Designing and Delivering Whole-Person Transitional Care:

The Hospital Guide to Reducing Medicaid Readmissions

TOOLBOX

ASPIRE

Agency for Healthcare Research and Quality

TOOL OVERVIEW

This package of tools accompanies the *Designing and Delivering Whole-Person Transitional Care: The Hospital Guide to Reducing Medicaid Readmissions*, which offers in-depth information about the unique factors driving Medicaid readmissions and step-by-step process for designing a locally relevant portfolio of strategies to reduce Medicaid readmissions. Some of the tools are adaptations of best-practice approaches to make them more relevant to the Medicaid population; many tools were newly developed through this project. This introduction offers an overview of the tools available in the package by briefly describing what they are, who should use them, and the time required to use them.

GUIDE SECTION	TOOL	DESCRIPTION	STAFF	TIME REQUIRED
1	Tool 1 Data Analysis	A spreadsheet that facilitates data analysis and interpretation to compare and contrast readmission patterns by payer.	Data analyst, business analyst, staff able to query administrative data.	6 hours.
1	Tool 2 Readmission Review	Adapted from the well-known STAAR approach, this one-page interview guide prompts clinical or quality staff to elicit a recounting of what happened between discharge and readmission from the patient/caregiver perspective.	Quality improvement, nursing, case management staff.	5-10 minutes per interview. Consider starting with 5 interviews; many teams later review ALL readmissions when the patient is readmitted.
2	Tool 3 Hospital Inventory	This tool prompts a comprehensive inventory of readmission reduction activity and related organizational and operational assets across departments, service lines, and units within the hospital.	Day-to- day champion, in collaboration with readmission reduction team.	4 hours. Take no more than 2 weeks (2 meetings) to complete.
2	Tool 4 Community Inventory	This tool prompts an inventory of postacute and community-based providers, agencies, and plans that can offer posthospital services.	Readmission reduction champion as a component of strategic planning; delegated to day-to- day lead or social worker to conduct in collaboration with community partners.	4-5 hours, delegated across multiple staff.
3	Tool 5 Portfolio Design	A PowerPoint deck that includes examples of readmission reduction portfolios that can be modified to develop the data-informed, multifaceted portfolio of readmission reduction efforts in your hospital.	Readmission reduction strategic leadership team.	3 to 4 hours.

GUIDE SECTION	TOOL	DESCRIPTION	STAFF	TIME REQUIRED
3	Tool 6 Operational Dashboard	A PowerPoint deck that provides an example of an operational dashboard to track measures of monthly discharge volume, monthly implementation measures, and monthly outcomes (readmission rates).	Readmission champion and day-to- day leader.	1 hour to review; 2 hours monthly to populate.
3	Tool 7 Portfolio Presentation	A PowerPoint slide deck that summarizes the findings of the quantitative and qualitative data review, hospital and community inventory, aim, target population, and data-informed strategy to reduce readmissions.	Readmission reduction champion and/or day-to- day leader.	2 hours.
4	Tool 8 Conditions of Participation	This 1-page handout offers an overview of the transitional care practices as outlined by the guidance and proposed changes to the CMS COPs. It can be used as a handout, in educational sessions, and as a guide to the work of your readmission reduction team.	Readmission reduction champion (in strategic planning); day-to-day leader (education and improvement work).	30 minutes to review and consider circulating or discussing at next readmissions team meeting.
4	Tool 9 Whole-Person Transitional Care Planning	This tool provides discharge planners with a set of prompts to identify readmission risks and to take steps to ensure those risks are addressed in the transitional care (discharge) plan.	Day-to-day readmission reduction champion to test, adapt, and incorporate into existing workflow with frontline staff.	Incorporate into regular discharge planning assessment and referrals.
4	Tool 10 Discharge Process Checklist	This tool, adapted from the CMS Conditions of Participation (COPs), provides a checklist of discharge elements that CMS states should be provided to all Medicare and Medicaid patients. This tool can be used to update existing processes and identify whether new processes and practices need to be implemented.	Readmission champion and day-to-day leader.	1 hour to review and 1-3 hours to discuss with hospital colleagues the extent to which various elements are reliably delivered.

GUIDE SECTION	TOOL	DESCRIPTION	STAFF	TIME REQUIRED
5	Tool 11 Community Resource Guide	This is a two-part tool: a community resource guide and a 1-page "quick reference" version. The purpose is to stimulate the development of an extended set of contacts at community agencies, specifically agencies and providers who can meet the posthospital and ongoing clinical, behavioral, and social service needs of the Medicaid population or other high-risk patients.	Delegate to a social worker to complete with community providers and agencies.	12 hours initially. Take no more than 1 month to draft. Update periodically (e.g., once or twice a year).
5	Tool 12 Cross Continuum Collaboration	This tool helps teams develop specific effective and timely linkages to services with cross-continuum clinical, behavioral, and social services providers.	Readmission day-to-day champion.	2 hours to review and apply recommendations.
6	Tool 13 ED Care Plan Examples	This tool provides an ED care plan template and examples of ED care plans. Hospitals can use this template, adapt the template, or draw inspiration from the examples to develop their own template to suit their specific needs and preferences.	Champion of efforts to reduce frequent utilization.	Target 30 minutes per patient to develop a care plan. Note that the first 10 patients may require significantly more time as the team learns what information to incorporate. Recommend weekly or biweekly meetings to review and discuss care plans.

Tool 1. Readmission Data Analysis and Interpretation

Brief Description: A quantitative readmission analysis tool.

Purpose: **Analyze hospital administrative data to evaluate readmission patterns.** Understanding readmission patterns is critical to designing an effective readmission reduction strategy. This straightforward analysis will highlight high-leverage opportunities to reduce readmissions for the hospital overall. This tool can be modified for your hospital's particular data analysis needs.

Instructions:

1. Ask a data analyst (in quality or finance) to conduct this analysis. Enter data in white cells; gray cells will calculate automatically.

   Use the following basic definitions:

   • Denominator: all adult inpatient discharges for a given 1-year period, less exclusions listed below
   • Numerator: all hospitalizations that occurred within 30 days of a discharge in the denominator
   • Readmission rate: number of readmissions (numerator) divided by number of discharges (denominator)

   Details:

   • Patient population: adults (18+)
   • Timeframe: past fiscal or calendar year, whichever is more convenient (12 months)
   • Discharge: discharge from the inpatient level of care
   • Exclusion: discharges deceased, transfers to acute care hospital, transfers to inpatient rehab hospitals, and discharges for childbirth-related DRGs
   • Payer: use the payer groups that are most relevant for your hospital. At a minimum, use “All Payer,” "Medicare," "Medicaid," and" Commercial." Include Medicaid Managed Care Plans in the “Medicaid” category. Most hospitals define “Medicare” as specifically Medicare fee for service.

2. Review and interpret the data to identify target populations with high readmission rates.

Staff: Data analyst, business analyst, staff able to query administrative data.

Time Required: 6 hours

Additional Resources: Section 1 of the *Hospital Guide to Reducing Medicaid Readmissions* for more information about quantitative data analysis. **Tool 2: Readmission Review** gives guidance to collect and analyze complementary qualitative data.

Hospitalwide All Condition, All Payer, and Payer Specific Readmission Analysis (adult, non OB) EXAMPLE

Table 1. Readmission Rate	All	Medicare	Medicaid	Commercial	Uninsured
# discharges	17000	9000	4000	3800	200
# readmissions	2550	1500	800	230	20
Readmission rate	15.0%	16.7%	20.0%	6.1%	10.0%

Table 2. Percentage of Discharges and Readmissions	All	Medicare	Medicaid	Commercial	Uninsured
% of total discharges by payer	100.0%	52.9%	23.5%	22.4%	1.2%
% of total readmissions by payer	100.0%	58.8%	31.4%	9.0%	0.8%

Table 3. Days Between Discharge and Readmission	All
# of readmissions within 0-4 days of discharge	625
# of readmissions within 10 days of discharge	1275
# of readmissions between days 0-30 of discharge	2550
% of readmissions in 0-4 days	25%
% of readmissions in 0-10 days	50%
% of readmissions in 0-30 days	100%

Table 4. Top Discharge Diagnoses Leading to Highest Number of Readmissions	Top 10 Discharge Dx Resulting in Readmission	# Readmissions	# Discharges	Dx Readmission Rate by Payer	Dx Readmissions as % of All Readmissions
All Payer	Heart Failure	120	500	24%	5%
	Sepsis	100	500	20%	4%
	Psychosis	80	400	20%	3%
	COPD	70	300	23%	3%
	Renal Failure	50	200	25%	2%
	Pneumonia	30	200	15%	1%
	Esophagitis and other digestive disorders	30	180	17%	1%
	UTI	25	175	14%	1%
	Alcohol/drug abuse or dependence	25	180	14%	1%
	Cellulitis w/o MCC	20	150	13%	1%
	Total, Top 10	550			
	Total, All Readmissions	2550			22%
Medicare	Heart Failure	200	1300	15%	8%
	COPD	30	300	10%	1%
	Intracranial hemorrhage	25	50	50%	1%
	Renal failure with CC	20	135	15%	1%
	Alcohol/drug abuse or dependence	20	115	17%	1%
	COPD with MCC	15	80	19%	1%
	Psychosis	15	100	15%	1%
	UTI	15	80	19%	1%
	Sepsis	10	145	7%	0%
	Respiratory failure	10	60	17%	0%
	Total, Top 10	360			
	Total, All Readmissions	2550			14%
Medicaid	Psychoses	300	1850	16%	12%
	Alcohol/drug abuse or dependence	60	700	9%	2%
	Liver failure	25	50	50%	1%
	Esophagitis and other digestive disorders	10	90	11%	0%
	Other antepartum diagnoses	10	40	25%	0%
	Cellulitis	10	100	10%	0%
	COPD with MCC	5	30	17%	0%
	Chest pain	5	35	14%	0%
	Renal failure with CC	5	35	14%	0%
	Alcohol/drug abuse or dependence, left AMA	5	50	10%	0%
	Total, Top 10	435			
	Total, All Readmissions	2550			17%

Data Entry (Example)

Table 5. Behavioral Health Comorbidities	All	Medicare	Medicaid	Commercial	Uninsured
# of discharges with a comorbid behavioral health diagnosis	5500	2500	1800	850	20
# of readmissions with a comorbid behavioral health diagnosis	1000	400	450	45	10
% of discharges with a comorbid behavioral health diagnosis	32.35%	27.78%	45.00%	22.37%	10.00%
% of readmissions with a comorbid behavioral health diagnosis	39.22%	26.67%	56.25%	19.57%	50.00%

Table 6. Discharge Disposition	All	Medicare	Medicaid	Commercial	Uninsured
# of discharges to home (without home health)	11200	4200	3000	2800	170
# of discharges to home health	1050	700	180	150	10
# of discharges to skilled nursing facility (SNF)	2000	2300	300	300	5
% of discharges discharged to home (without home health)	66%	47%	75%	74%	85%
% of discharges discharged with home health	6%	8%	5%	4%	5%
% of discharges discharged to SNF	12%	26%	8%	8%	3%

Table 7. Readmissions by Discharge Disposition	All	Medicare	Medicaid	Commercial	Uninsured
# of readmissions following discharge to home (without home health)	1850	700	830	300	20
# of readmissions following discharge to home health	200	110	55	30	5
# of readmissions following discharge to skilled nursing facility (SNF)	500	400	80	20	0
Readmission rate following discharge to home (without home health)	17%	17%	28%	11%	12%
Readmission rate following discharge to home health	19%	16%	31%	20%	50%
Readmission rate following discharge to skilled nursing facility (SNF)	25%	17%	27%	7%	0%

Table 8. High Utilizer Population	All	Medicare	Medicaid	Commercial	Uninsured
# of patients hospitalized 4 or more times in the past year	440	200	150	75	15
# of discharges by patients hospitalized 4 or more times in the past year	3375	1800	1200	300	75
# of readmissions by patients hospitalized 4 or more times in the past year	1435	800	520	100	15
% of readmissions by patients hospitalized 4 or more times in the past year	56%	53%	65%	43%	75%
Readmission rate of patients hospitalized 4 or more times in the past year	43%	44%	43%	33%	20%

Data Dashboard (Example)

Output Check

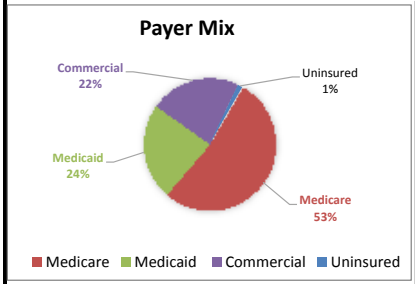
1.B4 indicates the total number of adult non-OB discharges (all payers) in a given year. Does this number look right? If not, circle back to your data analyst before moving ahead.

