



**HANDLE
TRANSITIONS
WITH CARE**



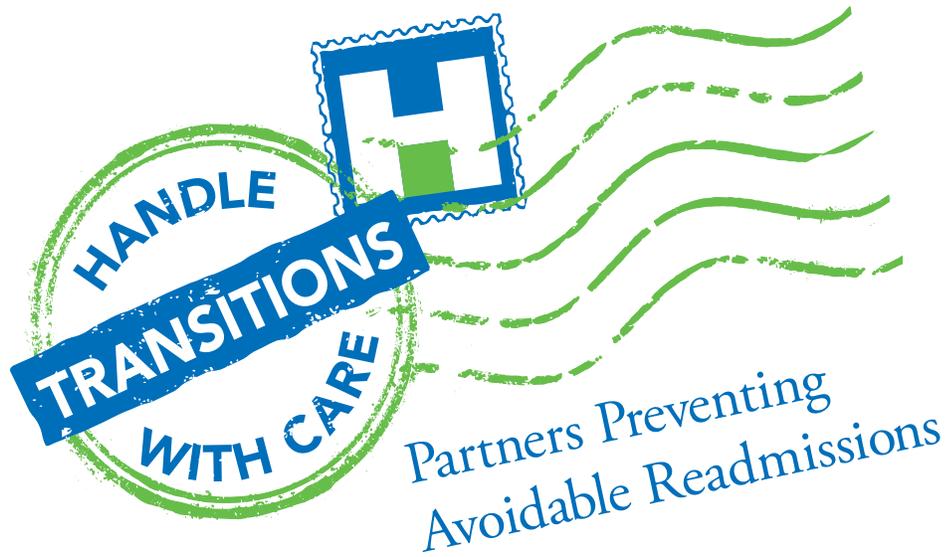
Partners Preventing
Avoidable Readmissions

READMISSIONS REDUCTION PLAYBOOK 1.0



Maryland
Hospital Association

 **COLLABORATIVE**
HEALTHCARE STRATEGIES



Support for the *Transitions: Handle with Care* campaign is provided by the Maryland Hospital Association.

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Maryland
Hospital Association



Dear Colleague:



It's a new era of health care in Maryland, with health care reform and the state's new Medicare waiver helping us focus on providing the right care, at the right time, and in the right place. Incentives now recognize value, not volume, and to succeed, hospitals must coordinate with others and function across health care settings and across organizational boundaries.

One immediate challenge, and one by which we will be closely measured, is to dramatically reduce readmissions. Moving Maryland's readmissions rate from among the highest in the nation to the national average by 2018 is a pillar of the new Medicare waiver. Early modeling has indicated that this could require from a 20 percent to as much as a 40 percent reduction in our readmissions rate over the five-year course of the waiver demonstration. Success will rely on partnerships. We know that breakthrough performance is realized when providers across settings work together — hospitals, physicians, home health agencies, nursing homes, behavioral health organizations, pharmacists, community groups, and more.

The Maryland Hospital Association launched the *Transitions: Handle with Care* campaign in March 2013 to prepare our members to overcome these new performance and financial challenges, and to stimulate the kind of local and state collaboration that this new era of care demands. *Transitions: Handle with Care* is a multi-stakeholder, statewide effort to reduce readmissions by fostering collaboration, using data strategically, and embracing solutions that are tailored to local communities. This work has been guided by Dr. Amy Boutwell, president of Collaborative Healthcare Strategies, who previously led similar efforts for the Institute for Healthcare Improvement. This playbook is a product of the campaign, and is a resource that provides your hospital team with solid, proven strategies to reduce readmissions.

Hospitals can take the lead, as we often do, but keeping people from returning to the hospital after treatment requires partners: patients and their families, as well as those in the community who care for patients when they leave our facilities. Implementing this playbook's strategies and nurturing these partnerships will ensure that what we do inside our walls translates to a healthier life outside our walls.

On behalf of the MHA and your colleagues across the state, thank you for your commitment to reducing readmissions, and welcome to an historic new era of care!

A handwritten signature in black ink that reads 'Carmela Coyle'.

Carmela Coyle
President & CEO, Maryland Hospital Association

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Transitions: Handle with Care is dedicated to helping hospitals and their cross-continuum partners identify high-impact strategies that reduce readmissions. This playbook is designed to update and accelerate your strategy to reduce readmissions, recognizing that all hospitals already have readmissions reduction efforts in place. But, as a field, these efforts have taken on greater significance because reducing readmissions is now a closely measured metric of Maryland's new Medicare waiver. Readmissions to any hospital, from any hospital, now affect us all, as the Medicare waiver tests must be passed as a state.

Why re-evaluate your readmissions reduction strategy now?

As a requirement of the new Medicare waiver, Maryland's hospitals must reduce readmissions by an estimated 5-10 percent per year, each year, in order to reach the national average Medicare readmission rate by 2018. In other words, between today and the end of 2018, we may need to reduce readmissions by an estimated 30 percent. This challenging goal will require new investments and expanded strategies.

Expanding your readmissions reduction portfolio

This playbook will outline a series of ideas for improving hospital-based services to help reduce readmissions from post-acute and community-based providers. The aggressive timelines outlined in the waiver and our consultation with national experts lead us to recommend that you develop and manage a multi-faceted portfolio of efforts that includes: improving standard care for all patients, improving collaborative care with post-acute providers, and providing transitional care services for high-risk patients leaving your hospital.

Investing for success

Financial incentives for hospitals to invest in effective transitions of care and alternatives to acute-care utilization are changing as most Maryland hospitals transition to a payment system based on global revenue. Reducing readmissions requires investment in: executive and clinical leadership, data analytics, information technology tools, training, and staff and new services.

“This transformation will require that you engage patients and families, their caregivers and the public.”

Communicating with patients, caregivers and the public

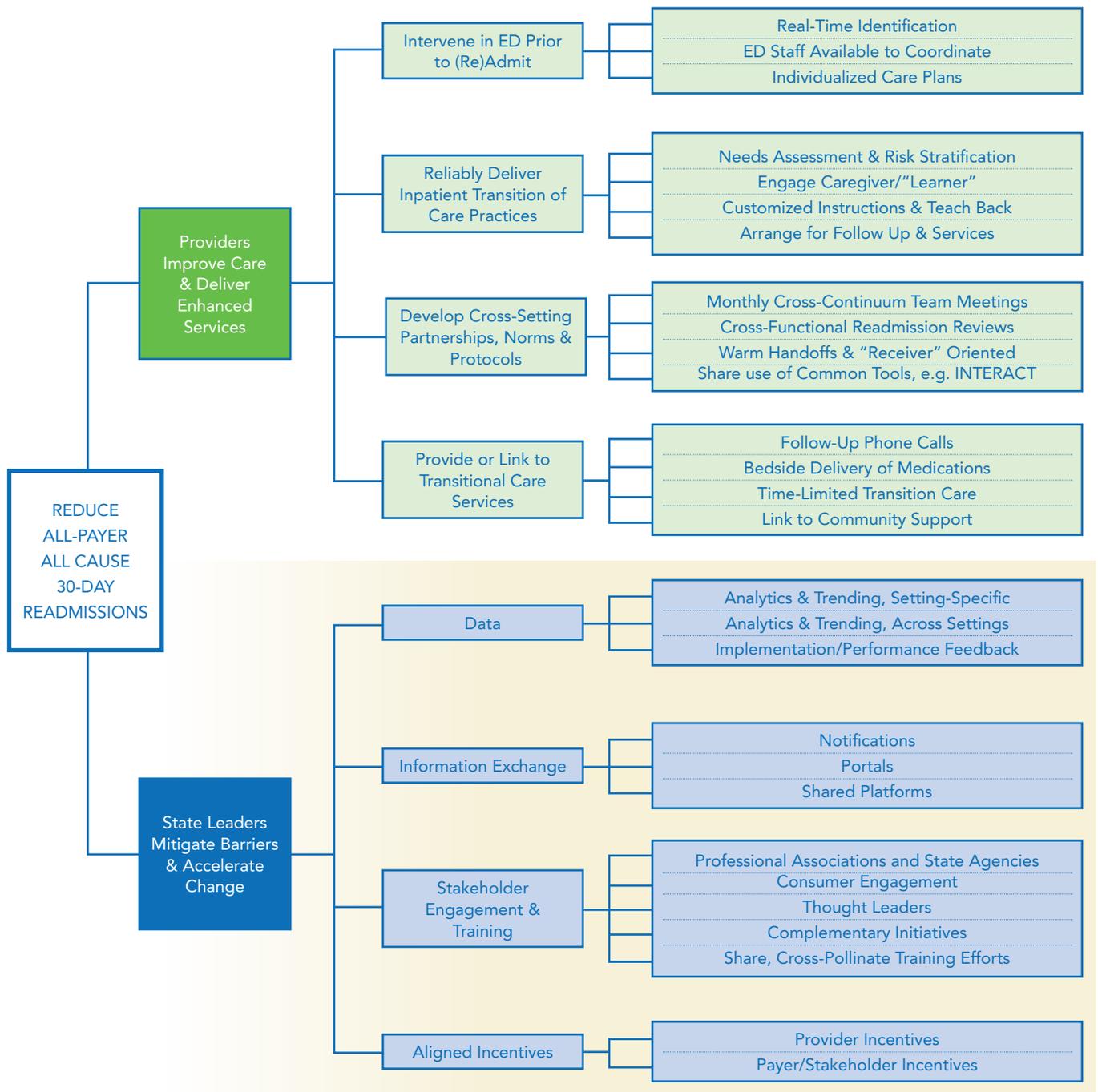
This transformation will require that you engage patients and families, their caregivers and the public. Often, the “secret sauce” of successful readmissions reduction initiatives is the degree to which patients and caregivers understand that we now see an unplanned return to acute care as avoidable, something we will work with them to prevent where safe and appropriate. Transparency, communication and active engagement will be crucial. This could start with an announcement of readmissions reduction efforts in local media, or a recurring column about improving care transitions in the hospital's newsletter. A sample press release is in the Appendix.

