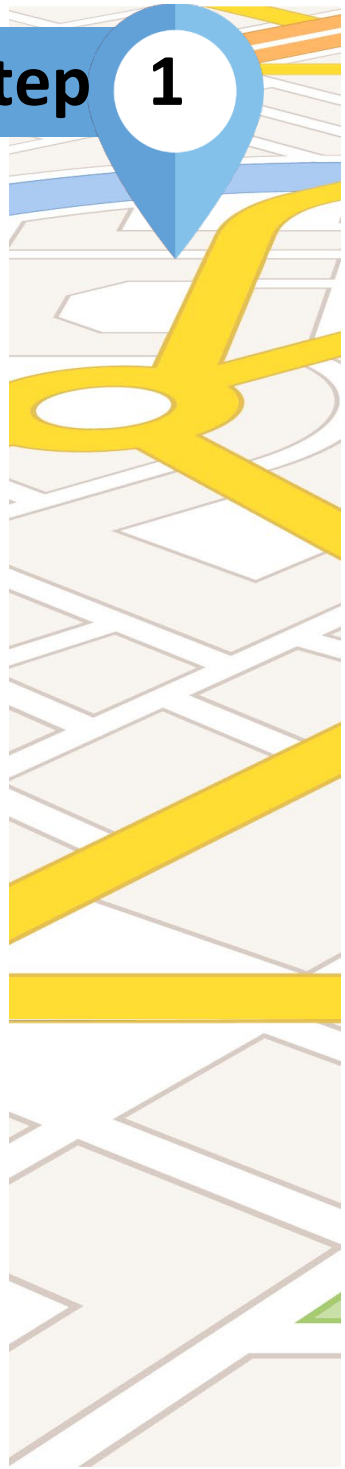
The Roadmap to Success:

Hospital Readmissions

HSAG HQIC

Know Your Readmitted Patients—Step 1

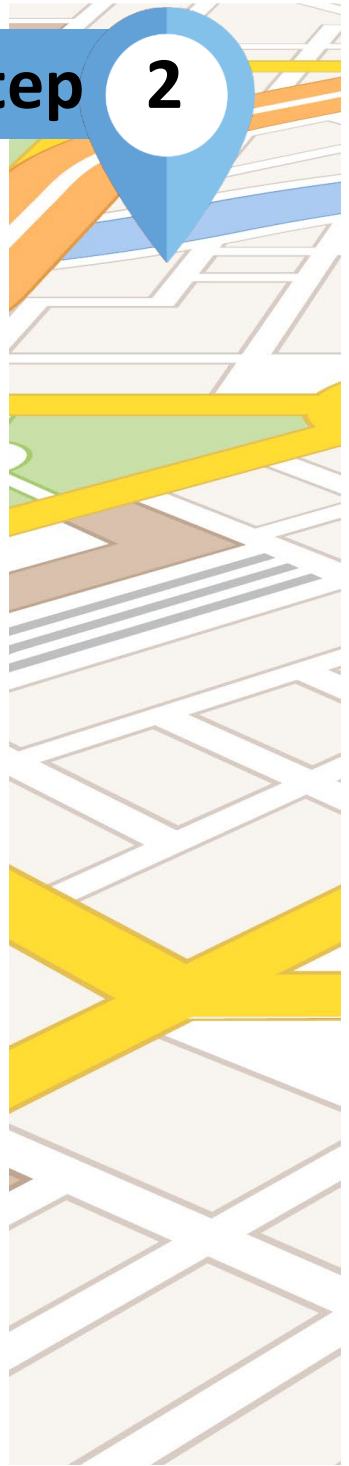


Rationale:
Determining the causes of readmissions will reveal gaps in care that patients are experiencing. Use this information to improve care transition practices and delivery of care by developing process improvement projects surrounding your findings. Readmissions to the hospital within seven days of discharge are common and many of those readmissions can be attributed to failures in post-discharge communication, planning, and follow-up.[1]

