HQIC Community of Practice Call

Readmissions: Multiple-Admission Patients

August 11, 2022

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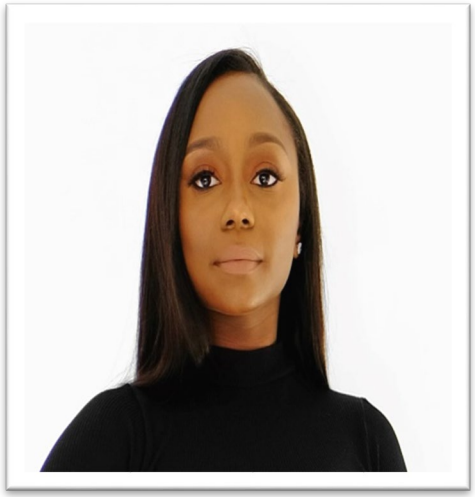
Introduction



Shaterra Smith
Social Science Research Analyst
Division of Quality Improvement Innovation
Models Testing
iQuality Improvement and Innovations Group
Center for Clinical Standards and Quality
Centers for Medicare & Medicaid Services

Welcome!

Agenda

- Introduction
- Today's topic
  - Readmissions: Multiple-Admission Patients

    Presenters:

    - Brenda Chapman, Program Manager, Eastern U.S. Quality Improvement Collaborative (EQIC), Healthcare Association of New York State (HANYS)
    - Maria Sacco, Director, Quality Advocacy, Research and Innovation Healthcare Association of New York State (HANYS)
- Open discussion
- Closing remarks

As You Listen, Ponder…

- What information can you leverage to help expand opportunities in your facilities and communities?
- What impactful actions can you take as a result of the information shared today?
- Where can you begin with your facility to continue to ensure safety, and a true patient-centered approach as you engage collaboratively with others?
- What activities do you have underway that will allow for you to expand and push forward in action over the next 30, 60 or 90 days?

Meet Your Speakers

Brenda Chapman, BS, RNC
Program Manager
Eastern US Quality Improvement Collaborative (EQIC),
Healthcare Association of New York State (HANYS)

Maria Sacco, RRT, CPHQ
Director, Quality Advocacy, Research and Innovation,
Healthcare Association of New York State (HANYS)

Multiple-Admission Patient Program

CMS Community of Practice Call

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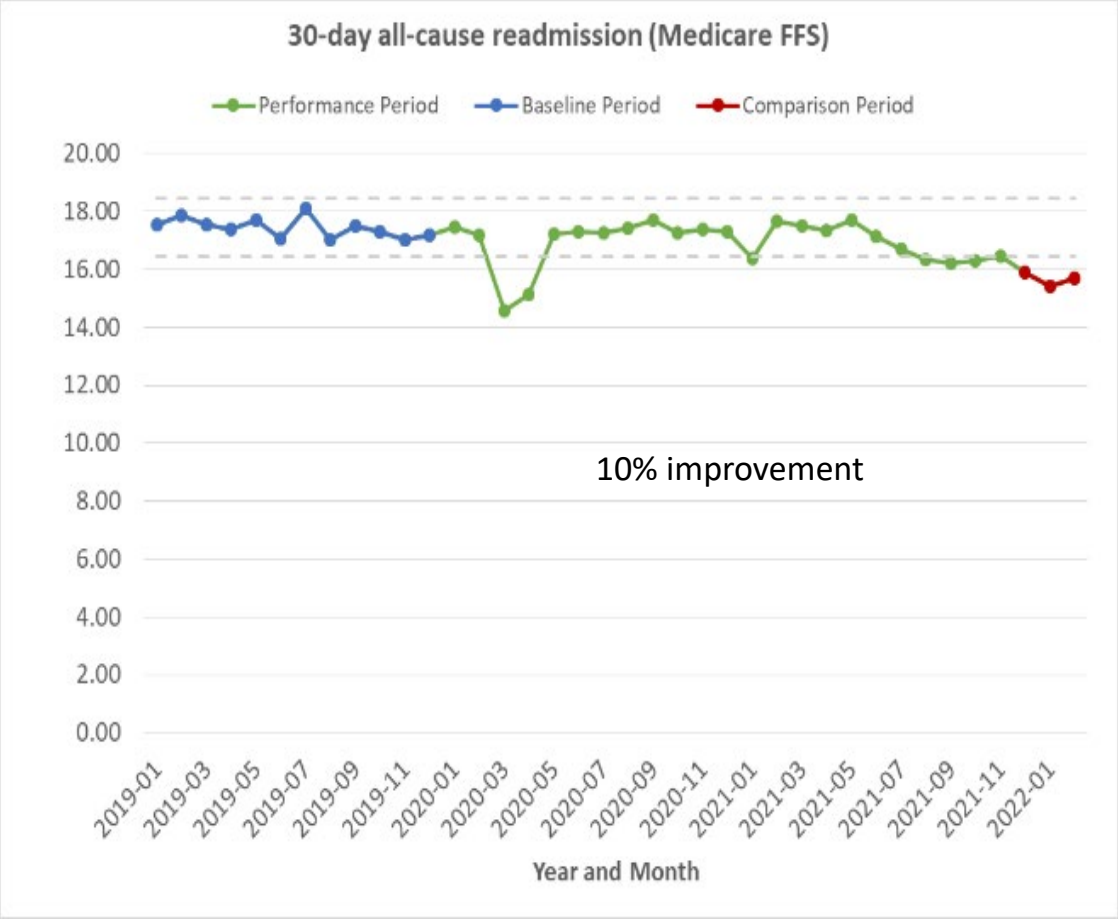
EQIC Goal

Reduce hospital readmission by 5%



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EQIC Care Partner program

Care Partner Framework

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STEP 1: Commit
- Dedicate a program leader
- Establish a care partner program
- Broadly promote the care partner role
- Continuously evaluate and improve the program

STEP 2: Identify
- Support patient to designate a care partner
- Introduce care partner to the medical team
- Identify a proxy care partner in special circumstances
- Display name and contact information of care partner in highly visible areas
- Provide a visual identifier for care partner to wear in the hospital

STEP 3: Include
- Orient the care partner to the unit environment and routine
- Invite care partner to daily patient rounds and bedside huddles
- Involve care partner in discussions about the patient's care plan
- Empower care partner to perform simple patient care activities

STEP 4: Prepare
- Assess care partner's education needs
- Educate care partner on essential care activities at home
- Allow care partner to demonstrate understanding using teach-back
- Integrate care partner into discharge planning
- Discuss and plan for post-discharge medical care with care partner

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https://qualityimprovementcollaborative.org/focus_areas/readmissions/tools_resources

Hospital priorities and goals

- ✓ Clinical quality
- ✓ Patient safety
- ✓ HCAHPS
- ✓ Reduce readmissions
- ✓ Decrease length of stay
- ✓ Value-based contracting payment
- ✓ External community reputation
- ✓ Clinician workforce satisfaction
- ✓ Deliver care with health equity
- ✓ Culture of safety and service excellence

It's the right thing to do!