Section 2: The *Transitions: Handle With Care* Driver Diagram



A driver diagram is a visual tool that depicts the set of actions that will lead to the outcome we want. It can be particularly helpful when numerous strategies and actions are required to achieve a goal as complex as statewide readmissions reduction.

The driver diagram below is an illustration of the two-part strategy behind *Transitions: Handle with Care*. Your hospital should develop its own driver diagram to reflect the actions that will help reduce readmissions for your patients. This playbook is based on this strategic model.





Before you set your strategy, understand why readmissions occur at your hospital

Much has changed in our collective understanding of why readmissions happen and how we can prevent them. Hospitals with successful strategies regularly reassess their data and their understanding of what drives readmissions within their patient populations. You may learn, for example, that avoiding readmissions is more about logistics, navigation, and communication than clinical protocols or medical complexity.

Review your data for yourself

Analytics partners can be valuable, but some readmissions reports from external sources are done with a pre-determined “cut” of the data, such as limited reporting of predetermined diagnostic categories, or for certain payers, and more. As a result, it’s preferable to examine your own raw data. A sample data analysis that has proven feasible for hospital finance or quality analysts to conduct in-house is in the Appendix.

In addition to basic administrative data analysis, your clinical, financial or information technology staff may be aware of potential additional analyses based on your organization’s unique data assets. For example, your administrative data may have a reliable primary care provider field, or “admission source” field, or your case management software may capture the specific discharge facility, or whether a person-to-person “warm handoff,” as opposed to an email or voice mail handoff, was completed. Or, your nursing documentation may contain information about readmissions risk assessment. All of these sources go well beyond billing data but are important to place on your hospital’s readmissions reduction dashboard. Taking advantage of data you are already collecting to drive improvement is a good first step.

Ask your patients, their families and their providers why readmissions occur

While it is important to have a good understanding of your organization’s readmissions data, data alone do not help us understand the kinds of barriers patients, families and providers face during the post-hospital transitional care period, or the circumstances leading patients to return to the hospital soon after discharge. Drawing from the Institute for Healthcare Improvement’s STate Action on Avoidable Rehospitalizations (STAAR) initiative,* we recommend your readmissions team conduct **10 “readmission interviews.”** These can uncover the “story behind the story:” going well beyond chief complaint, discharge diagnosis or other clinical parameters to understand the communication, coordination, or other logistical barriers in the days following discharge that resulted in a readmission.

“While it is important to have a good understanding of your organization’s readmissions data, data alone do not help us understand the kinds of barriers patients, families and providers face...”

If you’re worried that conducting patient interviews will be time-consuming, try using a simple script at the beginning of the interview. Readmission teams uniformly report that these interviews yield valuable information not found in chart reviews or data analyses.

While this document’s Appendix includes a sample script, the most important thing is to provide the patient, family member or provider an opportunity to detail why the patient had to return to the hospital. The prompts are only meant to help elicit the stories from the individuals you interview.

*See Appendix for additional information on the STAAR initiative

Inventory your current readmissions reduction efforts

Revisiting your readmissions reduction strategy is a good time to specifically inventory the various efforts your team has put into place over the past several years. This inventory should include:

- Completed efforts (i.e. trained staff on Teach-Back to ensure patients understand instructions and information, or had information technology staff place a high-risk flag in electronic medical records)
- Current efforts (i.e. refer high-risk patients to care transitions team; warm handoffs to skilled nursing facilities)
- Planned efforts that have gone undone (i.e. make appointments prior to discharge, hire staff)
- Attempted but abandoned efforts (be sure to know why)

Revisit your readmissions reduction strategy

Armed with an updated understanding of the readmissions patterns at your hospital, the reasons that patients, family and providers have offered for readmissions, and a comprehensive review of the completed, current, and intended but incomplete readmissions reduction efforts at your hospital, we invite you to revisit your readmissions reduction strategy. This strategy should be optimized to achieve immediate, measurable readmissions reductions this year and each year thereafter for the five years of the new waiver demonstration.

Know your hospital's readmissions reduction goal in context of the "waiver test"

As of April 2014, the Maryland Hospital Association and the state's Health Services Cost Review Commission are discussing how to quantify the annual readmissions reduction goals, and to design policies that meet the milestone performance requirements of the waiver. While the readmissions reduction goal a hospital sets for itself should be closely aligned with targets and payment policies set by the Health Services Cost Review Commission, your hospital's internal performance improvement goal may be more aggressive and more tailored to the hospital's own strategic goals than a readmissions target tied to a payment policy.

Recent Medicare data indicate that, from July 2012 through July 2013, there were 45,244 Medicare readmissions among 235,532 Medicare admissions in Maryland, for an all-cause readmission rate of 19.2 percent. The current U.S. national average is 17.4 percent, which is expected to continue decreasing at a steady rate. Current calculations estimate that Maryland will need to improve 5-10 percent per year, every year, to meet the U.S. national average by 2018. While there is no consensus on how low a hospital's readmissions rate should be, you are encouraged to set attainable goals that are tied to the statewide reduction goal.



Designing interventions for a specific subgroup versus for a hospital

Many health care providers in Maryland and across the nation have demonstrated safe and effective strategies to reduce readmissions. Among the subgroups within targeted high-risk populations, experience suggests that readmissions reductions of between 20 percent and 50 percent are possible. Some Maryland hospitals have already achieved similar results within high-risk subgroups.

However, very few hospitals have reduced their hospital-wide readmissions rate. There is a substantial and important difference between designing an intervention to reduce readmissions in a relatively small, well-defined high-risk target population, and designing a strategy to reduce overall hospital readmissions. Consider these three suggestions:

1. Model the impact of an intervention on the hospital-wide readmissions rate. A focused effort may have a high impact for the subgroup, but be sure to also model its impact on the hospital's overall readmissions rate. Typically, a hospital's initial push to enhance services for high-risk patients is very high in intensity, aimed at bringing down high readmissions within that subgroup. As you prepare to scale interventions across numerous high-risk groups and your full patient population, keep in mind the importance of moderate- and low-resource interventions that produce moderate results, but for more patients.

