READMISSIONS Key Driver Diagram Project Leader: _____ Date: ___/___/___

SMART AIM

Reduce hospital readmissions by 20 percent compared to the 2010 baseline by Dec. 8, 2014

GLOBAL AIM

KEY DRIVERS

- Patients at risk for readmission
- Self-management skills
- Coordination of information across the continuum
- Adequate follow-up and community resources
- Patient and Family Education

INTERVENTIONS

- ✓ Use an easy risk assessment tool and validate it using your own data
- ✓ Use risk assessment findings to stratify/identify patients' intervention group such as high/low risk and assign health coach to high-risk patients.
- ✓ Find primary caregiver and include them in the discharge plan.
- ✓ Communicate who the caregiver is to members of the health care team and use white board, chart special entry, etc., so there is a standard communication method.

- ✓ Perform medication reconciliation at admission and discharge to ensure accuracy.
- ✓ Educate patients on method for obtaining and taking medication once discharged.
- ✓ Involve pharmacy in medication reconciliation process
- ✓ Train clinical staff on teach-back using role pay and script specific teach-back questions
- ✓ Use "I" statements when speaking with patient and caregiver
- ✓ Involve patients and families in developing patient education materials

- ✓ Prior to leaving hospital, incorporate after-hospital resources and appointments in an after-care plan.
- ✓ Create a concise, standardized discharge form
- ✓ Work with SNF/nursing home to create concise transfer form
- ✓ Obtain accurate information about primary care physician at the time of admission and send completed discharge summary to post care provider/PCP within 72 hours of discharge.

- ✓ Schedule follow-up appointments with PCP within 7 days of discharge and do post discharge follow-up calls with patients within 24-72 hours.
- ✓ Work with patient and care providers to determine barriers to making and attending follow-up appointment(s)
- ✓ For those patients who are at the highest risk of readmission, consider home health and telehealth referrals, and home visits.
- ✓ Develop partnerships with community networks such as health ministry, pharmacies etc.,

- ✓ Hold a meeting to solicit advice and support from the community on how to reduce readmissions
- ✓ Convene a group of patients and caregivers to review educational materials before they are disseminated
- ✓ Train clinical staff on teach-back using role pay and script specific teach-back questions for staff