READMISSIONS

>>>

CHANGE PACKAGE

ACKNOWLEDGEMENTS

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How to Use this Change Package

This change package is intended for hospitals participating in the Hospital Improvement Innovation Network (HIIN) project led by the Centers for Medicare & Medicaid Services (CMS) and Partnership for Patients (PFP); it is meant to be a tool to help you make patient care safer and improve care transitions. This change package is a summary of themes from the successful practices of high performing health organizations across the country. It was developed through clinical practice sharing, organization site visits and subject matter expert contributions. This change package includes a menu of strategies, change concepts and specific actionable items that any hospital can implement based on need or for purposes of improving patient quality of life and care. This change package is intended to be complementary to literature reviews and other evidence-based tools and resources.

CURRENT DEFINITION OF HARM TOPIC The harm described in this change package is readmissions. A preventable readmission is an unplanned inpatient returning as an acute care inpatient to the same type of facility (short-term acute care) within 30 days of the date of discharge.

Magnitude of the Problem

Readmissions are common, expensive and frequently preventable. Nearly 20 percent of Medicare patients who are discharged from a hospital are readmitted within 20 days.[1] Additionally, a 2009 study showed that this rate rose to 34 percent when the observation period was increased to within 90 days of hospital discharge. According to this study, merely 10 percent of these readmissions were planned.

A growing body of evidence suggests that unplanned readmissions are associated with lower quality of care.[2] Unplanned readmissions are frequently the result of ineffective discharge processes including discharge planning, medical reconciliation, failed handoffs and insufficient patient education.[3] In addition to concerns regarding quality, readmissions are also very costly for the health care system and for patients. In 2010, the readmission rate of 19.2 percent cost Medicare $17.5 billion.[4] In 2012, CMS implemented the Medicare Hospital Readmissions Reduction Program to penalize hospitals for excess readmissions. In 2016, the majority of America's hospitals received a Medicare penalty associated with readmissions, totaling 528 million, suggesting that more improvement is possible.[5] In 2017, the maximum penalty for inpatient hospital payments is three percent, a nontrivial incentive for hospitals to reduce unplanned readmissions. As such, hospitals now face both a financial and moral imperative to reduce unplanned readmissions, which ultimately can result in improved outcomes and experiences for patients.

> HEN 1.0 Progress

- Through the work of the AHA/HRET Hospital Engagement Network, from 2011 through 2014, over 1,400 hospitals worked to reduce readmissions. Seven of the 31 states participating reduced readmissions by at least 20 percent. Under this initiative, 65,022 readmissions were prevented, saving an estimated $572,713,776.
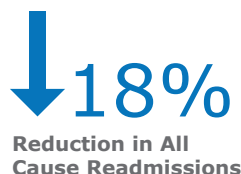
92% of Eligible Acute/CAH/Children's Hospital Reporting Data

↓**18%** Reduction in All Cause Readmissions
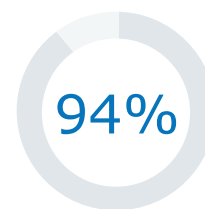
94% "Chance The Information Will Improve My Effectiveness/Results" of Positive Responses to Readmissions Education Events

WHAT DOES THAT MEAN?

65,022 READMISSIONS PREVENTED

$572,713,776 TOTAL PROJECT ESTIMATED COST SAVING

20% 7 states MEETING THE REDUCTION GOAL

> HEN 2.0 Progress

- Through the work of the AHA/HRET Hospital Engagement Network 2.0, from September 2015 through September 2016, over 1,500 hospitals worked to reduce readmissions. Five of the 34 states participating reduced readmissions by 20 percent. Under this initiative, 8,040 readmissions were prevented, saving an estimated $124,440,000.

92% of Eligible Acute/CAH/ Children's Hospital Reporting Data

↓**18%** Reduction in All Cause Readmissions

94% "Chance The Information Will Improve My Effectiveness/Results" of Positive Responses to Readmissions Education Events

WHAT DOES THAT MEAN?

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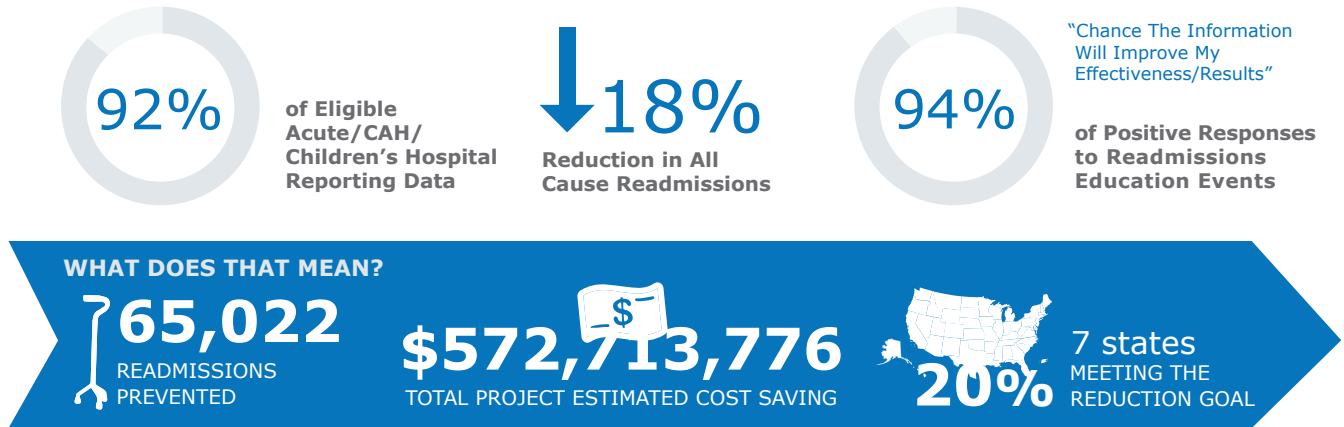
> HIIN Reduction Goals:

- Reduce all cause 30-day readmissions by 12 percent by September 27, 2018.

PART 2: MEASUREMENT

A key component to making patient care safer in your hospital is to track your progress towards improvement. This section outlines the nationally-recognized process and outcome measures that you will be collecting and submitting for the HRET HIIN. Collecting these monthly data points at your hospital will guide your quality improvement efforts as part of the Plan-Do-Study-Act (PDSA) process. Tracking your data in this manner will provide you with the valuable information you need to study your data across time, and determine the effect your improvement strategies are having in your hospital at reducing patient harm. Furthermore, collecting these standardized metrics will allow the HRET HIIN to aggregate, analyze, and report its progress towards reaching the project's 20/12 goals across all Adverse Event Areas (AEAs).

Nationally Recognized Measures: Process and Outcome

> Required Outcome Measures

- 30-day all-cause, all-payer hospital readmission rate

> Required Process Measures

- How many discharges received the transitional care service intended? This may be relevant for tracking the delivery of a "bundle" of transitional care best practices to "all" patients, or this may be the "enhanced" services you intended to deliver to a specific high-risk subgroup. For more information see pages 8-9 of this change package.

