Making Health Care Better *Together*

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

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)
Leadership/Culture	Leadership engaged in meetings/teams to review data and identify improvement opportunities	Health Care Leader Action Guide to Reduce Avoidable Readmissions (AHA)
Monitor/Assess	Medication reconciliation for patients with high readmission risk	Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation (AHRQ) Medication Reconciliation Improvement Stories (IHI)
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 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)
Health Equity	Assess health-related social needs and provide community resource information	NPSG.16.01.01 Improving health care equity for the hospital's patients is a quality and safety priority PRAPARE (Protocol for Responding to and Assessing Patients' Assets, Risks and Experiences) Screening Tool
	Identify disparities by stratifying data using sociodemographic characteristics	NPSG.16.01.01 Improving health care equity for the hospital's patients is a quality and safety priority
	Review Alliant Health disparities data by race and ethnicity.	
	Review Alliant Health disparities data by dual eligibility.	

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)
Visit the Alliant HQIC Website for More Resources, Webinars, and Success Stories
Alliant HQIC website

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