Patient and Family Engagement in Care Transitions

Empowering Patients for Better Outcomes

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KEYWORDS

• Care transitions • Patient empowerment • Team approach
• Patient outcome improvement • Patient discharge • Patient participation
• Patient-centered care • Patient education

KEY POINTS

- Patient and family empowerment starts with effective communication beginning at admission.
- A multidisciplinary team approach is the ideal method to address patients' needs and discharge barriers.
- Education throughout hospitalization and arranging postdischarge support can reduce readmissions.

CASE SCENARIO

Mr CHF is a 60 year old man with a history of moderate dementia, insulin-dependent diabetes mellitus, and New York Health Association class 4 congestive heart failure (CHF) exacerbations. He has recently lost his job, will lose his insurance in 6 months, and has been evicted from his apartment. He is currently residing in his car. He is being admitted for decompensated CHF.

INTRODUCTION

Patient outcomes are shaped not only by the care provided during hospitalization but also by how we prepare patients and families for the next stage of healing. While excellent inpatient care can improve immediate outcomes, the greater challenge often lies in ensuring that patients continue to thrive once they return home or transition into

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Abbreviation
CHF congestive heart failure

another setting. Too often, health care operates in silos, and clinicians overlook simple, but vital, concerns patients have about their care and abilities: *When can I shower again? When can I resume intimacy with my partner? How long until my quality of life returns to normal?*

Take, for example, the aforementioned case scenario. We may prescribe a new, expensive medication, but how realistic is that for someone on a fixed income? We may provide diet recommendations, but without understanding barriers like cost, food access, housing stability, or cultural preferences, these instructions can feel impossible to carry out. Addressing these questions requires more than medical expertise; it necessitates an understanding of individuals' life contexts.

While it is unrealistic for clinicians to solve every barrier that a patient may face, we can empower patients and families by equipping them with knowledge, tools, and confidence to advocate for themselves. Empowerment begins with honest conversations, early assessments of individual needs, and engagement in discharge planning from day 1 of hospitalization. It requires a coordinated, multidisciplinary approach to communication and a respect for patient autonomy in making choices to help maximize health outcomes following hospital discharge.

As Fig. 1 illustrates, patient empowerment and outcomes are multidimensional. True empowerment comes from shifting medical decision-making from clinicians alone to a shared process that includes patients and families, valuing their voices, and helping them achieve the best possible outcomes, even when not every challenge can be overcome.

TACKLING THE CHALLENGE OF PATIENT ENGAGEMENT

The landscape of modern health care is characterized by increasing clinical complexity, health care system deficiencies, and complex obstacles stemming from

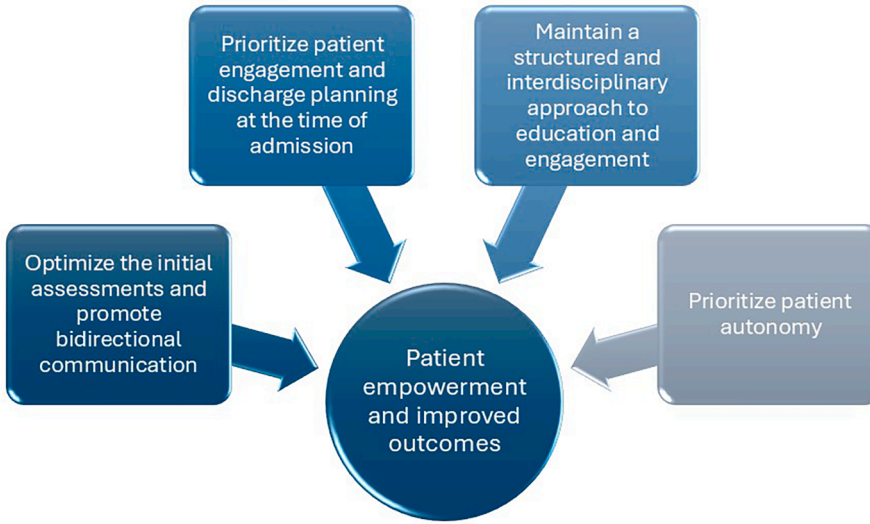

Fig. 1. Strategies to address patient empowerment during hospitalization.

