

**Designing and Delivering  
Whole-Person Transitional Care:**  
*The Hospital Guide to Reducing  
Medicaid Readmissions*

ASPIRE



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# DESIGNING AND DELIVERING WHOLE-PERSON TRANSITIONAL CARE: THE HOSPITAL GUIDE TO REDUCING MEDICAID READMISSIONS

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Before founding Collaborative Healthcare Strategies, Dr. Boutwell co-designed the Institute for Healthcare Improvement’s STAAR (State Action on Avoidable Readmissions) Initiative. STAAR was the first State-based approach to reducing readmissions that focused on improving transitions between settings by emphasizing “cross-continuum” partnerships. Dr. Boutwell is a graduate of Stanford University, Brown University School of Medicine, and Harvard’s Kennedy School of Government, where she received a Master’s in Public Policy and the Robert F. Kennedy Award for Excellence in Public Service. Dr. Boutwell received her clinical training in Internal Medicine-Primary Care at Massachusetts General Hospital.

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Dr. Bourgoïn is currently project manager and co-investigator on an AHRQ project to research the development of a re-engineered primary care visit to reduce readmissions. Her other research publications have included a qualitative study of Medicaid readmissions factors published in *The Joint Commission Journal on Quality and Patient Safety*; studies on cancer-related communication information-seeking behaviors in the *Journal of Health Communication, Health Communication, and Cancer*; and white papers on the pioneering “social” accountable care organization, Commonwealth Care Alliance, and chronic disease and health care among Hispanics in the United States. Dr. Bourgoïn received her Ph.D. in communication at the University of Pennsylvania.

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*Readmissions*. He is also directing an AHRQ project to research the development of a re-engineered primary care visit to reduce readmissions. Both AHRQ projects use “whole-person-care” strategies to improve care transitions.

Dr. Maxwell recently completed a study for the Blue Shield of California Foundation on whole-person care strategies in the safety net that are emerging nationally and in California. These include accountable care communities, duals demonstrations, and cross-sectoral collaborations between health care systems and housing and other social service agencies. Dr. Maxwell has also led a Robert Wood Johnson Foundation study looking at the early implementation of accountable care organizations (ACOs) in the safety net, including authoring widely read *Health Affairs* blog posts related to policy considerations for States interested in safety net ACOs and health center accountable care strategies. He is also directing related studies on accountable care strategies in the safety net for the Massachusetts Blue Cross and Blue Shield Foundation and the Weinberg Foundation.

Dr. Maxwell's research has been published in health and policy journals, such as *Health Affairs*, *New England Journal of Medicine*, *Health Care Management Review*, and *Annals of Family Medicine*. Recently, he was an author of a white paper on the pioneering “social” ACO, Commonwealth Care Alliance, as well as white papers for the Blue Shield of California Foundation on national and State approaches to whole-person care in the safety net. Dr. Maxwell received his Ph.D. in public policy from the Massachusetts Institute of Technology, where he also completed postdoctoral training in health economics and management.





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## INTRODUCTION

Reducing readmissions is a national priority for payers, providers, and policymakers seeking to achieve the Institute for Healthcare Improvement Triple Aim objectives of improved health and better care at lower cost. A core competency of the improved delivery system of tomorrow is to manage care across settings and over time to avoid unnecessary acute-care utilization, including readmissions. To that end, work to reduce readmissions is the same work that is required of hospitals and delivery systems to develop the infrastructure, care teams, processes, and partnerships needed to succeed in the value-based payment environment of the future.

Over the past several years, demonstrations, grant funding, research, and large-scale improvement efforts have increasingly emphasized addressing social and behavioral needs in efforts to reduce admissions and readmissions:

- The social work-based model of transitional care,<sup>1</sup>
- The allowance of budgeted resources to address “social and logistical” transitional care needs in demonstration models,<sup>2</sup>
- Investments in efforts to align and optimize social service resources to achieve cost-savings goals,<sup>3,4,5</sup> and
- A proliferation in complex care management programs for high utilizers and other high-cost, high-risk patients.<sup>6</sup>

All of these models, incentives, and demonstrations hold central a key premise: identifying and effectively addressing behavioral health and social needs are essential to improving care and reducing costs.

***Designing and Delivering Whole-Person Transitional Care: The Hospital Guide to Reducing Medicaid Readmissions*** is intended to help hospital-based readmission reduction teams design and deliver transitional care to address “whole-person needs” (clinical, behavioral, and social). This whole-person approach to transitional care is patient centered, data informed, evidence based, and field tested. This guide is aimed toward hospitals at all stages of readmission work and applies to teams working on Medicare, Medicaid, and all-payer target populations. The message of this guide is to expand readmission reduction efforts to include Medicaid patients, and in doing so, adapt strategies to better meet the clinical, behavioral, and social transitional care needs of all high-risk patients.

This guide has been written with the premise that an effective readmission reduction approach must be specific to your local context. Your approach should take into account your patient population, market incentives, organizational strategy and mission, available resources, and existing readmission reduction efforts.

The original version of this guide has been field tested by individual hospitals and groups of hospital quality improvement collaboratives. Based on a series of coaching and feedback calls with hospitals, the second release of this guide has been updated to provide updated tools and clearer guidance on who should use the tools and what to do with the output of the tools. It also offers new tools that can be used in the day-to-day working environment of hospital-based teams and cross-setting partnerships.

## WHY MEDICAID READMISSIONS?

**Adult nonobstetric Medicaid patients are at high risk of readmission.** The preponderance of analyses on readmissions has been conducted on the Medicare fee-for-service population. Much less has been published on readmissions in the Medicaid population. There may be a misperception about readmission issues in Medicaid, as Medicaid readmission rates that include pediatric and obstetric patients are low compared with Medicare readmission rates. However, adult Medicaid patients who are not hospitalized for childbirth (hereafter referred to as **adult nonobstetric Medicaid patients**) have readmission rates that are as high as or higher than those experienced by Medicare beneficiaries. For example:

- Medicaid all-cause 30-day readmission rates for patients ages 21-44 (19.2%) and 45-64 (21.6%) are higher than Medicare readmission rates (17.3%).<sup>7</sup>
- Medicaid heart failure readmission rates are higher than Medicare rates (29.1% versus 23.7%, all-cause 30-day readmission rate).<sup>8</sup>

**Applying transitional care models developed for Medicare populations may not effectively address the transitional care needs of Medicaid patients.** Medicaid patients face social and economic challenges that affect their health and their ability to navigate the health care system.<sup>9</sup> Discontinuities in coverage, low literacy, language barriers, lack of transportation, unstable housing, unstable employment, and poverty all contribute to readmission risk. In addition, the prevalence of behavioral health comorbidities is higher in the Medicaid population. Because of these differences, transitional care strategies that are effective for Medicare populations must be modified to better meet the transitional care needs of adult Medicaid patients. For example:

- In Massachusetts, 61% of hospitalized adult nonobstetric Medicaid patients had a behavioral health condition, in contrast to 40% of adult nonobstetric patients overall.<sup>10</sup>
- Also in Massachusetts, the readmission rate for Medicaid patients with behavioral health conditions is triple that of those without a behavioral health condition (24% versus 8%).<sup>11</sup>
- In South Carolina, the discharge diagnosis leading to the highest number of readmissions for adult nonobstetric patients was sickle cell disease; in comparison, sickle cell disease was not on the list of top Medicare discharges leading to readmission.<sup>12</sup>

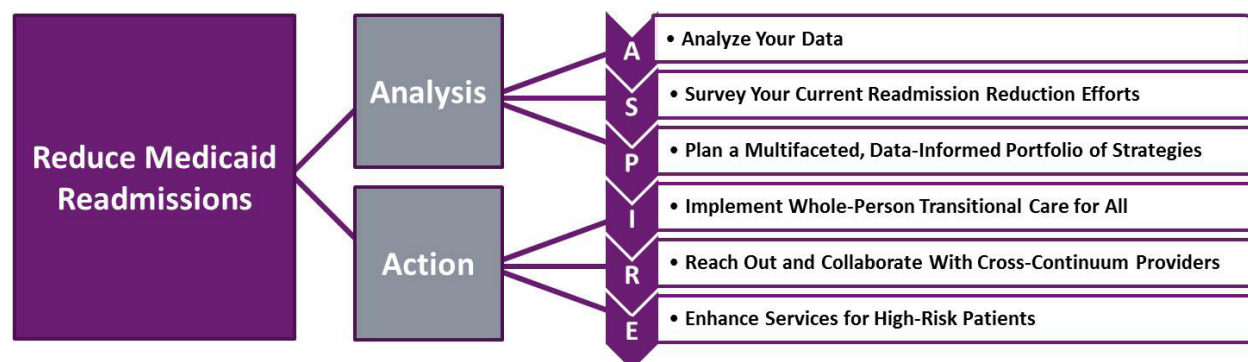
**The landscape of readmission-related payment policy, regulatory, and delivery system transformation efforts is rapidly evolving and includes Medicaid patients.** State and Federal payment policy, regulatory, and delivery system transformation efforts increasingly include Medicaid fee-for-service, Medicaid managed care, and all-payer populations. For example:

- The proposed Centers for Medicare & Medicaid Services (CMS) Discharge Planning Conditions of Participation<sup>13</sup> substantially raise the standards for hospital-based transitional care processes. In this document, CMS specifies that these expectations apply not only to Medicare patients but also to Medicaid patients.
- Medicaid delivery system reform incentive program (DSRIP) payments include readmission reduction performance targets. The New York DSRIP aims to reduce avoidable hospital use, including readmissions, by 25 percent;<sup>14</sup>
- State Medicaid agencies are engaging in alternative payment arrangements with providers, such as regional care organizations and accountable care organizations.<sup>15,16</sup>

## HOW TO USE THIS GUIDE

Below is a driver diagram that illustrates this guide’s framework of action for reducing Medicaid readmissions. To achieve the aim of reducing Medicaid readmissions, the two primary drivers required to achieve the aim in our model include **analysis** and **action**.

Analysis is required to expand teams’ understanding of the patterns and root causes of Medicaid readmissions, inventory and assess current readmission reduction efforts in the hospital and community, and develop a multifaceted portfolio of strategies to better match readmission reduction efforts to high-risk patients’ transitional care needs. Action is required to change transitional care in three complementary domains: improve hospital-based care, collaborate with “receiving” providers, and deliver enhanced services. The six secondary drivers correspond to the six sections of the guide, which are intended as steps for hospital teams to move through in their readmission reduction work. These six steps have also been organized into the acronym **ASPIRE** to help hospital teams remember and implement the full structure of this framework.



Although it will be beneficial for all members of hospital readmission reduction teams to read this guide, the sections are geared toward different audiences. The first three sections (“Analyze,” “Survey,” “Plan”) are directed toward the **executive or manager charged with developing an effective strategy to reduce readmissions**. The next two sections (“Implement” and “Reach Out”) are directed toward **directors or managers of clinical staff** who are empowered to improve transitional care practices within the hospital and in collaboration with community partners. The final section (“Enhance”) is written for both **executives and frontline managers** who are considering providing enhanced services for high-risk patients.

## Section 1: Analyze Your Data

Many hospitals' readmission reduction efforts began with and continue to focus on Medicare readmissions, without having examined the readmission patterns of their Medicaid population—specifically, their **adult nonobstetric Medicaid population**. Research demonstrates that this group has equal or higher readmission rates than Medicare beneficiaries and that they have distinct clinical, social, and behavioral needs that will likely require an adapted approach to existing readmission reduction efforts. This section highlights the key data collection and analyses required to understand the patterns and root causes of Medicaid readmissions.

*Relevant tools: Data Analysis, Readmission Review.*

## Section 2: Survey Your Current Readmission Reduction Efforts

Readmission reduction efforts have proliferated over the past several years, and many may have developed in isolation from each other. Understanding the current state is a prerequisite to developing an effective portfolio of strategies, assets, and resources that can be leveraged to reduce readmissions, including resources beyond the hospital walls. Engaging a diverse set of stakeholders in this process will enhance the comprehensiveness and accuracy of your understanding and ability to develop internal and external partnerships. This process can be used as a gap analysis, with special attention paid to identifying and developing Medicaid-specific efforts and community partners.

*Relevant tools: Hospital Inventory, Community Inventory.*

## Section 3: Plan a Multifaceted, Data-Informed Portfolio of Strategies

A multifaceted, data-informed portfolio of strategies is needed to effectively reduce readmissions hospitalwide. This section describes how to develop a specific aim statement and a multifaceted, data-informed portfolio of strategies to reduce readmissions. It also describes how to estimate the impact of those strategies and presents a sample operational dashboard that can be used to support implementation and continuous improvement.

*Relevant tools: Portfolio Design, Operational Dashboard, Portfolio Presentation.*

## Section 4: Implement Whole-Person Transitional Care for All

This section outlines the ways hospital-based transitional care should be improved for all patients, regardless of payer or readmission risk. We base our recommendations on the guidance and proposals of CMS, through an analysis of 2013 and 2015 documents. A focus is placed on practices to help staff better understand the patient, family, and community provider perspective; to reliably identify clinical, behavioral, and social service needs; and to ensure that effective linkage (not just referral) to posthospital services is executed.

*Relevant tools: Conditions of Participation Handout, Whole-Person Transitional Care Planning, Discharge Process Checklist.*

## **Section 5: Reach Out and Collaborate with Cross-Continuum Providers**

Collaborating with cross-continuum partners is crucial to ensuring that patients have their clinical, behavioral health, and social service needs met. Many hospital teams may be unaware of key stakeholders they can align with when expanding their focus to include Medicaid. Such partners may include social services, community case workers, behavioral health centers, State Medicaid agencies, and managed care plans. This section offers specific advice about how to engage in effective, results-oriented collaboration with providers and staff in other organizations.

*Relevant tools: Community Resource Guide, Cross Continuum Collaboration.*

## **Section 6: Enhance Services for High-Risk Patients**

For some patients, the best transition out of the hospital and reception into the next setting of care will not suffice to reduce readmission risk. This section describes enhanced services your hospital may choose to offer patients at high risk of readmission, such as transitional care services by interdisciplinary teams, including community health workers, navigators, social workers, pharmacists, nurse care managers, and providers. This section describes emerging design principles for high-utilizer programs managed by hospital-based teams, discusses the role of the emergency department in reducing readmissions, and includes a discussion of the role and types of care plans.

*Relevant tools: ED Care Plan.*



## SECTION 1: ANALYZE YOUR DATA

### WHO SHOULD READ THIS SECTION?

This section is targeted at the **executive** or **manager** charged with developing an effective strategy to reduce readmissions. A **data analyst** will be essential to achieve the work in this section.

### KEY POINTS

- Many hospitals' readmission reduction efforts began with and continue to focus on Medicare readmissions, without having examined the readmission patterns of their Medicaid population—specifically their adult nonobstetric Medicaid population.
- Research demonstrates that this group has equal or higher readmission rates than Medicare beneficiaries and that they have distinct clinical, social, and behavioral needs that will likely require an adapted approach to existing readmission reduction efforts.
- This section highlights the key data analyses required to understand the patterns and root causes of readmissions, with a focus on comparing and contrasting Medicare and Medicaid.

### KEY ACTIONS

#### Analyze your hospitals' readmissions data by payer

- Use **Tool 1: Data Analysis** to analyze hospital administrative discharge data to identify target populations at highest risk of readmission.
- Segment by Medicare, Medicaid, commercial, uninsured/self-pay, and all payer.
- Exclude patients under 18 and obstetric patients to examine Medicaid adult nonobstetric rates.

#### Interpret the data and identify target populations

- Use **Tool 1: Data Analysis** to identify high-leverage opportunities to reduce readmissions at your hospital. Noteworthy insights are likely to include:
  - Adult Medicaid readmission rates are as high as or higher than Medicare rates.
  - No one diagnosis or group of diagnoses makes up a majority of readmissions.
  - Behavioral health comorbidities are high among hospitalized Medicare and Medicaid patients.
  - One-quarter of 30-day readmissions occur within 4 days of discharge; one-half occur within 10 to 11 days of discharge.
  - Discharge disposition differs markedly for Medicare and Medicaid, with implications for followup.
  - High utilizers tend to represent less than 5 percent of the patient population but account for more than 50 percent of total readmissions.



### **Elicit the patient/caregiver perspective of readmissions**

- Use **Tool 2: Readmission Review** to interview five readmitted Medicaid patients while they are hospitalized.
- Inquire about social and logistical factors that may have led to readmission.
- Capture all the factors that contributed to readmission, not just one single issue.

### **Periodically reassess data to review root causes**

- Ensure that your quantitative and qualitative data and analyses are up to date when continuing to drive readmission reduction efforts.
- Inquire about social and logistical factors that may have led to readmission.
- Capture all the factors that contributed to readmission, not just one single issue.

## ANALYZE YOUR DATA

### *Analyze Your Hospital's Readmission Patterns*

#### **Which patients in your hospital have the highest readmission rates?**

Readmission reduction efforts often target patients who have conditions prioritized by payers' incentives or penalties, such as heart failure or chronic obstructive pulmonary disease. Hospital executives may be surprised to learn that these are **not the only groups** with high readmission rates.

As the executive in charge of developing a data-informed strategy to reduce readmissions, it is important for you to develop a strategy based on a full understanding of readmissions at your hospital, not limited to today's current payment or penalty policies. A full understanding of readmissions at your hospital will allow you to better place "penalty condition" readmissions in perspective. You will also be more able to consider the implications of your readmission reduction strategy in the context of various payer-based incentives or performance expectations.

Examine your **raw, unadjusted, all-payer** data to understand readmissions at your hospital, by payer.

Even if your hospital is already working on reducing readmissions for the Medicare population, your analyses may require some adaptations to include, compare, and contrast Medicaid readmissions. Sometimes hospitals rely on external sources to generate their readmission reports, which use a predetermined "cut" on readmission data. This type of report can limit potential insights. It is important to understand the limitations of such reports. Ask these questions about any externally produced or supplied readmission analyses you are using, or even your existing data analyses:

*"We were just focused on the three conditions heart failure, [heart attack], and pneumonia, but now we can see those are not our hospital's highest risk patients."*

DOES YOUR CURRENT READMISSION ANALYSIS...	WHY IT'S IMPORTANT
1. Produce whole-population (adults and children) Medicaid analysis, as opposed to one that focuses on the <b>adult nonobstetric Medicaid population</b> ?	<b>Data need to reflect the real picture:</b> To get a true sense of Medicaid readmissions, it is important to analyze the Medicaid adult nonobstetric population. The volume of low-readmission pediatric and obstetric discharges in the overall Medicaid population can give providers the impression there is “no readmission problem” in Medicaid. The adult nonobstetric population is the group that has a high readmission rate and distinct clinical, social, and behavioral needs that must be addressed in their transitional care.
2. <b>Exclude large segments of the patient population?</b> For example, does the report categorically exclude patients with behavioral health conditions, cancer, or other diagnoses? Is it limited to only the “penalty conditions”?	<b>What gets excluded gets ignored:</b> Do you agree that patients with behavioral health diagnoses or cancer should not be eligible to receive improved transitional care? Is that high quality? Is that good strategy or capacity building for an organization seeking to assume population risk or minimize losses from penalties?
3. Count all readmissions or does it <b>suppress “linked” readmission events</b> from the analysis? For example, does it only count readmissions that are “related” to the discharge condition, such that only one readmission per month might be counted even if several readmissions occurred for a patient within 30 days?	<b>Every readmission counts:</b> Do not use methods that suppress the total count of readmissions, especially recurrent readmissions in a short time. Much of the work to improve posthospital care and reduce readmissions focuses on these very events. If you use a method that suppresses these events, you will fail to detect the real progress that has occurred.
4. Capture readmissions to any hospital?	<b>Readmissions elsewhere are readmissions too:</b> Most hospitals today cannot determine when a patient is readmitted to a different institution, but the increase in health information exchanges will allow hospitals (such as all hospitals in Maryland) to see “other hospital” readmissions. This ability is especially important for hospitals in urban markets.

These limitations weaken the utility of the data analyses to offer insights into the readmission patterns at your hospital. Analyzing all readmissions presents your team with the full set of opportunities for improvement. The data will also be more timely than analyses from payers or external agencies. In addition, you will be able to run additional analyses as they occur to you and your team and track and trend patterns over time at will.

Use **Tool 1: Data Analysis**, which outlines a short set of readmission data analyses that can be conducted by a hospital-based analyst using hospital administrative data. Delegate the analytic query to a data analyst; forecast that it will likely take a day of work. Hospitals usually have an analyst in finance or quality who can run this query. This data analysis includes queries for readmissions and readmission rates by payer, timing of readmissions after discharge, top discharge diagnoses, discharge disposition and readmissions by discharge disposition, prevalence of behavioral health comorbidities, and high-utilizer readmission statistics.