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PART 3: APPROACHING YOUR AEA

> Suggested Bundles and Toolkits

- ASPIRE — Designing and Delivering Whole Person Transitional Care, retrieved at: http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/index.html

- Re-engineered Discharge (RED), retrieved at: http://www.bu.edu/fammed/projectred/index.html

- The Care Transitions Program®, retrieved at: http://caretransitions.org/

- Care Transitions Measure, retrieved at: http://caretransitions.org/wp-content/uploads/2015/08/CTM3Specs0807.pdf

- Transitional Care Model, retrieved at http://www.transitionalcare.info/

- Better Outcomes by Optimizing Safe Transitions, retrieved at: http://www.hospitalmedicine.org/Web/Quality_Innovation/Implementation_Toolkits/Project_BOOST/Web/Quality___Innovation/Implementation_Toolkit/Boost/BOOST_Intervention/BOOST_Tools.aspx

- INTERACT — Interventions to Reduce Acute Care Transfers, retrieved at: https://interact2.net/

Investigate Your Problem and Implement Best Practices

DRIVER DIAGRAMS: A driver diagram visually demonstrates the causal relationship between your change ideas, secondary drivers, primary drivers and your overall aim. A description of each of these components is outlined in the table below. This change package reviews the components of the driver diagram to help you and your care team identify potential change ideas to implement at your facility and to show how this quality improvement tool can be used by your team to tackle new process problems.

AIM	PRIMARY DRIVER	SECONDARY DRIVER	Change Idea
		SECONDARY DRIVER	Change Idea
	PRIMARY DRIVER	SECONDARY DRIVER	Change Idea

AIM: *A clearly articulated goal or objective describing the desired outcome. It should be specific, measurable and time-bound.*

PRIMARY DRIVER: *System components or factors that contribute directly to achieving the aim.*

SECONDARY DRIVER: *Action, interventions or lower-level components necessary to achieve the primary driver.*

CHANGE IDEAS: *Specific change ideas which will support or achieve the secondary driver.*

Drivers in This Change Package

REDUCE ALL-CAUSE 30 DAY READMISSIONS BY 12 PERCENT BY THE END OF 2018	USE DATA AND ROOT CAUSE ANALYSIS TO DRIVE CONTINUOUS IMPROVEMENT	ANALYZE DATA TO INFORM YOUR TARGETING APPROACH	Change Idea
		UNDERSTAND ROOT CAUSES OF READMISSIONS; ELICIT THE PATIENT, CAREGIVER AND PROVIDER PERSPECTIVES	Change Idea
		PERIODICALLY UPDATE APPROACH BASED ON FINDINGS; ARTICULATE YOUR READMISSION REDUCTION STRATEGIES	Change Idea
		DEVELOP A PERFORMANCE MEASUREMENT DASHBOARD TO USE DATA TO DRIVE CONTINUOUS IMPROVEMENT	Change Idea
	IMPROVE STANDARD HOSPITAL-BASED TRANSITIONAL CARE PROCESSES	ENGAGE PATIENTS AND THEIR CAREGIVERS TO IDENTIFY THE "LEARNER," UNDERSTAND CARE PREFERENCES AND ASSESS READMISSION RISK FACTORS	Change Idea
		FACILITATE INTERDISCIPLINARY COLLABORATION ON READMISSION RISKS AND MITIGATION STRATEGIES	Change Idea
		DEVELOP A CUSTOMIZED CARE TRANSITIONS PLAN, TAKING INTO ACCOUNT PATIENT PREFERENCES AND ADDRESSING READMISSION RISK FACTORS AND POST-HOSPITAL CONTACT NAMES AND NUMBERS	Change Idea
		USE TEACH-BACK TO VALIDATE PATIENT UNDERSTANDING; USE LOW HEALTH LITERACY TECHNIQUES AND/OR PROFESSIONAL TRANSLATION SERVICES TO OPTIMIZE UNDERSTANDING AND TEACH-BACK	Change Idea

REDUCE ALL-CAUSE 30 DAY READMISSIONS BY 12 PERCENT BY THE END OF 2018 *(continued)*			
IMPROVE STANDARD HOSPITAL-BASED TRANSITIONAL CARE PROCESSES	MAKE TIMELY POST-DISCHARGE FOLLOW UP PHONE CALLS TO FOLLOW UP ON SYMPTOMS AND REVIEW THE CARE TRANSITIONS PLAN	**Change Idea**
DELIVER ENHANCED SERVICES BASED ON NEED	PALLIATIVE CARE	**Change Idea**
	CONDITION SPECIFIC PROGRAMS	**Change Idea**
	PHARMACY INTERVENTION	**Change Idea**
	COMPLEX CARE MANAGEMENT	**Change Idea**
	ED PAUSE	**Change Idea**
COLLABORATE WITH PROVIDERS AND AGENCIES ACROSS THE CONTINUUM	IDENTIFY THE CLINICAL, BEHAVIORAL, SOCIAL AND COMMUNITY BASED SUPPORTS THAT SHARE THE CARE OF YOUR HIGH RISK PATIENTS	**Change Idea**
	CONVENE A CROSS-CONTINUUM TEAM OF PROVIDERS AND AGENCIES THAT SHARE THE CARE OF YOUR HIGH RISK PATIENT POPULATIONS	**Change Idea**
	IMPROVE REFERRAL PROCESSES TO MAKE LINKING TO BEHAVIORAL, SOCIAL AND COMMUNITY BASED SERVICES MORE EFFECTIVE AND EFFICIENT	**Change Idea**

REDUCE ALL-CAUSE 30 DAY READMISSIONS BY 12 PERCENT BY SEPTEMBER 2018

Primary Driver:

USE DATA AND ROOT CAUSE ANALYSIS TO DRIVE CONTINUOUS IMPROVEMENT

Secondary Driver > ANALYZE DATA TO INFORM YOUR TARGETING APPROACH

Many strategies exist to lower readmissions. Organizations will be most successful if they align their strategies with the specific needs of their population. A data analysis will help hospitals identify the groups with higher than average readmission rates, thus informing a more strategic targeting approach.

Change Ideas

> Analyze your data to identify the groups with higher than average readmission rates at your hospital, such as:

- All cause (adult non-OB) readmission rate
- Payer (Medicare, Medicaid, commercial, uninsured)
- Race, ethnicity, language
- Discharge disposition (SNF, home health, home, other)
- Behavioral health comorbidity
- Timing of readmissions
- High utilizers (four or more admissions in 12 months)
- Top 10 discharge diagnoses leading to highest numbers of readmissions
- What percentage of your overall readmission rate comes from your top 10 diagnoses list? Is it a majority or minority?
- Zip code or housing residence (group home, long term care)

> Use the Data Drill Down Tool: http://www.hret-hiin.org/resources/display/readmissions-data-drill-down-

Suggested Process Measures for Your Test of Change

- Conduct an annual assessment of your readmissions data and reprioritize your targeted populations and strategies.

Secondary Driver > UNDERSTAND ROOT CAUSES OF READMISSIONS; ELICIT THE PATIENT, CAREGIVER AND PROVIDER PERSPECTIVES.

Use chart review and patient interviews to determine reason(s) for readmission. Aggregate findings and use them to prioritize improvement efforts. Findings from post discharge phone calls should also be aggregated used in prioritization efforts.

Change Ideas

> Review medical records of readmitted patients for reason(s) and aggregate findings to prioritize efforts.

- Develop a list of potential reasons for readmission such as: medication management, discharge instructions, palliative care/hospice, care coordination, MD follow-up, psychosocial/family dynamics, patient/hospital did their best, other.
- Modify list over time.
- Review readmissions occurring within seven days.
- Check all reason(s) for readmission.

> Interview readmitted patients to determine why they believe they were readmitted and aggregate findings to prioritize efforts.

- Determine who will conduct interviews (nurses, case managers, other).