2. Properly execute targeted interventions to achieve the intended impact. An intervention aimed at a specific high-risk population requires at least three things to succeed:

- Effective screening for and identification of eligible patients
- Successful engagement of eligible patients in the intervention offered
- Reliable implementation of the intervention

Many high-intensity interventions are designed with the assumptions that 100 percent of the eligible patients will be identified, that all of those identified will engage in the new service, and that staff will consistently implement the service as intended. These assumptions are rarely realized. It is almost always more effective to include a patient in a program automatically and allow them to opt out, rather than to ask permission to "enroll" them in a new service. Human nature being what it is, patients typically see enrollment as an extra step in an already complex health care navigation. Also, do not assume that, just because a patient is identified and enrolled in the high-risk program, that he or she is receiving the same intensity or consistency of intervention as other patients in the cohort; this must be measured directly.



3. The standard of care for all patients must be improved. Designing improvements exclusively for high-risk or even multiple high-risk populations leaves the majority of your patients subject to standard care.

- The ways in which standard discharge practices fail to meet patient, caregiver, and post-acute provider needs have been detailed, and are key contributors to the need for change.
- The federal Centers for Medicare & Medicaid Services (CMS) significantly revised and updated expectations for the discharge process in its May 2013 Conditions of Participation; improvement is not just needed, but required. Additional information about the conditions is available in the Appendix.

Improving your hospital’s standard process for readmissions risk reduction and transitional care is not only required as a Condition of Participation in Medicare and Medicaid, but should serve as the foundation of your hospital’s reduction efforts. This is the modest change resulting in modest impact that affects the most patients. From a numerical standpoint, improving standard care for all patients may, in fact, prevent the most readmissions for your hospital.

Let’s run the numbers

In 2013, it was still common to encounter hospitals with one new high-risk readmissions reduction program. Often, this program was focused on providing enhanced services to a diagnosis-defined population, such as patients discharged with a primary diagnosis of heart failure. Often, the program had one new clinician dedicated to a small patient population. This meant that in some cases, not all of the possible eligible patients were identified, and not all of the identified patients were served, despite the intended impact of this program being to reduce readmissions by 20 percent.

In a typical hospital with 5,000 Medicare discharges annually and a 20 percent Medicare readmissions rate, we would expect 1,000 Medicare readmissions. The heart failure transitional care program with one FTE identified 250 and served 200 heart failure discharges, with an expected readmissions rate of 25 percent. The stated aim of the program was to reduce readmissions by 20 percent in this subgroup. Thus, we would expect 50 readmissions in this cohort (25 percent of 200) and hope to avert 10 readmissions annually (20 percent of 50). Although this program and this hard-working care transitions clinician achieved their objective and served these 200 discharges well, the hospital has only succeeded in reducing its Medicare readmissions rate by 1 percent (10 out of 1000).

This will not bring success. A portfolio of complementary strategies is needed.

	Number	Rate
# Medicare discharges/year	5,000 discharges	
Medicare readmissions rate		20%
# Medicare readmissions/year	1,000 (0.20*5000)	
High-risk intervention	200 discharges/year	
High-risk readmissions rate		25%
# Expected readmissions	50 (0.25*200)	
Expected impact of intervention		20%
# Readmissions averted by intervention	10 (0.2*50)	
Hospital-wide readmissions impact	10 readmissions avoided	10/1000= 1% overall

Develop a portfolio of efforts

Opportunities to reduce readmissions are numerous, involve various departments, existing and new staff, and new partnerships. Without a unifying framework, the list of to-dos can seem disconnected or, worse, optional. In fact, each is essential to a comprehensive strategy to reduce hospital-wide readmissions. The primary drivers represented in the driver diagram can provide one such unifying framework. They include responsibilities within the following areas:

- Emergency departments avoiding unnecessary admissions and addressing frequent utilizers
- Inpatient settings (medicine and surgery) improving standard processes for all patients
- Hospitals and skilled nursing facilities partnering to avoid re-hospitalizations
- Transitional care teams providing enhanced post-hospital services to patients at high risk of readmission for clinical or social reasons, who do not otherwise have such support
- Palliative care articulating plans to better manage recurrent symptoms as alternatives to hospitalization, with improved referrals to hospice care when needed

These five major components of a robust portfolio are the most common unifying strategies across a wide variety of hospitals nationally; your hospital-specific strategy may include others. We encourage you to consider action in each of these domains as you re-visit your strategy.

Portfolio Strategy



Let's run the numbers again

Here is an example of an expanded portfolio of efforts: a hospital will implement an improved set of standard, known processes for all admitted patients, consistent with the new CMS Conditions of Participation. In addition, the inpatient units will redesign care to incorporate a warm handoff protocol to skilled nursing facilities. Finally, the hospital will invest in a care transitions team who will provide 30 days of post-discharge coaching and support to high-risk patients who do not otherwise have access to transitional care. An example looks like this:

Let's Run the Numbers: *Three-part Strategy*

	Number	Rate
# Medicare admissions/year	5,000 admissions	
Medicare readmissions rate		20%
# Medicare readmissions/year	1,000 readmissions	
1. Improve standard care	5,000 admissions	20% readmissions rate
Expected effect		10%
# Expected readmissions reduction	100 readmissions avoided	
2. Collaborate with receivers	1,650 admissions (1/3 total)	30% readmissions rate
Expected effect		20%
# Expected readmissions reduction	99 readmissions avoided	
3. Enhanced service for pilot	200 admissions	25% readmissions rate
Expected effect		20%
# Expected readmissions reduction	10 readmissions avoided	
Hospital-wide readmissions impact	209 readmissions avoided	209/1000= 20% overall



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Model the Impact of Your Strategy

Focus on the numbers, drive down readmissions

As you are revisiting your strategy — what has been working, what hasn't, what good intentions went undone, and what new ideas should be added — model the impact of your strategy on your hospital-wide readmissions rates. Maintaining a laser focus on the extent to which the overall strategy can be expected to reduce readmissions is more important than ever as hospitals are measured independently and statewide.

Estimating impact: a simple example

A simple example of how to estimate the impact of readmissions reduction efforts comes from a template that CMS required of applicants to the Community-based Care Transitions Program. This template prompted applicants to think through some very helpful considerations in estimating the impact and assessing the efficiency of the resources they were requesting. An example is in the Appendix. The modeling includes:

- Total eligible discharges (target population)
- Total eligible discharges that will be served by the intervention (account for attrition)
- Readmissions rate among eligible discharges
- Estimated impact of the intervention
- Total number of readmissions avoided
- Average financial cost of a readmission
- Gross potential savings from averted readmissions
- Cost of the intervention (staff, IT, etc.)
- Net potential savings from averted readmissions

This exercise can provide a starting point to model the impact of your multi-faceted readmissions strategy and provide early feedback about the cost-efficiency of the investments required. Although simple, this can prompt deeper and more sophisticated conversations within your organization.





Improve Standard Care for All

“Why invest in improved care for all patients? Shouldn’t we focus on high risk only?”

Referring back to your data analysis, you probably found that the top 10 readmissions diagnoses for Medicare differed in important ways from the top 10 readmissions diagnoses for Medicaid, and that for either of them, the top 10 diagnoses that led to readmissions accounted for only 20 percent of total readmissions. Conditions such as frailty, depression, dementia, and the end-of-life stage are frequent drivers of readmissions, but are rarely primary diagnoses for hospitalizations and are thus not captured in administrative data analyses. Looking further, you would find that conditions with small-volume admissions, such as HIV, cancer surgery, or sickle cell, have very high readmission rates. Beyond clinically predicted risks, if you were able to quantify how many of your patients were on or newly starting high-risk medications, or required to take multiple medications, or have low literacy, are unstably housed or employed, or have no experience navigating the health care system, you would see that a majority of your patients have known risk factors for readmissions.

