Hospital Guide to Reducing Medicaid Readmissions

Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

The authors of this guide are responsible for its content. Statements in the guide should not be construed as endorsement by the Agency for Healthcare Research and Quality or the U.S. Department of Health and Human Services.

Hospital Guide to Reducing Medicaid Readmissions

Prepared for:

Agency for Healthcare Research and Quality
U.S. Department of Health and Human Services
540 Gaither Road
Rockville, MD 20850
www.ahrq.gov

Contract No. HHSA290201000034I

Prepared by:

Collaborative Healthcare Strategies, Inc.
Amy Boutwell, M.D., M.P.P.

John Snow, Inc.
James Maxwell, Ph.D.
Angel Bourgoin, Ph.D.
Sarah Genetti, B.A.

AHRQ Publication No. 14-0050-EF
August 2014

Suggested Citation:

Hospital Guide to Reducing Medicaid Readmissions. (Prepared by Collaborative Healthcare Strategies, Inc., and John Snow, Inc., under Contract No. HHSA290201000034I). Rockville, MD: Agency for Healthcare Research and Quality; August 2014. AHRQ Publication No. 14-0050-EF.

No investigators have any affiliations or financial involvement (e.g., employment, consultancies, honoraria, stock options, expert testimony, grants or patents received or pending, or royalties) that conflict with material presented in this report.

Table of Contents

Acknowledgments

The research team at Collaborative Healthcare Strategies (CHS) and John Snow, Inc. (JSI) would like to acknowledge and thank the many individuals and organizations who generously contributed their time, expertise, and insights to inform the development of this guide.

Agency for Healthcare Research and Quality (AHRQ)
We deeply appreciate the support and guidance provided by Dr. Joanna Jiang, Senior Research Scientist at AHRQ and Program Officer of this project.

Hospital Partners
When this project started in 2012, few hospitals were focused on reducing readmissions for the Medicaid population. The willingness of partnering hospitals to engage in this voluntary, exploratory work reflects these hospitals' dedication to continuous learning and improving patient care.

- Baystate Medical Center, Springfield, Massachusetts
- Temple University Medical Center, Philadelphia, Pennsylvania
- University Health System, San Antonio, Texas
- Frederick Memorial Hospital, Frederick, Maryland
- Huntsville Hospital, Huntsville, Alabama
- Olive View Medical Center, Sylmar, California
- Medical University of South Carolina, Charleston, South Carolina

Advisory Panel Members
Advisory panel members generously provided their expert perspectives to improve the quality of this work. Advisors included:

- **Stephanie Calcasola, RN-BC, M.S.N.**, Director, Quality & Medical Management, Baystate Health,
- **Larry Gage, J.D.**, President, National Association of Public Hospitals,
- **Sheryl Garland, M.H.A.**, Vice President for Health Policy and Community Relations, Virginia Commonwealth University,
- **Anne Gauthier, M.S.**, Senior Program Director, National Academy for State Health Policy,
- **Liza Greenberg, RN, M.P.H.**, Senior Consultant, Medicaid Health Plans of America,
- **Wendy Jameson, M.P.H., M.P.P.**, Executive Director, California Health Care Safety Net Institute,
- **David Kelley, M.D., M.P.A.**, Chief Medical Officer, Pennsylvania Department of Public Welfare Office of Medical Assistance Programs,
- **Deborah Kilstein, M.B.A.**, Vice President for Quality Management and Operational Support, Association of Community Affiliated Plans,

- **Jacqueline Kreinik, MS, RN**, Nurse Consultant, CMMI/CCSQ/QIIMTG/Partnership for Patients,
- **Sarah Levin, M.D.**, Physician/Clinical Educator, Contra Costa Health System,
- **Enrique Martinez-Vidal, M.P.P.**, Vice President for State Policy and Technical Assistance, AcademyHealth,
- **Maureen Milligan, Ph.D.**, Deputy Medicaid Director for Planning, Evaluation and Management, Texas Health and Human Services Commission,
- **Erica Murray, M.P.A.**, President and CEO, California Association of Public Hospitals and Health Systems,
- **Karen Rago, RN, M.P.A.**, Former Executive Director, Service Lines and Heart and Vascular Center, University of California, San Francisco,
- **Vickie Sears, RN, M.S.**, Improvement Coach, America's Essential Hospitals,
- **Kate Sherman, LCSW**, Manager, Readmission Quality Collaborative and PSYCKES Implementation Initiatives, New York State Office of Mental Health, and
- **Nancy Vecchioni, RN, M.S.N.**, Vice President for Medicare Operations, Michigan Peer Review Organization.

About the Principal Investigators

Amy Boutwell, M.D., M.P.P., is President of Collaborative Healthcare Strategies, a thought leadership and technical assistance firm that advises delivery system transformation efforts nationally. Dr. Boutwell advises several large-scale collaborative efforts aimed at system redesign to reduce readmissions and improve care across settings and over time, including the Quality Improvement Organization "Care Transitions" Aim, the Partnership for Patients Hospital Engagement Networks, the Centers for Medicare & Medicaid Services (CMS) Learning Systems for Accountable Care Organizations (ACOs) and Bundled Payments, the Massachusetts Health Policy Commission, and the statewide readmission reduction efforts of Maryland under their new CMS waiver.

Prior to founding Collaborative Healthcare Strategies, Dr. Boutwell codesigned the Institute for Healthcare Improvement's STAAR (State Action on Avoidable Readmissions) Initiative, the first community-based approach to reducing readmissions. 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 practices medicine at Massachusetts General and Newton-Wellesley Hospitals and is an Instructor in Medicine at Harvard Medical School.

James Maxwell, Ph.D., is JSI's Director of Research and Policy and nationally recognized for 20 years of research on health insurance, financing, and health reform. His recent work has focused on payment reform and delivery system transformations with health centers and other safety net providers. Dr. Maxwell is currently leading a project for the Agency for Healthcare Research and Quality on reducing Medicaid readmissions and strategies for improving care transitions. He is also leading studies on safety net ACO development for the Robert Wood Johnson Foundation and the Blue Shield of California Foundation. In addition, Dr. Maxwell has been studying and developing payment reform proposals for health centers in California with support from the California Primary Care Association and other foundations in California. He is also assisting in the development of a readiness assessment for health centers in preparing for health payment and delivery reforms.

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 paper for the National Association of Community Health Centers on value-based purchasing in safety net providers, as well as a paper for the Blue Shield of California Foundation on national approaches to whole-person care in the safety net.

Introduction

Reducing readmissions is a national priority for payers, providers, and policymakers seeking to achieve Triple Aim objectives of improved health and enhanced care at lower cost.[1] Hospital readmissions are frequent, costly, and highly variable across providers and geographic locations. A large body of evidence documents the numerous ways the transition out of the hospital and into the next setting of care can be inconsistent, unsafe, rushed, confusing, and ineffective. These processes can and must be improved to make the health care system safe, effective, and efficient. The process of reorganizing systems and services to effectively reduce readmissions is foundational to health care delivery redesign and accountable care.

For the past several years, the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (CMMI) have created incentives, instituted penalties, and provided technical assistance to providers and communities to improve care across settings and reduce readmissions. Prominent examples of these initiatives include:

- Hospital Readmission Reduction Program,
- Community-based Care Transitions Program,
- Bundled Payments for Care Improvement,
- Accountable Care Organizations,
- Partnership for Patients, and
- Quality Improvement Organization 10th Scope of Work.

Powerful incentives can create much needed attention and action. However, the vast majority of the incentives, new financing, and technical assistance have focused providers and communities on reducing readmissions for the Medicare fee-for-service population. Many of the tools and best practices for reducing readmissions were developed based on insights from the geriatric health service research literature. Thus, it is reasonable that many hospital readmission reduction initiatives target Medicare beneficiaries or conditions on the CMS readmission penalty list only.

However, all-payer data analyses show that the adult, nonobstetric Medicaid population has readmission rates as high as—or even higher than—the Medicare fee-for-service population. Hospitals will soon face pressures to reduce Medicaid readmissions as policymakers and payers focus on the unique needs of newly enrolled and dually eligible Medicaid patients at the State and Federal levels.

The Agency for Healthcare Research and Quality (AHRQ) commissioned this guide to identify ways evidence-based strategies to reduce readmissions can be adapted or expanded to better address the transitional care needs of the adult Medicaid population. This guide was developed over a 2-year period using quality improvement methodologies to identify:

- Clinical case for improvement,
- Similar and distinct transitional care needs of the population,
- Adaptations to existing best practices, and
- New or expanded strategies not contained in the existing body of toolkits on best practices for reducing readmissions.

Why Focus on Medicaid Readmissions?

To a large extent, best practice recommendations to reduce readmissions have emerged from the geriatric health services research literature and analyses conducted on the Medicare fee-for-service population. Few analyses have been published on readmissions in the Medicaid population. There may be a perception that there is not a "readmission problem" in Medicaid, as whole-population Medicaid analyses (including pediatric and obstetric patients) reveal comparatively low readmission rates. However, adult Medicaid patients who are not hospitalized for childbirth experience readmission rates that are as high as or higher than those experienced by Medicare beneficiaries.

AHRQ's Healthcare Cost and Utilization Project (HCUP) has produced a series of briefs on all-payer readmission patterns. These analyses reveal several novel insights about Medicaid readmissions, including:

- Readmission rates for adult Medicaid patients ages 45-64 are demonstrably high, at 24 percent.[2]
- Medicaid heart failure readmission rates are higher than Medicare rates: 30 percent versus 25 percent.[3,4]

The readmission patterns of the Medicaid population differ in important ways from those of the geriatric population.[1] Clinically, the younger adult Medicaid patient is hospitalized for a different set of illnesses, such as infections (e.g., hepatitis, HIV, endocarditis), behavioral health conditions (e.g., substance use disorders), and sickle cell disease, in addition to the consequences of chronic illness and poor access to ambulatory care. In addition, Medicaid patients experience many social and economic challenges that affect their health and their ability to navigate the health care system. Discontinuities in coverage, low literacy, language barriers, lack of transportation, unstable housing, unstable employment, and poverty all contribute to readmission risk. Because of these differences, the transitional care strategies that are effective for geriatric patients may need to be modified to better meet the posthospital needs of adult Medicaid patients.

In addition to the evidence that Medicaid adults have the highest readmission rates of any payer, this year marks the beginning of a massive expansion in Medicaid eligibility under the Affordable Care Act that has provided millions of adults with health coverage. Many newly covered adults will likely have little experience navigating the health care system, inexperience that may increase their risk of readmission if hospitalized. Thus, the importance of developing strategies to ensure effective transitions in care and posthospital support is more important now than ever to achieve the cost and quality objectives of the Medicaid program.

Furthermore, hospitals are facing mounting pressures to reduce Medicaid readmissions due to payment reforms and regulatory actions from State governments. Accountable care organizations and other alternative payment models require hospitals to demonstrate reductions in avoidable admissions and readmissions.

---

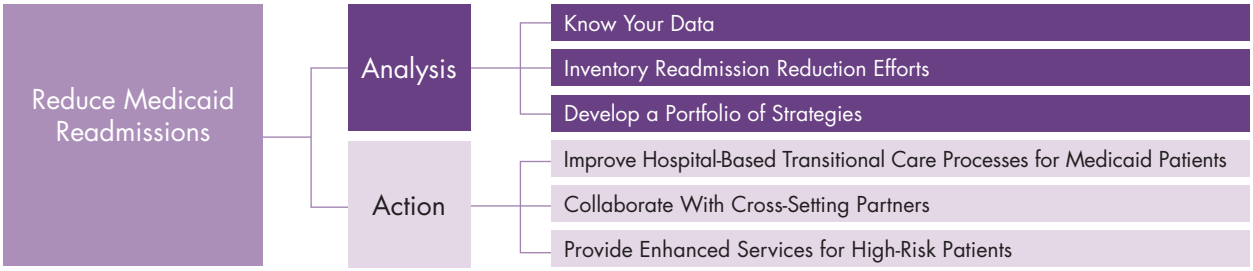
[1]This guide focuses on the adult, nonobstetric Medicaid population as a subgroup of Medicaid beneficiaries; further research is needed to describe readmissions in Medicaid obstetric and pediatric populations.

This trend is gaining additional momentum with the rapid growth of managed care enrollment and its extension to disabled and dual-eligible populations. The updated CMS Discharge Planning Conditions of Participation substantially raise the bar for standard hospital-based processes, which apply to Medicaid patients also. The evolving health care environment—regulation, payment, policy, and best practice—is pushing hospitals to expand their efforts to improve transitions in care and collaborative cross-setting care to reduce readmissions for all, including Medicaid patients.

How to Use This Guide

This guide is aimed toward hospitals at all stages of readmissions work, whether they have been focusing on Medicare patients for years, have successfully implemented best practices for all patients in all services, or are only beginning readmission reduction efforts. Understanding that each hospital is unique in terms of its patient population, payer mix, resources, and organizational structure, this guide is designed to help hospitals identify how to adapt or expand their existing efforts to reduce readmissions among their own Medicaid population.

Below is a driver diagram that illustrates a framework of action for reducing readmissions. The aim is to reduce Medicaid readmissions. To achieve this aim, the "primary drivers" include analysis and action, of which each is linked to three "secondary drivers." This guide is structured in six chapters corresponding to each of the "secondary drivers" listed below.



The first steps in expanding or adapting your hospital's readmission reduction efforts to better serve Medicaid patients are to:

- Analyze the root causes of readmissions,
- Inventory and align the current readmission reduction efforts in your hospital and community, and
- Examine the extent to which your current readmission reduction efforts meet the needs of your adult Medicaid patients.

The second steps are to adapt and expand your hospital's readmission reduction strategy by:

- Improving hospital-based processes to better target and serve Medicaid patients' needs,
- Expanding and strengthening Medicaid-specific cross-setting partnerships, and
- Providing enhanced services to patients at high risk of readmission.

Teams interested in updating their readmission reduction strategies to better serve the transitional care needs of the adult Medicaid patient should work through the first three sections of this guide. The "Analysis" steps (Sections 1-3) will inform your team's understanding of the similarities and differences in readmission patterns for Medicare, Medicaid, commercial, and all-payer populations; provide more information about what patients and their caregivers say about the barriers they encounter following a hospitalization; and enable you to examine the extent to which your hospital's current readmission reduction efforts address the transitional care needs of Medicaid patients.

The "Action" sections (Sections 4-6) guide readmission reduction teams through a parallel set of strategies that represent the minimum components of a comprehensive readmission reduction portfolio of strategies. Although the focus of this guide is to identify readmission risks, transitional care needs, and adaptations to best practices to better serve the transitional care needs of the adult Medicaid population, the process described herein is broadly applicable and may offer guidance for your hospital's readmission reduction work overall.

At the end of this guide is a set of 13 tools to assist in your efforts to reduce Medicaid readmissions. A roadmap to orient you to what these tools offer is available on page 5.

Overview of Guide Content

Section 1: Know Your Data

This guide begins with an explanation of how to analyze hospital administrative data and gather qualitative insights about Medicaid readmissions as they compare to Medicare or all-payer trends. This section offers specific actions, tools, and diagnostic questions to help you understand and interpret the root causes of readmissions at your hospital.