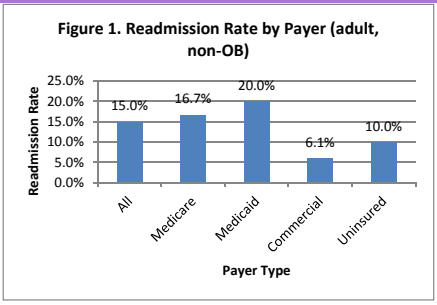
2. B6 and C6 report the readmission rate for your adult non-OB population overall and Medicare population overall. A hospitalwide adult non-OB readmisison rate might be around 10-14%; an all cause Medicare readmission rate might be around 14-18%. Are your numbers as expected? If not, work wtih your analyst to ensure you have accurate data output.

Topic 1: Readmission Rates by Payer.

What are the readmission rates by payer? Which payer group has the highest rate of readmissions? Which payer group has the highest total number of readmissions? What is the combined proportion of Medicare and Medicaid readmissions?

What you are looking for:





Medicaid readmission rates are high

Topic 2: Readmissions by Payer.

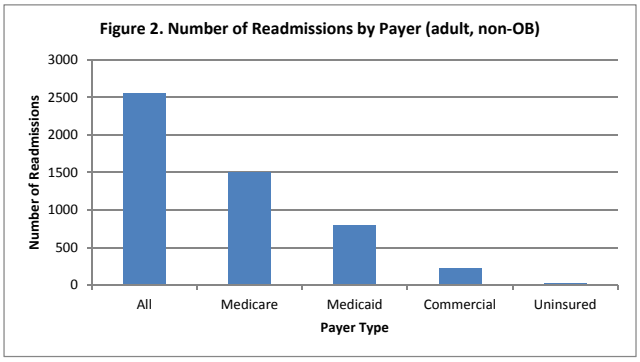
How many readmissions occur at your hospital every year? How many readmissions would be reduced if your hospital reduced readmissions by 20%; how many per year and per month?

What you are looking for:

Medicare + Medicaid readmissions make up majority of all readmissions

Readmission teams often focus on the readmission rate; look at the absolute number to put goal and operations in context

See calculatation below for a 20% reduction in total readmissions to get a sense of whether it might be an achievable readmission aim



# of readmissions that would need to be reduced if your hospital reduced readmissions by 20%	510
# of readmissions that would need to be reduced per month, for a 20% reduction in one year	43

Topic 3: Top Discharge Diagnoses.

What are the top 10 discharge diagnoses leading to readmissions, and how do they differ between Medicare and Medicaid? Does it make clinical, operationational, or mathematical sense to focus on a limited set of discharge diagnoses?

		What you are looking for:
Examine list of top discharge diagnoses leading to the most readmissions at the hospital (all payer). What is surprising?	list surprising diagnoses here	Look for sepsis, behavioral health diagnosis
Examine list of top discharge diagnoses leading to most readmissions for Medicare v. Medicaid. What is surprising?	list surprising observations here	Compare and contrast the top diagnoses for Medicare vs. Medicaid
Does it make sense to focus on a limited set of discharge diagnoses? If so, why? If not, why not?	list observations here	Top 10 diagnoses often account for only 20-40% of all readmissions
Diagnoses that result in many readmissions, or have high rates of readmission that merit attention:	list diagnoses here	Identify diagnoses, such as sepsis, sickle cell, substance use that are high risk but previously not addressed

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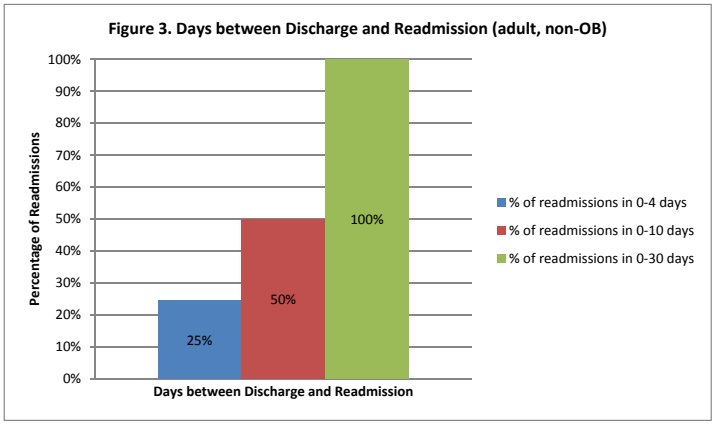
Topic 4: Behavioral Health Comorbidities.		
What percentage of discharges has a behavioral health comorbidity? How does this differ between Medicare and Medicaid?		What you are looking for:
% of all discharges with a behavioral health comorbidity	32%	Behavioral health comorbidities are frequent among hospitalized patients
% of all readmissions with a behavioral health comorbidity	39%	
% of Medicaid discharges with a behavioral health comorbidity	45%	Consider: Behavioral health conditions are a readmission risk factor. A strategy that includes addressing needs of patients with behavioral health conditions may be high leverage.
% of Medicaid` readmissions with a behavioral health comorbidity	56%	

Topic 5: Days between Discharge and Readmission.

What percentage of readmissions occurs within 4 days of discharge? Within 10 days?



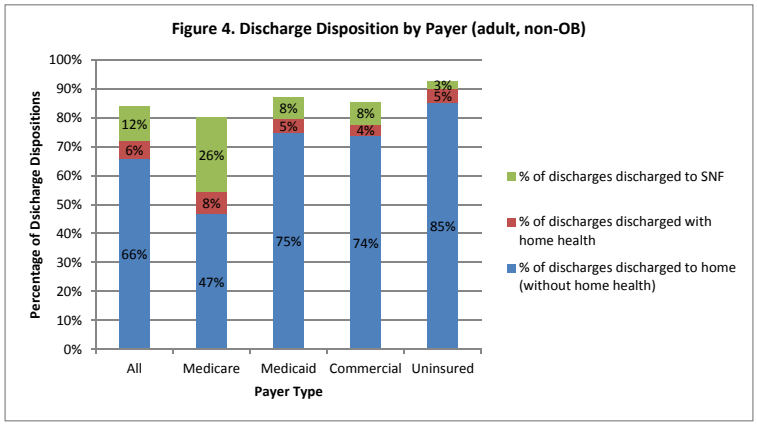
What you are looking for:

Typically, 25% of readmissions occur within 4 days and 50% of readmissions occur within 10 days of discharge.

Consider: Does your strategy prioritize early postdischarge followup contact?

Topic 5: Discharge Disposition by Payer.

How does the discharge disposition of Medicare and Medicaid patients differ?



What you are looking for:

The percentage of patients being discharged to home is much higher among Medicaid than Medicare.

Consider: While partnerships with SNFs may be relevant for Medicare readmissions, partnerships with community providers and agencies are important for Medicaid readmissions.

Data Dashboard (Example)

Topic 6: High Utilizers.		
How many patients were hospitalized 4 or more times in the past year (also known as "high utilizers")? What is the readmission rate for this group? What percentage of discharges has a behavioral health comorbidity? How does this differ between Medicare and Medicaid?		What you are looking for:
# of high-utilizing patients out of all patients	440	High utilizers tend to represent 5% of the patient population…
% of high-utilizer readmissions out of all readmissions	56%	…but account for >50% of total readmissions.
High-utilizer readmission rate	43%	Their readmission rate is usually ~40%
	Note: This population has a combination of clinical, behavioral, and social needs.	Note: This group can be readily identified in daily operations by the simple screen of a personal history of prior admissions.

Topic 7: Target Populations To Consider.		
What is the hospital's overall readmission rate, and which groups of patients have higher than average readmission rates? Which group experiences the most readmissions? Are there any high risk diagnoses to consider?		See the big picture when it comes to readmissions at your hospital. Consider the following groups:
Medicaid readmission rate	20%	A focus on adult non-OB Medicaid patients is data informed.
% of Medicare + % of Medicaid readmissions	90%	A focus on Medicare and Medicaid discharges is data informed.
% of patients with behavioral health comorbidities	39%	A focus on improving posthospital care for patients with behavioral health comorbidities is data informed.
Readmission rate among patients discharged to home (without home health)	17%	An exclusive focus on improving transitional care for patients discharged to home may not be data informed, although subgroups (such as Medicaid) of discharges to home are high risk.
Readmission rate among patients discharged to SNFs	25%	A focus on patients discharged to SNF (or any postacute care) is data informed.
% of readmissions from high-utilizing patients	56%	A focus on patients with a personal history of repeated hospitalizations is data informed.

TOOL 2: READMISSION REVIEW TOOL

Purpose

Readmission reviews are designed to elicit 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 experienced in the days after a patient's discharge that resulted in a readmission.

For the purposes of designing a data-informed portfolio of strategies, conduct 5 to 20 of these interviews to elicit the patient/caregiver perspective, humanize readmissions, and understand root causes that go beyond diagnoses or other "risk" categories. Be sure to interview at least 5 Medicaid patients and 5 caregivers.

For the purposes of improving transitional care for all patients, consistently conduct a "readmission review" for each readmitted patient, using the information about the person's actual challenges, barriers, or root causes to create a better discharge plan.

Description

Adapted from the well-known Institute for Healthcare Improvement's State Action on Avoidable Rehospitalizations (STAAR) approach, this tool prompts clinical or quality staff to elicit the patient or caregiver's perspective about readmissions.

Instructions

1. Identify patients in the hospital who have been readmitted.
2. Ask the patients/caregivers if they are willing to have a 5- to 10-minute discussion about their recent hospitalizations.
3. Capture patient/caregiver responses.
4. Analyze responses for new insight regarding "why" patients returned to the hospital soon after being discharged.

Staff

Quality improvement, nursing, case management staff.

Time Required

- 5-10 minutes to conduct each patient interview;
- 2-3 minutes to analyze each.

Many teams review ALL readmissions when the patient is readmitted. Some teams may be concerned that patient interviews will take too much time. You can address time constraints by using a simple framing script at the beginning of the interview (see next page). Readmission teams uniformly report that these reviews yield valuable information that would otherwise be difficult to obtain from charts or data.

Additional Resource

See Section 1 of the *Hospital Guide to Reducing Medicaid Readmissions* for more context about conducting readmission reviews and an example of readmission review findings.

Readmission Interview (5-10 minutes each)

The purpose of these interviews is to elicit the "story behind the chief complaint"—the events that occurred between the time of discharge and time of readmission. Rather than looking for the one reason for the readmission, capture all the factors that contributed to the readmission event.

Suggested script: "We are working to improve care for patients once they leave the hospital and noticed that you were here recently and now you're back. Would you mind telling me about what happened between the time you left the hospital and the time you returned? 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. It shouldn't take more than 5 minutes. Would that be okay with you?"

