Readmission Prevention Guide

Hospital readmissions within 30 days of discharge often indicate gaps in care coordination, inadequate discharge planning, or insufficient home support.

Preventing readmissions is not just a clinical responsibility but a strategic imperative for agencies.

Evidence-Based Strategies for Readmission Prevention

Research identifies several interventions proven to reduce readmissions:

1. **Timely Follow-Up**
    - First home visit within 24–48 hours of discharge significantly lower risk.
2. **Medication Management**
    - CMS reports medication errors as a leading cause of readmission. Reconciliation and education are essential.
3. **Client and Family Education**
    - Use of teach-back methods ensures understanding of care plans.
4. **Risk Stratification**
    - Identifying high-risk patients (CHF, COPD, diabetes, polypharmacy) allows agencies to target resources.
5. **Care Coordination**
    - Communicating with physicians, hospitals, and pharmacies to ensure continuity.
6. **Red-Flag Symptom Monitoring**
    - Early detection of worsening symptoms (e.g., CHF weight gain, COPD shortness of breath) triggers interventions before escalation.

Sample (Readmission Prevention Workflow)

Step 1: Hospital Discharge Transition

☐ Receive discharge summary from hospital
☐ Verify care plan, medications, and pending tests
☐ Schedule first home visit within 24–48 hours

Step 2: Intake & Initial Home Visit

☐ Conduct comprehensive assessment (risk screening)
☐ Identify high-risk clients (CHF, COPD, diabetes, recent falls, ≥5 medications)
☐ Perform medication reconciliation and create medication list
☐ Educate client/family using teach-back method

Step 3: Daily Monitoring and Communication

☐ Track vitals (BP, HR, O_2 sat, weight) and symptoms
☐ Document in Home Care Management app and flag changes
☐ Notify physician or nurse supervisor of red-flag signs
☐ Reinforce self-management strategies (diet, hydration, mobility)

Step 4: Multidisciplinary Coordination

☐ RN communicates weekly with PCP or hospital follow-up team
☐ Social worker addresses psychosocial needs (transportation, food insecurity)
☐ Therapy staff ensure safe mobility and environment modification

Step 5: Ongoing Education & Engagement

☐ Encourage adherence to follow-up appointments
☐ Use motivational interviewing to improve compliance

Step 6: 30-Day Follow-Up and Evaluation

☐ Track hospitalization events within 30 days
☐ Review outcomes
☐ Update care plan with care team and adjust workflows based on findings

Example Readmission Prevention Checklist

Client Name: _____ Date: _____

- ***Discharge plan reviewed?*** *☐ Yes ☐ No*
- ***Medication reconciliation completed?*** *☐ Yes ☐ No*
- ***High-risk conditions identified?*** *☐ CHF ☐ COPD ☐ Diabetes ☐ Other: _____*
- ***Home visit completed within 48 hours?*** *☐ Yes ☐ No*
- ***Vital signs monitored daily?*** *☐ Yes ☐ No*
- ***Red-flag symptoms identified and reported?*** *☐ Yes ☐ No*
- ***Education documented (teach-back used)?*** *☐ Yes ☐ No*
- ***Care coordination contacts logged?*** *☐ Yes ☐ No*
- ***Client readmitted within 30 days?*** *☐ Yes ☐ No*