Section 2: Inventory Readmission Reduction Efforts

This section prompts an inventory of readmission reduction efforts, examining departments, service lines, business units, performance contracts, grants, and research efforts across your hospital. Similarly, it offers guidance on how to conduct an inventory of Medicaid-specific partners' readmission reduction activities and relevant resources. Gathering all of this information in one place will allow your team to evaluate how well these efforts align with the needs of your Medicaid patients, what redundancies can be streamlined, and what gaps need to be addressed.

Section 3: Develop a Portfolio of Strategies

This section assists with synthesizing the information collected from the root cause data analysis and inventory and using it to inform a portfolio of strategies to reduce Medicaid readmissions. It walks through the process of specifying your readmission reduction objective and aims, selecting strategies for a multifaceted approach to readmission reduction, and quantifying the expected impact and return on investment for those strategies.

Section 4: Improve Hospital-Based Transitional Care Processes for Medicaid Patients

Building on best-practice recommendations from tools such as STAAR, BOOST, and RED, this section describes how to adapt these best practices to better serve Medicaid patients' needs, such as understanding readmission risk and transitional care needs more broadly than a set of target diagnoses, and inquiring about and linking patients to needed behavioral health and social support services. This section emphasizes the guidance enumerated in the Centers for Medicare & Medicaid Services Conditions of Participation, which require standardized, improved transitional care processes for all patients, not just those determined to be at high risk of readmission.

Section 5: Collaborate With Cross-Setting Partners

This section explains the essential utility of forming a cross-continuum team with partners who will be especially valuable in reducing Medicaid readmissions. Medicaid partners, such as social services, county health departments, crisis teams, community case workers, behavioral health centers, adult daycare centers, and Medicaid agencies and managed care plans are new stakeholders to align with when expanding your focus from Medicare only to include Medicaid. This section offers specific advice about how to evolve from cross-organizational relationship building to actionable collaboration in cross-setting care.

Section 6: Provide Enhanced Services for High-Risk Patients

This section describes enhanced services that your hospital may choose to offer patients at the highest risk of readmission. It explains different ways to fund these different types of enhanced services and provides specific advice on how to partner with payers.

Roadmap of Tools

This guide offers a set of tools to assist your efforts in reducing Medicaid readmissions. The tools are included at the end of this guide as a complete package, but they can also be downloaded online individually. The tools and their description are provided here for at-a-glance reference.

#	Tool	Description	Link
1	Data Analysis Tool	Extensively vetted 10-point analysis of data to facilitate a compare and contrast view of readmissions by payer to identify differences between Medicare, Medicaid, commercial, and all-payer rates.	Word PDF
2	Readmission Review Tool	Adapted from the well-known STAAR approach, this one-page review guide prompts clinical or quality staff to elicit the patient, caregiver, and provider perspectives about the causes of readmissions.	Word PDF
3	Data Analysis Synthesis Tool	This template creates a written narrative to describe the results from the quantitative data and readmission interviews.	Word PDF
4	Hospital Inventory Tool	This tool prompts a comprehensive inventory of readmission reduction activities across departments, service lines, and units within the hospital.	Word PDF
5	Cross-Continuum Team Inventory Tool	This tool prompts a comprehensive inventory of community-based providers and agencies that provide services helpful in the postdischarge settings.	Word PDF
6	Conditions of Participation Checklist	This one-page tool, adapted from the Centers for Medicare & Medicaid Services (CMS) Conditions of Participation surveyor guidance, prompts consideration of whether a set of standardized improvements is being provided to all patients, regardless of risk.	Word PDF
7	Portfolio Design Tool	This tool prompts readmission reduction teams to expand readmission reduction efforts to include action in at least three broad domains: improve standard care for Medicaid patients, collaborate with partners, and provide enhanced services for high-risk patients.	Word PDF
8	Readmission Reduction Impact & Financial Analysis Tool	This Excel sheet facilitates modeling of the impact of the strategies on your hospital's readmission reduction portfolio. It prompts teams to quantify which patients will be served by each strategy, their baseline readmission rate, and the projected readmission reduction. It also helps estimate the avoided utilization (payer cost) due to each strategy, accounts for the investment cost of the intervention (in tools, staff, time), and calculates net "savings" (to payers).	Excel PDF

Continued

#	Tool	Description	Link
9	Readmission Risk Tool	This tool is an educational and awareness-building tool for frontline staff, cross-continuum teams, and quality improvement leadership to quickly review the many factors leading to readmission. It highlights the fact that narrow targeting strategies will miss most readmission risks.	Word PDF
10	Whole-Person Assessment	This tool provides a checklist to prompt frontline staff to identify and address basic needs.	Word PDF
11	Discharge Information Checklist	This tool, adapted from the CMS Conditions of Participation, provides a checklist of information that needs to be provided to patients and their receiving providers at the time of transition.	Word PDF
12	Cross-Continuum Team How To Tool	This tool explains the benefits and process of building a cross-continuum team and offers a template for inviting partners to join and a sample workplan for the team.	Word PDF
13	Community Resource Guide Tool	This tool is modeled on a community resource guide developed by a community-based care management agency. It prompts the hospital readmission reduction team to identify specific contacts at community agencies to facilitate efficient referrals.	Word PDF

Section 1: Know Your Data

Key Actions

Analyze your hospitals' readmissions data by payer

- Exclude patients under 18 and obstetric patients to examine Medicaid adult non-OB rates.
- Segment by Medicare, Medicaid, commercial, uninsured/self-payer, and all-payer.
- Use the **Data Analysis Tool *(Tool 1)*.**

Ask patients "why" they needed to return to the hospital

- Interview 10 readmitted Medicaid patients while they are hospitalized.
- Inquire about social and logistical factors that may have led to readmission.
- Capture all the barriers and factors that contributed to readmission, not just one single issue.
- Use the **Readmission Review Tool *(Tool 2)*.**

Ask "receiving" community providers why the patient returned to the hospital

- Interview 10 community-based providers/organizations who are frequently involved in the posthospital care of Medicaid patients, such as plan-based care managers, behavioral health providers, community health workers, social workers, and home health coordinators.
- Use the **Readmission Review Tool *(Tool 2)*.**

Analyze results to check whether the following statements are true for your population

- 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.
- Roughly 25 percent of readmissions occur in <4 days and 50 percent in <10 days of discharge.
- Discharge disposition differs markedly for Medicare v. Medicaid with implications for followup.
- Patients primarily report that social and logistical factors led to readmission.
- Community providers observe that incomplete information contributes to readmissions.
- Use the **Data Analysis Synthesis Tool *(Tool 3)*.**

Examine readmission patterns in your community

- Compare same-hospital versus all-hospital readmission rates.
- If there is a high rate of other-hospital readmissions, consider implications for partnering with other hospitals to collaborate on reducing readmissions for a shared population.
- Attempt to identify geographic "hot spots," such as neighborhoods or housing units.

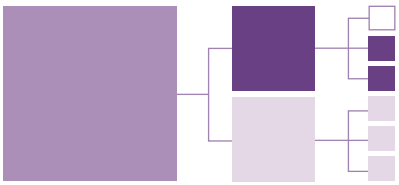
Share the data, findings, and insights

- Share the findings with hospital administration.
- Share the findings with hospitalists, emergency department physicians, medical specialists, psychiatrists, surgeons, quality improvement, nursing, case management, and social work.
- Post the findings and monthly statistics for staff of all departments to readily access.
- Share the findings at regularly held cross-continuum team meetings, and ask community partners to present their own data, findings, and insights.

Track performance and update analyses periodically

- Establish a system to flag patients as recently discharged or otherwise high risk when they present to the emergency department.
- Interview all readmitted patients at the time of readmission.
- Create a readmission dashboard to keep track of monthly readmissions data.

Section 1: Know Your Data



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

Often, readmission reduction efforts target conditions prioritized by payers' incentives or penalties, such as those targeted by the Centers for Medicare & Medicaid Services (CMS) (acute myocardial infarction, pneumonia, heart failure, chronic obstructive pulmonary disease, hip or knee replacement). Although these are common and rational ways to target readmission reduction work, readmission reduction teams may be surprised to learn that these methods do not target the patients at highest risk of readmission at their hospital. In addition, administrative data analyses alone offer only one view of the drivers of readmissions in your community; qualitative insights are essential to identify high-priority opportunities for improvement.

This section will guide readmission reduction teams through an efficient analysis of locally relevant readmission patterns to allow a more complete understanding of readmissions overall and an appreciation of the unique features of Medicaid readmissions. The purpose of these analyses is to inform action; although these analyses are essential, readmission reduction teams should spend no more time than necessary in this phase. Gather enough information to take action to address the problem effectively. The data collection and analysis process described in this section should take no longer than 1 month.

Understand Medicaid Readmission Patterns at Your Hospital

To determine where to start in reducing Medicaid readmissions, including whether your team needs to adapt or expand your efforts to better serve Medicaid patients, you need to understand your hospital's current readmissions patterns. An efficient reevaluation of readmission patterns at your hospital includes examining your own data, interviewing your readmitted patients, and gathering data and insights from community partners. Even if your hospital is already working on reducing readmissions for the Medicare population, it is useful to examine the Medicaid population specifically to understand these patients' unique characteristics and needs.

Sometimes hospitals rely on external sources to generate their readmission reports, which use a predetermined "cut" on readmission data, such as reporting for predetermined diagnostic categories, excluding certain diagnoses (such as behavioral health), or generating reports only for certain payer types. For the purposes of strategic planning, it is essential to examine your raw, unadjusted, all-payer data. These are data for improvement, not for analysis or judgment about relative performance. Identifying all readmissions presents your team with the full option set of opportunities for improvement.

In addition, it is useful to pursue any community- or population-level data, such as those available through State discharge databases, State or local health information exchanges, and payers. These data sources can provide you with all-hospital readmissions, not just same-hospital readmissions.

The **Data Analysis Tool** ***(Tool 1)*** specifies a well-vetted data analysis that will help your team evaluate all-payer and payer-specific readmission patterns among Medicare, Medicaid, commercial, and uninsured patients. Notably, the analyses for the Medicaid population focus on nonobstetric, nonpediatric patients. If feasible, analyze dual-eligible Medicare patients by identifying Medicare patients with a secondary Medicaid payer.

Data Analysis Tool *(Tool 1)*

- **Purpose:** Analyze hospital administrative data to evaluate readmission patterns.
- **Description:** Extensively vetted 10-point analysis of data to facilitate a compare and contrast view of readmissions by payer to identify differences between Medicare, Medicaid, commercial, and all-payer rates.
- **Staff:** Data analysis, business analyst, staff able to run administrative data.
- **Time required:** 4 to 6 hours.

In practice: Frederick Memorial Hospital

The importance of quantitative data

Frederick Memorial Hospital had been working on reducing readmissions for 3 years. When their quality improvement team analyzed their readmissions 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 psychiatric, whereas it was 0 out of 10 for their Medicare patients. These findings demonstrated that Frederick Memorial needs to use different readmission strategies and partnerships for Medicaid than Medicare patients.

Understand the Patient Perspective

The **Readmissions Review Tool** ***(Tool 2)*** is an instrument for collecting qualitative data from the patient, caregiver, and provider point of view, to gain a clearer understanding of "the story behind the story." This tool can help capture factors well beyond the chief complaint, discharge diagnosis, or other clinical parameters to reveal barriers in communication, coordination, or other logistics experienced in the days following discharge that resulted in a readmission. Using this tool can help identify the causes of readmissions from the patient perspective, making care more patient-centered. This data collection is particularly important for the Medicaid population for whom social and economic factors or longstanding care-seeking patterns are often factors contributing to readmissions.

Readmission Review Tool *(Tool 2)*

- **Purpose:** Obtain qualitative insights in to why readmissions occur.
- **Description:** Adapted from the well-known STAAR approach, this one-page interview guide prompts clinical or quality staff to elicit the patient, caregiver, and provider perspective about the causes of readmissions.
- **Staff:** Quality improvement, nursing, case management staff.
- **Time required:** 30 minutes per interview; 10-20 interviews suggested to start; many teams review ALL readmissions when the patient is readmitted.

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.	When asked how the hospital can help her and others prepare to leave the hospital, she said, "Make all appointments before I leave the hospital." **Key finding: Needed assistance navigating the health care system.**
35-year-old female 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 and left hospital AMA because she was afraid she would lose her job if she missed work. **Key finding: Financial and employment insecurity created significant barriers to care.**
61-year-old male on Medicaid hospitalized 8 times this year for shortness of breath. Lives in a single room occupancy unit.	Patient prefers to be in hospital; cannot be placed in skilled nursing facility due to criminal history. **Key findings: Housing instability, compounded by behavioral health issues.**
46-year-old Spanish-speaking-only female on Medicaid 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. **Key finding: No use of interpreter services; lack of teach-back to confirm understanding and clarify.**

These qualitative data offer insights into concrete problems and therefore solutions, beyond simply labeling patients as "noncompliant." Furthermore, interviews often reveal that there are numerous barriers or factors that lead to a readmission. Capture all factors that contribute to readmissions, as demonstrated in *Reasons for Readmission in an Underserved High-Risk Population: A Qualitative Analysis of a Series of Inpatient Interviews*[5] *and Factors Contributing to All-Cause 30-Day Readmissions: A Structured Case Series Across 18 Hospitals.*[6]

Understand Readmissions in Your Community

Although it is essential to understand readmission patterns from your own data sources, a more complete picture of readmission patterns is possible through a community-based analysis of hospital readmissions in your service area or community. This data analysis can enhance understanding of readmissions at a community level, including:

- Differences between same-hospital, other-hospital, and total readmission rates;
- Association between geographic proximity of ZIP Codes to hospitals and impact on utilization;
- Readmission rates from skilled nursing facilities, rehabilitation programs, or other postacute care facilities;
- High utilizers in a population who frequent multiple providers; and
- Total cost of readmissions, as well as total cost of care for high utilizers.

The best view of readmissions in a community would provide an all-payer, all-provider view of the utilization patterns in a geographic area. Potential data sources that could provide this view include:

- Regional health information exchange;
- Statewide discharge database; and
- Statewide all-payer claims database.

Payer data offer a longitudinal, cross-setting view of utilization and readmissions, with the obvious limitation that any one payer's view is limited to only their members or beneficiaries. The benefits of payer-provided data include:

- Total acute care utilization for the member/beneficiary population;
- Postacute utilization and readmission source;
- Primary care provider and ambulatory visit history;
- Clinical comorbidities;
- Medication refill histories;
- Plan high utilizers seen at your facility; and
- Total expenditures.

Because providers serve patients with multiple health plans and payer sources, it can be cumbersome for providers to reach out to individual plans for their population-specific readmission data. However, some payer-specific data assets are useful. Examples of sources of community data are below.

