Making Health Care Better *Together*

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Alabama Hospital Association
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Purpose: Use the evidence-based best practices and resources to create quality improvement action plans.

Facility/Hospital Name: ______________________________ **Date Completed:** ______________

Category	Best practice/Interventions	Links to resources, toolkits, webinars, etc.
Care Coordination	Navigator role utilized	Patient Navigator Program Leads to Better Understanding of Medications (American College of Cardiology, 2019)
Care Coordination	Transitional care program or department assists with post discharge needs	Transition Coaches® Reduce Readmissions for Medicare Patients With Complex Postdischarge Needs Transitional Care Department (SUNY Upstate)
Care Coordination	Utilize palliative care for non-hospice/end of life follow-up and care	Minimizing Readmission Penalties with Palliative Care (HFMA) Five Key Insights on Hospital Palliative Care Programs (CAPC, 2020) What are Palliative Care and Hospice Care? (NIH)
Care Coordination	Discharge follow up appointment with PCP within seven days & specialty care within 14 days	Improving Follow-Up Appointments Post Hospital Discharge (University of Kansas Health System)
Care Coordination	Conduct discharge follow-up calls within 48 hours of patient discharge, including ED	Re-Engineered Discharge (RED) Toolkit, How to Conduct a Post-Discharge Follow Up Call (AHRQ)
Education	Use teach back methodology for patients and family education (e.g. discharge instructions)	Health Literacy Universal Precautions - Teach Back Method (AHRQ) Always Use Teach Back! Toolkit
Leadership/Culture	Leadership engaged in meetings/teams to review data and identify improvement opportunities	Health Care Leader Action Guide to Reduce Avoidable Readmissions (AHA)
Medication Safety	Medication reconciliation at admission, transfer or discharge	Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation (AHRQ) Medication Reconciliation Improvement Stories (IHI)

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Monitor/Assess	Assess social determinants of health (SDOH) upon admission	PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences) Screening Tool
Monitor/Assess	Risk assessment conducted properly upon admission	The 8P Screening Tool LACE Scoring Tool
Patient and Family Engagement	Engage patient and family in discharge planning	IDEAL Discharge Planning
Patient and Family Engagement	Engagement of family in supporting care of patient upon discharge	Tool 7: Understanding and Enhancing the Role of Family Caregivers in the ReEngineered Discharge
Process Optimization	Meds to Bed Program	Meds to Beds Program video Meds to Beds Program (Journal of the American Pharmacists Association)

Professional Association/Other Websites
Guide to Reducing Disparities in Readmissions (CMS)
Caretransitions.org (Tools)
Hospital Discharge and Readmission (UpToDate)
American Hospital Association (AHA)
AHRQ
Institute for Healthcare Improvement (IHI)
Please visit the Alliant HQIC website for more resources, webinars and success stories
Alliant HQIC website

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