

# Care Transitions to Reduce Unplanned Readmissions

Hospital

Outpatient Care Provider

During Hospitalization

Patient and Family/Caregiver Engagement

Community Forum



Partnership for Patients



The following sections describe the components of the Care Transitions flow map. Tools corresponding to each section are included at the end of the toolkit. The toolkit aims to provide one best practice resource or set of data elements whenever possible. In cases where a best practice has not yet been determined, more than one example has been provided. Tools and resources have been hyperlinked throughout the document for easy navigation.

## 1. Readmission Risk Assessment

### Complete Risk Assessment

Multiple factors are believed to be associated with increased risk of readmission to the hospitals and repeat emergency room visits. Understanding these factors and identifying the most appropriate transitional care interventions to address them will enhance the efforts to reduce unnecessary readmissions. It is recommended that hospitals utilize a readmission risk assessment tool and deliver the needed interventions for the appropriate risk group.<sup>ii</sup>

#### Process

- Select a risk assessment tool and implement consistently in the community.
- Complete a risk assessment on every patient within 48 hours of admission.
- Develop a set of recommended interventions for each risk level.
- Update the risk assessment during the hospitalization as needed and adjust the interventions based on new findings.
- Include the identified risks in the [discharge summary](#) sent to the outpatient providers upon discharge.
- For continuous quality improvement, review randomly sampled readmission cases to validate the tool's predictions and assess if the tool is correctly identifying the high risk patients. Revise the interventions as needed.
- Examples of readmission risk assessment tools ([Tools 1.1 to 1.5](#)) are included in the Tools section of this document.

#### In Practice

A local health system adopted and implemented a risk assessment tool consistently throughout their health system. Within 48 hours of admission, all patients are assessed for their risk of readmission. Identified risk level and strategies carried out are documented in the patient's electronic medical record and case management summary. Upon discharge, the case management summary is sent to the primary care provider's office. When patients are readmitted, case management staff review previous admissions, risk score and strategies applied to determine if there were any missed opportunities and to validate the effectiveness of the risk assessment tool and strategies. Based on the findings, suggestions are made to modify the interventions.

## 2. Outpatient Provider Communication

Notify  
Primary Care Provider

For Moderate or High Risk,  
Discuss Plan of Care with Outpatient Care Providers

Primary care providers (PCP) and outpatient care providers often provide valuable information for the plan of care and the transition back to the community. Early communication between hospitals and outpatient providers plays a critical role in preventing an unnecessary increase in length of stay, incomplete medication reconciliation, duplicative or unnecessary services, and reducing unplanned readmissions. It is important that patients' outpatient care providers – including primary care providers (PCP), nursing homes and home health agencies – have been correctly identified upon admission as they will need to be contacted regarding the existing plan of care and ongoing treatment plan. Complete the notification to PCPs and other involved services (such as in-home services and skilled nursing facilities) when a patient receives treatment in the emergency department or is admitted to the hospital, especially for patients who are at a moderate or high risk for readmission.

### Process

- Payors ensure hospital staff have easy access to information about the patient's PCP as well as any in-home services received by the patient.
- Notify PCPs and other involved services (such as in-home services and skilled nursing facilities) of their patients' emergency department visit or hospital admission via shared electronic medical records or by fax including the reasons for hospitalization in the notification. For patients who are at high or moderate risk for readmission, the involved physicians should communicate directly.
- Obtain the patient's plan of care from the outpatient providers if a plan of care already exists.
- Often times, admission notifications that are sent in error to an incorrect provider are destroyed without any feedback to the sender. Adding a sentence such as ***"If you are not this patient's Primary Care Provider or you believe you have received this notice in error, please call/fax to (xxx) xxx xxxx"*** at the end of the notification has helped ensure this feedback loop occurs. An example of this is shown in the Tools section ([Tool 2](#)).
- Communicate with the payor of the wrong PCP and work with the payor to identify the correct PCP if applicable.

### In Practice

Some hospitals in our region notify the PCP via Epic in-basket notification if the provider is within the network and by fax if the provider is out of the network. PCP offices respond to the hospital using contact information provided on the notification if the patient is not their patient. This prompts the hospital staff/physicians to follow up with the patient to identify the patient's correct PCP so that discharge and follow-up information is sent to the correct provider for post-discharge care.