social determinants of health. These challenges are further complicated by an erosion of patient confidence and trust both in health care institutions and in conventional models of patient care and disease management.[1,2] Although this perspective is understandable, it often leads to misalignment between patients and care teams, manifesting as patient guardedness and reduced engagement in treatment planning and care progression. While lack of trust and confidence are often perceived as patient-derived, the primary responsibility for driving change lies with clinicians and health care institutions to cultivate an environment that fosters trust, collaboration, and effective therapeutic relationships.[3]

Patient attitudes toward health care institutions and providers are dynamic and can be significantly shaped by each interaction.[4] This fluidity presents valuable opportunities for the inpatient care team to establish and maintain a therapeutic relationship that fosters consistent patient engagement, accountability, and respect for patient autonomy. Cultivating patient confidence and trust directly influences patient satisfaction, patient safety, and outcomes (eg, length of stay and readmission rates), underscoring the importance of implementing diverse strategies that prioritize patient-centered care.

Once a patient enters the hospital, every individual that encounters the patient becomes a direct or indirect part of their recovery journey. As such, each point of contact represents an opportunity to comprehensively assess, engage, and align with the patient to ensure effective care progression. Because the goal of any hospitalization is to address acute or life-threatening illness and establish a trajectory toward recovery or stabilization, each care team member has a clearly defined and essential role. Empowering all members in alignment with this common goal ultimately empowers the patient during these transitions of care.

As a key member of the care team, the clinician plays a pivotal role in fostering this empowerment by guiding the patient and other care team members to take ownership of their contributions to the patient's recovery and care progression. The first step in this process is establishing an environment of trust, mutual respect, and consistent communication. As outlined in **Fig. 1**, several leadership empowerment strategies[5] can be implemented within health care settings to enhance patient engagement and improve patient outcomes.

Optimize the Initial Patient Assessment and Promote Bidirectional Communication

- Delegate authority and tasks[5] within the care team during the admission process. For example, with the knowledge that identification and assessment of social determinants of health and potential barriers to care progression will have an impact on the patient's immediate and long-term recovery, the case manager should have a standardized process for obtaining this information during the admission process. Standardized integration of the expertise of the multimodal care team helps to ensure that each component of the patient's overall care and progression is tended to, facilitating smooth progression through the hospital stay and successful transition to the outpatient setting.[6]
- Promote and prioritize patient education and bidirectional communication of expectations.

Prioritize Patient Engagement and Discharge Planning at Time of Hospital Admission

- Introduce the patient to the concept of a team-based approach at the time of admission and help them to anticipate the involvement of each team member as a part of their hospital course.

- At the time of admission, emphasize specific goals for the hospitalization to ensure a shared mental model and orientation toward progression to the next level of care on discharge.
- Provide the patient with a means of communicating questions about their hospital course and their discharge with members of the team by offering contact emails, phone numbers, and so forth, as appropriate.

Maintain a Structured and Interdisciplinary Approach to Education and Engagement

- Utilize the expertise of the care team, that is, pharmacy, nutritional services, and so forth to provide specific patient-centered educations (eg, pharmacy using a teach-back technique for new medications).
- Educate to inspire the patient's sense of confidence in their knowledge and ability to own their role in their recovery, promoting psychological empowerment.[7] Communication with each team member should incorporate teaching (pathophysiology, medication mechanism of action, nutrition, self-care, and so forth) and a bidirectional and empathetic exchange about ways that the patient can creatively impact the various components of their health and recovery.
- Maintain information-sharing[8] as an expectation and priority within the care team to ensure team alignment.
- Ensure that the care team is interdisciplinary rather than simply multidisciplinary; while multidisciplinary teams merely provide space for input from experts across multiple disciplines, interdisciplinary teams integrate the expertise and recommendations from each discipline to develop a cohesive plan for the patient.

