Health Services Advisory Group (HSAG)
Hospital Quality Improvement Contract (HQIC)
Hospital Readmissions and Care Transitions

2. Roadmap Overview

All About the Data

Use your HSAG HQIC readmissions data to develop successful strategies to reduce readmissions

HSAG HQIC

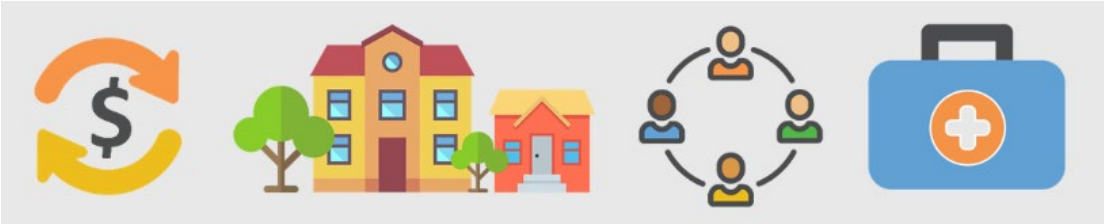
1. Know Your Readmitted Patients

- Review your data
  - Understand your readmitted population by performing 5-whys analysis for each case

HSAG HQIC

1. Know Your Readmitted Patients (cont.)

- Track and trend:
  - High-utilizer status
  - Readmissions sources
  - Unmet needs of readmitted patients
    - Social determinates of health
    - Undelivered durable medical equipment
    - Delay or non-arrival of home health services, etc.



1. Know Your Readmitted Patients (cont.)

- Track and trend:
  - Number of Medicare Fee-for-Service (FFS) and Medicare Advantage patients case managed beyond initial screening
  - Patients readmitted within 7 days

2. Engage Your Community in Care Transitions Improvement

- Set up and maintain a multidisciplinary task force
- Concentrate on improving care transitions with defined goals and structure
  - Include post-acute partners across settings
  - Set both a goal and a stretch goal to reduce readmissions within a defined period of time
  - Conduct a community inventory of available resources to address health disparities
  - Report progress to stakeholders regularly
  - Celebrate success, large or small

3. Assess Risk for Readmissions During the Hospital Stay

- Use readmission tools to help identify at-risk patients
  - HOSPITAL score, 8Ps BOOST tool, LACE score, etc.*
- Coordinate care for high-risk patients
  - Use an embedded electronic health record (EHR) risk assessment to evaluate social determinants of health
  - Use an EHR system to refer patients to community organizations based on individual social determinant needs

*HOSPITAL = low Hemoglobin, discharge from Oncology, low Sodium, Procedure, Index Admit Type, number of Admissions, Length of stay
LACE = Length of stay, Acuity of admission, Co-morbidities, number if Emergency department visits

3. Assess Risk for Readmissions During the Hospital Stay (cont.)

- Assess with family/caregivers the patient's potential for post-discharge risk
  - Falls
  - Adverse drug events (ADEs)
  - Disease-process exacerbation
- Provide educational materials and discharge instructions
  - Patient's primary language
  - Importance of follow-up monitoring
  - Compliance
  - Drug/food interactions
  - Potential ADEs

4. Create a Post-Discharge and Transition Plan

- Day 1, begin transition planning upon admission
- Hardwire multidisciplinary rounds into the care planning process
  - Address needs and goals of patients and families
- Ensure patients understand their condition and are empowered to care for themselves

  - Ask patients to assess effectiveness and understanding of the plan

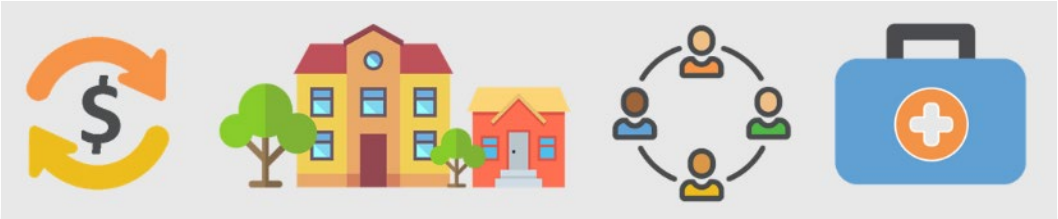
4. Create a Post-Discharge and Transition Plan (cont.)