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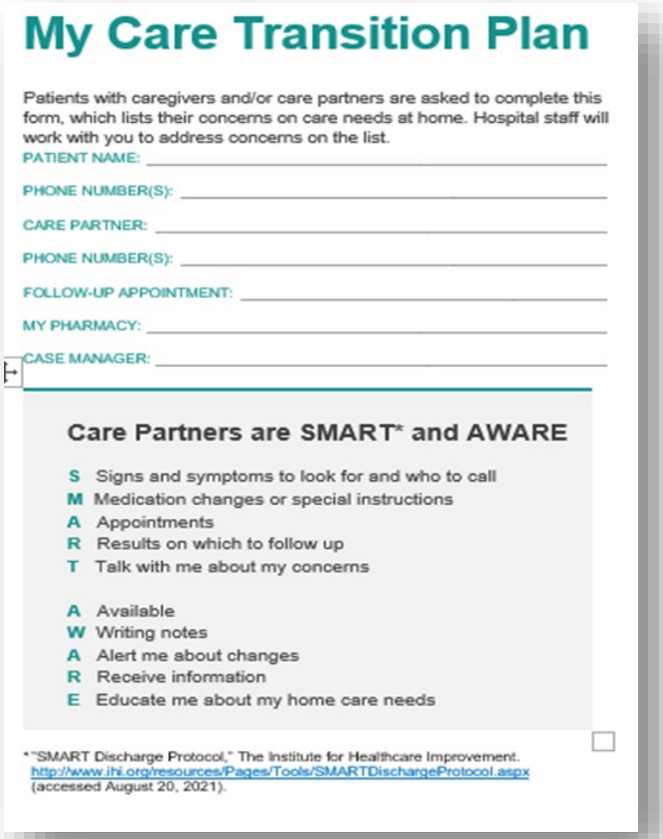
How to engage the patient and care partner

I = Include
D = Discuss
E = Educate
A = Assess
L = Listen



My Care Transition Plan

Patients with caregivers and/or care partners are asked to complete this form, which lists their concerns on care needs at home. Hospital staff will work with you to address concerns on the list.

PATIENT NAME: _____

PHONE NUMBER(S): _____

CARE PARTNER: _____

PHONE NUMBER(S): _____

FOLLOW-UP APPOINTMENT: _____

MY PHARMACY: _____

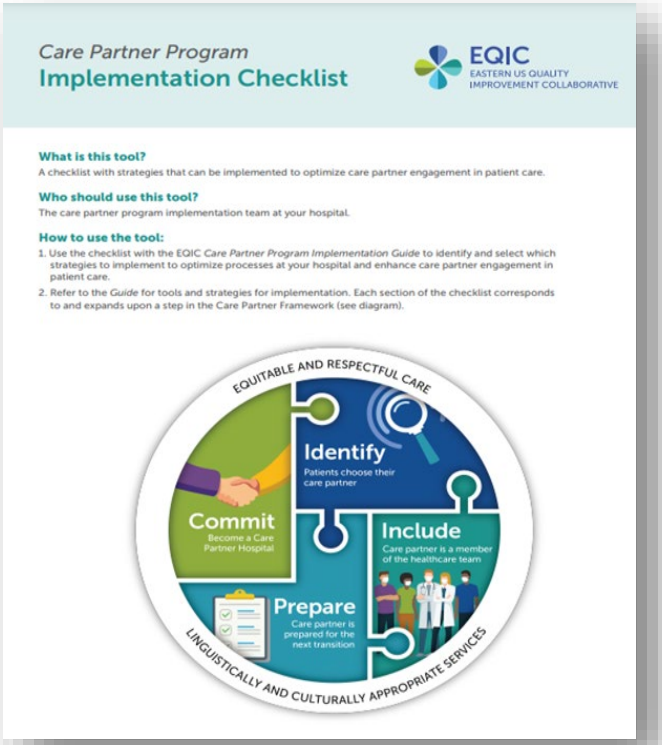
CASE MANAGER: _____

Care Partners are SMART* and AWARE

S Signs and symptoms to look for and who to call
M Medication changes or special instructions
A Appointments
R Results on which to follow up
T Talk with me about my concerns

A Available
W Writing notes
A Alert me about changes
R Receive information
E Educate me about my home care needs

*"SMART Discharge Protocol," The Institute for Healthcare Improvement. http://www.ihi.org/resources/Pages/Tools/SMARTDischargeProtocol.aspx (accessed August 20, 2021).



Care Partner Program
Implementation Checklist

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What is this tool?
A checklist with strategies that can be implemented to optimize care partner engagement in patient care.

Who should use this tool?
The care partner program implementation team at your hospital.

How to use the tool:
1. Use the checklist with the EQIC *Care Partner Program Implementation Guide* to identify and select which strategies to implement to optimize processes at your hospital and enhance care partner engagement in patient care.
2. Refer to the *Guide* for tools and strategies for implementation. Each section of the checklist corresponds to and expands upon a step in the Care Partner Framework (see diagram).

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MAP objectives

- Identify what EQIC's multiple-admission patient program is and why implementing one will benefit your facility.
- Identify principles and methodology to develop a multiple-admission patient program.
- Identify tools and resources for evaluation.

Evidence for a multiple-admission patient program

Patients who are frequently admitted to **hospitals** are likely to have multiple complex chronic conditions.

They also may have behavioral comorbidities that mediate their health behaviors, all of which results in acute episodes requiring hospitalization.

Complex interactions between patients' physical and mental condition, attitude, values, social situation and issues with care provision for both primary and secondary care are all causes of multiple hospital admissions.

Frequently admitted patients may have some distinguishing characteristics that require novel solutions.