- Develop an interview script/tool (e.g., Why do you believe you became sick enough to return to the hospital? What do you think needs to happen differently when you go home this time?)
- Use the Readmission Review Tool (#2): http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/medread-tools.html
- Aggregate reasons for readmission using the Readmission Review Tool: http://www.hret-hiin.org/resources/display/readmission-case-review-and-analysis-

Suggested Process Measures for Your Test of Change

- Review the next 10 readmitted patients who are currently inpatients.
- Review all readmissions from skilled nursing facilities.
- Review all readmissions for your high-risk target population(s).
- Review all readmissions.

Secondary Driver > PERIODICALLY UPDATE YOUR APPROACH BASED ON FINDINGS; ARTICULATE YOUR READMISSION REDUCTION STRATEGIES

Successful teams will match their strategies to the findings of their data and root cause analyses. For example, if your readmission reviews and root cause analyses suggest that there are a group of readmitted patients who would have benefitted from palliative care, then the improvement team should prioritize ideas to improve palliative care. If your patients are telling you that the reason they are being readmitted is due to confusion about what medications to take, then you would want to work on medication management. If they are telling you the reason they are being readmitted is because they couldn't get their medications from the pharmacy, you would want to explore transportation options or other approaches to deliver medications.
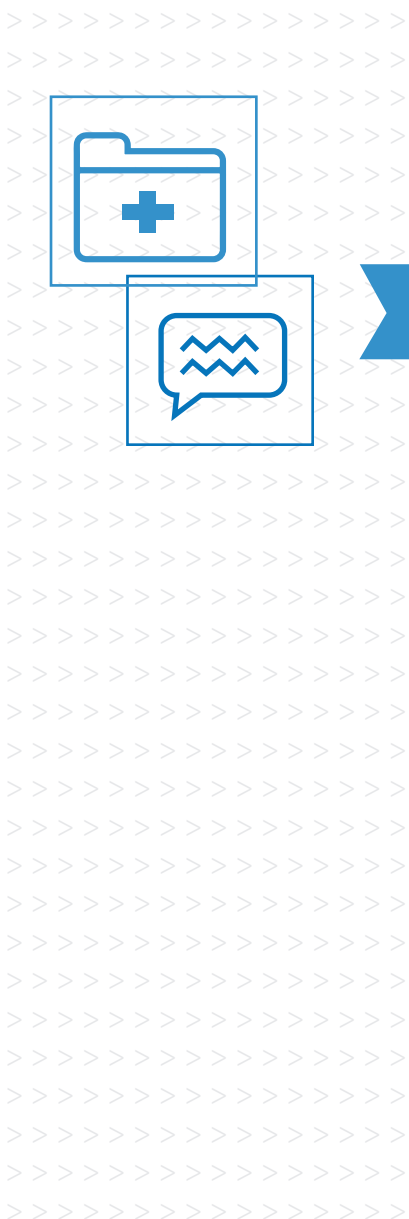
Change Ideas

> Review data analysis with your team

> Identify high risk populations to target

> Aggregate findings from root cause analyses and discuss with team

> Assess your current strategies for effectiveness and completeness

> Use a Pareto chart to help identify priorities

> Select specific strategies to test based on these priorities

> Articulate your updated strategy with a driver diagram

> Use Portfolio Design Tool (#5) and the Portfolio Presentation Tool (#7): http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/medread-tools.html

Suggested Process Measures for Your Test of Change

- Does your target population have a higher rate of readmission than your all cause hospital-wide readmission rate?
- Quantify what percentage of all discharges meet target population criteria.

Secondary Driver > DEVELOP A PERFORMANCE MEASUREMENT DASHBOARD TO USE DATA TO DRIVE CONTINUOUS IMPROVEMENT

You can't manage what you don't measure! Develop a way to measure the extent to which processes are implemented, for all patients and/or for your high-risk target population patients.
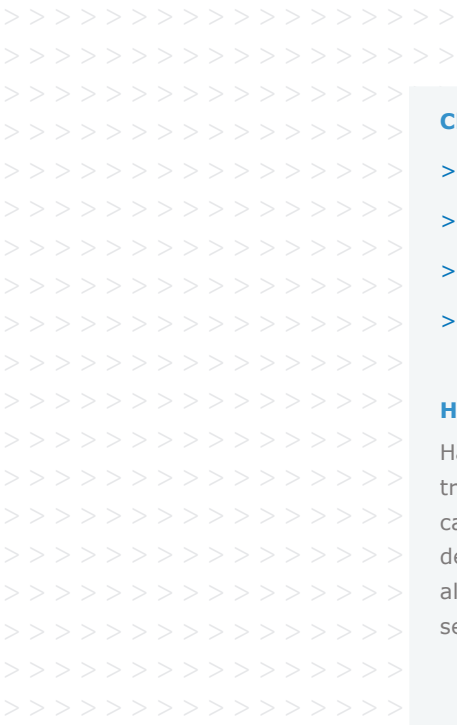
Change Ideas

> Track hospital-wide readmission rates monthly and display on a run chart.

> Track target population readmission rates monthly and display on a run chart.

> Track implementation of key practices or processes.

> Use Operational Dashboard Tool (#6): http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/medread-tools.html

Hardwire the process

Hardwiring is the result of highly reliable processes. Organizations with reliable processes track small failures, resist oversimplification, remain sensitive to operations, maintain capabilities for resilience and take advantage of shifting locations of expertise. By developing an ongoing learning and action loop, your hospital will avoid a one-size-fits all approach. You will target sub-populations with a higher risk of readmissions and select the most impactful strategies to reduce readmissions in these populations.

Primary Driver:

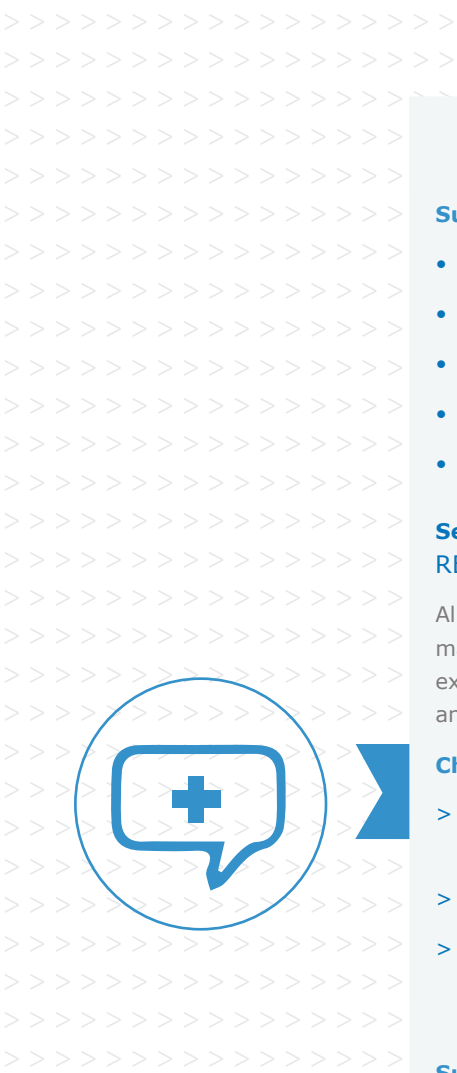## IMPROVE STANDARD HOSPITAL-BASED TRANSITIONAL CARE PROCESSES

Assess all patients for post-hospital care needs; identify patients who are members of high risk target populations upon admission; use interdisciplinary assessments and collaboration to develop care plans that will minimize readmission risks for all patients. Communicate effectively and in a culturally, linguistically and health-literacy appropriate manner.