- For high-risk medications (anticoagulants, opioids, and diabetic agents):
  - Engage pharmacists to educate patients
  - Verify patient comprehension using an evidence-based methodology

4. Create a Post-Discharge and Transition Plan (cont.)

- When patients meet high readmission-risk criteria, customize care coordination efforts for:
  - Social determinants of health (e.g., financial barriers, transportation, food insecurities, social isolation, housing, safety, etc.)
  - Patient-centered care, addressing potential transitional barriers
    - Continual process for each unique patient
    - Focus on optimal outcomes
    - Include the patient and caregivers in decision-making

(Cont.)



4. Create a Post-Discharge and Transition Plan (cont.)

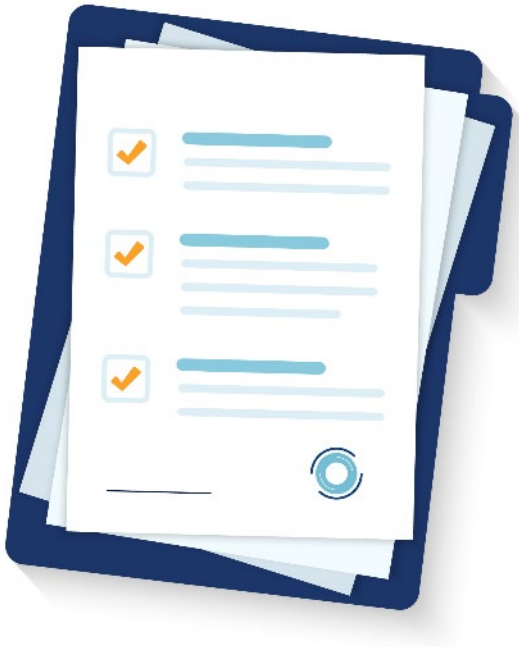
- When patients meet high readmission-risk criteria, customize care coordination efforts for:
  - Complex care needs using intensive case management
  - Access to specialized nurses and other resources to better manage health and care coordination throughout the care continuum
    - Dietitian, clinical pharmacist, behavioral therapist

5. Post-Acute Care Coordination and Communication: Discharged to Providers

- Follow up and monitor patients after discharge
- When patients are discharged to post-acute providers, communicate using:
  - Standardized communication routes
  - Bi-directional feedback

5. Post-Acute Care Coordination and Communication: Discharged to Providers (cont.)

- Perform a warm handoff or SBAR* with post-acute providers to review transition plan
- Coordinate monthly calls with post-acute settings to discuss challenges, successes, opportunities for improvement
- Conduct root cause analysis on all readmissions from post-acute settings
- Confirm with outpatient providers that they have received transition plans
  - Include discharge summaries and tests
- Alert of any outstanding results of tests or procedures



SBAR = Situation, Background, Assessment, Recommendation

5. Post-Acute Care Coordination and Communication: Discharged Home

- Confirm correct phone number for contacting patient post-discharge
- Implement a 24/7 telehealth program
- Use telehealth to increase access to medically underserved areas; include patients with limited mobility
- Use telehealth for high-risk patients
  - Daily monitoring of vitals
  - Follow up if vitals are abnormal

5. Post-Acute Care Coordination and Communication: Discharged Home (cont.)

- Partner with home health agencies that frontload visits
- Schedule the physician appointment for the patient
  - Instead of giving them an appointment card or asking them to do it themselves
- Ensure patients have transportation to the follow-up appointment

Thank you!

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