The analytic plan in Tool 1 has been used by State hospital associations and State data agencies to produce all payer statewide and hospital-specific readmission analyses. See the Massachusetts Center for Health Information and Analysis report for statewide all-payer analyses and hospital-specific reports based on this analytic plan.<sup>17</sup> The analytic plan includes the following elements, most often analyzed by payer-specific groups and on an all-payer basis:

1. Total discharges (alive; exclude transfers to inpatient care settings)
2. Total readmissions
3. Readmission rate
4. Percentage of discharges and readmissions by payer
5. Days between discharge and readmission, <4 days, <10 days, 11-30 days
6. Top 10 diagnoses resulting in highest number of readmissions
7. Percentage of all readmissions accounted for by the top 10 diagnoses
8. Proportion of all discharges with any behavioral health (including substance use) condition
9. Percentage of all readmissions with any behavioral health condition
10. Discharge disposition (home, home with home health care, skilled nursing facility)
11. Readmission rate by discharge disposition
12. Number of patients with a personal history of high utilization (4 or more admissions in a year)
13. Number of discharges among this group (“high utilizers”)
14. Number (and percentage of total) of readmissions among this group (“high utilizers”)
15. Readmission rate among high utilizers



### DATA ANALYSIS TOOL

**Purpose:** Analyze hospital administrative data to evaluate readmission patterns.

**1**

**Description:** A spreadsheet that facilitates data analysis and interpretation to compare and contrast readmission patterns by payer.

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

**Time required:** 6 hours.

## Interpret the Data and Identify Target Populations

The purpose of the analysis is to identify high-leverage opportunities to reduce readmissions and achieve your hospital's readmission reduction goal. As you interpret the findings of the data analysis, ask yourself the following questions:

QUESTIONS TO ASK	WHAT YOU'RE LOOKING FOR
<p>1. 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 percentage of Medicare and Medicaid readmissions?</p>	<ul style="list-style-type: none"> <li>• Medicaid readmission rates are high.</li> <li>• Absolute number and percentage of Medicaid readmissions relative to all readmissions will vary by hospital.</li> <li>• Medicare and Medicaid readmissions make up the majority of all readmissions.</li> </ul>
<p>2. 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?</p>	<ul style="list-style-type: none"> <li>• Readmission teams often focus on the readmission rate; look at the absolute number to put goal and operations in context.</li> <li>• Calculate 20% of total readmissions to quantify how many readmissions per year and per month would be reduced.</li> </ul>
<p>3. What are the top 10 diagnoses leading to readmissions, and how do they differ between Medicare and Medicaid? Does it make mathematical sense to focus on a limited set of discharge diagnoses?</p>	<ul style="list-style-type: none"> <li>• Compare and contrast the top diagnoses for Medicare and Medicaid.</li> <li>• Top 10 diagnoses often account for only 20% to 40% of all readmissions.</li> <li>• Identify diagnoses, such as sepsis, sickle cell disease, psychosis, and substance use that are frequent or high risk but previously not addressed.</li> </ul>
<p>4. What percentage of discharges has a behavioral health comorbidity (inclusive of substance use)? How does this differ between Medicare and Medicaid?</p>	<ul style="list-style-type: none"> <li>• Behavioral health conditions are frequent among hospitalized patients.</li> <li>• Behavioral health conditions are a readmission risk factor. A strategy that includes addressing needs of patients with behavioral health conditions may be high leverage.</li> </ul>
<p>5. What percentage of readmissions occurs within 4 days of discharge? Within 10 days?</p>	<ul style="list-style-type: none"> <li>• Typically, 25% of readmissions occur within 4 days and 50% of readmissions occur within 10 days of discharge.<sup>17</sup></li> <li>• Consider: Does your strategy prioritize early postdischarge followup contact?</li> </ul>
<p>6. How does the discharge disposition of Medicare and Medicaid patients differ?</p>	<ul style="list-style-type: none"> <li>• The percentage of patients being discharged to home is much higher for Medicaid than Medicare.</li> <li>• Consider: A distinct set of partnerships with community providers and agencies is important for Medicaid readmission reduction.</li> </ul>

QUESTIONS TO ASK	WHAT YOU'RE LOOKING FOR
<p>7. 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?</p>	<ul style="list-style-type: none"> <li>• High utilizers tend to represent less than 5% of the patient population but account for more than 50% of total readmissions.</li> <li>• Their readmission rate can be about 40%.</li> </ul> <p><b>Note:</b> This population has a combination of clinical, behavioral, and social needs.</p> <p><b>Note:</b> This group can be readily identified in daily operations by the simple screen of a personal history of prior admissions.</p>
<p>8. 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?</p>	<p>See the big picture when it comes to readmissions at your hospital. Consider the following groups:</p> <ul style="list-style-type: none"> <li>• Adult Medicaid patients? (high rate)</li> <li>• All Medicare and Medicaid patients? (majority of all readmissions)</li> <li>• Patients with behavioral health comorbidities? Readmission rates for sepsis, sickle cell disease?</li> <li>• Groups of patients most often discharged to postacute care?</li> <li>• Readmission rate of patients with a history of 4+ hospitalizations?</li> </ul>

These interpretation questions are built directly into **Tool 1: Data Analysis**.

### IN PRACTICE: A DATA-INFORMED SOCIALLY AND MEDICALLY HIGH RISK TARGET POPULATION

In 2014, a Disproportionate Share Hospital drafted a proposal to reduce readmissions for Medicare patients with the “penalty” conditions. The funding agency encouraged the hospital to examine patterns of readmissions, using the all-payer analyses in this guide. As a result of conducting this analysis, the hospital identified a target population at high risk for readmission. High risk was based on the presence of “social complexity” (homelessness, any behavioral comorbidity, including substance use, lack of primary care provider, or frailty) or “medical complexity” (pneumonia, heart failure, heart attack, COPD, diabetes, sepsis).

This definition consistently identifies 30% of all adult nonobstetric admissions to the hospital as “high risk” of readmission. The 30-day readmission rate for this target population is 25%, which is 2.5 times the hospital’s all-cause adult nonobstetric readmission rate of 10%.

In 2016, as the hospital prepares to participate in a Medicaid accountable care model, they reviewed this guide and the data analysis and expanded the high-risk target population criteria to include all adult Medicaid patients hospitalized for conditions other than childbirth.

## IN PRACTICE: INSIGHTS FROM QUANTITATIVE DATA ANALYSIS

Frederick Memorial Hospital had been working on reducing readmissions for 3 years. When their quality improvement team analyzed their readmission data, stratifying patients by payer type, they learned that Medicaid patients were much more likely to be discharged to a home environment than were Medicare patients (82% vs. 50%). They also discovered that among Medicaid patients, 4 of the top 10 readmission diagnoses were behavioral health conditions, whereas behavioral health conditions accounted for 0 of the top 10 diagnoses for their Medicare patients.

These findings demonstrated to the team the need to adapt their readmission strategies to better address the needs of patients with behavioral health conditions and the need to develop more partnerships with community-based providers and agencies that serve Medicaid patients.

In 2014, Addison Gilbert and Beverly Hospitals initiated a planning process to reduce readmissions. Initially, these hospital teams proposed to focus efforts on Medicare patients with heart attack, pneumonia, and heart failure. The Readmission Data Analysis revealed that 47% to 67% of readmitted patients had a behavioral health comorbidity. At Addison Gilbert Hospital, 78% of Medicaid patients had a behavioral health comorbidity.

The results of these findings resonated with the team clinically, and they knew that addressing the behavioral health needs of their patients would be critical to reducing readmissions. They now target patients with clinical, behavioral, and social needs and deploy a high-risk intervention team staffed to address these needs. (See <http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/chart/chart-case-study-011615.pdf>.)

## Elicit the Patient/Caregiver Perspective of Readmissions

Although understanding the patterns of readmissions through quantitative data analysis is essential to developing a robust and effective readmission reduction strategy, data analyses alone do not provide complete insight into the circumstances that lead to patient readmissions.

To understand the root causes of readmissions at your hospital, you must understand “the story behind the story”: the factors that lead to readmission that go well beyond the chief complaint, discharge diagnosis, or other clinical parameters. These root causes reveal barriers in communication, coordination, or other logistics experienced in the days after discharge.

*“Billing data aren’t going to tell you whether a patient needed a pharmacy intervention, needed a place to live, or couldn’t afford their medications.”*

Research based on this best practice that was originally developed by the Institute for Healthcare Improvement substantiates the importance of understanding the patient’s perspective and seeking to identify multiple factors (rather than single causes) that lead to readmissions. For example:

- A research team in a Philadelphia emergency department identified a root cause of 7-day ED returns as “fear and uncertainty” about their condition.<sup>18</sup>
- A research team from Kaiser Permanente in California identified “all” of the factors that contributed to a readmission event, avoiding the temptation to identify one single cause of a readmission. Rather than identifying the one reason for a readmission, the team found an average of nine factors that contributed to each avoidable readmission event.<sup>19</sup>

Patient and family/caregiver readmission reviews are a valuable component of understanding the system and human factors that lead to a readmission. This technique will ensure that the team does not “overmedicalize” readmission events or the interventions that could be expected to reduce readmissions. The patient interviews can also provide information on the gaps and barriers that exist in the hospital’s workflow for reducing readmissions.

Use **Tool 2: Readmission Review** to collect qualitative data to understand the root causes of readmissions from the patient/caregiver point of view. Understanding the patient perspective is particularly important for the Medicaid population to understand the challenges they face following a hospitalization.



## READMISSION REVIEW TOOL

2

**Purpose:** Obtain qualitative insights as to why readmissions occur from the patient or caregiver’s perspective.

**Description:** 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.

**Staff:** Quality improvement, nursing, case management staff.

**Time required:** 5-10 minutes per interview. Consider starting with 5 interviews; many teams later review ALL readmissions when the patient is readmitted.

As one of the people in charge of implementing strategies to reduce readmissions, you may not have the occasion to interact with patients on a daily basis. If possible, speak with five readmitted patients who are currently inpatients in your hospital. Request to speak to the patient and/or their caregivers for 5 minutes, asking them to describe their experience when they left the hospital and the days that ensued between the day of discharge and readmission. Ask what brought them back to the hospital, and what, if anything, they think could have been done to avoid needing to return. These qualitative data offer insight into concrete problems and solutions, beyond simply labeling patients as “noncompliant.”





Listen for the following elements of readmission experiences, including:

- A sense of leaving the hospital unprepared, or inadequately informed.
- A lack of specific instructions on what to do in the days following discharge.
- A lack of coordination of postdischarge services or followup.
- Changing circumstances after discharge in a way that led to the readmission.
- Challenges in accessing services: appointments, transportation, medications, equipment.
- A report to the primary care provider of posthospital symptoms or questions with instructions to return to the ED.
- A sense that readmissions are undesirable and frustrating.
- A sense that readmissions are O.K., expected, or otherwise as “following doctor’s orders.”

The following table includes examples of results from Medicaid patient readmission interviews.

PATIENT DESCRIPTION	READMISSION INTERVIEW FINDINGS
24-year-old, dual-eligible female with HIV/AIDS, hospitalized 8 times and visited the ER twice in the last year. First hospitalized for pneumonia, readmitted 8 days later for pneumonia. Did not have a primary care provider or an HIV care provider.	When asked how the hospital can help her and others prepare to leave the hospital, she said, “It would have been helpful if the hospital had made an appointment for me.”  <b>Key finding:</b> Needed assistance navigating the health system.
35-year-old female Medicaid patient recently released from jail. First hospitalized due to chest pain; left against medical advice. Readmitted 1 month later for chest pain.	The patient had difficulty paying for her reflux prescription. She left the hospital abruptly because she was afraid she would lose her job if she missed work.  <b>Key finding:</b> Financial and employment insecurity created significant barriers to care.
61-year-old male Medicaid patient hospitalized 8 times this year for shortness of breath. Has numerous comorbidities, any of which could cause shortness of breath. Lives in a single room occupancy unit.	Patient prefers to be in the hospital; cannot be placed in skilled nursing facility due to criminal history. Seeks accommodation and social diversion by being in the hospital.  <b>Key findings:</b> Housing instability, behavioral health conditions.
46-year-old Spanish-speaking-only female Medicaid patient with breast cancer. Hospitalized 6 times and visited the ER 3 times in the past year.	Patient received instruction in English, and her 12-year-old daughter was asked to translate. Patient had poor understanding of prescription instructions.  <b>Key finding:</b> No use of interpreter services; lack of Teach-Back to confirm understanding and clarify.

### **Periodically Reassess Data and Regularly Review Root Causes of Readmissions**

Successful efforts to reduce readmissions rely on regular data analyses and continuous monitoring of implementation and performance. Building on the initial quantitative and qualitative data analysis described in this section, as well as guidance given on using an operational dashboard in Section 3, you will need to periodically reassess readmission patterns and root causes. This practice will help to ensure these data are up to date and taken into account when continuing to drive readmission reduction efforts, both within the hospital and with cross-setting partners.



## SECTION 2: SURVEY YOUR CURRENT READMISSION REDUCTION EFFORTS

### WHO SHOULD READ THIS SECTION?

This section is targeted at the executive or manager charged with developing an effective strategy to reduce readmissions. To complete the work in this section, it is recommended that you engage a variety of hospital staff to ensure a comprehensive accounting of readmission reduction efforts at your hospital.

### KEY POINTS

- Readmission reduction efforts have proliferated over the past several years, and many may have developed in isolation from each other. Understanding the current state is a prerequisite to developing an effective, complementary portfolio of strategies.
- Assets that can be leveraged may not exclusively focus on readmission reduction; identify what is needed and determine whether it exists in the hospital or in the community.
- Resources exist to support patients' transitional care needs in the community; identify them.

### KEY ACTIONS

#### Inventory the readmission reduction efforts underway within the hospital

- Use **Tool 3: Hospital Inventory** to survey all activities and operational assets that can be considered to improve care so as to reduce readmissions.
- Engage stakeholders across clinical and administrative departments, service lines, and units.
- Assess the degree to which these readmission reduction initiatives apply to specific patient groups (e.g., all patients, Medicare patients only, Medicaid patients) and the degree to which the practices are implemented consistently or on an ad hoc basis.

#### Inventory community partners' transitional care services

- Use **Tool 4: Community Inventory** to survey the clinical, behavioral, and social service resources that exist in the community that could provide timely posthospital followup, monitoring, and assistance, and identify which of them your hospital regularly uses.
- Engage colleagues who know community resources best: hospital and community-based social workers, navigators, behavioral health providers, Medicaid plan care managers.

- Examine 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 reviews.
- Specifically identify providers, agencies, or plans that provide transitional care, high-risk case management, and other services to Medicaid patients.
- Specifically identify the behavioral health providers, especially behavioral health homes, multiservice centers, large clinics, and substance use disorder treatment providers in your region.

#### Conduct a gap analysis

- Identify which target populations are not well served by current readmission reduction activities.
- Consider whether current readmission reduction efforts address the root causes of readmissions for your target populations.
- Assess whether current readmission reduction efforts are consistently delivered to a high percentage of your target populations.
- Consider which strategies can be added to improve the comprehensiveness or efficacy of current readmission reduction efforts.

## SURVEY YOUR CURRENT READMISSION REDUCTION EFFORTS

### *Inventory Current Hospital Readmission Reduction Efforts*

Almost all hospitals have some readmission reduction efforts underway. Readmission reduction efforts have proliferated over the past several years, and many may have developed in isolation from each other. These efforts may be readily apparent to you, or they may not be visible at the executive level or across organizational departments. Therefore, it is advisable to make a one-time concerted effort during this strategic planning process to inventory the readmission reduction efforts across the organization.

*“We run the care coordinator pilot; I think nursing is working with IT on getting a high-risk flag in the record. I don’t know how that is coming...”*

Inventory all activities and operational assets that can be considered to improve care so as to reduce readmissions. Some of the assets you have in place may not be exclusively focused on or designed to reduce readmissions, but they are part of what your organization has potentially available to leverage, such as:

- Board or executive-level priority to reduce readmissions.
- Specific readmission reduction goal.
- Financial, quality, or other incentives to reduce readmissions.
- Presence of executive, administrative, or clinical champions.
- Transitional care services and staff (e.g., pharmacist technicians or pharmacists to conduct medication reconciliation, care navigators).
- Department- or service-line-based improvement efforts (e.g., initiatives led by nursing, case management, social work, quality, cardiology, pulmonary, hospital medicine, ED).
- Cross-setting collaborations (e.g., preferred providers, co-located liaisons, existing committees that promote coordination of care or effective referral practices).
- Information technology systems (e.g., readmission flags, workflow prompts, regular readmission reporting).
- Managed care, value-based, or risk contracts that reward decreased utilization or quality performance in transitional care (including accountable care organizations, bundled payment teams).

**Tool 3: Hospital Inventory** is designed to help you and your team inventory readmission reduction initiatives within the hospital. It prompts a compilation of readmission reduction activities across departments, service lines, and units within the hospital. You may want to engage the following stakeholders in some or all components of this process, as your colleagues will have varying knowledge of what is going on at the hospital:

- Director for Integrated Care/Care Coordination/Population Health
- Director of any alternative payment arrangements (e.g., accountable care organizations, bundled payment, duals demonstrations, shared savings contracts)
- Director of any Medicaid projects tied to reduced utilization (e.g., delivery system transformation initiatives, delivery system reform incentive payment programs)
- Director of Quality
- Director of Case Management
- Director of Social Work
- Director of Hospital Medicine
- Director of Emergency Medicine
- Director of Behavioral Health
- Information Technology (regarding flags, alerts, reports, other electronic medical records or software functionalities)

If any prior readmission reduction efforts were discontinued, review what worked and did not work to inform your efforts moving forward. If certain efforts were considered unsuccessful, always consider whether they were effectively (reliably, consistently) implemented; there may have been good ideas attempted several years ago that merit reconsideration.



### TOOL 3: HOSPITAL INVENTORY

**Purpose:** Understand your hospital's current readmission reduction efforts.

3

**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.

**Time required:** 4 hours. Take no more than 2 weeks (2 meetings) to complete.

## THE IMPORTANCE OF LEADERSHIP COMMITMENT TO REDUCING READMISSIONS

Reducing readmissions for a population or a hospital is an organizationwide effort that requires commitments and contributions from numerous departments, providers, and staff. Organizational leadership is essential to support, sustain, and codify the changes needed to achieve readmission reduction goals.

Not all successful readmission reduction efforts must start with the attention and commitment of senior hospital leadership, but all successful efforts eventually gain the full and active support of leadership. Identify an executive sponsor, inquire whether readmission reduction is a board-level priority, articulate the hospital's short-term and medium-term interests in reducing readmissions, and identify the time, staff, analytics, tools, and other resources available to achieve readmission reduction objectives.

If your team cannot command executive commitment from the start, then work on articulating the gaps in care and their impact on staff and patient satisfaction and safety, achieve some “quick wins,” and present the executive team with a request for support based on your teams’ actions. See also “Don’t Wait for Perfect: Get Started Immediately” at the end of Section 3.

### *Inventory Community Readmission Reduction Resources*

An active and robust collaboration with postacute and community-based partners that can serve the posthospital transitional care needs of your population is a crucial element of successful readmission reduction efforts. Important tasks such as transitioning patients into the care of “receiving” providers and addressing patients’ clinical, behavioral, and social needs requires teamwork between the patient/caregiver, the hospital, and postacute and community-based providers.

It is increasingly common for hospitals to have an effort underway to work with skilled nursing facilities on improving transitions and reducing readmissions, through formal or informal mechanisms. This cross-continuum improvement work is high leverage but would be most relevant for reducing Medicare readmissions, as a very small percentage of Medicaid patients are discharged to skilled nursing facilities.

As you inventory community providers and agencies on services available in the posthospital setting, focus on identifying providers and agencies that provide services and support that would meet the transitional care needs of the high-risk target populations you identified in your data analysis. Specifically work to identify providers, agencies, and resources relevant to the Medicaid population and others with behavioral health and social needs. Seek out services such as the following:

- Behavioral health providers
- Health homes
- Behavioral health homes
- Managed care plans offering high-risk-care management
- Providers of Medicaid home and community-based waiver services
- Food and transportation

- Legal services
- Transitional housing
- Peer, navigator, or advocate support
- Day programs
- Specialized service models for certain high-risk clinical conditions (e.g., sickle cell crises)

Guidance on how to identify, recruit, and collaborate with additional partners can be found in Section 5 (Reach Out to Collaborate With Cross-Setting Partners).

**Tool 4: Community Inventory** is designed to help you and your team inventory the different postacute and community-based providers, agencies, and payer resources you may want to engage in your efforts to reduce readmissions. The tool distinguishes partners that are especially useful for Medicare versus Medicaid populations. Often, hospital-based readmission reduction teams are surprised to learn of the available resources that do exist in the community, contrary to their assumptions about resource constraints. This tool can help identify a broader constituency of potential champions, allies, and implementation partners to support your efforts to reduce readmissions.