	Strategies	Tools and Resources
☐	Review your data. Understand your readmitted population by performing a "5 whys" analysis into each case.	• ThinkReliability Cause Mapping Training: https://www.thinkreliability.com/cause-mapping/what-is-root-cause-analysis/ • Agency for Healthcare Research and Quality (AHRQ) Readmission Review Tool: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/medicaidreadmitguide/mcaidread_tool2_readm_review.docx • 7-Day Readmission Checklist and Audit Tool (home health): https://www.hsag.com/globalassets/hqic/hsaghqic7dayaudittool.pdf • Whole-Person Care Transitional Planning Tool: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/medicaidreadmitguide/mcaidread_tool9_trans_care.docx • Healthcare Cost and Utilization Project (HCUP) Methods Series: https://www.hcup-us.ahrq.gov/reports/methods/2011_01.pdf • Camden Coalition of Healthcare Providers: https://camdenhealth.org/ • Robert Woods John Foundation: Managing Super-Utilizers: https://www.rwjf.org/en/library/articles-and-news/2014/02/improving-management-of-health-care-superutilizers.html
☐	To develop process improvements, track and trend: • High-utilizer status. • Readmissions source (nursing home, home health, or home with or without assistance). • Unmet needs (e.g., social determinants of health, undelivered durable medical equipment [DME], delay or non-arrival of home health services, etc.) of those who have been readmitted. • The number of Medicare Fee-for-Service (FFS) and Medicare Advantage patient cases managed beyond initial screening. • Patients readmitted within seven days.	

1 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128446/
https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf

Engage All in Care Transitions Improvement—Step 2



Rationale:
Assessment and management of high-risk patients are complex, multi-process, multi-role activities that requires consistent, systemic vigilance; evaluation; and communication across care units and settings. A multidisciplinary task force establishes shared responsibility and opens lines of communication.[2]

	Strategies	Tools and Resources
☐	Set up and maintain a multidisciplinary task force concentrating on improving care transitions with defined goals and structure. • Include post-acute partners in the task force to facilitate collaboration and open lines of communication across settings. • Set both a goal and a stretch goal for reducing readmissions within a defined period of time. • Conduct a community inventory of available resources to address health disparities in your community. • Report progress to stakeholders regularly. • Celebrate success, large or small.	• The Joint Commission—Transitions of Care: The Need for a More Effective Approach to Continuing Patient Care: https://www.jointcommission.org/-/media/deprecated-unorganized/imported-assets/tjc/system-folders/topics-library/hot_topics_transitions_of_carepdf • How to Guide: Improving Transitions From the Hospital to Skilled Nursing Facilities (SNFs): http://public.qualityforum.org/actionregistry/Lists/List%20of%20Actions/Attachments/86/IHI%20How%20To%20Guide-%20Improving%20the%20Transition%20from%20the%20Hospital%20to%20Skilled%20Nursing%20Facilities.pdf • Community Pharmacist-Led Service to Facilitate Care Transitions and Reduce Hospital Readmissions (access required): https://www.sciencedirect.com/science/article/pii/S1544319117308567 • Project BOOST® Implementation Guide: https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf • The Care Transitions Program: https://caretransitions.org/ • Post-Discharge Case Management, Clinic Combat Readmission: https://www.acphospitalist.org/archives/2015/12/success-story-postdischarge-care.htm • Community Health Workers Help Patients Manage Diabetes: https://www.thecommunityguide.org/content/community-health-workers-help-patients-manage-diabetes • Chronic Care Management: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

2 Project BOOST. And, https://www.ahrq.gov/sites/default/files/publications/files/redtoolkit.pdf
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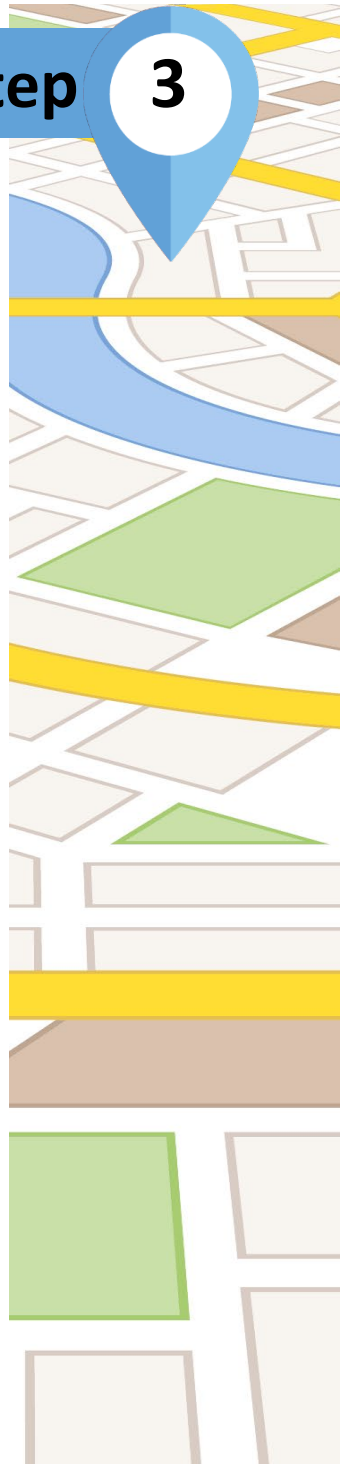
Assess Risk for Readmissions During the Hospital Stay—Step 3



