Readmissions Action Plan

Current All-Cause Readmissions Rate:

Improvement Goal (Percent Reduction):

 # Readmissions Needed to Prevent to Reach Goal:

Readmissions Improvement Team Members:

Driver for Improvement	Tasks Associated with this Driver	Our Plan / Gaps	Tools and Resources	First Step	Person Responsible
Use of data to inform improvement activities	Identify local target population (DRGs, Discharge Disposition, etc.) Identify local patient needs (from patient interviews)		Data drilldown tool Driver Diagram Driver of Utilization tool ASPIRE Interview Guide Readmissions Gap Analysis Tool		
Improve transitions of care	Discharge planning on admission Use of risk assessment tools to identify those patients at higher risk for readmissions Communication strategies for team members (white board, electronic notification, etc.) Follow up phone calls and appointments		ASPIRE Whole Person Care Planning Guide LACE BOOST		

Provide enhanced services based on need	Identify palliative care resources / process for referral Develop condition-specific programs for local population (specialty clinics, partnerships with providers for certain diagnoses, a local “bundle of care” for higher risk patients) Develop process for identification of recently discharged patients that present to ED, and develop a process for response in ED Identify patients with complex care needs/high utilizers and develop individualized care plans		Community Resource Planning Guide www.AuntBertha.com Specialty Resource Planning Guide Whole Person Care Planning Tool ED Individualized Care Plan Tool ED Pause Checklist		
Collaborate with providers and agencies across the continuum	Identify local agencies that contribute to our readmitted population: SNF, Home Health, Behavioral Health providers, Provider groups, LTAC		Cross-continuum collaboration tool		