- **Why were you hospitalized earlier this month?**
  - Prompt for patient/caregiver understanding of the reason for hospitalization.
- **When you left the hospital:**
  - How did you feel?
  - Where did you go?
  - Did you have any questions or concerns? If so, what were they?
  - Were you able to get your medications?
  - Did you need help taking care of yourself?
  - If you needed help, did you have help? If so, who?
- **Tell me about the time between the day you left the hospital and the day you returned:**
  - When did you start not feeling well?
  - Did you call anyone (doctor, nurse, other)?
  - Did you try to see or did you see a doctor or nurse or other provider before you came?
  - Did you try to manage symptoms yourself?
  - Prompt for patient/caregiver self-management techniques used.
- **In our efforts to provide the best possible care to you and others like you, can you think of anything that we—or anyone—could have done to help you after you left the hospital the first time so that you might not have needed to return so soon?**

Root Cause Analysis and Lessons Learned (2-3 minutes each)

The purpose of a root cause analysis is to understand the factors underlying patient readmissions so that you can develop processes to prevent readmissions. When analyzing each patient interview:

- Ask "why" 5 times to elicit the "root causes" of readmissions.
  - For example, an interview might reveal that a patient did not take her medication, which then contributed to her rehospitalization. Why did she not take her medication? She did not take it because she did not have it. Why? She did not go to pick it up from the pharmacy. Why…? Continue to ask until you have identified opportunities that your hospital team can address (e.g., bedside delivery of medication, teach-back, medication reconciliation; such services may exist for some patients but not others or may be delivered as available rather than consistently).
  - Try to avoid citing disease exacerbations or noncompliance as root causes. If those are factors, ask "why" again.
- Remember to identify all the reasons for the readmissions; there is rarely only one reason.
- Specifically seek to identify clinical, behavioral, social, and logistical factors that might have contributed to the readmission.
- See Section 1 of the *Hospital Guide to Reducing Medicaid Readmissions* for an example of interview findings and root cause analysis.

TOOL 3: HOSPITAL INVENTORY TOOL

Purpose

Readmission reduction efforts at your hospital have likely proliferated over the past several years, and many of these efforts may have developed in isolation from each other. The purpose of this tool is to prompt a comprehensive inventory of all readmission reduction-related efforts and other operational assets that can contribute to achieving your readmission reduction aim. This inventory will help your strategic planning work to formulate a data-informed, multifaceted portfolio of strategies.

Description

This tool prompts a comprehensive inventory of readmission reduction activity and related organizational and operational assets across departments, service lines, and units within the hospital.

Staff

Day-to-day champion, in collaboration with readmission reduction team. Engage a variety of stakeholders across the organization, as you and your colleagues will have varying knowledge of what is going on at the hospital.

Time Required

4 hours. Take no more than 2 weeks (2 meetings) to complete.

Additional Resource

See Section 2 of the *Hospital Guide to Reducing Medicaid Readmissions* for additional information.

TOOL 3: HOSPITAL INVENTORY TOOL

You probably have multiple types of readmission reduction activities underway at your hospital. You probably also have access to "assets" relevant to a robust readmission reduction effort. An inventory of readmission reduction efforts will reveal the administrative, clinical, health information technology, and other organizational assets already in place. Once you know what efforts and assets already exist, you can consider whether they are optimally aligned and coordinated. The inventory will also serve as an implicit gap-analysis of activities or assets not currently in place. You may identify the need to implement new practices as part of this process.

READMISSION ACTIVITY/ASSET	FOR WHICH PATIENTS?
ADMINISTRATIVE ACTIVITIES/ASSETS	
❑ Specified readmission reduction aim	
❑ Executive/board-level support and champion	
❑ Readmission data analysis (internally derived or externally provided)	
❑ Monthly readmission rate tracking (internally derived or externally provided)	
❑ Periodic readmission case reviews and root cause analysis	
❑ Readmission activity implementation measurement and feedback (PDSA, audits, etc.)	
❑ Provider or unit performance measurement with feedback (audit, bonus, feedback, data, etc.)	
❑ Other:	
HEALTH INFORMATION TECHNOLOGY ASSETS	
❑ Readmission flag	
❑ Automated ID of patients with readmission risk factors/high risk of readmission	
❑ Automated consults for patients with high-risk features (social work, palliative care, etc.)	
❑ Automated notification of admission sent to primary care provider	
❑ Electronic workflow prompts to support multistep transitional care processes over time	
❑ Automated appointment reminders (via phone, email, text, portal, or mail)	
❑ Other:	
TRANSITIONAL CARE DELIVERY IMPROVEMENTS	
❑ Assess "whole-person" or other clinical readmission risk	
❑ Identify the "learner" or care plan partner to include in education and discharge planning	
❑ Use clinical pharmacists to enhance medication optimization, education, reconciliation	
❑ Use "teach-back" to improve patient/caregiver understanding of information	
❑ Schedule followup appointments prior to discharge	
❑ Conduct warm handoffs to postacute and/or community "receivers"	
❑ Conduct postdischarge followup calls (for patient satisfaction or followup purposes)	
❑ Other:	
CARE MANAGEMENT ASSETS	
❑ Accountable care organization or other risk-based contract care management	
❑ Bundled payment episode management	
❑ Disease-specific enhanced navigation or care management (heart failure, cancer, HIV, etc.)	
❑ High-risk transitional care management (30-day transitional care services)	
❑ Other:	
CROSS-CONTINUUM PROCESS IMPROVEMENT COLLABORATIONS WITH:	
❑ Skilled nursing facilities	
❑ Medicaid managed care plans	
❑ Community support service agencies	
❑ Behavioral health providers	
❑ Other:	

TOOL 4: COMMUNITY INVENTORY TOOL

Purpose

Identify clinical, behavioral, and social service resources in the community that can improve posthospital care to reduce readmissions. The community inventory is complementary to the hospital inventory when developing a whole-person and data-informed portfolio of strategies to reduce readmissions. Knowing the resources that currently exist in the community is essential to effectively leveraging those resources through formal or informal collaborations.

Description

This tool prompts an inventory of community providers and agencies that provide services to meet the posthospital needs of patients so as to reduce readmissions.

Staff

Readmission reduction champion as a component of strategic planning; delegated to day-to-day lead or social worker to conduct in collaboration with community partners.

Time Required

4 hours.

Additional Resources

See Section 2 of the *Hospital Guide to Reducing Medicaid Readmissions* and Tool 11: Community Resource Guide.

TOOL 4: COMMUNITY INVENTORY TOOL

Many resources in postacute and community-based settings can be mobilized to support patients in the posthospital period. Too often, hospital-based teams think there are few resources in the community, without periodically updating their understanding of what resources exist. The Centers for Medicare & Medicaid Services (CMS) specifically requires hospitals to know the capabilities of postacute and community-based resources, including Medicaid home and community-based services. Specifically inquire whether timely postdischarge or transitional care services exist. Over the past several years, skilled nursing facilities, home health agencies, and provider-based, payer-based, or community agency-based (transitional or high risk) care management services have proliferated in response to delivery system transformation.

Use this tool to inventory clinical, behavioral, and social service resources in the community that could provide timely posthospital followup, monitoring, and assistance. Use this inventory to identify which resources your hospital regularly uses. Also use this inventory as an implicit gap analysis to stimulate a consideration of providers or agencies you may want to more regularly use as part of your updated whole-person, data-informed portfolio of strategies.

Tip: You might use this inventory as a brief internal team review of the postacute and community providers with whom you most frequently collaborate to provide high-quality transitional care and effective linkage to posthospital services. Your readmission reduction team can probably identify a handful of the below-listed providers or agencies. That provides you with the information you need to have a gap analysis of what other resources to look for in the community.

Tip: Specifically find out whether you currently work with providers or agencies that address the needs of the target populations identified as high risk in your data analysis and readmission interviews. Consider:

- Medicaid resources: Managed care organization care managers, home and community-based services
- Behavioral health resources: providers, drop in centers, peers, case workers
- Clinical resources: clinics with integrated social work, behavioral health, care management (e.g., dialysis, sickle cell disease, HIV, cancer), patient-centered medical homes, accountable care organizations, etc.
- Aging and disability services
- Social services
- Collaborations with law enforcement or the criminal justice system

Provider or Agency	Transitional Care Services [Examples]	Use?	
Clinical and Behavioral Health Providers		Yes	No
Community health centers, federally qualified health centers	[ability to accept new patients; timely posthospital followup; co-located social work, nutritional, pharmacy services, etc.]	❑	❑
Accountable care organization with care management or transition care	[high-risk-care management, transitional care to reduce readmissions, etc.]	❑	❑
Medicaid managed care organizations	[high-risk-care management, social work, wraparound services, etc.]	❑	❑
Program of All-inclusive Care for the Elder (PACE), Senior Care Options (SCO), Duals Demonstration providers	[capitated or risk-bearing providers focused on providing whole-person care to improve quality and reduce costs]	❑	❑
Medicaid health homes	[engagement, outreach, tiered care management; eligibility based on chronic and behavioral health conditions]	❑	❑
Multiservice behavioral health centers, including behavioral health homes	[prioritized posthospital followup; availability for new patients; co-located support services, etc.]	❑	❑
Behavioral health providers	[accepting new patients, prioritizing posthospital followup, etc.]	❑	❑
Substance use disorder treatment providers	[effective processes for linking patients from acute care to substance use disorder treatment]	❑	❑
Heart failure, chronic obstructive pulmonary disease (COPD), HIV, dialysis, or cancer center clinics	[urgent appointments for symptom recurrence, protocol-driven ambulatory management, social work, education, etc.]	❑	❑
Pain management or palliative care	[symptom management over time, often with behavioral health specialists and social workers, education, etc.]	❑	❑
Physician/provider home visit service	[timely postdischarge in home evaluation, coordination with primary care, specialists, pharmacy, home health, etc.]	❑	❑
Skilled nursing facilities	[onsite providers, warm handoffs, joint readmission reviews, INTERACT (Interventions To Reduce Acute Care Transfers) processes, transitional care from skilled nursing facility to home, etc.]	❑	❑
Home health agencies	[warm handoffs, joint readmission reviews, front-loaded home visits, behavioral health clinical expertise, etc.]	❑	❑
Hospice	[warm handoffs, joint readmission reviews, same-day home visits, etc.]	❑	❑
Adult day health	[daily clinical, nutritional, medication management, socialization, etc.]	❑	❑
Public health nurses	[home visits, outreach, education, clinical coordination, etc.]	❑	❑
Pharmacies	[bedside delivery, home delivery, medication therapy management, affordability counseling, blister packs, etc.]	❑	❑
Durable medical equipment	[same-day delivery; 30-day transitional care monitoring, education services, etc.]	❑	❑
Other			
Social Services			
Adult protective services	[safety evaluation, case management]	❑	❑
Area Agency on Aging (AAA)	[self-management coaching, chronic disease self-management, in-home personal support services, etc.]	❑	❑
Aging and Disability Resource Centers	[evaluate for eligibility for benefits and services; link to vetted providers]	❑	❑
Assisted living facilities	[onsite clinical, onsite behavioral, self-management coaching, adherence support, transportation, etc.]	❑	❑
Housing with services	[care management, onsite social work, onsite clinical, nutritional/food support, transportation, etc.]	❑	❑
Housing authority or agencies	[case management, facilitated process of pursuing housing options]	❑	❑
Legal aid	[securing benefits, access to treatment, utilities, rent, etc.]	❑	❑
Faith-based organizations	[personal and social support, transportation, meals, etc.]	❑	❑
Transportation	[transportation to meet basic and clinical needs]	❑	❑
Community corrections system	[case workers, social workers, collaboration on followup]	❑	❑
Other			

Tool 5: Portfolio Design

Brief Description: A PowerPoint deck that includes examples of readmission reduction portfolios that can be modified to develop the data-informed, multifaceted "portfolio" of readmission reduction efforts in your hospital.

Purpose: To facilitate the formulation of your hospital's readmission reduction plan as a set of data-informed and complementary strategies that support your readmission reduction aim.

This tool helps you consolidate your strategic planning by creating a multifaceted portfolio of strategies using a driver diagram. A driver diagram is a tool used in quality improvement and delivery system redesign that serves as an organizing framework to convey the theory of change. A driver diagram identifies the three or four primary ways you will achieve your aim. In relation to each "primary driver" are "secondary drivers": the mechanisms by which each primary driver will be achieved. For further guidance, see the Massachusetts Health Policy Commission Community Hospital Acceleration, Revitalization, and Transformation Investments (CHART) Driver Diagram Guide and the CMS Center for Innovation's Defining and Using Aims and Drivers for Improvement How to Guide

Instructions:

1. Draft the driver diagram to reflect your hospital's current or desired readmission reduction strategy.
2. Conduct a team meeting to answer the gap analysis questions. Consider whether anything is missing.
3. Finalize the driver diagram as a living document that will be periodically reviewed and modified.
4. Use the driver diagram to formulate a workplan and develop an operational dashboard to track progress.