### **For patients without an established primary care provider:**

When patients do not have an established primary care provider (PCP), it can create significant challenges for them to receive appropriate post-discharge care. Establish processes for these patients to get registered with a PCP for continuity of care.

- Before exploring the options, confirm with the patient and family if they have a primary care provider the patient sees regularly. If this is not known, do the following:
  - If the patient is insured, contact the insurance carrier to identify the patient PCP.
  - If the patient is uninsured and if the hospital has a primary care clinic or affiliated primary care practice, register the patient at the clinic.
  - If the hospital does *not* offer a primary care clinic or have an affiliated primary care practice, identify the largest primary care practice in your community or safety net clinics and make arrangements so that the patient can be registered at their clinic. See [Section 8](#).

### **3. Plan of Care**

Reinforce/ Revise  
Plan of Care

For high or moderate risk patients, a plan of care supports continuity of care. Often times, existing plans of care are not shared between involved providers, which may result in a missed opportunity for reinforcement and necessary modification of the plan of care. Seek input from the PCP, other involved services (such as in-home services and skilled nursing facilities) as described in Section 2, [Outpatient Provider Communication](#). [Tool 3](#) is a sample Plan of Care.

#### **Process**

- Obtain plan of care from the PCP and other involved services (such as in-home services, skilled nursing facilities and payors) when a patient is admitted to the hospital. Reinforce and revise the plan of care as necessary.
- If the patient is admitted for a new condition, develop a plan of care with input from the PCP and other involved services. Clearly state social and clinical issues that need to be addressed in addition to other important information such as discharge criteria, anticipated discharge barriers, proposed interventions, anticipated length of stay and possible discharge referrals.
- Involve the patient and family in creating and updating the plan of care.
- Ensure that the plan of care is accessible for all care providers such as the occupational therapist, respiratory therapist, dietician, social workers and discharge planners.

## In Practice

A local hospital has developed a unit-based rounding process for care providers to review the patients' care and needs at the patients' bedsides with patients and families involved. Discharge criteria, discharge needs and anticipated discharge dates are documented on the whiteboard in the patient's room and updated daily by care providers. Patients and families are also encouraged to write down questions and concerns on the patient bedside whiteboard. These questions are answered and the plan of care is reviewed and adjusted as necessary at daily rounds with the patient and/or family/caregiver.

### 4. Medication Reconciliation

#### Medication Reconciliation

Medication reconciliation is an important component of safe patient care at admission, during the hospital stay and immediately after transitioning from the hospital to another care setting or home. Accurate medication reconciliation reduces medication errors which could lead to increased patient harm and the possibility of a hospital readmission.

#### Process

- As an organization, create a standard process for reconciling patients' medications upon admission, during transfer between units within the hospital and upon discharge home or transfer to another care setting. Identify which discipline(s) are primarily responsible for this reconciliation process.
- When taking the patient's medication history, involve the patient, family, caregivers, appropriate care providers, and the patient's local pharmacy to get complete and accurate medication record. Consider that home health services and dialysis providers often have a list of current medications.
- Prior to discharge, review the reconciled medication list with the patient. Clearly identify each medication as newly added, unchanged, changed, or discontinued during the patient's hospital stay along with the purpose for the medication and reasons for the changes. Simple and easy to follow medication list tools should also be offered to the patients. ([Tool 4](#)).
- If the patient demonstrates an inability to understand or manage their medications, and is eligible for home health services, complete a referral to home health nursing services for medication management support.
- Use [Tool 4](#) to provide a medication list to the primary care provider and the patient/care giver.
- During post-discharge follow-up phone calls (see [Section 10](#)), provide the patient or caregiver an opportunity to ask any question they may have regarding their medications.

The Agency for Healthcare Research and Quality (AHRQ)'s Medications at Transitions and Clinical Handoffs ([MATCH](#)) Toolkit for Medication Reconciliation is a good resource for acute care facilities.

### In Practice

Working in partnership, a pharmacy and home health designed an inter-disciplinary, LEAN safe medication transition process for patients leaving the hospital and nursing homes and entering home health services. The admitting home health clinician verifies all medications in the home with the current orders, notes any discrepancies and sends a list with questions to pharmacy. The pharmacist at the pharmacy does a full reconciliation and communicates changes back to home health as needed. The prior process lacked efficiency, clarity and most importantly a quality and safety driven design. The ultimate goal was to maximize the scope of healthcare professionals through the design of a process to eliminate waste, resolve discrepancies thus preventing potential adverse drug events and hospital readmissions. Based on results, the estimated annual net savings range from \$900,000 to \$2.8 million.

