Readmission & Multi-Admission Patient Reduction Learning Collaborative

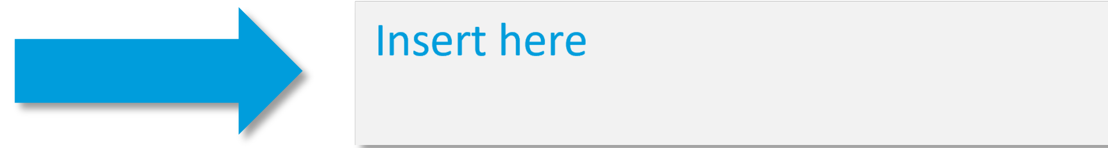
Workbook

February - September 2023

Telligen QI Connect™
Partnering to improve health outcomes through relationships and data
HQIC
Hospital Quality Improvement Contractors
CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Instructions for Using this Workbook

- This workbook is meant to be interactive. Look for the grey boxes where you can click to type in your notes directly on the slide or add in screenshots, attachments, hyperlinks, file names/paths, etc. that are relevant to your project.



- You can also Ctrl+Click on the hyperlinks or pictures of external resources to open them. Make sure you save your work in the external resources and send a copy to your Telligen Quality Improvement Facilitator along with this workbook.

Welcome

- Please complete this project workbook in its entirety. At the end of the collaborative, your workbook will contain all the necessary elements to create a project poster.
- We recommend saving all project materials to a designated folder on your work computer. Be sure to save your signed commitment form for the collaborative there, too.

Hospital Name:

Team Leader:

Senior Leadership Project Sponsor:

This slide corresponds to the "Title Page" section of your Collaborative Poster.

Objectives

- Develop an individualized, multidisciplinary program with clearly defined goals, process and outcome measures aimed at preventing hospital readmissions and reducing multi-admission patient utilization.
- Identify hospital available data sources and develop a process for analyzing readmission data, identifying multi-admission patients and assessing risk for readmission.
- Practice root cause analysis to inform the selection of evidence-based interventions that adequately address multi-admission patient factors.
- Implement customized interventions in real time while learning to evaluate effectiveness and make improvements that respond to your facility's unique needs.
- Develop and implement methods for engaging staff, providers, patients, families and community organizations in preventing readmissions.

This slide corresponds to the "Improvement Methods" section of your Collaborative Poster.

What are we trying to accomplish?

Relevant Project Definitions

- **Unplanned Readmission:** Inpatients returning as an acute care inpatient within 30 days of date of an inpatient discharge, to any facility, with the exception of certain planned admissions
- **Multi-Admission Patient:** A Medicare beneficiary who has four or more inpatient claims or five or more combination of emergency department, observation or inpatient claims within a 12-month period

Ctrl+Click for a Measure Specification Manual.

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/Telligen_QI_Connect_Measure_Specifications_Manual_Version_5.0.pdf

Background & Purpose

Write a few sentences describing the reason you decided to complete this project.

Your purpose can be about a desire to improve patient care and/or the business case (benefit to the hospital) associated with improving readmissions. You can cite research, or your purpose can be unique to your community. Example: According to one study, multi-admission patients are responsible for a large percentage of hospital admissions (12-28%) (Huang et al., 2020). Unplanned readmissions are costly and decrease many patients' quality of life. Another study cites unplanned readmissions as accounting for more than $17 billion in avoidable Medicare expenditures (Jencks et al., 2009).

Huang, M., van der Borght, C., Leithaus, M.*et al.* Patients' perceptions of frequent hospital admissions: a qualitative interview study with older people above 65 years of age. *BMC Geriatr* 20,332 (2020). https://doi.org/10.1186/s12877-020-01748-9

Jencks, S., Williams, M., Coleman, E. (2009). Rehospitalizations among patients in the Medicare fee-for-service program. *The New England Journal of Medicine* 360, 1418-1428. DOI: 10.1056/NEJMsa0803563

This slide corresponds to the "Background and Purpose" section of your Collaborative Poster.