Similar to the hospital inventory process, you may have a sense of some but not all of the active community partnerships or resources, or how your hospital uses them. Harness the insights of those who know the community resources best, such as your social workers or community-based navigators. If you already have a cross-continuum team in place, ask your cross-continuum team partners to assist in conducting this inventory.



#### **TOOL 4: COMMUNITY INVENTORY**

**4**

**Purpose:** Identify clinical, behavioral, and social service resources in the community that can support your patients' transitional care needs.

**Description:** This tool prompts an inventory of postacute and community-based providers, agencies, and plans that can offer posthospital services.

**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:** 4-5 hours, delegated across multiple staff.

## Conduct a Gap Analysis

Based on the findings of your quantitative data analysis, qualitative data analysis (interviews), and inventory of hospital and community-based readmission reduction efforts and related services, consider:

1. Which high-risk populations are being served by current readmission reduction efforts?
2. Which high-risk populations are not being served by current readmission reduction efforts?
3. Are the current readmission reduction processes and/or services consistently implemented for the current target population? How do you know?
4. Are the current readmission reduction processes and/or services inconsistently implemented for the current target population? How do you know? Can this be improved?
5. Do the strategies offered for the current target population effectively address the transitional care needs and root causes of readmissions? How do you know?
6. Have the strategies offered for the current target population reduced readmissions for the target population? How do you know?
7. Are there opportunities to better serve the current target population and reduce readmissions even more?
8. Are there opportunities to serve new target populations? Which populations? With which services, process improvements, and/or partners?

Section 3 offers guidance on how to address these gaps in a multifaceted, data-informed portfolio of strategies.



## SECTION 3: PLAN A MULTIFACETED, DATA-INFORMED PORTFOLIO OF STRATEGIES

### WHO SHOULD READ THIS SECTION?

This section is targeted at the **executive** or **manager** charged with developing an effective strategy to reduce readmissions. The work in this section builds on the successful completion of Section 1 (Analyze Your Data) and Section 2 (Survey Your Current Readmission Reduction Efforts).

### KEY POINTS

- Specify a readmission reduction goal; we encourage an all-payer or Medicaid-specific readmission reduction goal.
- Develop a multifaceted portfolio of strategies that address needs of high-risk target populations and root causes of readmissions.
- Estimate the expected impact of the portfolio of strategies to ensure that the readmission reduction goal could be achieved by this plan if the strategy is implemented effectively.
- Measure the implementation of your readmission reduction strategies and outcomes on a monthly basis to drive continuous improvement.

### KEY ACTIONS

#### Specify the goal and target populations

- Formulate a specific aim statement in the form of “what, for whom, by when.”

#### Formulate a portfolio of strategies

- Use **Tool 5: Portfolio Design** to describe your hospital’s portfolio of readmission reduction efforts in the form of a driver diagram.

#### Quantify the expected impact of your strategies

- Specify number of patients affected by each component of the strategy.
- Estimate the expected impact of each type of strategy.
- Quantify the resources needed to implement each strategy.
- Calculate the expected impact on readmissions.

#### Develop and use an operational dashboard to drive continuous improvement

- Use **Tool 6: Operational Dashboard** to establish a monthly tracking tool to monitor monthly volume, implementation measures, and outcomes for your target populations.

#### Share the data, insights, plan, and dashboard with staff and stakeholders

- Use **Tool 7: Portfolio Presentation** to share key data findings, insights, driver diagram of strategies, and operational dashboard with staff and stakeholders.

#### Don’t wait for perfect: Get started immediately

- Many hospital teams experience challenges or barriers to their quality improvement efforts. Many of these challenges and barriers are common, and it is possible to still make progress despite them.



## PLAN A MULTIFACETED, DATA-INFORMED PORTFOLIO OF STRATEGIES

### *Understand What a Multifaceted, Data-Informed Portfolio of Strategies Entails*

To reduce readmissions effectively, your approach must be **multifaceted**. Reducing readmissions requires improving hospital-based care processes. It also involves developing and strengthening handoffs, creating definitive linkages, communicating effectively, and coordinating with providers and agencies in the community. For some patients, the best care in the hospital, the best transition from the hospital, and the best linkage to posthospital providers will still not suffice to reduce readmissions. For these high-risk patients, posthospital enhanced transitional care services will be required to reduce readmissions. Sections 4 through 6 of this guide describe readmission reduction strategies that represent these different facets.

*“There is no silver bullet.”*

A strategic approach that is **data informed** should address the major findings of your quantitative (data) and qualitative (patient/caregiver interviews) data analyses (from Section 1). The hospital and community inventory of readmission reduction efforts (from Section 2) likely revealed several potential assets to leverage when designing a data-informed portfolio of strategies to reduce readmissions. It may have also revealed gaps in your current processes that you will want to address.

### *Specify the Goal and the Target Population*

A successful readmission reduction effort needs to specify what the goal is, usually in terms of a percent reduction in readmissions. Likewise, the readmission reduction goal is in reference to a specified, measurable population. What you decide to specify as the magnitude of the goal and the target populations of greatest importance will be driven by the strategic, clinical, quality, and financial goals of your hospital.

The goal should be data informed and specify:

- **What will be achieved?** Readmissions will be reduced.
- **For whom?** This is essential for measurement and operations.
- **By how much?** This tells leadership, staff, and stakeholders whether this is a substantive or minor change.
- **By when?** Time period creates pace and identifies endpoint.

For example, a readmission reduction goal may be, “We aim to reduce all-cause 30-day readmissions by 20% for high-risk patients by December 2018.” High-risk patients could be defined as patients who have had 4 or more hospitalizations in a year, patients with behavioral health conditions, and patients with sickle cell disease.

Examples of data-informed target populations include:

- Hospitalwide readmissions (specifically, all adult nonobstetric patients).
- Adult nonobstetric Medicaid patients.
- Patients with behavioral health comorbidities.
- Patients with unmet social needs as identified through a standard screen.
- Patients with a personal history of 4 or more hospitalizations in the past year.
- Patients discharged to skilled nursing facilities.

### *Formulate a Portfolio of Strategies*

Synthesize the information obtained from data analyses, readmission reviews, and inventories of readmission reduction assets and efforts at your hospital and in the community. Examine whether the root causes of Medicaid readmissions are being addressed by your current efforts, specifically whether:

- Hospital staff screen for Medicaid payer status as an independent risk of readmission,
- Strategies are in place to identify patients with comorbid behavioral health conditions, and
- Whole-person needs assessments are conducted to identify posthospital support needs.

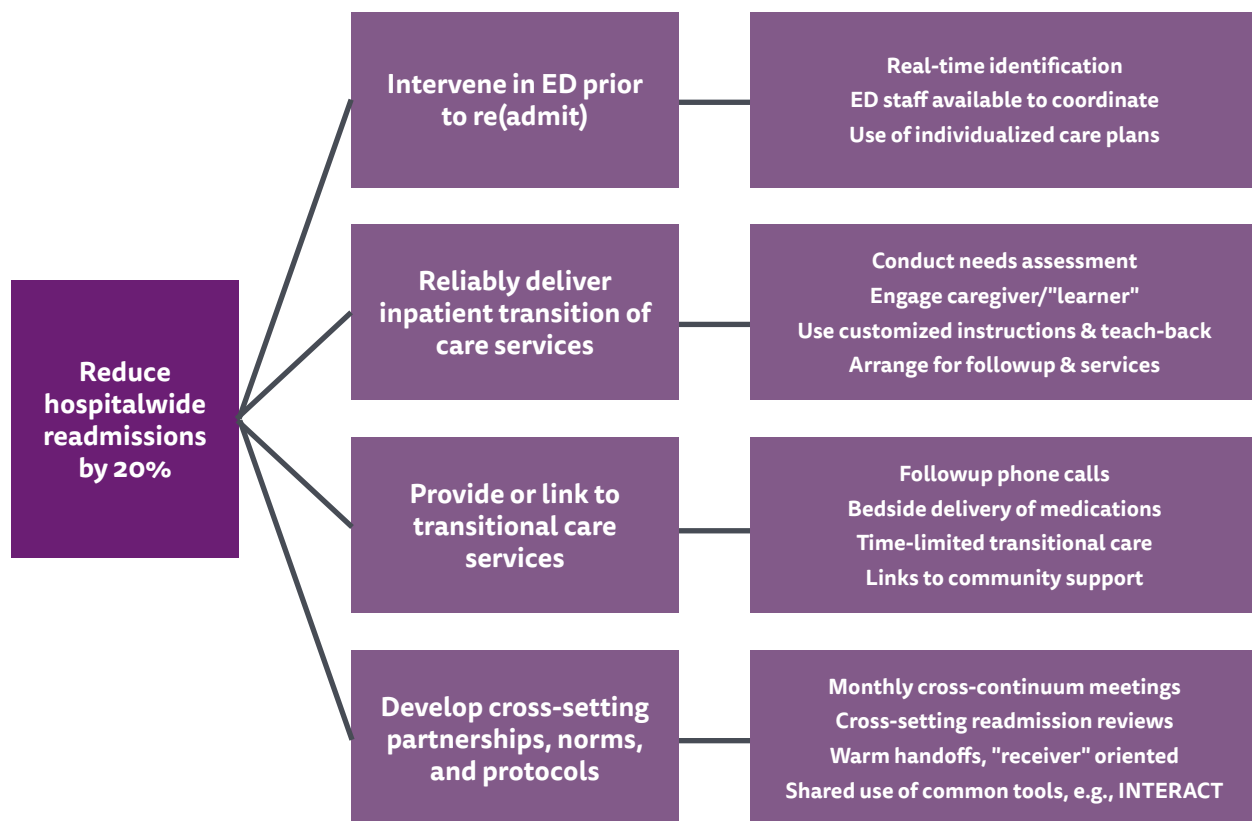
Evaluate the extent to which your hospital's readmission reduction efforts are coordinated and aligned with other efforts within the hospital. Evaluate the extent to which Medicaid-specific providers, plans, and social support services are fully engaged as partners in reducing readmissions. Identify whether any high-risk populations or root causes of readmission have no strategies currently in place.

A multifaceted portfolio should include strategies to:

- **Improve transitional care for all.** Improve standard hospital-based processes to systematically identify readmission risks for all patients; engage in interdisciplinary transitional care planning; work with the patient and the patient's caregiver to develop a plan that is feasible and addresses whole-person needs, not just presenting medical complaints; ensure effective linkage to followup care and services; and communicate the discharge plan to the primary care provider and other "receiving" providers.
- **Reach out to collaborate with cross-setting partners.** Identify providers, agencies, and plans that provide services to meet patients' posthospital clinical, behavioral, and social service needs. Develop collaborative working relationships, with norms and expectations for notification, warm handoffs, improved communication and coordination, and constructive feedback for continuous improvement. Develop new "referral pathways" with receiving providers aimed at ensuring timely linkage services.
- **Enhance services for high-risk patients.** Patients at high risk of readmission require additional transitional care services to reduce readmission rates.

To describe the portfolio of strategies in your hospital, use a driver diagram to convey the logic of how readmission reduction efforts are designed to meet the hospital's goal.

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 believe readmissions can be reduced for the target population. In relation to each “primary driver” are specific actions to implement primary drivers. The driver diagram is a helpful tool for you to display the logic of how each strategy or action is logically linked to achieving the primary aim.



### Sample Driver Diagram

In the above sample driver diagram from a Baltimore hospital, the aim is to reduce readmissions hospitalwide by 20 percent. The four primary drivers in their readmission reduction approach include strategies to:

1. Intervene in the ED prior to re(admit),
2. Reliably deliver inpatient transition of care services,
3. Provide or link to transitional care services, and
4. Develop cross-setting partnerships, norms, and protocols.

Each of these drivers is linked to a set of secondary drivers, which are the specific actions taken to implement the primary drivers.

Other sample portfolios and driver diagrams are available in **Tool 5: Portfolio Design**, which you can edit to develop your own driver diagram to reflect your readmission reduction portfolio of strategies. In addition to being a tool to support strategic program design, the driver diagram is a helpful illustration of the strategy for the purposes of communicating to internal and external stakeholders.



## TOOL 5: PORTFOLIO DESIGN

5

**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.

**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.

**Staff:** Readmission reduction strategic leadership team.

**Time required:** 3 to 4 hours.

## *Develop and Use an Operational Dashboard to Drive Continuous Improvement*

Monthly measurement of implementation and outcomes is the single most important tool you have to determine whether the strategies you have designed are being implemented and whether they have an impact on reducing readmissions. Measurement is the foundation for a continuous process improvement approach that will allow your team to optimize implementation of each strategy and improve the ways services are delivered to optimize effectiveness.

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 transitional care services as intended?" You may need to measure the delivery of one or more services to the target population. You may need to measure the delivery of "enhanced" services for a high-risk subgroup.
3. Outcomes: Track readmission rates for the hospital and for the target populations monthly to visualize trends over time. Track outcomes for patients who received the service and for patients who were eligible for, but did not receive, the service.

Identify the measures that will help you monitor and evaluate your portfolio of strategies. Develop a measurement for each element on your driver diagram, if possible. **Tool 6: Operational Dashboard** may serve as a helpful starting point.



## TOOL 6: OPERATIONAL DASHBOARD

6

**Purpose:** To illustrate the elements of an operational dashboard that will help teams and readmission champions improve implementation of the portfolio of strategies and analyze the impact of the strategies on readmission rates.

**Description:** 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).

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

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

## Quantify the Expected Impact of Your Strategies

The purpose of developing a multifaceted portfolio of strategies is to develop a strategy that is sufficiently robust to achieve your hospital's readmission reduction objectives. For each strategy, you should be able to estimate the expected impact of the strategy, provided that the strategy is consistently and effectively delivered as designed.

An example of an approach to quantifying expected impact can be adapted from a template that CMS required of applicants to the Community-based Care Transitions Program (CCTP). This template prompted applicants to estimate the impact of their program and assess the efficiency of the resources they were requesting, which was essentially a form of return on investment.

Estimating the impact of a strategy requires the following information:

- Total eligible discharges in the target population;
- Total eligible discharges that will be served by the intervention (account for attrition);
- Readmission rate for the target population;
- Estimated impact (on reducing readmissions) of the intervention;
- Total number of readmissions expected to be avoided by the strategy;
- Average cost (payment received) of a readmission;
- Gross potential savings (to payers) from averted readmissions;
- Cost of the intervention (staff, IT, etc.); and
- Net potential savings (to payers) from averted readmissions.

Each of the components of the estimate of impact is available for you to calculate:

- The discharge, readmission, and readmission rate numbers are available from your data analysis.
- Expected impact is an estimate of how effective you anticipate an intervention will be, if reliably implemented. You may be able to find examples in the literature about an intervention you intend to implement. However, you will need to adjust your estimates based on differences between hospital settings and between clinical-operational environments and research conditions.

- In the absence of reliable effectiveness information, you might set a reasonable expectation of impact, more of a realistic goal than a rigorous expectation. You might use estimates ranging from 5 percent (a minimally effective expectation) to 25 percent (the high end of measurable impact in a clinical operational environment). You might reasonably hope to achieve greater impact, but use caution when estimating impact of a set of strategies until you have implementation results.
- Readmissions x expected impact = avoided readmissions.
- Use your hospital's finance information to use an average reimbursement for a readmission at your hospital. As a frame of reference, \$12,300 was the average cost for an all-cause Medicaid readmission in 2013.<sup>7</sup>

## Share Data, Insights, and Plan With Staff and Stakeholders

The completed data analysis, updated aim statement, and portfolio of strategies will be of great interest to stakeholders. Locally relevant data and provider input are powerful motivators in efforts to stimulate change in your hospital and your community.

**Tool 7: Portfolio Presentation** is designed to help you share the results from this strategic planning process with internal staff and stakeholders and external partners, providers, and agencies.

*"The more we show people the results, the more they are engaged. You put the plan in place, you track, and you add and continue to add until you have everything. Success breeds success."*



7

### TOOL 7: PORTFOLIO PRESENTATION

**Purpose:** To provide readmission reduction leaders and managers a customizable 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.

**Description:** 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.

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

**Time required:** 2 hours.

## Don't Wait for Perfect: Get Started Immediately

It is not uncommon for a strategic planning process to reveal challenges or barriers in addition to opportunities, assets, and resources. Many readmission reduction teams encounter a variety of these issues; in our experience, teams believe these challenges are unique to their organization, but they are not. Whatever challenges or barriers you have uncovered, it is always possible to move forward and make progress. Below are some common difficulties that readmission teams encounter and recommendations for moving forward despite these barriers.

COMMON BARRIERS TO REDUCING READMISSIONS	WHAT YOU CAN STILL DO
We're still studying the root causes of readmissions.	Analyze just enough data to move forward. Limit the amount of data analysis to the key facts that will give your team actionable insights. If the process drags on, make sure your hospital is following best transitional care practices in a way that addresses Medicaid patients' needs.
The senior leadership doesn't care about Medicaid readmissions because we don't get penalized by Medicaid.	Although senior leadership can greatly influence the extent and direction of readmission reduction efforts, hospital-based processes and cross-continuum collaboration can be improved as a matter of clinical process improvement in daily care. The CMS Proposed Discharge Planning Conditions of Participation (CoPs) provide new incentives to expand efforts to include Medicaid patients.
We don't have the money to hire any full-time staff.	Hiring transitional care staff is often necessary to provide enhanced services. However, hiring new staff is only one method of reducing readmissions. Improving hospital-based transitional care processes and collaborating with cross-setting partners does not necessarily require new staff. It is also possible to consider redeploying existing staff.
We're waiting for the new electronic medical records system to be implemented.	Although implementing an EMR requires enormous effort, the workflows and functions of admission, medication reconciliation, multidisciplinary collaboration, transitional care planning, and followup over time do not all depend on the EMR. Integrate transitional care improvement team members with EMR implementation teams.
We have really limited access to primary care.	While followup appointments are important to address problems before they turn into preventable readmissions, it is possible to leverage other roles and partnerships to help ensure posthospital support.
There's no peer-reviewed literature to support any readmission reduction strategy.	Successful readmission reduction efforts use quality improvement and organizational change management techniques—leadership support, committed champions, broad engagement of staff across disciplines and departments, use of enabling tools and technologies, celebration of successes, and visible demonstrations of change. Draw on insights from organizational change and adaptive leadership to inform the successful execution of any readmission reduction strategy.
Our community is very limited in resources.	Community-based social workers report confidence in accessing services for patients with economic and social needs. Hospital-based providers may not be fully aware of the resources available. Engage your cross-continuum team to identify available services.



## SECTION 4: IMPLEMENT RELIABLE, WHOLE-PERSON TRANSITIONAL CARE FOR ALL

### WHO SHOULD READ THIS SECTION?

This section is directed at **directors and managers of clinical staff** who are empowered to improve standard hospital-based processes and practices to identify, address, and mitigate readmission risk factors for all hospitalized patients.

### KEY POINTS

- Improve hospital-based processes and practices to effectively identify patients' readmission risk factors, and address those readmission risk factors as part of a forward-looking transitional care plan that provides individualized guidance and effective linkage to followup and services.
- The recommendations for improving hospital-based processes in this section are based on our analysis of CMS surveyor guidance and proposed changes to the Discharge Planning Conditions of Participation. These recommendations represent a considered compilation of a range of best practices and represent the new and emerging standard expectations. See also **Tool 8: Conditions of Participation Handout**.

### KEY ACTIONS

#### Identify all patients at high risk of readmission

- Use a 30-day return flag in the ED to identify patients who are returning within 30 days; consider whether these patients can be safely and effectively managed in alternative settings.
- Develop an automated flag or brief screen on admission to identify patients at high risk of readmission based on the findings of your data analysis and patient interviews.

#### Assess "whole-person" transitional care needs

- Adapt an admission nursing or case management assessment to incorporate elements from **Tool 9: Whole-Person Transitional Care Planning** to prompt a broader view of transitional care planning.
- Conduct a brief "readmission interview" for all readmitted patients to understand why they were readmitted; use these insights to inform a transitional care plan that addresses them.

#### Communicate the posthospital care plan simply and effectively

- Address patient and caregivers' priorities first.
- Focus on three to five messages and provide anticipatory guidance ("what to watch for and what to do").
- Identify the "learner" and include him or her in all communications.
- Use teach-back to confirm understanding of self-care messages.
- Provide written materials at the third grade reading level and in the patient's preferred language.



### **Link patients to followup and posthospital services**

- Make appointments for primary, specialty, and behavioral health care before discharge.
- Go beyond “referring” patients to necessary services; ensure linkage to reduce barriers to care.
- Use **Tool 10: Discharge Process Checklist** to make sure that the elements of your discharge process align with CMS documents.