Staff: Readmission reduction leadership team.

Time Required: 3-4 hours.

Additional Resource: See Section 3 of the *Hospital Guide to Reducing Medicaid Readmissions*.

Create a Driver Diagram – 1

Refer to Guide Section 3 for additional information

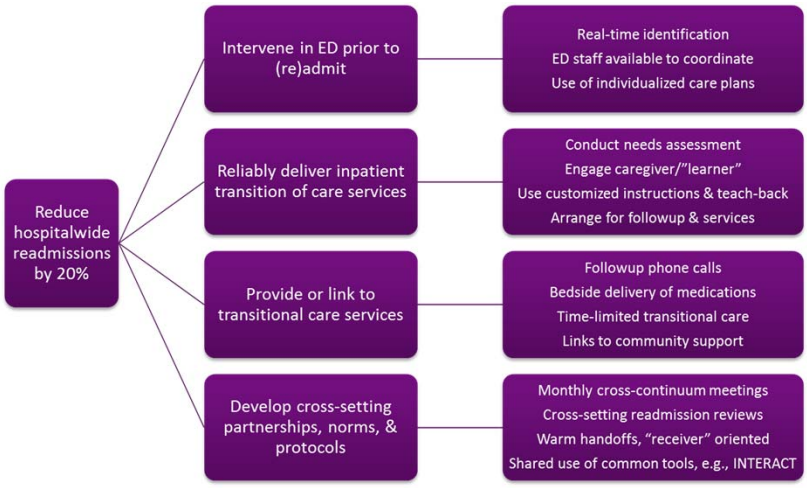
1. Specify the goal and target population.
   i. The goal should be data informed and specify what will be achieved (e.g., a reduction in readmissions) for whom, by how much, and by when.
2. Identify three or four primary ways the aim will be achieved.
   i. Consider: improving hospital-based transitional care processes, collaborating with cross-setting partners, and delivering enhanced services in the set of primary drivers. There may be others depending on your target population and resources available.
   ii. You might identify which of these efforts are currently in place and which you are identifying as new elements in the portfolio of efforts.

Create a Driver Diagram – 2

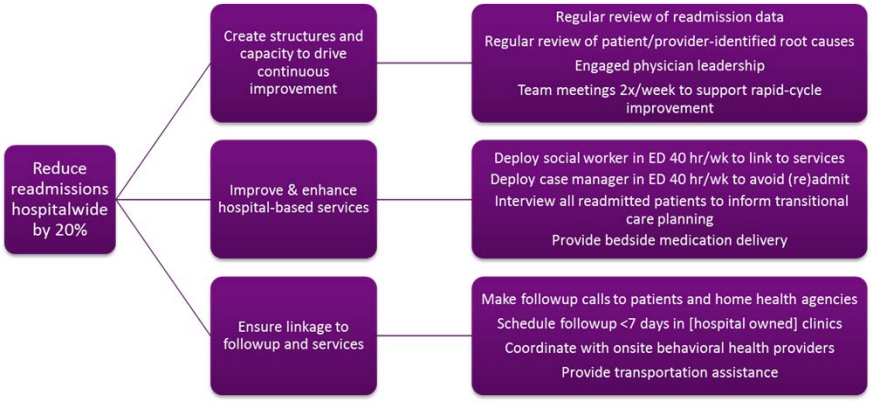
3. Analyze your first draft driver diagram to consider:

- ❑ Are all readmission reduction-related activities captured?
- ❑ Will this strategy address the root causes of readmissions for your target population?
- ❑ What target populations have not been prioritized? Why?
- ❑ What strategies have not been prioritized? Why?
- ❑ Are the following data-informed or high-leverage elements included? If not, why not?
  - ❑ Medicaid adults
  - ❑ Behavioral health
  - ❑ Social support needs
  - ❑ High utilizers
  - ❑ High-risk diagnoses based on your data (sepsis, renal failure, sickle cell disease, etc.)
  - ❑ Discharges to postacute care settings
  - ❑ Collaborations with managed care organizations (MCOs), behavioral health providers, clinics, social services, housing services
- ❑ Does this strategy align with value-based/alternative payments and other incentives?
  - ❑ Medicare readmission penalties? Medicare value-based purchasing (total cost)?
  - ❑ Medicaid readmission penalties? Medicaid MCO at-risk contracts? Delivery System Reform Incentive Payment goals?
  - ❑ Board-level goals relating to quality, patient experience, disparities, or stewardship?

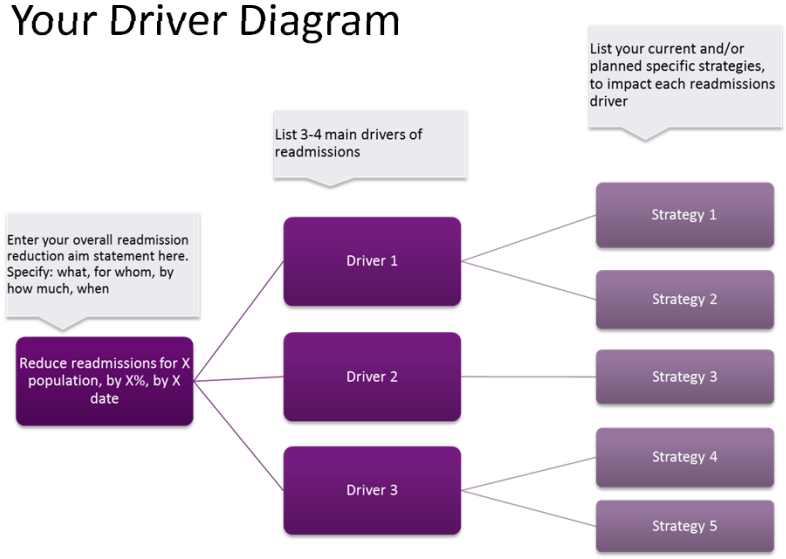
Example 1: Baltimore Hospital



Example 2: Chicago Hospital



Your Driver Diagram



Tool 6: Operational Dashboard

Purpose: Whatever process you put into place to reduce readmissions, measurement is the single most important tool you have to determine whether the processes you have put into place are having an impact on reducing readmissions. Develop a monthly operational dashboard to track and review:

1. **Target population volume: "**How many total discharges were there? How many target population discharges were there?"
2. **Services delivered:** "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.
3. **Outcomes**: Track readmission rates for the hospital and for the target populations monthly to visualize trends over time.

Brief description: A 3-part operational dashboard, consisting of measures of monthly discharge volume; monthly implementation measures; and monthly outcomes (readmission rates).

Staff: Readmission champion and day-to-day leader.

Time: 1 hour to review; 2 hours monthly to populate.

Additional Resource: See Section 3 of the *Hospital Guide to Reducing Medicaid Readmissions* regarding measurement and reliable implementation.

Operational Dashboard: Volume and Implementation

Volume, past month	Number or %
Number of (adult non-OB) discharges	[#]
Number of discharges in target population 1	[#]
Number of discharges in target population 2	[#]
Total number of discharges in target populations	[#]
% of all discharges that are target population discharges	[%]

Implementation of Service Delivery	Number or %
Number of discharges in[target population 1] that received [strategy 1]	[#]
% of discharges in [target population 1] that received [strategy 1]	[%]
Number of discharges in[target population 2] that received [strategy 2]	[#]
% of discharges in [target population 2] that received [strategy 2]	[%]
Total target population discharges that received intended strategy	[#]
% of target population discharges that received intended strategy	[%]

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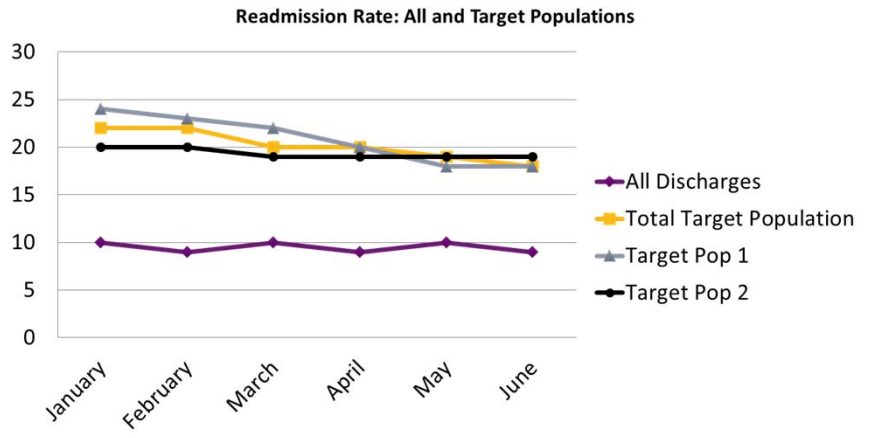
Operational Dashboard: Outcomes



Tool 7: Portfolio Presentation

Brief Description: PowerPoint slide deck that summarizes the findings of the quantitative and qualitative data review, hospital and community inventory, aim, target population, and data-informed strategy to reduce readmissions.

Purpose: Provides readmission reduction leaders and managers a customizable PowerPoint presentation to communicate your hospital's approach to reducing readmissions. This presentation can be used for the board, executive leadership, department managers, frontline staff, and external (cross-continuum) partners.

Staff to Complete: Readmission reduction champion and/or day-to-day leader.

Time Required: 2 hours.

Additional Resources: See Section 3 of the *Hospital Guide to Reducing Readmissions*, and Tools 1-6, which include the Data Analysis, Readmission Review, Hospital Inventory, Community Inventory, Portfolio Design, and Operational Dashboard tools.

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[Hospital] Readmission Reduction Strategy

[Date]

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Readmissions: Current State

- [Hospital's] current readmission rates:
  - Medicare FFS: [from data analysis]
  - Medicaid (managed or FFS): [from data analysis]
  - Hospitalwide (adult non-OB): [from data analysis]

  [insert 1-2-3 year monthly readmission rates with a trendline indicating whether readmission rates are improving] or

  [insert how current rates compare to state or national averages] or

  [insert how current rates compare to top 10% performers]

Why Update Our Readmission Reduction Strategy?

