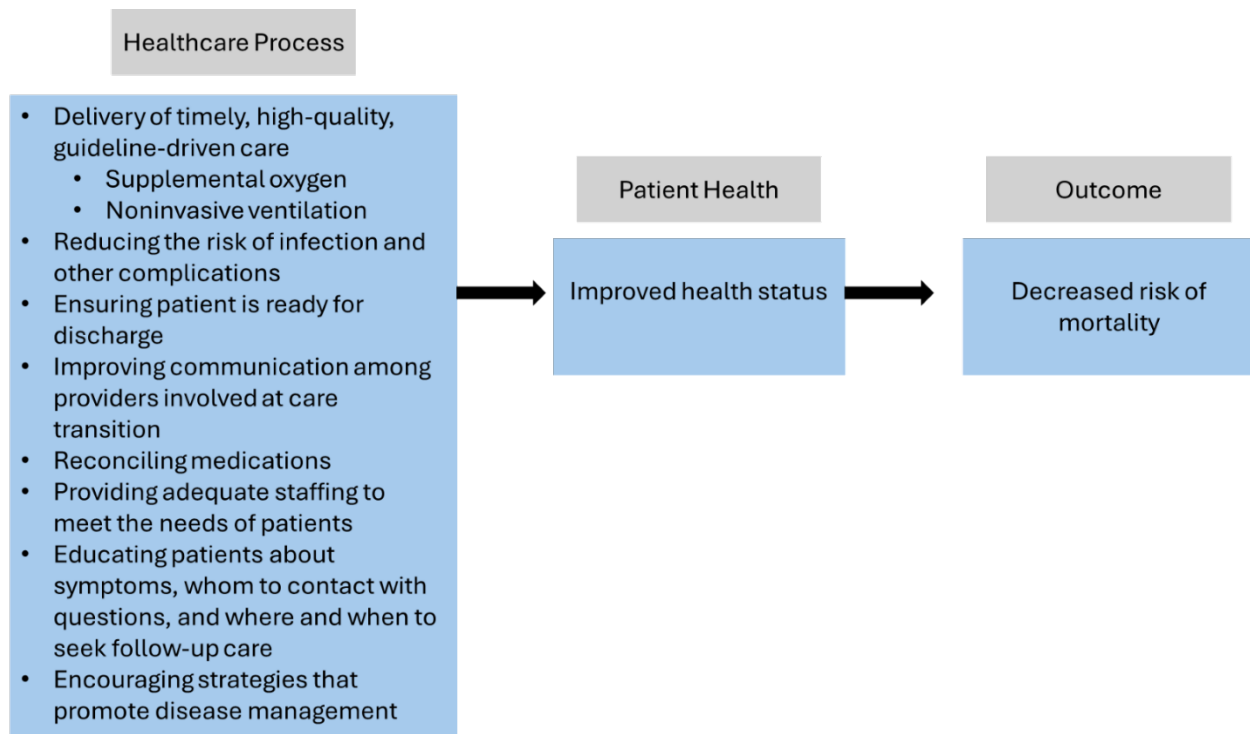


Hybrid HWM Logic Model



[Figure 2](#) indicates some of the many care processes that may influence readmission risk. Measurement of patient outcomes allows for a broad view of quality of care that encompasses more than what can be captured by individual process-of-care measures. Complex and critical aspects of care, such as: communication between providers, prevention of, and response to, complications, patient safety and coordinated transitions to the outpatient environment, all contribute to patient outcomes but are difficult to measure by individual process measures. Each of these activities can contribute to the overall goal of decreasing risk of admission by improving patient health status. The strongest evidence supporting the efficacy of improved discharge processes and enhanced care at transitions is a randomized controlled trial by the Project RED (Re-Engineered Discharge) intervention. In this study piloting a discharge intervention program, a nurse was assigned to each patient as a discharge advocate, responsible for patient education, follow-up, medication reconciliation, and preparing individualized discharge instructions sent to the patient's primary care provider. In addition, there was a follow-up phone call from a pharmacist within 4 days of discharge, which demonstrated a 30% reduction in 30-day readmissions.¹

References:

1. Patel PH, Dickerson KW. Impact of the Implementation of Project Re-Engineered Discharge for Heart Failure patients at a Veterans Affairs Hospital at the Central Arkansas Veterans Healthcare System. *Hosp Pharm.* 2018;53(4):266-271. doi:10.1177/0018578717749925.