Prioritize Patient Autonomy

- Minimize a sense of powerlessness for the patient by encouraging questions and maintaining a stance of active listening.
- Emphasize best practices from a medical perspective and teach back when the patients communicate their goals and wishes related to overall care.

To apply these strategies to the case scenario, as the team initiates care for Mr CHF, it is essential to gather comprehensive information regarding social determinants of health, past medical history, and medication and nutritional adherence. The patient engaging in a bidirectional dialog with each care team member serves multiple purposes: First, it helps to establish an environment of trust and mutual respect; Second, it helps to identify clinical information crucial to the development of an effective treatment plan; and finally, it helps to initiate steps for effective discharge planning by proactively addressing any identified barriers. The most effective approach to address Mr CHF's acute illness while setting him up for success postdischarge is to standardize measures that foster his understanding of the team's goals and promote active engagement in his treatment plan. By maintaining a commitment to patient-centered care, the team can support Mr CHF in feeling empowered during this hospitalization and through future transitions of care.

INTEGRATING METHODS FOR EFFECTIVE COMMUNICATION

Effective communication is an essential clinical competency for patient-centered care and has a direct impact on patient engagement, alignment,[9] and outcomes. Readmission rates, for example, are directly correlated with both the quality of clinical care and patient education.[10] Prioritizing and optimizing effective communication can help mitigate eroded patient trust and facilitate positive patient–provider interaction.

Consistent and structured communication engages both the patient and family more effectively for shared decision-making and care progression. This engagement is most effectively championed by the physician, although organizational workflow structures must emphasize this communication as a baseline component of any patient-centered strategy across the care team, as patients are often reluctant to ask questions.[11]

Case continued...

In treating the Mr CHF's decompensated CHF, he is diuresed into acute renal failure and needs to initiate hemodialysis. The medical team reaches out to the patient's daughter, who is distraught, as she was unaware of how sick he was and of his current living situation.

The hallmarks of effective communication in the inpatient setting are consistent: clear education and anticipatory guidance initiated at admission and reinforced throughout the hospital stay. **Fig. 2** lists specific elements of communication that prioritize shared decision-making, ensuring autonomy and alignment are central to the patients' care. Quality communication involves discussion about the treatment plan but also the expected impact on quality of life beyond the hospital. As the physician is the most authoritative source of real-time clinical insight during hospitalization, communication should be thorough and transparent to foster trust, promote alignment, and mitigate the tendency for patients and families to seek outside information to fill knowledge gaps.[3] In the case scenario presented, had Mr CHF's daughter been more effectively engaged, informed of his condition, and provided with anticipatory guidance of potential clinical trajectories, she would likely have been better prepared—both emotionally and logistically—for the possible clinical outcomes. If "knowledge is power," then the most effective way to empower patients and families is through robust, multilayered education delivered with structure, consistency, and clarity.

Inherent to the role of a physician is the responsibility to be an effective teacher, to facilitate patient understanding, not merely to convey information. To accomplish this, physicians must understand health literacy and how a patient's ability to obtain, interpret, and apply health information directly affects their engagement in treatment, discharge follow-up, medication adherence, and readmission risk.[12,13] Health literacy varies widely and often averages at or below a sixth grade reading level[14] highlighting the importance of clear, understandable communication.