### **Provide real-time information to receiving providers, service agencies, and health plans**

- Complete discharge summaries at the time of discharge. Notify primary care, behavioral health, and Medicaid health plans of the admission and invite collaboration on the transitional care plan.

### **Ensure timely postdischarge contact with patients**

- Expand usual set of followup forms of contact and arrange as appropriate to the patient’s needs.

# IMPLEMENT RELIABLE, WHOLE-PERSON TRANSITIONAL CARE FOR ALL

## *Implement Whole-Person Transitional Care for All*

In May 2013, CMS issued new guidance for assessing whether hospitals are in compliance with the CMS Discharge Planning Conditions of Participation (COPs).<sup>20</sup> In November 2015, CMS issued a proposed revision to the Discharge Planning COPs.<sup>21</sup> These documents provide an excellent synthesis of many of the well-known best practices to improve the transitional care process and represent the future of required performance.

Moreover, the CMS guidance and rules specify **new and unique** elements particularly germane to reducing Medicaid readmissions and improving whole-person transitional care, such as:

- Hospitals should remind staff that the CMS Discharge Planning regulations **apply to Medicaid** as well as Medicare patients;
- Improved transitional care expectations apply to **all hospitalized patients**, regardless of level of care, diagnosis, or readmission risk;
- **Behavioral health** followup needs should be included as part of the discharge plan;
- Hospitals must **arrange for** (not just refer to) posthospital services;
- Hospitals must provide patients with **data to inform choice** of postacute providers; and
- Hospitals must follow up with **high-risk patients** after discharge.

*“There are so many processes here that are broken that we need to fix. They’ll say, ‘We can’t do anything for this guy,’ but it’s because there are so many gaps in so many places at the same time, so the ball never drops in the same place. There’s a lot we need to do to systematize the effectiveness of these processes.”*

These new expectations are best practices that will improve transitional care for **all patients, including but not limited to patients identified as being “at high risk” for readmission.** The clear message and expectation CMS is articulating in these documents is that every hospitalized patient requires improved, safe, and effective care practices. These practices should more comprehensively assess transitional care needs; incorporate patient and caregiver preferences; and be communicated clearly to patients, caregivers, and “receiving” providers. In addition, linkage to clinical and service followup (including making appointments) is a task of discharge planning for all patients.

These CMS guidance and proposed rules support this guide’s core recommendation about how to best reduce readmissions for Medicaid patients: improve transitional care for all patients, specifically including Medicaid patients. This content is summarized in **Tool 8: Conditions of Participation Handout.**



## TOOL 8: CONDITIONS OF PARTICIPATION HANDOUT

8

**Purpose:** 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/or proposed changes to the CMS COPs. It can be used as a handout, in educational sessions, and as an aid to guide the work of your readmission reduction team.

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

**Time required:** 30 minutes to review and consider circulating or discussing at next readmissions team meeting.

In addition to the regulatory compliance rationale, improving transitional care for all patients is important for clinical quality, impact, and efficiency. The literature has established that current transitional care processes are lacking in almost every respect; each patient, regardless of diagnosis, payer, or presence of comorbidities/complexities should have a safe transition out of the hospital and into the next care setting. It is also more effective and efficient to improve standard care for all patients than to rely on incomplete and time-intensive methods to identify a subset of patients for whom to improve these basic elements of hospital-based care.

## THE INEFFICIENCIES OF CASE FINDING

A heart failure (HF) discharge advocate screens admissions hospitalwide daily to identify patients with a primary diagnosis of HF. The hospital has 10,000 admissions (adults) per year; 5 percent have a primary discharge diagnosis of HF and 20 percent have a secondary discharge diagnosis of HF. The discharge advocate was charged to find the 500 (5% of 10,000) patients who would ultimately be coded in hospital billing data as an HF diagnosis-related group (DRG). However, clinically there were at least 2,500 (25% of 10,000) patients with HF. Based on these calculations, the HF discharge advocate would need to screen and serve 500 to 2,500 patients annually, or 1 to 8 new patients per day, 365 days per year. The discharge advocate works 200 days per year and serves 2 to 3 new patients daily, or 500 annually, leaving 2,000 heart failure patients unserved by this program. Although clinically this is a valuable service for the 500 patients served by the HF discharge advocate, the relative readmission reduction for all heart failure patients is 6%.

	NUMBER	READMIT %	EXPECTED READMITS
HF patients served by discharge advocate	500	25%	125
HF patients not served by discharge advocate	2,000	22%	440
25% reduction by discharge advocate			25% * 125 = 31
Readmission reduction for all HF patients	565 - 31 = 534 = 6% reduction HF readmits		

This section explains how to implement reliable, whole-person transitional care for all patients, highlighting the practice changes that are particularly well matched to improve transitional care for Medicaid patients:

- Identify all patients at high risk of readmission;
- Assess all patients for clinical, behavioral, and social needs;
- Communicate with patients simply and effectively;
- Link patients to followup and posthospital services;
- Provide real-time information to receiving providers; and
- Ensure timely postdischarge contact with patient/family.

### ***Adapt Processes To Improve Transitional Care for Medicaid Patients***

The following table highlights standard transitional care processes to be inclusive of Medicaid patients' needs and the whole-person needs of all patients. The checklist of strategies below outlines the best practices described in this section and why these activities are particularly relevant for Medicaid patients.

STRATEGY	ACTIVITIES IMPLEMENTED	MEDICAID RELEVANT ADAPTATIONS
<b>1. Identify all patients at high risk of readmission reliably.</b>	✓ Create a high-risk readmission flag.	Automating flags or alerts reduce burden of screening for clinical staff. Some hospitals' data analyses suggest that all adult non-OB Medicaid patients are at "high risk" of readmission: that is an easy alert to automate.  Automation promotes reliability.
<b>2. Assess whole-person needs, including social and behavioral health.</b>	✓ Use <b>Tool 9: Whole-Person Transitional Care Planning</b> to inquire about: (1) behavioral health issues; (2) housing, legal concerns, transportation, and food insecurity, and (3) other social, logistical, or personal issues that may need to be addressed to reduce readmission risk.  ✓ Interview readmitted patients to understand the factors that resulted in their readmission; address these factors in the new transitional plan.	When readmission risks are viewed through the lens of Maslow's hierarchy of needs, it is clear that efforts to reduce readmissions by optimizing self-management or long-term health status will fail for individuals with unmet fundamental survival needs. Medicaid patients are more likely to have unmet social needs that contribute to inappropriate utilization of services.

STRATEGY	ACTIVITIES IMPLEMENTED	MEDICAID RELEVANT ADAPTATIONS
<p><b>3. Communicate the posthospital care plan simply and effectively.</b></p>	<ul style="list-style-type: none"> <li>✓ Inquire about patients' and caregivers' priorities for posthospital needs. Address these priorities first.</li> <li>✓ Identify the "learner," also known as the "care plan partner," who may not be a friend or family member (e.g., health plan care manager).</li> <li>✓ Focus on three to five self-care messages and provide anticipatory guidance ("what to watch for and what to do").</li> <li>✓ Ask the patient/caregiver to repeat information to confirm understanding of self-care messages ("teach-back").</li> <li>✓ Provide written materials at the third grade reading level and in the patient's preferred language.</li> </ul>	<p>More information is not better information, especially for patients with low health literacy. The best information is delivered in small increments, repeated and clarified, and customized to be directly relevant to the patient's short-term needs.</p> <p>Engaging patients and caregivers to understand their needs and experiences helps establish rapport, which can facilitate more effective posthospital care. Many Medicaid patients may be socially isolated and their posthospital support network may be community-based or plan-based care managers or navigators.</p>
<p><b>4. Link patients to followup and posthospital services.</b></p>	<ul style="list-style-type: none"> <li>✓ Link patients to primary care.</li> <li>✓ Link patients to behavioral health.</li> <li>✓ Link patients to social services.</li> <li>✓ Consider bedside delivery of medications; procurement of common supplies such as glucometers; and transportation vouchers.</li> </ul>	<p>Patients experience barriers to obtaining needed medical supplies, accessing timely followup, and advocating for services, if needed. An effective transitional care plan will ensure these tasks are completed for Medicaid patients, based on the barriers and challenges of navigating the health care and social services system.</p>
<p><b>5. Provide real-time information to receiving providers, service agencies, and health plans.</b></p>	<ul style="list-style-type: none"> <li>✓ Complete discharge summaries at the time of discharge.</li> <li>✓ Notify primary care and behavioral health providers at admission and discharge.</li> <li>✓ Notify the Medicaid health plan prior to discharge.</li> <li>✓ Invite receiving providers to collaborate on the care plan.</li> <li>✓ Use <b>Tool 10: Discharge Information Checklist.</b></li> </ul>	<p>According to a 2016 Massachusetts study, 61% of adult Medicaid inpatients had a comorbid behavioral health condition. Patients with behavioral health conditions are at higher than average risk of readmission. Arranging followup with a behavioral health provider is a Medicaid-relevant adaptation to arranging followup care.</p> <p>Increasingly, hospitals will find that Medicaid adults in managed care plans have a care manager: remembering to collaborate and communicate with that resource is a Medicaid-relevant adaptation to communicating with relevant "receiving" providers of care.</p>
<p><b>6. Ensure timely postdischarge contact.</b></p>	<ul style="list-style-type: none"> <li>✓ Confirm patient's phone number while in the hospital.</li> <li>✓ Specifically ask where the patient will go after discharge; do not assume "home" is a permanent residence.</li> <li>✓ Ensure that the posthospital followup contact arranged is appropriate to the patient's needs.</li> </ul>	<p>Your readmission data analysis likely revealed that roughly 25 percent of all 30-day readmissions occur within 4 days of discharge and that about half of readmissions occur within 10 days of discharge. It is thus imperative to arrange for immediate support for patients in the first days following discharge to avoid readmissions.</p> <p>Posthospital followup contact needs to be adapted to be more successful for Medicaid patients: Ask for a backup number and contact person. Ask if they answer the phone or if they feel limited by minute constraints. Tell patients someone will be calling to check on them when they get home. Consider offering to text, which does not consume cell phone minutes.</p>

## **Reliably Identify All Patients at High Risk of Readmission**

As a result of your hospital-specific data analysis, you have identified a target population of patients at high risk of readmission. It is operationally very helpful to use data to identify patients who are part of groups with higher than the hospital's average rate of readmissions.

Your hospital's health IT department can create a flag on the ED tracker board or in the inpatient electronic medical record to identify to all users that a patient is known to be at high risk of readmissions. The health IT department can adapt and/or use the same flagging devices that are already in place, such as:

- Flag to identify patients who require isolation precautions or other infection control measures;
- Flag or icon to identify patients in payer-specific contracts, such as ACO, bundle, etc.; and
- Existing 30-day readmission flags.

The purpose of having an automated flag for high risk of readmission is to identify the patients who should receive augmented services while in the hospital and who may require posthospital transitional care services. An automated flag can create operational efficiencies, such as:

- Saving staff time in assessment; patients are identified based on known high-risk features.
- Automating consults that high-risk patients may benefit from, such as daily interdisciplinary care coordination rounds; social work consult; pharmacist consult; and consideration for palliative care evaluation.
- Populating "work lists" for staff in different services, reducing time in emailing, texting, etc., such as prioritized patient list for interdisciplinary rounds, notification lists for attending physicians, and notification lists for unit nurse managers.

### **IN PRACTICE: AUTOMATED FLAG CREATES EFFICIENCIES**

#### **Flag That Populates Work List Saves Hours a Day**

A hospital in Massachusetts has a 10-person team dedicated to improving care for patients with behavioral health conditions who present to the hospital. The model rests on navigators in the ED and in the inpatient setting being able to identify patients with behavioral health conditions. That way, initial engagement, assessment, and offer of posthospital continuation of care and support can occur before discharge.

For the first 6 months of the program, the nurse navigator assigned to engage with inpatients was spending 3 hours every morning reviewing each admission to med/surg to identify through the clinical record which patients had behavioral health conditions. The purpose of her job was to engage, assess, and facilitate continuation of care; no one ever intended a third of her day to be spent on case finding. The hospital prioritized the development of an automated flag to provide her with a list every morning at 7 a.m. of the target population patients. This returned 3 hours a day, or 15 hours of her week, back to clinical care.

## IN PRACTICE: IT NOTIFICATION FACILITATES NEW PROCESS

### IT Flag for Patients Discharged to Skilled Nursing Facilities

A hospital in Texas was focused on improving the transition for patients being discharged to skilled nursing facilities because their data demonstrated that one of the groups with the highest readmission rates at their hospital were all discharges to skilled nursing facilities. They intended to conduct a pharmacist-led medication reconciliation prior to discharge for this target population. Under normal workflow operations, this would be unreliably implemented, because discharges are usually hastened once a patient and SNF agree to the discharge disposition, there is a perception of lack of time, and the notification of the pharmacist would rely on busy floor staff.

The team developed an automated alert to the pharmacist once the case manager entered the discharge disposition of SNF into the record. The notification served several purposes: served as an alert for a transitional care service, saved the floor staff time in notifying the pharmacist, saved the pharmacist time in case finding, and generated a list of all patients who met “criteria” for the service, thus allowing measurement and process improvement.

## *Assess All Patients for Clinical, Behavioral, and Social Needs*

A large number of clinical, functional, social, and demographic features place patients at risk of readmission. As you work with staff to more consistently identify and address patients’ readmission risks, you may find that a preponderance of hospitalized patients have one or more conditions or needs that place them at risk for readmission. While it may seem overwhelming to identify “so many” patients with conditions and needs that place them at risk of readmission, consider how many risks go unidentified and unaddressed when systematic whole-person screening is not in place.

## STANDARD CARE INCLUDES PATIENTS WITH SUBSTANCE USE DISORDERS

Substance abuse is an example of a common comorbidity among hospitalized Medicaid patients that can cause hospital staff to feel that patients do not want to or cannot engage in their care. However, this challenge makes it especially important to redouble efforts to ally with patients who have current substance use disorders, because these patients will benefit from all elements of improved standard care. Although it may be tempting to disregard these patients due to a perception that they are not active participants in their health, these patients have numerous barriers to navigating care in the community.

The standard actions described in this section (e.g., conducting a whole-person risk assessment, engaging patients and caregivers, arranging for followup and services, and communicating with receiving providers) are equally relevant for patients with comorbid substance use. Readmission interviews of patients with active substance use have revealed that these patients report experiences similar to all patients: they were confused, had difficulty obtaining (medications, equipment), lacked reliable transportation, did not have primary care, needed alternative ambulatory access, were not offered referral to behavioral health services, or experienced barriers attempting to navigate the behavioral health system.

### **Ask Patients “Why” and What Their Needs Are**

A simple and often overlooked method of assessing patient-centered, whole-person needs is to ask the patient. Similar to the readmission review in Section 1, asking patients about what has brought them back to the hospital offers insights into root causes that can be addressed through hospital-based transitional care processes. In this context, asking patients about why they came to the hospital, regardless of whether it is an admission or readmission, is a helpful standard practice.

Asking patients why they came to the hospital can sometimes reveal very specific, concrete, and possibly straightforward needs to address. Many avoidable readmission stories are rooted in misunderstandings or difficulties that patients have accessing timely care in the ambulatory setting. It is essential for a readmission reduction team and clinical staff to view readmissions through a lens that includes readmissions or admissions as straightforward “failures” to access needed services and supports in the community setting, rather than seeing all readmissions as either medically essential or due to a failure on the patient’s part.

#### **IN PRACTICE: LISTENING TO THE PATIENT**

##### **Insights from Asking “Why”**

A 53-year-old man with HIV/AIDS presented to the hospital with a chief complaint of “unable to walk” and was promptly admitted to the medicine service. The next morning, once the medical team reviewed all his labs and vitals and noted he appeared to be clinically stable, the attending asked the patient to restate “why” he presented to the hospital. The patient very clearly explained why he ended up in the hospital: he had run out of his gout prevention medication and his inability to bear weight on his leg was simply a result of a gout flare. The patient was seeking local steroid treatment for the flare, which he had had in the past. Because he presented with the label of HIV/AIDS and had been recently hospitalized, he was admitted for an issue that could have been managed for him as an outpatient.

### **Specifically Inquire About Basic Needs and Factors That Affect Self-Care**

The social, economic, and geographic conditions in which individuals live have a profound impact on individuals’ health status. Hospital staff often consider these “social needs,” such as food and shelter, beyond the hospital’s scope of practice or ability to influence. When readmission risks are viewed through the lens of Maslow’s hierarchy of needs, it is clear that efforts to reduce readmissions by optimizing self-management or long-term health status will predictably fail for individuals whose pressing fundamental survival needs are unmet.

Prompt recognition of complex nonclinical (“social”) needs can greatly affect the likelihood that those needs can be addressed, rather than deferred, prior to discharge. Hospital providers should inquire about *social supports, economic constraints, coping strategies, self-management capabilities, and social support networks*. This task will often require going well beyond the brief “social history” that is contained in the physician’s admission history and physical. Developing such an assessment is part of the professional skill set of social workers. Engaging a social worker as part of the inpatient quality improvement team is recommended.



To conduct a whole-person assessment:

- Inquire about housing, legal concerns, transportation, food insecurity, financial stress and insecurity, and personal safety;
- Inquire about substance use or mental health needs and whether the patient is in treatment;
- Inquire about whether the patient is newly enrolled in Medicaid;
- Link patients to the appropriate referrals and resources to address those needs; and
- Populate and update a list of Medicaid-relevant resources to address these needs.

**Tool 9: Whole-Person Transitional Care Planning** is designed to help hospital staff identify essential basic needs and social complexities and facilitate effective and timely referrals to community and payer-based resources. This information can be used (1) to directly address the issues identified by the patient/caregiver; (2) observe and learn more about the patient’s understanding of his or her condition, ability to navigate the health care system, and engagement in self-advocacy and self-management; and (3) identify broad themes in common root causes of readmissions to be addressed across the board.



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### TOOL 9: WHOLE-PERSON CARE PLANNING

**Purpose:** To reliably identify whole-person patient needs and assist in addressing those needs.

**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 readmissions champion to test, adapt, and incorporate into existing workflow with frontline staff.

**Time required:** Incorporate into regular discharge planning assessment and referrals.

### Contextualize the Present Illness Using Utilization History

The initial assessment at the time of hospital admission is of critical importance to setting the diagnostic, therapeutic, and transitional care plan for a patient. It is during the first hours and days of a hospitalization that the major issues and needs of a patient are identified; the rest of the hospitalization is frequently the time that those needs are addressed. It is difficult to introduce additional needs, especially complex social needs, toward the end of a hospitalization, precisely because they are complex and often cannot be addressed with limited time. The earlier in the hospitalization these social needs are recognized, the more time there will be to explore options for addressing them.

The initial assessment, including the physician’s history and physical, must be conducted using the best and most complete medical and social information available. Although this statement may seem self-evident, often hospital-based physicians assess the patient’s hospital-based needs only in the context of information that is immediately available to them. When hospital-based physicians do not have ready access to longitudinal information, patients’ symptoms may be interpreted as new or serious enough to warrant hospital-level evaluation when in fact they are much more chronic, recurrent, or otherwise not as straightforward as the “chief complaint” may

suggest. This kind of assessment is important for any “index” hospitalization, but particularly so for readmissions. Placing the patient’s presentation in the context of a recent hospitalization is essential to guide immediate inpatient plans and to understand what failures of the ambulatory or postacute care settings led to an unplanned return to the hospital setting.

By working with incomplete information, hospital-based providers risk re diagnosing known conditions, departing from established treatment plans, or failing to address the original barriers that kept patients from following through with a previously developed care plan. Even though collecting complete information is initially more time consuming, it is better clinical care and ultimately the most effective way to understand patients’ needs and expectations. Conducting this whole-person assessment will allow staff to use the full course of the hospital stay to address needs, explore expectations, and craft a more comprehensive ambulatory-based strategy for accessing care in the future.

To best use existing information on the patient:

- Ask the patient about hospitalizations and ED visits in the past 6-12 months;
- Consistently obtain medical records from other facilities;
- Use prior utilization history and care-seeking patterns to inform the assessment ; and
- Take a longitudinal view of patients, place their hospital utilization in the context of other care-seeking (or avoiding) patterns, and use this information to inform the care plan.

## ***Communicate With Patients Simply and Effectively***

### **Engage Patients and Caregivers in Postdischarge Planning**

Engaging with patients and their caregivers to understand their needs, experiences accessing care in the community, and perspectives on what they need to avoid future hospitalizations is a useful avenue for establishing a meaningful therapeutic alliance. Establishing such an alliance will result in more effective identification of posthospital needs, which will lead to more comprehensive and realistic transitional care plans. Understanding the real or perceived barriers that patients and their caregivers will encounter in the postacute or community-based setting will help hospital-based providers to adopt a more proactive, advocacy-based approach to ensuring that followup-services are arranged before the transition from the hospital.