## 5. Social/Resource Barriers Assessment

### Social/Resources Barrier Assessment

Addressing social and resource barriers early in the admission not only prevents unnecessary readmissions, but also proactively prevents delayed discharges and unnecessary increases in length of stay.

#### Process

- Evaluate and complete an assessment of the patient's home-going needs and potential barriers to care including support requirements.
- If a patient falls in the high or moderate readmission risk category and is eligible for home health, provide the patient with a list of home health agencies to choose from and complete a referral.
- Request home health services early in the stay to assure time for the home health liaison to make contact, making it more likely that the services will be accepted by the patient.
- Incorporate the assistance of the patient's preferred agency's liaison in assessing and mitigating barriers to the home health plan.
- Whenever possible, connect patients with the available community resources in the area prior to discharge from the hospital.
- Ensure that all identified social and resource barriers are addressed appropriately and necessary arrangements are made before patient leaves the hospital ([Tool 5](#)).

## 6. Patient and Family/Caregiver Engagement and Teach Back

### Teach Back

### Patient and Family/Caregiver Engagement

Research shows that providing patient-centered care through partnership and collaboration with patients and their caregivers:

- Improves patient safety and quality of care.
- Improves patient engagement and satisfaction.
- Reduces the cost of care.<sup>iii</sup>

Encouraging patients and family members to participate as members of their health care team is essential to ensuring a safe care transition process and reducing preventable readmissions. Not all patients are equally activated, and it is important to assess each patient's activation level and tailor teaching approaches to the patient's level. This can be done using either the [Patient Activation Measure™](#) (PAM) or through observation of activated behaviors during interactions with the patient. On admission, establish the date and time for teaching and inform the support person and patient to be there. If the patient is too ill or unable to provide input, perform an assessment to determine who the primary caregiver will be for the patient post-discharge and/or who is most capable of understanding the education.

[Institute for Patient-and Family-Centered Care](#) identifies four core principles of patient-and family-centered care:

- Dignity and Respect
- Information Sharing
- Participation
- Collaboration<sup>iv</sup>

Each of these principles builds on the previous principle. Without trust, attained through treating patients with dignity and respect, and information shared in an unbiased, timely and accurate way, patients may not feel empowered to participate as partners in their care.

### **Process**

The Institute for Healthcare Improvement (IHI) recommends using "Teach Back" and health literacy principles to assess the patients' and their caregivers' understanding of the discharge plan. Health literacy includes actual literacy (reading ability), cultural competency, appropriate language and many other factors. A well-educated person may function at a low level of health literacy when ill, stressed and vulnerable.

### **Health Literacy**

In order to determine the best approach to communicate in a way that minimizes confusion for patients, families and caregivers, it is important to consider their health literacy. According to the Agency for

Healthcare Research and Quality (AHRQ), “over a third of patients have limited health literacy, which results in their not understanding what they need to do to take care of their health. Limited health literacy is associated with poor management of chronic diseases, poor ability to understand and adhere to medication regimes, increased hospitalizations, and poor health outcomes.”<sup>v</sup> AHRQ and the University of North Carolina have developed a [Health Literacy Universal Precautions Toolkit](#) designed to provide all primary care providers with a systematic approach to reducing the complexity of medical care and ensure that patients can succeed in the health care environment.<sup>vi</sup>

## **Teach Back**



Teach Back is one of the most effective methods for educating patients. Teach Back involves asking the patient or family and caregiver to recall and restate in their own words what they thought they heard during education or other instructions. Refer to Harrison Medical Center’s tool [Tool 6](#).

Teach Back is used to assess patient and family understanding of information and education to improve their ability to perform self-care, take medications, recognize warning signs/symptoms, access help, and more. It includes the following:

- Explain needed information: Include the patient and family caregivers.
- Check for understanding: Ask in a supportive way for them to explain in their own words what was understood. For example, “I want to make sure I explained everything to you clearly. Could you explain to me in your own words...?”
- Check for understanding by the patient after each portion of the information. For example, after telling the patient how to take their water pill and again after explaining the reasons to call the doctor.
- Patients and caregivers should not feel Teach Back is a test. The emphasis is on how well you explain the concepts, placing the responsibility on the teacher not the learner.
- If a gap in understanding is identified, offer additional teaching or explanation followed by a second request for the patient to explain in their own words. Emphasize what they must do when they get home.
- Use multiple opportunities while the patient is in the hospital for review of important information to increase patient and family caregiver recall and confidence.
- If the patient or family caregiver cannot Teach Back, inform the care providers in the next care setting and adjust the transition plan accordingly.