Physicians must ensure that both written and verbal communication is clear, understandable, and encourages open dialog.[15] Creating an environment that encourages dialog, for example, by asking open-ended questions, enables clinicians to more effectively gauge and meet patients at their level of understanding and comfort. Providers should use plain language instead of medical jargon; for example, saying "weak

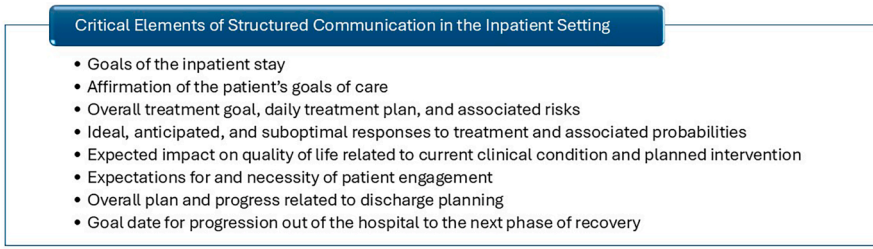

Fig. 2. Critical elements of structured communication in the inpatient setting.

heart" or "fluid buildup" rather than "CHF" helps create a visual understanding for patients and families. Combining oral and written instructions with the teach-back method ensures comprehension, improves retention, and supports better outcomes, particularly in conditions with high readmission rates.[16] When patients and families are in the hospital, the care team can provide hands-on education for tasks such as dressing changes, insulin injection, or selecting and preparing healthy foods. Multimedia tools, including videos, webinars, and tutorials for complex devices such as pleural catheters or pacemakers can enhance both patient and family understanding and satisfaction.[17]

SETTING EXPECTATIONS FOR HOSPITALIZATION USING A TEAM-BASED APPROACH

Setting Clear Expectations Throughout the Duration of the Hospital Course

The point of admission offers an ideal opportunity to establish patient education and communication as strategic priorities for the hospital stay, while setting clear, shared expectations for the course of care. Patient interaction within an interdisciplinary care team should follow a standardized workflow aligned with each member's role. For example, care management should take the lead in communicating with patients and families about postacute care options and outpatient resources. As the primary driver of patient throughput and the trusted authority for patients and families, the physician should consistently incorporate key aspects of care progression into their routine patient and family communication.

Comprehensive educational materials that draw on the entire care team can enhance patient engagement and help ensure alignment with acute care expectations in the hospital. From outlining treatment plans to coordinating discharge, these materials guide patients through their care progression and help ensure alignment with the care team's goals.[18] The structured progression benefits not only the health care organization but also the patient, supporting better outcomes and a smoother care experience.

Case continued…

With Mr CHF's permission, the medical team has been reaching out to the daughter periodically to provide her with updates and answer questions. She would like to provide emotional support for her father, as she can see that his prolonged hospital stay is starting to take a toll on him. She wonders where he is in his treatment course and how long it will take him to get well enough to leave the hospital.

Fig. 3 is a model of a patient tool that we developed and use during the admission process for our hospitalized patients. It is an educational reference that is provided to patients and families along with case management counseling and serves as a guide map for the hospital stay, allowing patients to more clearly understand the journey in the acute care setting. It outlines the goals of the hospital stay, explains the stages of hospitalization, and offers suggestions for patient and family engagement with the care team. Serving as a dynamic tool for education and communication, it also provides care team members with standardized language (eg, "progression," "momentum of improvement," "next level of recovery," and so forth) to ensure consistent messaging. In the case scenario, Mr CHF and his daughter could have used a similar inpatient roadmap to better understand the care progression and engage more effectively with the team regarding the patient's current state and next steps.

Managing patient expectations at every stage of the hospital journey is essential to effective care progression. The primary goal of hospitalization is to address acute medical needs and facilitate a safe discharge, ideally, back to the care of the outpatient physicians. A "safe discharge" encompasses more than ensuring adequate

