The Roadmap to Success:

Hospital Readmissions

Preparing for Your Journey

Any successful journey begins with planning and preparation. Three key areas should be addressed before beginning any quality improvement or patient safety initiative.

Leadership Commitment

The success of a project can be determined by the level of commitment and support from leadership. It is important for hospital leaders to communicate a consistent, frequent message in support of the project. The executive project champion can establish accountability, dedicate resources, and break through barriers.

Project Champion

It is important to have a person(s) who is a significant influence with frontline staff, physicians, and other key personnel. Frequently, one thinks of physicians as champions since they are instrumental in garnering provider buy-in and practice change. However, depending on the project, it can be any key personnel with the authority and skills to influence change, lead by example, and assist in essential messaging of the goals and vision for a project.

Multidisciplinary Project Team

The project team should consist of representatives from key areas throughout your facility with the skills, knowledge, and experience in their fields of expertise. A team member should possess strong communication skills, have a collaborative mindset, and show a commitment to change. It is vital to **have representation from frontline staff who will be impacted most by the change**. It is also important to keep the size of your team manageable. Remember, a team can have ad hoc members whose roles are to provide expertise in a specific area for a short period of time.

Know Your Readmitted Patients—Step 1

Rationale:

Determining the causes of readmissions will reveal gaps in care that patients are experiencing. Use this information to improve care transition practices and delivery of care by developing process improvement projects surrounding your findings. Readmissions to the hospital within seven days of discharge are common, and many of those readmissions can be attributed to failures in post-discharge communication, planning, and follow-up.[1]

	Strategies	Tools and Resources
☐	Review your data. Understand your readmitted population by performing a "5 whys" analysis for each case.	• Guidance for Performing Root Cause Analysis (RCA) with Performance Improvement Projects (PIPs): https://www.cms.gov/medicare/provider-enrollment-and-certification/qapi/downloads/guidanceforrca.pdf • Implementing Care Transitions Teams to Mitigate Hospital Readmissions: https://pmc.ncbi.nlm.nih.gov/articles/PMC10265694/ • Hospital Readmission From Post-Acute Care Facilities: Risk Factors, Timing, and Outcomes: https://pmc.ncbi.nlm.nih.gov/articles/PMC4847128/ • Home Health Care Reducing Readmissions Toolkit: https://quality.allianthealth.org/wp-content/uploads/2024/01/Home-Health-Care-Reducing-Readmissions-Toolkit-FLHA-Co-Brand_508.pdf • Social Determinants of Health: https://www.cdc.gov/about/priorities/why-is-addressing-sdoh-important.html • Guide for Reducing Disparities in Readmissions: https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf • Transitions of Care Standard 2.0: https://transitionsofcare.org/standards/standard-2/ • Rapid (7-day) Readmissions to Inpatient Medical Service at a Tertiary Academic Medical Center: https://pmc.ncbi.nlm.nih.gov/articles/PMC11878884/
☐	To develop process improvements, track and trend: • High-utilizer status. • Readmissions source (nursing home, home health, or home with or without assistance). • Unmet needs (undelivered durable medical equipment, delay or non-arrival of home health services, etc.) of those who have been readmitted. • Social determinants of health, as defined by the World Health Organization, are the conditions in which people are born, grow, live, work and age. They may include financial or economic limitations, poor health, literacy, and more. • Patients readmitted within seven days.	

1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128446/
https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf

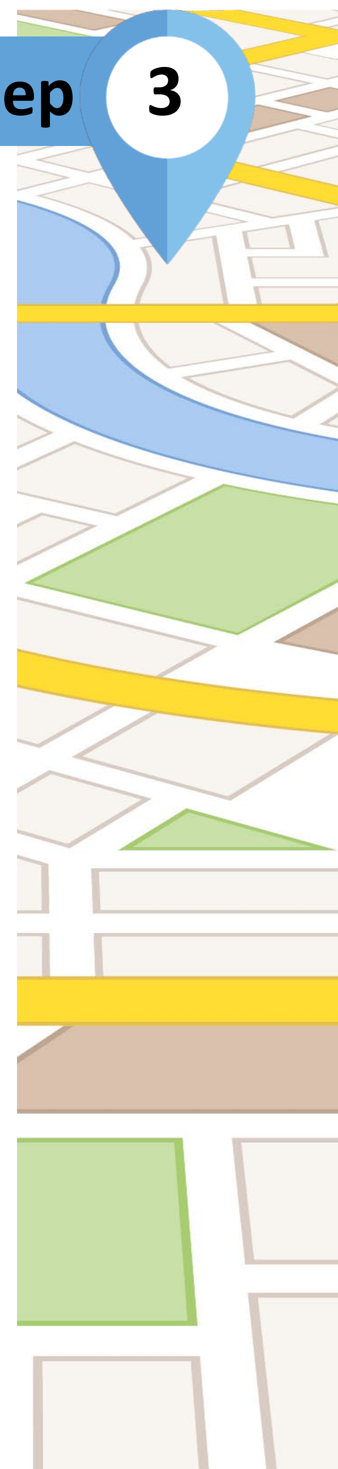
Engage All in Care Transitions Improvement—Step 2