It’s no longer a nice-to-do: it’s a must-do! The new CMS Conditions of Participation

The May 2013 Conditions of Participation draw from well-known best-practice recommendations and require hospitals to demonstrate the following activities:

- Analyze and trend readmission data
- Review readmissions and look for root causes
- Have a standard, known discharge planning process
- Use an evidence-based method for screening patients for discharge planning needs
- Assess — and reassess — patients for their discharge planning needs
- Engage patients in assessing needs and in planning for after-hospital care
- Engage patients’ families, caregivers, and others in creating a discharge plan
- Know the capabilities of post-acute and community providers, including support services
- Arrange for post-discharge services and support services prior to discharge
- Teach patients and their families self-care skills using the teach-back technique
- Provide a customized written discharge plan for all patients
- Communicate effectively with “receiving” providers

“We’ve reviewed our processes and have all of these elements in place”

Although meeting the letter of the law regarding the Conditions of Participation may require adequate demonstration of policies and procedures in place, we strongly encourage your readmission improvement teams to embrace them to extend, deepen, and make more reliable the policies and procedures you have in place. Meeting the spirit of the conditions will transform your inpatient teams into caregivers who incorporate a whole-person view of each patient, recognize their needs prior to entering the hospital, and anticipate and provide for their needs after leaving the hospital. Your teams will recognize they cannot adequately understand this perspective without seeking input from families, caregivers, and outpatient providers, and that addressing these needs requires intense collaboration with community-based and post-acute providers that goes well beyond a vendor relationship. Your teams will no longer wait until the day of discharge to teach patients and caregivers what to expect after leaving the hospital and to outline what follow-up arrangements have been made. Patients and families will no longer feel rushed and confused, will have guidance specifically tailored to their needs, will understand their next steps, and will know who to call with questions. The result: You will see higher satisfaction scores.

Learning from others and adapting for your organization

The most common lesson learned from successful hospitals is that each of their solutions was tailored to the unique context of their organization. Although we encourage you to establish a standard protocol using these elements, implementing each one reliably will require testing and customization. Your teams will require coaching, permission to try and fail, and resources to implement what works.

A Few Implementation “Pearls” From the Field:

Conditions of Participation Requirement	Example From the Field
Know and trend data	Create a monthly readmissions dashboard, drawn from variety of sources; post the dashboard on the intranet and/or units for transparency.
Review readmissions and analyze root cause	Interview all readmitted patients; this serves as a root cause analysis tool as well as an opportunity to improve care for that specific patient.
Have a standard, known process	Map the activities of the assessment through discharge planning process from the patient view and identify gaps and redundancies.
Screen for discharge needs	The BOOST 8P tool is a great starting point to identify numerous readmission risks, education, and support service needs upon discharge.
Assess and reassess	Reassess based on clinical changes, functional debility, delirium, inability to perform “teach back” and social needs that come to light.
Engage patients and families and caregivers	Identify the “learner” or “care plan partner” for every patient. This is the person who will help execute the self-care and follow-up plans.
Know capabilities of post-acute providers	Cross-continuum team meetings, INTERACT Nursing Home Capabilities Checklist; a “community resource fair” during lunch or local conference.
Arrange for services	Use capacity in your staff (unit secretary, nurse call center, satisfaction call center) to schedule appointments prior to discharge.
Use teach-back	Care team identifies 3-5 self management and/or follow-up tasks for the patient/learner to know in the next week; use same messages across settings.
Customized Care Plan	The RED After Hospital Care Plan is a great example of plain-language, need-to know discharge instructions and a visual, intuitive medication list.
Communicate with “receivers”	A Boston system requires the discharge summary dictated <24h; a North Carolina system conducts warm handoffs for all SNF patients.



Improve Transitions Across the Continuum

Use your cross-continuum team to extend and multiply your efforts

By definition, a transition involves a “sending” (referring) and “receiving” (accepting) provider. The **best transition out of your setting is only as good as its reception into the next setting.**

There are several concrete and practical objectives when forming a cross-continuum team.

Some of the more immediate are:

- Declare to your referral partners your hospital’s readmissions reduction goals
- Describe the efforts your hospital is implementing to reduce readmissions
- Understand what your referral partners are doing to reduce readmissions
- Understand what information your receivers need to avoid a bounce-back to your hospital
- Strengthen relationships among providers who share the care of common patients
- Broaden the base of problem-solving for groups of patients, or specific high-risk patients
- Identify committed referral partners that will help you achieve your goals

Most Maryland hospitals have formed some version of cross-continuum partnerships. Many are thriving and high-value, while others are in development. The learning sessions we have held for the *Transitions Handle with Care* campaign have demonstrated the value of consistently meeting with, and working on improvements with, your referral partners.

Forming a cross-continuum team does not, and should not, represent a major new strategic business decision. Cross-continuum teams start with the providers with which you already share high-risk patients. Acknowledge that not all potential partners are at the table, and allow the group to expand naturally over time. Often, starting with a small group allows for stronger relationships and the creation of a common agenda; growth springs from that.

A cross-continuum team might include:

- Skilled nursing facilities
- Home health agencies
- Hospice
- Elder service providers
- Social service providers, including housing services
- Adult day health programs
- Outpatient pharmacies, especially if they engage in bedside delivery or educational services
- Practice managers from large group practices, local patient-centered medical homes, accountable care organizations
- Behavioral health providers, especially behavioral health homes

“Cross-continuum teams start with the providers with which you **already** share high-risk patients.”

Essential actions of the cross-continuum team

While some readmissions advocates have been known to question investment in cross-continuum meetings because of the perception that they are “just talk,” the fact is the cross-continuum team is a valuable tool to develop multi-disciplinary professionalism, establish efficient communications strategies, identify common patterns in readmissions that may elude the hospital’s perspective, and more:

- Relationship building: Providers meeting other providers who share the care of their common patients is a key objective of the meetings.
- Multi-disciplinary professionalism: Understanding the priorities, challenges, and perspectives of professionals who deliver care in different settings is an essential component of a modern health care team.
- Readmissions reviews: It is important that receivers’ perspectives of accepting patients from the hospital be shared, thus creating a culture of constructive criticism to identify specific improvements to the process.
- Shared problem solving: Set an organic action agenda that borrows from the quality improvement mantra, “see a problem, fix a problem.” Prioritize addressing the challenges identified by the receiving providers before you ask them to change.

Subgroups and task forces

Just as your hospital has a multifaceted readmissions reduction effort, it is likely that you will develop a multifaceted agenda for your cross-continuum team. As a team grows and evolves, we often see the subgroups form. Not all divisions are segmented by setting; some challenges may require one representative from each setting to be on a subcommittee.

Examples include:

- Updated and shared heart failure education materials across settings
- Improved communication of goals of care across settings
- Notification of the broader care team of the admission or discharge
- “Who’s on first” for care coordination (patient-centered medical home, accountable care organization, hospital, payor, etc.)
- How to engage patients, families and caregivers in improvement across settings
- Implementing INTERACT (Interventions to Reduce Acute Care Transfers) for emergency department, hospitalist, skilled nursing facility, and more
- Efficient referrals to adult day care services (case managers, primary care provider)
- Physician to physician communications (hospitalist, skilled nursing facility medical director, primary care provider)
- Developing a cross-setting readmissions dashboard

Examples of a cross-continuum team invitation letter, meeting agenda, and potential community partners are in the Appendix.