Examples of Where To Find Community – Level Readmission Data	
All-Payer, All-Provider Data	**Payer Data**
Maryland: the statewide health information exchange (HIE), CRISP, provides hospital-specific, regional, and State-level monthly readmission reports with only a 30-day lag time. CRISP uses the ADT (admission, discharge, transfer) feed from hospitals to the HIE to create these near real-time reports. The data include all patients, all payers. Hospitals receive confidential patient-specific information, same-hospital readmissions, and other-hospital readmissions, while regional and State reports are public.	The **Medicare Quality Improvement Organization** (QIO) program provides data analyses to hospitals and community coalitions. Although the data are limited to Medicare fee-for-service beneficiaries only, the QIOs provide examples of analyses, including admissions and readmissions per 1,000 beneficiaries; readmissions at a locally relevant geographic unit; total discharges to skilled nursing, home health, hospice, and home; and readmissions among patients discharged to those settings.
Massachusetts: an independent State agency, the Center for Health Information and Analysis (CHIA), is responsible for Massachusetts all-payer claims data. An all-payer claims analysis can provide not only a comprehensive view of readmission patterns (similar to that available through discharge databases and HIEs), but also factors associated with readmissions, such as use of postacute and ambulatory care following discharge, comorbidities and medical complexity, prescription information, total acute care utilization, and total medical expenditures.	The **New York State Office of Mental Health** has developed the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES), a HIPAA-compliant,* Web-based portfolio of tools designed to share Medicaid fee-for-service and managed care data. User-friendly clinical summaries provide up to 5 years of individual client treatment history across all settings, including diagnoses, medications, and inpatient and outpatient services, to support clinical review, treatment planning, care coordination, and discharge planning. Quality reports summarize data at the State, region, and hospital level on more than 50 quality concerns, including high utilization of emergency and inpatient services, hospital readmissions, and psychotropic prescribing practices. Quality reports are linked to individual clients with quality flags to focus quality improvement efforts. *HIPAA is the Health Insurance Portability and Accountability Act.

Interpret the Data

Once you have collected these quantitative and qualitative readmissions data, as well as community-level data, it is time to interpret them. The **Data Analysis Synthesis Tool** ***(Tool 3)*** summarizes the results in an easily understood format that can help communicate the insights from the analyses.

Data Analysis Synthesis Tool (Tool 3)

- **Purpose:** Summarize and interpret the findings from data and interviews.
- **Description:** This template creates a written narrative to describe the results from the quantitative data and readmission interviews.
- **Staff:** Quality improvement staff.
- **Time required:** 2 hours.

As you examine the data more closely, remember that the purpose of the analysis and synthesis is to find insights that can lead to effective action. The following questions can help you identify high-leverage opportunities to reduce readmissions in your hospital:

1. What is the proportion of Medicare versus Medicaid patients at your hospital?
2. What are the Medicare and (adult, non-OB) Medicaid readmission rates at your hospital?
3. How many readmissions occurred for Medicare and Medicaid patients in the past year?
4. How many readmissions do you need to avoid this year to achieve your readmission goal?
5. What proportion of readmissions occurs within 4 days of discharge? Within 10 days? What does that suggest about postdischarge contact and followup?
6. How does the discharge disposition of Medicare and Medicaid patients differ?
7. What do these data suggest about the cross-continuum partnerships needed to collaborate with relevant postdischarge providers for Medicaid? Medicare?
8. How did the top 10 diagnoses leading to readmissions differ between Medicare and Medicaid? What is different? Is anything surprising? Did any set of diagnoses make up more than half of readmissions?
9. How many patients were hospitalized at your hospital more than 3 times in the past 12 months? For Medicare? For Medicaid? What is the readmission rate for this subgroup?
10. What would be the savings to payers of reducing hospitalizations among high utilizers by 20 percent?

Share the Data, Findings, and Insights

The data, interview findings, and insights generated by the readmission reduction team will be of great interest to leaders, clinicians, staff, and stakeholders well beyond the membership of the readmission reduction team. Locally relevant data, locally gathered patient stories, and locally obtained provider input are very powerful motivators in efforts to stimulate change in your hospital and your community. Post this information visibly in the hospital and on the hospital's Web site for all departments and staff to readily access.

Share the findings with the hospital's executive team and with quality, hospital medicine/internal medicine, emergency medicine, psychiatry, nursing, case management, and social work, as well as the hospital's patient and family advisory committee. Consider also engaging finance, specifically the team that negotiates contracts with Medicaid Managed Care plans, information technology (IT), community relations, spiritual care/clergy, and volunteer services. Hospital administration should share this information with the board. Share the findings at regularly held cross-continuum team meetings, and ask community partners to present their own data, findings, and insights.

Track Performance and Update Analyses Periodically

Successful efforts to reduce readmissions rely on regular data analyses and continuous monitoring of implementation and performance. Not only is it important to monitor readmission rates over time, but it is also important to create a system of flagging patients as recently discharged or otherwise high risk when they present to the emergency department (ED).

Consider establishing the following:

- Automated flag in the ED chart if a patient was discharged <30 days ago.
- Automated flag in the electronic medical record if the patient has had more than three hospitalizations this year.
- Manual flag (as by patient registration) for the above features.
- Tool-based or manual tracking of high-risk patients for 30(+) days postdischarge.
- Encounter notification to alert providers and hospital care transition team when patients present to ED, are discharged from hospital, or discharged from skilled nursing facility (SNF).

Interview every readmitted patient while he or she is still in the hospital. This step accelerates your efforts to engage frontline clinical staff in learning about the importance of standardized, reliable transitional care and posthospital supports and makes the readmission reduction team aware of and actively engaged with all readmitted patients. This practice will rapidly increase awareness hospitalwide about the prevalence of readmissions, expand providers' understanding of the circumstances under which patients are readmitted, and identify potential opportunities for improvement for the individual patient as well as the system as a whole.

Track readmissions monthly for all patients, as well as payer-specific (e.g., adult nonobstetric Medicaid, Medicare fee for service) and target populations. Do not ask frontline clinical staff to track readmissions based on their individual patient discharges because patients may be admitted to

different floors or different services, return during staff/champion days off, etc. Create a readmission dashboard to include outcomes for the following population segments:

- Hospitalwide, all-cause 30-day readmission rates;
- Payer-specific all-cause 30-day readmission rates—Medicare, Medicaid, Medicaid Managed Care, and dual eligible may be most informative;
- High utilizers; and
- Other high-risk patients (e.g., medically complex, behavioral health, postacute discharges).

Consider including the following process measures on your readmission dashboard:

- Number and type of cross-continuum partners engaged.
- Number of readmission reviews conducted; percentage of all readmissions that makes up.
- Percentage of all discharges with more than 90 percent of all elements in "transitional care bundle" delivered.
- Number of patients served by transitional care services; percentage of total that makes up.

Section 2: Inventory Readmission Reduction Efforts

Key Actions

Inventory the readmission reduction efforts underway within the hospital

- Query clinical leaders, administrative champions, and researchers.
- Query service lines: oncology, orthopedics, cardiology, neurology, geriatrics, care management.
- Query clinical departments, including hospital medicine, emergency medicine, surgery, and psychiatry.
- Query nursing, case management, social work, quality, and compliance.
- Assess the degree of communication and standardization that currently exists on readmissions across service lines and clinical departments.
- Utilize the **Hospital Inventory Tool *(Tool 4)*.**

Inventory Medicaid-specific community partners' transitional care services

- Identify Medicaid-specific providers, such as federally qualified health centers, community health centers, Medicaid health homes, community mental health providers, substance use providers, home health providers with strong behavioral health capabilities, and adult daycare centers.
- Establish points of contact at Medicaid health plans to facilitate posthospital care management.
- Identify current hospital Medicaid-specific community resources, such as housing services, legal assistance, transportation assistance, nutrition assistance, health departments, community health workers, and peer supports.
- Use the **Cross-Continuum Team Inventory Tool *(Tool 5)*.**

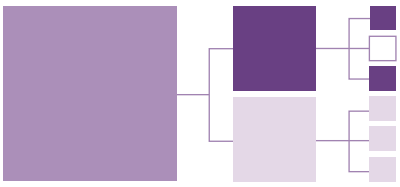
Analyze the current transitional care process

- Check whether there is a known standard transitional care process.
- Examine whether hospital-based transitional care practices apply to all patients.
- Assess the level of variation in transitional care by departments, units, or services lines.
- Use the **Conditions of Participation Checklist *(Tool 6)*.**

Assess leadership commitment to reducing readmissions

- Evaluate the leadership focus on responding to Medicare and Medicaid readmission penalties.
- Evaluate leadership's awareness of the new CMS Discharge Planning Conditions of Participation.
- Examine the market forces that provide incentives for reducing Medicaid readmissions.
- Identify which hospital leaders will provide executive sponsorship.
- Inquire whether readmissions work will be reported to the board.
- Identify the time, staff, analytics, tools, and resources available for this work.

Section 2: Inventory Readmission Reduction Efforts



"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…."

The second step to reducing Medicaid readmissions is taking an inventory of your hospital's current readmission reduction efforts, including external partnerships that will help reduce readmissions. Readmission reduction efforts have proliferated over the past several years and may have developed in isolation from each other. Gathering all of this information in one place will allow your team to evaluate how well these efforts align with the needs of your Medicaid patients, what redundancies can be streamlined, and what gaps still need to be addressed.

Inventory Readmission Reduction Efforts Throughout the Hospital

Take inventory of all readmission reduction efforts, including complementary efforts, such as improved medication reconciliation, staff training in teach-back, IT system flags for readmitted patients, cross-setting collaborations, payer contracts with readmissions as a component, research projects, patient/family advisory council, and provider-initiated small-scale improvement efforts. Inquire of departments such as emergency, hospital medicine, cardiology, geriatrics, pulmonary, oncology, orthopedic surgery, case management, social work, patient relations, and medical records/IT. Also include managed care contracting, other value-based contracts (including bundled payments, etc.) and organization- or investigator-initiated grants. If any prior readmission reduction efforts were discontinued, it is useful to review what worked and did not work in those efforts and why these strategies were abandoned.

The **Hospital Inventory Tool** ***(Tool 4)*** is designed to help your team take stock of the different readmission reduction initiatives within the hospital. In the process of conducting this inventory, your readmission reduction team will identify a broader constituency of potential champions, allies, and implementation partners to support your efforts to reduce readmissions.

Hospital Inventory Tool *(Tool 4)*

- **Purpose:** Understand your hospital's current readmission reduction efforts.
- **Description:** This tool prompts a comprehensive inventory of readmission reduction activity across departments, service lines, and units within the hospital.
- **Staff:** Quality improvement, readmission reduction team members.
- **Time required:** 2-4 hours.

Inventory Efforts and Resources That Exist Beyond the Hospital

An active and robust collaboration with patients/families and community partners beyond the hospital is a crucial element of successful readmission reduction efforts. Important tasks such as transitioning patients successfully into the care of "receiving" providers across different health care settings, addressing patients' social and clinical posthospitalization needs, and supporting patients' behavioral health needs require teamwork between the patient/family, the hospital, and other community-based providers that offer services that support patient health and well-being, directly and indirectly.

Consider your hospital's current partners that are particularly relevant to the Medicaid population. They may offer community-based care management, supportive services, transitional housing, and other resources that address the Medicaid-specific drivers of readmissions your team uncovered during your work in Section 1. Guidance on how to identify, recruit, and collaborate with additional partners can be found in Section 5 (Collaborate With Cross-Setting Partners).

The **Cross-Continuum Inventory Tool** ***(Tool 5)*** provides a checklist of different partners from beyond the hospital that you may want to engage in your efforts to reduce readmissions. The checklist distinguishes partners that are especially useful for Medicare versus Medicaid readmissions and can help your team identify potential collaborators in your efforts. If you already have a cross-continuum team in place, ask your cross-continuum team partners to assist in conducting this inventory. 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.

Cross-Continuum Team Inventory Tool *(Tool 5)*

- **Purpose:** Identify community partners' efforts to improve posthospital support.
- **Description:** This tool prompts a comprehensive inventory of community-based providers and agencies that provide helpful services posthospitalization.
- **Staff:** Quality improvement leadership, cross-continuum team.
- **Time required:** 4-5 hours.

Analyze Your Hospital's Current Transitional Care Processes

Once you have a sense of readmission reduction and transitional care improvement efforts within the hospital and available community resources, the next step is to examine your hospital's current "discharge process" (hereafter referred to as "transitional care process"). The transitional care process may differ floor to floor or between service lines or clinical departments. Thus, it may be important for your readmission reduction team to anticipate examining transitional care processes across a variety of services or units.

Ask the following questions to guide your initial efforts to document the current state:

- Do transitional care processes vary by department, service line, or floor/unit?
- Is there a vague concept of what "should" happen for all patients, without a detailed understanding of the extent to which those actions occur consistently for all patients?
- Is "care transitions" included in the electronic health record (EHR) for tracking and analysis?
- How do you engage the patient and family in the transition care processes?
- Is any system in place for performance feedback and continual improvement?
- Who/which team or committee is "assigned" to the overall performance and operations of "care transitions"?

It can be a challenge to document transitional processes because they include a variety of actions at various stages. These actions may:

- Start in the emergency department (e.g., identification of recent discharge, decision to admit),
- Continue at admission (e.g., readmission risk assessment),
- Continue through the hospitalization (e.g., engaging patients and caregivers in understanding care preferences and using teach-back to reinforce self-management messages), and
- Include the many actions that occur in preparation for discharge (e.g., communicating with receiving clinicians, arranging for postdischarge followup and services).

Because these actions occur over time, across shifts, and by numerous staff of various disciplines, it is valuable to identify whether a standard, known process exists that:

- Starts in the emergency department.
- Occurs throughout the hospitalization.
- Involves staff across days and shifts.
- Involves multidisciplinary tasks.
- Specifies responsibility for each individual task.
- Can be reviewed, tracked, and measured to support continuous improvement.

The 2013 CMS Hospital Conditions of Participation (COPs) require all hospitals that receive payment for Medicare and Medicaid patients to comply with a series of guidelines for how patients must be discharged from the hospital. This 39-page document encompasses many of the well-known best practices to improve care transitions. Although all hospitals should follow these guidelines, many follow only some of them or follow them incompletely.

Use the **Conditions of Participation Checklist Tool** ***(Tool 6)*** to assess how well your hospital is complying with the letter and the spirit of these transitional care elements, and what areas need improvement. Of note, CMS specifically reminds hospitals and surveyors that these COPs apply to all *Medicare and Medicaid beneficiaries*, not just those identified as at high risk of readmission.

Section 4 of this guide (Improve Hospital-Based Transitional Care Processes for Medicaid Patients) offers information on how to adapt best transitional care practices to better serve the needs of Medicaid patients.

Conditions of Participation Checklist Tool *(Tool 6)*

- **Purpose:** Review whether current practice meets updated CMS guidelines.
- **Description:** This one-page tool, adapted from the CMS Conditions of Participation surveyor guidance, prompts consideration of whether a set of standardized improvements are being provided to all patients, regardless of "risk."
- **Staff:** Quality improvement, nursing, case management staff.
- **Time required:** 2 hours.

Should We Do Process Flow Mapping?

Process flow mapping is a foundational component of the Lean method for process improvement. While engaging in process flow mapping is an invaluable exercise to help define the observations made while taking inventory of intrahospital activities, the analysis can be time consuming. As a note of caution, some hospitals get "stuck" at this point and lose months in the effort to establish "current state" and do not work in parallel to make urgently needed improvements. It is important to not get mired in analysis and to press forward with improving the transitional care process.

Assess 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.

Some high-volume Medicaid hospitals may have yet to engage in readmission reduction efforts because they are not strongly incentivized by Medicare readmission penalties. For other high-volume Medicaid hospitals, Medicaid managed care plans may have had payment policies relating to readmissions, so the incentive to reduce Medicaid readmissions is more pressing. In still other markets, Medicaid limited the number of inpatient days per year per beneficiary, creating an indirect incentive to avoid repeated rehospitalizations, because excess hospital days are uncompensated.

