Community Interventions: Hospital

In order to accurately represent what is occurring in the community, it is important to gather all relevant information about interventions that are in place. This will allow you to identify and assemble the many resources and strengths that exist in your community. Together, coupled with information learned through community discussions and root cause analysis activities, you can then identify opportunities to build upon what already exists to drive future interventions and collaborative work.

Please indicate interventions and strategies that have been implemented in the hospital setting to reduce readmissions and improve care transitions. Include a description for each intervention, including the tools used to implement, date started, and information you monitor to determine the success of the intervention. A few common interventions and strategies are listed; please describe additional interventions not listed and provide additional information as appropriate.

INTERVENTION	DESCRIPTION/TOOLS	INITIATED MONTH/YEAR	MEASURES
Check those implemented: ☐ Project Re-Engineering Discharge (RED) ☐ Better Outcomes for Older Adults through Safe Transitions (BOOST) ☐ Institute for Healthcare Improvement (IHI) Transforming Care at the Bedside ☐ Hospital to Home ☐ **Specific interventions:** ◯ Standardized education ◯ Standardized education used cross-settings (please specify) ◯ Teach-back ◯ Discharge instructions/education tailored to patient's health literacy ◯ Medication reconciliation at discharge ◯ Situation, Background, Assessment, Recommendation (SBAR) communication ◯ Communication with community physicians regarding admission	List/describe specific populations/units: List/describe specific tools used:		List process measures tracked (e.g., # patients identified, # received intervention, # successful documentation): List/describe outcome measures tracked (e.g., 30-day readmission rates for the population who received the intervention):

INTERVENTION	DESCRIPTION/TOOLS	INITIATED MONTH/YEAR	MEASURES
◯ Schedule patient follow-up appointment prior to discharge ◯ Discharge follow-up calls ◯ Standardized transfer communication process ◯ Standardized transfer communication tool ◯ Provided clinician contact information to post-acute provider upon discharge ◯ Provide discharge summary to community physician at discharge ◯ Process to address end-of-life discussions for use by physicians and/or staff ◯ Standardized process to assess discharge			Other information monitored to assess the success of the intervention/program:
List/describe other interventions used to improve care transitions/reduce avoidable rehospitalizations, and indicate whether each is based on another program or "homegrown."	List/describe specific populations/units: List/describe specific tools used:		List process measures tracked (e.g., # patients identified, # received intervention, # successful documentation): List/describe outcome measures tracked (e.g., readmission rates for the population who received the intervention): Other information monitored to assess the success of the intervention/program:

INTERVENTION	DESCRIPTION/TOOLS	INITIATED MONTH/YEAR	MEASURES
List/describe specialized programs for targeted populations:	List/describe specific populations/units: List/describe specific tools used:		List process measures tracked (e.g., # patients identified, # received intervention, # successful documentation): List/describe outcome measures tracked (e.g., readmission rates for the population who received the intervention): Other information monitored to assess the success of the intervention/program:
List collaborations with community organizations to improve care transitions/ reduce avoidable rehospitalizations:	List/describe collaborative activities: List/describe specific tools used:		Information monitored to assess the success of collaborative activities:

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