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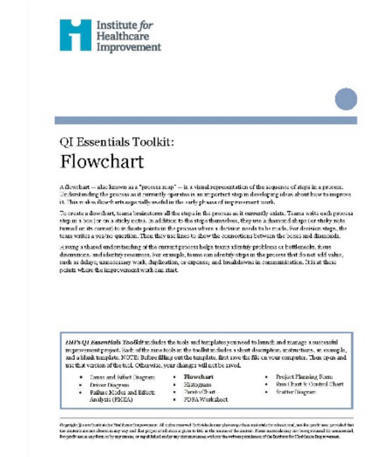
Current State

Describe the processes your hospital currently has in place to reduce readmissions.

Tip: Use the shapes or SmartArt in this PowerPoint to create your map in the space below or on a new slide, or use the flowchart template to the right and either take a screenshot and insert it here or save it as a separate file and include the file name/path here.

Ctrl+Click to use a flowchart template.

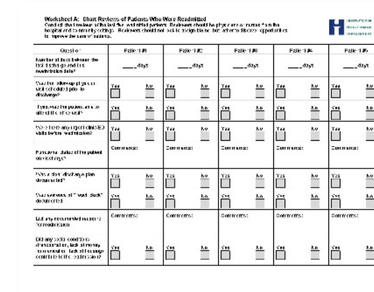

Institute for Healthcare Improvement

QI Essentials Toolkit:
Flowchart

Conduct chart reviews of readmitted patients.

Tip: Use the fillable chart review template to the right. Save it as a separate file and include the file name/path below.

Ctrl+Click for a template to perform chart reviews of patients who were readmitted.



https://www.ihi.org/resources/Pages/Tools/Flowchart.aspx

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/IHI-Flow-Chart-Template.pdf

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/ReadmissionsDiagnosticTool_STAAR.pdf

This slide corresponds to the "Assessment" section of your Collaborative Poster.

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Problem Statement

Identify a problem with your current process.

Example: January 2022 - July 2022 Medicare FFS readmission data reveals a readmission rate of 24% - a 10% increase compared to 2021. We do not have written readmission reduction program guidelines. 60% of department leaders and 85% of bedside staff cannot verbalize their daily role in readmission reduction. 90% of staff are not able to locate the hospital's written readmission reduction guidelines.

This slide corresponds to the "Problem Statement" section of your Collaborative Poster.

Establish the Team and Project Scope

Document a rough project outline, team member roles and responsibilities, and your project goals.

Consider community-based organizations as members of your team. Does your hospital already have a list started? You may insert your team's AIM statement (to be completed on slide 12) into your project charter. Note: This document does not have to be set in stone – you can make changes and add details as the project progresses. Tip: Use the fillable templates to the right. Save them as separate files and include the file names/paths below.

Ctrl+Click for a template to document a list of behavioral, clinical and social service resources available in your community.

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Multiple-admission Patient Program
Transitional Care Community Resource List

What is this tool?
A document to collect a list of the behavioral, clinical and social service resources available in the community. The list is an opportunity for hospitals to identify local services to promptly meet the transitional care needs of patients to help reduce readmissions.

Who should use this tool?
The MAP program team at your hospital.

How to use this tool?
Use this document to gather contact information and establish available services of local community based organizations. Having this information in a comprehensive list facilitates timely post-discharge follow up and monitoring.

Type of resource	Provider or agency name/phone number	Care services provided *Description of service, capacity and geographic area*	Service area (towns or ZIP codes)	Agency contact person *Name/number/fax/email*
Clinical services				
Behavioral health providers				
Behavioral health clinics				
Primary care providers				
Mental health providers				
Psychiatric centers				
Home health agencies				
Community health centers/Federally qualified health centers				
Health homes				
Hospice homes				

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Worksheet to Create a Performance Improvement Project Charter QAPI

What is a project charter? A project charter clearly establishes the goals, scope, timing, milestones, and team roles and responsibilities for an Improvement Project (PIP). The charter is typically developed by the QAPI team and then given to the team that will carry out the PIP, so that the PIP team has a clear understanding of what they are being asked to do. The charter is a valuable document because it helps a team stay focused. However, the charter does not tell the team how to complete the work; rather, it tells them what they are trying to accomplish.

Use this worksheet to define key charter components.