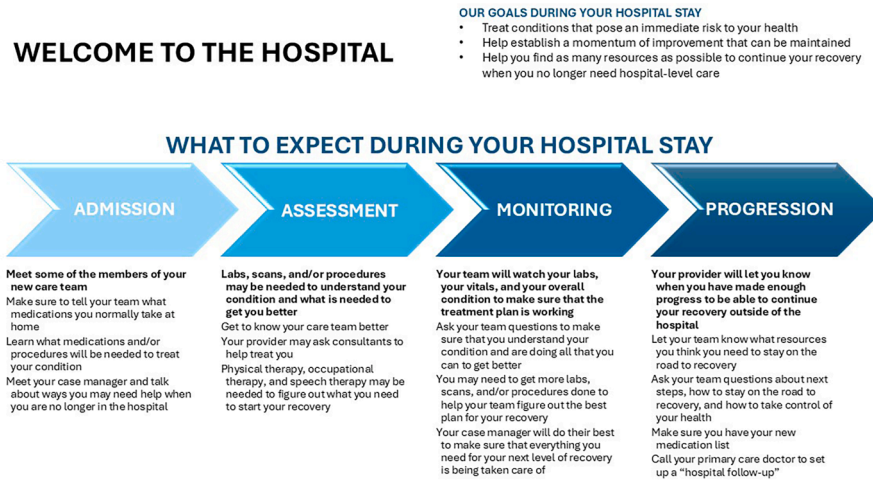

Fig. 3. Inpatient reference map.

resources and follow-up; it also involves minimizing harm through mitigating the risk of nosocomial infection (eg, by optimizing length of stay) and deconditioning, and through prioritizing early recovery efforts. Optimizing length of stay (ie, minimizing excess or avoidable days in the hospital setting) requires intentional patient communication and education to foster engagement and ownership. Well-informed patients, empowered by knowledge and understanding, are more likely to actively participate in their care and improve length of stay.[19]

Case continued…

The patient has been in the hospital over a week and is starting to feel weaker every day. The team consults physical and occupational therapy, but some days the patient declines working with the therapists due to fatigue, and now that he is requiring hemodialysis, he has missed therapy sessions. He is concerned that he may not be able to take care of himself the same way he used to when he gets discharged.

Just as optimizing length of stay is important for health care organizations to reduce patient harm, patients must understand their personal role in prioritizing early recovery. Elderly patients spend approximately 85% of their hospital stay in bed and 12% in a chair, leading to significant deconditioning that affects physical, cognitive, and emotional wellness.[20] With an estimated 5% loss of muscle strength per day of bed rest, and 10 days of bed rest equating to 10 years of muscle aging, deconditioning is a major risk factor for posthospital disability, dependency, readmission, institutionalization, and mortality.[18] Educating patients about these risks is a crucial aspect of care, promoting engagement in activities that mitigate these risks. Initiated at admission and reinforced throughout the hospitalization, this education should orient patients toward steady improvement rather than complete recovery during the hospital stay.

The Importance of Team-Based Communication with Unified Expectations

Interdisciplinary communication is critical and must be carefully aligned. In the case scenario presented, consider how Mr CHF and his daughter might respond when different members of the care team convey conflicting expectations. For instance, the Care Manager may suggest he could be discharged home in 3 days, based on

typical CHF cases, while the physician indicates he may require acute inpatient rehabilitation, and the physical therapist suggests skilled nursing facility-level rehab. When the interdisciplinary team finally convenes, they learn that the patient does not have insurance coverage for a skilled nursing facility, does not meet criteria for acute inpatient rehab, and will likely go home with hemodialysis. The patient is unsure what to tell his family; the plan of care has not been clearly communicated to his daughter, and misaligned messages leave both patient and family frustrated and confused.

How can we empower our patients and families given this level of complexity? One key strategy is to avoid making promises to the patient until the team reaches consensus. Communication can be optimized by standardizing consistent, clear verbiage across all disciplines. For example,

Case manager
I am going to talk with all members of the team to make sure that we are aligned with the best plan for you for next steps from the hospital, and we will start planning immediately to have you prepared for when you are ready for discharge.

Physician
Your heart failure has worsened, and we will need to start you on dialysis, which we believe will be an ongoing need for you. Let me talk with our Case Management team and therapists to understand the options that we have for you for your next level of care.

Physical therapist
I have done my assessment, but I need to huddle with the team to make sure that we have the best plan for you for discharge and that we can keep following you and working with you until you are discharged.

