Facilitators and Barriers to Effective Transitional Care

**Key Findings**
Based on site visits at 22 diverse hospitals and health systems across the United States, we found that effective care transitions require: 1) True community partnership, 2) High-quality communication, 3) Patient & family engagement & 4) Ongoing evaluation and adaptation.

**Facilitators of Transitional Care**
- Collaborating within & beyond the hospital
- Tailoring to needs of patients & caregivers
- Generating buy-in
  - Efficient information management
  - Comprehensive patient education
  - Championing TC
  - Involving patients/caregivers in TC
  - Evaluating and adapting implemented TC protocols
  - Provider engagement
  - Coordination with community partners
  - Strategic prioritization of TC services

**Barriers to Transitional Care**
- Poor Integration of TC Services
- Unmet Patient, Caregiver Needs
- Under-utilized TC Services
- Lack of Buy-in
  - Duplication of effort
  - Poor information management
  - Communication issues
  - Lack of Coordinated Implementation of TC Programs
  - Suboptimal patient and caregiver education
  - Insufficient Home Health breadth and quality
  - Underutilized palliative care
  - Inconsistent prioritization
  - Insufficient Home Health breadth and quality
  - Lack of physician engagement
  - Limited resources

"Disease isn’t what brings patients back to the hospital. What brings them back is inability to see their doctor, inability to get food, inability to get their meds."

**Total sites = 22**
**Total participants = 810**

**Read more here**

What is Project ACHIEVE?
Project ACHIEVE aims to 1) Rigorously evaluate care transition strategies, and 2) Understand what matters most to patients and caregivers during care transitions. These results are one component of this 5-year, $15 million study funded by the Patient Centered Outcomes Research Institute (PCORI).