PROJECT OVERVIEW

Name of project:
Example: Reduction in use of position change alarms

Problem to be solved:
Example: Alarms going off frequently detract from a homelike environment and may give staff a false sense of security.

Background leading up to the need for this project:
Example: Residents and families have complained about the sound of alarms going off frequently. Staff feel pressure to do "something" when a resident falls.
[Tip: Reference specific background documents, as needed.]

The goal(s) for this project:
Example: Decrease the percentage of residents with position change alarms used on XX unit by 25% by XX/XX/XX.
[Tip: See Goal Setting Worksheet]

Scope – the boundary that tells where the project begins and ends.
The project scope includes:
Example: Use of position change alarms on XX unit.

Disclaimer: Use of this tool is not mandated by CMS, nor does its completion ensure regulatory compliance.

Ctrl+Click for a worksheet to create a performance improvement project charter.

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/2022-06-13_transitional_care_community_resource_list.docx

https://www.telligenqiconnect.com/wp-content/uploads/2022/05/Create-a-Performance-Improvement-Project-Charter-fillable.pdf

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Additional Team Members

Patient and Family Representative:

Community Organizations:

Other Key Stakeholders (e.g., unit staff, ED staff):

Who is your Telligen Quality Improvement Facilitator (Rachel Megquier or Ann Loges)?

This slide corresponds to the “Title Page” section of your Collaborative Poster.

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AIM Statement

Write an AIM statement.

Example: By September 2023, our hospital will form a quality improvement team to establish a Readmission Reduction Program that will write staff guidelines. By the end of the project, 100% of department leaders and bedside staff will be able to locate the written guidelines and verbalize their daily role in readmission reduction to reduce our hospital's unplanned readmission rate from 25% in 2022 to 18% in 2023.

By **, the** **at**

will implement

to improve

by **to benefit**

Ctrl+Click for a template to develop your AIM statement.

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/Develop-AIM-Statement.pdf

This slide corresponds to the "AIM Statement" section of your Collaborative Poster.

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Data Report – Gathering Meaningful Insights

Document some first impressions after reviewing the Telligen-provided readmission/multi-visit patient report. Consider these questions:

- *How many patients on your report meet the multi-visit patient definition on slide 6?*
- *What trends in patient demographics are you seeing?*
- *What trends in diagnosis codes are you seeing?*
- *Does number of diagnoses codes correlate with multiple admissions?*
- *Does the patient's discharge code seem to impact their likelihood of readmission?*
- *What information would you like to know that is missing from this report?*

Document a list of potential internal data sources for future monitoring of readmissions.

This slide corresponds to the "Metrics/Data" section of your Collaborative Poster.

Perform a Root Cause Analysis (RCA)

Use your problem statement (slide 9) to create a fishbone diagram.

Tip: See the example below. Click each box to erase the example and type in your own answers.

Equipment

Process

People

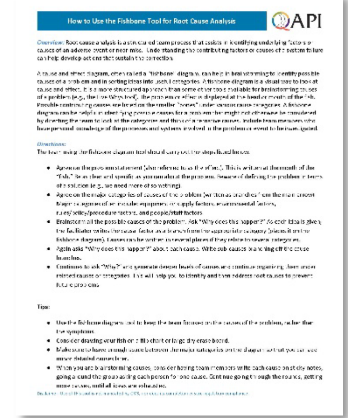
Problem

Materials

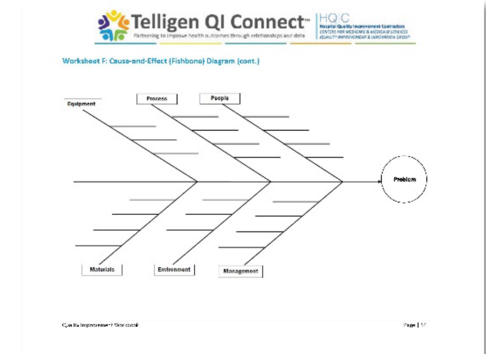
Environment

Management

Ctrl+Click for detailed instructions on using the fishbone tool for root cause analysis.