Patients who are frequently admitted to US **academic medical centers** are likely to have multiple complex chronic conditions and may have behavioral comorbidities that mediate their health behaviors, resulting in acute episodes requiring hospitalization.

This information can be used to identify solutions for preventing repeat hospitalization for this small group of patients who consume a highly disproportionate share of healthcare resources.

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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

Szekendi, M. K., Williams, M. V., Carrier, D., Hensley, L., Thomas, S., & Cerese, J. (2015). The characteristics of patients frequently admitted to academic medical centers in the United States. *Journal of Hospital Medicine*, 10(9), 563-568. https://doi.org/10.1002/jhm.2375

What is a multiple-admission patient?

EQIC definition:

An individual who has four or more admissions in a 12-month period.

Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html

Braet, A., Weltens, C., Sermeus, W. and Vleugels, A. (2015), Risk factors for hospital re-admissions. *J Eval Clin Pract*, 21: 560-566. https://doi.org/10.1111/jep.12320

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EQIC MAP program framework

STEP 1: Design your MAP program

STEP 2: Identify patients who meet MAP program criteria

STEP 3: Assess readmission risk

STEP 4: Customize interventions

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Multiple-admission Patient
Program Framework

STEP 1: Design your MAP program

- Create an internal multidisciplinary team
- Identify and invite community-based organizations to collaborate with your team
- Define program goals and measures
- Evaluate and adopt MAP program tools and resources
- Develop staff education for the MAP program

STEP 2: Identify patients that meet MAP program criteria

- Develop data sources for reports
- Review and determine eligible patients
- Develop EMR notifications
- Create a plan for healthcare team communication

STEP 3: Assess readmission risk

- Evaluate readmission risk using a standard assessment tool
- Gather information from patient and care partner
- Regularly review risk data to identify and mitigate risk trends
- Identify and address any health equity and social determinants of health concerns for the patient

STEP 4: Customize interventions

- Create an individualized plan for each patient
- Coordinate a discharge plan with the MAP program team
- Engage emergency department staff in MAP program
- Ensure follow-up communication with post-discharge provider(s) occurs
- Provide post-discharge support and follow up

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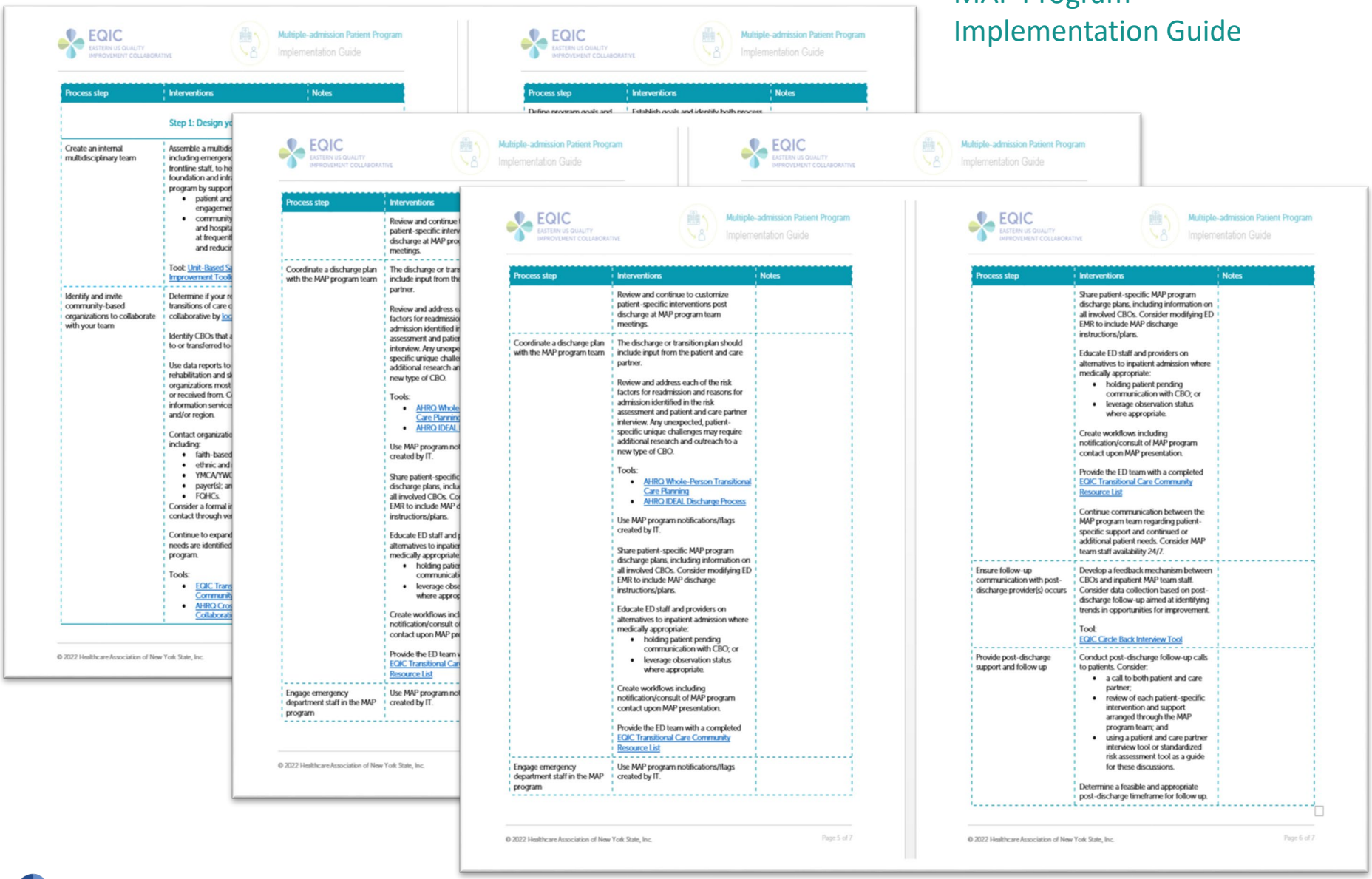
MAP Program Implementation Guide



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Multiple-admission Patient Program
Implementation Guide

Process step	Interventions	Notes
Coordinate a discharge plan with the MAP program team	The discharge or transition plan should include input from the patient and care partner. Review and address each of the risk factors for readmission and reasons for admission identified in the risk assessment and patient and care partner interview. Any unexpected, patient-specific unique challenges may require additional research and outreach to a new type of CBO. Tools: • AHRQ Whole-Person Transitional Care Planning • AHRQ IDEAL Discharge Process Use MAP program notifications/flags created by IT. Share patient-specific MAP program discharge plans, including information on all involved CBOs. Consider modifying ED EMR to include MAP discharge instructions/plans. Educate ED staff and providers on alternatives to inpatient admission where medically appropriate: • holding patient pending communication with CBO; or • leverage observation status where appropriate. Create workflows including notification/consult of MAP program contact upon MAP presentation. Provide the ED team with a completed EQIC Transitional Care Community Resource List	
Engage emergency department staff in the MAP program	Use MAP program notifications/flags created by IT.	