- **[insert rationale for quality, patient experience here]**
  - Commitment to delivering the right care, right location; many readmissions reflect a failure to deliver on that commitment.
  - Considering "whole-person" needs following a hospitalization is a commitment to delivering safe, effective, and person-centered care.
- **[insert rationale for current financial incentives here]**
  - Share Medicare readmission penalty amounts since FY13
  - Share Medicare value-based purchasing gains/losses this year
  - Share [any] Medicaid penalties or gains/losses for risk contracts
- **[insert rationale for future financial incentives here]**
  - Share plans for transitions to risk- or value-based contracts
- **[insert other vision/mission/stewardship commitment here]**

[Hospital] Readmission Data Analysis

	All Payer	Medicare	Medicaid
Total discharges			
Total readmissions			
Readmission rate			
Top 3 diagnoses resulting in most readmissions	1. 2. 3.	1. 2. 3.	1. 2. 3.
% of all discharges with a behavioral health diagnosis			
% of all readmissions occurring <4 days			
Readmission rate for discharges to postacute care (skilled nursing facility or home health)			
# of patients with 4+ admissions/year			
Readmission rate for those with 4+ admissions/year			
Other [your choice]			

Insights From Readmitted Patient Interviews

- [use direct quotes when possible]
- [provide 2-3 sentence vignettes of readmitted patients]
- [summarize themes]
- [highlight unexpected findings]
- [avoid medicalized interpretations such as “noncompliant”]

What Exists: Hospital and Community Inventory

Hospital-Based Efforts

- [readmission flag]
- [readmission risk assessment]
- [automated primary care notification]
- [medication reconciliation efforts]
- [whole-person needs assessment]
- [interdisciplinary care planning]
- [goals of care discussions]
- [palliative care]
- [customized patient information]
- [teach-back]
- [schedule appointments and services]
- [bedside delivery of medications]
- [warm handoffs]
- [followup phone calls]
- [transitional care programs]

Community-Based Efforts

- [adult day health programs]
- [PACE, SCO, other total care providers]
- [comprehensive behavioral health centers]
- [community mobile crisis teams]
- [behavioral health homes]
- [Medicaid health homes]
- [community health worker programs]
- [peer support programs]
- [social support services]
- [medical-legal advocacy services]
- [housing with services agencies]
- [physician/provider home visit services]
- [use of INTERACT processes and tools]
- [SNFs with onsite clinical providers]
- [front-loaded home care episodes]
- [home care agencies with behavioral health expertise]

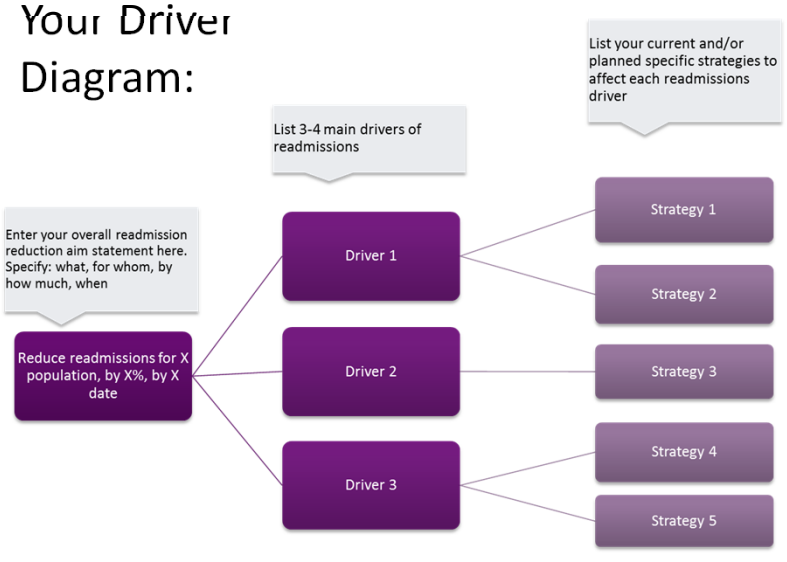
Readmission Reduction Goal and Target Population(s)

- [specify the hospital's specific readmission reduction goal]:
  - what will be achieved [e.g., reduce readmissions]
  - for whom – specific target population [e.g., for all adult inpatients]
  - by how much [e.g., by 20%]
  - by when [e.g., over the next 2 years]
- [specify the target population or populations]
  - [e.g., Hospitalwide readmissions, all adult non-OB inpatients]
  - [e.g., patients at high risk of readmission: adult non-OB Medicaid, any behavioral health comorbidity, or any unmet social need]
  - [e.g., patients with a personal history of 4+ hospitalizations/year]
  - [e.g., all patients discharged to postacute care]

Readmission Reduction Goal and Target Population(s)

- Goal: [state goal]
  - Current rate: [x%]
  - Current number of readmissions: [y]
  - [goal reduction] in readmissions: [z fewer readmissions per year]
- Target population: [specify]
  - Number of discharges per year in target population(s)
  - Number of readmissions per year in target population(s)
  - Number of discharges per month in target population(s)
  - Number of readmissions per month in target population(s)
  - Number of readmissions avoided per month in target population(s) if [goal reduction] is achieved

Your Driver Diagram:



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Readmission Reduction Team

- Executive sponsor
- Champion
- Day-to-day lead
- Team members
  - Nursing
  - Case management
  - ED
  - Hospital medicine
  - Social work
  - Chaplain
  - Pharmacy
  - Data analyst
  - IT
  - Key 2-4 community partners

Measures of Success

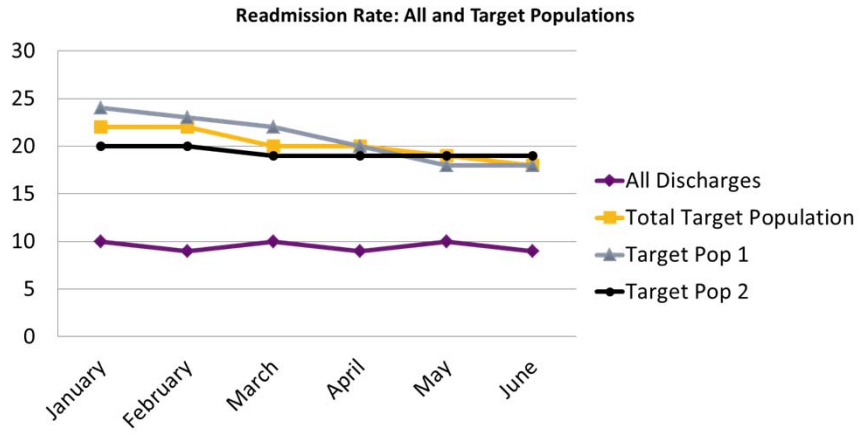
- Monthly implementation statistics
  - % of patients who received intended service(s)
  - [specify services, such as completed discharge checklists, or appointments scheduled, or followup phone calls completed]
  - Aim to achieve >80% reliable delivery of intended services
- Monthly readmission rates
  - Hospitalwide
  - Specific target populations
  - [Aim to see a measurable trend of improvement within 9 months]
  - [Aim to achieve goal by month 24]

Operational Dashboard: Volume and Implementation

Volume, past month	Number or %
Number of (adult non-OB) discharges	[#]
Number of discharges in target population 1	[#]
Number of discharges in target population 2	[#]
Total number of discharges in target populations	[#]
% of all discharges that are target population discharges	[%]

Volume, past month	Number or %
Number of discharges in[target population 1] that received [strategy 1]	[#]
% of discharges in [target population 1] that received [strategy 1]	[%]
Number of discharges in[target population 2] that received [strategy 2]	[#]
% of discharges in [target population 2] that received [strategy 2]	[%]
Total target population discharges that received intended strategy	[#]
% of target population discharges that received intended strategy	[%]

Operational Dashboard: Outcomes



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Next Steps and Timeline

- [consider organizing the next steps by “driver” rather than department to promote interdisciplinary collaboration]

TOOL 8: CONDITIONS OF PARTICIPATION HANDOUT

Purpose

In November 2015, the Centers for Medicare & Medicaid Services (CMS) issued a proposed revision to the Conditions of Participation (COPs). CMS specified new and unique elements that are particularly germane to reducing Medicaid readmissions and improving whole-person transitional care. Many hospitals have implemented some elements of these new CMS COPs for their high-risk patients. These best practices will improve care for all patients, especially Medicaid and other patients with high-risk diagnoses (e.g., HIV, liver disease, sickle cell disease), behavioral health conditions, and social support needs.

This tool is meant to assist in promoting awareness of the contents of the CMS COPs so that hospital staff can better understand how their work relates to CMS guidance.

Description

This 1-page handout offers an overview of the transitional care practices as outlined by the guidance and proposed changes to the CMS COPs. It can be used as a handout, in educational sessions, and as a guide to the work of your readmission reduction team.

Staff

Readmission reduction champion (in strategic planning); day-to-day leader (education and improvement work).

Time Required

10 minutes to review and consider circulating or discussing at next readmission team meeting.

Additional Resources

Tool 10: Discharge Information Checklist and Section 4 of the *Hospital Guide to Reducing Medicaid Readmissions* for additional information.

Improving Transitional Care for All Patients

CMS has recommended that hospitals do the following to improve discharge planning, now referred to as "transitional care." These expectations apply to Medicare and Medicaid patients.

- ✓ Have a documented discharge planning process, approved by the hospital's governing board;
- ✓ Provide discharge planning for all inpatients, observation patients, and certain ED patients;
- ✓ Analyze and track readmission rates;
- ✓ Review readmissions to look for patterns;
- ✓ Conduct root cause analyses on readmissions to assess whether the discharge planning process meets patients' needs;
- ✓ Craft a discharge plan that can be realistically implemented;
- ✓ Actively solicit the input of the patient and family/friends/support persons;
- ✓ Address behavioral health followup as part of the discharge plan;
- ✓ Provide customized education to patients and their caregivers;
- ✓ Provide oral instructions using the teach-back technique;
- ✓ Arrange for (not just refer to) posthospital services;
- ✓ Know the capabilities of postacute and community-based providers, including Medicaid home- and community-based services;
- ✓ Provide patients data to help inform their choice of high-quality postacute providers;
- ✓ Know options for Medicaid long-term services and supports, or have a contact at the State Medicaid agency who can assist with these issues; and
- ✓ Follow up with high-risk patients after discharge.

[Our hospital] is working to meet these expectations—and we need your help. Please contact your manager or supervisor if you have feedback or ideas to improve how we deliver safe and high-quality transitional care to all our patients. For more information, contact [Readmission Champion].

TOOL 9: WHOLE-PERSON TRANSITIONAL CARE PLANNING TOOL

Purpose

The social, economic, and geographic conditions in which individuals live have a profound impact on individuals' health status. Efforts to reduce readmissions by optimizing self-management or long-term health status will predictably fail for individuals whose pressing fundamental survival needs are not met.

Prompt recognition of complex nonclinical ("social" needs), such as housing, transportation, and social support, can greatly affect the likelihood that those needs can be addressed, rather than deferred, prior to discharge. This task will often require going well beyond the brief "social history" that is contained in the physician's admission history and physical.

Furthermore, reliable identification of these needs is necessary but not sufficient to reduce readmissions. The 'active arm" of efforts to reduce readmissions is in ensuring a successful linkage to the anticipated range of care and support services after discharge. The easier it is to "see a problem, fix a problem," the easier it will be for your hospital staff to execute a safe, effective transition reliably for your patients.

Description

This tool provides discharge planners with a set of prompts to identify readmission risks and to take steps to ensure those risks are addressed in the transitional care (discharge) plan.

Staff

Day-to-day readmission reduction champion to test, adapt, and incorporate into existing workflow with frontline staff.

Time Required

Incorporate into regular discharge planning assessment and referrals.

Additional Resources

See Section 4 of the *Hospital Guide to Reducing Medicaid Readmissions* for more information on implementing a reliable, whole-person transitional care process, and **Tool 11: Community Resource Guide** for community resource information that can be used to populate the right side of the Whole-Person Transitional Care Planning Tool.

Tool 9: Whole-Person Transitional Care Planning Tool

Readmissions rarely result from a singular breakdown in the transition of care and posthospital supports. A team at Kaiser Permanente in Northern California reviewed more than 500 adult readmissions (all payer, all ages) from across 18 of their hospitals. Among 250 readmissions they deemed to be potentially avoidable, an average of 9 factors contributed to each readmission.[1]

The message from this person-centered view of readmissions is that no single issue defines readmission risk. Take a "whole-person" view of transitional care and ongoing care needs to better identify not only risk of readmission, but also transitional care services and supports needed to address those needs so you can minimize readmission risk.

As is evident by the many domains on this assessment form, it can be a valuable tool for not only hospital discharge planners, but also for "receiving" providers and agencies in postacute and community-based settings. Best practice is to share this assessment with "receiving" providers in the community. As your cross-continuum team gains experience with whole-person, cross-setting assessment, you may be able to gain efficiencies when patients return to the hospital and this comprehensive view of their needs has already been completed and is shared with the inpatient team from the outpatient setting.

[1] Feigenbaum P, Neuwirth E, Trowbridge L, Teplitsky S, Barnes C, Fireman E et al. Factors Contributing to All-cause 30-day Readmissions. Medical Care. 2012;50(7):599-605. Accessed July 28, 2016.

WHOLE-PERSON CARE TRANSITIONAL PLANNING TOOL

Readmission Risks and/or Posthospital Needs

Uncover patient's nonclinical issues and challenges in accessing posthospital care to prevent avoidable hospitalizations in the future.