By educating families and allowing them to ask questions, the care team can help them feel more confident in managing care at home and less anxious about the upcoming transition. In the aforementioned communication scenario, this approach ensures consistent messaging and keeps the family engaged rather than creating confusion or fracturing therapeutic relationships.

ENSURING PATIENT AND FAMILY-CENTEREDNESS AT THE TIME OF HOSPITAL DISCHARGE

As emphasized throughout this article, hospital discharge is far more than an administrative task of finalizing orders and prescriptions. It is a complex, interdisciplinary process that requires proactive planning, coordination, and collaboration across the inpatient team and ideally also involving outpatient providers. The transition from hospital to home is a pivotal stage in a patient's recovery, one that is often both hopeful and intimidating for families.

Many patients require additional support, whether through home health services or temporary placement in postacute care settings, such as rehabilitation or skilled nursing facilities. Empowering families during this transition means equipping them with the knowledge, confidence, and resources to provide safe and effective care at home. When patients and families are well-prepared for this transition, the risk of postdischarge complications and readmission are significantly reduced.

In addition to the strategies addressed earlier, it is essential to remain empathetic and offer emotional support and understanding. Families often shoulder significant emotional and/or physical burdens when a loved one leaves the hospital. For patients

unable to make their own decisions, the health care power of attorney may face complex family dynamics, emotional strain, and financial responsibilities related to postacute care arrangements.

While much research has focused on the provider perspective of discharge planning, such as the key elements of discharge summaries,[21–23] relatively little has explored the experiences of patients and families. The American College of Physicians, Society of Hospital Medicine, and Society of General Internal Medicine's Transitions of Care Consensus Conference identified several essential components of effective discharge communication,[24] including several elements that can be directly addressed with families to reduce stress and enhance confidence in managing postdischarge care.

Case continued…

The daughter is struggling financially, as she will need assistance taking care of her father, because she also has young children at home. She is willing to take her father into her home to care for him on discharge. Although, the CHF team is recommending guideline-directed medical therapy including Entresto, which was cost prohibitive. The team mentions that end stage renal disease (ESRD) patients can get Medicare, so the patient and the family can initiate the process of getting new insurance coverage, which can help cover costs. The team educates the patient and the daughter on diet, lifestyles modifications, and medications.

Acknowledging financial limitations for patients and families when transitioning out of the hospital is important. Medication nonadherence, often driven by cost, is a leading driver of readmissions and medical errors.[25] Simplifying regimens with affordable, easily accessible, or low-copay to no-copay medications can improve adherence. Ensuring patients have their medications in-hand at discharge further reduces barriers such as transportation challenges or delays from prior authorizations. In health care systems with in-house or contracted commercial pharmacies, "meds-to-beds" programs can mitigate these barriers, improve medication adherence, and reduce readmission rates across vulnerable patient populations.[26,27] Providers can empower families by ensuring they understand what condition the medicine treats and the associated side effects associated. A multimodal team approach is best for this conversation: pharmacy tech and pharmacist education have been shown to reduce readmissions and are cost-effective interventions.[28]

A variety of other resources can help reduce the burden on patients and caregivers during discharge transitions. When available, home health services can provide valuable support, offering physical and occupational therapy to enhance mobility and independence, skilled nursing for clinical needs such as vital sign monitoring, intravenous catheter care and wound management, and home health aides to assist with activities of daily living. Beyond providing direct care, these services also educate and reassure patients and families, strengthening their confidence in providing care at home, an effect shown to reduce readmissions.[29,30] Additional supports may include private-pay home services, diagnosis-specific programs (eg, addiction recovery groups), and community resources for housing, transportation, and food assistance.

Case conclusion

The team discusses home health options with the daughter, and she and the patient choose from the available options. The patient is discharged with a follow-up appointment scheduled. Upon discharge, the patient and daughter take the time to complete the patient feedback survey and give 5 out of 5 stars.

