Transition of Care Program for Inpatient & Observation Units

Project Management Office │ Suffolk Care Collaborative

www.suffolkcare.org

GNYHA Post-Acute Care Workgroup

April 27th, 2017 │ 9:30am – 12:00pm

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Special thanks to
Dr. Amy Boutwell, MD, Founder, Collaborative Healthcare Strategies and SCC’s TOC Program Model Contributor
Reducing hospital readmissions is a national priority for payers, providers and policy makers seeking to achieve Triple Aim objectives of improved health and enhanced care at lower cost.

Adverse post-discharge events are dangerous and costly.

Some studies have shown that as many as one in five patients can suffer an adverse event from hospital to discharge home.

Studies in the Medicare population show that 20% of Medicare patients discharged from a hospital were readmitted within 30 days. Readmissions were estimated to cost a total of $17.4 Billion.

Medicaid Re-admission rates for adults are also very high at 24% and may be even higher than Medicare rates for certain conditions like heart failure.

Many Transitions of Care Models exist. Most models are from geriatric healthcare services.

6 most common TOC Frameworks:

- Transitional Care Model (TCM)
- Care Transitions (CTI) Program SM
- Project Boost (Better Outcomes of Older Adults through Safe Transitions)
- Project Red (Project Re-engineered Discharge)
- Chronic Care Model (CCM)
- INTERACT (Interventions to Reduce Acute Care Transfers)

Few models address hospital readmissions in the Medicaid Population.

The SCC TOC Model was created to address the specific needs of the Medicaid population of Suffolk County.

**Top Medicaid Diagnoses** | **Top Medicare Diagnoses**
--- | ---
1. Mood Disorder | 1. Congestive Heart Failure
2. Schizophrenia | 2. Sepsis
3. Diabetes Complications | 3. Pneumonia
4. Complications of Pregnancy | 4. COPD
5. Alcohol-Related | 5. Arrhythmia
7. Congestive Heart Failure | 7. Acute Renal Failure
8. Sepsis | 8. Acute Myocardial Infarction
9. COPD | 9. Complication of Device
10. Substance-use Related | 10. Stroke

*Reference: Hines et al. [Conditions With the Largest Number of Adult Hospital Readmissions by Payer, 2011](http://www.hcup-us.ahrq.gov/statbrief.cfm?BriefID=575).*
Our Community Needs Assessment for Suffolk County revealed:

- Suffolk County has approximately 240,000 Medicaid members.
- Medicaid members had 34,944 hospital discharges in 2012.
- Medicaid members had 119,932 total ED visits of which 72% were potentially avoidable.
- The main driver of inpatient admission was for perinatal care, psychiatric disorders, cardiovascular disease and substance use disorders.
- Cancer, diabetes and asthma also contributed high numbers.
- 4 out of 11 hospitals in our PPS have higher potentially preventable readmission rates above their expected values.
- All hospitals in the PPS can reduce preventable readmissions.
Behavioral Health Challenges of Our Medicaid Patients

• 23% of our PPS Medicaid members are defined as behavioral health recipients (member* with 1+ claims with a primary or secondary behavioral health diagnosis).

• Behavioral health recipients represent 58% of admissions to the hospital and on average have a 1.65X longer length of stay in the hospital than non-behavioral health recipients.

• Behavioral health recipients cost, on average, 4.65 times more per recipient and represent 58% of total Medicaid spending.
Program Development
- PMO Standardization & Tools
- Program brand
- Program webpage
- Program Leadership
- Facility Champions Engagement
- Hospital Implementation Plan written
- Performance Logic Deployment & Training
- SME Engagement

Program Implementation
- TOC Model
- Implementation Toolkit
- Program Protocols
- Program Tools
- Training Curriculum & Services
- Onboard Director TOC
- Learning Collaboratives & Hospital presentations
- Deploying TOC Care Managers
- MAX Series Participation

Program Monitoring, Integration & Performance Improvement
- Program Integration
- Regional Care Transitions Workgroups
- Quality Improvement & Assurance Plan/Activities
- Action Plan & RCA
- Special Projects Portfolio
PROGRAM DEVELOPMENT