### **Address Patients’ Priorities First**

Transitional care social workers report that their posthospital followup efforts are most successful when approached from the perspective of first addressing the patients’ priorities. The BRIDGE model of transitional care is rooted in the social work discipline. BRIDGE care coordinators always start every interaction with an inquiry about the patients’ needs and priorities. They address those priorities before moving into elements of transitional care needs that may be part of the clinician’s agenda.

Two excellent resources to reference in your hospitals’ efforts to effectively engage patients and caregivers include the AHRQ Guide to Patient and Family Engagement<sup>22</sup> and the United Hospital Fund’s Next Step in Care Web site (<http://www.nextstepincare.org/>).

### **Identify the “Learner” or “Care Plan Partner”**

During the process of interviewing and assessing the patient, it is important to identify whether the patient himself or herself is the primary “learner,” has a “care plan partner,” or needs one identified. For various reasons, patients may not always be the most receptive or appropriate “learner” of care plan information. Similarly, Medicaid-focused readmission reduction teams have found it wise to consistently identify a “care plan partner” in all cases, as having an additional point of contact provides the team with a better ability to successfully follow up with the patient—or care plan partner—after discharge.

Although providers always work to engage directly with patients to emphasize the critical importance of active self-management for long-term healthy living, some patients may not be ready or willing to engage in these conversations. But they may have friends, family, or other support people who are highly motivated to receive these instructions.

The “care plan partner” is a person of the patient’s choosing, recognizing that primary support people exist in a variety of familial, nonfamilial, and cultural constructs. Identifying these learners will increase the probability that this critical information will be delivered to a person of relevance in the patient’s life to benefit posthospital recovery and followup.

For some individuals, especially those who may be socially isolated, live alone, lack significant connections, or live with behavioral health challenges or ongoing substance use, a community-based professional may be the appropriate “learner.” Consider actively involving the following individuals (with patient permission) with whom the patient may have an ongoing relationship as the care plan partner for individuals who lack other supports:

- Health plan care managers
- Social workers
- Behavioral health specialists
- Group home staff
- Nursing home staff
- Community-based case workers
- Health home navigators
- Peer supports
- Personal care attendants
- Community corrections officers
- Community health workers
- Lay health navigators
- Volunteer members of faith communities

This approach will foster cross-continuum collaboration, help establish a longitudinal care plan, and help them achieve their care management goals on behalf of their client.

### **Use Teach-Back**

Teach-Back is a best practice strategy that providers can use to deliver customized, relevant information to patients and caregivers.<sup>23</sup> The technique helps providers deliver customized patient-centered information in manageable increments by:

- Verbalizing information to the identified learner, focusing on three to five messages.
- Providing an opportunity for clarification.
- Asking the patient/caregiver to repeat the information back to confirm understanding.
- Providing anticipatory guidance—“what to watch for and what to do.”

### **Customize Instructions To Be Directly Relevant to the Patient’s Short-Term Needs**

Your team’s readmission interviews will likely reveal that patients and caregivers often leave the hospital confused. Research shows that patients all too frequently cannot state why they were in the hospital, what medications they should take, and what symptoms they should watch for in the days after discharge. At least part of the solution lies in providing person-centered, plain-language, customized information and instructions for patients.

The evidence for the need for change comes from your patient interviews: if patients are confused, the information they received is not effective. Health literacy findings emphasize that more information, and more detailed information, is not better information. The best information is delivered in small increments, repeated and clarified, and customized to be directly relevant to the patient’s short-term needs.

#### **PATIENTS WHO LEAVE AMA NEED SIMPLE, KEY INFORMATION**

When patients want to leave the hospital prematurely (“against medical advice”), it is a challenging and often emotionally charged interaction. In these circumstances, it may be difficult or impossible to deliver all elements of a complete transition in care. However, it is often feasible to use the few minutes of the interaction to verbalize key information, keeping the advice to three to five key messages, and to confirm understanding. Furthermore, providers can attempt to identify a receptive “learner” if it is not the patient. Finally, ensure patients can obtain medications and make arrangements for urgent followup.

### **Keep Written Information at an Elementary Reading Level**

Too often, discharge paperwork and patient education materials are dense, generic, and written at an inappropriately advanced literacy level. They provide little to no anticipatory guidance other than the phrase, “Call 911 or return to the ED with any of the following...” Project RED has developed an “[after hospital care plan](#)” that is written at an elementary reading level and contains essential basic self-management information, including a chart listing medications and when to take each.

Other hospitals have recreated similar written materials with the following features:

- Is written at third or fourth grade reading level;
- Uses the patient's preferred language;
- Includes the reason for hospitalization;
- Includes a plain language list of medications, doses, and times to take them;
- Includes dates and times of followup appointments with phone numbers of the offices; and
- Includes symptoms to watch for, what to do about them, and whom to contact (including name and number) if symptoms arise.

In addition, AHRQ's [Health Literacy Universal Precautions Toolkit](#) has detailed information about health literacy best practices.<sup>23</sup>

### HEALTH LITERACY FOR MEDICAID PATIENTS

Social workers and discharge planners at the Virginia Commonwealth University (VCU) Health System have been working to improve methods for educating patients at the time of discharge. They have learned that written materials must be provided at the most basic reading level. For example, patients with an eighth grade education may only have a third grade reading level, while even those with a high school education may struggle to understand specific clinical and medication instructions, according to a recent pilot study conducted by the VCU clinical team. They received feedback that some patients have no idea why they are taking certain medications, what side effects to look for, when they should take medications, and what foods to avoid when taking the medications (including the impact of using over-the-counter drugs). According to the American Medical Association, a good way to address Medicaid patients with limited reading comprehension in a nonthreatening manner is to ask, "How comfortable are you with your reading skills?"

### *Link Patients to Followup and Posthospital Services*

Reliable identification of high-risk patients and assessment of their 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 systems a hospital has in place to execute a safe, effective transition is the most important feature of a successful readmission reduction program. A successful system will anticipate needs in the posthospital setting and ensure that followup, services, monitoring, and other supports are in place to support stable recovery and access to care in the community, which will help minimize the need for readmission.

### **Connect Patients Without Primary Care Providers to Clinicians and Resources in the Community**

Patients without primary care physicians may be given a physician referral number and instructions to follow up with a physician in 1 to 2 weeks. This approach is not an effective way to ensure that Medicaid patients are established with a primary care physician and receive timely posthospital followup. This task may be difficult for some individuals to sequence and execute, especially when barriers in the process arise.

For example, patients who call the referral number may find that few physicians accept Medicaid patients. Patients who find a physician to follow up with may encounter a much longer wait for a “new patient” appointment and have no option to be seen within 1 to 2 weeks. These barriers to getting established with new providers for Medicaid patients can be expected to worsen as the number of newly insured individuals already exceeds 8 million nationally, all of whom require new primary care physicians.

Hospitals serious about reducing readmissions have an interest in directly facilitating referrals and followup for hospitalized Medicaid patients. It is significantly more feasible for clerical and clinical staff in hospitals to advocate for early followup of patients in order to avoid readmissions. Cross-continuum team partners can help establish efficient processes for connecting patients with primary care in the community. High-volume Medicaid practices can be particularly helpful, such as resident clinics, Medicaid medical homes, behavioral health homes, Medicaid plans, community health centers, and federally qualified health centers.

It is a best practice to schedule a primary care followup visit prior to discharge. In some States, such as the transition of care model for Medicaid in New York that is part of the Delivery System Reform Incentive Program (DSRIP), it is a requirement. Because this has been an ad hoc and inconsistent practice, this time-consuming task has often been attempted by well-intended discharge planners and hospitalists.

As this becomes a standard expectation for all patients, hospital clinical staff should be completely relieved of scheduling. Each hospital will need to develop a new system to assign scheduling of postdischarge followup appointments to the staff most appropriate for the task. By systematically delegating scheduling of postdischarge followup appointments to a specific nonclinician role, that team can and will develop the local knowledge, systems, and skills to get the job done efficiently and effectively.

## **IN PRACTICE: ACCESS CENTER SCHEDULES APPOINTMENTS**

### **Let the Experts Schedule Appointments**

Temple University Hospital lets people with the knowledge and resources to make effective followup calls check up on patients and help them make appointments. In 2013, Temple University Hospital's Access Center scheduled about 20,000 appointments, including followup appointments. Under the management of the vice president for clinical integration, the Access Center expanded their core competencies to make posthospital followup phone calls, including scheduling followup appointments.

The Access Center staff are far better equipped than patients to make followup appointments, because the staff can see all the patient's records, have built relationships with primary care providers, and have their best back-office contact information. The Access Center relies on the inpatient nursing teams to get the patient's contact information for the 72 hours after they leave the hospital. The Access Center makes three attempts to reach each patient within 48 hours of discharge to home.

In addition to setting up appointments during these calls, staff ask about patient satisfaction and how the patient is doing. If necessary, Access Center staff can escalate the call to a nurse to answer clinical questions. By removing many of the barriers patients experience in making followup appointments, Temple University Hospital's Access Center can provide better access to followup care.

## **Ensure That Patients Have or Can Obtain Medication, Supplies, and Transportation**

A particularly challenging and error-prone component of care during transitions between settings is ensuring that medication recommendations are accurate and clearly communicated to patients, caregivers, and outpatient providers. Extensive [toolkits](#) and best practice recommendations have been authored on the subject of medication reconciliation and medication therapy management, and they are invaluable components of readmission reduction efforts.<sup>24</sup>

Medicaid-specific medication issues are unique in several interesting ways. First, Medicaid beneficiaries generally appear to have better access to prescription medications than the Medicare fee-for-service population due to coverage policies. However, it is important for hospital-based staff to be aware of ways coverage policies can limit Medicaid patients' ability to obtain recommended medications. For example:

- States may limit the number of prescriptions that can be filled per month. It is essential for hospital-based prescribers to be aware of this policy so that they can prioritize essential prescriptions or advocate with the agency for exceptions.
- Hospital-based prescribers are rarely sensitive to medication formularies, which leaves the work of alternatives or substitutions to outpatient providers. Patients who cannot afford prescribed medications may wait until scheduled followup appointments to bring this issue to the attention of their physician, which allows a lapse in medication regimen.
- Hospital-based prescribers are rarely involved in filling out prescriptions prior to authorization paperwork, which creates another barrier for patients who present to pharmacies and learn the medication is not authorized.
- Copayments, even when nominal, present financial barriers to obtaining medications.
- Transportation or other logistical barriers to physically obtaining medications are common and can be mitigated by providing bedside delivery of medications prior to discharge.

In addition, patients experience barriers to obtaining needed medical supplies postdischarge. Patients may need scales, glucometers, nebulizers, and other devices but may have no idea how to obtain these supplies if the hospital does not facilitate this procurement. Transportation is a frequent challenge, not only to get to and from medical appointments, but also to the pharmacy, medical supply provider, physical therapy, behavioral health treatment, and other treatment venues. To get around these barriers, hospitals should consider procuring common supplies, such as glucometers, nebulizers, and scales for patients, and providing transportation vouchers.

## ***Provide Real-Time Information to Receiving Providers***

Community-based providers are rarely notified when their patients are hospitalized and even more rarely receive real-time information about the hospitalization and posthospital care plan early enough for the information to be clinically helpful. Outdated practice norms and medical staff guidelines that require discharge summaries to be completed within 30 days of discharge are not aligned with the need for improved collaboration between “senders” and “receivers” at times of transition.

Best practices include audited requirements that physicians complete discharge summaries within 24 hours of discharge. Other informal collegial practices include contacting the primary care physician at the time of admission and at the time of discharge via email, text, or phone to

provide a brief update and invite collaboration on the plan. This communication can also greatly facilitate a posthospital appointment, as physicians may be able to identify flexibility in their schedules that office staff cannot otherwise find.

In addition to communicating with the primary care physicians, it is important to communicate with patients' other relevant specialists (e.g., HIV physicians), behavioral health providers (especially psychiatric medication prescribers if medications have been adjusted), community-based care managers, and Medicaid health plan care managers.

**Tool 10: Discharge Process Checklist**, adapted from the CMS COPs, provides guidance regarding the necessary information that should be shared with receiving providers, as well as how that information should be acquired and used.



### TOOL 10: DISCHARGE PROCESS CHECKLIST

**Purpose:** Provide updated guidance to readmission reduction teams for updating discharge processes, based on CMS documents.

10

**Description:** This tool, adapted from the CMS 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.

## *Ensure Timely Postdischarge Contact With Patients*

The readmission data analysis (Section 1) likely revealed that roughly 25 percent of all 30-day readmissions occur within 4 days of discharge and that about half of readmissions occur within 10 days of discharge. It is imperative to arrange for immediate support for patients in the first days following discharge.

Hospital teams often interpret posthospital “followup” as synonymous with “primary care physician appointment.” This is because the shorthand “followup” has, for years, meant followup with the physician in the office.

The past several years of successful work to reduce readmissions has significantly expanded the concept of posthospital followup. The value-added service is referred to here as “**followup contact**”: not limited to a physician, not limited to a billable appointment, and not limited to an office. Patients may benefit from or require followup contact with a primary care physician, specialist, behavioral health clinician, primary care nurse, (non-primary care) in-home doctor or advanced practice nurse, transitional care worker, or care manager from a practice, plan, accountable care organization, bundled payment provider, or patient-centered medical home. In skilled nursing facilities, posthospital contact would include nurse or provider encounters.



Posthospital followup contact might be made in person at a scheduled office visit, in person at an unscheduled drop-in nursing visit, or in person in the community or in the home. It may be made via phone, text, email, or face to face via video conferencing.

Consider a broader view of posthospital followup contact. The extensive examples of successful efforts in diversifying the operations in terms of who, how, when, and why posthospital followup contact occurs are reflected in practices observed by numerous types of providers. These include accountable care organizations, bundled payment providers, patient-centered medical homes, behavioral health homes, CMS Community-based Care Transitions Program, and other large-scale State delivery system reform efforts.

When implementing posthospital followup contact, consider:

- Who can provide posthospital followup contact?
- How can that contact be delivered?
- When should that contact occur?
- What is the purpose of posthospital contact?

QUESTION	POSSIBLE REPSONSES
Who can provide followup contact?	Hospital based staff, primary care provider-based staff, social service agency staff, behavioral health clinic staff, health home, managed care plan care manager. By role, type, any of the following: pharmacist, nurse, social worker, community health worker, care manager, hospital call center.
How can followup contact be delivered?	In person in office (discharge clinic, primary care, behavioral health home), in person in home, in person in postacute care, face to face via teleconference, via phone, or via closed-loop text, email, or portal message.
When should contact occur?	Within 48 hours of discharge, consistent with practices of accountable care organizations, bundled payment providers, Community-based Care Transitions Program, patient-centered medical home, and others.
What is the purpose of followup contact?	General wellness check; general review of plan, medications and whether obtained, and services expected and whether initiated; confirmation of medical appointment, logistical feasibility, including ability to get there, and reminder to “call me first” with any questions.

## Reliably Implement Processes

Many hospital teams implement these best practices on a limited set of patients or implement them based on staff availability. However, the reliable implementation of these practices—every time, for all patients—is the best way to ensure the greatest clinical impact and efficiency. Your hospital team can monitor the reliability and effectiveness of your processes using **Tool 6: Operational Dashboard** (see also Section 3).

To support reliable implementation, you may want to:

- **Integrate enabling tools and technologies.** Leverage existing tools and technologies to support changes to the workflow. For instance, this section described the use of flags to reliably identify all patients at high risk of readmission; you may also use technology to standardize the whole-person needs assessment as part of the electronic medical record to ensure its consistent implementation.
- **Update or create written standard operating procedures for transitional care.** These written procedures guide the practices of hospital staff and serve as a reference tool for staff to better understand implementation of hospital practices. These procedures should be aligned with the CMS Discharge Planning Conditions of Participation and any additional enhancements your hospital may choose to add.
- **Develop a revised workflow, roles, and responsibilities.** Updating and expanding transitional care processes to incorporate best practices, serve an expanded set of patients at high risk of readmission, and focus on effective and timely linkage of posthospital services and supports represents new work for the organization. As the person in charge of reducing readmissions for the organization, you alone cannot make all the changes needed to establish, test, measure, analyze, improve, and strengthen the transitional care system in the hospital. You will likely need the combined efforts of numerous individuals in a variety of departments across the organization. You may want to articulate the roles and responsibilities of those who play a role in implementing the readmission reduction strategy and improving transitions of care.
- **Develop and deploy training materials.** The updated transition of care processes will require training staff in a variety of departments and disciplines. Developing a training curriculum and strategy may prove useful to educating and engaging clinical staff in the new processes. Training needs to emphasize why changes to responsibilities are necessary, how the revised portfolio of staff responsibilities collectively contribute to the hospital's goals of reducing readmissions, and what specific responsibilities have changed.

Improving transitional care processes across a complex organization is incredibly challenging and is a journey, not just a “project.” The work of improving transitional care and reducing readmissions is the work of health care delivery transformation: working to make standard, day-to-day care processes more effective, efficient, high quality, and person centered.



## SECTION 5: REACH OUT TO COLLABORATE WITH CROSS-CONTINUUM PROVIDERS

### WHO SHOULD READ THIS SECTION?

This section targets department directors and managers who are empowered to initiate and support formal and informal collaborations with other organizations, including behavioral health, social services, and Medicaid managed care plans' care management departments.

### KEY POINTS

- CMS regulations require hospitals to demonstrate that they are aware of the capabilities of postacute and community-based services, including services for Medicaid patients.
- Many hospital teams perceive that resources in their communities are scarce. However, many community agencies wish hospitals would refer patients more frequently for the services they can provide.
- To effectively link patients to services, it is essential to cast aside the assumption that no services are available and refresh an inventory of clinical, behavioral, and social services.

### KEY ACTIONS

#### Expand your cross-continuum partnerships to include Medicaid-relevant providers

- Identify providers and agencies who can meet Medicaid patients' needs and the whole-person needs of all your hospital's patients. Use **Tool 11: Community Resource Guide** to create a community resource directory and quick reference sheet.

#### Identify and collaborate with care management entities

- Identify the entities that provide care management, including managed care organizations, patient-centered medical homes, health homes, behavioral health homes, accountable care organizations, and other health and social service agencies.
- Reach out to five to eight care management entities from this inventory to inquire about how your hospital staff can better collaborate with and more effectively link patients to them.

#### Improve "referral pathways" to ensure timely and effective linkages to services

- Use **Tool 12: Cross-Continuum Collaboration** in your efforts to:
  - Prepare data and questions to inform a strategic discussion.
  - Make specific requests to improve the volume and timeliness of patient referrals.
  - Test and refine process improvements.
  - Measure the reliability and effectiveness of the processes.

#### Collaborate with cross-continuum partners to address key gaps in services

- Work with partners to identify persistent gaps in services.
- Collaborate across settings and with payers to address gaps in services.

## REACH OUT TO COLLABORATE WITH CROSS-CONTINUUM PROVIDERS

### *Initiate Collaboration With Cross-Continuum Providers*

The best transition out of the hospital is only as good as the “reception” into the next setting of care. Effective, timely linkage to clinical and social services is an essential component of reducing readmissions.

*“We would be thrilled if someone from the hospital called us.”*

CMS’s policies signal a clear expectation that hospitals are in a position to lead delivery system transformation in their communities. CMS policies that focus on reducing readmissions, such as readmission penalties and value-based purchasing programs and the proposed Discharge Planning Conditions of Participation, all state or suggest that the hospital is charged with delivery system redesign. Hospitals need to identify and convene clinical, behavioral, and social service providers; work to align health with other social and human services; and optimize referrals and handoffs between the hospital and existing services.

CMS also encourages hospitals to lead and actively participate in efforts to identify and better coordinate among providers and services that do exist, identify gaps in services, and work to develop capacity to address these gaps. These activities are consistent with the initiatives of the Quality Innovation Networks that are under the Quality Improvement Organization program and the newly developed Accountable Health Communities demonstration.

### **Identify Community Resources**

Many hospital teams perceive that resources in their community are scarce, even though many community agencies wish hospitals would refer patients more frequently for services they can provide. While it is objectively true that too many communities lack essential services, hospitals that have implemented the advice given in this guide, including safety net and high-volume Medicaid hospitals, have improved their understanding and identification of the resources and services available to patients in their communities.

*“You need to understand; we have no resources in our community.”*

To effectively link patients to services, the first step is to **cast aside the assumption that no services are available**. When hospital teams look for clinical, behavioral health, and social services, they find more resources than were expected. It is also important to understand what types of “wraparound services” are available from Medicaid health plans to address basic needs in the context of patients’ health care needs.