Ctrl+Click for a fishbone diagram template.



https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/Downloads/FishboneRevised.pdf

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/TelligenHQIC_QualityImprovementWorkbook508_FNL.pdf#page=14

This slide corresponds to the "Assessment" section of your Collaborative Poster.

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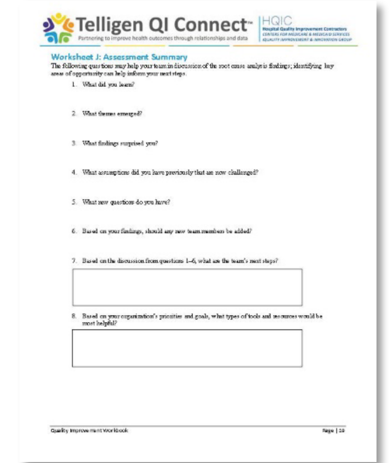
Assessment Summary

After creating your fishbone diagram, complete the assessment summary.

Tip: You can also perform a RCA for an individual readmission to dig deeper and clarify your understanding of why a particular readmission occurred. This process will help you zero in on your project interventions. Use the readmissions surveillance tool below and to the right.

1. *What did you learn?*
2. *What themes emerged?*
3. *What findings surprised you?*
4. *What assumptions did you have previously that are now challenged?*
5. *What new questions do you have?*
6. *Based on your findings, should any new team members be added?*
7. *Based on the discussion from questions 1-6, what are the team's next steps?*
8. *Based on your organization's priorities and goals, what types of tools and resources would be most helpful?*

Ctrl+Click for the assessment summary.



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Worksheet J: Assessment Summary

The following questions may help your team in discussion of the root cause analysis findings; identifying key areas of opportunity can help inform your next steps.

1. What did you learn?
2. What themes emerged?
3. What findings surprised you?
4. What assumptions did you have previously that are now challenged?
5. What new questions do you have?
6. Based on your findings, should any new team members be added?
7. Based on the discussion from questions 1–6, what are the team's next steps?
8. Based on your organization's priorities and goals, what types of tools and resources would be most helpful?

Quality Improvement Workbook — Page | 19

Ctrl+Click for a readmissions surveillance tool.

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/TelligenHQIC_QualityImprovementWorkbook508_FNL.pdf#page=19

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/readmissions_surveillance_tool-1.xlsm

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Do

What changes can we make that will result in improvement?

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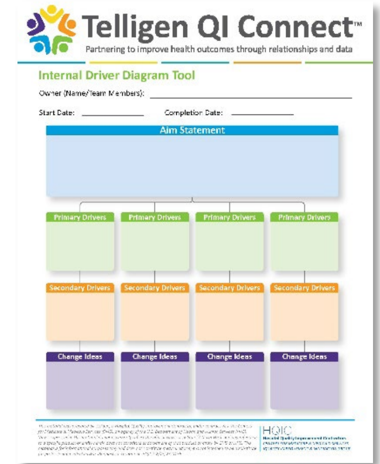
Selecting an Intervention – The Driver Diagram

Ctrl+Click for a driver diagram template.



Return to your AIM statement (slide 12). Begin thinking about which aspects of your fishbone diagram take priority in directly impacting and achieving your aim.

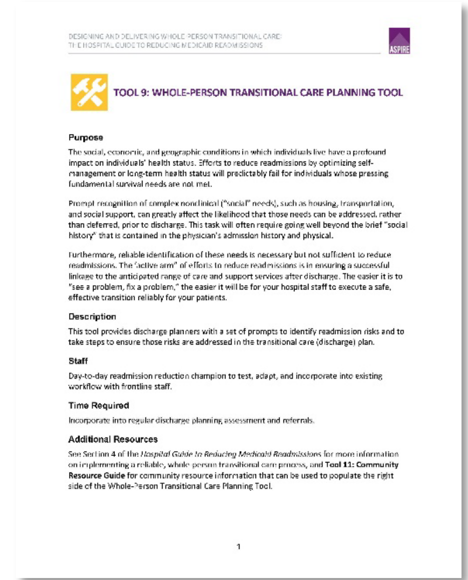
Complete the driver diagram template and brainstorm potential change ideas. Make sure you engage multidisciplinary team members.