- Program brand
- Program webpage
- Program Leadership
- Facility Champions Engagement
- Provider Engagement
Hospital TOC Implementation Plan WBS

1. Hospital Initiation of Program Including Building Internal Capacity to Implement TOC Program
2. DSRIP Project TOC Program Quarterly Reporting Initiate
3. TOC Program Training Completed for Hospital Staff
4. TOC Model is implemented for IP & OBS Units (including PSYCH)
5. IT & EMR Requirements Completed
6. Observation Model Implementation Plan for Hospital Complete

Performance Logic Deployment & Training

<table>
<thead>
<tr>
<th>Project Plan</th>
<th>Est Start</th>
<th>Est Complete</th>
<th>Status</th>
<th>Milestone Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transition of Care Model Implementation Plan for Hospital Complete</td>
<td>10/2/16</td>
<td>12/31/16</td>
<td>Completed</td>
<td>Completed</td>
</tr>
<tr>
<td>Hospital Initiation Program Implementation &amp; Success NASCAR TOC Program</td>
<td>10/2/16</td>
<td>12/31/16</td>
<td>Completed</td>
<td>Completed</td>
</tr>
<tr>
<td>Hospital Staffing &amp; Physician Capacity Optimized</td>
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<td>12/31/16</td>
<td>Completed</td>
<td>Completed</td>
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<td>Hospital Physician Productivity and Capacity Optimization</td>
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<td>12/31/16</td>
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<td>Completed</td>
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<tr>
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<td>10/2/16</td>
<td>12/31/16</td>
<td>Completed</td>
<td>Completed</td>
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<tr>
<td>Performance Logic Deployment &amp; Training</td>
<td>10/2/16</td>
<td>12/31/16</td>
<td>Completed</td>
<td>Completed</td>
</tr>
<tr>
<td>TOC Model Implementation for Hospital</td>
<td>10/2/16</td>
<td>12/31/16</td>
<td>Completed</td>
<td>Completed</td>
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<tr>
<td>TOC Model Implementation for Hospital</td>
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<td>12/31/16</td>
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<td>10/2/16</td>
<td>12/31/16</td>
<td>Completed</td>
<td>Completed</td>
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</tbody>
</table>
December 14, 2015: TOC Model Development Kick off

- Program on Reducing Avoidable Hospital Utilization, with a theme of best practices and promising strategies of Medicaid patients in the transitions of care.
- Understand the CMS Discharge Planning Conditions of Participation for Hospitals

February 10, 2016: TOC Model Design Workshop

- Aligned signals in the market – Medicare readmission penalties, Medicare value based purchasing, ACO, bundle payment, Medicare Transition of Care Codes, and the new CMS Discharge Planning Requirements under CMS conditions of participation.
- Results of hospital survey on transition of care results revealed Variation across hospitals in practices targeting readmission reduction
- Most hospitals use some method to identify readmission risk
- Most hospitals working on patient education and medication management
- Few hospitals working on efforts to ensure follow-up
- Few hospitals have processes to coordinate with community providers
- Few hospitals track services delivered and outcomes after discharge
- Facilitated engagement exercise included:
  - Reviewed each of the TOC/OBS model requirements as baseline specifications
  - Identify what is currently in place
  - Identify the ways the PPS can meet the requirement
- Assumptions:
  - There are some opportunities to standardize
  - There are some opportunities to allow variation
  - We will emerge with a sense of how we will meet the requirements

March 15, 2016: TOC Project Committee Meeting

- Review TOC Model Narrative and Endorse

March 2016: Board of Directors Meeting

- BOD Approval of Model

https://www.federalregister.gov/articles/2015/11/03/2015-27840/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals
TOC MODEL ELEMENTS

Step 1: Real-Time Identification of Patients at High Risk of Readmission

Step 2: Early Notification of Patient and Partners of Planned Discharge

Step 3: Provision of a Written TOC Plan

Step 4: Timely Completion of the Discharge Summary

Step 5: Initiation of a 30-day TOC period with PCP Updates
REAL-TIME IDENTIFICATION OF PATIENTS AT HIGH RISK OF READMISSION: SOCIAL NEEDS SCREEN