In Maryland, hospitals now operate within a fixed global budget, aligning incentives across all payers to reduce readmissions. Some high-volume Medicaid hospitals are, or are preparing to become, accountable care organization or otherwise bear financial risk for utilization and quality, thus making efforts to reduce readmissions an invaluable core competency for current or future payment arrangements.

Payment policies are by no means the only motivation for reducing readmissions. Complying with accreditation surveys and avoiding citations may motivate hospital leaders to evaluate the extent to which the organization is in compliance with the new CMS Discharge Planning COPs. Other hospitals may be motivated by patient satisfaction scores or by comparative performance data

transparency. Many hospitals lead with a quality strategy and place enormous value in pursuing the highest standards in quality care as a professional, ethical, and organizational value in and of itself. Finally, hospitals with demonstrably poor readmission rates or poorly defined transitional care practices may do well to consider the harm of unsafe transitions on patients, their families, and the hospital's reputation and financial risk, should unsafe practices be revealed in the press or other outlets.

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.

Section 3: Develop a Portfolio of Strategies

Key Actions

Synthesize the findings from Sections 1 and 2

- Examine whether the root causes of Medicaid readmissions are being addressed.
- Identify whether there are drivers of readmissions with no strategies for reduction in place.
- Evaluate the extent to which current readmission reduction efforts specifically include Medicaid patients.
- Evaluate the extent to which current readmission reduction efforts are coordinated and aligned within the hospital.
- Evaluate the extent to which Medicaid-specific community-based providers and supports are fully engaged as partners in reducing readmissions.
- Evaluate the extent to which hospital readmission reduction efforts are aligned with Medicaid health plans' programs.

Specify your updated readmission reduction objective and aims

- Articulate the objective, or purpose, for readmission reduction efforts (e.g., to avoid penalties, lead with quality metrics, respond to incentives, execute work for a grant).
- Formulate a specific aim statement in the form of "what, by when."
- Identify the executive sponsor for this work who reports to the CEO or board on readmissions.

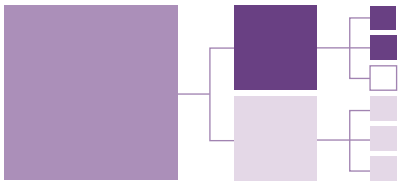
Develop a portfolio of strategies to achieve the readmission reduction objective

- Improve standard hospital-based processes for all, consistent with CMS COPs, with special attention paid to the needs of the Medicaid population.
- Collaborate with "receivers" and other partners across settings to improve transitions.
- Provide enhanced services to high-risk patients.
- Use the **Portfolio Design Tool *(Tool 7)*.**

Quantify the expected impact and return on investment for the portfolio of 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 and financial impact.
- Use the **Readmission Reduction Impact and Financial Analysis Tool *(Tool 8)*.**

Section 3: Develop a Portfolio of Strategies



"There is no silver bullet."

Hospital leaders may wonder why their readmission reduction efforts have failed to reduce readmissions over time. This outcome may result from basing the targeting strategy purely on responding to payer-based incentives (e.g., penalties) without reflecting on the hospital's own local patterns of readmissions, or from a pilot effort never being scaled and spread to other units or high-risk subpopulations. Other times it may be because you had no readmission reduction champion supporting continuous improvement based on monthly trending data.

The analyses and inventory recommended in Sections 1 and 2 guided your readmission team through an updated and expanded analysis of the root causes of readmissions and what readmission reduction efforts are currently underway in your hospital and among your community partners. This section discusses the following steps to develop a locally specific, data-driven portfolio of strategies to reduce readmissions:

1. Synthesize data and inventory information.
2. Specify your readmission reduction objective and aims.
3. Develop a multifaceted approach to achieve your objective.
4. Quantify the expected impact of the portfolio of strategies.

Synthesize Data and Inventory Information

Synthesize the information obtained from data analyses, readmission reviews, and the current inventory of readmission reduction efforts at your hospital. 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 needs.

Identify whether there are drivers of readmissions with no strategies in place. 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.

Specify Your Readmission Reduction Objective and Aims

Before discussing what the hospital's readmission reduction aim is (what, for whom, by when), it is helpful to clearly articulate the hospital's readmission reduction objective. Why is there a readmission reduction effort? What incentives is the hospital responding to? What organizational values is this aligned with? For example:

- Readmissions are a national quality priority; we need to demonstrate activity in this area;
- Our mission is quality driven and reducing readmissions is a quality of care issue;
- We are attempting to avoid Medicare readmission penalties;
- We are exposed to or anticipate Medicaid readmission penalties;
- Patients want to have successful hospital stays and not be readmitted;
- We have a grant to reduce readmissions;
- We have an interest in reducing uncompensated/low margin readmissions;
- Readmission avoidance is a core competency in our population management/risk strategy; or
- We are anticipating a change in Medicaid payment policy that will provide a strong financial incentive to reduce Medicaid readmissions.

Once it is the objective of your readmission reduction work is clear, you can specify the elements of an improvement aim statement: what, for whom, by when. The aim should support why you are working to reduce readmissions by quantifying the improvement that needs to occur to achieve that objective. Examples include:

- Reduce all-cause 30-day readmissions for adult nonobstetric Medicaid patients from 25 percent to 20 percent by December 2015.
- Reduce all-cause 30-day readmissions for high-risk patients by 25 percent, from 28 percent to 21 percent by December 2015.
- Reduce our hospitalwide all-cause 30-day readmission rate by 20 percent by December 2015.

Develop a Multifaceted Approach To Achieve Your Objective

You should now have an updated understanding of the patterns of readmissions at your hospital; the reasons for readmissions from the patient, family, and provider perspective; a comprehensive review of the completed, current, and intended but incomplete readmission reduction efforts at your hospital to date; and the resources you have available to you to reduce readmissions. With this information, you can revisit your readmission reduction strategy.

The most effective way to reduce Medicaid readmissions is through a multifaceted approach that takes action in the following domains:

- Improve hospital-based transitional care processes for Medicaid patients;

- Collaborate with cross-setting partners; and
- Provide enhanced services for high-risk patients.

Use the **Portfolio Design Tool** ***(Tool 7)*** to assist you in developing strategies in each domain. The figure below illustrates the strategy development process, with examples of strategies in each domain.

Portfolio Design Tool (Tool 7)

- **Purpose:** Develop a portfolio of strategies to reduce readmissions.
- **Description:** This tool prompts readmission reduction teams to expand readmission reduction efforts to include action in at least three broad domains: improve standard care for Medicaid patients, collaborate with partners, and provide enhanced services for high-risk patients.
- **Staff:** Readmission reduction champion, readmission team.
- **Time required:** 2-4 hours.

Develop a Portfolio of Strategies

Improve Hospital-Based Transitional Care Processes for Medicaid Patients

- Flag discharge <30d in chart
- ED-based efforts to treat & return
- Broaden view of readmission risks; assess "whole-person" needs
- Develop transitional care plans that consider needs over 30 days
- Ask patient & support persons what help they need; share with them their needs/risk assessment
- Use teach-back, target the appropriate "learner"
- Customize information
- Arrange for posthospital followup
- Use a checklist for all patients

Collaborate With Cross-Setting Partners

- Use ADT notifications with medical and behavioral health providers
- Ask community providers what they need and how they want to receive it
- Collaborate to arrange timely followup
- Perform "warm" handoffs and opportunity for clarification
- Form a cross-continuum team that can access resources your staff are unaware of
- Constantly refresh your awareness of social and behavioral health resources
- Broaden partners to include Medicaid health plans and their care managers
- Identify community partners with social work and behavioral health competencies

Provide Enhanced Services for High-Risk Patients

- Segment "high risk"—varying types of service & levels of intensity
- Strategy for high utilizers
- Strategy for navigating care
- Strategy for accessing resources
- Strategy for self-management
- Strategy for frailty/medically complex
- Strategy for end-of-life trajectory
- Strategy for recurrent stable symptoms, etc., individual care plans

Key: ED = emergency department; ADT = admission, discharge, transfer.

Quantify the Expected Impact of the Portfolio of Strategies

Developing a multifaceted strategy of efforts focused on what, for whom, by when allows your readmission reduction team to estimate the projected impact of individual and collective efforts. An example approach comes from a template that CMS required of applicants to the Community-based Care Transitions Program (CCTP). This template prompted applicants to think through some helpful considerations in estimating the impact and assessing the efficiency of the resources they were requesting, which was essentially a form of ROI.

The modeling includes:

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

The **Readmission Reduction Impact and Financial Analysis Tool** ***(Tool 8)*** can serve as a starting point for modeling the impact of your multifaceted readmission strategy and provide feedback about the cost-efficiency of the investments required to operate the portfolio of efforts.

Readmission Reduction Impact and Financial Analysis Tool *(Tool 8)*

- **Purpose:** To quantify patients served, projected impact, and estimated savings (to payer) of hospital-specific readmission reduction efforts.
- **Description:** This Excel sheet facilitates modeling of the impact of the strategies in your hospital's readmission reduction portfolio. It prompts teams to quantify patients to be served by each strategy, baseline readmission rate, and projected readmission reduction. It also helps estimate the avoided utilization (payer cost) due to each of the strategies, accounts for the investment cost of the intervention (in tools, staff, time), and calculates net "savings" (to payers).
- **Staff:** Quality improvement leadership, business analyst.
- **Time required:** 2-4 hours.

Model the Impact of Your Strategy, or "The Fallacy of the 1 FTE"

Guided by a narrow concept of readmission risk or by a primary motivation to avoid diagnosis-specific readmission penalties, many hospitals have hired a new clinician to intensify transitional care services for a subgroup of patients. This strategy may greatly improve care for the individuals served but may not result in the desired outcome at the organizational level.

Consider the following example. Hospital A has 5,000 Medicare discharges annually and a 20 percent Medicare readmission rate, thus projecting 1,000 readmissions. Hospital A hires a transitional care full-time equivalent (FTE) to provide enhanced services to heart failure patients transitioning to home without home care. This FTE attempts to manually screen for heart failure patients, narrows to those who with Medicare fee for service, and further narrows to those who are being discharged to home without home care. The transitional care FTE screens three times more patients than he or she serves and suspects he or she misses several patients identified late in the hospitalization as having heart failure. Ultimately, this FTE provides high-quality transitional care services to 200 patients and reduces readmissions in this subgroup by 20 percent.

As illustrated in the table below, the impact of this successful transitional care service is 10 fewer readmissions. The overall impact on Medicare readmissions is just a 1% reduction. The impact on the hospitalwide all-payer readmission rate is undetectable.

	Number	Rate
Medicare discharges/year	5,000 discharges	
Medicare readmission rate		20%
# Medicare readmissions/year	1,000	(.20*5,000)
Transitional care heart failure intervention	200 discharges/year	
Heart failure readmission rate		25%
Expected # readmissions	50	(.25*200)
Expected impact of intervention		20%
# Readmissions averted by intervention	10	(.2*50)
Impact of strategy on Medicare readmissions	1%	(10/1,000)

In Practice: Frederick Memorial Hospital

Starting small and expanding gradually

Frederick Memorial began their readmission reduction efforts by focusing on heart failure patients. During this pilot, they did not hire any FTEs and tracked how many patients they could touch and affect. Extrapolating data collected from this effort, they estimated the impact they could make on patients throughout the hospital, what it would cost, and how much it would save. With this plan, they got the support of senior leadership, which was critical for hiring new FTEs. Frederick Memorial also created a dashboard with the ideal list of items they wanted by identifying the different domains of their readmission reduction efforts (using the BOOST institutional assessment tool), three to five strategies they needed to focus on in each domain, the responsible staff, and the timeframe for the work. Although the number of fields populated in this dashboard was initially low, it gradually became fuller and more specific over time. Frederick Memorial thought they would break even in the first year after their pilot, but instead had a 7:1 ROI and have held steady since.

Get Started Immediately

Many quality improvement teams encounter barriers to their readmission reduction efforts. Whatever your hospital's particular issues are, it is always possible to move forward and make progress. Below are some common difficulties that readmission teams encounter and recommendations for moving forward, notwithstanding these barriers.

Common Barriers to Reducing Readmissions	What You Can Still Do
'We're still studying the root causes of readmissions."	As mentioned in Section 1, it is important to gather just enough data to move forward. Limit the amount of data collection and analysis to the key facts that will give your team actionable insights. If that process drags on, make sure your hospital is following best transitional care practices in a way that addresses Medicaid patients' needs (Section 4).
"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. In particular, see Sections 4 and 5 to look at strategies to modernize standard hospital-based processes and partner with outpatient providers.
"We don't have the money to hire any FTEs."	Hiring transitional care staff is often necessary to provide enhanced services. However, hiring one or several FTEs is only one method of reducing readmissions. Improving hospital-based transitional care processes (Section 4) and collaborating with cross-setting patterns (Section 5) 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 are core functions of EMRs. 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 (Sections 5 and 6); this makes it all the more important to provide high-quality transitional care for all (Section 4).
"There's no peer-reviewed literature to support this readmission reduction strategy."	Successful readmission 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 5).

Section 4: Improve Hospital-Based Transitional Care Processes for Medicaid Patients

Key Actions

Begin readmission reduction efforts in the emergency department

- Create a flag for high utilizers and potential 30-day readmissions in the ED.
- Create care continuity and institutional memory in the ED by creating individualized care plans.
- Use health information exchange portals in the ED to identify care-seeking patterns and consistent symptomatic presentations, and to confirm whether the presentation is acute or chronic.
- Staff a dedicated readmission avoidance clinician in the ED to coordinate with outpatient providers and social services for patients with low-acuity presentations.

Contextualize the history of present illness within longitudinal utilization information

- Ask the patient about hospitalizations and ED visits in the past 6-12 months.
- Consistently obtain records from other providers, medical and behavioral health.
- Take a longitudinal view of patients, place their hospital utilization in the context of other care-seeking (or avoidant) patterns, and use this information to inform the care plan.
- Use the ***Readmission Risks Tool (Tool 9)***.

Specifically inquire about social and behavioral health needs

- Inquire about housing, legal concerns, transportation, and food insecurity.
- Inquire about substance use or mental health needs and whether they have treatment.
- Inquire about whether the patient is newly enrolled in Medicaid.
- Link patients to the appropriate referrals and resources to address those needs.
- Use the ***Whole-Person Assessment Tool (Tool 10)***.

Listen to all the reasons patients return to the hospital

- Ask patients why they needed to return to the hospital.
- Recognize there are often numerous factors leading to a readmission; capture all and avoid looking for a singular reason.

Effectively engage patients and caregivers

- Inquire about and address patients' and caregivers' priorities when discussing posthospital needs.
- Identify the "learner," also known as the "care plan partner," who may not be a family member.
- Consistently use medical interpreters to communicate with patients when indicated.

Use teach-back

- Verbalize information, focusing on three to five short-term self-care messages.
- Provide an opportunity for clarification.
- Ask the patient/caregiver to repeat information back to confirm understanding ("teach-back").
- Provide anticipatory guidance ("what to watch for and what to do")

continued

Key Actions (cont'd)

Customize written information and write it at an elementary reading level

- Provide individually tailored information.
- Develop written materials at the third grade reading level and in the patient's preferred language.
- Include which symptoms to watch for, what to do, and whom to call.

