10 STEPS FOR YOUR READMISSION REDUCTION PROGRAM

A patient’s care doesn’t end when they’re discharged from the hospital; the true continuum of care extends into the patient’s daily life at home and in the community.

1. Call the patient within two days of discharge.
3. Frontload homecare and ensure patient “touches.”
4. Conduct a home safety evaluation.
5. Install durable medical equipment prior to discharge.
6. Order an emergency alert/medication reminder system and preprogram phone numbers.
7. Implement fall prevention program, intervention, and education.
8. Provide in-home education on new diagnoses or unmanaged chronic conditions.
9. Connect the patient with community resources.
10. Establish a best practice for follow-up phone calls after discharge.