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Process step	Interventions	Notes
	Share patient-specific MAP program discharge plans, including information on all involved CBOs. Consider modifying ED EMR to include MAP discharge instructions/plans. Educate ED staff and providers on alternatives to inpatient admission where medically appropriate: • holding patient pending communication with CBO; or • leverage observation status where appropriate. Create workflows including notification/consult of MAP program contact upon MAP presentation. Provide the ED team with a completed EQIC Transitional Care Community Resource List Continue communication between the MAP program team regarding patient-specific support and continued or additional patient needs. Consider MAP team staff availability 24/7.	
Ensure follow-up communication with post-discharge provider(s) occurs	Develop a feedback mechanism between CBOs and inpatient MAP team staff. Consider data collection based on post-discharge follow-up aimed at identifying trends in opportunities for improvement. Tool: EQIC Circle Back Interview Tool	
Provide post-discharge support and follow up	Conduct post-discharge follow-up calls to patients. Consider: • a call to both patient and care partner; • review of each patient-specific intervention and support arranged through the MAP program team; and • using a patient and care partner interview tool or standardized risk assessment tool as a guide for these discussions. Determine a feasible and appropriate post-discharge timeframe for follow up.	

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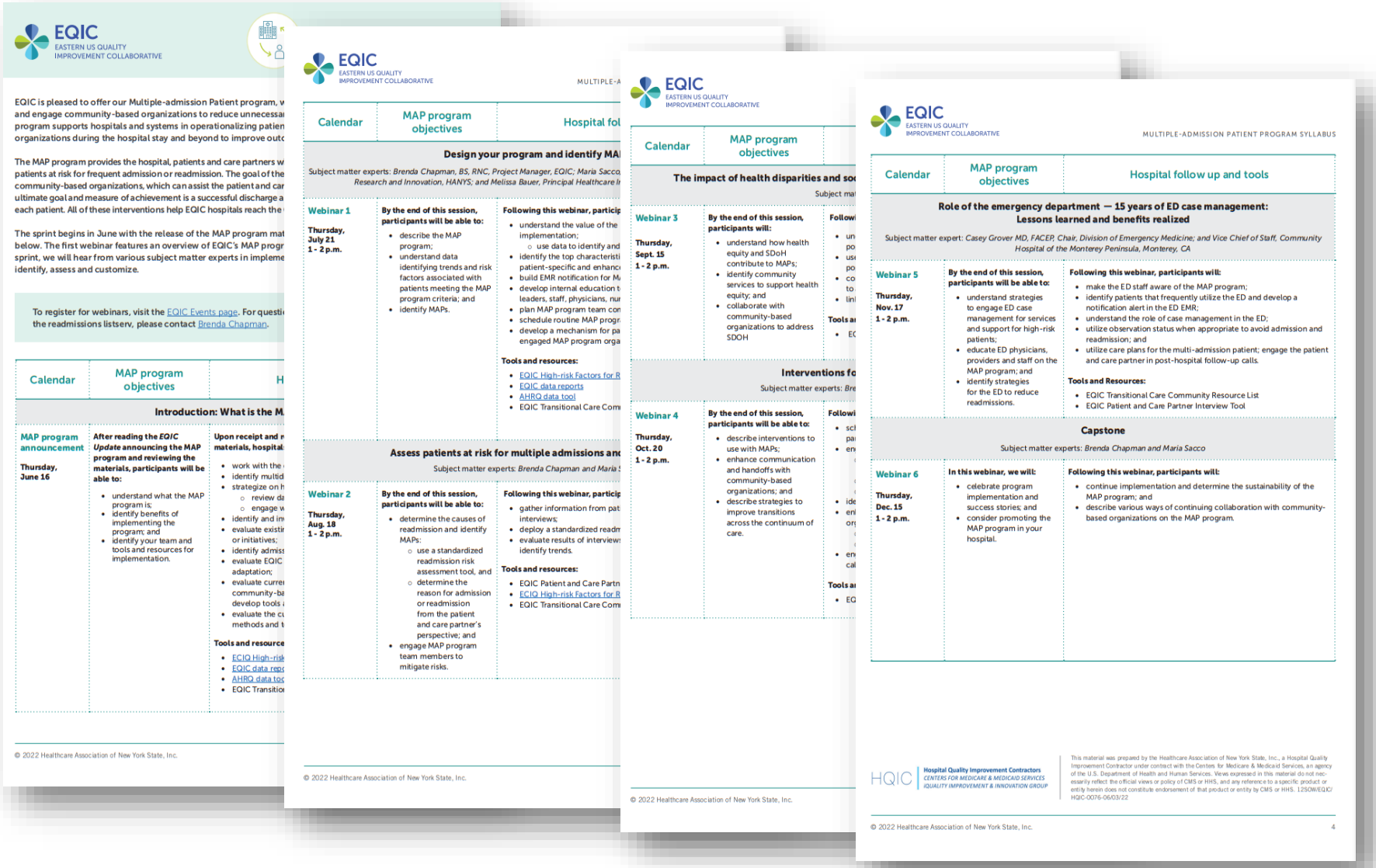
MAP Program Syllabus



