Readmission Prevention Program

In response to health care reform measures, Complete Care Strategies has developed our Readmission Prevention Program.

Integrating nurses, social workers, and a specially trained home care team, our program is designed to keep people at home and to avoid readmission.

According to a study by the New England Journal of Medicine in 2009, 20% of Medicare patients are readmitted to the hospital within 30 days of discharge. Various studies show that 75% of readmissions are preventable. The current changes in health care reform reflect efforts to reverse these statistics as hospitals are penalized for patients readmitted within 30 days of discharge.

When patients are discharged either from the hospital or a rehab AND receive our home care, our prevention program is initiated. While we can't promise success in all cases, we can promise that we will follow all guidelines to keep people in their homes and avoid readmissions.

Program Design (30 day duration)

- *Professional staff will interface with discharge planners before they are discharged from either the hospital or rehab*
- *CCS recommends a 30 day supply of medication upon discharge*
- *RN or LPN to open case, train caregivers on site, visit the first week, set up pill box and follow-through with physician(s)*
- *Licensed social worker will visit the first week, follow-up with doctors' appointments, communicate with family, and oversee caregivers. Caregivers are trained to record and report vital signs daily*
- *Caregivers follow dietary guidelines*
- *Daily weight monitoring*
- *Assess for edema*
- *Caregivers will strictly follow prescribed medication guidelines*
- *Caregivers are trained to understand warning signs of specific illnesses which precipitated the hospitalization*
- *Follow-through with doctors' appointments*

Complete Care Strategies

Innovative Care Management. Patient Advocacy. Home Care.

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A Division of Elder Connections

Certified Care Managers and Licensed Non-Medical Home Care.