ACCESS TO AMBULATORY CARE

- ❑ No regular source of care
- ❑ Difficulty with transportation to medical care
- ❑ Work/family responsibilities that pose barrier to appointments
- ❑ Regular use of emergency room for care

ACCESS TO BEHAVIORAL HEALTH CARE

- ❑ History of receiving behavioral health services
- ❑ Concern about emotional or mental health
- ❑ Alcohol or drugs affecting health and wellness
- ❑ Needs linkage to behavioral health services

FUNCTIONAL STATUS

- ❑ Functional limitations
- ❑ Cognitive limitations, including executive function
- ❑ Low self-activation or self-efficacy
- ❑ Disabled, may qualify for Aging and Disability Resource Center or other services

UNSTABLE/INADEQUATE HOUSING

- ❑ Lack of stable housing
- ❑ Lack of heat or cooling
- ❑ Environmental hazards affecting health (mold, etc.)
- ❑ Lack of safety and security within or outside the home

FINANCIAL INSECURITY

- ❑ Difficulty paying for basic survival needs (shelter, food)
- ❑ Difficulty paying medical-related costs (copays, supplies)
- ❑ Must prioritize survival versus medical needs

FOOD INSECURITY/ACCESS

- ❑ Lacks access to adequate amounts of food
- ❑ Lacks access to nutritious or medically appropriate diet

SOCIAL CONNECTION/ISOLATION

- ❑ Lives alone
- ❑ Lacks friends/family/connections

LEGAL ISSUES

- ❑ Barriers due to insurance coverage, utilities, pending eviction
- ❑ Recent or repeated incarceration or detention

LANGUAGE OR LITERACY ISSUES

- ❑ Low literacy, low numeracy
- ❑ Low health literacy—diagnoses, medications, care plan
- ❑ Low or no ability to speak English

Actions to Take Prior to Discharge

Use the improvement motto, "See a problem, fix a problem." This list represents possible interventions you may identify for a patient. Modify it to meet the most common needs for your patient population.

INTERDISCIPLINARY CARE PLANNING AND COORDINATION

- ❑ Obtain high-risk readmission team consult
- ❑ Contact an MCO, ACO, PCMH, health home care manager, as applicable
- ❑ Contact community clinical, behavioral, and social service providers
- ❑ Obtain pharmacist consult
- ❑ Obtain social work consult
- ❑ Obtain pain management or palliative care consult, as applicable
- ❑ Obtain psychiatry consult, as applicable
- ❑ Develop individualized transitional care plan
- ❑ Share plan with ED, outpatient providers, community service providers

PROVIDE SERVICES

- ❑ Identify whether eligible for (Medicaid) health home and contact health home to initiate screening and enrollment process
- ❑ Contact MCO, ACO, PCMH, health home medical director if high-risk patient is not currently in care management to advocate for enhanced services
- ❑ Arrange for bedside delivery of medications
- ❑ Discuss cost of medications, how patient will obtain them; modify as needed
- ❑ Discuss transportation and arrange as needed
- ❑ Offer to provide transitional care followup services (if available)

ARRANGE FOR NEXT STEPS

- ❑ Ensure all patients have a primary care provider or temporary provider ("bridge" clinic)
- ❑ Schedule followup with primary care provider
- ❑ Schedule followup with relevant specialists
- ❑ Schedule followup with behavioral health provider
- ❑ Initiate initial eligibility screen for services (health home, adult day, etc.) or allow social/support service entity to screen patient prior to discharge
- ❑ Ask for best contact number for purposes of postdischarge followup call

LINK TO POSTHOSPITAL SUPPORTS AND SERVICES

- ❑ Link to transitional care navigating and support services for 30 days
- ❑ Link to community behavioral health services
- ❑ Link to community health worker or navigator programs
- ❑ Link to housing with services agency
- ❑ Link to food program
- ❑ Link to county health department provided services
- ❑ Link to community/faith-based or volunteer services
- ❑ Link to Medical-Legal Partnership
- ❑ Link to adult day health services
- ❑ Link to language-concordant navigation or advocacy services

TOOL 10: DISCHARGE PROCESS CHECKLIST

Purpose

Provide updated guidance to readmission reduction teams for updating discharge processes, based on Centers for Medicare & Medicaid Services (CMS) documents.

Description

This tool, adapted from the CMS Conditions of Participation (COPs), provides a checklist of discharge elements that CMS states should be provided to all Medicare and Medicaid patients. This tool can be used to update existing processes and identify whether new processes and practices need to be implemented.

Staff

Readmission champion and day-to-day leader.

Time Required

1 hour to review and 1-3 hours to discuss with hospital colleagues the extent to which various elements are reliably delivered.

Additional Resources

See **Tool 8: Conditions of Participation Handout** for an overview of CMS COP content and Section 4 of the *Hospital Guide to Reducing Medicaid Readmissions* for additional information.

TOOL 10: DISCHARGE PROCESS CHECKLIST

This checklist is a tool to promote optimal adherence to the processes and practices outlined as guidance and proposed updates to the CMS Discharge Planning Conditions of Participation.[i] Review your current processes, including written discharge information and documentation, to identify the extent to which they adhere to the intent of these discharge process elements. In addition, hospitals should have a written discharge process. Regularly review readmissions to identify root causes of readmissions, and use those insights to continually improve the discharge process.

Hospitals Must Provide the Following…	Details per CMS 2013 Surveyor Guidance* and 2015 Proposed Rule Documents†	Status
1. A discharge plan for all inpatients and observation patients	As specified in the November 2015 proposed Discharge Planning COPs.†	❑
2. A brief reason for hospitalization and principal diagnosis	Many patients do not know why they were in the hospital.	❑
3. A brief description of hospital course of treatment	Many patients do not know what was done for them in the hospital.	❑
4. The patient's condition at discharge	Include cognitive function.* Include functional status.* Include social support structure.*	❑
5. Specifically address comorbid behavioral health conditions	Include plan for followup care for behavioral health conditions.†	❑
6. A medication list—an actual list of medications, *not* a referral to the list in the medical record*	Identify changes made during the patient's hospitalization.*	❑
7. A list of allergies	Food allergies.* Drug allergies and drug intolerances.*	❑
8. Pending test results	When the results are expected.* How to obtain the test results.*	❑
9. A copy of the patient's advance directive	Applicable when the patient is being transferred to another facility.*	❑
10. A brief description of care instructions	Customized instructions for self-care.* Consistent with the training provided to patient and caregiver.*	❑
11. Effective linkage of patients to posthospital clinical, behavioral, and social services	The hospital must demonstrate knowledge of capabilities of postacute and community providers, including Medicaid providers and social service providers.*†	❑
12. Data for patients/caregivers to facilitate a data-informed choice of postacute providers	As per the Improving Medicare Past Acute Transformation (IMPACT) Act of 2014.†	❑
13. A list of all followup appointments scheduled prior to discharge	This list should include provider name, date, and time.*	❑
14. Transmittal of discharge summary within 48 hours of discharge	Transmit or make available the discharge summary to community providers within 48 hours.†	❑
15. Followup with patients at high risk of readmission	The proposed COPs do not state how or when to provide followup, allowing flexibility.†	❑

[i] Developed based on the *May 17, 2013, Centers for Medicare & Medicaid Services updated interpretive guidelines for hospital discharge planning (CMS Revision to State Operations Manual (SOM), Hospital Appendix A - Interpretive) and †November 2015 proposed CMS Discharge Planning Conditions of Participation (Medicare and Medicaid programs revision to requirements for discharge planning for hospitals).

TOOL 11: COMMUNITY RESOURCE GUIDE

Purpose

Many hospital readmission reduction teams perceive that no community resources are available, even though community behavioral health and social service providers state they rarely receive referrals from hospitals. The purpose of this community resource guide is twofold: first, to demonstrate that there are community resources; and second, to generate an updated list of those resources for use by hospital discharge planners and others charged with effectively linking patients to services to meet the full range of their posthospital needs.

Description

This is a two-part tool: a community resource guide and a 1-page "quick reference" version. Feel free to edit these tools to fit your needs. The purpose is to stimulate the development of an extended set of contacts at community agencies, specifically agencies and providers who can meet the posthospital and ongoing clinical, behavioral, and social service needs of the Medicaid population or other high-risk patients.

The community resource guide template is modeled on a community resource guide developed by a Medicaid community-based care management agency in Alabama. It prompts the hospital readmission reduction team to identify community agencies that offer services across a range of clinical, behavioral, and social domains. The guide prompts the developer to identify and list specific contacts at community agencies to facilitate effective referrals from the hospital to a single point of contact.

The 1-page quick reference version of the community resource guide is for frontline staff, identifying commonly needed services for patients with clinical, behavioral, and social service needs posthospitalization.

Staff

Delegate to a social worker to complete with community providers and agencies.

Time required

12 hours initially. Take no more than 1 month to draft. Maintain these lists as living resources that will require periodic (once or twice a year) updating.

Additional Resources

See Section 4 of the *Hospital Guide to Reducing Medicaid Readmissions* for information on the CMS Discharge Planning Conditions of Participation to know the specific capabilities of community services, including Medicaid-relevant partners. Use the quick reference part of this tool to populate **Tool 12: Whole Person Transitional Care Planning** so that once a need has been identified, the contact information to link the patient with that service is readily available.

TOOL 11: COMMUNITY RESOURCE GUIDE

The first step to using community resources to address patients' social and behavioral health needs is to identify community agencies and other organizations that can help meet those needs. Many hospitals perceive that there are limited or no community resources available, without having made a concerted effort to look for these resources. This tool will help you populate a resource guide to quickly and efficiently connect patients to the services they need.

Starting on the next page is a template to fill in information about your community resources. This resource guide will be especially helpful to the discharge coordinators, community health workers, patient advocates, volunteers, or other people who will help patients access clinical, behavioral, and social services.

The best version of this guide would be developed in collaboration with community providers and agencies so that each listing includes a specific point of contact ready and willing to accept referrals from hospital staff and able to work in a timely manner with hospital staff to provide the information needed to ensure effective and timely linkage to services after a hospitalization.

To populate this resource guide, draw from the following information sources:

1. **Your cross-continuum team partners.** A highly useful function of your cross-continuum team is to ask them to help populate an inventory of community-based services that can meet the clinical, behavioral, and social service needs of patients after hospitalization.
2. **Care management contacts at Medicaid health plans.** A clinical/quality leader at the hospital (e.g., director of case management, population health, or quality) should identify a key contact at each Medicaid health plan who can identify the types of supports and services the plan is providing or can provide for patients at high risk of readmission. This point of contact is different from the existing health plan contact for utilization review. The point of contact is essential to facilitate time-sensitive discussions to ensure posthospital supports and services are in place.
3. **Your hospital social workers, especially recent hires from plans or community practice or agencies.** Social workers are trained to understand the comprehensive landscape of social services in a community. Social workers from community providers or agencies will offer updated insights into community resources.
4. **A focused online search.** Conducting an online search for community resources in your area can be a quick way to find potential partners and their contact information. This can be a useful adjunct to what the social workers and cross-continuum team partners are aware of. Specifically seek out: Medicaid health homes; behavioral health homes; community behavioral health clinics; behavioral health clinics with navigators or care managers; public health-funded navigators or care managers; aging and disability resource centers; area agencies on aging; adult day health; housing authority or housing with service providers; food banks; pharmacies offering medication therapy management; pharmacies that offer blister packs; pharmacies that deliver medications to beside or home, etc.
5. **2-1-1.** Most of the United States has access to 2-1-1, a telephone hotline that specializes in health and human services information and referral. This can also be a useful supplemental method of research for resources you may not have thought of.