SUMMARY

Transitions of care are defining moments in a patient's health journey. Each moment is an opportunity for the care team to create a positive and lasting impact on the patient and the family, serving as an impetus for forward momentum in recovery and a greater sense of ownership and authority in overall well-being. As illustrated by Mr CHF's case, successful discharge requires more than resolving acute medical issues—it demands early identification of barriers, clear and consistent communication, and active engagement with both patients and families. Empowerment comes from equipping patients and caregivers with knowledge, resources, and confidence, while ensuring that each member of the multidisciplinary team delivers a unified message with intent. By prioritizing education, alignment, and patient-centered communication from admission through discharge, we can reduce readmissions, strengthen trust, and improve long-term outcomes. Ultimately, empowering patients and families during hospitalization and at time of discharge is not an adjunct to care; it is central to achieving safe, effective, and compassionate healing beyond the hospital walls.

CLINICS CARE POINTS

- Prioritizing and optimizing effective communication can help mitigate eroded patient trust and facilitate positive patient–provider interaction.
- Quality communication involves discussion about the treatment plan but also the expected impact on quality of life beyond the hospital.
- The point of admission offers an ideal opportunity to establish patient education and communication as strategic priorities for the hospital stay, while setting clear, shared expectations for the course of care.
- Interdisciplinary communication is critical and must be carefully aligned. Communication can be optimized by standardizing consistent, clear verbiage across all disciplines.
- Hospital discharge is more than an administrative task of finalizing orders and prescriptions; it is a complex, interdisciplinary process that requires proactive planning, resource identification and coordination, and collaboration across the inpatient team and, ideally, outpatient providers.

DISCLOSURE

The authors have no disclosures.

REFERENCES

1. Mechanic D. Changing medical organization and the erosion of trust. Milbank Q 1996;74(2):171–89. PMID: 8632733.
2. Goold SD. Money and trust: relationships between patients, physicians, and health plans. J Health Polit Policy Law 1998;23(4):687–95.
3. Asan O, Yu Z, Crotty BH. How clinician-patient communication affects trust in health information sources: temporal trends from a national cross-sectional survey. PLoS One 2021;16(2):e0247583.
4. Griffith DM, Bergner EM, Fair AS, et al. Using mistrust, distrust, and low trust precisely in medical care and medical research advances health equity. Am J Prev Med 2021; 60(3):442–5. Epub 2020 Nov 15. PMID: 33208267; PMCID: PMC7902381.