<table>
<thead>
<tr>
<th>Access to Primary Care</th>
<th>No regular Primary Care Practitioner</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Difficulty with transportation to medical care</td>
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<tr>
<td></td>
<td>Work/family responsibilities that interfere with appointments</td>
</tr>
<tr>
<td></td>
<td>Regular use of emergency room for care</td>
</tr>
<tr>
<td></td>
<td>Access to a medical professional/ organization who helps with your care</td>
</tr>
<tr>
<td>Access to BH Care</td>
<td>History of behavioral health services</td>
</tr>
<tr>
<td></td>
<td>Concern about emotional or mental health</td>
</tr>
<tr>
<td></td>
<td>Alcohol or drugs affecting health and wellness</td>
</tr>
<tr>
<td></td>
<td>Prescription medications affecting function</td>
</tr>
<tr>
<td>Unstable/ Inadequate Housing</td>
<td>Lack of stable housing</td>
</tr>
<tr>
<td></td>
<td>Lack of heat or cooling</td>
</tr>
<tr>
<td></td>
<td>Environmental hazards affecting health (mold, etc.)</td>
</tr>
<tr>
<td></td>
<td>Lack of safety and security within or outside the home</td>
</tr>
<tr>
<td>Food Insecurity/ access</td>
<td>Lacks access to adequate amounts of food</td>
</tr>
<tr>
<td></td>
<td>Lacks access to nutritious or medically appropriate diet</td>
</tr>
<tr>
<td>Legal Issues</td>
<td>Barriers to access, coverage, benefits, specialty evaluations or testing, medications, utilities, stable housing</td>
</tr>
<tr>
<td></td>
<td>Recent or repeated incarceration or detention</td>
</tr>
<tr>
<td>Language or Literacy Issues</td>
<td>Low literacy, low numeracy</td>
</tr>
<tr>
<td></td>
<td>Low health literacy – diagnoses, medications, care plan</td>
</tr>
<tr>
<td></td>
<td>Low or no ability to speak English</td>
</tr>
</tbody>
</table>

SOCIAL NEEDS SCREEN IMPLEMENTATION EXAMPLE
Transition of Care Post-Discharge Workflow

TOC Provider begins to coordinate 30-day services for patient upon discharge

Navigation to social determinants of health, such as food, including medically tailored food, housing, including supportive housing & transportation

TOC Providers include:
- Health Homes
- Managed Medicaid Care Organizations
- Care Management Organizations

30-Day Patient Care
- Patient Education on diagnosis, reason for hospitalizations & discharge instructions
- Communication check points with patient, including PCP follow-up appointment
- Updates to PCP during 30-day follow
- Provide medical and behavioral support
- End of Life Planning, including MOLST, as appropriate
The SCC has operationalized a Care Management Organization.

Technical infrastructure provided through partnership with Cerner.

Identified TOC Care Manager Activities & Tools for Success.

Created a standardized TOC Care Manager Workflow.

Embedded SCC Care Managers in Hospitals and Primary Care Practices across the county.

Embedded TOC Care managers offering 30-day TOC services for patients identified as high risk.

TOC Care Manager Activities:
- Visitation prior to discharge
- Collaboration in the acute setting
- Support Post-D/C Provider Appointments and address social needs
- Follow High-Risk Patients for 30-days
Using Care Management to Address Barriers Associated with the Social Determinants of Health

- Income/Poverty
- Financial Instability/Sustainability
- Access to Food
- Access to Clothing
- Safe and Affordable Housing
- Availability of Resources
- Community Safety
- Safe, Reliable, Affordable Transportation
- Education
- Cultural Needs
- Lack of Child Care
- Lack of Elder Care
- Coordination/Support