Rationale:
Assessment and management of high-risk patients are complex, multi-process, multi-role activities that require consistent, systemic vigilance; evaluation; and communication across care units and settings. A multidisciplinary task force establishes shared responsibility and opens lines of communication.[2]

	Strategies	Tools and Resources
☐	Set up and maintain a multidisciplinary task force concentrating on improving care transitions with defined goals and structure. • Include post-acute partners in the task force to facilitate collaboration and open lines of communication across settings. • Set both a goal and a stretch goal for reducing readmissions within a defined period of time. • Conduct a community inventory of available resources to address health disparities in your community. • Report progress to stakeholders regularly. • Celebrate success, large or small.	• Partnership with Post Acute Care Providers: https://paanalytics.com/building-successful-partnerships/ • Community Pharmacist-Led Service to Facilitate Care Transitions and Reduce Hospital Readmissions (access required): https://www.sciencedirect.com/science/article/pii/S1544319117308567 • Project BOOST® (Better Outcomes for Older Adults through Safe Transitions) Implementation Guide: https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf • Chronic Care Management: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

2 https://www.ahrq.gov/sites/default/files/publications/files/redtoolkit.pdf

Assess Risk for Readmissions During the Hospital Stay—Step 3



Rationale:

Reduce the probability for subsequent rehospitalization by focusing on transitional interventions for those identified as high risk for readmission based on associated factors. Causes of readmissions are often related to unmet social factors, which impact an individual's health.[3] Addressing gaps in patient and caregiver preparedness during hospitalization is crucial to mitigate barriers and invoke confidence in a safe and appropriate plan of care prior to discharge.[4]

	Strategies	Tools and Resources
☐	Use tools to help identify those who are at risk for readmission and may need additional support following discharge. • 8Ps BOOST tool (problem with meds, psychological, principal diagnosis, physical limits, poor health literacy, patient support, prior hospitalization, and palliative care) • Project RED (Re-engineered Discharge) toolkit • LACE score (Length of stay, Acuity of admission, Co-morbidities, number of Emergency department visits)	• The 8Ps BOOST Screening Tool Identifying Your Patient's Risk for Adverse Events After Discharge: https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/8ps_riskassess-1.pdf • Project RED Toolkit: https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html • LACE Index Scoring Sheet: https://www.albertahealthservices.ca/frm-21046.pdf • PRAPARE (Protocol for Responding to and Assessing Patient's Assets, Risks, and Experiences): Implementation and Action Toolkit: https://prapare.org/wp-content/uploads/2021/10/Full-Toolkit.pdf • Post-Hospital Syndrome—A Condition of Generalized Risk: https://pmc.ncbi.nlm.nih.gov/articles/PMC3688067/ • Discharge Planning Assessment Tool: https://www.myamericannurse.com/discharge-planning-assessment-tool/ • Discharging Planning and Transitions of Care: https://psnet.ahrq.gov/primer/discharge-planning-and-transitions-care • Your Discharge Planning Checklist: https://www.medicare.gov/publications/11376-your-discharge-planning-checklist.pdf
☐	Use an embedded electronic health record risk assessment that evaluates social determinants of health to comprehensively coordinate care for high-risk patients. Refer patients to pertinent community organizations based on their individual social determinant needs.	
☐	Assess the patients' potential for post-discharge risk for falls, adverse drug events (ADEs), disease-process exacerbation, etc., with family/caregivers once they are discharged.	
☐	Provide educational materials and discharge instructions in the patients' primary language that include: importance of follow-up monitoring, compliance, drug-food interactions, and potential for ADEs.	