Hospital to Skilled Nursing Facilities

Improving the transition from hospital to post-acute facility (skilled nursing, inpatient rehabilitation, and other similar facilities) is a high-leverage opportunity for improvement for the following reasons:

- Readmissions rates are generally highest between hospitals and post-acute facilities
- Warm handoffs can be implemented, with opportunities for clarification
- Clinical changes can be identified and addressed in the facility, or via treat and return from the emergency department

Best practices to improve the transition from hospital to skilled nursing facilities include:

- Know your data – for the hospital and each skilled nursing facility
- Jointly review readmission events between hospital and skilled nursing facility
- Form a working group with numerous providers to improve efficiency and enhance learning
- Use readmissions reviews to generate specific ways to improve handoffs and emergency department transfers
- Implement nurse to nurse warm handoffs, with the hospital nurse to call the skilled nursing facility within 24 hours to “circle back”
- Provide phone/pager number for questions and clarifications
- Send written hard copies of pain medication prescriptions at transfer
- Send a three-day supply of narcotics and other difficult-to-obtain medications to the skilled nursing facility
- Adopt the principle that the receiver defines what information it needs to assume care
- Refer to the INTERACT-3 hospital to skilled nursing facility example transfer document
- Skilled nursing facilities adopt INTERACT-3 practices
- Work with emergency department teams to use the INTERACT forms; treat and return rather than readmit
- Ensure a safe transition from the skilled nursing facility to home using similar hospital to home practices

A worksheet prompting specific action planning to improve your hospital to skilled nursing facility transitions is in the Appendix.





Hospital to Home Health

The transition from hospital to home health (nurse, therapist, medical social worker, home health aide) is a high-leverage opportunity for improvement for the following reasons:

- They typically represent the second highest rates of readmission (second to skilled nursing facilities)
- By definition, patients have “readmissions risks” (need skilled care, multiple comorbidities)
- Clinicians scheduled to provide follow-up soon after discharge are an important asset

Best practices to improve the transition from hospital to home health include:

- Know your data – for hospital and for each agency
- Jointly review cases of readmissions from home health and generate ideas for improvement
- Form a home health work group to meet with several agencies at once and share learning
- Have a home health liaison meet with the patient, caregiver, and staff prior to discharge
- Provide first contact within 24 to 48 hours; consider daily contact by phone for first 14 days
- Front-load the episode by providing intense contact by phone and in person at initiation
- Provide patients and caregivers with a symptom-specific action plan with customized info
- Provide “call me first” instructions to the patient and caregivers
- Ensure all patients have a primary care provider and follow-up within three to five days
- Ensure medications are clarified within 48 hours of episode initiation; escalate if needed
- Ensure equipment and prescriptions are received; escalate if needed
- Discuss goals of care, reason for hospitalization, home care goals, and patient goals
- Obtain orders for other disciplines, to provide “head-to-toe” treatment plan
- Create a high-risk alert system so staff on call are informed of high-risk patients
- Share readmission risk assessments conducted inpatient with post-acute providers

A worksheet prompting specific action planning to improve your hospital to home health transition is in the Appendix.





Hospital to Home with Services

The transition from hospital to home is the most common transition type, and it is fraught with challenges for patients, caregivers, and community-based providers. Patients should not leave the hospital without:

- A **follow-up appointment** three to five days following discharge
- A **contact number** (hospital or otherwise) to call with questions post-discharge
- A clear, accurate **medication list**, with **confirmed ability** to obtain medications
- A **verbalized understanding** of why they were hospitalized and self-care instructions

Best practices to improve the transition from hospital to home include:

- Identify patients at high risk of readmission based on clinical, utilization, and social factors
- Identify the “learner:” do not assume the patient will retain information
- Use “teach-back” with patients/caregivers
- Ensure goals of care discussions are communicated to receiving clinicians
- Complete discharge summary at the time of discharge
- Ensure follow-up appointments are made prior to discharge
- Ensure follow up of some sort (phone, visit, office) occurs within 24 to 72 hours for high-risk patients
- Provide a direct linkage to existing community-based care managers
- Provide transitional care for high-risk patients without community-based care managers
- Use hospital-based or community pharmacists to assist with medication management
- Provide bedside delivery of medications to reduce barriers to adherence
- Know local services and support and optimize available resources

A worksheet prompting specific action planning to improve your hospital to home transitions is in the Appendix.





Emergency Department–based Interventions

Reducing readmissions by focusing on the “front door”

Many readmissions reduction best practices have been developed from a body of literature that documented the failures of the discharge process and vulnerabilities of the post-discharge period. Thus, strategies to reduce admissions and readmissions from the emergency department are relatively under-described. However, some of the most successful examples of these strategies include the emergency department:

- One strategy used by Maryland’s Total Patient Revenue hospitals (those operating under a global budget) was to staff social workers in the emergency department to connect individuals to community resources
- The Massachusetts General Hospital’s CMS High Cost Beneficiary Demonstration¹ notified the patient’s extended care team when registered by emergency department triage; the care team was expected to propose and coordinate ambulatory care as an alternative to an admission
- INTERACT (Interventions to Reduce Acute Care Transfers), the gold-standard resource for skilled nursing facilities to reduce readmissions and avoid unnecessary admissions, focuses heavily on providing complete, succinct information to the emergency department and facilitating evaluate-and-return when safe and appropriate

Best practices to reduce (re)admissions from the emergency department include:

- Train emergency department staff on how to use INTERACT forms from skilled nursing facilities; encourage emergency department physicians to call to clarify the nature of the complaint, especially if the patient cannot provide detailed information
- Develop an understanding with local skilled nursing facilities about the circumstances under which they can accept patients back from the emergency department
- Ask local skilled nursing facilities to fill out the INTERACT “Nursing Home Capabilities List,” and post it in key areas of the emergency department to facilitate returns for low-acuity conditions
- Staff a dedicated admission avoidance care transitions clinician in the emergency department to coordinate with families, outpatient providers, and social services for patients with low-acuity presentations who could be discharged without admission
- Create a flag in the emergency department record to make it visible to staff that the patient is a frequent user or a potential 30-day readmission
- Create individualized care plans for frequent users who present with recurrent but otherwise stable complaints

¹ Available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Reports/downloads/mccall_mgh_cmhcb_final_2010.pdf



Medicaid Readmissions

Why focus on Medicaid readmissions?

Because most of the best practice recommendations to reduce readmissions were derived from research on the older adult population, there is a need to consider what the unique issues and patterns are for the younger, socially and/or medically complex population.

What do we know about patterns of Medicaid readmissions?

- Adult (non-obstetric) Medicaid readmissions rates are higher than Medicare rates
- More than 80 percent of adult Medicaid patients are discharged to home
- High prevalence of psychiatric discharge diagnoses leading to readmissions
- Unstable housing is a known risk for frequent emergency department and acute utilization

How to ensure your readmission portfolio addresses Medicaid-specific issues

- Run your data by payer type: Medicare v. Medicaid v. commercial, and examine the differences
- Interview Medicaid patients readmitted to your hospital; listen to what barriers they experienced between discharge and readmission
- Expand your cross-continuum team partners to include Medicaid-serving agencies that could mitigate those barriers, such as primary care providers, specialists, and patient-centered medical homes that take Medicaid patients, behavioral health providers, adult day health, housing agencies, transportation services, and legal advocates
- Engage Medicaid managed care plans in developing population-specific approaches to drivers of frequent acute care utilization and solutions for specific individuals
- Leverage other community resources to help patients navigate the health care system, such as faith-based organizations and volunteer groups, community health workers, etc.





Behavioral Health

What do we know about behavioral health readmissions?

According to Health Services Cost Review Commission data, three of the top 10 diagnoses leading to readmissions in 2012 were psychiatric diagnoses (see list below). Many behavioral health conditions are not listed as primary diagnoses, and are either listed as comorbidities, or not listed or even adequately recognized, when present. Thus, the presence of behavioral health conditions among readmitted patients is high and likely substantially under-reported.

Diagnoses Leading to Readmission All Payers, Maryland 2013

1. Heart failure
2. Sepsis
3. COPD
4. Pneumonia
5. Bipolar disorder
6. Renal failure
7. Schizophrenia
8. Kidney and urinary tract infection
9. Major depression
10. Arrhythmia

Promising approaches:

- Improve standard care, for all patients; this lowers the chance you miss a high-risk patient
- Ask the patient if he/she has any behavioral health concerns; patients usually respond truthfully
- Inquire if the patient receives services from a local behavioral health provider; this can reduce the sensitivity associated with a particular diagnosis or specific service
- Resist modifying psychiatric medications without contacting the outpatient prescriber
- Always arrange for follow-up with a patient's behavioral health provider following discharge, just as you would for medical and other service providers
- Refer patients with behavioral health comorbidities to skilled nursing facilities and home health agencies that have specialized training in, or more experience in, behavioral health
- Seek out the behavioral health providers in your area and identify three things you can improve in the short term; establish a primary point person at their agency and your hospital to engage in real-time problem solving for patients, as needed
- Co-develop individualized care plans with multi-disciplinary input, including behavioral health providers



Palliative Care and End of Life

What is the role of palliative care in reducing readmissions?

