RARE Reducing Avoidable Readmissions Effectively

Typical Failures in Hospital Discharge Planning

Medication Management

- Medication errors and adverse drug events
- Multiple drugs exceed patient's ability to manage
- Medication reconciliation does not align with medications patient is taking when patient arrives home
- New medications not available on discharge, patient may have difficulty filling in timely manner

Transition Care Support

- No follow-up appointment, or follow-up needed with additional provider expertise
- Follow-up too long after hospitalization
- Believe follow-up is solely the responsibility of the patient
- Inability to keep follow-up appointments because of illness or transportation issues
- Lack of an emergency plan, including telephone number the patient should call first
- Multiple care providers; patient believes someone is in charge

Patient and Family Engagement

- Failure to actively include the patient and family caregivers in identifying needs and resources, and planning for the discharge
- Unrealistic optimism of patient and family to manage at home
- Lack of understanding of the patient's physical and cognitive functional health status that may result in a transfer to a care setting that does not meet the patient's needs
- Multiple drugs exceed patient's ability to manage
- Patient/family failure to ask clarifying questions on instructions and plan of care
- The care provided by the facility unravels as the patient leaves the hospital (i.e., poorly understood cognition issues emerge)
- Multiple care providers; patient believes someone is in charge
- Patient lack of adherence to self-care, (e.g., medications, therapies, daily weights, or wound care) because of poor understanding or confusion about needed care, transportation, how to schedule appointments, or how to obtain or pay for medications

Comprehensive Discharge Planning

- Failure to actively include the patient and family caregivers in identifying needs, resources, and planning for the discharge
- Failure to recognize worsening clinical status in the hospital
- Lack of understanding of the patient's physical and cognitive functional health status that may result in a transfer to a care setting that does not meet the patient's needs
- Not addressing whole patient (underlying depression, etc.)
- No advance directive or planning beyond do not resuscitate status
- Assuming the patient is the key learner
- No follow-up appointment, or follow-up needed with additional provider expertise
- Written discharge instructions that are confusing, contradictory to other instructions, or not tailored to a patient's level of health literacy or current health status
- Poor understanding that social support is lacking
- Lack of an emergency plan, including telephone number the patient should call first
- Patient returns home without essential equipment (e.g., scale, supplemental oxygen, or equipment used to suction respiratory secretions)

Transition Communications

- Poor documentation of hospital care (evidence-based care missing or incomplete)
- Medication discrepancies
- Discharge plan not communicated in a timely fashion, or not adequately conveying important anticipated next steps
- Poor communication of the care plan to the nursing home team, home health care team, primary care physician, or family caregiver
- Current and baseline functional status of patient rarely described, making it difficult to assess progress and prognosis
- Discharge instructions missing, inadequate, incomplete, or illegible
- Patient returning home without essential equipment (e.g., scale, supplemental oxygen, or equipment used to suction respiratory secretions)

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