It is understandable that hospital providers would not necessarily have an up-to-date and working knowledge of the completeness of resources in their community. In fact, it may be quite challenging to try to do so. Services in the community are ever changing, as funding may vary, eligibility rules change, and waiting lists may pose a barrier to timely access. All these factors contribute to making what is available for patients in your community a challenging and time-consuming undertaking. However, if you challenge your hospital team to identify the services that do exist, you will likely find many more options than you previously knew of.

This section offers several recommendations for strengthening your hospital's ability to effectively link patients with the range of clinical, behavioral, and social service needed to improve transitional care and reduce readmissions:

- Expand your cross-continuum team to include Medicaid-relevant clinical and social service providers.
- Identify and collaborate with patients' care managers from practices, plans, and agencies.
- Develop new "referral pathways" to ensure effective and timely linkages to followup and services.
- Work with partners and stakeholders to identify and fill gaps in services.

### **Expand Your Cross-Continuum Partnerships To Include Medicaid-Relevant Ones**

Over the past several years, hospital-convened "cross-continuum teams" have developed primarily to meet the posthospital needs of the Medicare patient. As a result, we observe that hospitals' cross-setting partnerships most commonly consist of providers and agencies most suited to meet the needs of the older adult: skilled nursing facilities, home health, hospice agencies, and Area Agencies on Aging.

*"There are many resources in the city, but it can be hard to find them. We need to inventory them and collect this information in one place."*

Use **Tool 11: Community Resource Guide** to expand your readmission reduction efforts by identifying providers and agencies that are likely to meet Medicaid patients' needs and the whole-person needs of all your hospital's patients. Hospitals can readily expand their cross-setting partnerships to include Medicaid-relevant health care providers, and social service agencies, such as those listed below:

#### Medicaid-Relevant Clinical Providers

- Behavioral health centers
- Community health centers
- Behavioral health homes
- Resident physician clinics
- Patient-centered medical homes
- Substance use treatment centers
- Adult daycare centers
- Medicaid managed care plans

#### Medicaid-Relevant Service Agencies

- Health homes
- Group homes
- Housing authority
- Transportation providers
- County health departments
- Food assistance
- Legal advocacy assistance
- Peer support



## TOOL 11: COMMUNITY RESOURCE GUIDE

11

**Purpose:** To generate an updated list of community 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 two-part tool contains a community resource guide to identify community agencies offering services across a range of clinical, behavioral, and social domains and a 1-page quick reference version of this guide for frontline staff.

**Staff:** Social worker, to complete with community providers and agencies.

**Time required:** 12 hours initially. Take no more than 1 month to draft. Update periodically (e.g., once or twice a year).

## IN PRACTICE: NORTH ALABAMA COMMUNITY CARE'S RESOURCE GUIDE

### Gathering community resource information in one place

A Medicaid community-based care management agency in Alabama developed a resource guide to identify the community resources available to patients at the time of discharge to help address medical, housing, and other social needs. This resource guide includes organizational and contact information, by category, for a variety of services available to adults and children in their region.

By containing all the information in a single document, this community resource guide helps care coordinators transition patients out of the hospital efficiently with ready and comprehensive access to resources they may need to avoid readmission. Create a similar inventory for your community and periodically update it so that your staff can refer patients to posthospital services based on the needs they identify by using **Tool 2: Readmission Review**.

## IN PRACTICE: DEDICATED RESOURCE REFERRAL STAFF

### Linking patients to social support services in the community

Building on the partnerships developed with onsite community-based agencies, an academic safety net hospital in the South implemented a program to help patients meet their basic needs, such as food and fans. This trained volunteer-based program, staffed by college, nursing, and medical students, meets Medicaid patients while they are in the ED, rather than at the time of discharge.

This program helps address whole-person and basic needs to facilitate better health and reduce avoidable use of health care resources. This model, based on Health Leads, is the foundation of the CMS Accountable Health Communities model that seeks to systematically screen patients for health-related social needs and link patients to services accordingly.

## IN PRACTICE: NEW PARTNERSHIP WITH BEHAVIORAL HEALTH CENTER

A hospital had established a vibrant cross-continuum community coalition. The coalition was composed primarily of postacute and aging services providers. Together over the years, the coalition had developed a shared understanding of the opportunity to reduce readmissions, reviewed readmission data together, reviewed readmissions to identify root causes, and developed better processes for handing off patients from the hospital to postacute providers.

After several successful years and in response to new market incentives, the hospital expanded its focus from Medicare readmissions to all-payer readmissions. In the course of reviewing the composition of the cross-continuum team, the hospital recognized there were no behavioral health providers. The natural first choice was the large community behavioral health center.

The collaboration started with a meeting between the director of programs at the behavioral health center and the director of case management at the hospital. They arranged to begin monthly collaborative team meetings with the behavioral health center contact, ED case management, behavioral health crisis team, and inpatient psychiatry service to reduce inappropriate ED use and readmissions by:

- Gaining a better understanding of the behavioral health center's services;
- Establishing a key contact in each organization to facilitate collaboration;
- Sharing data by using the State health information exchange to notify both the center and ED/hospital providers when a behavioral health center patient entered the ED;
- Providing training in motivational interviewing for hospital staff who care for patients with behavioral health diagnoses;
- Making health center enrollment packets available at the hospital; and
- Creating individual care plans for high utilizers.

## *Identify and Collaborate With Patients' Care Managers*

Hospitals, especially safety net hospitals, are often strapped for resources to deliver high-touch services to their high-risk patients. A frequent source of untapped potential is existing care management, care transition, and other related services for patients from practices, plans, and agencies.

Identifying and collaborating with patient's existing care managers is a worthwhile enough endeavor that it has been singled out in this guide as a uniquely valuable set of partnerships. Benefits include:

- Reduced cost for the hospital and health care system.
- Allies to improve continuity of care.
- Reduced redundancy and confusion about the patient's care.
- Greater access to information about the patient's history.
- Greater access to resources, beyond what the hospital may know of or have access to.

The rapid expansion of care delivery redesign and alternative payment models has increased the availability of services intended to provide high-quality care at a lower total cost. In addition, investment in delivery system redesign is increasing through the private, public, nonprofit, and grant-making sectors. Therefore, it is worthwhile to reexamine the presence and prevalence of care management and other support services that may be available to your high-risk patients.

### **IN PRACTICE: COLLABORATING WITH THE MEDICAID CARE ORGANIZATION CARE MANAGER**

An urban high-volume Medicaid hospital in Chicago began developing emergency department care plans for high utilizers by starting with their top high utilizer, “Ellen,” who had been hospitalized 17 times in the past year. Ellen had chronic pain from a connective tissue disorder, uncontrolled diabetes, and related issues, including drug-seeking behavior, aggression, and reluctance to trust others. Despite numerous consults, multidisciplinary rounds, social work evaluations, and administrative attention, little progress was being made in Ellen’s care. The team thought there was nothing else they could do.

Acting on the recommendations of this guide, the readmission reduction team invited Ellen’s Medicaid care organization (MCO) care manager to collaborate on her care and work together to reduce future readmissions. The MCO care manager mobilized resources beyond what the hospital could offer, including physician home visits, therapist home visits, social work home visits, and physical therapy in the home. The care manager worked tirelessly to maintain regular contact with Ellen. After the initiation of this collaboration, Ellen had no additional readmissions. Given their successful collaboration, the hospital continued to work in partnership with the MCO care managers to develop care plans for the four next highest utilizers of medical and behavioral health services.

Inventory your community for the presence of the following programs, agencies, or organizations, which may indicate the presence of care management, social work, or navigator resources:

- Accountable care organization
- Patient-centered medical home
- Bundled payment initiator
- Health home
- Behavioral health home
- Medicaid managed care
- Medicaid behavioral health plan
- CMS-funded services from Center for Medicare and Medicaid Innovation demonstration initiatives
- State Innovation Model initiatives
- Duals-demonstration programs
- Medicaid Delivery System Reform Incentive Payment (DSRIP) programs
- Medicaid Delivery System Transformation Initiatives programs
- Local or national foundation grant-funded initiatives
- State agency-funded initiatives



- State behavioral health agency
- Housing authority or housing agencies
- Transition programs for individuals involved with the criminal justice system
- Peer support programs
- Faith-based organizations
- Volunteer organizations

By no means is it possible to keep track of all the providers and agencies that might provide care management, social work, or navigation services. But, in the pursuit of refreshing your readmission reduction team's understanding of the scope of services available to your patient population, it may be informative to conduct this inventory and raise awareness of potential resources for patients.

Identify five to eight of the organizations, providers, or agencies from the above list to work with to understand how to better leverage their efforts in the best interest of your shared patients. Inquire:

- How can hospital staff learn that the patient has a case manager from your organization?
- How can hospital staff identify the right point person to connect with from your organization?
  - Can the care management organization identify a single point of contact?
- When would your organization like to know that your patient/client has been hospitalized?
- How can hospital staff collaborate with your staff on the transitional care plan, specifically to arrange postdischarge contact?
- What type of service or support do you provide a patient/client after a hospitalization?

### **IN PRACTICE: COMMUNITY AGENCY-FUNDED TRANSITIONAL CARE NAVIGATORS**

An independent State commission funded a number of community agencies statewide to provide health care and social service navigators to individuals with chronic medical conditions who reside in certain ZIP Codes identified as having high rates of acute care utilization. Not all hospital staff were aware that these navigators existed, and some patients may not have known that they were eligible for navigator services.

Patients who were successfully linked to these services had very good outcomes. This is an example of a "nonclinical" State entity funding health-related supportive services. Programs like these should be part of a hospital's tapestry of available resources to consider when discharging patients to those targeted communities.

Increasingly, clinics and other large practices are becoming patient-centered medical homes. If a local health center is a patient-centered medical home, develop a process to involve the practice care coordinator in collaborating in the transitional care plan and to provide timely followup contact. These practices can support clinical coordination by providing the hospital with automated alerts that their patients have been admitted (not just discharged). See the example of “Coordinating With Local Health Center” for how admission notification can meaningfully improve the care provided in the hospital, as well as improve and ensure timely posthospital followup.

### **IN PRACTICE: PATIENT-CENTERED MEDICAL HOME “REACHES IN” AND TRANSITIONS THE PATIENT “OUT”**

A core competency of PCMH is to have a practice-based care manager. Among other things, the PCMH care manager is responsible for providing posthospital followup to reduce readmissions and re-engage the patient in care. It is helpful to know what the practice-based care manager does.

A PCMH-based care manager describes her process for providing transitional care to patients of the practice. On a daily basis, she starts her day by reviewing a list of the practice’s patients who have been seen in the ED or admitted to the practice’s affiliated hospital the day before. She calls all patients who were seen in the ED as a matter of course, without regard to age, payer, or diagnosis. She also calls all the patients who are admitted to the hospital, with the intention of working with the patient or caregiver to start to arrange for followup and coordination of care.

On behalf of her large hospital-affiliated group practice, she conducts this transitional care likely without the knowledge of the inpatient team. There would be an opportunity to create efficiencies for the inpatient staff if the inpatient staff were aware of the practices of the PCMH.

### **IN PRACTICE: COORDINATING WITH LOCAL HEALTH CENTER**

A large regional hospital tested a process for improved collaboration with the local community health center in the transitional plan of care for their shared, predominantly Medicaid, patient population. The hospital discovered that the clinic had a dedicated care manager, consistent with the patient-centered medical home model. Leveraging that resource, the hospital-based director of case management and the clinic-based care manager “ran the list” of hospitalized clinic patients the morning after they were admitted.

The clinic already had a process for identifying their patients after they were seen in the ED or after discharge. But in discussing ways to improve care transitions, they determined that discussing patients at the time of admission might be best practice. The hospital case manager noted how extensive the clinic-based care coordinator’s knowledge was of the whole-person needs and her ability to establish a plan for patients during their stay as well as postdischarge. Both the hospital and the community health center found this collaboration helpful and feasible.

## Develop New and Improved “Referral Pathways” To Ensure Linkage to Services

In some cases, simply identifying the presence of a service or support in the community will not suffice to ensure timely and effective linkage to that service. Resources are limited, and each organization has its own workflow and processes.

In many cases, busy hospital and health care providers might get frustrated or overwhelmed trying to work through other organizations’ eligibility criteria or intake processes. A structured series of discussions, based on specific requests and inquiries, can be effective to establish clarity around how to more effectively link patients to services.

As mutually interdependent but independent community organizations, it is appropriate to engage in a transparent data-informed planning discussion. The parties can explore the extent to which an organization can accommodate increased referrals for services, which services can be accommodated, and whether processes and workflow within that organization can be reworked to respond to requests for services within hours or days of discharge.

Consider working through the following steps as you prepare to approach a community service provider for a discussion about working together to better meet patients’ needs in the posthospital period.

### Prepare

Preparation is valuable to ensure that your collaboration is goal oriented and data informed. Understand the patient-related and logistical issues you are trying to address through this partnership.

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, how many target population discharges there are per day/week, and a description of your working understanding of which factors contribute to readmissions.
3. **Prepare questions** to learn more about the services they offer and their capabilities.

### Ask

Specific requests direct the conversation toward action. Be open to new ideas and relationships, as well as requests that may be made of your hospital team.

1. **Make a request – capacity:** Ask the provider/agency to consider whether they have capacity to accept a consistent volume of referrals for posthospital care. What volume of daily/weekly referrals could they absorb?
2. **Make a request – timeliness:** Timely posthospital contact is a priority, so ask the provider/agency to work with you on developing a reliable process to ensure linkage to posthospital services, optimally prior to discharge or within 1 to 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

Get started once you have a new process to try out. Start small to minimize wasted effort while still gaining enough operational experience to refine your process as needed.

1. **Test** 10 patients. Reflect:
  - How long did it take to identify 10 patients with a need for 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 the 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 with minimal 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.

## Reflect and Improve

Once you have tested 10 patients, you have enough operational experience to reflect on what you learned from the "test."

- How long did it take to identify 10 patients with a need for 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 be improved?

## Measure

As the entity accountable for readmissions, your work to identify and develop effective and timely referral pathways to posthospital social, behavioral, and other transitional care services is

focused on developing strategies that work. The only way to know whether the referral pathways are working is to measure performance. Measure the following aspects of the process until you feel the processes are working well:

**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] prior to discharge?
- Does the provider/agency staff report that 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] prior to discharge?

Decide whether to adopt, adapt, or abandon elements of this new, efficient, and effective “referral pathway.” Work with the partner organization to identify ways to continually improve the referral and linkage 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 with minimal wasted rework;
- Organization staff can effectively anticipate a start date for service delivery 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.

Build a portfolio of effective referral pathways to meet the timely posthospital needs of your patients at high risk of readmission. Create efficiencies for you and your staff by “batching” the types of needs and services and creating more direct, less time-consuming processes for linking patients to these services:

- Peer to peer support
- Community care management
- Community social work
- Full-service behavioral health support: substance use treatment, groups, therapy, prescribers
- Practices with integrated behavioral and somatic care
- Practices with care managers, such as PCMHs

- Legal advocacy
- Housing agencies
- Housing with services providers
- Aging services organizations
- Aging and disability resource centers
- Managed care organizations with care management, social services, “wraparound” services
- Health homes
- Capitated providers capable of addressing behavioral health and health-related social needs, such as Program of All-Inclusive Care for the Elderly, Senior Care Options, Medicaid MCOs, regional care organizations, ACOs, Medicaid ACOs, providers with plan-based risk-bearing contracts, Medicaid-contracted community care management organizations (e.g., Community Care of North Carolina, North Alabama Community Cares)

### IN PRACTICE: EMBEDDED LIAISONS TO PROVIDE DIRECT LINKAGES TO CARE

In 2015, a safety net hospital in Maryland identified a need to efficiently and effectively connect patients who lack primary care to a provider. The hospital partnered with a nearby federally qualified health center to co-locate FQHC liaisons in the hospital. These liaisons register patients who lack primary care physician with the primary care services and schedule a postdischarge appointment before the patient leaves the hospital.

This partnership provides increased access to primary care, effective linkage to primary care, and more timely followup care for patients discharged from the hospital. In return, it gives the FQHC an opportunity to engage new patients in care.



### TOOL 12: CROSS CONTINUUM COLLABORATION

12

**Purpose:** To help teams develop specific, effective, and timely linkage to services with cross-continuum clinical, behavioral, and social service providers.

**Description:** This tool assists with a series of structured discussions about how to more effectively link patients to cross-continuum provider services.

**Staff:** Readmission day-to-day champion.

**Time required:** 2 hours to review and apply recommendations.

## ***Collaborate With Partners To Redesign Care To Address Key Gaps in Services***

For some patient populations, entirely new approaches for managing chronic, recurrent, and urgent clinical issues will be needed. Other patient populations will need new approaches to meet essential survival and security needs to help stabilize clinical issues. These new approaches will require a higher level of collaboration and innovation distinct from interdisciplinary or cross-continuum coordination. Sometimes delivery system redesign is the most effective and cost-efficient way to manage resource-intensive root causes of readmission.

A clear example of this need is reflected in the efforts to reduce ED visits and readmissions for patients with sickle cell disease. Sickle cell disease is an illness characterized by pain crises that require urgent intravenous pain management and intravenous fluid administration. When treated promptly and appropriately, patients can be successfully cared for in a matter of hours rather than days in the hospital. Identifying the need to plan for and respond to patients in sickle cell crises in dedicated clinical settings is a known and effective intervention that can keep patients out of the emergency room and hospital when avoidable.

As illustrated by the two examples below, redesigned care is needed to achieve improved care at lower cost for this patient population. In the first example, the hospital and two regional Medicaid managed care plans collaborated to invest in comprehensive care management to improve quality and reduce avoidable acute-care utilization. In the second example, a different hospital and two of their regional Medicaid managed care plans collaborated to invest in a community health worker program.

### **IN PRACTICE: REDESIGNING CARE TO OFFER SICKLE CELL CLINICS**

Johns Hopkins Hospital and two Medicaid managed care plans established a sickle cell clinic. The Sickle Cell Center for Adults at Johns Hopkins uses an interdisciplinary approach to care, integrating primary care, hematology, social work, home visits, and nonclinical support services such as transportation for their patients. The Center partnered with two managed care organizations, Amerigroup and Priority Partners, to establish a per member per month fee to cover the services beyond direct health care, such as care coordination and case management. The clinic provides care urgently and efficiently to patients experiencing acute pain crises and provides more expert management. The clinic has achieved a readmission rate of 24 percent compared with benchmarks in the 30 to 50 percent range.

Similarly, the Medical University of South Carolina (MUSC) noted that sickle cell patients made up about 10 percent of admissions and 30 percent of readmissions, most of which were due to a small number of patients. MUSC began offering ED-like services in their university internal medicine clinic (e.g., IV hydration, pain management). A list of frequent sickle cell patients was given to the ED so that those patients could be sent directly to the clinic. Each patient would receive individualized care plans for acute and chronic care based in the internal medicine clinic instead of the ED.

## **Conclusion**

In conclusion, hospital-based readmission reduction teams should develop robust cross-setting collaborations with services and supports that exist in the postacute and community settings. Although it may seem that there are no services and supports in the community, be sure to look first. There may be clinical, behavioral health, and social services available that are well matched to meet the transitional care needs of your patients, but referral pathways and collaborative processes may need to be initiated or improved to more effectively use those services. Developing effective cross-continuum partnerships is not only an expectation of hospitals in the proposed updates to the Discharge Planning Conditions of Participation—it is the foundation of improving health care delivery across settings and over time.





## SECTION 6: ENHANCE SERVICES FOR HIGH-RISK PATIENTS

### WHO SHOULD READ THIS SECTION?

This section targets the people in charge of **designing** enhanced post-hospital transitional care services for high-risk patients as well as the person in charge of **implementing** those services.

### KEY POINTS

- Enhanced services describe services that go beyond standard care to address the clinical, behavioral, and social needs that place some patients at high risk of readmission. Enhanced services start during the hospitalization and continue in the days to weeks postdischarge, often for 30 days.
- The adult Medicaid population would benefit from adaptations to transitional care models tested on Medicare populations. The adaptations are those that better assess and meet whole-person posthospital transitional care needs, such as including social workers and community health workers as members of interdisciplinary care teams.
- A subset of high-risk patients are those with a personal history of repeated hospitalizations. These patients, referred to as “high utilizers,” appear to benefit from intensive efforts to identify the “driver of utilization” and address that driver—health care related or not—in order to slow a cycle of repeated hospital use.
- The emergency department is an important setting of care in which to reduce readmissions. Flags, alerts, care plans, and dedicated care teams can be used to safely and appropriately offer community-based support and followup as an alternative to readmission.