3 https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5018668/
https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf
https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/8ps_riskassess-1.pdf

4 https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf

Create a Post-Discharge and Transition Plan—Step 4

Care Continuum and Coordination Planning

Rationale:

Enhancing patient activation and engagement in decision-making increases patient and family participation, ownership, and empowerment of a treatment and discharge plan. Initiating education upon admission prepares the patient and/or family to care for his or her condition prior to discharge.[5] Addressing gaps in patient and caregiver preparedness during hospitalization is crucial to mitigate barriers and invoke confidence in a safe and appropriate plan of care prior to discharge.[6]

	Strategies	Tools and Resources
☐	Begin transition planning upon admission on day 1.	• Discharge Planning and Transitions of Care: https://psnet.ahrq.gov/primer/discharge-planning-and-transitions-care • Impact of Discharge Rounds on Patient Flow and Hospital Outcomes: https://pmc.ncbi.nlm.nih.gov/articles/PMC12433610/ • Patient PASS (Preparation to Address Situation [after discharge] Successfully): https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/pass-3.pdf • Assessing the Impact of Adding Pharmacist Management Services to an Existing Discharge Planning Program on 30-Day Readmissions: https://www.sciencedirect.com/science/article/abs/pii/S1544319121005525 • Reducing Hospital Readmissions: https://www.ncbi.nlm.nih.gov/books/NBK606114/
☐	Hardwire multidisciplinary rounds into the care planning process to comprehensively address the needs and goals of the patients and families.	
☐	Ensure patients understand their condition and are empowered to care for themselves. • Ask patients to assess the effectiveness of the discharge plan in facilitating understanding.	
☐	For high-risk medications (anticoagulants, opioids, and diabetic agents), engage pharmacists to educate patients, verifying patient comprehension using an evidence-based methodology.	
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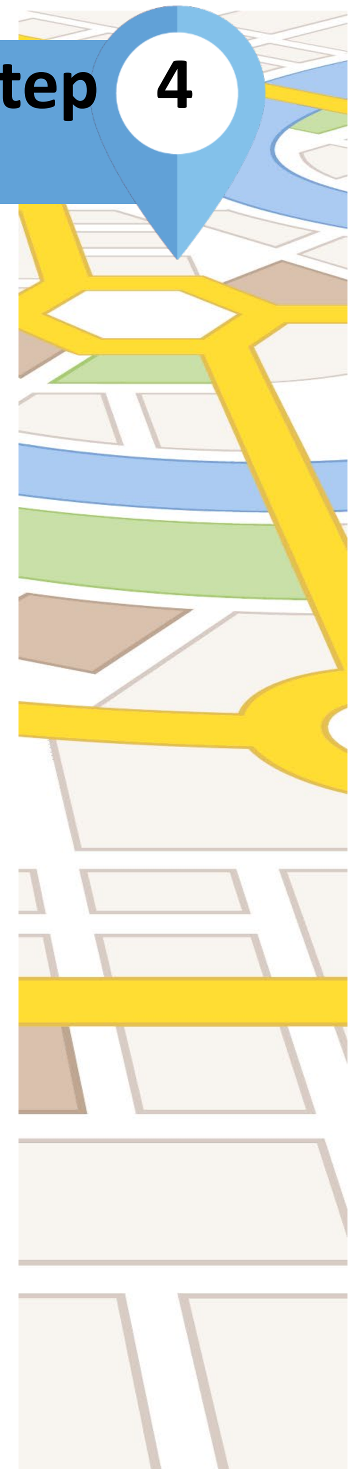
5 https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5734517/
https://www.ncbi.nlm.nih.gov/pubmed/29395026
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3912296

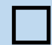
6 https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html

Create a Post-Discharge and Transition Plan—Step 4

Care Continuum and Coordination Planning (cont.)



	Strategies	Tools and Resources

	*(Continued from previous page)*
	
	When patients meet high readmission-risk criteria, focus customized care coordination efforts on:
	• Social determinants of health.
	  – Financial barriers, transportation, food insecurities, social isolation, housing, safety, etc.
	• Patient-centered care planning that addresses potential transitional barriers.
	  – Continual process customized for each patient focusing on optimal outcomes while including the patient, family, and caregivers in decision-making.
	• Complex care needs using intensive case management.
	  – Access to specialized nurses and other resources that can assist in better managing health and care coordination throughout the care continuum.
	    ○ Dietitians, clinical pharmacists, behavioral therapists, etc.
		• Preventing Drug-Related Adverse Events Following Hospital Discharge—The Role of the Pharmacist: https://pmc.ncbi.nlm.nih.gov/articles/PMC5774326/
		
		• Social Determinants of Health: The Impact of This Overlooked Vital Sign: https://pmc.ncbi.nlm.nih.gov/articles/PMC12224330/
		