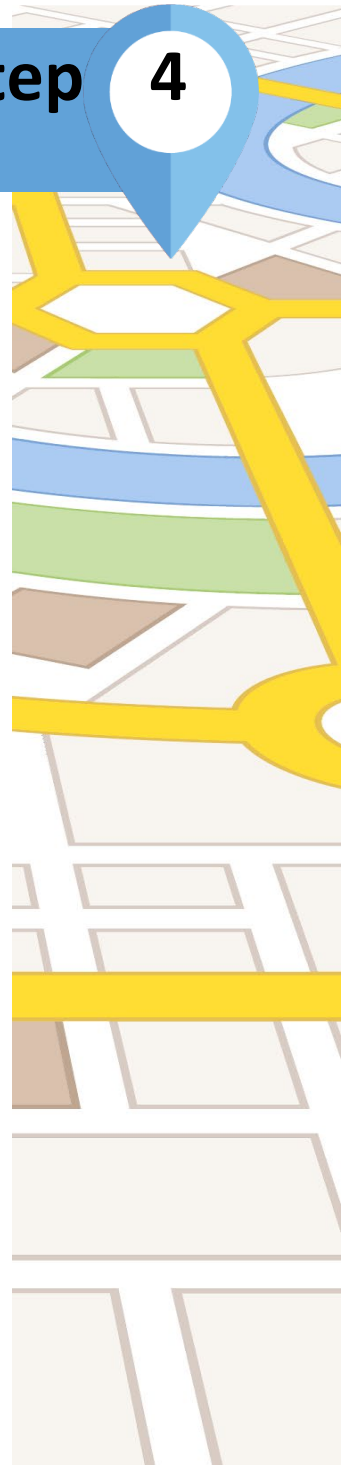
Rationale:
Reduce the probability for subsequent rehospitalization by focusing on transitional interventions for those identified as high risk for readmission based on associated factors. Causes of readmissions are often related to unmet social factors, which impact an individual's health.[3] Addressing gaps in patient and caregiver preparedness during hospitalization is crucial to mitigate barriers and invoke confidence in a safe and appropriate plan of care prior to discharge.[4]

	Strategies	Tools and Resources
☐	Use tools to help identify those who are at risk for readmission and may need additional support following discharge. • HOSPITAL score [low Hemoglobin, discharge from Oncology, low Sodium, Procedure, Index admit Type, number of Admissions, Length of stay] • 8Ps BOOST tool • LACE score [Length of stay, Acuity of admission, Co-morbidities, number of Emergency department visits], etc.).	• My Shared Care Plan: http://www.ihi.org/resources/Pages/Tools/MySharedCarePlan.aspx • The 8Ps BOOST Screening Tool Identifying Your Patient's Risk for Adverse Events After Discharge: https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/8ps_riskassess-1.pdf • Hospital Readmission Risk Score Calculator: https://qxmd.com/calculate/hospital-score • LACE Tool: https://www.besler.com/lace-risk-score/ • Shared Decision-Making Resources: https://www.ahrq.gov/health-literacy/curriculum-tools/shareddecisionmaking/tools/index.html
☐	Use an embedded electronic health record (EHR) risk assessment that evaluates social determinants of health to comprehensively coordinate care for high-risk patients. • Refer patients to pertinent community organizations based on their individual social determinant needs.	
☐	Assess the patients' potential for post-discharge risk for falls, adverse drug events (ADEs), disease-process exacerbation, etc., with family/caregivers once they are discharged.	
☐	Provide educational materials and discharge instructions in the patients' primary language that include: importance of follow-up monitoring, compliance, drug-food interactions, and potential for ADEs.	