### KEY ACTIONS

#### Adapt transitional care services to better address “whole-person needs”

- Adapt models that strictly promote self-management skill development to include navigation, advocacy, direct linkage to services, and resources to meet short-term needs.
- Adapt programs that narrowly focus on disease management to include whole-person needs.

#### Develop new services to improve care for frequently hospitalized patients

- Understand high utilization as a symptom of an unmet clinical, behavioral, or social need.
- Identify the “drivers of utilization”: the person-centered root cause of utilization, as opposed to the chief complaint or admitting diagnosis.

#### Use care plans as a tool to improve care over time and across settings

- Develop care plans to improve clinical management, care coordination, and identification of clinical, behavioral health, and social services in place or planned.
- Be clear on the primary user, purpose, and elements of different types of care plans.
- See **Tool 13: ED Care Plan Examples** for reference in developing ED care plans.

#### Engage the ED in efforts to reduce readmissions

- Identify high-risk patients upon (re)presentation at the ED through automated flags.
- Develop strategies to support ED providers in making a decision to discharge a patient back into the care of the enhanced care team, as safe and appropriate.

## ENHANCE SERVICES FOR HIGH-RISK PATIENTS

### *Enhance Services for Patients at High Risk of Readmission*

For some patients, the best transition out of the hospital (as discussed in Section 4) and reception into the next setting of care (as discussed in Section 5) will not suffice to avoid readmission. Patients at high risk of readmission may benefit from additional services and supports in the days to weeks after a hospitalization. These additional services and supports are the subject of a burgeoning field of clinical and operational research, as health care providers seek to define what posthospital transitional care models are effective and cost-efficient to reduce readmissions for high-risk populations.

*“I think that there’s always going to be a group of folks that’s going to need somebody to help them. That’s never going to change.”*

For the purposes of this discussion, enhanced services are:

- Services that are **not provided to all** hospitalized patients as part of routine care;
- Services **offered to subgroups** of patients who are identified to be at “high risk” of readmission;
- Services that are delivered to the patient **after discharge**, often for 30 days;
- Services that are deployed at provider expense to improve care so as to reduce readmissions; and
- Services that are **delivered by** hospital staff or by contracted staff.

The term “enhanced” is used here to denote services that are not typically offered under fee-for-service payment models. The services described in this section represent a collection of the “enhanced” services that many hospital teams today are just learning about, testing, and expanding on.

Notably, what is considered an enhanced service for one hospital may be considered standard care in another hospital. Like many process improvement best practices that emerged years ago, such as Teach-Back and bedside delivery of medications, it is anticipated that the processes described in this section will become increasingly common among hospitals as delivery system transformation evolves.

A robust portfolio of readmission reduction strategies will likely include a set of enhanced services deployed for a number of target population groups. There may be, and likely should be, several target populations that your data analysis has identified as high risk for readmission.

For the purposes of this discussion, patients at high risk of readmission are:

- Identified in the data as having **higher than average** readmission rates;
- Identified based on the presence of certain **clinical, behavioral health, or social needs**;
- Identified on the basis of population readmission rates, such as **payer type** (e.g., duals, Medicaid adult nonobstetric) or **discharge disposition** (e.g., discharges to postacute care) or **high utilization**;

- Assessed to **not have sufficient or timely access** to posthospital services and supports, as through a payer, patient-centered medical home, or other accountable care entities; and
- Referred to as a **target population** for the deployment of enhanced services.

Enhanced services should be designed to meet the clinical, behavioral health, and social needs of each target population. Often, different models of enhanced services and different investments in staff to support different models are needed to address the root causes of readmissions for each target population. Consider the following examples of enhanced services that address the root causes of readmission for these data-informed target populations:

- Adult patients with sickle cell disease: An extended-hours ambulatory care setting capable of delivering timely and evidence-based clinical care for patients experiencing sickle cell crises;
- Adults with developmental or behavioral health needs who live in group homes: A dedicated clinical liaison assigned to collaborate with area group homes to help them develop strategies to address changes in clinical status and need for clinical evaluation that minimize reliance on the emergency department (ED) when an emergency is not present;
- Patients discharged to skilled nursing facilities for short-term stays: A transitional care liaison assigned to assist patients and their families/caregivers in the transition from skilled nursing facility to home; and
- Individuals with a personal history of 4 or more hospitalizations in the past 12 months: An interdisciplinary care team deployed to identify and address unmet clinical, behavioral health, and social needs that have resulted in a cycle of high utilization.

As you read this section, consider your hospital's high-risk populations and your hospital's readmission reduction goal. Also think about the short- and medium-term investments in transformation and capabilities your hospital is willing and able to make to be successful in value-based payment models. Because delivering enhanced services requires an investment of resources, it is important to engage in data-informed strategic planning to give the executive in charge of reducing readmissions a reasonable estimate of the expected impact of the enhanced services on readmission rates.

The previous sections of this guide provide the foundation for that strategic planning process (see Sections 1 and 2 and Tools 1-4), including:

- Quantification of the all-payer and payer-specific discharge volume;
- Quantification of the all-payer and payer-specific readmission volume and rates;
- Identification of target populations with higher than average readmission rates;
- Identification of target populations with high absolute numbers of readmissions;
- Inventory of existing efforts in the hospital that can be leveraged without additional expense;
- Inventory of existing resources in other entities that can be leveraged without additional expense; and
- Identification of person-centered factors that result in readmissions, so as to not overmedicalize solutions.

See Section 3 for guidance on estimating the impact of an enhanced service on readmission rates and potential savings. Expect that a well-designed and effectively implemented enhanced service will reduce readmissions by 20 percent for the target population, which is aligned with minimally accepted effects of other transitional care and readmission reduction models and efforts.

The remainder of this section describes enhanced services and other emerging practices that are proving useful to hospital teams in their efforts to reduce readmissions for patients at high risk:

- Adapt transitional care services to more effectively address whole-person needs;
- Develop new services to improve care for frequently hospitalized patients (“high utilizers”);
- Use care plans as a tool to improve care over time and across settings; and
- Engage the ED in readmission reduction strategies.

## **Adapt Transitional Care Services to More Effectively Address Whole-Person Needs**

*Transitional care services* are intended to deliver services and supports to patients at high risk of readmission so as to reduce the 30-day readmission rate of that high-risk population. Transitional care services are a set of services that start before discharge and continue after discharge for a defined timeframe in the posthospital period. Because most incentives (and penalties) focus on the 30-day readmission rate, many transitional care programs deliver services for a 30-day time period.

Two well-known transitional care models have been developed and tested in the older adult, Medicare population:

- The Transitional Care Model, developed by Naylor and colleagues;<sup>25</sup> and
- The Care Transitions Intervention, developed by Coleman and colleagues.<sup>26</sup>

*“It’s always been about social work fundamentals: meeting the patient where they are, counseling, teaching, educating. To expect people who are already working and living at a deficit to be able to readily navigate these systems is just unrealistic.”*

These evidence-based models, developed to reduce 30-day readmissions for Medicare beneficiaries, have been shown to reduce readmissions by 20 percent in randomized controlled trials. The models have subsequently been deployed at much larger scale and expanded to populations other than the original trial populations. The driving force behind the large-scale testing and implementation of these and similarly designed transitional care models was the Centers for Medicare & Medicaid Services (CMS) Community-based Care Transitions Program (CCTP), which launched in February 2012 and is scheduled to run for 5 years.

CCTP provides useful lessons for providers seeking to adapt transitional care models to address Medicaid patients’ posthospital needs to reduce readmissions. In CCTP, hospital and community-based agency partnerships implemented evidence-based transitional care models to address root causes of readmissions among specific high-risk target populations of Medicare fee-for-service beneficiaries. Of particular relevance to adapting transitional care service models

to better meet the needs of the adult Medicaid population, some CCTP sites identified several needs that transitional care workers frequently encountered:

- Behavioral health comorbidities,
- Economic stress,
- Food insecurity,
- Social isolation,
- Lack of transportation,
- Lack of in-home caregiver support, and
- Lack of urgent or timely access to a community-based physician.

Some CCTP sites used lay (nonclinician) coaches, nurse coaches, social workers, pharmacists, and advanced practice nurses as transitional care service providers. Several teams budgeted resources to address common health-related social and economic needs, such as prescription copayment assistance, transportation assistance, and short-term personal care assistance.<sup>27</sup>

Because many hospitals began their readmission reduction efforts with the Medicare population, they have developed high-risk transitional care programs for Medicare-specific diagnoses. For example, many hospitals have developed transitional care services targeted at Medicare patients with heart failure who are discharged to home. In this case, the transitional care service would naturally focus on posthospital management of heart failure and services such as:

- Medication reconciliation in the home setting, with specific attention to dose changes;
- Self-management with regard to diet, fluid intake, medications, symptom, weight and fluid status monitoring;
- Scheduling of appointments;
- Referral to a dedicated heart failure clinic; and
- Use of a nurse-led diuretic titration protocol.

The transitional care providers for this team might include a heart failure advanced practice nurse, a nurse care manager, a self-management coach, and a pharmacist. These transitional care services are likely helpful for heart failure patients of all payer types, not limited to Medicare fee-for-service beneficiaries.

When considering the transitional care needs of the adult Medicaid population, you will likely encounter clinical, behavioral health, and social needs among your high-risk target populations. Addressing the “whole-person” needs of patients—clinical, social, behavioral health, and logistical—is essential to effectively reduce readmissions.

Patients routinely encounter barriers that prevent them from getting medications, transportation, appointments, answers to questions, reassurance, information in their preferred language, and other essential services. Having staff and services available to address these whole-person needs greatly increases patients’ likelihood of having their needs met, which can avert readmissions.

For instance, a Medicaid-specific high-risk target population may be patients with behavioral health conditions. Transitional care services designed to best meet the needs of this high-risk group would focus on using effective engagement techniques, such as:

- Effectively establishing trust and rapport,
- Using motivational interviewing,
- Identifying patient priorities, and
- Providing in-person navigation services to ensure linkage to clinical, social, and behavioral health care in the community.

The transitional care providers for this team might include a behavioral health advanced practice nurse, a social worker, and a community health worker.

Transitional care models have heretofore been described primarily with reference to the specific role of the transitional care service provider, such as transitional care coach or transitional care advanced practice nurse. As transitional care models have been widely deployed and adapted, a range of transitional care providers exist: coach, navigator, advanced practice nurse, pharmacist, social worker, community health worker.

Increasingly, hospital teams are deploying interdisciplinary transitional care teams, leveraging these complementary skill sets to address the transitional care needs of their high risk populations. Either role-specific transitional care or interdisciplinary transitional care may be well matched to meet the transitional care needs of your high-risk populations.

### **Medicaid-Specific Adaptation: Use Social Workers and Community Health Workers**

Of particular relevance to the adult Medicaid population are transitional care models that focus on addressing behavioral and social issues in addition to medical issues. The Bridge model of transitional care<sup>1</sup> is a social worker-driven transitional care model demonstrated to reduce all-cause readmissions by 20 percent<sup>28</sup> and has been identified by AHRQ as a service delivery innovation.<sup>29</sup> The way the Bridge model describes the range of skills used and types of services deployed to patients and their families/caregivers covers well the nature of the human, interpersonal, economic, behavioral, and logistical transitional care needs of high-risk patients.

*“Our [navigators] are flexible, proactive, and persistent; they address all needs. Each of them has incredible interpersonal skills.”*

The social work professional competencies particularly well suited to engaging with patients with social and behavioral health needs include identifying and addressing readmission risk factors, conducting motivational interviewing, identifying services in place, and assessing eligibility for additional services. Bridge social workers adopt a person-in-context orientation to normalize this observation and anticipate that patients’ needs will change, and are expected to change, over the days to weeks after a hospitalization.<sup>30</sup>

### **IN PRACTICE: SOCIAL WORK TRANSITIONAL CARE**

Recognized as an AHRQ Service Delivery Innovation, and recently published as an evidence-based transitional care model in the *Journal of the American Geriatrics Society*, the Bridge Model is a social worker-led transitional care model. Social workers assess “whole-person” transitional care needs and work with patients, their families, providers, and community service agencies to address posthospital needs over a 30-day period. Developed at Rush University Medical Center, the Bridge model has been implemented for a target population that includes patients with social and behavioral health needs, including the following criteria: live alone, no source of emotional support, no support system in place, discharged with a social service referral, and a severe psychosocial need.

The social worker calls the high-risk patient within 2 days of discharge and first focuses on developing rapport with the patient or his or her caregiver. In more than 80 percent of cases, the social worker identifies problems to be addressed, with about three-fourths of these problems not becoming apparent until after discharge. The three most common problems are difficulty coping with change, caregiver stress, and problems managing medical care, including medications. Other common issues include trouble obtaining community services, communication breakdowns between providers, trouble managing a new treatment or diagnosis, and difficulty understanding the discharge plan.

A May 2016 external claims-based analysis demonstrated a statistically significant 20 percent reduction in all-cause, any-hospital readmissions with the Bridge Model.

In addition to social workers as transitional care workers, community health workers (CHWs) have skills sets well matched to address the transitional care needs of Medicaid patients. CHWs are also known as community health advocates, community health representatives, community health outreach workers, lay health educators, peer health promotors, and promotores de salud. CHWs may be members of a provider-based or agency-based team and often serve as trained peer navigators who can help bridge gaps in care.

CHWs help patients fill prescriptions, remind patients to take their medicine, navigate the complicated health system, follow up on why patients missed an appointment, provide informal counseling and social support, and alert providers about important changes in patient health. Patients may feel more comfortable revealing sensitive information such as the lack of food or heat in their homes to CHWs or reveal challenges with reading or understanding instructions that they may not reveal to medical professionals.

### **IN PRACTICE: COMMUNITY HEALTH WORKERS**

Temple University Hospital started a community health worker (CHW) program to augment their efforts to reduce readmissions among heart failure and other high-risk patients. The hospital assigns a CHW to all patients with three or more readmissions in the past year. The CHWs meet with patients as early as possible during the hospitalization and try to meet with the patient multiple times before discharge. This connection while in the hospital makes it much easier to continue the relationship in the posthospital setting.

By design, CHWs meet with patients independently of doctors and nurses. CHWs have noted that patients feel more comfortable telling them about psychosocial and economic problems that may prevent them from adhering to their care plan, such as being unable to afford heat in their home or not understanding what the doctor said.

### **Interdisciplinary Transitional Care Teams**

Rather than focus on transitional care as defined by the contributions of only one role type, hospital-based **interdisciplinary care teams** are emerging as an increasingly common approach to addressing the needs of patients with medical, behavioral, and social readmission risk factors. Interdisciplinary teams may be composed of a varying combination of physician champion, program manager, data analyst, nurse practitioner, nurse care managers, visiting nurses, social workers, behavioral health specialists, pharmacists, and navigators/CHWs.

#### **IN PRACTICE: INTERDISCIPLINARY TRANSITIONAL CARE TEAM**

A large safety net hospital in California has an eight-member interdisciplinary transitional care team:

- Pharmacist
- Chronic obstructive pulmonary disease (COPD) RN
- Congestive heart failure (CHF) RN
- Social worker
- Two community health outreach workers
- Program manager
- Data analyst

The team serves patients admitted with COPD, CHF, or HIV. They actively screen for marginal housing and substance use disorder. They describe their work as “actively supporting” patients. They accompany, support, touch base, and follow up. They hold “drop in” visits in an outpatient conference room at the hospital, during which hours patients can connect with the team and have specific questions or needs addressed. Notably, all clinical members of the team do home visits. The team states their success is due to working as an interdependent, highly collaborative team.

### **Transitional Care Services Targeting Staff Caregivers**

As you consider the root causes of readmissions for your target population, consider that some transitional care services may need to be deployed to support not only patients but also their caregivers. Caregivers of all types—formal, informal, familial, nonfamilial, paid, and unpaid—are often the appropriate recipients of transitional care services.

With particular relevance to the adult Medicaid population, caregivers may be personal care attendants or staff in long-term care facilities and group homes, and they should receive enhanced transitional care services on behalf of these high-risk patients. For patients who are residents of long-term care facilities or group homes, you may find opportunities to execute warm handoffs with staff. In addition, you may be able to engage in care planning to respond to changes in clinical status, and deploy a hospital-based liaison to the facility or group home to facilitate effective stabilization and communication in the posthospital period.



## Develop New Services To Improve Care for Frequently Hospitalized Patients

A subgroup of patients at highest risk of readmission are patients who have a personal history of frequent hospitalizations, otherwise referred to as “high utilizers.” This phrase is a descriptive if somewhat indelicate term to identify patients who are collectively characterized by the number of hospitalization events in a specified time.

Improving care for high utilizers is a mathematically high-leverage strategy to reduce your hospital’s overall readmissions. High utilizers make up a small percentage of patients who account for a disproportionately high percentage of all hospital readmissions. As demonstrated by a Massachusetts all-payer analysis, high utilizers (defined as patients who had 4 or more hospitalizations in a 12 month period) were 7 percent of all hospitalized patients and accounted for 59 percent of all readmissions.<sup>31</sup>

According to an AHRQ all-payer analysis, high utilizers have 30-day all-cause readmission rates that are four to nine times as high as those of non-high utilizers.<sup>32</sup> Thus, if a hospital can improve care for this population, the impact on hospitalwide readmissions can be significant.

When designing a program to improve care for frequently hospitalized patients, the following definitions may help:

- **High risk versus high utilizer:** The terms *high risk* and *high utilizer* are sometimes used interchangeably, which causes confusion. High-risk patients have risk factors that place them at high risk of a readmission. High utilizers are a small subgroup of high-risk patients. High utilizers are defined as patients with a recent history of a certain threshold of hospital use (see below), whereas “high-risk” patients are identified based on clinical or needs assessments.
- **High utilizer versus high cost:** High utilizers are individuals who have frequent utilization of the acute care setting. Often, they also have higher than average total costs of care, but not all high utilizers are high cost and not all high-cost patients are high utilizers. These are related but not specifically overlapping patient populations.
- **Utilization threshold:** *High utilization* is defined as a threshold of utilization in a defined period. Programs variably use thresholds based on 3, 4, 5, or more hospitalizations, usually in a 6- or 12-month period. In its statistical analyses of high utilizers, AHRQ uses the threshold of 4 or more inpatient admissions in a 12-month period.<sup>33</sup>
- **Utilization type:** A distinction is made between high utilizers of the ED and high utilizers of the inpatient setting, although these populations have some overlap. For the purposes of reducing readmissions, be sure that you design a program for inpatient high utilizers. Inpatient high utilizers have a profile of medical complexity or frailty such that they are often admitted every time they present to the ED. These patients may have avoidable admissions that represent an opportunity for improvement. Inpatient high utilization is the more expensive type of high utilization, at a ratio of roughly 10:1 (e.g., \$10,000 for a hospitalization vs. \$1,000 for an ED visit). There are also excellent opportunities to improve care for high utilizers of the ED, which are beyond the scope of this document.
- **Transitional care versus intensive care management:** As described earlier, transitional care services are by definition expected to be of short duration, commonly not more than 30 days so as to affect a 30 day readmission rate. Improving the care of high utilizers is a longer term undertaking. It can take several attempts at engagement before mobilization of services, coordination among services, and behavior change support can culminate

in success over time. The timeframe for high-utilizer programs is similar to that of other intensive care management programs: a minimum of 90 days, with ranges from 90 to 180 days to a year or more.

### Principles of Improving Care for High Utilizers

Several dozen high-utilizer programs are underway across the United States. Although the specific definition of high utilizers and the specific composition of the teams who serve them vary, the following recommendations developed by Dr. Amy Boutwell have proven helpful for teams working to improve the care of inpatient high utilizers:<sup>32</sup>

1. Identify the patient in **real time**. The opportunity to intervene with a high utilizer is when they are in the hospital. Develop a flag or alert system in the registration system, the ED tracker board, or the electronic medical record to identify high utilizers when they hit the threshold definition of x visits in y months.
2. Engage patients while they are **onsite**. Hospital-based high-utilizer teams have the unique and powerful opportunity to engage with high utilizers while they are in the hospital. Prioritize effective engagement; focus on developing a helpful relationship and offer to help them in some way.
3. View utilization as a **symptom** of unmet behavioral or social needs and diagnose accordingly. Do not “overmedicalize” repeat utilization. Identify what shortcoming in access to care or services is manifested by frequent hospitalizations.
4. Engage an **interdisciplinary care team** to effectively address complexity. Recognize that effectively addressing complex needs requires interdisciplinary (including cross-setting) input. Interdisciplinary case conferencing is a common practice seen in high-utilizer programs. Often, addressing “complexity” means understanding and prioritizing social needs and understanding how to work to effect behavior modification. Expect that improving care for high utilizers will require coordination among existing service agencies and providers as well as mobilization of services not yet in place.
5. Adopt a “**continuation of care**” approach and be proactive in establishing followup contact. View followup with high utilizers as an appropriate continuation of care for any patient. Followup is a part of safe, high-quality, and appropriate care. Be proactive in ensuring timely posthospital followup contact.
6. **Bepatient and persistent**. Working with high utilizers is about engaging patients, reducing harm, changing behavior, and managing complexity over time. The objective is to help bring someone from a high-utilization state to a lower utilization state. There are rarely quick fixes.
7. Use **care plans** to improve care for high utilizers, across settings and over time. Care plans are a tool of care management. High-utilizer care plans should summarize the history of repeated hospitalizations and ED visits, identify the drivers of repeated utilization, and identify the dedicated high-utilizer care team, providers, and services involved in patient care. A specific type of care plan—the ED care plan—can help convey to ED providers that clinical, behavioral, and social needs are well understood, that there is a dedicated team and a range of providers involved in the patients’ care, and that consultation with this team is encouraged before a decision to admit.

