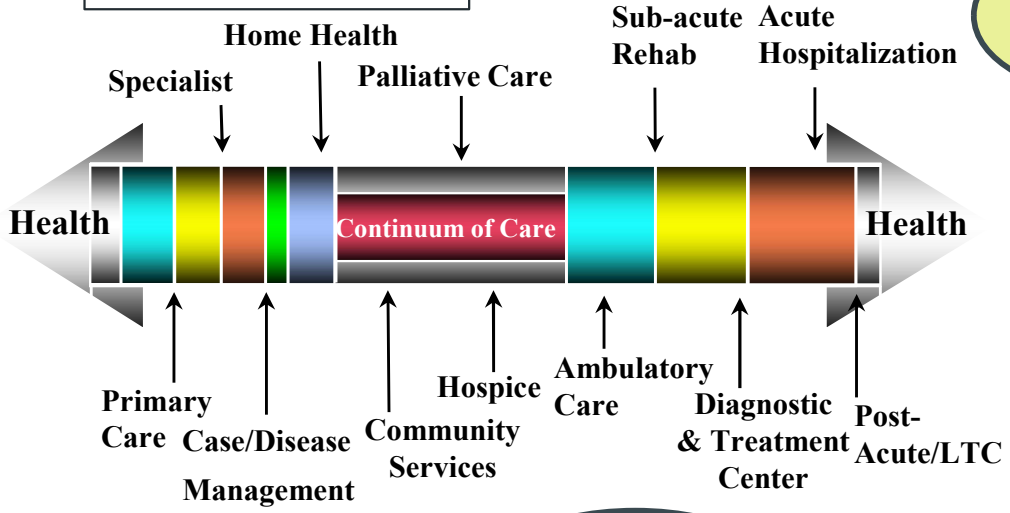
Nurse or social work case manager needs to conduct an assessment including SDOH and develops educational plan which is shared with care team and transferred to the next care setting

Medication Management Services & Coordination

Conduct & complete a comprehensive patient and caregiver medication intake and needs assessment, develop a medication plan which is shared with the collaborative care team

Physical Health, Mental Health/SUD, Social Determinants of Health Triune

Providers need to assess the whole individual. Ensure complete assessment of all areas to avoid missing crucial factors that may significantly affect others; they are not separate domains but integrated.



Transition Planning

Collaborative care planning & implementation, use shared decision making with patient & family incorporating findings of patient assessment including Social Determinants of Health

Information Transfer

Implement bi-directional communication with provider to provider at the next level of care and provide information to the patient and family caregiver

Healthcare Provider Engagement & Shared Accountability Across the Healthcare Continuum

Identify interdisciplinary care teams: MD, pharmacist, APN RN, SW, CM, allied health, community health workers, and community agencies to ensure that a healthcare provider is responsible for the care of the patient at all times

Follow-Up Care

Ensure timely access to medications and key healthcare providers & communicate importance to patients and their family caregiver