3 https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5018668/
https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf
https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/8ps_riskassess-1.pdf

4 https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf

Create a Post-Discharge and Transition Plan—Step 4
Care Continuum and Coordination Planning

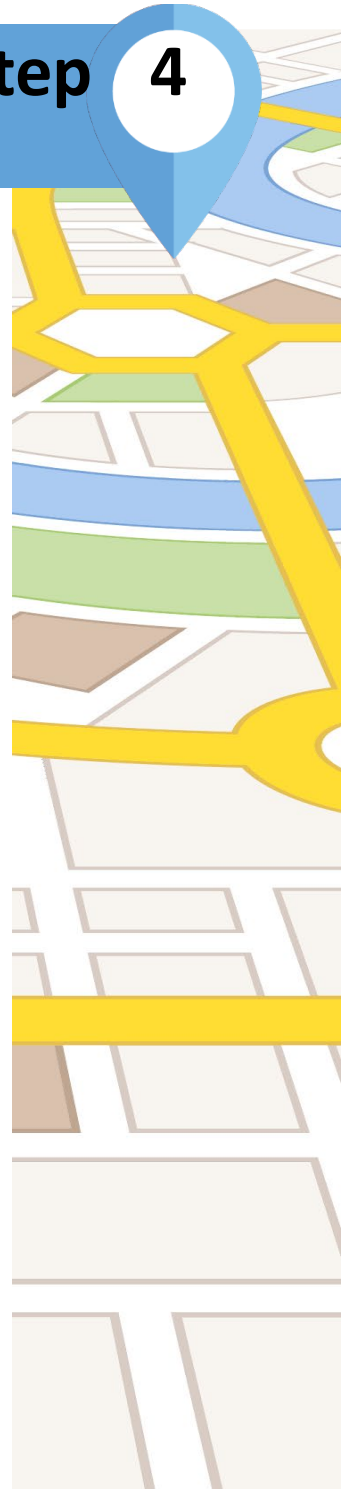


Rationale:
Enhancing patient activation and engagement in decision-making increases patient and family participation, ownership, and empowerment of a treatment and discharge plan. Initiating education upon admission prepares the patient and/or family to care for his or her condition prior to discharge.[5] Addressing gaps in patient and caregiver preparedness during hospitalization is crucial to mitigate barriers and invoke confidence in a safe and appropriate plan of care prior to discharge.[6]

	Strategies	Tools and Resources
☐	Begin transition planning upon admission, day 1.	• Institute for Healthcare Improvement (IHI) How-to Guide on Multidisciplinary Rounds: http://www.ihi.org/resources/Pages/Tools/HowtoGuideMultidisciplinaryRounds.aspx • Patient PASS (Patient Preparation to Address Situations Successfully): https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/pass-3.pdf • IHI My Shared Care Plan: http://www.ihi.org/resources/Pages/Tools/MySharedCarePlan.aspx • Designing and Delivering Whole-Person Transitional Care: Hospital Guide: https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html • Medications at Transitions and Clinical Hand-offs (MATCH) Study: https://link.springer.com/article/10.1007/s11606-010-1256-6 • A Community Pharmacist-Led Service to Facilitate Care Transitions and Reduce Hospital Readmissions (registration required): https://www.sciencedirect.com/science/article/pii/S1544319117308567 • Medication Discrepancy Tool by Eric Coleman, MD: https://caretransitions.org/wp-content/uploads/2015/08/MDT.pdf
☐	Hardwire multidisciplinary rounds into the care planning process to comprehensively address the needs and goals of the patients and families.	
☐	Ensure patients understand their condition and are empowered to care themselves. • Ask patients to assess the effectiveness of the discharge plan in facilitating understanding.	
☐	For high-risk medications (anticoagulants, opioids, and diabetic agents), engage pharmacists to educate patients, verifying patient comprehension using an evidence-based methodology.	
☐	When patients meet high readmission-risk criteria, focus customized care coordination efforts for … (*Continued on next page)*	

Create a Post-Discharge and Transition Plan—Step 4
Care Continuum and Coordination Planning (cont.)