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MULTIPLE-ADMISSION PATIENT PROGRAM SYLLABUS

Calendar	MAP program objectives	Hospital follow up and tools
Role of the emergency department — 15 years of ED case management: Lessons learned and benefits realized Subject matter expert: *Casey Grover MD, FACEP, Chair, Division of Emergency Medicine; and Vice Chief of Staff, Community Hospital of the Monterey Peninsula, Monterey, CA*		
Webinar 5 **Thursday, Nov. 17** **1 - 2 p.m.**	**By the end of this session, participants will be able to:** • understand strategies to engage ED case management for services and support for high-risk patients; • educate ED physicians, providers and staff on the MAP program; and • identify strategies for the ED to reduce readmissions.	**Following this webinar, participants will:** • make the ED staff aware of the MAP program; • identify patients that frequently utilize the ED and develop a notification alert in the ED EMR; • understand the role of case management in the ED; • utilize observation status when appropriate to avoid admission and readmission; and • utilize care plans for the multi-admission patient; engage the patient and care partner in post-hospital follow-up calls. **Tools and Resources:** • EQIC Transitional Care Community Resource List • EQIC Patient and Care Partner Interview Tool
Capstone Subject matter experts: *Brenda Chapman and Maria Sacco*		
Webinar 6 **Thursday, Dec. 15** **1 - 2 p.m.**	**In this webinar, we will:** • celebrate program implementation and success stories; and • consider promoting the MAP program in your hospital.	**Following this webinar, participants will:** • continue implementation and determine the sustainability of the MAP program; and • describe various ways of continuing collaboration with community-based organizations on the MAP program.

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Step 1: Design your program

- Create an internal multidisciplinary team
- Identify and invite community-based organizations to collaborate with your team
- Define program goals and measures
- Evaluate and adopt MAP program tools and resources
- Develop staff education for the MAP program

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Step 1 tools

- Unit-Based Safety Quality Improvement Toolkit
- Locating your QIO-QIN https://qualityimprovementcollaborative.org/focus_areas/readmissions/tools_resources
- EQIC Transitional Care Community Resource List
- AHRQ Cross-Continuum Collaboration Tool

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Unit-Based Patient Safety and Quality Improvement Toolkit

Unit-Based Patient Safety and Quality Improvement Toolkit

A partnership of the Healthcare Association of New York State and the Greater New York Hospital Association.

Introduction

The Centers for Medicare
Improvement and Innova
(HACs) and readmission
Greater New York Hospit
NYS) in collaboration wit
with hospitals since 2012
duce HACs and readmis
of these efforts is leverag

Frontline care givers ofte
crease the occurrence of
efforts, hospital leaders c
harm prevention strategie

The following section des
develop a culture of safet

NYSPFP Unit-Based Safety

The Unit-Based Safety Appro
active learning and bringing
bedside and is characterized

- Awareness and involveme processes
- Identification and implem care processes to ensure practices (e.g., bedside a patient safety checklists)
- Education and developme to-date knowledge on evi and the principles of the s

1 P. Cohen, Ptaskiewicz M., and M *Permanente Journal* vol. 14, no. 2

Chapter 1. Getting Started: How to Improve

NYSPFP suggests that hospital teams use the "M mended by the Institute for Healthcare Improveme Study-Act (PDSA) cycle. Additional tools, resource tials toolkit[4] are also included in the NYSPFP toolk

Hospital teams should review the Model for Impro those that best suit their needs.

The following tool summarizes the Model for Impro

1.1 Model for Improvement

What is the tool?

Developed by the Associates in Process Improvement, the Model for Improvement is the framework used by the IHI for accelerating process change. A simple but transformative model, it is not intended to replace existing change models adopted by organizations.[5]

The model has two parts:

- Three fundamental questions, which set the overall plan for the improvements
- PDSA cycle, which could be used to test changes selected by the team

When should the tool be used?

The Model for Improvement tool can be used by the team when it is charged with improving a process. The model provides direction on how the team should set the project aim, select measures and changes, and test, implement, and spread. Using the model will lead the

4 Institute for Healthcare Improvement. "Quality Improvement Essentia ment-Essentials-Toolkit.aspx (accessed on November 8, 2017).
5 Institute for Healthcare Improvement. "How to Improve."(2017). http:// November 8, 2017).

Chapter 2. Planning and Implementing Your QI Project

This chapter contains tools to use in planning and implementing an improvement project and tracking progress to maintain desired changes.

The tools are organized to correspond with different stages of the start of a QI project. Unit-based teams can use all of the tools or select the specific tools that best match their needs.

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

Selecting an effective team prior to starting the QI initiative
2.1 Selecting your Team

Gathering ideas for intervention/change and identifying opportunities for improvement
2.2 Brainstorming
2.3 Obtain and Use Frontline Knowledge
2.4 Engage Patients and Family Caregivers in your QI Project
2.5 Flowcharting

Planning and preparing for challenges to the success of your QI project
2.6 Organizational Readiness Tool
2.5 Flowcharting
2.7 Developing Measures

Tools to plan and roll out your QI project
2.8 Action Planning Tool
2.9 PDSA

Tools to track the success of the project
2.10 Displaying and Sharing your QI data
2.11 Holding an Effective HAC Team/QI Meeting

2.1 Selecting your Team

What is the tool?

Each quality initiative should have a dedicated team of individuals with defined roles who are responsible for planning, implementing, and measuring results. This tool is a guide for identifying and selecting core team members and assigning appropriate roles.

The team should be comprised of individuals interested in the improvement subject who will function well together and have some subject-specific expertise to contribute to the initiative. Team members' roles should include but not be limited to the following:

- Executive sponsors
- Day-to-day leaders
- Technical experts
- Clinical leaders
- Unit-based champions

When should the tool be used?

It should be used at the beginning of the initiative to create a cohesive team. Quality improvement at the unit level benefits from input from individuals who work with the processes every day. Participation by various stakeholders will ensure that consideration is given from many viewpoints and that new ideas are available for the team to consider.