- Use a standardized template to prompt nurses and other clinicians to document the patient’s understanding of what was taught, for example, a formatted Teach Back note in the patient’s chart.

Adapted from: Rutherford, P. et al. *How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2012. [www.IHI.org](http://www.IHI.org).

## 7. Advanced Care Planning at the End-of-Life

### End of Life Planning

The Agency for Healthcare Research Quality Research (AHRQ) has found that most patients have not participated in advanced care planning, yet many are willing to discuss what they want when encountering a serious illness and end-of-life care.<sup>vii</sup> A recent American Hospital Association study regarding patients’ wishes at the end of life revealed that 80 percent of patients wish to avoid hospitalization.<sup>viii</sup> Patients who have advance care planning involvement spend 10 fewer days in the hospital during their last two years and have fewer readmissions than those without as many elect to spend the time at home with family. When patients are involved with and educated on end-of-life care outside of the hospital, hospitalizations rates in the subsequent 30 to 180 days are decreased by 40 percent to 50 percent.<sup>vii</sup>

One way to determine patients' preferences for end-of-life care is to discuss hypothetical situations and find out their opinions on certain treatment options. These opinions can help clarify and predict their preferences if they should become incapacitated and unable to make their own decisions. In a nationwide public effort, [The Conversation Project](#), co-founded by Pulitzer Prize winner Ellen Goodman, offers tools, guidance and resources necessary to start the conversation with their loved ones, in the home setting, about their wishes and preferences.<sup>ix</sup> In addition, the Institute for Healthcare Improvement (IHI) initiated the [Conversation Ready Project](#) to ensure that health care providers and systems are ready to incorporate these early and necessary conversations operationally. Piloting hospitals will be researching, developing and testing processes. These early adopters will identify demonstrated methods including new tools and strategies to create a “Conversation Ready” package, which will be shared throughout.<sup>ix</sup>

Palliative care, hospice care and advanced care planning are often confused with one another. Hospice care is typically delivered to patients (benefit and eligibility depends on insurer) who are expected to have limited survival. Palliative care consultation services can help as a resource either on an inpatient or outpatient basis to understand options. Training in advanced care and end-of-life planning, and in the ability to engage patients in these conversations, is encouraged for all primary care practitioners and all related care team members to improve their confidence in optimally understanding and following through on each patient's end of life wishes.

## Process

Researchers sponsored by AHRQ have suggested a five-part process that physicians can use to structure discussions on end-of-life care:

- Initiate a guided discussion.
- Introduce the subject of advanced care planning and offer information.
- Prepare and complete advanced care planning documents.
- Review the patient's preferences on a regular basis and update documentation.
- Apply the patient's desires to actual circumstances.<sup>vii</sup>

The most proactive approach is through standardization of three on-going conversations:

- Initiating Advance Directive discussions while people are still healthy – encouraging conversations with family members and writing those wishes down.
- Discussing Advance Directives after terminal illness diagnosis and updating Advance Directives based on current diagnosis.
- Initiating [POLST](#) and updating Advance Directives as part of ongoing care for chronic conditions.
- Ensuring that POLST moves with the patient between settings; helping patients understand the limitations of POLST (not the same as an Advanced Directive).

## 8. Scheduling the Follow-up Appointment

### Schedule Follow-up Appointment

When discharged from the hospital, patients are at risk for complications as they adapt to a new activity level, diet, home environment, support system, updated treatment plan and changed medications. There is a relationship between early physician follow-up and 30-day readmission among Medicare beneficiaries hospitalized for heart failure. Patients who are discharged from hospitals with early follow-up appointment dates have a lower risk of 30-day readmission.<sup>x</sup> Most Medicare readmissions occur in the first few days post-discharge, with half of all 30 day readmissions in our region occurring by the 11<sup>th</sup> day post-discharge from the hospital.<sup>xi</sup> Therefore, it is critical to ensure that moderate and high risk patients have access to a prepared, effective post-discharge appointment within the first few days following discharge. A follow-up appointment should always be made after an emergency room visit or an unplanned hospitalization.