	Strategies	Tools and Resources
☐	*(Continued from previous page)* When patients meet high readmission-risk criteria, focus customized care coordination efforts on: • Social determinants of health – Financial barriers, transportation, food insecurities, social isolation, housing, safety, etc. • Patient-centered care planning that addresses potential transitional barriers – Continual process customized for each patient focusing on optimal outcomes while including the patient, family, and caregivers in decision-making. • Complex care needs using intensive case management – Access to specialized nurses and other resources that can assist in better managing health and care coordination throughout the care continuum. ○ Dietitian, clinical pharmacists, behavioral therapists, etc.	• Preventing Drug-Related Adverse Events Following Hospital Discharge—The Role of the Pharmacist: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5774326 • How-to Guide—Prevent Adverse Drug Events by Implementing Medication Reconciliation: http://www.ihi.org/resources/Pages/Tools/HowtoGuidePreventAdverseDrugEvents.aspx • Discharge Checklist Tool: https://caretransitions.org/wp-content/uploads/2015/06/Discharge-Checklist-RWJF-Website.pdf • Teach-Back Toolkit: http://www.teachbacktraining.org/home • Teach-Back Competency Guide: http://higherlogicdownload.s3.amazonaws.com/HEALTHLITERACYSOLUTIONS/b33097fb-8e0f-4f8c-b23c-543f80c39ff3/UploadedImages/docs/Teach_Back_-_10_Elements_of_Competence.pdf • Teach-Back Starter Sentences: https://www.hsag.com/globalassets/hqic/hsaghqictbstartersentences.pdf

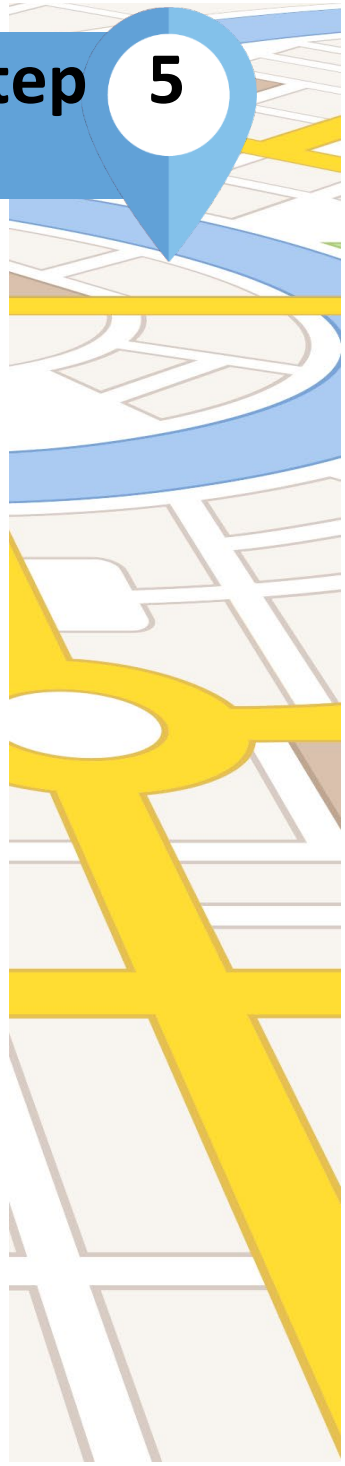


5 https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
https://caretransitions.org/wp-content/uploads/2016/02/Family-caregivers%E2%80%99-experiences-during-transitions-out-of-the-hospital.pdf
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5734517/
https://www.ncbi.nlm.nih.gov/pubmed/29395026
https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3912296/

6 https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf
https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
https://www.cms.gov/About-CMS/Agency-Information/OMH/Downloads/OMH_Readmissions_Guide.pdf

Follow Up and Monitor Patient After Discharge—Step 5

Post-Acute Care Coordination and Communication



Rationale:

Readmission rates are usually the highest from SNFs (approximately 25 percent). Building and maintaining a successful partnerships with post-acute providers requires effective communication, collaboration, and commitment to reduce readmissions and improve patient outcomes.[7]