Clearly explain medication information

- Explain what to take, when, why, and how, as well as what side effects to look for.
- Explain what to do and whom to call if side effects develop.
- Discuss how the patient will get medications and identify any financial or logistical barriers.

Provide an early posthospital point of contact

- Options in the home or community include: postdischarge phone calls, home visits, community health workers, visiting nurses, pharmacists, and health plan care managers.
- Options in medical settings include: non-physician office visits, visits with transitional care teams, urgent care centers, discharge clinics, and appointments in the ED during slow hours.

Connect patients to primary care, behavioral health, and social services as needed

- Establish a process for referring unassigned patients to primary care providers.
- Establish a process for referring patients to behavioral health providers.
- Assess and address social needs in the community setting.
- Provide high-risk patients with navigators or advocates to minimize barriers to care.

Ensure that patients have or can obtain medication, supplies, and transportation

- Consider bedside delivery of medications.
- Procure common supplies, such as glucometers and scales for patients.
- Provide transportation vouchers.
- Consider allocating a discretionary account to cover medically necessary incidentals.

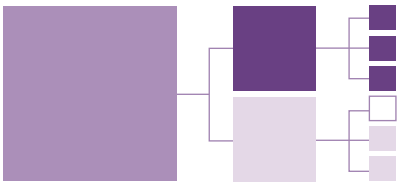
Provide real-time information to receiving providers and health plans

- Complete discharge summaries at the time of discharge.
- Notify primary care and behavioral health providers at admission and prior to discharge.
- Notify the Medicaid health plan prior to discharge to facilitate posthospital care.
- Provide an opportunity for collaboration and clarification about the care plan.
- Use the ***Discharge Information Checklist (Tool 11)***.

Use a checklist to ensure all transitional care elements are reliably provided

- Develop a transitional care checklist.
- Use the transitional care checklist for all patients, not just high risk.
- Deploy the transitional care checklist across all departments.
- Monitor and provide feedback regarding transitional care checklist use.

Section 4: Improve Hospital-Based Transitional Care Processes for Medicaid Patients



"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."

Your hospital's readmission reduction team is likely well versed in the best-practice recommendations from Better Outcomes by Optimizing Safe Transitions (BOOST), STate Action on Avoidable Rehospitalizations (STAAR), and Re-Engineered Discharge (RED):

- Assess readmission risk,
- Use teach-back to better inform patients of their self-management tasks,
- Engage support persons as active learners in the transitional care process,
- Intensify efforts to ensure accurate medication management,
- Make timely followup appointments,
- Provide clear written information to patients,
- Provide timely information to outpatient providers,
- Make postdischarge followup phone calls, and
- Use a checklist to ensure reliable delivery.

This section provides guidance on adapting or expanding hospital-based transitional care efforts to better serve the needs of adult Medicaid patients.

New CMS Guidance Elevates Expectations

In May 2013, CMS issued new guidance for assessing whether hospitals are in compliance with the CMS Discharge Planning COPs.[ii] The guidance document that CMS issued to surveyors provides an excellent blueprint for modernizing hospital-based transitional care planning processes. Notably, CMS emphasizes that the Discharge Planning COPs apply to Medicaid as well as Medicare patients.

[ii]This guidance is provided to accreditation entities, such as the Joint Commission and others, to bring specificity to the questions and domains of activity that surveyors assess during site visits.

Furthermore, the processes summarized below describe what should be delivered as standard care for all *Medicare and Medicaid patients*, not only patients identified as high risk for readmission. This document provides a valuable synthesis of many of the well-known best practices to improve the transitional care process. CMS specifies that hospitals must:

- Have a documented discharge planning process;
- Analyze and track their readmission rates;
- Review readmissions to look for patterns;
- Conduct root cause analyses on readmissions to assess whether their discharge planning process meets patients' needs;
- Craft a discharge plan that can be realistically implemented;
- Actively solicit the input of the patient and family/friends/support persons;
- Provide customized education to patients and their caregivers;
- Provide verbalized instructions using the teach-back technique;
- Arrange for posthospital services;
- Know the capabilities of postacute and community-based providers, including Medicaid home- and community-based services; and
- Know options for Medicaid long-term services and supports, or have a contact at the State Medicaid agency that can assist with these issues.

Improve Care for All Patients, Not Just for High-Risk Patients

Many hospitals have implemented some elements of these new CMS COPs. The challenge many hospitals face in achieving hospitalwide readmission reductions is moving beyond making improvements for only a subgroup of high-risk patients and improving the transitional care process for all patients. There are many reasons to improve transitional care for all patients.

First is the regulatory compliance rationale: the 2013 CMS COPs make it clear that improved processes are required for all Medicare and Medicaid patients. Since public payers typically make up a majority of safety net hospitals' payer mix, the efficient response to this requirement is to improve care systematically.

Second is the clinical quality rationale: the literature has established that current transitional care processes are lacking in almost every respect. Each patient, regardless of admission diagnosis, payer, or presence of comorbidities/complexities should have a safe and effective transition out of the hospital and into the next care setting.

Third is the clinical impact and clinical efficiency rationale: it is 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 discharge advocate screens admissions hospitalwide daily to identify patients with a primary diagnosis of heart failure. The hospital has 10,000 admissions (adults) per year; 5 percent have a primary discharge diagnosis of heart failure and 20 percent have a secondary discharge diagnosis of heart failure. The discharge advocate was charged to find the 500 (5% of 10,000) patients who would ultimately be coded in hospital billing data as a heart failure diagnosis-related group (DRG). However, clinically there were at least 2,500 (25% of 10,000) patients with heart failure. Based on these calculations, the heart failure discharge advocate would need to screen and serve 500 to 2,500 patients annually, or 1-8 new patients per day, 365 days per year. The discharge advocate works 200 days per year and serves 2-3 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 heart failure 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 highlights the opportunities to implement the best practices now contained in the CMS COPs and, where needed, make adaptations to best serve the unique needs of Medicaid patients. This section is organized into six subsections, drawn from complementary domains addressed in RED, BOOST, STAAR, and the CMS COPs:

1. Conduct a comprehensive "whole-person" assessment, starting in the ED;
2. Engage the patient and family/caregivers in developing a plan of care;
3. Provide customized information, using teach-back and other modalities;
4. Arrange for followup and services;
5. Provide information to receiving providers in the community; and
6. Use a checklist to ensure reliable delivery of intended services for every patient.

The table below illustrates the different domains of the transitional care process that are addressed in RED, BOOST, STAAR, and the CMS COPs.

Best Practice	Assess Needs	Engage Patient & Caregivers	Provide Customized Information	Arrange Followup	Provide Information to Receivers	Use a Checklist
RED		X	X	X	X	X
BOOST	X	X	X		X	X
STAAR	X	X	X	X	X	
CMS COPs	X	X	X	X	X	X

Conduct a Comprehensive Whole-Person Assessment

Readmission reduction starts in the emergency department, prior to admission

In the current body of readmission reduction work, best practice recommendations typically start at the point of admission to the inpatient setting. However, the "starting point" of readmission reduction efforts should shift solidly into the ED arena, where admission decisions are made. This process is especially relevant for adapting your work to better address Medicaid readmissions. Your root cause analysis may have revealed that patients seek care preferentially in the ED for a variety of reasons. The emergency department is an important care setting in which to identify patients at imminent risk of readmission.[7]

In the ED, hospitals should:

- Create a flag in the ED record to make it visible to staff that the patient is a high utilizer or potential 30-day readmission;
- Use health information exchange portals to identify care-seeking patterns and consistent symptomatic presentations, and to confirm whether the presentation is acute or chronic;
- Create care continuity and institutional memory in the ED by making individualized care plans to facilitate consistent management of complex medical, behavioral, and social issues; and
- Staff a care transitions clinician in the ED dedicated to readmission avoidance consistently to coordinate with families, outpatient providers, and social services for patients with low-acuity presentations who can be discharged from the ED without an admission.

Contextualize the history of present illness with longitudinal utilization information

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 not only for any "index" hospitalization, but particularly so for readmissions, when placing the patient's presentation in the context of a recent hospitalization is essential to guide

the 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 rediagnosing 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 avoidant) patterns, and use this information to inform the care plan.

View readmission risks broadly

A large number of clinical, functional, social, and demographic features place patients at risk of readmission. Review the factors on the **Readmission Risk Tool** ***(Tool 9)***, and consider, "Which of our patients do not have any of these issues?"

Readmission Risks Tool *(Tool 9)*

- **Purpose:** At-a-glance listing of readmission risk factors.
- **Description:** This tool is an educational and awareness building tool for frontline staff, cross-continuum teams, and quality improvement leadership to quickly review the numerous factors that lead to risk of readmission. It highlights the fact that narrow targeting strategies will miss numerous patients with these issues.
- **Staff:** Hospitalists, nursing, case management, cross-continuum teams.
- **Time required:** Quick review and discussion at meeting; post in workrooms.

Specifically inquire about basic needs ("social determinants")

The social, economic, and geographic conditions in which individuals live have a profound impact on individuals' health status. Hospital staff often consider that these "social needs," such as food and shelter, are 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 fail for individuals whose pressing fundamental survival needs are unmet.

For Medicaid patients, 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 remember to inquire about social supports, economic constraints, coping strategies, self-management capabilities, and social support networks in detail. This task will often require going well beyond the brief "social history" that is contained in the physician's admission history and physical.

Hospitals and hospital providers committed to reducing readmissions will quickly recognize the value of a detailed whole-person needs assessment. Taking a broad view of what the patient needs from this hospitalization, including considering why the patient decided or needed to use the hospital setting rather than the ambulatory setting, will identify the specific ways a readmission can be avoided. 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 (see Section 5).

The **Whole-Person Assessment** ***(Tool 10)*** provides a series of questions to ask about unstable housing, economic insecurity, food insecurity, substance abuse, and behavioral health diagnoses. The tool is designed to help hospitals identify essential basic needs and social complexities and facilitate effective and timely referrals to community and payer-based resources. Develop the companion **Community Resource Guide Tool** ***(Tool 13)*** discussed in Section 5 to help floor staff increase appropriate referrals.

Whole-Person Assessment Tool *(Tool 10)*

- **Purpose:** Identify patient-specific functional, social, logistical needs, and facilitate referral to supports available in the community.
- **Description:** This tool provides a checklist to prompt frontline staff to identify and address basic needs.
- **Staff:** Frontline staff in the hospital, including social workers, case managers, etc.
- **Time required:** 20 minutes to assess; conduct at least 24 hours prior to discharge for sufficient time to act on information and make referrals.

Engage Patients and Caregivers in Developing a Care Plan

Capture all the reasons patients returned to the hospital

A simple and often overlooked method of figuring out why the patient returned to the ED is to ask, "Why did you need to return to the hospital so soon after your last hospitalization?" Asking patients why they came to the hospital that day can sometimes reveal very simple solutions that can prevent their return. For instance, a 53-year-old man with HIV/AIDS presented to the hospital with a chief complaint of "unable to walk" and was admitted to the medicine service. The next morning, the patient 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, which could have been seen in a rheumatologist's office in a same-day outpatient visit. Many avoidable readmission stories are rooted in misunderstandings or difficulties that patients have accessing timely care in the ambulatory setting, rather than purposeful nonadherence.

A team at Kaiser Permanente reviewed 523 readmissions of all adults over age 18 across 14 Northern California Kaiser hospitals. Using the "readmission interview" technique of the STAAR Initiative, the team had a novel approach: rather than adjudicating a singular reason for each readmission, they cataloged all the issues that continued to the readmission, including all the factors cited by patients or their caregivers. The team found that an average of nine issues contributed to each potentially avoidable readmission.[6]

Address patients' priorities first

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.

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[8] and the United Hospital Fund's Next Step in Care Web site (http://www.nextstepincare.org/).

Identify the "learner"

Mr. R is a 55-year-old man with diabetes and congestive heart failure who was hospitalized for high blood sugar. The physician approached Mr. R to discuss dietary and self-management recommendations intended to help avoid future similar hospitalizations. Mr. R did not take his eyes away from the football game on the TV, pointed to his wife, and said, "Talk to her. She's the boss."

For various reasons, patients may not always be the most receptive or appropriate "learner" of care plan information. Although providers always work to engage directly with patients to emphasize the critical importance of active self-management for long-term healthy living, the example of Mr. R shows that 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 STAAR Initiative recommends that hospital staff identify the "learner" for each patient, sometimes alternatively called the "care plan partner." It 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,
- Community-based case workers,
- Peer supports,
- Community corrections officers,
- Community health workers, and
- Lay health navigators

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.

Provide Customized Information Using Teach-Back

"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."

Use teach-back

Teach-back is a best practice strategy that providers can use to deliver customized, relevant information to patients and caregivers.[9] 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 they are confused, then 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.

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 patients' 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.[10]

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 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?"

Arrange Followup and Posthospital Services

Your 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. Thus, the imperative to arrange for immediate support for patients in the first days following discharge is apparent in your own hospital's readmission patterns.

Provide an early posthospital point of contact

Postdischarge followup is often interpreted as "physician appointment." However, early contact posthospitalization does not necessarily need to be defined as a face-to-face physician appointment. Two notably successful Medicaid transitional care models, Community Care North Carolina (http://www.communitycarenc.com/) and North Alabama Community Care,[iii] use nonphysician early contact via phone and home visits to identify needs posthospitalization. In addition, two Medicare programs, the CMS Community-based Care Transitions Program (http://innovation.cms.gov/initiatives/CCTP/) and the new Medicare transitional care payment codes[11] use nonphysician, virtual, and home-based contact to ensure early contact posthospitalization.

High-volume Medicaid providers often cite the lack of primary care capacity in their community as a major barrier to reducing readmissions. This shortage is a challenge, and increased access to primary care is an urgent national and community-specific need. However, as demonstrated by the above Medicare and Medicaid transitional care models, posthospital followup and support can be provided in other ways. Hospitals may look to many other creative options for clinical followup posthospitalization, such as resident clinics, urgent care centers, postdischarge clinics, and slow hours

[iii]See, for example, Transition of Care Program, at http://www.naccnetwork.com/transition-of-care-program-2/.

in emergency departments. Posthospital contact can be provided by physician extenders; visiting nurses, especially those with behavioral health expertise; social workers; community care managers, plan-based care managers, community health workers, and patient advocates; and others. Identify these resources through the **Community Resource Guide Tool** ***(Tool 5)***, discussed in Section 5.

Tips To Reach Patients by Phone

Disposable cell phones, limited minutes, and a concern that a blocked or general hospital number may be a billing department have all been raised as potential barriers to making successful phone contact with Medicaid patients after hospitalization. Providers who have been able to effectively reach patients by phone recommend that you:

- Tell patients that you will be calling to check on them when they get home, to make sure they are able to get their medications and get to their appointments. Providers report that when patients are expecting a call from a known clinician (including community health worker) they will answer the phone.
- Try to call from a nonblocked number.
- Confirm the cell phone number directly with the patient. Do not rely on administrative records, as cell phone numbers are frequently outdated.

In Practice: Temple University Hospital

Let the experts schedule appointments

Temple University Hospital lets people who have the knowledge and resources to make effective followup calls check up on patients and help them to make appointments. In 2013, Temple University Hospital's Access Center scheduled about 20,000 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. To date, the Access Center has made 3,500 followup phone calls, with a completion rate of 63 percent.

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 personal contact information, have no language barriers, and in many ways, have more knowledge about how to navigate the hospital system.

