Get your patients ready for

DEPARTURE

Six models to match each patient with the right discharge plan

PATIENT	AGE	CONDITION	STATUS	GATE
SMITH	84	PNEUMONIA	STANDBY	A1
FOSTER	63	SEPSIS	DISCHARGE	C7
SAMS	72	STROKE	DELAYED	B3
DAVIS	39	FRACTURE	DISCHARG	

Model

LACE Index

Predicts risk of readmission and death within 30 days, using both primary and administrative tools.

Criteria assessed

- LOS in days for index hospitalization
- Acuity of illness at time of index admission
- Charlson comorbidity score
- ED visits in previous six months

Model

Krumholz/Yale Model

Predicts risk of 30-day all-cause readmissions for heart failure patients 65 years or older.

Criteria assessed

- Demographics
- Occurrence of in-hospital cardiac arrest
- Medical history
- Diagnostics on admission (e.g., LVEF)

Model

Philbin Tool

Predicts risk of readmission for HF patients 65 years or older using administrative data.

Criteria assessed

- Demographics
- Comorbidities
- Hospital type and location
- Process of care
- Clinical outcomes

Model

Patients at Risk of Rehospitalization (PARR) Algorithm

Predicts risk of readmission within one year for patients with a wide range of reference conditions that improved care management has the ability to influence.

Criteria assessed

- Demographics
- Comorbidities
- Substance abuse
- Past utilization
- Hospital's past performance

Model

Project BOOST 8P Screening Tool

Assess patients upon admission to identify those at high risk of adverse events post-hospitalization. This tool includes risk-specific interventions hospitals can use throughout the patient's stay to mitigate post-discharge issues.

Criteria assessed

- Problem medications
- Psychological issues
- Principal diagnosis
- Polypharmacy
- Poor health literacy
- Patient support
- Prior hospitalization
- Palliative care

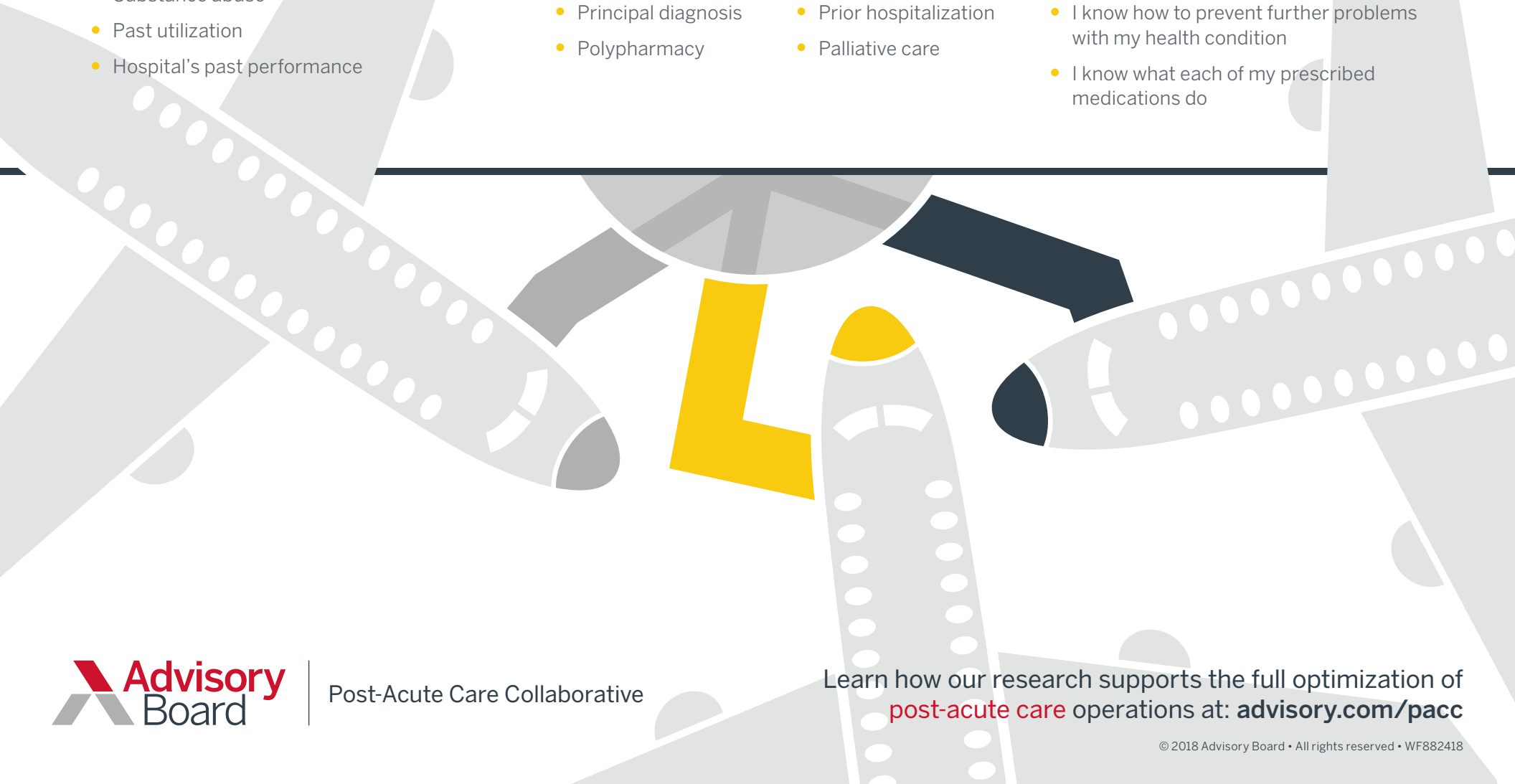
Model

Patient Activation Measure

Thirteen-item, evidence based measure that assesses a patient's knowledge, skill, and confidence to self-manage after discharge. It is administered to patients as a questionnaire for self-evaluation. Score allows caregivers to infer a patient's risk of noncompliance post-discharge and tailor self-management education and follow-up contact accordingly.

Example questions

- I know how to prevent further problems with my health condition
- I know what each of my prescribed medications do



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