



Goal: Prevention of 30-day Readmissions

Strategy: Ensure core processes are in place to prepare patient, family, and post-acute care partners for successful post-hospital transition.

Tactics	Tasks	Tools
1. Establish and maintain core processes	Maintain a multidisciplinary task force for ongoing monitoring and evaluation of readmission reduction strategies and progress toward the goal	<ul style="list-style-type: none"> • HSAG HQIC Readmissions Reduction Diagram • HSAG HQIC Readmissions Resources Fishbone
2. Conduct data analysis and patient interviews	Review: <ul style="list-style-type: none"> • Readmission trend analysis, using HSAG HQIC data reports (Readmissions/Secure Data Portal Dashboard) • Internal concurrent data • Readmitted patient charts and conduct patient interviews 	<ul style="list-style-type: none"> • HSAG HQIC Secure Data Portal
3. Ensure basic discharge process elements are complete	<ul style="list-style-type: none"> • Conduct readmissions risk analysis (LACE)¹ • Ensure durable medical equipment is ordered and delivered • Make and communicate date and time for medical doctor follow-up appointment • Ensure contact is made with patient within 72 hours post-discharge (call or visit) 	<ul style="list-style-type: none"> • Modified LACE Tool
4. Use patient/family teach-back method	Ensure understanding of: <ul style="list-style-type: none"> • Reason for hospitalization • Medical condition(s) management • Medication use and address expectations/side effects 	<ul style="list-style-type: none"> • Teach-Back Starter Sentences • Hospital Teach-Back Training Slides
5. Collaborate with post-acute providers	Partner with: <ul style="list-style-type: none"> • Local skilled nursing facilities (SNFs)/acute rehab to optimize collaboration and communication • Local home health (HH) agencies to optimize collaboration and communication • Primary care physicians and clinic to establish protocol to accommodate hospitalized patients for follow-up appointments within one week 	<ul style="list-style-type: none"> • SNF Re-Hospitalization Risk Assessment • HH Partner Assessment Tool 72 hour/7-day
6. Activate patient/family participation to optimize health	<ul style="list-style-type: none"> • Evaluate support system • Address health literacy • Address social determinants 	<ul style="list-style-type: none"> • Readmissions Interview Tool • Health Literacy: A Prescription to End Confusion

1. Length of stay, Acuity of admission, Comorbidities, Emergency department visit in the past six months (LACE)