COMMUNITY CLINIC, BEHAVIORAL, SOCIAL SERVICES RESOURCE GUIDE FOR [HOSPITAL NAME]

Primary and Specialty Providers

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	RELEVANT POSTDISCHARGE AND/OR CARE MANAGEMENT SERVICES
[Community Health Center]	[Point person]	[XXX]	[Will schedule followup check with RN <48h via phone or in person]
[Patient-Centered Medical Home]	[Point person]	[XXX]	[Care manager will take lead on transitional care planning]
[Patient-Centered Medical Home 2]	[Point person]	[XXX]	[Practice has systems for posthospital followup calls, discharge plan review and appointments; uses CMS Transitional Care Codes for applicable patients]
[Visiting House Call Service]	[Point person]	[XXX]	[Can schedule timely in-home followup appointments; will coordinate with patient's primary care provider and specialists]
[Sickle Cell Clinic]	[Point person]	[XXX]	[Contact center care coordinator for warm handoff; center has onsite social worker]
[HIV/AIDS Clinic]	[Point person]	[XXX]	[Care manager will take lead on transitional care planning; clinic has integrated behavioral health and social work]
[High-Volume Dialysis Center]	[Point person]	[XXX]	[Contact center care coordinator for warm handoff; center has onsite social worker]
[Urgent Care for timely followup]	[Point person]	[XXX]	[Can accommodate timely postdischarge followup checks within 1 week if patient cannot get into primary care]

Behavioral Health Providers

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	RELEVANT POSTDISCHARGE AND/OR CARE MANAGEMENT SERVICES
[Behavioral Health Center]	[Point person]	[XXX]	[Call on admission with any questions; call for warm handoff; will schedule all patients for posthospital followup <5 days]
[Behavioral Health Center]	[Point person]	[XXX]	[Taking new patients; will prioritize posthospital patients]
[Integrated Primary Care/Behavioral Health practice]	[Point person]	[XXX]	[Will provide timely posthospital behavioral health appointments for established patients of the practice]
[Living Room]	[Point person]	[XXX}	[Drop-in behavioral health peer support and onsite care management and linkage to behavioral health treatment]
[Regional Community Behavioral Health Service Provider]	[Point person]	[XXX]	[Community care navigators and peer advocacy specialists available for patients with xxx needs]

Substance Use Disorder Providers

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	RELEVANT POSTDISCHARGE AND/OR CARE MANAGEMENT SERVICES
[Hospital Substance Use Disorder consult service]	[Point person]	[XXX]	[Substance Use Disorder consult service will arrange for posthospital timely followup with medical, behavioral, and social services]
[Behavioral Health Center]	[Point person]	[XXX]	[Clinic works with Hospital Substance Use Disorder service to provide timely bridging of suboxone-eligible or initiated patients to clinic]
[Regional Community Behavioral Health Service Provider]	[Point person]	[XXX]	[Substance Use Disorder peer advocacy specialists available for patients considering engaging in treatment and recovery]
[Community Substance Use Disorder Agency]	[Point person]	[XXX]	[Provides a navigator immediately postdischarge and for 45 days until referral and intake to treatment can be initiated]

Dental Providers

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	RELEVANT POSTDISCHARGE AND/OR CARE MANAGEMENT SERVICES
[Dental provider]	[Point person]	[XXX]	[Accepts Medicaid patients; will prioritize patients who presented to acute care for dental-related pain or infection]
[Dental provider 2]	[Point person]	[XXX]	[Accepts Medicaid patients; will prioritize patients who presented to acute care for dental-related pain or infection]
[School of Dentistry]	[Point person]	[XXX]	[Accepts all patients regardless of insurance type; willing to commit to make appointments within 1 week of discharge]

Adult Day Programs

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	RELEVANT POSTDISCHARGE AND/OR CARE MANAGEMENT SERVICES
[Adult Day provider 1]	[Point person]	[XXX]	[Eligibility: XXX; Will prioritize hospital referrals to accommodate starts within 2-3 days of discharge]
[Adult Day provider 2]	[Point person]	[XXX]	[Daily activity, medication administration, nutrition]
[Adult Day provider 3]	[Point person]	[XXX]	[Will prioritize posthospital referrals; call 3 days prior to discharge if possible to evaluate and process eligibility]

Housing and Rent Assistance

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	RELEVANT POSTDISCHARGE AND/OR CARE MANAGEMENT SERVICES
[Housing provider]	[Point person]	[XXX]	[Shelter availability; case management services provided for those engaged in shelter services]
[Housing provider 2]	[Point person]	[XXX]	[Outreach and mobile services available]
[Housing provider 3]	[Point person]	[XXX]	[Temporary medical respite available postdischarge]

Financial Assistance

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	RELEVANT POST DISCHARGE AND/OR CARE MANAGEMENT SERVICES
[Hospital charitable fund]	[Point person]	[XXX]	[Foundation-provided funds to provide one-time respite to patients with cash/financial assistance needs to secure medical treatment or recommendations (e.g., copays, medical equipment]
[Community nonprofit agency]	[Point person]	[XXX]	[description]
[Community social service agency]	[Point person]	[XXX]	[description]

Food Assistance

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	RELEVANT POST DISCHARGE AND/OR CARE MANAGEMENT SERVICES
[Food assistance program]	[Point person]	[XXX]	[description]
[Mobile food pantry]	[Point person]	[XXX]	[mobile delivery for patients who lack transportation or who are unable to travel]
[Church food pantry]	[Point person]	[XXX]	[Open daily from 3-6pm; services available for 1 year]

Transportation Assistance

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	RELEVANT POSTDISCHARGE AND/OR CARE MANAGEMENT SERVICES
[Hospital transportation assistance]	[Point person]	[XXX]	[Van service within 20 mile radius of hospital; for medical appointments, lab or radiology testing]
[Agency 2]	[Point person]	[XXX]	[description]
[Agency 3]	[Point person]	[XXX]	[description]

Aging, Disability, Personal Care Services

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	RELEVANT POST DISCHARGE AND/OR CARE MANAGEMENT SERVICES
[Service provider, such as Area Agency on Aging]	[Point person]	[XXX]	[Can connect patient/family to vetted in-home personal service provider; call 2 days before discharge]
[Service provider, such as Aging and Disability Resource Center]	[Point person]	[XXX]	[“No wrong door” policy to connecting patients/families with aging issues or disability needs to vetted providers; often patients may be eligible for subsidized or Medicaid waiver services; call 2-3 days prior to discharge to screen for eligibility and initiate connection to services]
[Service provider, such as Medicaid Home and Community Benefit Waiver Program]	[Point person]	[XXX]	[Can mobilize services in the home for patients who would otherwise meet nursing home level of care; call 2-3 days prior to discharge to initiate screen for eligibility and initiate care planning]

Legal Assistance

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	RELEVANT POSTDISCHARGE AND/OR CARE MANAGEMENT SERVICES
[Medical/Legal Partnership]	[Point person]	[XXX]	[Legal advocacy to secure benefits, treatment, housing, utilities]
[Legal Service Advocates]	[Point person]	[XXX]	[description]
[Hospital legal department]	[Point person]	[XXX]	[Section 35 or guardianship needs]

Volunteer and Faith-Based Services

ORGANIZATION NAME	CONTACT PERSON	NUMBER/EMAIL	RELEVANT POSTDISCHARGE AND/OR CARE MANAGEMENT SERVICES
[Volunteer Agency, such as YMCA]	[Point person]	[XXX]	[peer navigators, community volunteers]
[Volunteer Agency, such as community nonprofit]	[Point person]	[XXX]	[community health worker navigators to provide social support and assistance in navigating social and medical services]
[Faith-based organization]	[Point person]	[XXX]	[volunteers to help patients make appointments, drive to appointments, run errands, care for pets during and following a hospitalization; not limited to congregation members]

QUICK COMMUNITY RESOURCE REFERENCE LIST FOR [HOSPITAL NAME]

Patient Centered Medical Home [Name]	Contact Name, Number: Service: [transitional care, complex care management] Eligibility:[accepting new patients, will prioritize new hospital referrals]
Behavioral Health Clinic [Name]	Contact Name, Number: Service: Eligibility:
Substance Use Disorder Treatment [Name]	Contact Name, Number: Service: Eligibility:
Adult Day [Name]	Contact Name, Number: Service: Eligibility:
Pharmacy [Name]	Contact Name, Number: Service: [e.g., medication therapy management, blister packs, home delivery] Eligibility:
Housing [Name]	Contact Name, Number: Service: Eligibility:
Food [Name]	Contact Name, Number: Service: Eligibility:
Legal Advocacy [Name]	Contact Name, Number: Service: Eligibility:
Transportation [Name]	Contact Name, Number: Service: Eligibility:
Medicaid Home and Community-Based Waiver Program [Name]	Contact Name, Number: Service: Eligibility:
Area Agency on Aging [Name]	Contact Name, Number: Service: Eligibility:
Volunteer Navigators/Assistants [Name]	Contact Name, Number: Service: [e.g., social support, transportation, errands] Eligibility:
MCO Care Management [Name]	Contact Name, Number: Service: [e.g., telephonic care management; wraparound services available] Eligibility:[members of the Managed Care Plan at high risk of readmission]

EXAMPLE QUICK RESOURCE REFERENCE FOR HOSPITAL ABC

Care Management **Readmissions Community Care, Inc.**	**Contact:** Mary, Director (555) 555-5555 **Services:** Community agency-provided care management, focusing on basic social services; referrals to short-term or ongoing care management based on their funders' approved criteria. They are working with us to align definitions.
Behavioral Health **Psychiatric Assessment Center**	**Contact:** Penelope, Program Director (555) 555-1234 **Hours:** 24/7 **Services:** Urgent outpatient (<24hr) mental health treatment services to Readmissions County residents suffering from acute or serious mental disorders or an emotional crisis. All individuals determined to require urgent mental health care are initially assessed and treated at the Center, then linked to other mental health programs as needed.
Behavioral Health **Mental Health Services of Readmissions County**	**Contact:** Pat, Director (555) 555-5678 **Hours:** 9am-5pm, Mon-Fri **Services:** Full range of mental health services, primarily intensive case management services, psychiatric medication evaluation, and followup to 30 seriously mentally ill homeless individuals. Services can include providing funding for housing, emergency housing, and one-time rental subsidies.
Substance Use Disorder Treatment **Courage Recovery Center**	**Contact**: Bob, Director (555) 555-4321 **Services:** Comprehensive substance abuse treatment and other health care services at its clinics or through community linkages. Outpatient methadone maintenance, HIV testing and counseling, group therapy, opiate detoxification, primary medical care, counseling, pregnancy services.
Substance Use Disorder Treatment **Readmissions County Cares**	**Contact**: Chelsea, Director (555) 555-6666 **Services:** First-time screening for alcohol or tobacco use, short outpatient counseling including focus on motivation, intensive outpatient treatment, residential (live-in) care, medically managed detoxification, marriage and family counseling, self-help groups, drug substitution therapies, and newer medicines to reduce craving.
Substance Use Disorder Treatment **MedReadmissions Treatment Centers**	**Contact:** Terry, Program Director (555) 555-7777 **Services:** Outpatient addiction treatment services for individuals dependent on opioids/narcotics. Provides supervised medication-assisted treatment with the use of methadone. Treatment team includes a Medical Director, Program Director, Clinical Supervisor, nurses, and trained counselors who work with each patient to create an individualized treatment plan based on their specific needs. Also offers case management services and referrals to community resources.