Secondary Driver > ENGAGE PATIENTS AND THEIR CAREGIVERS TO IDENTIFY THE "LEARNER," UNDERSTAND CARE PREFERENCES, AND ASSESS READMISSION RISK FACTORS.

Optimize involvement and communication throughout the hospitalization to proactively plan for an effective care transition. Find out what matters to the patient, in addition to what is the matter with them. Perform an enhanced admission assessment that includes identification of their primary caregiver, readmission risk factors and discharge care needs – for all patients. If a patient has a prior admission, analyze previous discharge plan failures and care transition challenges, and identify potential barriers to self-management to be addressed more effectively in the future.

Change Ideas

> Use or modify the CMS discharge planning checklist: https://www.medicare.gov/Pubs/pdf/11376-discharge-planning-checklist.pdf.

> Use or modify the Whole Person Transitional Care Planning Tool (#9): http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/medread-tools.html.

> Identify potential barriers to self-management including limited financial resources and lack of a support network.

> Identify the patient's goal and document that goal on the whiteboard or state it in rounds so that it is known to the entire patient care team.

> Identify the patient's primary caregiver and document that on the whiteboard or in a standard field in the EMR.

> Use of modify the Next Step in Care Checklist for Family Caregivers: http://nextstepincare.org/Caregiver_Home/Leaving_the_Hospital

> Include the patient's primary caregiver as a member of the health care team.

> Use risk of readmission assessment tool such as: LACE http://www.hret-hiin.org/resources/display/modified-lace-tool or BOOST http://www.hret-hiin.org/resources/display/project-boost-implementation-toolkit

Suggested Process Measures for Your Test of Change

- Sample a small number of patients (e.g., 10 cases per month) to evaluate if:
- The "learner" or family caregiver was identified and documented;
- A whole-person assessment was conducted;
- If they received the CMS discharge planning checklist;
- Patient goals were ascertained and documented.

Secondary Driver > FACILITATE INTERDISCIPLINARY COLLABORATION ON READMISSION RISKS AND MITIGATION STRATEGIES

All complex patients, including those at high risk of readmission, benefit from care managed by a multidisciplinary team. Depending on a patient's specific needs, consider expanding the care team to include hospitalists, pharmacists, physical, occupational, and respiratory therapists, case managers, social workers and nutritionists.

Change Ideas

> Identify the members of the interdisciplinary care team based on the patient's needs. Include family members or other caregivers.

> Implement multidisciplinary rounds to anticipate and prepare for discharge.

> Communicate care transition plans among the team. Test various communication approaches to determine what is best for your team. Some approaches to consider include: whiteboards, encrypted emails, or specific care transitions software.

Suggested Process Measures for Your Test of Change

- Evaluate the effectiveness of multidisciplinary rounds using 10 cases.
- Number of rounds completed within the desirable period (e.g., within 48 hours after admission).
- Number of patients and families engaged in the rounds (e.g., bedside rounds).

Secondary Driver > DEVELOP A CUSTOMIZED CARE TRANSITIONS PLAN, TAKING INTO ACCOUNT PATIENT PREFERENCES AND ADDRESSING READMISSION RISK FACTORS AND POST-HOSPITAL CONTACT NAMES AND NUMBERS

To manage their care post-discharge, patients and their caregivers need a personalized and easily comprehendible plan with clear instructions. The plan should be co-developed with the patient and caregiver in accordance with their preferences. If effective, the plan will serve to guide the patient's transition from the hospital to their next level of care linking them to post-acute providers.

Change Ideas

> Determine the patient's and caregiver's priorities and needs.

> Use the reasons for readmission to shape the plan.

> Select three to five red flags and actions to use for teach-back.

> Link to post-hospital follow-up services and appointments:
  - Schedule follow-up appointments that work for the patient and their caregiver. For
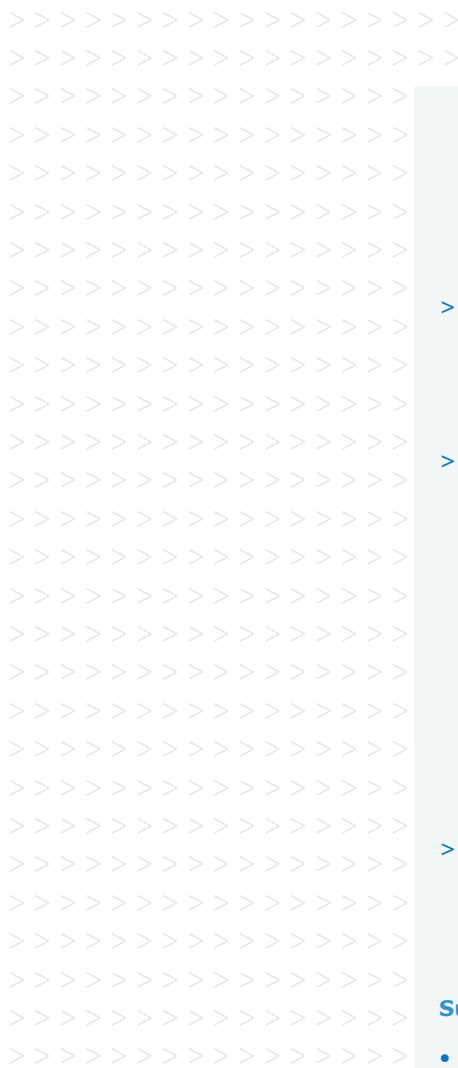
patients with a high-risk of readmission, a follow-up appointment or clinical contact within 48 to 72 hours may be necessary. Consider hospital-run follow-up clinics if timely access to a primary care physician is not available.

- Identify a PCP for patients who do not have one.

> Work with patients and caregivers to identify any barriers to addressing other follow-up needs such as medications, special diets, or transportation barriers. If barriers are identified, determine how they might be resolved. For example, extended supply of medications obtained prior to discharge or medications mailed to the patient.

> A patient-centered plan should include information about:

1. Contact information for the primary physician and other key care providers
2. Medications to be continued at home including name, purpose, dosage, frequency
3. Follow-up appointments scheduled
4. Other orders related to patient self-care such as diet and activity
5. Information about the diagnosed disease(s) or condition(s)
6. Signs and symptoms that warrant a phone call to the physician
7. Signs and symptoms that warrant a visit to the emergency department
8. A form on which a patient can record questions to ask at the follow-up appointment

> Use the Discharge Planning Checklist (#10) which prompts teams to provide the information required as indicated by the most recent CMS Surveyor Guidance and Proposed Discharge Planning Conditions of Participation: http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/medread-tools.html

Suggested Process Measures for Your Test of Change

- Sample a small number of patients each month (e.g., 10 cases per month) and determine each patient's plan with instructions or health record included:

1. Contact information for the primary physician and other key care providers
2. Medications to be continued at home including name, purpose, dosage, frequency
3. Follow-up appointments scheduled
4. Information about the reason for hospitalization
5. Signs and symptoms that warrant a phone call to the physician
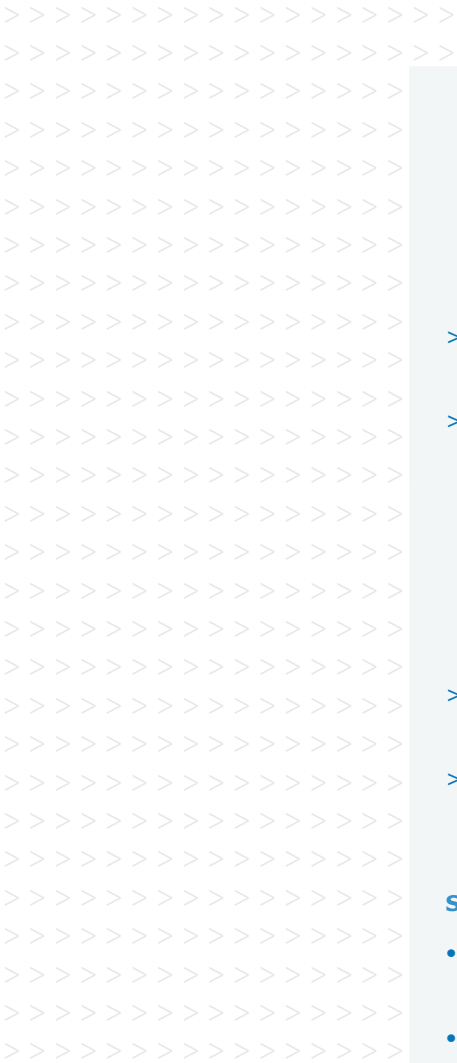6. Who to call after discharge with questions

Secondary Driver > USE TEACH-BACK TO VALIDATE PATIENT UNDERSTANDING; USE LOW HEALTH LITERACY TECHNIQUES AND/OR PROFESSIONAL TRANSLATION SERVICES TO OPTIMIZE UNDERSTANDING AND TEACH-BACK.

Not all patients will have the same ability to learn and implement self-management techniques. Health literacy is "the ability to obtain, process and understand health information to make informed decisions about health care." Limited health literacy has been associated with self-management difficulties, medication errors, and higher health care costs. Teach-back is a communication tool to validate the patient's understanding of instructions. Teach-back is a method wherein clinicians ask patients, in a non-threatening manner, to recite the instructions provided. If a patient or caregiver cannot effectively teach-back, additional support is needed.

Change Ideas

> Formally assess health literacy using a tool such as those found in the AHRQ Health Literacy Tool Kit at http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html

- Focus on improving communications with patients. Limit the use of medical jargon, ask open-ended questions, and use the teach-back technique (see below).
- Improve written educational materials. Use documents that are easy-to-read and incorporate images.
- Ensure written materials align with and reinforce verbal instructions.

> Review patient-facing materials to ensure they are written at no higher than a fourth grade reading level and are clearly presented.

> Use role-play to train clinical staff how to perform teach-backs and observe technique. Consider creating videos starring your own staff that display examples of "good" and "could be better" teach-back examples. Some tips for good teach-back include:

- Use "I" statements when speaking with patients and caregivers (e.g., "To make sure I did a good job explaining your medications, can you tell me…?")
- Script specific teach-back questions staff can use (e.g., "Can you tell me who you would call if you gained five pounds?")

> Designate where and how the status of patient understanding will be documented in the medical record.

> Consider using motivational interviewing techniques to help a patient be more engaged in learning self-management skills. Motivational interviewing is a technique to increase the participation and desire of the patient to carry out self-management tasks.

Suggested Process Measures for Your Test of Change

- Sample a small number of patients (e.g., 10 cases per month) to determine the number who received teach-back, as documented in the record.
- Monitor the use and effectiveness of teach-back through observation and validation of patient understanding.
- Sample a small number of patients who needed professional interpretation services who received them during teach-back/discharge teaching.

Secondary Driver > MAKE TIMELY POST-DISCHARGE FOLLOW-UP PHONE CALLS TO FOLLOW UP ON SYMPTOMS AND REVIEW THE CARE TRANSITIONS PLAN.

Although patients and their caregivers may be able to teach-back their discharge plan, they may have questions or need reinforcement once they are discharged. To meet this need, hospitals can develop a process to call and/or otherwise contact high-risk patients to ensure that they can carry out their plan of care. Determine if the plan has been understood and whether and changes or revisions are necessary.

Change Ideas

> Determine which patients will be telephoned, who will complete the calls and when the calls will occur. Gather and analyze information from these calls to identify trends that can inform your readmission team. For example, repeated patient questions about medications may guide your team to revise medication education materials or processes.

> Advise patients to anticipate a follow-up call from an identified hospital staff member and confirm the specific phone number where they can be reached. Do not assume that phone number is the number in their medical record; patients may be staying with a relative or neighbor during their recovery.
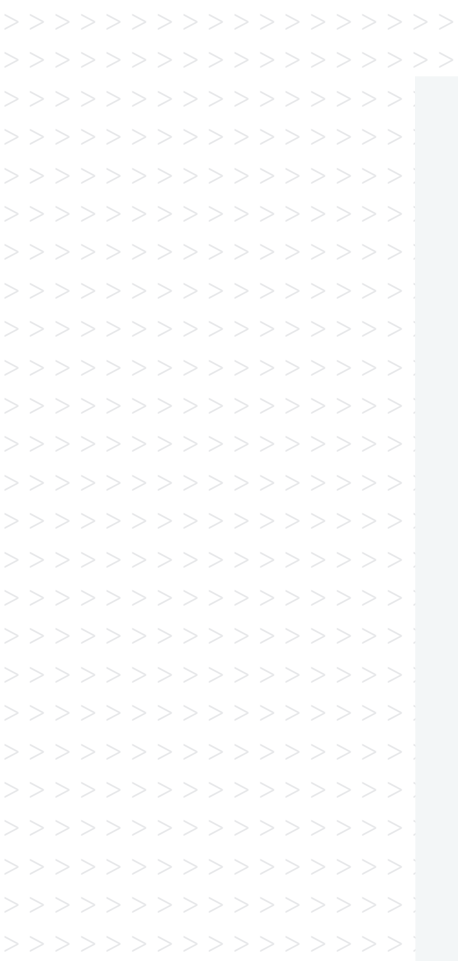
> Determine if patterns are occurring with unanswered calls (e.g., a specific time of day, the location of the patient, or the patient's level of engagement).

> Maximize the continuity of post-discharge calls when possible by assigning one individual to follow-up and connect with the patient or caregiver.

> Use the guidance from Project RED's Tool on how to conduct a post discharge phone call: http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/redtool5.html

Suggested Process Measures for Your Test of Change

• Percent of calls placed within a defined time, e.g., 48 hours of discharge

• Percent of calls answered by patients and/or caregivers

• Analysis of questions posed or clarifications offered during the phone call

Hardwire the Process

Reliable hospital-based transitional care processes occur when all staff are aware of these processes, have the tools to complete these processes and receive feedback regarding the level at which they complete these processes. Staff should be involved in the development and testing of processes. Taking advantage of shifting expertise is a component of high reliability. Including a family member or care provider on your multidisciplinary team is one way to include expertise about the home setting to inform the clinical team. Other team members will also serve as experts, thus using all the combined knowledge to develop the best plan.

Primary Driver:

DELIVER ENHANCED SERVICES BASED ON NEED

While all patients should receive an improved reliable discharge, patients who are at high risk of readmission require additional efforts to support them after hospitalization and reduce their risk of readmission. Services should be customized based on the patient and the availability of resources.

> Many examples of post-hospital "enhanced services," including transitional care, disease-specific programs, pharmacy interventions, and more, are available at: www.huddleforcare.org

Secondary Driver > PALLIATIVE CARE

Many successful readmission reduction teams credit attending to goals of care, end of life care, and palliative care and pain management as a component of their improvement strategy.