Too many patients repeatedly return to the acute care setting because they experience chronic, recurrent symptoms that are a manifestation of a stable process, or chronic persistent symptoms that are inadequately managed. Symptom management, goal setting, providing anticipatory guidance and synthesizing a coordinated plan of care across numerous providers are among the numerous contributions a palliative care provider can offer that can substantively improve the quality of patients' care and reduce acute-care utilization.

- **Tip from the field:** one hospital has an automatic palliative care/hospice referral protocol for patients who meet specified criteria and have been hospitalized more than three times in six months.

What is the role of hospice in reducing readmissions?

Many of us recognize that hospice is an underutilized resource that can add quality to an individual's life when they are on an end-of-life trajectory. Unfortunately, most hospitals report that their physicians are reluctant to refer patients to hospice until death is imminent. Hospitalists can be encouraged to engage in additional training in end-of-life care to better equip them to take leadership roles in having these conversations with patients earlier, as appropriate.

- **Tip from the field:** hospice agencies may be willing to meet with a patient and family for an advisory consultation, even before a decision to transfer to hospice has been made.

What is the role of MOLST forms in reducing readmissions?

Medical Orders for Life Sustaining Treatment (MOLST) forms¹ are a reflection of a conversation that a physician has had with a patient or their proxy about goals of care and wishes for a variety of interventions, including hospitalization. MOLST forms are not limited to "code status discussions," although they do document that. A local initiative to increase the use of MOLST would certainly increase the frequency of conversations that patients and their providers have in the inpatient and outpatient settings, and lead to more frequent and more complete consideration of health care goals and preferences.

- **Tip from the field:** one hospital changed its standard admission order set to reliably prompt admitting physicians to document code status and whether patients have a MOLST form in effect.

¹ Available at: http://marylandmolst.org/pages/molst_form.htm



Glossary and Links to Resources

We have referred to many well-known best practice toolkits and other resources throughout this playbook. Below are brief descriptions and links for your reference:

INTERACT: Interventions to Reduce Acute Care Transfers

- Gold-standard reference for skilled nursing facilities to reduce the frequency of transitions to the emergency department
- Set of process improvement recommendations and tools; integrated transformation
- Focus areas: early detection of change in clinical status, effective nurse-physician communication, numerous evidence-based protocols for management of common issues on-site, goals of care communication training, skilled nursing facility capabilities list, nursing home to emergency department transfer form and guidance for hospital-to-skilled nursing facility transfer data elements
- When implemented well, reduces acute-care transfers by about 30 percent
- Resources are free at: <http://interact2.net/>

STAAR: State Action on Avoidable Rehospitalizations

- First resource aimed at reducing readmissions at a state level, through local collaboration (“cross-continuum teams”) and state-level coordinated action
- Views all improvement efforts as shared task between “senders” and “receivers”
- Developed the “readmission interview” approach and the “cross-continuum team” concept
- Issue briefs: Measuring Rehospitalizations at the State Level, Working Together in a Cross-Continuum Team; Engaging Physicians; Effect of Readmission Penalties
- Health Affairs publication describes state efforts in four states: Boutwell et. al., July 2011
- How-to guides customized to each transition
- Resources available at: www.ih.org/staar

RED (Re-Engineered Discharge)

- Five part intervention: discharge checklist, discharge advocate, patient education avatar, patient-friendly after-hospital care plan, and post-discharge pharmacist phone call
- Together, these interventions reduced return to emergency department or readmission by about 30 percent
- Developed first “discharge checklist,” composed of 11 elements, widely used
- Developed the concept that “when discharge is everyone’s job, it is no one’s job”
- Discharge advocate is intended to ensure all components of checklist are complete by the multi-disciplinary professionals in the hospital, not directly perform each task
- New guidance on “How to Conduct the Post Discharge Phone Call” very helpful
- Resources free at: <http://www.bu.edu/fammed/projectred/toolkit.html>

BOOST: Better Outcomes for Older adults through Safer Transitions

- Focused on the hospital-based quality improvement team
- Reviews fundamentals of setting up and executing a successful quality improvement effort
- BOOST 8P Tool is widely used throughout the nation to prompt a robust consideration of readmission risks, and then address/mitigate those risks
- TARGET tool is a multi-faceted tool incorporating risk assessment, risk mitigation, a universal discharge checklist, and a general assessment of preparedness for discharge
- Emphasizes the role of the hospitalist in championing the improvement effort
- Emphasizes the use of teach-back as a core transformation in patient communication
- Resources free at: www.hospitalmedicine.org/boost
- Teach-back curriculum available for a fee at that same site (click on "resource room")

Colorado Foundation for Medical Care "Care Transitions Toolkit"

- Multifaceted tools aimed at the community coalition/cross-continuum team specifically
- Contains most information about conducting a readmissions root cause analysis
- Unique focus area on building coalitions in communities and community engagement, including development of a community charter or memoranda of understanding
- Focuses on obtaining and using community or common data sources
- Endorses using many and all relevant quality improvement tools and care models
- Resources free at www.cfmc.org/integratingcare/toolkit

Next Step in Care

- Developed for family caregivers by the United Hospital Fund
- Caregiver-specific tools and resources to prompt a complete discussion of goals of care and care preferences, engaging the caregiver in after-hospital care planning, understanding what post-acute care entails, and a discharge planning worksheet
- Resources free at www.nextstepincare.org

CMS Discharge Planning Conditions of Participation

- Issued May 2013
- Link to complete 39-page surveyor guidance document at:
<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-32.pdf>

[Forthcoming] Hospital Guide to Reducing Medicaid Readmissions

- Co-designed by Collaborative Healthcare Strategies and John Snow Inc.
- Anticipated release June 2014
- Collaborative Healthcare Strategies and MHA will distribute when available



Online Resources

Web-based quality improvement resources

- The Institute for Healthcare Improvement provides a **step-by-step model for improvement** with access to tools and improvement stories. Available at www.ihf.org
- The Department of Community and Family Medicine of Duke University Medical Center offers free, interactive learning modules on **quality improvement, anatomy of errors, and mistake proofing care**. Available at <http://patientsafetyed.duhs.duke.edu/>
- The Agency for Healthcare Research and Quality (AHRQ) boasts an array of resources, including:
 - a guide to **patient and family engagement** in quality and safety, a resource to help hospitals work as partners with patients and families to improve quality and safety. Available at www.ahrq.gov
 - access to the powerful, **evidence-based teamwork system** designed for health care professionals – TeamSTEPPS – available at <http://teamstepps.ahrq.gov/>
 - the **Health Care Innovations Exchange**, created to speed the implementation of new and better ways of delivering health care. Search, learn, and network the Exchange at www.innovations.ahrq.gov
- The Public Health Foundation maintains a **performance management toolkit** and quality improvement resources at www.phf.org
- The American Society for Quality's Knowledge Center links to tools, publications and webcasts and videos on **Lean, Six Sigma** and creating a **quality-focused business culture** and many other topics. Available at www.asq.org



Presentations and Webinars

Transitions: Handle with Care Presentations and Webinars Available Online at:
www.mhaonline.org/quality/transitions-handle-with-care

Statewide Meetings

March 2013 Kick-off Meeting

- Pre-work packet
- Amy Boutwell – keynote presentation
- HSCRC presentation and data
- Special Populations Presentation: Behavioral Health
- Special Populations Presentation: Hospice
- Special Populations Presentation: Medicaid
- SMART Discharge Protocol
- Targeted Solutions Tool presentation
- Regional Coalition Success Stories
- Amy Boutwell – working session

