

Hospital: _____

Pilot Unit: _____



Aim Statement: _____

Key Changes	Processes	Status of Change	Ideas for Testing & Designing Reliable Processes	Process Measures	Who will lead? Timeline?
I. Perform Enhanced Assessment of Post-Hospital Needs	a. Involve family caregivers and community providers as full partners in completing a needs assessment of patients' home-going needs.				
	b. Reconcile medications upon admission.				
	c. Create a customized discharge plan based on the assessment.				
	d.				
	e.				

Preparing to Test: Your team is collecting baseline data; meeting with key informants or team members and constituents; flowcharting or observing the process.

Testing: Your team is trying a change to see if the change results in improvement; there is no assumption that the change tested is permanent yet. A test of change involves complete Plan-Do-Study-Act cycles¹:

Implementing: Your team is making a successful change permanent. Implementation will often require changing documentation, written policy, hiring, training, and organizational infrastructure - activities usually not required in the testing phase. Implementation, like testing, will require the use of multiple Plan-Do-Study-Act cycles for continued learning.

Standard Work in Place (with >90% reliability): Your team has developed a highly specified process which is currently in use; documentation exists that indicates the process is followed at least 90% of the time.

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II. Provide Effective Teaching & Facilitate Enhanced Learning	a. Identify all learners on admission.				
	b. Redesign the patient education process				
	c. Redesign patient teaching print materials				
	d. Use Teach Back regularly throughout the hospital stay to assess the patient's and family caregivers' understanding of discharge instructions and ability to perform self-care.				
	e.				

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III. Provide Real-time Handover Communications	a. Reconcile medications at discharge.				
	b. Provide customized, real-time critical information to the next clinical care provider(s)				
	c. Give patients and family members a patient-friendly discharge plan.				
	d. For high-risk patients, a clinician calls the individual listed as the patient's emergency contact to discuss the patient's status and plan of care				

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IV. Ensure Timely Post-Hospital Care Follow-Up	a. Identify each patient's risk for readmission.				
	b. Prior to discharge, schedule timely follow-up care and initiate clinical and social services based upon the risk assessment.				
	c.				
	d.				

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