Change Ideas

> Develop criteria for an automatic referral for palliative care consult that includes a set number of readmissions (e.g., four or more admissions in a 12 month period).

> Include an individual knowledgeable of the palliative care program in multidisciplinary rounds; provide in-service training to physicians, nurses.

> Develop a process for obtaining palliative care consultation within 48 hours of patient admission.

> Develop accessible educational materials for patients and families on the benefit of palliative care.

Suggested Process Measures for Your Test of Change

• The number of palliative care consults on a monthly basis.

Secondary Driver > CONDITION SPECIFIC PROGRAMS

Dedicated condition specific clinics or programs may exist or might need to be developed in order to address patients' needs for more intensive, responsive and proactive disease management. Examples could include a specific program for patients with sickle cell disease or a specific program for patients with behavioral health conditions, diabetes, CHF, or COPD. Condition-specific episodes of care ("bundles").

Change Ideas

> Based on your data analysis determine if specific patient populations/conditions might benefit form an intensified program to intensify clinical support and post discharge follow up.

> Based on your resources and patient needs design a program and or collaborate with community resources such as the American Lung Association — Better Breathers Club.

> Chronic disease self management classes can be effective for a wide range of patients living with chronic illness regardless of specific diagnosis.

Suggested Process Measures for Your Test of Change

• The number of patients enrolled in condition specific programs vs. the number eligible for enrollment.

Secondary Driver > PHARMACY INTERVENTION

Issues associated with medications (i.e. the correct medication, medication availability) are leading causes of readmissions. Adding dedicated pharmacist resources to specifically address these issues is useful to many readmission reduction efforts. Pharmacist duties can include: Medication reconciliation, medication optimization, coordination with insurance companies, patient and caregiver education, and optimizing affordability of regimens.

Change Ideas

> Develop criteria for referral to care transitions pharmacist (i.e., total number of medications, high-risk medications, new start of high risk medication, and current admission due to medication issue).

> Allocate time for a pharmacist to work with patients in-hospital and post-hospital.

Suggested Process Measures for Your Test of Change

• Number of patients meeting criteria for referral to care transition pharmacist.

• Percent of referrals meeting each criterion (i.e., polypharmacy, high-risk medications)

• Number of patients seen by care transition pharmacist.

• Percent of referred patients who are seen by care transition pharmacist.

Secondary Driver > COMPLEX CARE MANAGEMENT

More vulnerable patient populations may benefit from additional interventions and resources that can help to address both non-clinical as well as clinical needs. These populations may include: those with four or more readmissions in a year, behavioral health patients; homeless patients; patients with end-stage renal disease (ESRD); those infected with human immunodeficiency virus (HIV); and children with complex, chronic conditions. Complex care management will include both clinical and non-clinical supports and services. Complex care management should prioritize the following contacts: face to face encounter in the hospital, timely post hospital contact, frequent contacts in person, virtually, via phone or texts, as indicated by patient needs.
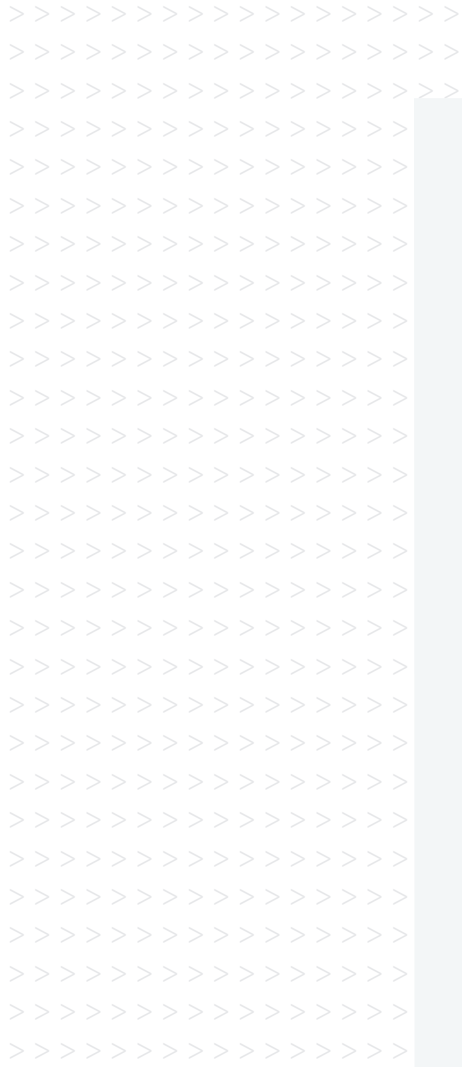
Change Ideas

> Deploy an interdisciplinary complex care team to work with patients who require intensive, whole-person complex care management.

> Consider including the following role types: RN, SW, Pharmacist, community health worker/navigator.

> Consider dedicating a program manager and data analyst time to administer and track the program's effectiveness and impact on reducing readmissions.

> Complex care management teams collaborate with all providers and agencies and residences involved in the shared care of the person.

> Complex care management teams develop care plans, and share them with the Emergency Department in a way that can help bring longitudinal and multifaceted insight into the patient to the point of care in the ED (see below).

Suggested Process Measures for Your Test of Change

• The number and percent of high utilizers (four or more admissions/year) who are enrolled in a complex care management program.

Secondary Driver > EMERGENCY DEPARTMENT PAUSE

Pause and question the need for readmission. If a patient who was recently discharged from the hospital returns to the emergency department (ED), the patient is often readmitted for "continuity," or because Emergency Medicine physicians may have been trained that a readmission represents a "failed discharge plan," and thus the patient should be readmitted to develop a better plan. If a member of the care transitions team is more knowledgeable about the patient, alternatives to readmission can sometimes be achieved through use of community resources. Patients who frequently use the ED and are readmitted might benefit from a high utilizer care plan that describes the reasons for the plan e.g. repeated utilization, the background of utilization and testing, assessment of the drivers of this utilization and recommendations.

Change Ideas

> Develop a method for ED staff to know if the patient was hospitalized in the previous 30 days via visual alert on the tracker board or in the EMR.

> Embed care transitions coordinator or other knowledgeable staff in the ED if possible. Alternatively, have knowledgeable staff able to respond rapidly to ED staff.

> Determine if transitions coordinator can develop an alternative plan instead of readmission, such as discharge with follow up by the condition-specific clinic, complex care team, or primary care provider (PCP) the following day.

> Consider if observation status is an appropriate level of care if returning home or return to a skilled nursing facility is inappropriate.

> Develop a high utilizer care plan. Use the ED Care Plan Tool (#13): http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/medread-tools.html

Suggested Process Measures for Your Test of Change

> Presence of a visual, real-time notification that a patient has been discharged in the past 30 days.

> Presence of a visual, real-time notification that a patient is a high utilizer, is a member of a high-risk target population, and/or in complex care management.
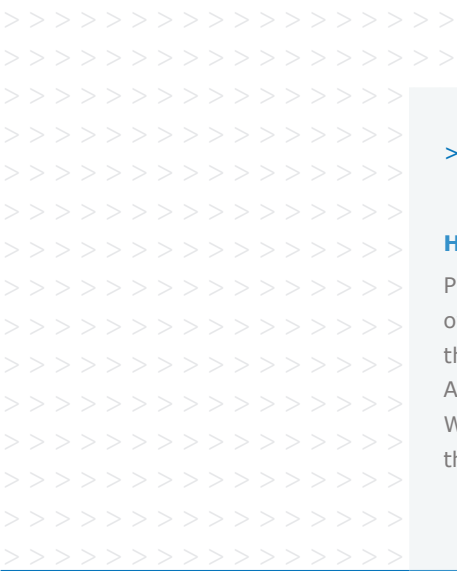
> Number of high risk target population patients (e.g. high utilizers, or patients in complex care management, etc.) who have a care plan accessible to ED providers.