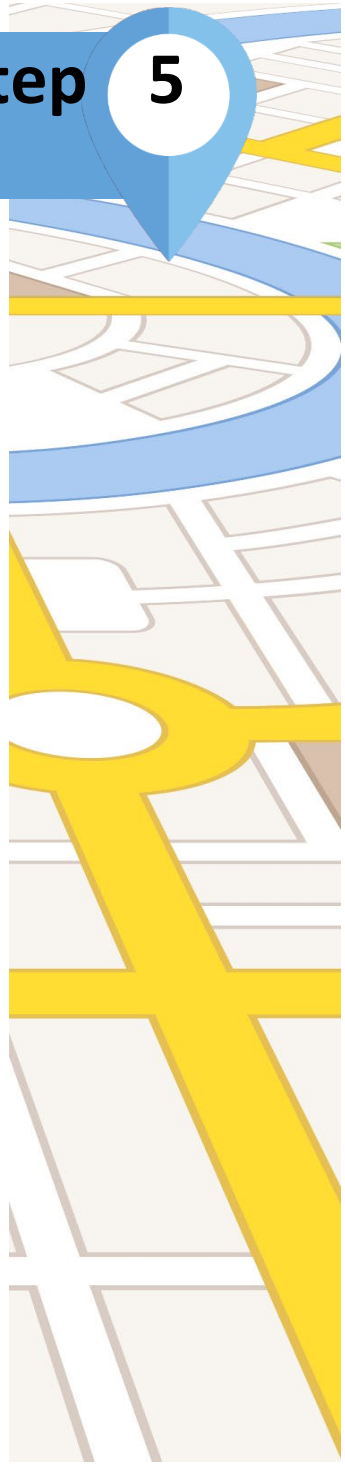
	Strategies	Tools and Resources
☐	When patients are discharged to post-acute providers, use standardized communication routes and bi-directional feedback to communicate about high-risk and/or recently discharged/readmitted patients. • Perform a warm hand-off or SBAR (Situation, Background, Assessment, Recommendation) with post-acute providers to review transition plan. • Coordinate monthly calls with post-acute settings to discuss challenges, successes, and opportunities for improvement. • Conduct a root cause analysis on all readmissions from post-acute settings. • Confirm with outpatient providers that they have received transition plans, including discharge summaries and pertinent tests. • Alert post-acute providers of any outstanding results of tests or procedures.	• Patient PASS: A Transition Record: https://www.hospitalmedicine.org/globalassets/clinical-topics/clinical-pdf/pass-3.pdf • Post-Acute SBAR for Sepsis: https://www.hsag.com/globalassets/hqic/hsaghqic_sepsissbar.pdf • INTERACT® SBAR Communication Form (registration required): http://pathway-interact.com/download/sbar-communication-form/ • INTERACT Hospital to Post-Acute Care Transfer Form (registration required): http://pathway-interact.com/download/hospital-post-acute-transfer-form/ • INTERACT Hospital to Post-Acute Care Hospital Data List (registration required): http://pathway-interact.com/download/snf-nf-hospital-data-list/ • Institute for Safe Medication Practices (ISMP) Medication Safety Self-assessment for High-Alert Medications: https://www.ismp.org/assessments/high-alert-medications
	When patients are discharged home … (*Continued on next page)*	

7 https://www.hospitalmedicine.org/globalassets/professional-development/professional-dev-pdf/boost-guide-second-edition.pdf

Follow Up and Monitor Patient After Discharge—Step 5

Post-Acute Care Coordination and Communication (cont.)

	Strategies	Tools and Resources
☐	*Continued from previous page)* When patients are discharged home: • Confirm the correct phone number for contacting the patient post-discharge. • Implement a 24/7 telehealth program. • Use telehealth to increase access to medically underserved areas and patients; take into account patients with limited mobility. • Use telehealth for high-risk patients, including daily monitoring of vitals and following up when monitoring indicates abnormal vitals. • Partner with home health agencies that frontload visits. • Schedule the primary care provider appointment for the patient instead of giving him or her an appointment card or asking them to do it themselves. • Ensure patients have the means to arrive at follow-up appointments.	• American Telemedicine Association (ATA): https://www.americantelemed.org/ • AHRQ Post Discharge Follow-up Script: https://www.ahrq.gov/patient-safety/settings/hospital/hai/red/toolkit/redtool5.html • California Health Care Foundation (CHCF) Post Hospital Follow-up Visit (Eric Coleman): https://www.chcf.org/publication/the-post-hospital-follow-up-visit-a-physician-checklist-to-reduce-readmissions/



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