5. Ye P, Liu L, Tan J. Influence of leadership empowering behavior on employee innovation behavior: the moderating effect of personal development support. Front Psychol 2022;13:1022377. PMID: 36600721; PMCID: PMC9806223.
6. Lockwood C, Mabire C. Hospital discharge planning: evidence, implementation and patient-centered care. JBI Evid Synth 2020;18(2):272–4. PMID: 32229736.
7. Konczak LJ, Stelly DJ, Trusty ML. Defining and measuring empowering leader behaviors: development of an upward feedback instrument. Educ Psychol Meas 2000;60:301–13.
8. Vecchio RP, Justin JE, Pearce CL. Empowering leadership: an examination of mediating mechanisms within a hierarchical structure. Leadersh Q 2010;21:530–42.
9. Kaslow NJ, Dunn SE, Henry T, et al. Collaborative patient- and family-centered care for hospitalized individuals: best practices for hospitalist care teams. Families. Systems, & Health 2020;38(2):200–8.
10. Dhaliwal JS, Dang AK. Reducing hospital readmissions. In: StatPearls. Treasure Island (FL): StatPearls Publishing; 2025 [Updated 2024 Jun 7].
11. Panahi S, Spearman B, Sundrud J, et al. The impact of patient autonomy among uninsured free clinic patients. Journal of Patient Experience 2023;10. https://doi.org/10.1177/23743735231179041.
12. Mamedova S, Pawlowski E. NCES data point: adult literacy in the United States. Data point United States department of education national center for education statistics. 2019. Available at: https://nces.ed.gov/pubs2019/2019179/index.asp. Accessed December 29, 2023.
13. John-Baptiste A, Naglie G, Tomlinson G, et al. The effect of English language proficiency on length of stay and in-hospital mortality. J Gen Intern Med 2004;19(3):221–8. PMID: 15009776; PMCID: PMC1492154.
14. Tucker CA. Promoting personal health literacy through readability, understandability, and actionability of online patient education materials. J Am Heart Assoc 2024;13(8):e033916. Epub 2024 Apr 3. PMID: 38567677; PMCID: PMC11262515.
15. Zeng J, Gao Y, Hou C, et al. The impact of doctor-patient communication on medication adherence and blood pressure control in patients with hypertension: a systematic review. PeerJ 2024;12:e18527. PMID: 39619180; PMCID: PMC11608562.
16. Boyde M, Peters R, New N, et al. Self-care educational intervention to reduce hospitalisations in heart failure: a randomised controlled trial. Eur J Cardiovasc Nurs 2018;17(2):178–85.
17. Schooley B, Singh A, Hikmet N, et al. Integrated digital patient education at the bedside for patients with chronic conditions: observational study. JMIR mHealth uHealth 2020;8(12):e22947. PMID: 33350961; PMCID: PMC7785403.
18. Han TS, Murray P, Robin J, et al. Evaluation of the association of length of stay in hospital and outcomes. Int J Qual Health Care 2022;34(2).
19. Brown AE, Press VG, Meltzer DO. Association of health confidence with hospital length of stay and readmission. J Hosp Med 2024;19(9):794–801. Epub 2024 May 16. PMID: 38751348.
20. Chen Y, Almirall-Sánchez A, Mockler D, et al. Hospital-associated deconditioning: not only physical, but also cognitive. Int J Geriatr Psychiatry 2022;37(3):10.
21. Silver AM, Goodman LA, Burton M, et al. Optimizing discharge summaries: a survey of inpatient clinician perspectives and the path to standardization. J Gen Intern Med 2025. https://doi.org/10.1007/s11606-025-09740-y.
22. Silver AM, Goodman LA, Chadha R, et al. Optimizing discharge summaries: a multispecialty, multicenter survey of primary care clinicians. J Patient Saf 2022;18(1):58–63. PMID: 33395016.

23. Robelia PM, Kashiwagi DT, Jenkins SM, et al. Information transfer and the hospital discharge summary: national primary care provider perspectives of challenges and opportunities. J Am Board Fam Med 2017;30:758–65.
24. Snow V, Beck D, Budnitz T, et al. J Hosp Med 2009;4(6):364–70.
25. Pirmohamed M, James S, Meakin S, et al. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. BMJ 2004;329-(7456):15–9.
26. Stedge B, Xu J, Kubes JN, et al. Meds to beds at hospital discharge improves medication adherence and readmission rates in select populations. South Med J 2023;116(3):247–54.
27. McAlister FA, Youngson E, Kaul P, et al. Early Follow-Up after a heart failure exacerbation: the importance of continuity. Circ Heart Fail 2016;9(9):e003194. PMID: 27618853.
28. Mekonnenn AB, McLachlan AJ, Brien JA. Pharmacy-led medication reconciliation programmes at hospital transitions: a systematic review and meta-analysis. J Clin Pharm Ther 2016;41(2):128–44. Epub 2016 Feb 23.
29. Branowicki PM, Vessey JA, Graham DA, et al. Meta-analysis of clinical trials that evaluate the effectiveness of hospital initiated post-discharge interventions on hospital readmissions. J Healthcare Quality 2017;39(6):354–66.
30. Hoyer EH, Brotman DJ, Apfel A, et al. Improving outcomes after hospitalization: a prospective observational multicenter evaluation of care coordination strategies for reducing 30 day readmissions to Maryland hospitals. J Gen Intern Med 2018;33:621–7.