



# Reducing Potentially Preventable Readmissions (PPRs)

# **Top Evidence-Based Strategies**

## **Enhanced Admission Assessment**

Conduct an enhanced admission assessment of discharge needs and begin discharge planning upon admission.

#### **Readmission Risk Assessment**

Conduct a formal readmission risk assessment. Align interventions to patient's needs and risk stratification level.

#### **Enhanced Medication Reconciliation**

Perform medication reconciliation at time of admission, changes in level of care, and at time of discharge.

## **Comprehensive Patient Education**

Provide patient education that is culturally sensitive and incorporates health literacy concepts. Include information on diagnosis and symptom management, medications, and post-discharge care needs.

## **Caregiver Identification/Engagement**

Identify primary caregiver, if not the patient, and include him/her in education and discharge planning.

#### **Teach-Back Method**

Use teach-back to validate patient and caregiver's understanding.

## **Post-Discharge Follow-Up Appointments**

Before discharge, schedule follow-up medical appointments and arrange for post-discharge tests/labs. For patients without a primary care physician (PCP), work with health plans, Medicaid agencies, and other safety-net programs to link patient to PCP.

## Post-Discharge Follow-Up Calls

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 appointment, etc.

# **Timely Discharge Summaries**

Send discharge summary and after-hospital care plan to the primary care provider within 24 to 48 hours of discharge.

### **Collaboration with Downstream Providers**

Collaborate with post-acute care and community-based providers to ensure continuity of care.

**Source:** Health Research & Educational Trust. *Preventable Readmissions Change Package: 2015 Update.* Chicago, IL. Health Research & Educational Trust. Dec 2015. https://www.aha.org/sites/default/files/hiin/HRETHEN ChangePackage Readmissions.pdf

This material was prepared by Health Services Advisory Group (HSAG), a Quality Innovation Network-Quality Improvement Organization (QIN-QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. QN-12SOW-XC-12212021-05