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/Driver-Diagram_9.pdf

This slide corresponds to the "Actions" section of your Collaborative Poster.

Suggested Interventions – Customize Based on Your RCA

Ctrl+Click for the whole-person transitional care planning tool.



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

ASPIRE

TOOL 9: WHOLE-PERSON TRANSITIONAL CARE PLANNING TOOL

Purpose

The social, economic, and geographic conditions in which individuals live have a profound impact on individuals' health status. Efforts to reduce readmissions by optimizing self-management or long-term health status will predictably fail for individuals whose pressing fundamental survival needs are not met.

Prompt recognition of complex nonclinical ("social" needs), such as housing, transportation, and social support, can greatly affect the likelihood that those needs can be addressed, rather than deferred, prior to discharge. This task will often require going well beyond the brief "social history" that is contained in the physician's admission history and physical.

Furthermore, reliable identification of these needs is necessary but not sufficient to reduce readmissions. The "active arm" of efforts to reduce readmissions is in ensuring a successful linkage to the anticipated range of care and support services after discharge. The easier it is to "see a problem, fix a problem," the easier it will be for your hospital staff to execute a safe, effective transition reliably for your patients.

Description

This tool provides discharge planners with a set of prompts to identify readmission risks and to take steps to ensure those risks are addressed in the transitional care (discharge) plan.

Staff

Day-to-day readmission reduction champion to test, adapt, and incorporate into existing workflow with frontline staff.

Time Required

Incorporate into regular discharge planning, assessment and referrals.

Additional Resources

See Section 4 of the *Hospital Guide to Reducing Medicaid Readmissions* for more information on implementing a reliable, whole-person transitional care process, and **Tool 11: Community Resource Guide** for community resource information that can be used to populate the right side of the Whole-Person Transitional Care Planning Tool.

1

Consider these intervention examples.

Remember to start small. What intervention aligns with your project aim? Discuss your own ideas with your team and your Telligen Quality Improvement Facilitator.

- *Develop a process for identifying MAPs at admission (e.g., EHR alerts).*
- *Augment your process for identifying risk for readmission (next slide).*
- *Augment your medication reconciliation process.*
- *Customize and/or update discharge instructions for top diagnoses resulting in readmissions.*
- *Implement "whole-person care" transitional planning tool.*
- *Implement or augment your post-discharge follow up call process.*

Ctrl+Click for the AHRQ Re-Engineered Discharge (RED) Toolkit.

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/mcaidread_tool9_trans_care-1.docx

https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/redtool5.html

This slide corresponds to the "Actions" section of your Collaborative Poster.

Readmission Risk Assessment

A key intervention in preventing hospital readmissions is to identify a patient's risk prior to discharge. Begin thinking about how you will augment your risk assessment process.

Ctrl+Click for the high-risk factors for readmission patient tracking tool.

Ctrl+Click for the LACE Index for Readmission tool.

https://qualityimprovementcollaborative.org/focus_areas/readmissions/docs/mitigating_risk_factors_for_readmission.pdf

https://www.mdcalc.com/calc/3805/lace-index-readmission

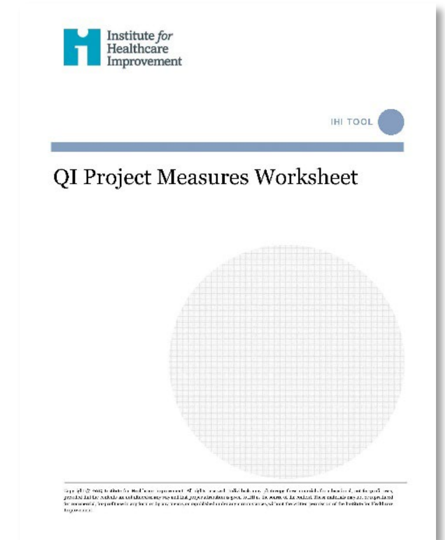
This slide corresponds to the "Actions" section of your Collaborative Poster.

Measures - Process, Outcome and Balancing

Complete the measures worksheet to develop your process and balancing measures.

Ask yourself, how will we know a change is an improvement?
Your outcome measures are “# of Unplanned Readmissions” and “# of Multi-Admission Patients.”