- Family Dynamics
- Chronic Disease
- Justice System Interaction
- Lack of Physical Activity
- Access and Affordability of Medications
- Relationship with Medical Providers
- Religious/Spiritual Needs
- Health Literacy
- Employment/Vocational Needs
- Access to Care
- Palliative Care Needs

- Language Barriers
- Social Isolation
- Behavioral Health Diagnosis with Treatment
- Behavioral Health Diagnosis without Treatment
- Undiagnosed Behavioral Health
- Tobacco Use
- Substance Use/Abuse
- Affordability of Utilities
- Development/Acquired Disabilities

TOC CARE MANAGERS PLAY A KEY ROLE IN ADDRESSING SOCIAL DETERMINANTS OF HEALTH
### Section 1: Project Management Office
- Clinical Guidelines Summary
- Facility Champion & Performance Logic Directory

### Section 2: TOC Program Protocols & Guidelines
- Social Needs Screen Example
- TOC Program Protocols

### Section 3: Training Curriculum
- Training Guidelines for Hospital Partners
- Care Coordination & Transition Management Program

### Section 4: Implementation Plan
- TOC/OBS Hospital Implementation Plan
- ICD 9 & 10 BH Codes

### Section 5: OBS Program
- Opportunity Assessment
- Clinical & Financial Template

### Section 6: Reporting to the SCC
- Patient Engagement
- Documents to be Returned

### Section 7: Community Resources
- AHRQ Medicaid Readmissions Toolbox
- CMS Readmissions Reduction Program
Transition of Care Program Training

SCC TOC Module Curriculum
- Offered in SCC TOC Program Implementation Toolkit and on SCC’s Web-based Learning Center
- Learning Module Overview:
  Module 1: TOC Model Training
  Module 2: Community Orientation
  Module 3: Care Coordination Methodology, Protocol & Treatment
- SCC’s Director for Care Transitions also provided on-site trainings for participating hospital staff to fulfill training requirements.

Care Coordination & Transition Management (CCTM-RN) Program
- Initiative began in September of 2016
- Certification provided by the American Academy of Ambulatory Care Nursing.
- 25 RNs across all 11 hospitals participated in the prep-course and will take the exam.
- Upon certification certified RN’s will be able to train hospital staff using the CCTM curricula and tools with any one of the 13 program modules.
- [https://www.aaacn.org/cctm](https://www.aaacn.org/cctm)
Action Plan

• Created COPD Super Utilizer List
• Created a Flagging System
• Created 62 patient profiles
• Opened a COPD Unit
• Created a secured shared drive to document and communicate within the action team
• Educated the frontline staff
• Created a multidisciplinary COPD Plan of Care
• Created a workflow for COPD patients
• Created a care coordinated note template
• Created a Home Assessment tool
• Created a Graduation Protocol
• Created Health Home enrollment spread sheet
• Established a Brookhaven Better Breathers Club

COMMON ATTRIBUTES

• Majority lived alone
• Over 80% have concurrent Behavioral Health diagnosis
• All met criteria for Health Home & some for Home Care

Improved Process

☑ Changed the ED and Inpatient Unit culture of treating super utilizers via education of staff, EMR flagging of cohorts; sharing of patient success stories with staff

☑ Created in depth Assessment process in ED and referral to HH and PCP immediately

☑ Utilized motivational interviewing techniques

☑ Began true Care coordination with external agencies, such as OP providers, Health Homes, Home Care, residential providers, Inpatient and ED staff

☑ Conducted Case Conferences on patient to change their pattern of behavior Care, residential providers, Inpatient and ED staff

Sample Size

• Total number of COPD ED visits/patients from Jan 2015 to Sept 2015
• 432 COPD ED visits (62 patients) & 71 COPD readmissions (27 patients)
<table>
<thead>
<tr>
<th>Total Cohort (61 patients)</th>
<th>Before</th>
<th>After</th>
<th>Result (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED VISITS</td>
<td>65.1/month</td>
<td>36.3/month</td>
<td>-44%</td>
</tr>
<tr>
<td>ED IP ADMISSIONS</td>
<td>15.5/month</td>
<td>8.5/month</td>
<td>-45%</td>
</tr>
<tr>
<td>ED READMISSIONS</td>
<td>5.3/month</td>
<td>3.75/month</td>
<td>-29%</td>
</tr>
</tbody>
</table>

75% of patients are enrolled in a Health Home & Engaged Health Home to educate care managers of their benefit and application process.
**Goal:** “Create an empowered, cohesive program with central and facility buy-in that addresses medical and non-medical factors of care, engaging patients with a patient-centered focus across the care continuum.”