## Process

### For patients with an established PCP:

- Schedule discharge appointments based on the triage grid ([Tool 1.1](#)).
- For patients who are at a high or moderate risk for readmission, hospital staff schedules a follow-up appointment with the PCP prior to discharge.
- Work with the patient and their caregiver to determine and address existing barriers in attending their follow-up appointment such as transportation or availability of the caregiver to accompany them to the appointment. (Refer to [Social/Resources Barrier Assessment](#))

- Ensure that the patient and their caregiver understand the purpose and importance of the follow-up appointment. Encourage the patient or their caregiver to reschedule the appointment if they are unable to make the scheduled time. In the discharge instructions, document the follow-up appointment date, time, provider and reason for the appointment.
- If in-home service referrals are made, include the date and time of the primary care follow-up appointment on the referral so the agency can support getting the patient to the appointment and can notify the physician of any significant findings prior to the appointment.
- [Tool 8](#) is a list of data elements to include when scheduling a follow-up appointment.

**For patients without an established PCP:**

As described in [Section 2](#), make attempts for the patient to get registered with a PCP for continuity of care if they do not currently have an established PCP. In addition, develop processes for those patients to receive necessary follow-up appointments within the recommended time frame.

- If the patient is insured with a managed care plan, contact the plan to provide the patient with assistance getting the necessary follow-up appointments.
- If the patient is uninsured and if the hospital has a primary care clinic or affiliated primary care practice, work with the clinic to identify the number of appointments that should be reserved for post-hospital visits. Make arrangements between clinics and hospitals that if a slot has not been filled for a post-discharge visit by certain time/day before the appointment, it is released for general appointment scheduling by the clinic. This negotiation should involve hospital senior leadership in the discussions to set overall priorities.
- If the hospital does *not* have a primary care clinic or an affiliated primary care practice (or internal negotiations fail), identify other clinics in the community that provide primary care services. Discuss the need for primary care follow-up appointments for patients that are a high risk for readmissions and determine how many “slots” may be available for these patients. The discussion with the clinics will likely be more successful when the responsibility for creating the new-patient appointments is equitably spread across all of the clinics providing primary care services in the community. Make formal arrangements with each practice administrator to reserve a specific number of appointment slots per day. If a slot has not been scheduled by 3:00 p.m. the day before the appointment, it will be released to schedule appointments for others.
- In addition, some communities in our region have [Project Access programs](http://projectaccessnw.org/) (<http://projectaccessnw.org/>) that have arrangements with primary care providers within the community to donate primary care for low-income uninsured people. It may be possible to make arrangements for these slots to be used for uninsured and underinsured patients that are at high risk for readmission to the hospital.

## In Practice

A local health system has developed an internal process to ensure that patients without primary care providers receive proper follow up care when discharged from the hospital. Each primary care provider has 1-2 slots per week reserved for these patients. The provider is chosen on a rotational basis depending on where the patient would like to receive care. These slots, if not filled 48 hours in advance, will return to pre-book status and be available for other patients.

Evaluate these arrangements at least quarterly to ensure there are an adequate number of available slots without having reserved too many slots. Over time, strengthen these relationships with cooperative practices and remove arrangements where the partnerships are not working.

Adapted from: Schall M, Coleman E, Rutherford P, Taylor J. *How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at [www.IHI.org](http://www.IHI.org).

## 9. Discharge Communication – Verbal Handover/Send Discharge Summary

Verbal Handover  
Send Discharge Summary

The discharge summary is completed when the patient is discharged from the hospital. It describes the reasons for admission, what procedures, investigations and treatments were done in the hospital and what follow-up is needed once discharged, including a list of reconciled medications and medication management needs. It is one of the most common methods used by hospital physicians to communicate with family doctors.<sup>xii</sup> Quality and timing of the discharge summary help prevent avoidable readmissions.

According to the Institute of Healthcare Improvement (IHI), “Approximately 20 percent of Medicare beneficiaries are discharged from the hospital to a skilled nursing facility. Poorly executed care transitions negatively affect patients’ health, wellbeing, and family resources as well as unnecessarily increase health care system costs. Continuity in patients’ medical care is especially critical following a hospital discharge. Research highlights that nearly one-fourth of Medicare beneficiaries discharged from the hospital to a skilled nursing facility (SNF) are readmitted to the hospital within 30 days, costing Medicare \$4.34 billion in 2006.”<sup>vi</sup> This excerpt highlights the importance of careful consideration, planning and handoff when transferring patients out of the hospital regardless of the discharge destination.