Ctrl+Click for the IHI Quality Improvement Project Measures Worksheet.



https://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Project-Measures-Worksheet.aspx

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/QI-Project-Measures-Worksheet.pdf

This slide corresponds to the “Actions” section of your Collaborative Poster.

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Intervention Planning

Use the templates to plan each step of your intervention. Assign responsibilities to team members and outline your measurement strategy.

Ctrl+Click for a Plan-Do-Study-Act (PDSA) Planning Worksheet example.

Ctrl+Click for a template to develop a quality improvement action plan.

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/TelligenHQIC_QualityImprovementWorkbook508_FNL.pdf#page=28

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/TelligenHQIC_QualityImprovementWorkbook508_FNL.pdf#page=30

This slide corresponds to the "Actions" section of your Collaborative Poster.

Staff Communication & Education

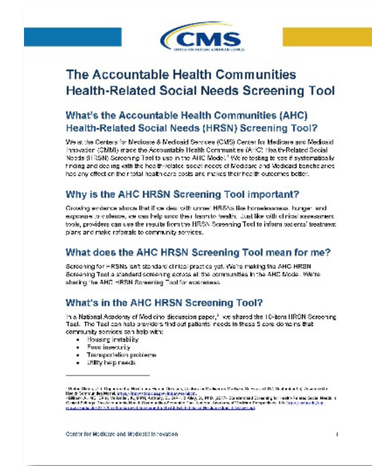
Use this page to develop a plan to share the process change with frontline staff. Consider these questions:

- *How will you educate staff and ensure their understanding? (e.g., lunch and learn, staff meeting, email with read receipt, quiz)*
- *How will you engage staff in your project? (Consider that your staff might be asking themselves, “What’s in it for me?”)*

This slide corresponds to the “Actions” section of your Collaborative Poster.

Patient & Family Engagement and Social Determinants of Health

Implement a social needs risk screening tool.


CMS

The Accountable Health Communities Health-Related Social Needs Screening Tool

What's the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool?

We at the Centers for Medicare & Medicaid Services (CMS) Center for Medicare and Medicaid Innovation (CMMI) made the Accountable Health Communities (AHC) Health-Related Social Needs (HRSN) Screening Tool to use in the AHC Model.[1] We're testing to see if systematically finding and dealing with the health-related social needs of Medicare and Medicaid beneficiaries has any effect on their total health care costs and makes their health outcomes better.

Why is the AHC HRSN Screening Tool important?

Growing evidence shows that if we deal with unmet HRSNs like homelessness, hunger, and exposure to violence, we can help undo their harm to health. Just like with clinical assessment tools, providers can use the results from the HRSN Screening Tool to inform patients' treatment plans and make referrals to community services.

What does the AHC HRSN Screening Tool mean for me?

Screening for HRSNs isn't standard clinical practice yet. We're making the AHC HRSN Screening Tool a standard screening across all the communities in the AHC Model. We're sharing the AHC HRSN Screening Tool for awareness.

What's in the AHC HRSN Screening Tool?

In a National Academy of Medicine discussion paper,[2] we shared the 10-item HRSN Screening Tool. The Tool can help providers find out patients' needs in these 5 core domains that community services can help with:

- Housing instability
- Food insecurity
- Transportation problems
- Utility help needs

Center for Medicare and Medicaid Innovation 1

Ctrl+Click for the Accountable Health Communities Health-Related Social Needs Screening Tool.

Establish a process for regularly engaging patients and families.

E.g., patient interviews

EQIC
Multiple-admission Patient Program
Patient and Care Partner Interview Tool

What is this tool?

Who should use this tool?

How to use this tool:

FOR INTERNAL USE ONLY

Patient Name

Date of admission (current admission):

☐ Patient
☐ Care partner or family member
☐ Both
☐ Other

Name of interviewer:

Date:

Section 1: General admission or readmission

Ctrl+Click for a patient and care partner interview tool.

https://innovation.cms.gov/files/worksheets/ahcm-screeningtool.pdf

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/2022-06-13_patient_and_care_partner_interview_tool.docx

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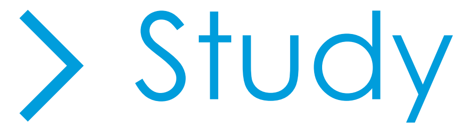

Has the current state changed?

