Five Key Areas Known to Reduce Potentially Preventable Readmissions (PPRs)

Your organization and others across the care continuum are called upon to focus on five key areas known to reduce PPRs. By implementing and spreading these best practices, organizations can become more effective—more rapidly—in reducing PPRs. You may choose to work on any of the following five key areas based on the priority area identified by your organization:

1. **Comprehensive discharge planning**—Focus on ensuring that all of a patient's needs are considered and included in a comprehensive discharge plan, with input from the patient and family. Interventions may consist of written, visual, or recorded discharge plans that include and consider follow-up appointments, medications, nutritional needs, family support, transportation, health literacy, knowing whom to call, social problems, and red flags. Use complex case management to support super-utilizer (five or more emergency department visits and/or four or more admissions) visits using a patient-centered care approach. Develop a high-readmission risk criterion to address further barriers.
2. **Medication management**—Focus on improving the use of medications for the patient's condition and ensuring that the patient understands the purpose of the medications and is taking them in the correct manner at the correct time. Interventions may include medication reconciliation, patient/family education on medications, medication therapy management, and medication set-up simulations for the patient/family.
3. **Patient and family engagement**—Focus on ensuring that processes are in place to engage patients/family, elevate the status of family caregivers as essential members of the team, and prepare the patient and family to manage care at home. Interventions may include such methodologies as teach-back, collaborative conversations and communication, and simulations with the patient and family members.
4. **Transition care support**—Focus on ensuring that transition plans are in place and followed so that the patient's care is coordinated between one caregiver and another. Interventions may include the role of care coach, transition coordinator, and post-transition follow-up care.
5. **Transition communications**—Focus on ensuring that effective communication occurs between sending and receiving caregivers (e.g., hospital, emergency department, home care, home, primary/specialty care, skilled nursing facility or rehab). Interventions may include processes for transferring information, providing discharge summaries in a timely manner, defining accountability for care, communicating the plan of care, methods for talking directly with sending or receiving caregivers, and specifying key information—which may include current health status, follow-up needs, pending test results, red flags, medications, and special patient needs.

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