November 14, 2013

- Participant workbook
- Hospital presentations:
 - Hospital to Skilled Nursing Facilities – Johns Hopkins Health System
 - Hospital to Home Health – New York Methodist Hospital
 - Hospital to Home – Adult Day Medical Services - Easter Seals
 - Hospital to Home – Pharmacy Services - Washington Adventist
 - Bring it Together: The Portfolio Approach – Frederick Memorial Hospital

Webinars

(all presentations and recordings are available online)

- *Knowing Your Readmissions Data: The First Step to Effective Change*
- *Improving Care Transitions for Mental Illness and Substance Use Disorder*
- *Involving Patients and Families in Reducing Avoidable Readmissions*
- *The Role of Pharmacists and Local Pharmacies in Reducing Avoidable Readmissions*
- *Partnering with Medicaid Managed Care*
- *Nursing Homes – Reducing Unnecessary Hospital Transfers, Admissions and Readmissions*
- *Improving Care Transitions between Hospital and Home Health*
- *Addressing Health Care Disparities and Health Literacy to Reduce Hospital Readmissions*
- *Partnering at the Local Level to Reduce Behavioral Health Readmissions*
- *Strategies for Success Under New Medicare Waiver: Part 1*
- *Strategies for Success Under New Medicare Waiver: Part 2*

Section 8: Appendix



Template Press Release

This is a template press release for distribution to media announcing your participation in the campaign. We suggest working with your hospital communications staff to present this to local media outlets.

FOR IMMEDIATE RELEASE

Month, Day, 2014

Contact:

[Name, Title]

[Phone Number]

[HOSPITAL NAME] PARTICIPATING IN STATEWIDE CAMPAIGN TO REDUCE READMISSIONS

[CITY], Maryland —[HOSPITAL NAME] is participating in the *Transitions: Handle With Care* campaign, a statewide effort that brings together hospitals and other community providers who coordinate care for patients after they leave the hospital. The goal is to reduce by 5 to 10 percent per year for the next five years readmissions within 30 days of a hospital discharge. This is in line with a statewide goal aimed at bringing Maryland's readmissions rates to the U.S. national average by 2018.

Specifically, [HOSPITAL NAME] has developed a "cross-continuum team" with numerous community-based care providers in the region, including: [LIST ALL ORGANIZATIONS YOU ARE WORKING WITH HERE]. This highly innovative cross-setting and multidisciplinary collaboration recognizes that the follow-up care patients receive after leaving the hospital is as important as the care they received during their hospital stay.

"When re-hospitalizations occur soon after discharge, we ask ourselves what we could have done to better prepare the patient or coordinate among their other community providers to avoid a return so soon," said [HOSPITAL LEADER'S NAME, TITLE]. "[HOSPITAL NAME] is pleased to be part of the campaign because not only can we help patients and their families in our community spend more nights in their own beds instead of in the hospital, but we can also help make health care more affordable for all Marylanders."

Hospital staff at [HOSPITAL NAME] have been working on reducing avoidable readmissions, specifically on [ADD SPECIFIC HOSPITAL FOCUS] discharge planning, medication management, patient and family engagement, transition care support, and transition communications. They have reached out to other health care organizations in the community to work together in a concerted effort in these areas.

The *Transitions: Handle with Care* campaign was created and is being led by the Maryland Hospital Association in collaboration with more than 20 state-level associations and stakeholder agencies. The initiative is coordinating with many readmissions-reduction efforts in the state.

"The entire nation is tackling this complex health care issue," said [HOSPITAL LEADER'S NAME, TITLE]. "[HOSPITAL NAME]'s participation in this program shows that we are committed to being a leader in improving patient care and in strengthening the coordination of care across our entire community. Furthermore, we can help Maryland lead the country in reducing avoidable readmissions."

Section 8: Appendix



Readmissions Data Analysis

Use the most recent 12 months of data available, calendar or fiscal year. Count readmissions as any return to the inpatient setting for any reason within 30 days of discharge from the inpatient setting. This analysis is for adult medical/surgical patients, non-OB, non-pediatric. Exclude discharges that are coded as deaths or transfers to another acute care hospital.

Data Element	Medicare	Medicaid	Commercial	Total
1. Total number of adult discharges <i>(exclude transfers, deceased, <18 yrs, OB)</i>				
2. Total number of individual patients				
3. Total number of 30-day readmissions				
4. Overall readmission rate (#3/#1)				
5. Discharge disposition, from #1 a. Home b. Home with home health c. SNF				
6. Number of days between discharge and readmission <i>(frequency plot of discharge days 0-30 and the number of readmissions that occurred on each post-discharge day)</i>				
7. Top 10 discharge diagnoses resulting in readmissions <i>(from the index discharge, run for each payer class)</i>				
8. High-utilizing population (H.U.) a. Number of people hospitalized >3 times in the past 12 months (H.U.) b. Total number of hospitalizations among H.U. c. Discharge disposition of H.U. d. Top 10 discharge diagnoses among H.U. e. 30-day readmission rate among H.U.				



Readmission Interview Protocol*

Section 1: Brief chart review (10-15 minutes)

Elicit the following basic information:

- Date of first admission:
- Date of first discharge:
- Chief complaint and medical issues during first hospitalization:
- Discharge disposition:
- Was a follow-up appointment made prior to discharge?
- Date of readmission:
- Days between discharge and readmission:
- Site of care readmitted from (home, SNF, home health, etc.):
- Readmission chief complaint and medical issues during the second hospitalization:
- Discharge disposition (if they are no longer in the hospital):

Section 2: Patient /family caregiver interview (10-15 minutes)

Suggested script: "We are working to improve the discharge process and noticed that you have been in the hospital twice recently. I'd like to ask you for about 10 minutes of your time to provide us with some feedback about what happened between the time you were discharged and the time you returned to the hospital. This will help us understand what we might be able to do better for you, and what we might be able to do better for our patients in general. Would that be OK with you?"

- Why were you in the hospital (dates of the first admission)?
- What did the hospital team do to help you get ready to leave the hospital?
- Did the hospital team talk to you about what to do and expect once you left the hospital?
- Did you know who to call if you had questions or problems?
- Tell me about anything that was unclear or confusing or difficulty for you when you left the hospital.
- I see you went to discharged disposition. How did it go once you got there?
- Did any new symptoms or issues come up after you were discharged?
- Did you see a doctor, nurse, or other provider after you were discharged? Who?
- Why do you think you needed to come back to the hospital?
- Was there anything we could have done differently to help keep you from needing to come back?
- Do you have any other suggestions for us?
- Thank you!

Section 3: Provider interview (3-5 minutes)

Suggested script: "We are working to improve care transitions and reduce avoidable readmissions. One of your patients was recently readmitted to our hospital and we'd like to ask for your perspective about opportunities for improvement in our overall processes. It will take no more than five minutes of your time."

- Did you know the patient was admitted on (first hospital date)?
- Did you know the patient was being discharged to (setting) on (date)?
- Did the patient contact you after discharge?
- Did our hospital contact you at all about the admission or discharge plan? If so, describe interaction.
- Did you have contact with the patient after discharge? If so, describe the interaction.
- Why do you think the patient ended up being readmitted?
- Do you think there was anything that could have been done (socially or clinically) to prevent this?

*Adapted from the original IHI STAAR Readmission Review Tool



Cross-Continuum Team Sample Invitation Letter

Dear Colleagues and Partners,

[YOUR ORGANIZATION] invites you to join us at a *first cross-continuum team* meeting to improve care transitions and reduce avoidable readmissions on [DATE] from [TIME] at [LOCATION].

[YOUR ORGANIZATION] is committed to high-quality, safe care, including at times of transition between care settings. [YOUR ORGANIZATION] has embraced the performance requirements of the new waiver with CMS and has recently made *reducing avoidable readmissions through improving care* a top quality initiative. Our aim is to reduce readmissions [X] percent over the next 12 months.

We know that *our success depends on strong partnerships with you* – the providers with whom we share the care of patients in the greater [YOUR NAME] community.