Homeless Services **Multi-Service Drop in Center**	**Contact:** Jennifer, Manager (555) 555-8888 **Hours:** 10am - 2pm, Mon-Fri **Services:** Offers access to snacks and water; hot showers and laundry facilities; assistance for acquiring identification, benefits, and/or employment.
Homeless Services **Hope House**	**Contact:** Marcos, Program Director (555) 555-1111 **Hours:** 7:30am – 6pm Mon – Fri, 7:30am – 1pm Sat-Sun. **Services:** Daytime showers, laundry services, free medical and dental clinics and day shelter. Has a client services manager and case manager on staff who provide referrals for housing, mental health, and substance abuse treatment.
Housing Services **Community Housing Resource Center**	**Contact:** Nick, Manager (555) 555-2222 **Hours:** 12-5pm Mon, 10am-3pm Tues-Thurs (appointments required) **Services:** Partial payment assistance for rent/mortgage (must provide copy of current least agreement); new housing (first month's rent only, deposits must be paid); utilities (must provide past due notice; deposits and late fees are not paid). **Eligibility:** Must have an appointment, show proof of Readmissions County residency, proof of income and Social Security cards for all family members, and confirm changes in situation that require assistance.
Housing Services – Mentally Ill **Pine Haven Transitional Housing**	**Contact:** John, Director (555) 555-3333 **Office Hours:** 8am – 4pm, Mon-Fri; staff hours 24/7 **Services:** Temporary housing for adults (18+) with diagnosed mental illness during their transition from the hospital to another care provider, for 3-10 days, until another form of housing is ready to receive the individual (e.g., assisted living facility). Staff available 24/7, case manager onsite. Medication assistance available.
Food Services **Readmissions Valley Food Bank**	**Contact:** Angel, Manager (555) 555-4444 **Hours:** 10-4 Mon-Wed, 12-3 Thurs-Fri **Services:** Food pantry available for those requiring emergency food assistance. Clients may be eligible once every 30 days with proper documentation. Encouraged to apply for SNAP assistance. **Eligibility:** Show proof of Readmissions County residency.
Transportation Assistance **Readmissions Express Transit**	**Contact:** Greg, Transportation Manager (555) 555-1010 x555 **Service Hours:** Planned service routes at 6am, 12pm, and 6pm, Mon-Fri. **Services:** Buses travel a predetermined route and schedule Mon-Fri from several designated stops that span Readmissions County. $1 fare each way. No preregistration/qualification required.
Transportation Assistance **South Readmissions County Transit**	**Contact:** Rhonda, Manager (555) 555-5566 **Service Hours:** 7am – 5:30pm **Services:** Prearranged transit services coordinated by Senior Center volunteers with volunteer drivers who are willing to transport residents living in rural unincorporated communities of Readmissions County.

TOOL 12: CROSS CONTINUUM COLLABORATION TOOL

Purpose

This tool helps teams develop specific effective and timely linkages to services with cross-continuum clinical, behavioral, and social services providers.

Description

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 followup contact. Central to developing improved processes for posthospital 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.

Use this tool to prepare for and initiate a series of structured discussions about how to more effectively link patients to cross-continuum provider services. After testing this process with a few key providers, build a portfolio of effective referral pathways to meet the timely posthospital needs of your patients. Create efficiencies by "batching" the types of needs and services and creating more direct, less time-consuming processes for linking patients to services. Collaboration is key to establishing a shared understanding and agreement of how processes can be improved to accommodate more patients, with the services they need, in a timely manner.

Staff

Readmission day-to-day champion.

Time required

2 hours to review and apply recommendations.

Additional Resources

See Section 5 of the *Hospital Guide to Reducing Readmissions* for more information on how specific efforts to improve care transitions by working with providers and agencies across the continuum are part of an effective and robust portfolio of efforts to reduce readmissions for all patients, including Medicaid patients.

TOOL 12: CROSS-CONTINUUM COLLABORATION TOOL

Use this tool to prepare for and initiate a series of structured discussions about how to more effectively link patients to cross-continuum provider services. Collaboration is key to establishing a shared understanding and agreement of how processes can be improved to accommodate more patients, with the services they need, in a timely manner.

PREPARE

1. **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.
2. **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.
3. **Prepare questions** to learn more about the services they offer and their capabilities.

ASK

1. **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?
2. **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.
3. **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.

TEST

1. **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 postdischarge?
   - How can the processes to identify, refer, link, and connect within 48 hours of discharge be improved?
2. **Decide** whether to adopt, adapt, or abandon elements of this "referral pathway."
3. **Continue to improve** the process so that:
   - Your staff reliably identifies patients with needs that can be met by the service provider;
   - Your staff can place a referral easily with minimal wasted time;
   - The organization can receive high-quality referrals to minimize wasted rework;
   - The organization staff can anticipate a start date and plan schedules accordingly;
   - The patient accepts the service with a minimum of waste (late refusals); and
   - Services are delivered in a timely manner within hours to days of discharge.

MEASURE

1. **Reliability of Hospital-Based Needs Assessment**
   - How many patients were identified to have a need [for a service] this month?
   - What percentage of the target population is that?
   - Do we believe we are effectively screening and identifying the need in the hospital?
2. **Effectiveness of the "Referral Pathway"**
   - How many patients were referred to [the service] this month?
   - How many patients were effectively linked to [the service] this month?
   - Is there a difference between the number of patients referred and the number of patients effectively linked? If so, why? Can that gap be closed?
   - Does the hospital staff report that the referral pathway is easy and straightforward? What barriers do they encounter in attempting to refer and definitively link the patient to [the service] before discharge?
   - Does the provider/agency staff report the referral pathway is easy and straightforward? What barriers do they encounter when receiving the referrals and acting to definitively link the patient to [the service]?

TOOL 13: ED CARE PLAN

Purpose

The purpose of the emergency department (ED) care plan is to create institutional memory across numerous providers; make easily visible prior recurrent presentations and related testing; identify a patient's existing clinical, behavioral, and social services; and recommend strategies to promote safe, high-quality care in the ED.

Description

This tool provides an ED care plan template and examples of ED care plans. Hospitals can use this template, adapt the template, or draw inspiration from the examples to develop their own template to suit their specific needs and preferences.

Instructions for Care Plan Development

Step 1. Identify desired care plan elements. Using a structured template helps. Keep ED care plan to 1 page only. Consider who the primary audience is and what the desired use of the document is.

Step 2. Identify an ED care plan champion. This person will either directly develop the ED care plan or will delegate that task to a specific person. The care plan champion will schedule meetings to review and finalize care plans.

Step 3. Identify who will be involved in developing, reviewing, and finalizing care plans versus who will receive communication about and a copy of a care plan.

Step 4. Identify which populations of patients would benefit from an ED care plan. This might be patients who are frequent users of the ED (for example, patients with 10 or more ED visits in the past year), or patients who are frequently hospitalized (for example, patients with 4 or more hospitalizations in the past year), or patients with a specific need for consistent high-quality care across providers (patients with chronic pain syndromes, behavioral or safety concerns, other rare management issues). Create care plans for patients after they have most recently presented (e.g., create care plans for the target population patients who presented this week).

Step 5. Schedule regular interdisciplinary meetings to discuss and finalize care plans. Aim to discuss and finalize a minimum of four care plans per hour meeting. The interdisciplinary care plan meetings might include representation from Emergency Department, Hospital Medicine, Social Work, Case Management, Behavioral Health, Palliative Care, Quality, Risk Management, and others.

Step 6. Identify location to store care plan (e.g., in electronic medical record, health information exchange, shared drive, or paper binder) and train providers on what to do when a patient has a care plan in his or her record.

Staff

Champion of efforts to reduce frequent utilization.

Time Required

Target 30 minutes per patient to develop a care plan (the first 10 patients may require significantly more time as you learn what information to incorporate). Recommend weekly or biweekly meetings to review and discuss care plans.

Additional Resource

See Section 6 of the *Hospital Guide to Reducing Medicaid Readmissions*.

ED CARE PLAN TEMPLATE

Patient Name	
Patient MRN	
DOB / Age / Gender	
Care plan date	Date care plan created: _____ Date(s) modified: _____
Situation [Reason for care plan]	[Provide brief (1 line) summarizing history of repeated presentations and reason for this care plan]
Background [Patterns of utilization and summary of relevant testing]	[Provide 2-3 sentences summarizing history of repeated presentations, including symptomatic complaints. List presentations in past (12) months, list or provide count of number of relevant tests (e.g., abdominal CT scans). Summarize what has been tried in the past.]
Assessment [Drivers of repeated utilization, resource(s) in place]	[Provide interdisciplinary assessment of the drivers of utilization] [Identify the clinical, behavioral, and social services in place, with contact names and numbers]
Recommendations [Directed at ED clinical staff to promote safety, quality, consistency and otherwise advance care]	[Provide recommendations to promote safety, quality, consistency of care] [Provide recommendations to minimize harm – such as avoiding certain medications or repeated tests without clear benefit] [Provide specific name/team/service to call while patient is in ED]
Whom to contact about care plan:	Name: _____ Phone/Email: _____

ED CARE PLAN EXAMPLE 1

HIGH-RISK PATIENT ASSESSMENT

Clinical Background

- History of [list diagnoses] with [frequent ED visits] for [list symptoms here]
- Is connected to [list relevant resources here]

Clinical Challenge

- 17 inpatient admissions at this hospital in past year; numerous other admissions at other area hospitals
- Requests [e.g., IV opioids]; declines other alternatives
- Attempts to manage presenting symptoms often unsuccessful

Name:

DOB:

Age:

Gender:

MRN:

Standards of Care:

- [Enumerate professional society and evidence-based management principles]
- [Narcotics have a high potential for abuse]
- [Medical ethics do not require prescribing a medication when you judge the risks to be greater than the benefits, even if the patient demands the medication]
- [Consider non-narcotic medications such as xxx]
- [Check the State prescription drug monitoring program before prescribing controlled substances]
- [An oral or written agreement for chronic pain medication management may be useful]

Recommended Intervention – Emergency Department

- [Rule out any emergency medical condition or life-threatening condition]
- [Attempt to treat symptomatic pain without the use of narcotics]
- [For safety place a sitter in the room]
- [If you feel medication is indicated, use [medication, dose, route; medication, dose, route]. Do not use [medication route].]
- [Contact case management as early in presentation as possible]
- [If no need for ongoing hospital care is indicated, patient will be contacted within 48 hours for followup at XXX clinic]

Recommended Intervention – Attending Physician

- [If patient cannot be discharged from ED, consider observation status]
- [Avoid narcotics; if medication treatment is indicated, attempt regimen, above]
- [Contact case management, social work, and pain management on admission]
- [Patient has primary care provider, pain management contract, hospital case management]

Recent Studies

- 14 Abdominal and CXR films in 2015 without significant findings
- 4 KUB in 2015 without findings
- 3 Ab CT Jan 2015, Apr 2015, May 2015; no significant findings
- 2 Chest CT Jan, Feb 2015, unremarkable
- Stress Thallium Mar 2015, normal

For Help With High-Risk Case Management, Call:

Dr. XXX
Administrator
Director of Case Management
Complex Care Manager 1
Complex Care Manager 2

ED CARE PLAN EXAMPLE 2

This is an example of a "Complex Care Plan" (ED Care Plan) that is currently in use and highly regarded by staff at a hospital with an ED high-utilizer program. The use of this "complex care plan" is to inform management decisions in the ED, consistent with what the guide describes as the ED care plan: creates institutional memory across different providers; makes visible recurrent presentations; summarizes repeated testing to inform diagnostic decisionmaking; identifies the patient's existing clinical, behavioral, and social services; and recommends management strategies that promotes safe, high-quality care in the ED.

Note that this plan has the following structural elements: date created and/or date last modified (this will help the new user know how current the resources and recommendations are); SBAR type format (S= reason for plan; B= brief history of recurrent presentations; A: summary of prior visits, tests, existing resources; R: recommendations); and consistent structure (each care plan has same format). The team uses this structured Word document.

As with all examples, feel free to modify this template to best suit your needs.

Patient:
Age/Sex:
MRN#:
DOB:

[Acute or ED] Care Plan

Care Plan Date:

- [date plan was created and/or last updated]

Reason for Care Plan:

- [short phrase to describe high risk/frequent use]

Brief History:

- [brief 2-3 sentences summarizing recurrent presentations]
- Identify the "driver of utilization": why does the patient repeatedly return to acute care?

Utilization Summary:

- [summarize past 12 months of ED visits, hospitalizations, relevant diagnostic tests]
- ED visits past 12 months:
- Hospitalizations past 12 months:
- CXR past 12 months [location, findings]
- CT scans past 12 months: [location, findings]

Clinical and Support Resources:

- [list clinical, behavioral, and social services - including contact names]

Key Contacts:

- [list primary contacts from the above and/or person from "complex care team" at hospital to contact when patient is in the ED]

Recommendations:

- [list strategies to improve management in ED and involvement of relevant teams/providers/agencies]
- [list any next steps to take in ED to advance the plan to promote quality and reduce high-frequency use]