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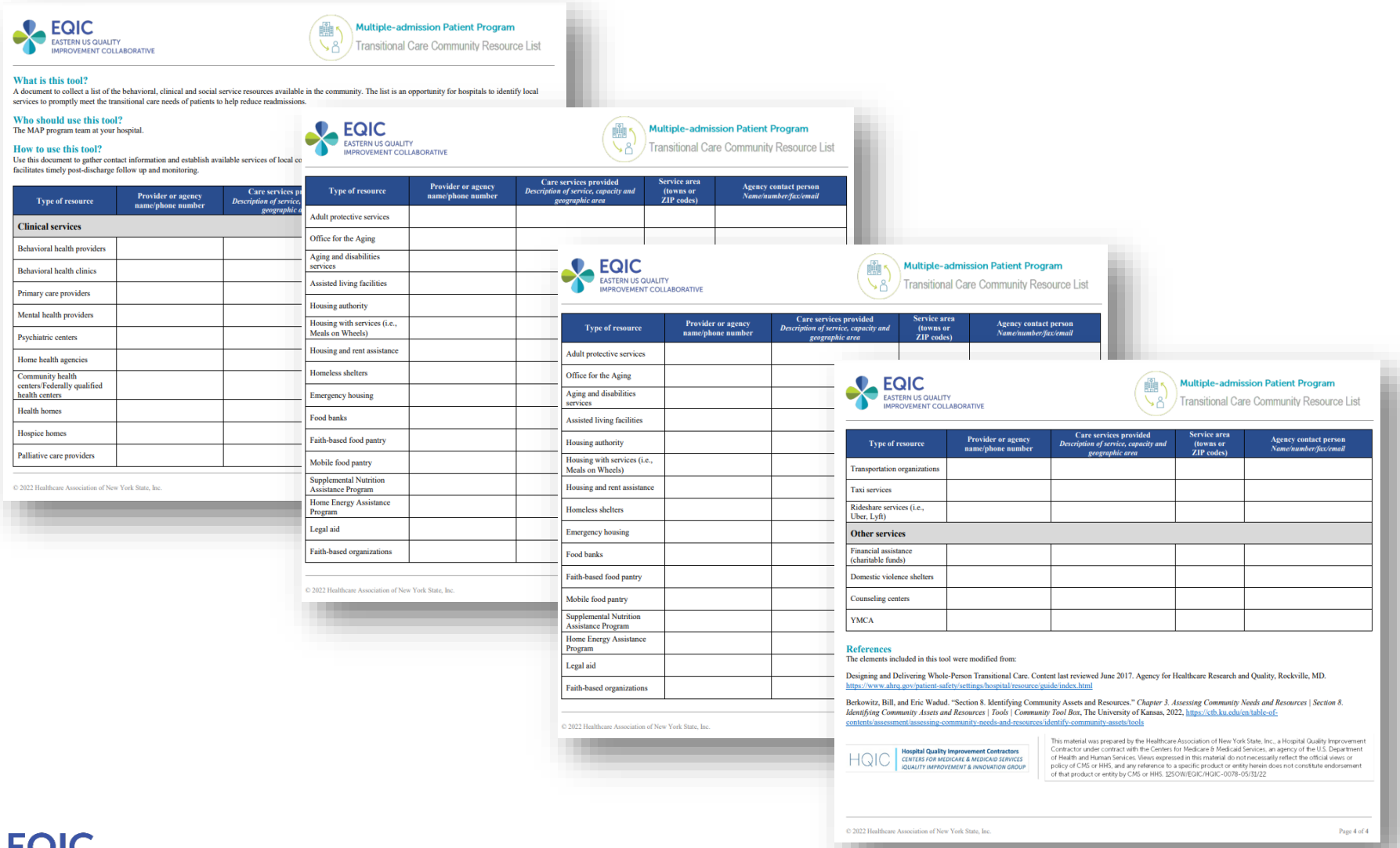
https://qualityimprovementcollaborative.org/focus_areas/readmissions/tools_resources/

EQIC Transitional Care Community Resource List



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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 co
facilitates timely post-discharge follow up and monitoring.

Type of resource	Provider or agency name/phone number	Care services p *Description of service, geographic*
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		
Palliative care providers		

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Multiple-admission Patient Program
Transitional Care Community Resource List

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*
Adult protective services				
Office for the Aging				
Aging and disabilities services				
Assisted living facilities				
Housing authority				
Housing with services (i.e., Meals on Wheels)				
Housing and rent assistance				
Homeless shelters				
Emergency housing				
Food banks				
Faith-based food pantry				
Mobile food pantry				
Supplemental Nutrition Assistance Program				
Home Energy Assistance Program				
Legal aid				
Faith-based organizations				

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Transitional Care Community Resource List

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*
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Home Energy Assistance Program				
Legal aid				
Faith-based organizations				

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Multiple-admission Patient Program
Transitional Care Community Resource List

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*
Transportation organizations				
Taxi services				
Rideshare services (i.e., Uber, Lyft)				
Other services				
Financial assistance (charitable funds)				
Domestic violence shelters				
Counseling centers				
YMCA				

References
The elements included in this tool were modified from:

Designing and Delivering Whole-Person Transitional Care. Content last reviewed June 2017. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/patient-safety/settings/hospital/resource/guide/index.html

Berkowitz, Bill, and Eric Wadud. "Section 8. Identifying Community Assets and Resources." *Chapter 3. Assessing Community Needs and Resources | Section 8. Identifying Community Assets and Resources | Tools | Community Tool Box*, The University of Kansas, 2022, https://ctb.ku.edu/en/table-of-contents/assessment/assessing-community-needs-and-resources/identify-community-assets/tools

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Step 2: Identify patients who meet MAP criteria

- Develop data sources for reports
- Review and determine eligible patients
- Develop EMR notifications
- Create a plan for healthcare team communication

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Step 2 tools

- EQIC data reports
- AHRQ data tool

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EQIC multiple-admission patient data

Hospitalwide All-Condition, All-Payer, Readmission Analysis Age 18+

EQIC-Wide Results

Table 6. High Utilizer Population	All
# of patients hospitalized 4 or more times in the past year	4,771
# of discharges by patients hospitalized 4 or more times in the past year	29,271
# of readmissions by patients hospitalized 4 or more times in the past year	14,981
% of readmissions by patients hospitalized 4 or more times in the past year	21%
Readmission rate of patients hospitalized 4 or more times in the past year	51%

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The framework of this report was modeled after The Agency for Healthcare Research and Quality Medicaid Readmissions tool. It has been modified and pre-populated with hospital-specific data for informational purposes.