Hardwire the Process

Providing enhanced services based on need demonstrates the principle of resistance to oversimplification. By using these secondary drivers, you will customize solutions for the needs of your highest risk patients rather than providing the same services to all. Additionally, the capability for resistance is hardwired through an ED pause process. When a patient returns to the ED following an acute care discharge it becomes clear that the prior discharge plan for the patient was unsuccessful and needs to be modified.

Primary Driver:

COLLABORATE WITH PROVIDERS AND AGENCIES ACROSS THE CONTINUUM

Reliable discharge processes are initiated in the hospital but their effectiveness often depends on follow up and collaboration with community providers and resources.

Secondary Driver > IDENTIFY THE CLINICAL, BEHAVIORAL, SOCIAL AND COMMUNITY BASED SUPPORTS THAT SHARE THE CARE OF YOUR HIGH RISK PATIENTS

Using information from your data, root cause analysis, readmission reviews, and patient-centered care planning work, consider whether the hospital team is optimizing the opportunity to collaborate with clinical, behavioral, social and other supportive services, residential providers, payers across the continuum who share in the care of your high risk patients.

Change Ideas

> Conduct a periodic (e.g. annual) survey of community resources, especially providers and agencies that can meet the behavioral health and social service and support needs of your high risk patients.

> Explore community resources such as the YMCA, faith-based organizations, senior and disability service agencies, peer recovery services, etc.

> Work with health plans to identify their care management resources.

> Use the Community Inventory Tool (#4): http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/medread-tools.html

Suggested Process Measures for Your Test of Change

• Completion of an inventory of cross-continuum and community based clinical, behavioral and social supports.

• Identify which providers or agencies have availability to serve new patients.

• Identify which providers or agencies have ability to provide timely post-discharge follow up contact.

Secondary Driver > CONVENE A CROSS-CONTINUUM TEAM OF PROVIDERS AND AGENCIES THAT SHARE THE CARE OF YOUR HIGH RISK PATIENT POPULATIONS

The hospital, as a leader in the local healthcare market, and as accountable for readmissions, is in a position to convene and lead efforts to improve collaborative care across settings and providers. Review readmission data, discuss root causes, and identify opportunities to engage in joint quality improvement efforts.

Change Ideas

> Participate in regional community coalitions facilitated by QIO/QINs
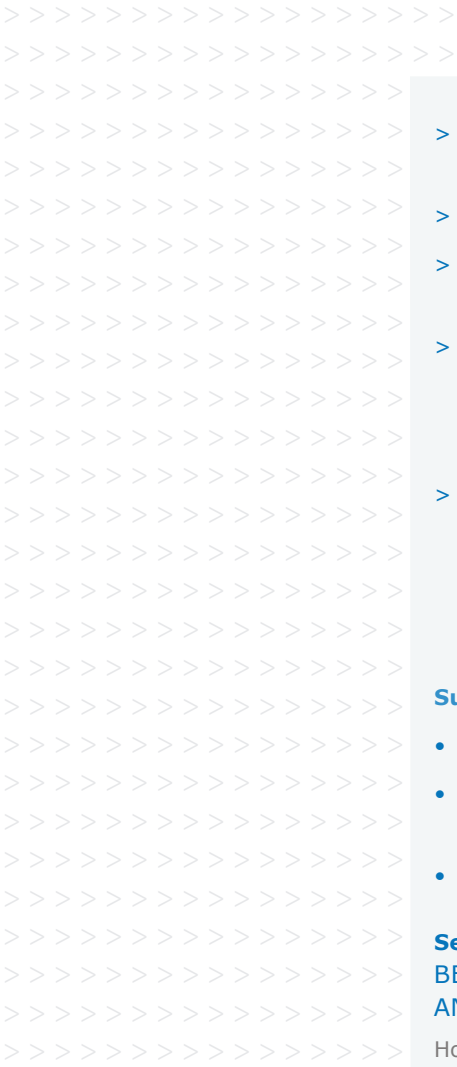
> Review readmission data; be transparent about the hospital's current readmission rate and readmission reduction goal.

> Review readmissions as a group and discuss root causes from a cross-setting perspective.

> Meet regularly to engage in shared learning on topics of mutual importance, such as heart failure management, palliative care, etc.

> Invite community partners and clinical teams to visit your hospital and offer to spend time at their facility — Walk a mile in my shoes. This opportunity to observe the other person's environment can create a shared knowledge base of the services provided and challenges for each organization.

> Identify specific opportunities to improve care processes to reduce readmission, such as:

  • Implement a process for verbal handoffs a.k.a. warm hand offs from hospital clinicians (physician and/or nurse) to community partners.

  • Use a standardized transfer form to communicate information from the hospital to the SNF and SNF to hospital/ED. Tools: http://interact2.net

Suggested Process Measures for Your Test of Change

• Number of completed standard discharge forms transferred to a SNF.

• Number of warm hand off phone calls from the hospital to community partners within 48 hours of transfer.

• Number of SNFs that have fully implemented INTERACT in their facilities.

Secondary Driver > IMPROVE REFERRAL PROCESSES TO MAKE LINKING TO BEHAVIORAL, SOCIAL AND COMMUNITY BASED SERVICES MORE EFFECTIVE AND EFFICIENT

Hospital readmission reduction teams need to identify the clinical, behavioral, and social services providers ready, willing, and able to collaborate with the hospital to ensure effective linkage to services and timely follow-up contact. Central to developing improved processes for post hospital care is to work with cross-continuum providers on developing a clear understanding of potential referral volume and to discuss shared expectations for what an effective referral-linkage process looks like.

Change Ideas

> Use Cross-Continuum Collaboration Tool (#12) to develop specific effective and timely linkages to services with cross-continuum clinical, behavioral, and social service providers. http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/medread-tools.html

> Reach out to a service provider, or group of providers who provide similar services, to initiate a transparent, data-informed planning discussion to explore improving linkages to services for patients. Set up a meeting.

> Prepare data on your hospitals' target population and how many target population discharges there are per day/week, and describe your working understanding of what factors contribute to readmissions.

> Prepare questions to learn more about the services they offer and their capabilities.

> **Make a request** — capacity: Ask the provider to consider whether they have capacity to accept a consistent volume of referrals. What volume of daily/weekly referrals could they absorb?

> **Make a request** — timeliness: Timely posthospital contact is a priority. Ask the provider/agency to work with you to develop a reliable process to ensure linkage to posthospital services, optimally before discharge or within 1-2 days of discharge.
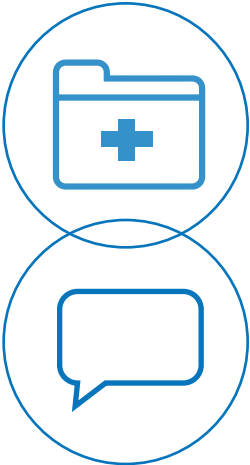
> **Make a request** — getting started: You have a process in place to identify patients at high risk of readmission who are admitted everyday at your hospital. Ask the provider/agency if you can initiate your test of better linking high-risk patients to their services by testing the new process on the next 10 patients who need their services.

