

ELIMINATE HARM ACROSS THE BOARD

Days Since Last Readmission

READMISSIONS PREVENTION:

- Conduct enhanced admission assessment of discharge needs and begin discharge planning at admission
- Conduct formal risk of readmission assessment; align interventions to patient's needs and risk stratification level
- Perform accurate medication reconciliation at admission, at any change in level of care and at discharge
- Provide patient education that is culturally sensitive, incorporates health literacy concepts and includes information on diagnosis and symptom management, medications and post-discharge care needs
- Identify primary caregiver, if not the patient, and include him/her in education and discharge planning
- Use teach-back to validate patient and caregiver's understanding
- Send discharge summary and after-hospital care plan to primary care provider within 24 to 48 hours of discharge
- Collaborate with post-acute care and community-based providers including skilled nursing facilities, rehabilitation facilities, long-term acute care hospitals, home care agencies, palliative care teams, hospice, medical homes, and pharmacists
- Before discharge, schedule follow-up medical appointments and post-discharge tests/labs; for patients without a primary care physician, work with health plans, Medicaid agencies and other safety-net programs to identify and link patient to a PCP
- Conduct post-discharge follow-up calls within 48 hours of discharge; reinforce components of after-hospital care plan using teach-back and identify any unmet needs, such as access to medication, transportation to follow-up appointments, etc.