Top discharge DRGs leading to the highest number of readmissions

Hospitalwide All-Condition, All-Payer, Readmission Analysis Age 18+
EQIC-Wide Results

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Table 3. Top Discharge DRGs Leading to Highest Number of Readmissions	Top 10 Discharge DRGs Resulting in Readmission	# Readmissions	# Discharges	DRG Readmissions as % of All Readmissions
871	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS \	3,908	30,847	5%
291	HEART FAILURE AND SHOCK WITH MCC	2,932	18,330	4%
177	RESPIRATORY INFECTIONS AND INFLAMMATIONS WITH MCC	2,886	34,348	4%
885	PSYCHOSES	2,284	20,643	3%
999	UNGROUPABLE	2,201	3,569	3%
897	ALCOHOL, DRUG ABUSE OR DEPENDENCE WITHOUT REHAE	1,624	11,866	2%
189	PULMONARY EDEMA AND RESPIRATORY FAILURE	1,144	7,043	2%
872	SEPTICEMIA OR SEVERE SEPSIS WITHOUT MV >96 HOURS \	943	9,812	1%
190	CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH MCC	894	5,542	1%
392	ESOPHAGITIS, GASTROENTERITIS AND MISCELLANEOUS DI	852	9,591	1%
	Total, Top 10	19,668		
	Total, All Readmissions	71,556		27%

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Data by discharge disposition

Hospitalwide All-Condition, All-Payer, Readmission Analysis Age 18+

EQIC-Wide Results

Table 5. Discharge Disposition Details	All
# of discharges to home (without home health)	394,905
# of discharges to home health	113,705
# of discharges to skilled nursing facility (SNF)	82,576
# of discharges to other	63,278
% of discharges discharged to home (without home health)	60%
% of discharges discharged with home health	17%
% of discharges discharged to SNF	13%
% of discharges discharged to other	10%
# of readmissions following discharge to home (without home health)	32,522
# of readmissions following discharge to home health	16,018
# of readmissions following discharge to skilled nursing facility (SNF)	10,931
# of readmissions following discharge to other	12,085
Readmission rate following discharge to home (without home health)	8%
Readmission rate following discharge to home health	14%
Readmission rate following discharge to skilled nursing facility (SNF)	13%
Readmission rate following discharge to other	19%

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Target populations to consider

Hospitalwide All-Condition, All-Payer, Readmission Analysis Age 18+

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EQIC-Wide Results

Table 9. Target Populations To Consider	
What is the hospital's overall readmission rate, and which groups of patients have higher than average readmission rates? Which group experiences the most readmissions? Are there any high-risk DRG's to consider?	
% of patients with behavioral health comorbidities	63%
Readmission rate among patients discharged to home (without home health)	8%
Readmission rate among patients discharged to SNFs	13%
% of readmissions from high-utilizing patients	21%

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Step 3: Assess readmission risk

- Evaluate readmission risk using a standard assessment tool
- Gather information from patient and care partner
- Regularly review risk data to identify and mitigate risk trends
- Identify and address any health equity and social determinants of health concerns for the patient

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Step 3 tools

- EQIC High-risk Factors for Readmission Tracking Tool
- EQIC Patient and Care Partner Interview Tool
- EQIC Readmission Discovery Tool
- EQIC Health Equity Tools and Resources
- AHRQ ED Care Plan

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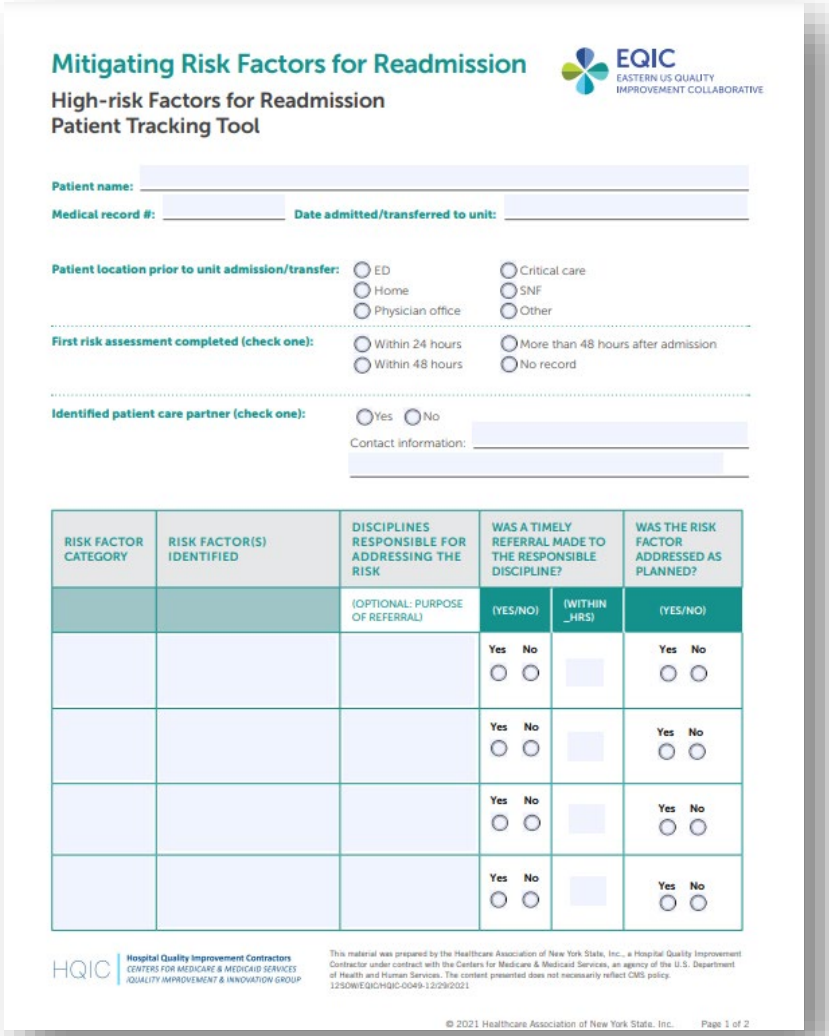
High-risk Factors for Readmission Patient Tracking Tool



Mitigating Risk Factors for Readmission

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High-risk Factors for Readmission Patient Tracking Tool

Patient name: _____

Medical record #: _____ **Date admitted/transferred to unit:** _____

Patient location prior to unit admission/transfer:
◯ ED ◯ Critical care
◯ Home ◯ SNF
◯ Physician office ◯ Other

First risk assessment completed (check one):
◯ Within 24 hours ◯ More than 48 hours after admission
◯ Within 48 hours ◯ No record

Identified patient care partner (check one): ◯ Yes ◯ No
Contact information: _____