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, they 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.

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 1-2 weeks. This is not an effective way to ensure that Medicaid patients are established with a primary care physician and receive timely posthospital followup. First, this may be a difficult task for some individuals to sequence and execute, especially when barriers in the process arise.

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 1-2 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 follow-up 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.

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.

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 to occur.

- 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, etc., 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, etc. 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.

The **Discharge Information Checklist** ***(Tool 11)***, adapted from the CMS COPs, provides guidance regarding the necessary information that should be shared with receiving providers.

Discharge Information Checklist *(Tool 11)*

- **Purpose:** Examine whether the standard information that should be provided to all patients and receiving providers at time of discharge is given, regardless of readmission risk.
- **Description:** This tool, adapted from the CMS COPs, provides a checklist of information that needs to be provided to patients and their receiving provider at the time of transition.
- **Staff:** Quality improvement, nursing, case managers, hospitalist staff.
- **Time required:** N/A: tool used for informing a review of existing processes.

Use a Checklist To Ensure Reliable Delivery of Intended Services

Many tasks in the transitional care process go undone not for lack of good intentions and hard work, but for lack of a defined process, role specification, and accountability. A checklist can provide important prompts and reminders to staff to ensure all elements of an improved transitional care process are provided and completed for every patient, every time.

Project RED (Re-Engineered Discharge) has provided invaluable guidance to the hospital field in providing specific guidance on re-engineering the discharge process for higher quality and higher reliability. A key concept in Project RED is a shared discharge checklist. As described by RED, the 11 items on the discharge checklist are not one person's responsibility to directly complete. Rather, the checklist helps hospital staff across days, shifts, and roles to see what elements have and have not been completed.

An innovative concept in Project RED is the role of the "discharge advocate," who is not intended to directly provide all elements of the process, but rather to contribute to those tasks and ultimately ensure all elements are complete for each patient prior to discharge. In addition, the discharge advocate is identified as a consistent point of contact for the patient in the postdischarge period.

The **CMS COPs Checklist** ***(Tool 6)*** and the **Discharge Information Checklist** ***(Tool 11)*** can help you update your transitional care checklist. In addition to these resources, the INTERACT toolkit (Interventions to Reduce Acute Care Transfers) has produced a checklist for complete hospital-to-SNF transitions[12] and SNF-to-ED transitions.[13]

Deliver Improved Hospital-Based Care for All Patients

This section about improving hospital-based transitional care to better serve the transitional care needs of Medicaid patients would be incomplete without a note on challenging clinical circumstances. Your team's readmission interviews will likely elicit stories from patients who left the hospital against medical advice, or patients with an active substance use disorder. Often, it can seem impossible to expect that hospitals can effectively influence the transitional care outcomes of these patients. Nonetheless, invite an open self-evaluation and reconsideration of the extent to which clinical staff offer information, counseling, and facilitation of followup for these patient populations.

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.

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.

Section 5: Collaborate With Cross-Setting Partners

Key Actions

Form a cross-continuum team

- Start with "coalition of the willing," partners who are eager to collaborate.
- Engage high-volume Medicaid providers, such as federally qualified health centers, community health centers, resident clinics, behavioral health centers, adult daycare centers, substance use treatment facilities and providers, and pharmacists.
- Engage Medicaid-specific support and service agencies, such as public health departments, group homes, transitional and supportive housing, transportation, food, and legal assistance.
- Engage Medicaid and Medicaid managed care and behavioral health carve out plans' case managers.
- Use the **Cross-Continuum Team How To Tool *(Tool 12)***.

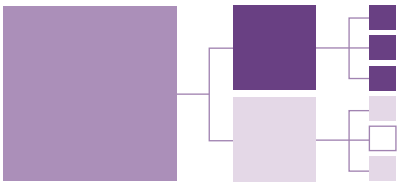
Identify community resources for Medicaid patients

- Create a cross-continuum inventory of resources for a wide range of clinical, behavioral health, and social service needs.
- Ask cross-continuum partners to recommend or develop efficient methods to link patients to community-based resources at the time of discharge.
- Use 2-1-1 and people familiar with local social services to create a comprehensive inventory.
- Ask Medicaid health plans for information about available wraparound services.
- Use the **Community Resource Guide Tool *(Tool 13)***.

Collaborate with cross-continuum partners

- Meet regularly.
- Discuss recently readmitted patients to develop a common understanding of transitional care challenges and opportunities for improvement.
- Identify a point person at each agency who can route questions internally and facilitate collaboration.
- Develop a "pick up the phone and call" relationship with Medicaid-relevant community providers and health plans who can help facilitate posthospital services prior to discharge.

Section 5: Collaborate With Cross-Setting Partners



"We would be thrilled if someone from the hospital called us."

Improving hospital-based transitional care processes is essential. However, the best transition out of the hospital is only as good as the reception into the next setting of care. Forming partnerships with "receiving" providers—postacute, community-based, payer-based, and social services—not only helps to ensure that the clinical and transitional care provided by hospitals is more likely to succeed in the posthospital setting, but also substantively extends and deepens the resources and services available to patients.

Over the past several years, forming cross-continuum partnerships has emerged as a core competency of effectively delivering care across settings and over time. The STAAR Initiative emphasized the benefits of forming a "cross-continuum team," the Care Transitions Aim of the CMS QIO program provided technical assistance and support to "community coalitions," and the CMS Community-based Care Transitions Program requires cross-setting partnerships between hospitals and community-based organizations to provide cost-efficient and effective transitional care services in the posthospital period. Accountable Care Organizations (ACOs) and Bundled Payments for Care Improvement (BPCI) teams are focusing on developing strategies to improve care across settings when not all care settings are part of the same organization.

Whatever they are called, cross-continuum teams are much more than just coffee talk and networking venues. Providers with effective cross-setting partnerships cite the trust, transparency, shared goals, real-time problem solving, shared operational strategies, and clinical comanagement pathways as foundational to their success in transforming into value-based delivery systems.

There are several specific reasons and practical benefits to forming a cross-continuum team, including the opportunity to:

- Declare your hospital's readmission reduction goals to referral partners;
- Identify committed postacute and community-based providers and agencies;
- Discuss aligning efforts to improve posthospital care and reduce readmissions;
- Obtain "user" feedback from "receiving" providers;
- Learn what information "receiving" providers need to effectively assume care;
- Discover how to efficiently connect patients to community-based services and supports;

- Identify shared high-needs or high-risk patients within a community; and
- Actively solve common collective problems or barriers for current shared patients.

Aligning and leveraging your existing community resources is efficient and mutually beneficial. This section discusses how to form a cross-continuum team, identify and engage with partners specifically relevant for Medicaid patients, and develop collaborative, problem-solving relationships to meet patients' posthospital needs. As specified by the CMS COPs, improving transitions in care by working more closely with postacute and community providers and understanding Medicaid supports not only is "nice to do," but also is considered crucial to achieving effective and safe care after hospitalization.

Form a Cross-Continuum Team

"Who's not our partner at this point? There's so much out there."

Forming a cross-continuum team does not need to represent a major new strategic business decision. Cross-continuum teams should begin with a "coalition of the willing"—that is, partners who are eager to collaborate and work toward a shared aim of reduced readmissions. Begin with providers, agencies, and Medicaid health plans with whom you commonly share patients. Expand the network of engaged stakeholders as challenging posthospital care needs are identified through your efforts, data, and patient interviews.

To date, 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 and hospice agencies, and area agencies on aging.

Hospitals can readily expand their cross-setting partnerships to include providers and health plans who serve a high volume of Medicaid patients, such as:

- Medicaid health plans;
- Medicaid behavioral health carve out plans;
- Federally qualified health centers;
- Community health centers;
- Resident clinics;
- Behavioral health centers;
- Adult daycare centers;
- Substance use treatment facilities;
- Medical interpreters;
- Nurse associations;

- Pharmacists; and
- Nearby hospitals, urgent care, or freestanding emergency departments.

In addition, a cross-continuum team that can address Medicaid patients' needs should include partners who provide a broad range of essential and supportive services, such as:

- County health departments;
- Group homes;
- Transitional and supportive housing;
- Shelters;
- Transportation services;
- Food assistance;
- Legal assistance; and
- Peer support.

Many high-volume Medicaid hospitals cite resource scarcity as a limitation in their ability to reduce readmissions, while Medicaid plans and community-based agencies report that hospitals rarely, if ever, reach out to them for assistance. This reflects an outdated concept that if the hospital does not provide the service, the service does not exist. Hospital staff do not need to know what all the resources are in a community, but they need to know whom to work with to access existing resources for patients. The cross-continuum team accomplishes that goal.

The **Cross Continuum Team How To Tool** ***(Tool 12)*** describes the process of building a cross-continuum team and offers a list of different partners your hospital might consider working with. The tool also provides a template for inviting partners to this team.

If you already have a cross-continuum team, identify ways to expand your team to include Medicaid-relevant providers, payers, and agencies in addition to Medicare-relevant providers and agencies. Refer to the **Cross-Continuum Inventory Tool** ***(Tool 5)*** for a list of Medicare- and Medicaid-relevant cross-continuum team partners.

Cross-Continuum Team How To Tool (Tool 12)

- **Purpose:** To advise and assist with the formation of a cross-continuum team.
- **Description:** This tool explains the benefits and process of building a cross-continuum team and offers a template for inviting partners to join it.
- **Staff:** Quality improvement leadership, cross-continuum team.
- **Time required:** N/A; tool used for informing how to convene this team.

Identify Community Resources for Medicaid Patients

> *"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."*

Social conditions have a great effect on morbidity and mortality, and it follows that they affect hospital readmission rates as well. For the Medicaid population especially, the vulnerabilities patients face in terms of food insecurity, inadequate housing, financial difficulties, behavioral health, and other issues are risk factors that can send them back to the hospital. Many hospitals ignore these nonmedical risk factors and define them as "not their problem," but hospitals still must care for patients who return with a preventable readmission. Many of these readmissions can be prevented through effective partnerships with community resources that are designed and equipped to address these social determinants of health. Both the hospital and patients will benefit if patients can successfully access and use existing community resources.

Unfortunately, many hospitals perceive that there are limited or no community resources available, even though community agencies wish hospitals would refer patients more frequently for services they can provide. The first step to being able to meet patients' needs is to know which community agencies provide which services. This step includes understanding what types of "wraparound services" are available from Medicaid health plans to address basic needs in the context of their health care needs.

The **Whole-Person Assessment Tool** ***(Tool 10)*** lists different types of basic needs that may be optimally addressed by plans, Medicaid agencies, or community-based agencies. Traditionally, hospitals may have assumed that the responsibility for linking patients with supportive services fell outside their role as acute-care providers. However, as stated in the CMS COPs and as reflected by the increased accountability of hospitals for transitional care, it is now essential for hospitals to screen for, anticipate, refer, and connect patients to supportive services to ensure posthospital stability. The following are starting places for identifying community resources for each of these areas:

1. **Your cross-continuum team partners.** A highly useful function of your cross-continuum team is to ask them to help populate an inventory of community-based services that can meet the clinical and nonclinical needs of Medicaid patients after hospitalization. Their knowledge and experience with these services will be helpful in creating efficient linkages to care.
2. **Key contacts at Medicaid health plans.** Representatives from Medicaid health plans should be invited to the cross-continuum team meetings, but depending on geography, they may not be able to attend in person as local service providers can. A clinical/quality leader at the hospital (e.g., director of quality) should identify a key contact at each Medicaid health plan who can understand and clarify the types of supports and services the plan can provide and to which types of patients. Most important, the hospital and each plan should develop a clinical (not just utilization review) point of contact to facilitate time-sensitive discussions about posthospital supports and services to reduce readmissions;
3. **Your hospital social workers.** Social workers are trained to understand the comprehensive landscape of social services in a community. Over time, hospital-based social workers may benefit from inservices or networking with community-based colleagues to refresh connections and understanding of available programs and resources especially relevant to younger adults and Medicaid patients, as the landscape continually changes in any community.

4. **A search engine.** Searching online for community resources in your area can be a quick way to find potential partners and their contact information. This research method can be useful in addition to what the cross-continuum team partners and social workers are aware of.
5. **2-1-1.** Most of the United States has access to 2-1-1, a telephone hotline that specializes in health and human services information and referral. Calling 2-1-1 can also be a useful supplemental method of research for hard-to-find community resources.

2-1-1 San Diego

2-1-1 San Diego provides information assistance services for a variety of social and health services through a centralized county call center. They can link clients to and assess eligibility for public assistance and other community-based programs, including CalFresh (SNAP), utility assistance, financial assistance, housing, child care and early education, veteran services, shelter and homeless services, mental health services, disaster response, and health navigation. Highly trained navigators collect basic information from clients while referring them to appropriate services in the county or community through a warm handoff. As of January 2014, 2-1-1 San Diego had applied to become enrollment specialists for Medi-Cal to enhance the health navigation services they currently provide.

Having identified the available resources in such areas as housing assistance, substance abuse treatment, and other health and social services, consolidate this information into a document using the template provided by the **Community Resource Guide Tool** ***(Tool 13)***. Share this compilation with discharge coordinators, patient advocates, community health workers, and all other staff who assist with the transitional care process.

Community Resource Guide Tool (Tool 13)

- **Purpose:** Develop an updated resource guide of community resources relevant to providing posthospital supports and services to Medicaid patients.
- **Description:** This tool is modeled on a community resource guide developed by North Alabama Community Care. It prompts the cross-continuum team to identify specific contacts at community agencies to facilitate efficient referrals to services.
- **Staff:** Hospital readmission team, cross-continuum team.
- **Time required:** 10 hours.

In Practice: North Alabama Community Care

Gathering community resource information in one place

North Alabama Community Care (NACC) 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, on which the Community Resource Guide Tool (Tool 13) is modeled, includes organizational and contact information, by category, for a variety of services available to adults and children in the Huntsville, Alabama, region.

By containing all of the information in a single document, NACC's guide helps their 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 so that your staff can refer patients to needed posthospital services based on the needs they identify by using the **Whole-Person Assessment Tool *(Tool 10)***.

In Practice: Medical University of South Carolina

Linking patients to social support services in the community

Building on the partnerships developed with onsite community-based agencies, the Medical University of South Carolina implemented a program called HealthLinks 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 emergency department, rather than at the time of discharge. This program helps to address "whole person" and basic needs in order to facilitate better health and reduce avoidable utilization of health care resources.

Collaborate With Cross-Continuum Partners

Some hospital readmission champions are unsure of what the specific actions of the cross-continuum team are and may not consistently invest in cross-continuum meetings because of the perception that they are "just talk." To the contrary, the cross-continuum team is a valuable forum to develop multidisciplinary relationships, establish efficient communication strategies, establish efficient referral pathways, identify common patterns in readmissions that may elude the hospital's perspective, and problem solve.

The goals of these meetings should be to:

1. **Establish cross-setting, multidisciplinary relationships.** Develop a shared understanding of the priorities and perspectives of professionals who deliver care in different settings. Build a culture of constructive criticism and cooperation.
2. **Establish efficient communication strategies.** Identify point persons from each agency to facilitate efficient, direct communication. This coordination will facilitate provider-provider feedback, patient-specific problem solving, and efficient referral processes.
3. **Share information and data.** Information about transitional care services, processes, and other efforts among local organizations is essential to reduce redundancy of efforts and leverage each partner's strengths. Data from the hospital, providers, and agencies should be

shared so that cross-continuum team members are aware of progress (or lack thereof) and can help identify opportunities for focus.