Suggested Process Measures for Your Test of Change

- Test 10 patients. Reflect:
  - How long did it take to identify 10 patients who needed the provider/agency's service? (1 day, 1 week, 1 month?)
  - What does that say about the hospital's processes for screening for the social/behavioral or other transitional care needs among patients identified as at high risk of readmission?
  - How did the process go on the hospital side?
  - How did the process go on the provider/agency side?
  - How long did it take to initiate contact/service for the patient post discharge?
  - How can the processes to identify, refer, link, and connect within 48 hours of discharge be improved?

Hardwire the Process

Establish processes and tools to ensure discharge follow-up and use of community resources that work into the existing workflow in the hospital. Involve staff in the development, improvement and implementation of processes and tools. Track small failures to find opportunities to improve the processes.

PDSA in Action | Tips on How to Use the Model for Improvement

Choice of Tests and Interventions for Readmission Reduction: Based on the findings from your data analysis, select improvement priorities. Your priorities might be based on criteria such as potential impact, level of readiness or availability of resources. If, for example, you wished to begin interviewing readmitted patients, you could:

> Review a few sample patient interview questions.

> Select an interview tool that appears to be compatible with the resources and needs of your organization.

> Ask: "Is there anything we need to modify before we test this here?"

> If yes, make the modification.

PLAN   Tomorrow, one nurse will test the patient interview tool on his/her first admission.

DO   The nurse tests the patient interview tool.

STUDY   At the end of the shift, the team debriefs with the nurse to ask questions such as:

> "Were there any challenges in completing the tool?"

> "Were you able to collect the information from the patient?"

> "How much time did it take to complete the tool?"

> "Are there any suggestions for modifications of the tool for the process?"

ACT   Make any recommended changes and re-test to determine if the changes are an improvement.
If no changes are suggested, plan additional testing with more patients the following day.

Once the patient interview tool has been tested successfully on several more patients, you can expand the test to other nurses. Document each PDSA cycle so you will have a record of the changes you implemented. You can run several PSDA cycles in parallel. For example, while one group is working on the patient interview tool, another might be testing changes to obtain accurate information about the PCP. Coordinate the findings from all your PDSA cycles so that you can keep track of the entire project.

Potential Barriers

> Depending on the payment structure in place in facilities, reducing preventable readmissions may not be aligned with reimbursement at the current time. Understanding the financial ramifications of readmissions and their reduction helps to identify potential economic benefits for institutions and patients.

> Reducing preventable readmissions is challenging work because it requires the involvement of many individuals and systems both within and beyond the hospital. Time and resources must be expended to understand the organization's current level of performance and to identify performance gaps, as well as to select the appropriate interventions to address the needs identified in the gap analysis. After the interventions are selected they should be tested, adapted, and implemented, as appropriate. Common barriers to implementation include: organizational drift towards other strategic priorities, a lack of accountability and expectations for completion of the initiative and inadequate availability of resources.

Enlist administrative leadership as sponsors to help remove or mitigate barriers

> Align readmission reduction efforts with strategic business priorities.

> Enlist a senior leader as a champion to advocate for the initiative.

> Enlist a senior leader to mitigate barriers and provide adequate resources to support the improvement efforts.

> At least monthly, review processes, barriers, and outcome measures with the senior leader

Change not only "The Practice," but also "The Culture"

> Promoting changes in cultures and practices can be very challenging. It is common for people to be reluctant to give up what is comfortable and replace it with what is unknown. However, change is critical for quality improvement. Health care professionals may be more receptive to change if the process is framed in a way that highlights the benefits for patients and providers. Suggestions include:

  • Keep the patient "front and center." Show the expected benefits of the change.

  • Share patient stories of prevented readmissions.

  • Unite and motivate staff around the aim. Use respected champions in a breadth of professions to advocate for the change and demonstrate the benefits of new processes and collaborative implementation.

> Another cultural shift that promotes positive outcomes is the transition from a paternal approach, in which patients are told what to do, to a patient-centered approach, wherein patients play pivotal roles in their care. For example, some clinicians would be unfamiliar with asking patients why they believe they needed to return to the hospital or validating the patients' understanding of educational information. Explaining the value of patient engagement will be helpful to shift towards a more positive empowering culture. Shift from labeling the patient as non-compliant to having a greater appreciation of their barriers and beliefs.

> Readmission reduction work often includes the need to collaborate with both clinical and non-clinical members of the community. An excellent first step is to look beyond the walls of the hospital and bring community partners together to collaborate.

PART 4: CONCLUSION AND ACTION PLANNING

Reducing preventable readmissions decreases stress for patients and their families. Understanding and implementing care transition strategies, in accordance with a patient's need, reduces the countless burdens encountered by patients and families. Hospitals should state their aim to reduce readmissions and resource their effort to do so. Organizational plans to reduce readmissions should be informed by data and evaluated and modified as needed to ensure their effectiveness.

APPENDIX I: PREVENTABLE READMISSIONS TOP TEN CHECKLIST

Associated Hospital/Organization: HRET HIIN Project

Purpose of Tool: A checklist to review current or initiate new interventions to prevent avoidable readmissions in your facility

Reference: www.hret-hiin.org

Preventable Readmissions Top Ten Checklist

Develop a data-informed targeting strategy to identify target populations with higher than average rates of readmissions. Deliver enhanced readmission reduction strategies to these "target population" patients.

Identify root causes of readmissions based on interviewing patients, caregivers and providers. Prioritize your improvement strategies based on those that will address the root causes of readmissions among your patients.

Improve care transition processes for all patients, regardless of readmission risk. Refer to the proposed practices articulated in the proposed CMS Conditions of Participation for Discharge Planning.

Provide a customized transitional care plan for all patients.

Effectively communicate with patients and caregivers. Use translation services, teach-back, motivational interviewing and materials written in plain language.

Deliver enhanced readmission reduction services for your target populations based on their root causes of readmissions.

Design a high utilizer approach for patients with four or more admissions per year. Identify their "driver of utilization," and use care plans to improve care across settings.

Engage the emergency department as a new site of readmission reduction activities.

Collaborate with clinical, behavioral, and social service providers to improve cross-setting care processes for shared patient populations. Ensure you are aware of the services and supports that are available from other providers and agencies in your community.

Measure what you implement, driving to reliable delivery of improved processes.

PART 6: REFERENCES

1. Jencks SF, Williams MV, Coleman EA. Rehospitalizations Among Patients in the Medicare Fee-for-Service Program. *N Eng J Med*. 2009;360(14):1418.

2. Benbassat, J. and Mark Taragin. Hospital Readmissions as a Measure of Quality of Health Care: Advantages and Limitations. *Archives of Internal Medicine* 160, no. 8 (2000): 1074-1081.

3. Alper E, O'Malley TA, Greenwald J. *UpToDate: Hospital Discharge and Readmission.* Accessed on July 15, 2015. http://www.uptodate.com/contents/hospital-discharge-and-readmission

4. Centers for Medicare & Medicaid Services. *"National Medicare Readmission Findings: Recent Data and Trends."* Office of Information Product and Data Analytics (2012). Accessed at http://www.academyhealth.org/files/2012/sunday/brennan.pdf

5. Jordan, R. Medicare's Readmission Penalties Hit New High Retrieved at: http://khn.org/news/half-of-nations-hospitals-fail-again-to-escape-medicares-readmission-penalties/ http://khn.org/news/more-than-half-of-hospitals-to-be-penalized-for-excess-readmissions/