medisolv Readmissions Prevention Checklist

Sample Interventions

These interventions are sample guidelines a hospital could use to initiate a readmissions prevention program. These scores are derived from the LACE index methodology. For more information on this methodology, check out our blog: http://blog.medisolv.com/readmission-prevention-checklist-download

Score 0-4 — 2% – 4.3 % Chance of Readmission

- ❑ Normal discharge planning
- ❑ Discharge phone call within 72 hours
- ❑ Discharge appointments made for patient prior to discharge within 7 days
- ❑ Referral to Dr. Smith if no Primary Care Physician
- ❑ Appropriate disease specific and medication education

Score 5-9 — 5.1% – 10.3% Chance of Readmission

- ❑ Normal discharge planning
- ❑ Discharge phone call within 72 hours
- ❑ Discharge appointments made for patient prior to discharge within 7 days
- ❑ Referral to Dr. Smith if no Primary Care Physician
- ❑ Appropriate disease specific and medication education

Score 10-13 — 12.2% – 19.8% Chance of Readmission

- ❑ Normal discharge planning
- ❑ Discharge phone call within 72 hours
- ❑ Discharge appointments made for patient prior to discharge
- ❑ Referral to Dr. Smith if no Primary Care Physician
- ❑ Pharmacy-perhaps they would do discharge medication education within 72 hours
- ❑ Care manager referral
- ❑ Multidisciplinary team
- ❑ Consider swing bed
- ❑ Consider home health
- ❑ Consider palliative care
- ❑ Discharge planning/case manager huddle
- ❑ Appropriate disease specific and medication education

Score 14-19 — 23% – 43.7% Chance of Readmission

- ❑ Normal discharge planning
- ❑ Discharge phone call within 72 hours
- ❑ Post follow up appointment phone call
- ❑ Discharge appointments made for patient prior to discharge within 48 hours
- ❑ Referral to Dr. Smith regardless of Primary Care Physician situation
- ❑ Pharmacy-discharge education as well as a follow up call
- ❑ Care manager referral
- ❑ Multidisciplinary team
- ❑ Consider swing bed
- ❑ Consider home health
- ❑ Consider palliative care
- ❑ Consider hospice
- ❑ Discharge planning/case manager huddle
- ❑ Appropriate disease specific and medication education
- ❑ Incorporate home visit as part of discharge process
- ❑ Consider care conference with family