4. **Define objectives, challenges, and expected outcomes.** Hospitals should declare their readmission reduction goal (what, by when, for whom) to cross-continuum team partners and describe the hospital-based initiatives underway to achieve that. Hospital leaders should outline the need for cross-setting collaboration and invite the community partners to join them in helping to achieve the goal. Specify the expected outcomes of the collaboration in both the short and long term.

5. **Share problem solving.** Start each meeting by describing the transitional care experience of a shared patient. Use those "readmission review" stories to identify ways partners across settings can improve their own processes and improve shared handoffs/referrals and service for patients after hospitalization. Set an organic action agenda that borrows from the quality improvement mantra, "See a problem, fix a problem." Prioritize addressing the challenges identified by the "receiving" providers before you ask them to change.

Cross-continuum teams take many different forms, and the different forms can serve different purposes. All forums and partnerships can create value for your hospital:

- **Community coalition:** This is a gathering of all willing and interested acute, postacute, and community-based providers, plans, service agencies, and other solution providers. The format is open invitation and new participants are the norm. This venue is particularly helpful for raising awareness about best practices to improve cross-setting care; reviewing readmission stories from a variety of perspectives; sharing locally successful ideas and approaches; demonstrating new technologies, tools, or services; and fostering a vibrant network of individuals interested in and working on improving cross-setting care from a variety of perspectives. Some community coalitions regularly engage 100 to 400 people in a region.
- **Cross-continuum team:** A subset of a community coalition or in place of a broader coalition, the cross-continuum team is typically composed of 10 to 30 individuals from local postacute, community-based providers and agencies. The team serves as a steering committee for optimizing handoffs, efficient referrals, and effective use of existing resources in the community.
- **Cross-continuum partners:** These are sometimes also referred to as "Joint Quality Committee," invoking a closer, more formalized venue for improving specific aspects of care of which "sending" and "receiving" providers are interdependent. A subset of a cross-continuum team, these may represent three to five leaders at the managerial level collaborating in an effort to deliver care across settings of care and over time (acute, postacute, home) or may represent three to five managerial leaders collaborating to develop shared transitional care strategies for a given transition type (e.g., hospital to skilled nursing facility handoffs).
- **Preferred providers:** Increasingly seen when providers enter into alternative payment arrangements, these typically include a small number of postacute skilled nursing facilities, inpatient rehabilitation centers, or home health agencies. Hospitals and preferred providers may establish formal shared expectations, codevelop standardized clinical pathways, and implement shared protocols for managing care across settings and over time. Frontline clinicians from each care setting may be in contact daily or several times a week to hold virtual care management rounds or to intervene early when a patient's clinical status changes to avoid return to the acute-care setting.

- **Hospital-payer collaborations:** Hospital providers may not be used to collaborating with health plans or Medicaid agency contacts in efforts to develop posthospital care plans. However, Medicaid payers and plans have strong incentives to reduce readmissions and can mobilize resources to meet a variety of patient needs for equipment, phones, transportation, integrated (behavioral and medical) care management, disease-specific care management, complex care management, social work, and transitional care followup calls. Payers and plans have a "whole person" view of high-risk patients and can identify care-seeking patterns that individual providers do not see in their own records. It helps to establish a point of contact between the Medicaid health plans or agency and your clinical readmission champion, develop a "pick up the phone" ad hoc problem-solving relationship, and meet with payers via conference call or in person quarterly.

In summary, formal and informal collaborations with providers, payers, and agencies that share in the care of your Medicaid population will extend and strengthen your hospital's direct efforts to improve transitions and reduce readmissions. Consider the following modes of engaging with partners.

Group	Members	Function	Meeting Intervals
Community Coalition	Broad attendance, open to all (50-100+ attendees)	Networking, awareness, educational events	Quarterly
Cross-Continuum Team	Committed, representative group of postacute and community-based providers and agencies (10-30 organizations)	Improved cross-setting communication, linkage to care and existing resources	Monthly
Cross-Continuum Partners	Managerial-level subgroup with a specific shared aim engaged in interdependent improvement efforts (5-10 organizations)	Subgroup of full team, a focused action implementation group such as improving hospital-SNF handoffs, improving ED-community resource linkages.	Monthly
Preferred Providers	Frontline clinicians actively executing shared cross-setting care pathways among a defined group of organizations (3-8)	Clinical management of patients across care settings, over time, according to shared strategies	Daily to weekly
Payers	Hospital readmission champion, medical directors, or care management directors of plans	Development of problem-solving relationship to mobilize resources and services available through plans to address posthospital needs	Ad hoc and quarterly

In Practice: Frederick Memorial Hospital

Partnering with community behavioral health providers

The Way Station is a community behavioral health organization that provides a broad range of services in a variety of settings to meet the needs of children, adolescents, adults, and families. The Way Station reached out to Frederick Memorial Hospital to address the needs of their shared patient population as the Way Station prepared to become a behavioral health home. Neither organization had prior experience working with the other. Frederick Memorial began monthly collaborative team meetings with the Way Station, ED case management, behavioral health crisis team, and inpatient psychiatry service to reduce inappropriate ED utilization and readmissions by:

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

In Practice: Baystate Health Center

Coordinating with local health center medical home

Baystate Health in Springfield, Massachusetts tested a process for more closely engaging the local clinic-based primary care team in the transitional plan of care for their shared, predominantly Medicaid, patient population. A hospital-based quality manager and the clinic-based care coordinator "ran the list" of hospitalized clinic patients the morning after they were admitted.

The clinic already had a process for identifying their patients who were seen in the ED and for patients who were discharged. But through their cross-setting partnership they determined that discussing patients at the time of admission might be best practice. The hospital-based quality manager noted how extensive the clinic-based care coordinator's knowledge was of the "whole-person" needs and could establish a targeted plan for patients during their stay as well as postdischarge. Both the hospital and the community health center found this collaboration helpful and feasible.

Section 6: Provide Enhanced Services for High-Risk Patients

Key Actions

Segment high-risk patients by their posthospital transitional care needs for:

- Lower intensity, shorter term services, such as postdischarge phone calls.
- Higher intensity, shorter term services, such as a multidisciplinary transitional care team.
- Lower intensity, longer term services, such as community health worker support.
- Higher intensity, longer term services, such as a dedicated sickle cell clinic.

Deliver services that address Medicaid patients' social, logistical, financial, clinical, and behavioral health needs, modeled on examples such as:

- Community health workers.
- Transitional care social workers (BRIDGE).
- Medication optimization, bedside delivery, and pharmacist followup calls.
- Community Care North Carolina.
- North Alabama Community Care.
- Johns Hopkins and Medical University of South Carolina Sickle Cell Clinics.
- New York Medicaid Delivery System Reform Incentive Payment (DSRIP) Program.
- Hennepin Health.
- FUSE model of supportive housing.

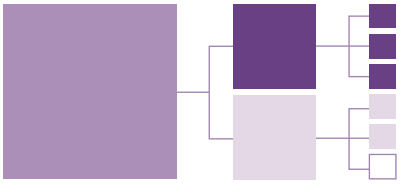
Explore different methods of financing enhanced services

- Hospital financed, based on avoidance of readmission penalties.
- Hospital financed, as a strategic investment in integrated care/population management to prepare capacity and infrastructure to engage in alternative payment models.
- Hospital financed, through community benefits in response to community needs assessments.
- Payer financed, through payments for transitional care or episodes of care over time.
- Payer financed, through alternative payment models that reward cost-efficient care.
- Payer financed, as direct service provided by the health plan (care management, social work).
- Payer financed, as contracted services provided by a third party.
- Funder- or foundation-issued grants at the local, State, and national levels.

Know the value of your proposed readmission reduction strategies to payers

- Use quantitative tools in this guide (Tools 1, 3, 7, and 8) to inform collaborations with payers to align efforts and deliver timely, cost-efficient care to improve quality and reduce costs.

Section 6: Provide Enhanced Services for High-Risk Patients



"I think that there's always going to be a group of folks that's always going to need somebody to help them. That's never going to change."

For some patients, the best transition out of the hospital and reception into the next setting of care will not suffice to reduce the risk of readmission. For this group, "enhanced services" will be needed to facilitate and ensure stability in the posthospital setting. "Enhanced services" are any of a variety of services that are tailored to the transitional care needs of specific subgroups of patients.

By definition, enhanced services go beyond the standard transitional care that patients at your hospital receive (see Section 4). Enhanced services require mobilizing and/or redeploying existing internal staff, repurposing existing resources into this new service line, or investing new resources.

This section describes the range of enhanced services that are well matched to meet the transitional care needs of the adult Medicaid population, key features of these services, and examples from the field. Unlike the practices in Section 4 (Improve Hospital-Based Transitional Care) and Section 5 (Collaborate With Cross-Setting Partners), which apply to all patients' transitional care, this category of enhanced services is defined as those additional services provided to specific subgroups of patients who experience readmission rates much higher than the population or hospital average.

The financial rationale for investing in posthospital enhanced services is that the relatively low cost of community-based supports, even when applied to numerous individuals, is less than the cost incurred by the significantly more costly recurrent hospitalization. A component of the cost of the averted hospitalization must be used to finance the provision of enhanced services. Providers participating in shared savings, bundled payments, global budgets, or capitation or who are subject to penalties or incentives based on readmission rates or acute hospital use overall will be more readily able to justify investing in enhanced services postdischarge to avert readmissions than hospitals that are not subject to these pressures. Hospitals that do not yet have these financial incentives should consider anticipating payment models that reward efforts to reduce hospital utilization, because they will accelerate your organization's capacity to align with market changes focused on the Triple Aim.

Types of Enhanced Services

> *"We don't call them 'noncompliant.' They have an adherence problem to their plan of care. How do we help them adhere to it? Do the PCPs and psychiatrists talk to each other? How can we be the liaison between them so that they can get the best care?"*

Hospitals, community providers, community agencies, and payers are actively developing, testing, and implementing services to address the transitional care or ongoing care management needs of individuals at high risk of readmission. Before investing in a new service, hospitals and other providers should be sure to inventory the available resources from other providers, community-based agencies, social service agencies, and payers for their high-risk populations, as discussed in Section 5 of this guide.

Increasingly, hospitals, health systems, accountable care organizations, and payers are responding to the needs of their most vulnerable patients by delivering enhanced services to patients at high risk of readmissions and overall health care service utilization.

There are many examples of enhanced services, ranging from a small number of randomized controlled tested care models, to services provided based on return-on-investment calculations for payers, to locally relevant services iteratively optimized to improve outcomes for defined subgroups.

One way to make sense of the heterogeneity we observe in the field is to classify the types of enhanced services as varying in intensity of service (or resources) and varying in time horizon of service provision.

Intensity of service refers to the combination of expense and service-delivery intensity, such as the number of contacts and/or the licensure level of the staff and/or the number of staff and/or the tools or technologies deployed that may either add to the cost of service or reduce the cost of service. Examples of varying levels of intensity of service include:

- Low intensity: 3 postdischarge followup phone calls provided by an offsite nonclinician;
- Medium intensity: weekly postdischarge followup phone calls provided by a community-based social worker who assesses and reassesses clients for barriers to care and makes referrals to existing services; and
- High intensity: multidisciplinary care team, composed of nurse practitioner, nurse care manager, pharmacist, social worker, behavioral health specialist, and community resource specialist who coordinate clinical, behavioral, and social services for patients identified at high risk of readmission.

Time horizon of service refers to whether the intent of the service is to provide time-limited service (days to weeks) or ongoing support (months or more). Perhaps the more relevant definition of "short term" is synonymous with "temporary," because such services are intended to effectively establish links with care and resources in the community. Services that are designed as "ongoing" emphasize the benefits of continuous relationships that are essential to serve the neediest and most challenging of individuals with complex medical and social issues.

Examples of services with varying time horizons include:

- A postdischarge phone call within 4 days of discharge;
- A defined transitional care model consisting of 4 transitional care interactions at defined time points within 30 days of discharge;
- A fluid posthospital care model that reassesses patients every 15 days for unresolved needs and allows engagement past 30 days postdischarge; and
- A care model that uses the hospital transitional care process as an entrée to long-term care management services.

Lower intensity, shorter term services

Low-intensity, shorter term services focus on providing support in the immediate posthospitalization time period to ensure followup with the care plan. The intensity of service may consist of nonclinician or clinician-provided phone calls; nonclinician phone calls may have a clinical manager overseeing a team that can manage via phone any clinical issues that arise. The posthospital phone call service may be slightly more resource intensive if cloud-based communications, responses, implementation performance, and/or program results tracking technology tools are engaged to optimize performance. The time-horizon is days to weeks postdischarge.

Postdischarge phone calls are increasingly prevalent. Variation exists in methods of operationalizing postdischarge contact. In fact, some patients receive postdischarge phone calls from numerous providers, which may be an inefficient use of resources and could be counterproductive if it increases patient anxiety or introduces confusion.

Examples of operationalizing postdischarge phone calls include:

- Hospital floor nurse, discharge planner, or case manager makes one postdischarge phone call at 24-48 hours to patients he or she discharged as part of daily workflow;
- Hospital call center, nurse helpline, or scheduling center makes one postdischarge phone call at 24-48 hours to all discharged patients;
- Hospital-based "discharge advocate" or other inpatient transitional care facilitator or manager makes one postdischarge phone call at 24-48 hours to all discharged patients;
- Community-based "discharge advocate" makes 3 phone calls, at 24h, 5 days, and 10 days postdischarge;
- Medicaid or commercial health plan makes one postdischarge phone call at 24-72 hours to inquire about symptoms and clarify questions about followup; and
- Medical home or primary care practice makes one postdischarge phone call to answer questions, review care plan, and arrange followup appointment.

Refer to the toolkit that Project RED developed on how to conduct a postdischarge phone call.[14]

Moderate intensity, shorter term

Slightly more intensive in resources are transitional care services that focus on medication reconciliation, medication education, bedside delivery of medications, pharmacist-provided medication optimization, and pharmacist-provided followup phone calls. Other moderate-intensity transitional care investments include providing patients with tablets, cell phones, or smart phone apps to allow secure messaging; and providing customized patient information, programmed prompts, and reminders and performance tracking for program management.

Numerous challenges exist at times of transition to ensure accurate medication reconciliation, medication teaching, and logistical and financial ability to access (pick up and pay for) medications. Local pharmacies may offer bedside delivery of medications combined with a suite of enhanced services to facilitate hospitals' efforts to provide medication optimization, medication reconciliation, and pre- and postdischarge medication-focused teaching.

The intensity of these services can be increased by using technology tools to facilitate medication optimization; decision support; timely access to pharmacy benefit manager databases to facilitate accurate medication reconciliation; access to controlled substance prescription registries to facilitate safe prescribing practices; implementation performance management; and outcome tracking of the service. The time horizon of medication optimization, delivery, education, and followup services is most typically limited to days to weeks postdischarge.

Higher intensity, shorter term

The health care system is notoriously difficult to navigate, especially for individuals with low literacy, those with low health literacy, those who are newly covered and inexperienced with the health care system, and those living in poverty. Patients routinely encounter barriers that prevent them from getting medications, transportation, appointments, answers to questions, information in their preferred language, and other essential needs to follow through on providers' recommendations.