This section of the toolkit focuses on discharges from hospital to home with primary care provider follow-up and discharges from hospital to a skilled nursing facility.

## Process

- Perform verbal handoff from clinician to clinician when a high risk patient is transitioned home or to a sub-acute care setting. Verbal handoff enables the providers to discuss the treatment plan in detail, areas of concern that need attention in the post-discharge period, alert the receiving facility/provider to be prepared to accept the patient and ensure that they are capable of providing the recommended care for the patient. (Please refer to [Tool 1.1](#) and [IHI – How to guide – transition from hospital to SNF](#) )
- Complete a discharge summary (DC summary) that includes data elements shown on [Tool 9](#).
- Establish reliable and sustainable processes to ensure that outpatient providers receive a document containing sufficient information to allow them to manage the patient on the day of the patient’s follow up appointment. Hospitals should create expectations that physicians and systems provide a complete DC summary to the PCP, SNF, or other follow-up care provider within 24-48 hours after discharge or prior to the patients’ scheduled follow-up appointment, whichever comes first.
- Provide the patient or caregiver a copy of the discharge instructions that includes the plan of care, specific signs and symptoms that warrant follow up with clinician, when to seek emergency care, how to contact the primary care physician, and a 24/7 phone number for advice about questions and concerns along with date and time of the follow-up appointment.

### In Practice

A hospital in our region provides read-only electronic medical record (EMR) access for the outpatient providers such as PCP, skilled nursing facilities and home health agencies in the area. This expedites the receipt of necessary information by the PCPs and post-acute providers in time for the patients’ follow-up appointments.

## 10. Follow-up Phone Call

### Follow-Up Phone Call

After the patient is discharged from the hospital and prior to seeing the outpatient provider for post-discharge care, it is important to communicate with the patient or caregiver via a phone call and/or visit to ensure that they are able to follow their plan of care. This is recommended for all patients but especially encouraged for high and moderate readmission risk patients. If the patient has been discharged home without any in-home services assistance, this follow-up phone call also serves as an opportunity to re-evaluate if a referral to an in-home service agency or other community resource might be beneficial. To avoid redundant calls or failure to call at all, communities should discuss and agree on who is accountable to make the follow up call.

## Process

- Use the triage grid risk level to do follow-up call (see Triage Grid – [Tool 1.1](#)).
- Prior to discharge, ask the patient or their caregiver about the best time to call and best number to call. Include this information on the plan of care and discharge summary.
- During the follow-up call, it is recommended that the following items be discussed with the patient/caregiver:
  - Confirm that the transportation arrangements are made and the patient or their caregiver is aware of the date, time and provider they will see at the follow-up appointment.
  - Offer assistance if the patient needs to change the appointment time or problem-solve through transportation options.
  - Encourage the patient to arrive at the appointment on time, and to bring their medication in a bag or small box and a list of any questions they have for the primary care provider to the appointment.
  - Offer the patient or caregiver an opportunity to ask any question they may have regarding the medication.
- Develop a process to transfer the calls to the appropriate provider if a patient or caregiver has specific questions. (e.g. medication-related questions should be redirected to a pharmacist),

[Tools 10.1 and 10.2](#) include scripts that can be used by clinical and non-clinical staff when making the follow-up call.

### In Practice

A local hospital has mechanisms and processes set up to make automated interactive follow up phone calls using a vendor. The patient's staff nurse educates the patient/caregiver prior to discharge to expect this phone call within 48 hours of discharge. They provide the patient with verbal as well as written instruction explaining the call and its purpose. The automated call starts with a personal greeting from the Chief Nursing Officer with a brief introduction that the call is regarding the patient's recovery and that a short series of questions will be asked. The prompts are user friendly using simple verbiage. If a clinical or satisfaction concern is identified, a designated hospital clinician is alerted to call the patient back to provide additional assistance. This is found to be well received by patients/caregivers.

### In Practice

When high and moderate readmission risk patients are discharged from the hospital, case managers from a hospital in our make verbal handoff calls to the case managers at the outpatient clinics. This ensures the outpatient provider is aware that the patient is discharged from the hospital, knows the follow-up appointment date/time and when to make the follow-up calls. It also provides an opportunity for a detailed discussion between the hospital and clinic case managers regarding the care plan and follow-up considerations.