Evaluate Intervention Effectiveness

Return to your action planning tool and PDSA worksheet (slide 21) to continue customizing your intervention based on progress to date.

What are the new processes or systems in place? List the permanent changes that have been made.

List the project successes, barriers and potential solutions.

This slide corresponds to the "Results/Analysis" section of your Collaborative Poster.

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Review the Data

Return to your measures worksheet (slide 20) to review your process and balancing measures.

Review available data from previously identified data sources.
Review Medicare FFS claims in CDS (note that claims data for your intervention period may not be available yet).
Did the team achieve the AIM statement?

This slide corresponds to the "Results/Analysis" section of your Collaborative Poster.

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Act

Was our intervention successful?

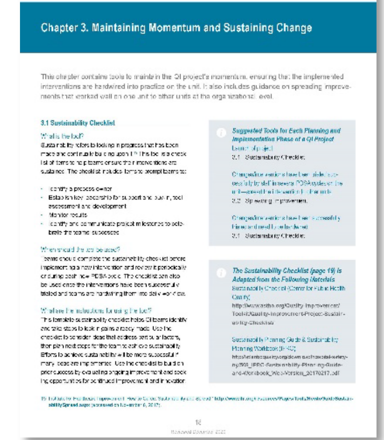
How can we modify to create more improvement?

Steps for Sustaining Change

Use this page to jot down your plans to continue this project. Consider the following questions:

What success can be repeated or replicated?
What next steps can be taken to sustain, spread, share?
What barriers still exist? What next steps can be taken to overcome barriers?
How would this process be sustained during a Public Health Emergency?
Has your team achieved original project aim yet? If yes, what is your new aim? If no, what strategies can you try next?

Ctrl+Click to complete a sustainability checklist.



Chapter 3. Maintaining Momentum and Sustaining Change

This chapter contains tools to maintain the QI project's momentum, ensuring that the implemented interventions are hardwired into practice on the unit. It also includes guidance on spreading improvements that worked well on one unit to other units at the organizational level.

3.1 Sustainability Checklist

- Identify a process owner
- Monitor results

Suggested Tools for Each Planning and Implementation Phase of a QI Project

The Sustainability Checklist (page 19) is Adapted from the Following Materials

https://www.telligenqiconnect.com/wp-content/uploads/2023/02/NYSPFP_PatientSafety_Toolkit_Sustainability-Checklist.pdf

This slide corresponds to the “Next Steps” section of your Collaborative Poster.

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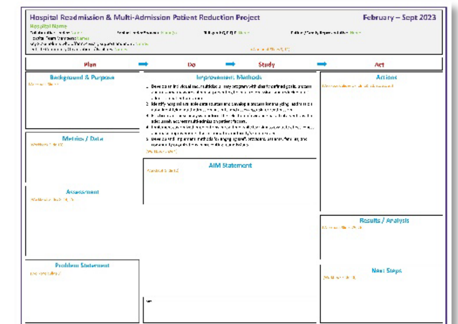
Project Poster

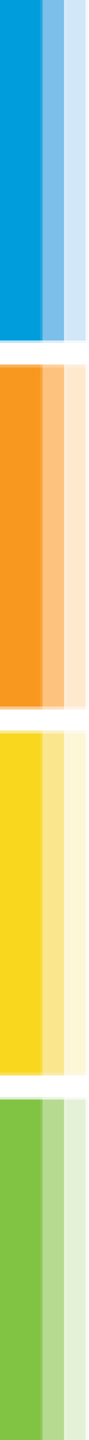
Work with Telligen to begin compiling your project poster.

Share your project poster with hospital-wide staff, board of directors and other HQIC hospitals.

Ctrl+Click for a poster template.



https://www.telligenqiconnect.com/wp-content/uploads/2023/02/Readmissions-Collab-Poster-Template-Draft_-add-Abstract-and-Charter-detailsv2.pptx



Note-Taking Page

Note-Taking Page

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