Unstable housing, unsafe living environments, family crises, job insecurity, food insecurity, utility or power shutoffs, and other stressors magnify the difficulty of navigating an already complex system. For some patients living with these stressors, an advocate skilled in accessing resources and navigating the health care system is an essential component of an effective transition after a hospitalization.

An example of a higher intensity, short-term transitional care service is the BRIDGE Model of social worker-provided transitional care.[15] BRIDGE coordinators work with patients iteratively during and after their hospital stay, focusing on issues of greatest concern to the individual and working to ensure services, supports, medications, equipment, and appointments are arranged. The BRIDGE care coordinators perform "whole person" assessments in the hospital, immediately after hospital discharge once the patient is in the home setting, and a third time 4 weeks following discharge. BRIDGE social workers serve as comprehensive social workers to their transitional care clients, sometimes dedicating hours to addressing and resolving specific client needs in the posthospital period.

Lower intensity, longer term

Low-intensity, longer term services are focused on providing longer term connections to advocates, navigators, community health workers, community based care teams, and other resources to establish and maintain a therapeutic alliance, trust, and access to supports and services with the objective of stabilizing needs and providing continuity. An example of service in this category is a community health worker program.

Community health workers (CHWs)—also known as community health advocates, community health representatives, community health outreach workers, lay health educators, peer health promoters, and promotores de salud—can be an effective resource to help bridge gaps in care. They 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. The U.S. Health Resources and Services Administration (HRSA) has produced a toolbox that explains different CHW program models, how to implement CHW programs, and how to evaluate their impact.[16]

In Practice: Temple University Hospital

Community health workers connect with patients

Temple University Hospital started a 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 post-hospital 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.

Moderate intensity, variable term

Examples of increasingly resource-intense services include those that rely on licensed transitional care or care management professionals, either singularly or as part of a multidisciplinary care team. Resource intensity can be conceived of as higher skilled, and thus more costly staff; as more staff; or as more frequent and intensive contacts (such as daily phone calls, home visits, coordination of support services, and coordination of care plans with medical and behavioral health providers). The more intensive investment in services often reflects the many complex needs of the target population. Thus, few moderate-intensity services abruptly discontinue patient contact at 30 days postdischarge and aim to deescalate service intensity as needs are addressed over time.

Nurse Care Managers

An example of services in this category are plan-based integrated care managers or social workers. Medicaid health plans may provide telephonic-based nurse care managers to serve as coaches and medical navigators to patients over a variable time period, based on patients' needs, plan protocols, and clinical judgment. Plans also use social workers when the members' needs are predominantly nonclinical in nature. Often health plans identify patients for care management or social services based on their analyses of claims-based utilization history or by the presence of targeted diagnoses, such as diabetes or heart failure. Increasingly, nurse care managers and socials workers are being employed by accountable care organizations to serve the same roles.

Hospital staff may not know that the patient has a care manager based in the health plan; this service is something that hospital staff should routinely ask about. If the service is present, they should contact the care manager and involve him or her as part of the transitional care plan. Ask the point people from your local Medicaid health plans to consider establishing a referral process for plan-based care management based on frontline clinicians' assessment of needs and risks to augment the retrospective claims-based criteria the plans use.

Multidisciplinary Care Teams

At the hospital or health-system level, multidisciplinary care teams are emerging as a preferred model for addressing the needs of high-utilizing patients and those with complex medical or social needs. Multidisciplinary teams may be composed of a varying combination of physician champion, nurse practitioner, nurse care managers, visiting nurses, social workers, behavioral health specialists, pharmacists, and navigators/outreach workers.

Hospital-based high-risk care teams have several benefits, including real-time access to patients, starting in the ED, creating an opportunity to intervene before a decision to readmit; collaboration with ED clinicians, inpatient hospital physicians, nurses, and case managers; ability to use the hospital stay to orient the patient to posthospital services and supports; and opportunity to develop institutional memory about patients' complex care needs by developing individualized complex care plans.

The CMS Center for Medicaid and CHIP Services issued a July 2013 Informational Bulletin titled "Targeting Medicaid Super-Utilizers To Decrease Costs and Improve Quality," outlining the features of several different models of multidisciplinary care teams. The brief reviews policy issues, data and decision support tools, financial models for payment, targeting strategies, and clinical services provided by a variety of multidisciplinary care team models across the United States.

High intensity, longer term

High-intensity, long-term services may be most frequently provided by entities that bear full or partial financial risk for utilization and population health. Services in this category are characterized by an effort to address total costs of care, and the factors that drive health care utilization and are most often oriented toward long-term stabilization and continuity. Hennepin Health, a Medicaid Accountable Care Organization, exemplifies this approach to improving care to reduce costs.

Population Health Management—"Social ACO Model"

Hennepin Health is an accountable care organization (ACO) committed to addressing social determinants of health by integrating health and social services for whole-person care. Hennepin Health is instituting a high-risk care management team for their high-cost population. A risk-assessment tool is routinely used to assess social and behavioral needs, including housing, food security, substance use, and mental health. The care of each high-risk patient is then coordinated by a single accountable care coordinator who collaborates with a larger team comprised of professionals from medicine, behavioral health, and social services ("the coordinator of coordinators"). The intensive case management may be initiated due to repeated hospitalizations, but it is not limited to transitional care, and extends for an indefinite time period until stabilization is achieved.

Sickle Cell Clinics

For some high-risk patient populations, entirely new approaches for managing chronic, recurrent and urgent clinical issues will be needed. A clear example of this need for care delivery redesign –distinct from multidisciplinary care coordination – are strategies to reduce emergency department and hospital utilization for individuals 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. See the box on the following page for two examples of managing sickle cell crises in dedicated clinical settings—keeping patients out of the emergency room and hospital when avoidable.

In Practice: Successful sickle cell clinics

Johns Hopkins Hospital and two Medicaid managed care plans established a sickle cell clinic. The clinic can respond urgently and efficiently to patients experiencing acute pain crises, keep patients out of the hospital, and provide more expert management. The clinic has reduced total hospital utilization, readmissions, and ED visits and has been recognized as an innovation by the Maryland Department of Health and Mental Hygiene. 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 (MCOs), 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. With the MCOs supporting the Center's integrated approach to care, the Center achieved a readmission rate of 24 percent compared with a range of 30.3 to 50.5 percent for comparison hospitals in the University Health System Consortium.

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 utilizing 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.

Supportive Housing: The FUSE Model

A significant percentage of the hospitals' and the community's highest utilizers of ED visits and hospitalizations will have unstable housing. Some hospitals may view housing as out of their scope of influence. However, as providers assume financial risk for populations, developing the community capacity to provide supportive housing as an alternative to repeated acute care utilization will need to be part of a comprehensive strategy. There are several examples of "housing first" initiatives that demonstrate the profound importance of addressing housing as priority among all other needs, with beneficial impact on acute care utilization.

The Corporation for Supportive Housing developed the FUSE Model (Frequent Users Systems Engagement Model) to assist vulnerable people who frequently moved between shelters, jails, treatment programs, EDs, and the streets. Implementation of FUSE is locally adapted, based on three fundamental components: data-driven problem solving, policy and system reform, and targeted housing and services. An early evaluation of the FUSE model found a significant reduction in admissions and total days in jails and shelters, reduced incarceration rates, reduced drug use, and increased social support.[17]

Governor Andrew Cuomo of New York created a Medicaid Redesign Team in 2011, which included a workgroup on affordable housing. The State announced a $75 million investment in supportive housing in 2012-2013 and an $86 million investment in the 2013-2014 budget for high-cost Medicaid beneficiaries. At the time of publication, New York had submitted a waiver to the Federal Government to invest $150 million annually in expanding access to supportive housing.

Finance Enhanced Services

As Medicaid managed care rapidly expands across the country, hospitals and plans can align interests in reducing avoidable hospital utilization through new collaborations. As Medicaid plans, ACOs, and agencies are increasingly being pressured to achieve the Triple Aim goals, they often have new incentives to work with hospitals and their community partners on high-cost case management programs. Medicaid health plans and ACOs are increasingly being paid through risk-based contracts that reward them for reducing their total costs, which are driven by avoidable admissions and readmissions to hospitals. Thus, Medicaid health plans have growing incentives to partner with hospitals on care transitions and to delegate care management functions to hospitals and other health provider groups.

Financing models for enhanced services across the wide variety of service intensities and time horizons discussed earlier in this chapter are similarly varied. When financial pressures are sufficiently substantive at the hospital level—such as readmission penalties, nonpayment for readmissions, short-stay audits, patient safety issues with long ED waits, long lengths of stay because of socially complex discharges, or financial accountability for a population or total revenue (as in Maryland)—the hospital will likely invest in enhanced services. In markets in which Medicaid agencies and Medicaid health plans do not incentivize hospitals to reduce readmissions, it is likely that hospitals have not invested in these types of innovative enhanced services.

In some States, such as North Carolina and a pilot in Alabama, the Medicaid agency has invested in an infrastructure of multidisciplinary community-based care coordination, including transitional and longitudinal care management. Numerous evaluations of the clinical and cost-effectiveness of Community Care North Carolina (CCNC) have been published and demonstrated hundreds of millions of dollars in Medicaid savings.[18] Early results from pilot replication of the CCNC model in Alabama are similarly encouraging.

Currently, the New York Medicaid's Delivery System Reform Incentive Payment (DSRIP) Program represents a groundbreaking negotiation between State leadership and CMS to reinvest $8 billion in savings from the Governor's Medicaid Redesign Team into care redesign efforts. Detailed examples of the types of models of care considered high quality and cost efficient are available in the DSRIP Project Toolkit.

Enhanced services may be funded by a hospital, payer, funder, or foundation; reinvestment of shared savings from risk-bearing contracts; or in a combination of ways. Hospital providers are closest to patients who frequently use acute-care services and thus have frontline, clinical, organizational, and community-based insights about the drivers of acute care utilization that payers or other funders lack. In addition, hospitals can directly influence standard care, targeting strategies, staff training, and physician engagement and can elicit real-time patient and caregiver feedback.

These abilities are invaluable assets for plans or funders who have an interest in reducing readmissions. Leveraging those assets and armed with the methodologies of this guide (including Tools 1, 3, 7, and 8), your hospital will be well positioned to work with payers and funders to build a business case that will offer cost-efficient enhanced services that improve quality and patient experience of care, while reducing avoidable costs to achieve the Triple Aim.

References

1. Berwick DM, Nolan TW, Whittington J. The Triple Aim: care, health, and cost. Health Aff (Millwood) 2008;27(3):759-69..
2. Wier LM, Barrett MS, Steiner C, et al. All-cause readmissions by payer and age, 2008. HCUP Statistical Brief #115. Rockville, MD: Agency for Healthcare Research and Quality; June 2011. Available at: http://www.hcup-us.ahrq.gov/reports/statbriefs/sb115.pdf. Accessed June 12, 2014.
3. Elixhauser A, Steiner C. Readmissions to U.S. hospitals by diagnosis, 2010. HCUP Statistical Brief #153. Rockville, MD: Agency for Healthcare Research and Quality; April 2013. Available at: http://www.hcup-us.ahrq.gov/reports/statbriefs/sb153.pdf. Accessed June 12, 2014.
4. Boutwell A, Maxwell J, et al. Reducing hospital readmissions for Medicaid patients through a patient-centered and community-based approach: final report to the Agency for Healthcare Research and Quality. Boston, MA: John Snow, Inc.; June 2013.
5. Long T, Genao I, Horwitz L. Reasons for readmission in an underserved high-risk population: a qualitative analysis of a series of inpatient interviews. BMJ Open 2013 Sep 19;3(9):e003212.
6. Feigenbaum P, Neuwirth E, Trowbridge L, et al. Factors contributing to all-cause 30-day readmissions: a structured case series across 18 hospitals. Med Care 2012 Jul;50(7):599-605.
7. Rising KL, White LF, Fernandez WG, et al. Emergency department visits after hospital discharge: a missing part of the equation. Ann Emerg Med 2013 Aug;62(2):145-50. Epub 2013 Apr 4.
8. Guide to patient and family engagement in hospital quality and safety. Rockville, MD: Agency for Healthcare Research and Quality; June 2013. Available at: http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/guide.html. Accessed June 10, 2014.
9. DeWalt DA, Callahan LF, Hawk VH, et al. Tool 5: The teach-back method. In: Health literacy universal precautions toolkit. (Prepared by North Carolina Network Consortium, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, under Contract No. HHSA290200710014.) Rockville, MD: Agency for Healthcare Research and Quality; April 2010. AHRQ Publication No. 10-0046-EF. Available at: http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthliteracytoolkit.pdf. Accessed June 10, 2014.
10. DeWalt DA, Callahan LF, Hawk VH, et al. Health literacy universal precautions toolkit. (Prepared by North Carolina Network Consortium, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill, under Contract No. HHSA290200710014.) Rockville, MD: Agency for Healthcare Research and Quality; April 2010. AHRQ Publication No. 10-0046-EF. Available at: http://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/healthliteracytoolkit.pdf. Accessed June 10, 2014.

11. Frequently asked questions about billing Medicare for transitional care management services. Baltimore, MD: Centers for Medicare & Medicaid Services; August 21, 2013. Available at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/FAQ-TCMS.pdf. Accessed June 10, 2014.

12. Hospital to nursing home transfer data list. INTERACT Version 3.0 tool. Florida Atlantic University; 2011. Available at: http://interact2.net. Accessed June 10, 2014.

13. Acute care transfer document checklist. INTERACT Version 3.0 tool. Florida Atlantic University; 2011. Available at: http://interact2.net/docs/INTERACT%20Version%203.0%20Tools/Communication%20Tools/Communication%20Between%20the%20Nursing%20Home%20and%20Hospital/INTERACT%20Acute_Care_Transfer_Checklist_v7%20Jan%2019.pdf. Accessed June 10, 2014.

14. Tool 5: How To conduct a postdischarge followup phone call. In: Re-Engineered Discharge (RED) Toolkit. Rockville, MD: Agency for Healthcare Research and Quality; March 2013. AHRQ Publication No. 12(13)-0084. Available at: http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/redtool5.html. Accessed June 10, 2014.

15. The Bridge Model. Chicago, IL: Bridge Model National Office. Available at: http://www.transitionalcare.org/the-bridge-model/. Accessed June 10, 2014.

16. Office of Rural Health Policy. Community health workers evidence-based models toolbox. Rockville, MD: Health Resources and Services Administration; August 2011. Available at: http://www.hrsa.gov/ruralhealth/pdf/chwtoolkit.pdf. Accessed June 11, 2014.

17. Breaking the cycle of incarceration & homelessness: evaluating the Corporation for Supportive Housing's FUSE Program. New York, NY: Jacob and Valeria Langeloth Foundation; November 5, 2013. Available at: https://www.langeloth.org/pagecontent.php?postid=28. Accessed June 10, 2014.

18. Artiga S. Community Care of North Carolina: putting health reform ideas into practice in Medicaid. Washington, DC: Kaiser Commission on Medicaid and the Uninsured, Kaiser Family Foundation; May 2009. Available at: http://www.dhcs.ca.gov/provgovpart/documents/waiver%20renewal/community%20care%20of%20north%20carolina%20(2).pdf. Accessed June 10, 2014.

AHRQ Pub. No. 14-0050-EF
August 2014

www.ahrq.gov