		• Use and Effectiveness of the Teach-Back Method in Patient Education and Health Outcomes: https://pmc.ncbi.nlm.nih.gov/articles/PMC6590951/
		
		• Teach-Back Competency Guide: http://higherlogicdownload.s3.amazonaws.com/HEALTHLITERACYSOLUTIONS/b33097fb-8e0f-4f8c-b23c-543f80c39ff3/UploadedImages/docs/Teach_Back_-_10_Elements_of_Competence.pdf

Follow Up and Monitor Patient After Discharge—Step 5

Post-Acute Care Coordination and Communication

Rationale:

Readmission rates are usually the highest from skilled nursing facilities (approximately 25 percent). Building and maintaining successful partnerships with post-acute providers requires effective communication, collaboration, and commitment to reduce readmissions and improve patient outcomes.[7]

	Strategies	Tools and Resources
☐	When patients are discharged to post-acute providers, use standardized communication routes and bi-directional feedback to communicate about high-risk and/or recently discharged/readmitted patients. • Perform a warm hand-off or SBAR (Situation, Background, Assessment, Recommendation) with post-acute providers to review transition plans. • Coordinate monthly calls with post-acute settings to discuss challenges, successes, and opportunities for improvement. • Conduct a root cause analysis on all readmissions from post-acute settings. • Confirm with outpatient providers that they have received transition plans, including discharge summaries and pertinent tests. • Alert post-acute providers of any outstanding results of tests or procedures.	• Patient PASS—A Transition Record: https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/pass-3.pdf • Communication During Transitions of Care: https://psnet.ahrq.gov/perspective/communication-during-transitions-care • Exploring Transitional Care: Evidence-Based Strategies for Improving Provider Communication and Reducing Readmissions: https://pmc.ncbi.nlm.nih.gov/articles/PMC4606859/ • Hospital Readmission for Post-Acute Care Facilities: Risk Factors, Timing, and Outcomes: https://pmc.ncbi.nlm.nih.gov/articles/PMC4847128/
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7 https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf

Follow Up and Monitor Patient After Discharge—Step 5

Post-Acute Care Coordination and Communication (cont.)

	Strategies	Tools and Resources
	Continued from previous page) When patients are discharged home: • Confirm the correct phone number for contacting the patient post-discharge. • Implement a 24/7 telehealth program. • Use telehealth to increase access to medically underserved areas and patients; take into account patients with limited mobility. • Use telehealth for high-risk patients, including daily monitoring of vitals and following up when monitoring indicates abnormal vitals. • Partner with home health agencies that collaborate in reducing readmissions. • Schedule the primary care provider appointment for the patient instead of giving him or her an appointment card or asking them to do it themselves. • Ensure patients have the means to arrive at follow-up appointments.	• The Benefits of Telehealth for Post-Discharge Care: https://openloophealth.com/blog/the-benefits-of-telehealth-for-post-discharge-care • Revolutionizing Healthcare: How Telemedicine Is Improving Patient Outcomes and Expanding Access to Care: https://pmc.ncbi.nlm.nih.gov/articles/PMC11298029/ • AHRQ Post Discharge Follow-up Script: https://www.ahrq.gov/patient-safety/settings/hospital/hai/red/toolkit/redtool5.html • California Health Care Foundation (CHCF) Post Hospital Follow-up Visit (Eric Coleman): https://www.chcf.org/wp-content/uploads/2017/12/PDF-PostHospitalFollowUpVisit.pdf

Your Final Destination

Now that you have reached your destination, it is important that your efforts are not futile. One of the most challenging aspects of quality improvement and change is sustaining the gains. These key tactics will help you ensure ongoing success.

Ensuring Your Process Is Stable

Most projects involve monitoring of both process and outcome measures. These data play an important role in identifying when you have achieved change. It is important to review your data to identify and address special cause variation; recognize positive trend changes (six to eight data points at or above goal); and achieve predictable, consistent results.
Remember: *"Every system is perfectly designed to get the results it gets."*—W.E. Deming

Control Plan/Sustainability Plan

A control or sustainability plan is a method for documenting the key elements of quality control that are necessary to ensure that process changes and desired outcomes will be maintained. At a minimum, this plan should include ongoing monitoring of process steps that are critical to quality, frequency of monitoring, sampling methodology, and corrective actions if there is noted variation.

Project Hand-Off

Depending on the size of your facility and resources that are available, it may be necessary to hand off your project to a "process owner." A process owner is a person or department responsible for monitoring a process and sustaining the changes according to the control or sustainability plan. The person or department should be the entity that will most significantly experience the gains of the improved process or project.

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