## IN PRACTICE: HIGH-UTILIZER PROGRAM

A large community hospital designed an inpatient high-utilizer program as a component of their existing efforts to reduce readmissions. They defined high utilizers as adults with 4 or more hospitalizations in a 12-month period. Based on prior year data, they found 400 patients met these criteria. Collectively, these 400 people had 2,200 readmissions and as a group had a readmission rate of 40 percent.

*“We do whatever it takes.”*

The program was designed to prioritize engagement, outreach, provision of social and behavioral health care services, and referral to palliative care, as needed. The team is composed of three smaller teams of one social worker and one community health worker each. The three teams are supported by a nurse care manager, pharmacist, medical director, and data analyst/program manager.

The program has been successful in engaging more than 80 percent of high utilizers and in following up with more than 60 percent of patients within 2 days of discharge. The program is tracking 30-day readmission rates as well as pre-post intervention utilization and will use an internal historical control group for comparison.

### Measuring the Impact of High-Utilizer Programs

Ultimately, the purpose of including a high-utilizer program in your readmission reduction portfolio of strategies is to reduce 30-day readmission rates for your hospital. However, because high utilizers may require weeks or months of engagement to help them move from a state of high utilization to lower utilization, the impact of a high-utilizer program on 30-day readmission rates may lag.

As an alternative or supplementary measure to 30-day readmission rates, you may want to measure the change in utilization overall, comparing the 6 or 12 months “pre-intervention” to the 6 or 12 months “post-intervention.” When using a pre-post comparison of utilization, count admissions: compare total admissions before the patient received the high-utilizer services to total admissions after the patient started receiving the services.

Because some high utilizers move from a state of high utilization to lower utilization on their own (i.e., without special services), you may consider randomizing exposure to the high-utilizer service or you may identify another type of control group to measure impact. High-utilizer teams seeking to understand the impact of their services would use the “pre-post” change in utilization among the control group as the baseline change in utilization upon which to compare the pre-post change in utilization among the intervention group.

## Use Care Plans as a Tool To Improve Care Over Time and Across Settings

“Care plan” is a heterogeneous term that has its genesis in disease management and other care management programs. Care plans are rarely used in the hospital setting, but care plans of a few significant subtypes are emerging as essential tools in high-risk transitional care and high-utilizer care management. In the current context of transitional care and high-utilizer programs, the term “care plan” appears to encompass at least three different types of care plans that prove useful to improve the management of high-risk patients across settings and over time:

- **Longitudinal care plan:** a comprehensive plan to achieve health-promoting goals and objectives. Specific goals regarding clinical, behavioral, and functional status are often included and are measured via serial assessments over time. This type of care plan is longer term and may assume the ongoing support of a care manager over time.
- **Transitional care plan:** a plan that identifies posthospital needs, patient priorities, and readmission risks and the methods to address those needs, priorities, and risks in the 30 days postdischarge. By definition, the transitional care plan would include the plan to ensure effective communication with and re-establishment with the patient’s providers and services within that 30-day transitional period;
- **ED care plan:** summary information for the ED provider to inform safe, effective, and consistent care in the ED and facilitate discharge with team-based followup, as appropriate.

The types of care plans differ in terms of audience and purpose. It may be instructive to consider using more specific terminology for “care plans,” because it is unlikely that one “care plan” type would meet the needs of the primary users of these plans: at minimum, ED providers, transitional care teams, and longitudinal care managers.

### The Longitudinal Care Plan

**Primary users:** Care managers, with or without the input of an interdisciplinary team.

**Purpose:** The longitudinal care plan enables comprehensive, longer term patient support, often focused on chronic disease management. For high utilizers, it can be adapted to include a comprehensive assessment of clinical, behavioral health, and social needs. The purpose is to manage care over time to promote health and high-quality care and to minimize avoidable costs.

**Content:** Most care management programs are already accustomed to working with longitudinal care plans. The longitudinal care plan is a living document and record of patient needs; goals; natural supports; clinical, behavioral, and social service providers; and action steps to meet patient needs. Longitudinal care plans commonly focus on chronic disease self-management and other programmatic quality indicators.

When adapting longitudinal care plans to improve care for high utilizers, you may need to add sections to specifically capture “drivers of utilization” and strategies to respond to an ED presentation, should one occur. Hospital-based care teams include the following elements as part of a longitudinal care plan for high utilizers; these elements are rarely seen in traditional disease management care plans:

- Total number of ED visits in the past 12 months
- Total number of hospital admissions in the past 12 months
- Readmission risk factors

- “Drivers” of utilization
- Behavioral health needs
- Social and support care needs
- Medical, behavioral, and social support providers involved in the patient’s care

### **Transitional Care Plan**

**Primary users:** Transitional care worker, patient, primary care provider.

**Purpose:** The transitional care plan focuses on anticipating needs and planning for care in the days to weeks after discharge from the acute care setting. As opposed to a discharge summary, which reports primarily on the activities that occurred during the hospitalization, the transitional care plan provides forward-looking planning for the clinical, behavioral, social, and other service supports that will be needed in the days to weeks after hospitalization.

**Content:** The elements of a transitional care plan may not be significantly different from the elements of a longitudinal care plan, but there is a salient difference in time horizon. By definition, transitional care will be time limited to some extent, usually 30 days. Transitional care seeks to transition the patient from the acute care setting to the community setting safely, effectively, and always with a collaborative handoff and “return” to the community-based providers and services with whom the patient is connected.

The transitional plan may also seek to address shorter term needs for followup, services, and other supports, using options and means that may not be part of a long-term solution. The transitional care plan is the output of the readmission risk assessment, insights gleaned from a readmission patient and family interview, and specific plans in place to follow up with needed clinical and social service providers.

Key elements of the transitional care plan include:

- Plain language description of why the patient was hospitalized.
- Readmission risk factors.
- Followup plan for clinical issues.
- Followup plan for behavioral health needs.
- Followup plan for social and support needs.
- Transitional care contact person with phone number.
- Instructions to call the key contact person with any questions or if patient presents to the ED.

### **ED Care Plan or “Care Summary”**

**Primary users:** ED clinicians.

**Purpose:** The ED care plan is intended to improve the management of the patient the next time he or she presents to the ED. The ED care plan promotes consistency in acute care management across providers by creating institutional memory of the patient across numerous presentations.

**Content:** The ED care plan is a condensed summary of prior utilization, prior repeated testing, “drivers” of repeated presentations, and services that are in place. It may contain recommendations for ED providers to consider regarding ED-based management or decisions to admit. It is written to be used in the ED, to inform ED decisionmaking and ED treatment

decisions. An effective “ED care plan” may be as brief as the text embedded in the readmission flag on the ED tracker board identifying that there is a dedicated high-risk care team, with a request to contact the team for more information before a decision to admit.

Key elements include:

- “One liner” of medical history, preferably in medical terminology.
- Summary of social factors and behavioral health conditions.
- “Drivers” of utilization.
- Specific actions to improve the patient’s care in the ED, such as de-escalation plan, symptom management plan, care to minimize repeated tests and imaging, or alert to avoid using certain controlled substances.
- Recommended options that could avoid a readmission to inpatient care, usually by contacting the dedicated care management team.

Limit this content to 1 page of easy-to-skim, action-oriented content. Position this information no more than “2 clicks” away (i.e., click on icon, click to open summary). ED care plans are developed by the hospital-based high-utilizer care team and include review and collaboration with ED staff.

Among these three care plans, the ED care plan is the most recent to develop as a means of reducing avoidable readmissions among high-utilizer patients. To assist your hospital team in using ED care plans, this guide offers **Tool 13: ED Care Plan Examples**, which includes samples of ED care plans and a template that your team can modify and use.

As you work to develop ED care plans, consider the following:

- **Brevity:** Care plans will be used if they give ED providers the essential summary information in a way that saves them time by avoiding an extensive medical record review and promotes high-quality care in the ED. The plan should be no more than 1 page; shorter is better.
- **Audience:** The intended audience is ED providers and clinicians. Develop the “clinical snapshot” and recommended interventions with the end-user in mind. In this case, using provider-specific language (e.g., one liners, clinical abbreviations) will meet the clinical communication needs appropriately.
- **Summarize the “utilization” part of “high utilizer”:** This summary is not just a clinical summary but a utilization profile. Summarizing the sheer magnitude of utilization for clinical decisionmakers will help prompt thinking: “Why would admitting the patient this time be any more helpful than the last x times?” Also, summarizing the key tests (imaging, stress tests, psych exams, social work assessments, palliative care evaluations, pain service evaluations, etc.) can help the ED provider know what has already been offered. Although ED providers do review the chart, they cannot possibly review the fullness of everything that has been offered to a patient repeatedly over time.
- **Delegate the synthesis, and collaborate on the plan:** It is not typically efficient to hold a case conference to create the care plan summary. Delegate the drafting of the care plan summary to a care manager, social worker, nurse navigator, or other member of the high-risk care team. Bring that summarized information to the case conference to form the basis of a more efficient and focused collaboration on what the recommended next steps might be.



### TOOL 13: ED CARE PLAN EXAMPLES

13

**Purpose:** To create institutional memory across numerous providers by making easily visible prior recurrent presentations and related testing and existing clinical, behavioral, and social services and recommending 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 it, or draw inspiration from the examples to develop their own template to suit their specific needs and preferences.

**Staff:** High-utilizer care team, in collaboration with ED staff.

**Time required:** 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.

## Engage the ED in Readmission Reduction Strategies

To date, many readmission reduction efforts have been focused on improving the “transition out” of the hospital and the “reception in” to the next setting of care. However, some innovative hospital teams have identified opportunities to reduce readmissions when the patient presents to the ED, prior to the decision to (re)admit.

High-risk transitional care teams and high-utilizer programs aim to provide services and supports to patients so that they do not need to return to the acute care setting soon after discharge. However, some patients have care-seeking patterns or other drivers of utilization that will take time to reorient. In other cases, some patients are sent in to the ED by postacute or community-based providers, and the patient is merely following directions to present for evaluation.

Under “standard care” conditions, patients who present to the ED are evaluated anew each time they present for evaluation. Of course, ED providers take into consideration recent notes from recent visits as a course of their review of the medical records, but, almost by definition, high-risk patients have numerous records and a lengthy history. It is that very fact that identified the patient as “complicated” and “high risk,” which frequently results in a decision to admit so as to not miss attending to any “complex” feature of their care.

Several factors contribute to a decision to admit a high-risk patient who was recently discharged, other than an observed change in acute clinical status:

- In emergency medicine training, providers were taught that if a patient returned to the ED soon after discharge, there was a “failed discharge” and the patient should return to the inpatient treating team.
- The high-risk patient has numerous medical problems, likely has a long medication list, and appears to be medically complex, prompting a tendency to (re)admit.

*“In previous times, the path would’ve been to simply admit the patient, and we’ll sort it out 5 days later. We’re becoming more accustomed to having resources in the ER to help us discharge patients from the ED. That’s a culture change.”*

- The emergency medicine provider may not be aware of the services and supports that have been put in place to support a high-risk patient, prompting a tendency to (re)admit.
- The provider may lack longitudinal knowledge of the patient and his or her prior presentations or baseline clinical status, prompting a tendency to (re)admit for what might otherwise be known to be minor, if any, derangements from baseline.

Several opportunities to develop new systems, processes, and services could contribute to a hospital's multifaceted portfolio of strategies to reduce readmissions.

First, identify patients in the ED who have been discharged within the past 30 days. Many ED tracker boards have a 30-day return icon. The value of this flag can only be leveraged if ED staff have been oriented to the flag and know what the desired response to the flag is. The orientation can be as simple as a notice in the ED electronic medical record or via email or an in-service announcement.

The response to the ED flag may be for the ED provider to assess whether an admission can be appropriately avoided. Or it may be to prompt a case management or social work evaluation to assess whether services, supports, or other options for discharge from the ED are available.

Second, ED care teams have an opportunity to reflect on their standard practices regarding (re) admitting certain high-risk groups. For example, the readmission rate of patients from skilled nursing facilities is high. As demonstrated in the “In Practice” box below, some EDs have developed practice patterns or operating assumptions regarding the need to (re)admit patients from postacute care settings.

Just as with any opportunity for improvement, identify whether any patterns of (re)admission from the ED warrant attention. Examine the data, and ask the staff why such a high percentage of certain patients are (re)admitted from the ED. As demonstrated below, processes of awareness, data analysis, root cause analysis, re-education, and small-scale practice change resulted in changing what had become a rote practice pattern of (re)admitting almost all patients who presented to an ED from the SNF setting.

### **IN PRACTICE: TREAT AND RETURN FOR SNF PATIENTS AVERTS (RE)ADMITS FROM ED**

A statewide training effort was made in Massachusetts to engage all skilled nursing facilities in sending a standardized and comprehensive “transfer packet” to the ED. The transfer packet was compiled in a purposeful effort to improve the quality of information flow between SNF and ED and to inform the ED of the facility's capabilities. Specifically, the packet was used to notify the ED that the patient could be returned to the facility, if safe and appropriate.

The chief of a two-ED practice evaluated their SNF admission rates and noticed the ED admitted a very high percentage of all transfers from SNFs. When he queried his colleagues, their answers revealed outdated information about SNF capabilities and an operating assumption that if the patient was “sent in,” it was with the expectation of admission.

The chief set a goal for the department to, as safe and appropriate to do so, treat and return more patients each week than the last week. Over a 9-month period, the number of treat and returns from SNF steadily, and safely, increased.



Third, engage the hospitalist in the decision to (re)admit. In a statewide focus group of hospitalists in New York, one of the most common ideas proposed by hospitalists to more effectively reduce readmissions was to focus on the “front door”: the decision to admit. Most commonly, hospitalists do not make the decision to admit. Rather, they accept referrals for admission from ED providers. Hospitalists in the New York focus group<sup>34</sup> expressed interest in collaborating with ED providers to discuss whether a readmission is necessary, based on the recently developed assessments and discharge plan from the prior hospitalization.

Fourth, if the hospital has a transitional care team or a high-utilizer program, use the 30-day return flag in the ED to notify the team that one of their patients is in the ED, and notify the ED provider that the patient is part of the transitional care or high-utilizer program. Because the high-risk care team knows the patient, works with the patient’s providers, and knows the patient’s services and supports in the home and community, the team can assure the emergency medicine provider of a safe discharge plan, if discharge is clinically appropriate.

Fifth, if the hospital has a transitional care team or high-utilizer program, these dedicated care teams can provide knowledge of the patient’s baseline clinical and functional status to ED providers. This context is crucial for ED providers to understand whether the current presentation represents an acute change in condition or reflects a chronic poor clinical and functional status, but no acute change.

### **IN PRACTICE: HIGH-RISK CARE TEAM AVERTS (RE)ADMITS FROM ED**

A highly successful high-risk, high-cost care management demonstration program leveraged the emergency department as an important opportunity to avert an admission or readmission. When a high-risk patient registered in the ED, a notification was sent to the care management team. The expectation was that the team would collaborate with ED staff to identify whether a discharge, rather than (re)admission, was a safe and appropriate option.

*“Our patients look bad on their best day.”*

In reflecting on their success factors, the program cited the care managers’ and primary care physicians’ longitudinal knowledge of their patients as critical to providing context to admission decisions. They stated, “Our patients look bad on their best day,” reflecting the importance of knowing a patient’s “baseline” to accurately determine whether an acute change in clinical status has occurred. In addition, the fact that a high-cost complex patient had a “team” willing to provide timely and close followup allowed care to be delivered in the home or other lower cost settings.

## ***In Summary: Key Features of High-Risk and High-Utilizer Programs***

The innovations in health care delivery in response to avoiding readmission penalties, managing patients under shared savings, bundled payments, global budgets, and other arrangements continue to demonstrate new ways patients can be effectively managed to reduce readmissions through higher quality care at lower costs. Major concepts tested and lessons learned from these efforts include:

- **Identify high-risk patients in real time.** The opportunity to effectively engage with high-risk patients, especially high utilizers, is when they are onsite in the ED or hospital. That we have the high-risk patient in our care is a unique asset that hospital providers and dedicated care teams should leverage.
- **Attend to whole-person needs.** All longitudinal programs, whether 30-day transitional care, 90-day bundles, or annual management in accountable care contracts, have learned that successfully avoiding readmissions requires attending to social, behavioral, and clinical needs.
- **Systematically screen for social needs.** The CMS Accountable Care Communities demonstration is testing the premise that screening and addressing health-related social needs in health care delivery settings can promote improved care at lower total cost.
- **Do not systematically exclude people with behavioral health needs.** Regrettably, some policy and population health messages in the field suggest, directly or indirectly, that patients with behavioral health needs including substance use disorder should be categorically excluded from efforts to promote better care at lower cost. The ill-advised theory is that patients with behavioral health conditions may not be affected by these models, despite a lack of evidence or rationale to justify such discrimination.
- **Do not overmedicalize complexity.** The companion insight to addressing whole-person needs is to avoid the tendency to overmedicalize patients' needs or deploy medical-type interventions to address nonmedical needs. Many high-risk patients travel through the health care system labeled as "complex." To be sure, many patients at high risk of readmissions have numerous comorbidities and have been prescribed complicated medication regimens.

As teams look for the root causes of readmissions and the drivers of utilization, they come to observe that "complex" patients have drivers of readmission that do not require more or better medical decisionmaking or "doctoring." Rather, these patients require the skills of understanding competing priorities, understanding the person in context, understanding motivation, and engagement. These behavioral and social factors are often issues that traditional medical teams are underprepared or underresourced to address, so we call them "complex." Teams that are properly skilled and resourced to address these needs demonstrate they can do so to great effect.

- **Be flexible.** Transitional care and episode management teams have demonstrated creativity in responding to health-related social needs, personal support needs, and behavioral change management in many national and State-led efforts, such as the CMS Community Based Care Transitions Program and the Massachusetts Community Hospital Acceleration, Revitalization, & Transformation Investment Program. These teams rely on flexibility to have the discretion to address patients' pressing needs for additional material or human service resources. Flexing when needed is hard to regulate or legislate but appears to be a frequent feature of success.

- **Try, try again.** Teams have learned that it may take two, three, or more attempts at successfully engaging a high-risk patient in the services they have to offer (whether it is linking to new resources, intensive care coordination, etc.). Rather than putting an individual patient in the “refused” category, they have adopted the approach that they will continue to ask and attempt to engage each time the patient re-presents to the facility.
- **Frame services as “continuation of care.”** Teams have found that target population patients may not respond as well as one might expect to being introduced to a “new program” or “special team.” Teams are finding much better success by simply taking a “continuation of care” approach and offering the patient whatever services they have. They introduce services using language such as “as part of what we do,” and “it’s my job to help you with...”
- **Select the right people for the job.** Almost all teams state that they feel they have the right people with the right combination of skills to focus on these high-risk target populations. Teams report that high-risk and high-utilizer work requires a willingness to be very flexible within one’s scope of practice and requires excellent patient-facing engagement skills as well as comfort working as part of a team.
- **Professionally manage implementation.** When finances are on the line, such as for accountable care organizations and bundled payments, there is dedicated, professional management. At a minimum, successful programs have a dedicated program manager. Often, but not always, that dedicated program manager manages the program based on data—people eligible, patients served, key services delivered, and outcomes. Data inform continuous improvement until goals are achieved.

In today’s market, enhanced services are commonly deployed for patient populations for which the hospital or health system is under a performance, shared-savings, or risk-based contract or grant. Consistent with this guide’s primary recommendation regarding how to better reduce readmissions for Medicaid patients, ***we recommend that hospitals move as expeditiously as possible to deliver enhanced services to target populations in a payer nonspecific manner.*** To sustain investment in these services, hospitals and physician groups should ***actively pursue alternative payment models*** with Medicaid payers that would reward innovation in care delivery for high-risk Medicaid patients.

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