To that end, we are hosting an open “cross-continuum” meeting among hospitals, skilled nursing facilities, home health agencies, aging service providers, assisted living facilities, primary care practices, pharmacies, and other interested stakeholders. We hope to foster an *active and highly productive community-based coalition* of providers working in alignment toward a common goal of safe transitions in care for our common patients.

Please join us! We will be [SERVING LUNCH] *during this working meeting*. Please come for all or part of the meeting. If you are not available, we would welcome a colleague from your organization.

We look forward to working together toward the improved care of our patients in [YOUR COMMUNITY]. Please do not hesitate to contact me with any questions.

Kind regards,



Sample Agenda for Your First Cross-Continuum Team Meeting

Length: 60 minutes
Setting: Hospital/other conference room
Attendees: Hospital readmissions reduction team

- Executive sponsor (Chief Medical Officer, Chief Quality Officer, Chief Nursing Officer, Director of Case Management, etc.)
- Day-to-day leader (readmissions champion)
- Quality
- Nursing
- Hospitalist/physicians
- Emergency department (including ED case management)
- Patient advocate
- Post-acute and community-based providers
- Skilled nursing facilities
- Home health and hospice
- Behavioral health
- Adult day health
- Large group practices, patient centered medical home, Accountable Care Organizations
- Local pharmacy
- HMO/MCO that might be providing case management to patients
- Senior service providers (e.g. Area Agency on Aging, assisted living)
- Social service providers (e.g. housing, transportation)

Agenda:

- Introductions of hospital team and community based providers
- Review a readmission case study together
- Review readmissions data – hospital data, and any available partner data
- Share your hospital's readmission reduction goal (what by when)
- Invite partners to describe readmissions reduction efforts in their settings
- Brainstorm opportunities to collaborate on shared objectives
- Next steps
 - Next meeting in one month
 - Setting (hospital, community center, post acute facility, etc.)
 - Additional partners to invite
 - Establish follow-up items



Hospital to SNF Action Planning Worksheet

This worksheet is a suggested discussion guide to help you identify opportunities for improvement.

1. Know your data and review readmission events

- Hospitals: Do you track readmissions from SNFs (and/or other facilities)? By facility?

- Hospitals: What is your hospital's readmission rate from SNFs?

- SNF/facility: Do you track (re)admissions to the hospital?

- SNF/facility: Describe how your facility measures acute (re)hospitalization.

- Both: Do you review readmissions from SNF? Together?

- Both: Do you use a structured format? Involve both hospital and SNF? Patient/families?

2. Identify opportunities for improvement

- Hospitals: What improvement efforts do you have in place? How are they working?

- SNF/facility: What improvement efforts do you have in place? How are they working?

- Both: Do new/other partners or facilities or professionals need to be involved?

- Both: Have you considered warm (verbal) handoffs?

- Hospitals: Have you considered providing contact information for clarification?

- Hospitals: Do all SNF patients leave with documented goals of care?

- Both: Do you jointly review medications to identify any that may be difficult to obtain?

- SNF/Facility: Do you use the INTERACT tools? Which ones?

- Hospital: If yes (above) have you trained your ED staff to use INTERACT tool?

Specific ACTION STEPS we will take to improve our hospital to SNF transitions:



Hospital to Home Health Action Planning Worksheet

This worksheet is a suggested discussion guide to help you identify opportunities for improvement.

1. Know your data and review readmission events

- Hospitals: What is your hospital's readmission rate from home health?

- Home Health: Do you track (re)admissions to the hospital?

- Home Health: Describe how your agency measures acute (re)hospitalization.

- Both: Do you review readmissions from home health? Together?

- Both: What are the major reasons why home health patients are readmitted?

2. Identify opportunities for improvement

- Hospitals: Have you implemented any improvements to the transition to home health?

- Hospitals: Have you attempted to broaden your number of referrals for home health? How?

- Home Health: What improvement efforts do you have in place? How are they working?

- Both: What other partners might be involved? (e.g. agencies with behavioral health skills)

- Home Health: Do you ensure contact within 24-48 hours?

- Home Health: Do you use the Health Information Exchange, CRISP to find out when your patient has gone to the ED?

- Home Health: How can a patient with a change in clinical status avoid the ED?

- Hospital: How can the ED work with home health to facilitate treat and release?

Specific ACTION STEPS we will take to improve our hospital to home health transitions:



Hospital to Home Action Planning Worksheet

This worksheet is a suggested discussion guide to help you identify opportunities for improvement.

1. Know your data and review readmission events

- Hospitals: What is your hospital's readmission rate from home?

- Hospitals: Do you review readmission events from home? Do readmission reviews include interviews of outpatient providers and patient/caregiver perspectives?

- Both: What are the major reasons why patients are readmitted from home?

2. Identify opportunities for improvement

- Hospitals: Have you implemented any improvements to the transition to home?

- Hospitals: Are the above improvements targeted at a subgroup, or implemented for all?

- Partners: What improvement efforts do you have in place? How are they working?

- Partners: What comprises an effective transition into your care?

- Both: What other partners should be engaged (adult day, behavioral health, pharmacy)?

- Both: Do you have a direct point of contact with local behavioral health? Patient Centered Medical Home?

- Partners: Do you use CRISP for notification reports (ED/admit/discharge/transfer)? For viewing reports?

- Both: Do you have patient/caregiver advisors available to provide guidance?

Specific ACTION STEPS we will take to improve our hospital to home transitions:

Section 8: Appendix



Readmission Strategy Impact Estimator

Use this template to estimate the financial and readmission reduction impact of your portfolio.

Template Available Online at:

www.mhaonline.org/quality/transitions-handle-with-care

Readmission Reduction Impact and Financial Analysis Tool			
Basic Data		Example	Source of Data
A	Number of (non-OB, adult) discharges, past year (#)	5000	your data
B	Number of (non-OB, adult) readmissions, past year (#)	625	your data
C	(non-OB, adult) readmission rate (calculation)	12.5%	calculate: B/A
D	Average cost (reimbursement) per (non-OB, adult) admission (\$)	\$ 9,000	your data
E	Total cost readmissions, past year (calculation)	\$ 5,625,000	calculate: BxD
Impact of Readmission Reduction Strategies			
<i>Strategy 1: Improve Standard Hospital Based Care for All</i>			
G	Target population strategy 1 will serve (#)	ALL	your strategy
H	Number of admissions strategy 1 will serve (#)	5000	your data
I	Readmission rate among target population (%)	12.5%	your data
J	Readmissions among target population (calculation)	625	calculate: HxI
K	Estimated impact of strategy 1 in reducing readmissions (%)	10%	your estimation
L	Number of readmissions averted (calculation)	63	calculate: JxK
M	Estimated savings of strategy (\$, calculation)	\$ 562,500	calculate: LxD
<i>Strategy 2: Intensive Community Social Service Support for High Utilizers</i>			
N	Target population strategy 2 will serve (#)	250	your strategy
O	Number of admissions strategy 2 will serve	850	your data
P	Readmission rate among target population (%)	30%	your data
Q	Readmissions among target population (#, calculation)	255	calculate: OxP
R	Estimated impact of strategy 2 in reducing readmissions (%)	30%	your estimation
S	Number of readmissions averted (calculation)	77	calculate: QxR
T	Estimated savings strategy 2 (\$, calculation)	\$ 688,500	calculate: SxD
Total Strategy Impact			
U	Total estimated readmissions avoided of strategies 1 & 2 (calculation)	139	calculate: L+S
V	Readmission rate after strategies 1 & 2 implemented (calculation)	9.7%	calculate: (B-U)/A
W	Total estimated savings of strategies 1 & 2	\$ 1,251,000	calculate: M+T
Cost of Readmission Reduction Strategies			
X	Estimated cost of implementing strategy 1	\$ 100,000	your estimation
Y	Estimated cost of implementing strategy 2	\$ 200,000	your estimation
Z	Total cost of implementing strategies 1 & 2	\$ 300,000	calculate: X+Y
Net Savings and Readmission Reduction			
	Net savings	\$ 951,000	calculate: W-Z
	Total readmission reduction	22%	calculate: U/B