**Patient Success Story**

67 yo M with 5 hospitalizations in past month/last admission 3/14/2017; 7 admissions in last 12 months.  
**DOU:** No support system, lack of housing, financial issues, psychosocial issues, hx of substance abuse

**How we addressed DOU:**
- SW referral to Dwyer Peer Support Program with MHA to assist him with services since he is a veteran and Hand in Hand Elder Care which assisted with finding appropriate housing based on medical and psychosocial needs.
- The patient further referred to Long Beach Assisted Living where SW was in contact with the DOA, made intake appt., educated pt, and arranged transport to appt.
- Patient was screened and interviewed and accepted into the program for Long Beach 4/19/2017
The **Learning Collaborative Approach** focuses on spreading, adopting and adapting best practices across multiple settings and introducing opportunities in organizations that promote the delivery and implementation of effective programs.

The **Care Transitions Learning Collaborative** was attended by all 11 Suffolk County Hospitals and over 20 Suffolk County Nursing Homes currently participating in DSRIP.

**Collaborative Goals included:**

- Enhance the existing partnerships and communication lines between acute care facilities and skilled nursing facilities in care transitions intervention programs.
- Promote best practice sharing that will aide in the development of collaborative solutions.
- Design opportunities to empower and educate patient/caretaker and families to participate in planning of care.
- Partner to coordinate the transition of care period
Regional Care Transitions Workgroups

- DSRIP Project 2biv, 2bix & 2bvii Integrated
- In person geographical cohorts
- Concentrated **focus on performance improvement within network**
- Solutions from experience & regional trends
- Enhances ideas and collaboration
- Promotes ID of best practices
- Saves time, energy, decrease stress
The SCC INTERACT Program has operationalized a **Quality Improvement & Assurance Plan** for SNF partners of the PPS modeled after the SCC PI Plan.

Regional meetings were hosted to engage SNFs geographically and enabled each participating skilled nursing facility (SNF) to submit an **Action Plan**.

SCC utilized **Qualtrics**, a web-based survey platform to capture the **Action Plan** from each participating SNF using a customized survey, allowing for data organization, manipulation, and reporting.

Each SNF had a unique Qualtrics's link to access the Action Plan template to input information and submit a completed plan. Qualtric's link allows each SNF to access their completed Action Plan to provide updates on an routine basis.

Within the Action Plan, each SNF was asked to select **Performance Improvement (PI) Focus Areas** which has provided key PI themes across all participating SNFs. The Action Plan also called for the SNF to identify and describe **Action Tasks** that would be operationalized to support improving each selected **PI Focus Area**.

<table>
<thead>
<tr>
<th>Pain Management</th>
<th>Early Warning Signs of Sepsis/UTI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance Directives/MOLST/eMOLST</td>
<td>Fall Prevention</td>
</tr>
<tr>
<td>Communication</td>
<td>INTERACT Tool(s)</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>Patient/Family Education</td>
</tr>
<tr>
<td>Medical Coverage</td>
<td>Discharge Process</td>
</tr>
<tr>
<td>Admission Process</td>
<td>Weight Loss</td>
</tr>
<tr>
<td>Antipsychotic Medications</td>
<td>Behavioral Health Services</td>
</tr>
<tr>
<td>Cardiac Services</td>
<td>Acute Respiratory Services</td>
</tr>
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</table>
Action Plan Results from Quality Improvement Activity via DSRIP Project 2b: INTERACT and participating SNF’s:

<table>
<thead>
<tr>
<th>23</th>
<th>Number of Participating SNFs Quality Action Plans Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>65%</td>
<td>Reported areas of improvement related to decreasing hospitalizations</td>
</tr>
<tr>
<td>50%</td>
<td>Reported areas of improvement in decreasing sepsis hospitalizations or reduction of falls</td>
</tr>
<tr>
<td>66</td>
<td>Total number of performance improvement focus areas identified. Early warning signs of sepsis/UTI and communication were the most frequently selected PI focus areas.</td>
</tr>
<tr>
<td>49</td>
<td>Total number of action tasks identified. Staff In-Service/Education was the top action task category.</td>
</tr>
</tbody>
</table>
# Special Projects Portfolio: Care Transitions Program

## Special Project Name | Outcome/Deliverable | Project Category | Facility/Region | Status |
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Example</td>
<td>What is the end result, product</td>
<td>Regional or County?</td>
<td>All</td>
<td>Planning</td>
</tr>
<tr>
<td>1-800 Health Home Project</td>
<td>1-800 # for referrals</td>
<td>County</td>
<td>All</td>
<td>Planning</td>
</tr>
<tr>
<td>Communicating SNF Clinical Capabilities Project</td>
<td>Link on website to see SNF Clinical Capabilities &amp; hard copies distributed to all hospitals</td>
<td>County</td>
<td>All</td>
<td>In Progress</td>
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<tr>
<td>Sepsis Education at SNFs Project</td>
<td>Educational Material/Training Session to be recorded/held at participating SNFs</td>
<td>Regional</td>
<td>All</td>
<td>Planning</td>
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</table>

## Priority | PICK | Due Date | Project Manager | Progress Notes |
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>high</td>
<td>Easy / Low Value</td>
<td>4/23/17</td>
<td>Ralph Thomas</td>
<td>Notes on status and external stakeholder engagement, meetings, etc.</td>
</tr>
<tr>
<td>high</td>
<td>Hard / High Value</td>
<td>5/1/17</td>
<td>Ralph Thomas</td>
<td>Utilize Island-Wide HH bi-weekly WG to our advantage</td>
</tr>
<tr>
<td>normal</td>
<td>Easy / High Value</td>
<td>8/1/17</td>
<td>Ralph Thomas</td>
<td>Dr. Efferen to have call with Dr. Nick Fitterman of NWH 5/22</td>
</tr>
<tr>
<td>normal</td>
<td>Hard / High Value</td>
<td>5/1/17</td>
<td>Ralph Thomas</td>
<td>Survey sent out to all SNF partners; Alexandra sent individual reminder emails on 3/30/17; Ralph FUP 4/13; as of 4/18, 6 outstanding</td>
</tr>
</tbody>
</table>

Notes on status and external stakeholder engagement, meetings, etc.
ADDITIONAL READING REFERENCES
HOSPITAL GUIDE CONTENTS:

- Why focus on Medicaid Readmissions?
- Know Your Data
- Inventory Readmission Efforts
- Develop a Portfolio of Strategies
- Improve Hospital-based Transitional Care
- Collaborate with Cross Setting Partners
- Provide Enhanced Services
- 13 new Tools

http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/
Readmission Reduction Tools

1. Readmission Data Analysis
2. Readmission Interview
3. Data Analysis Synthesis
4. Hospital Inventory
5. Cross-Continuum Team Inventory
6. Conditions of Participation Checklist
7. Portfolio Design
8. Readmission Reduction Impact
9. Readmission Risk
10. Whole-Person Assessment
11. Discharge Information Checklist
12. Forming a Cross-Continuum Team
13. Community Resource Guide

http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/
Promote Hospitalist – ED Collaboration

1. Flag 30-day returns in the ED record
2. Promote collaboration between Emergency Medicine and Hospital Medicine on the decision to admit
3. Encourage Hospital Medicine see the patient in the ED
4. Collaborate with referring providers, especially SNFs
5. Capture the “story behind the story”
6. Form a joint quality review committee of EM and Hospital Medicine to review low-acuity admissions and readmissions

Boutwell et al, New York State Partnership for Patients 2014