Coaching Package

COMMUNITY COALITIONS

Readmissions

This quality improvement tool assists providers with identifying key strategies and developing actionable plans associated with improving readmissions.

Provider Name: ______________________ **Date Completed:** ____________

	Ten Key Strategies	Action Plan
1	Identify high utilizers and analyze unadjusted, all-payer data (four inpatient admissions or five or more ED, observation and inpatient stays combined in 12 months). When possible, include ED visits/stays at other providers in your service area.	
2	Establish a process for obtaining the patient/care partner perspective to gain insight into the root cause of the readmission. Utilize open-ended questions such as, "Would you mind telling me about what happened between the time you left the hospital and the time you returned?"[1]	
3	Engage Emergency Departments (1) Implement an ED Alert System for real time identification of a high utilizer's return to the ED and/or a return within 30 days of discharge (2) Utilize ED care plans for identified high utilizers (3) Bi-directional warm hand-offs with post acute providers.	
4	Initiate risk assessment upon admission and implement transitional care plans that align with patient goals for care for all identified risks including clinical, behavioral, and social risk factors as well as areas of concern identified by the patient and care partner.	
5	Utilize palliative care referrals for patients with a new or existing serious illness. Include palliative care consult, goals of care and progress notes in information provided to next level of care (e.g. PCP, SNF, Home Health or ED).	

1 Designing and Delivering Whole-Person Transitional Care The Hospital Guide to Reducing Medicaid Readmissions ASPIRE Guide Tool: Readmission Review https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html

Quality Improvement Organizations
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CENTERS FOR MEDICARE & MEDICAID SERVICES

ALLIANT QUALITY
The Quality Improvement Services Group of ALLIANT HEALTH SOLUTIONS

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	Ten Key Strategies	Action Plan
6	Engage patients and caregivers in discharge planning. Utilize teach back and materials in the patient's preferred language and at the appropriate literacy level (consider use of zone tools, bedside delivery of medications, procurement of common supplies).	
7	Arrange for discharge follow-up appointments with primary care and specialty care providers or other community based services. Communicate the discharge plan and patient goals for care to physicians and other post-acute providers.	
8	Conduct discharge follow-up calls within 48 hours of patient discharge. Set the stage for post discharge contact, confirm telephone number and care partner availability.	
9	Develop and utilize a dashboard to monitor and share progress.	
10	Collaborate with cross-continuum partners and community based agencies to improve care transition processes, develop referral path ways and identify gaps in existing services.	

Links to Resources	
Designing and Delivering Whole-Person Transitional Care (Aspire Guide)	Improving Health Literacy in Older Adults
Hospital Decision Guide	Project Red
Disease Specific Zone Tools	Challenges for Beneficiaries in Care Transitions
Interact	Beneficiary Care Activities and Transitions Journey Map
CMS ACO Care Coordination Toolkit	Community Coalitions
IHI	Teach Back

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