RISK FACTOR CATEGORY	RISK FACTOR(S) IDENTIFIED	DISCIPLINES RESPONSIBLE FOR ADDRESSING THE RISK	WAS A TIMELY REFERRAL MADE TO THE RESPONSIBLE DISCIPLINE?		WAS THE RISK FACTOR ADDRESSED AS PLANNED?
		(OPTIONAL: PURPOSE OF REFERRAL)	(YES/NO)	(WITHIN _HRS)	(YES/NO)
			Yes ◯ No ◯		Yes ◯ No ◯
			Yes ◯ No ◯		Yes ◯ No ◯
			Yes ◯ No ◯		Yes ◯ No ◯
			Yes ◯ No ◯		Yes ◯ No ◯

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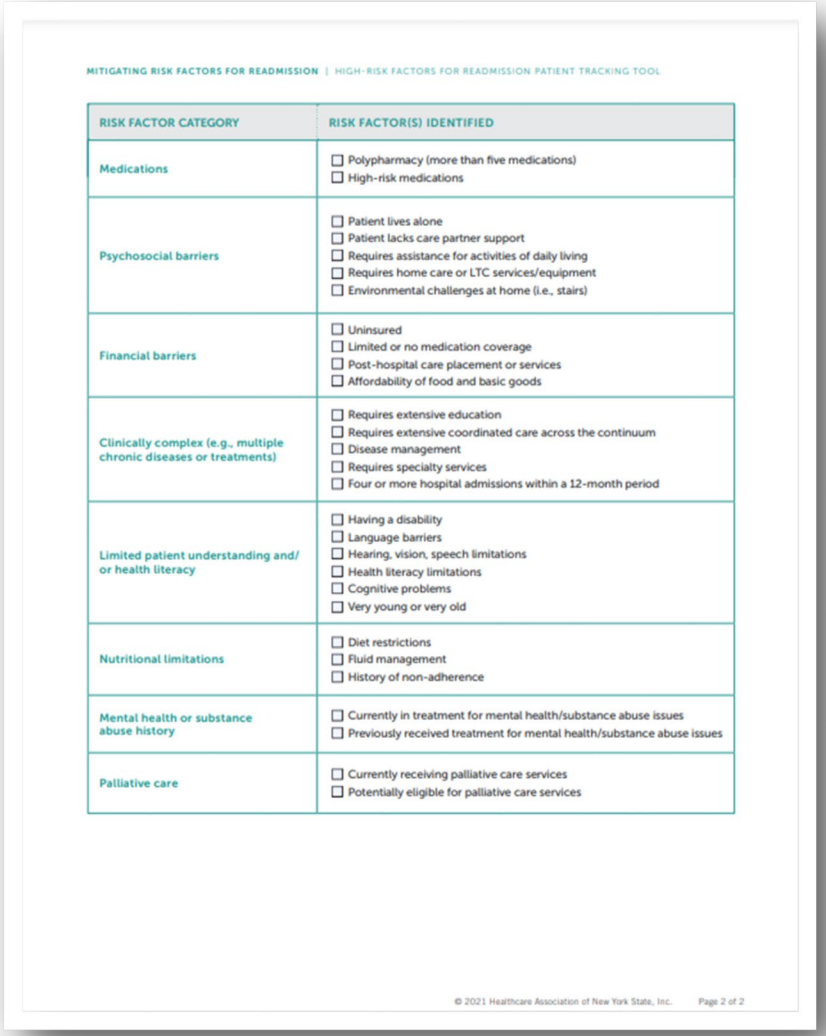

RISK FACTOR CATEGORY	RISK FACTOR(S) IDENTIFIED
Medications	☐ Polypharmacy (more than five medications) ☐ High-risk medications
Psychosocial barriers	☐ Patient lives alone ☐ Patient lacks care partner support ☐ Requires assistance for activities of daily living ☐ Requires home care or LTC services/equipment ☐ Environmental challenges at home (i.e., stairs)
Financial barriers	☐ Uninsured ☐ Limited or no medication coverage ☐ Post-hospital care placement or services ☐ Affordability of food and basic goods
Clinically complex (e.g., multiple chronic diseases or treatments)	☐ Requires extensive education ☐ Requires extensive coordinated care across the continuum ☐ Disease management ☐ Requires specialty services ☐ Four or more hospital admissions within a 12-month period
Limited patient understanding and/or health literacy	☐ Having a disability ☐ Language barriers ☐ Hearing, vision, speech limitations ☐ Health literacy limitations ☐ Cognitive problems ☐ Very young or very old
Nutritional limitations	☐ Diet restrictions ☐ Fluid management ☐ History of non-adherence
Mental health or substance abuse history	☐ Currently in treatment for mental health/substance abuse issues ☐ Previously received treatment for mental health/substance abuse issues
Palliative care	☐ Currently receiving palliative care services ☐ Potentially eligible for palliative care services

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Multiple-admission Patient Program

Patient and Care Partner Interview Tool

What is this tool?

In the case of a multiple-admission patient or readmission within 30 days of last discharge, this tool helps hospitals gather information from the patient, care partner and/or family member on non-medical factors that may have contributed to the admission or readmission. The questions are designed so the answers provide a deeper understanding of the patient's and care partner's perspectives, challenges and barriers. With this information, hospitals can identify commonly recurring opportunities for improvement in current discharge processes and better optimize discharge plans.

Who should use this tool?

This tool should be used by designated MAP team members, such as quality improvement, nursing, case management or other designated staff. This tool is *not* designed to be given to a patient or care partner to complete and return to staff; it should be completed by a hospital team member.

How to use this tool:

- Identify patients in the hospital who have been readmitted within 30 days of discharge from the hospital and/or patients that meet your facility's MAP criteria.
- Ask the patient and/or care partner if they are willing to have a short (10- to 15-minute) discussion about their recent admission or readmission.
- The interviewer will ask the below questions and record the answers.
- Analyze responses for insight on why patients have returned to the hospital so soon after their discharge.
- EQIC encourages you to conduct the interview when the patient's care partner or family member is present to provide more robust information.

FOR INTERNAL USE ONLY

Patient Name:

Medical record number:

Date of admission (current admission):

If applicable, admitted from which community-based organization?

Who is responding to this survey or being interviewed?

- ○ Patient
- ○ Care partner or family member
- ○ Both
- ○ Other

If other, please explain:

Name of the care partner, family member or other person present:

Relationship to patient:

Name of interviewer:

Date:

Section 1: General admission or readmission

EQIC Patient and Care Partner Interview Tool

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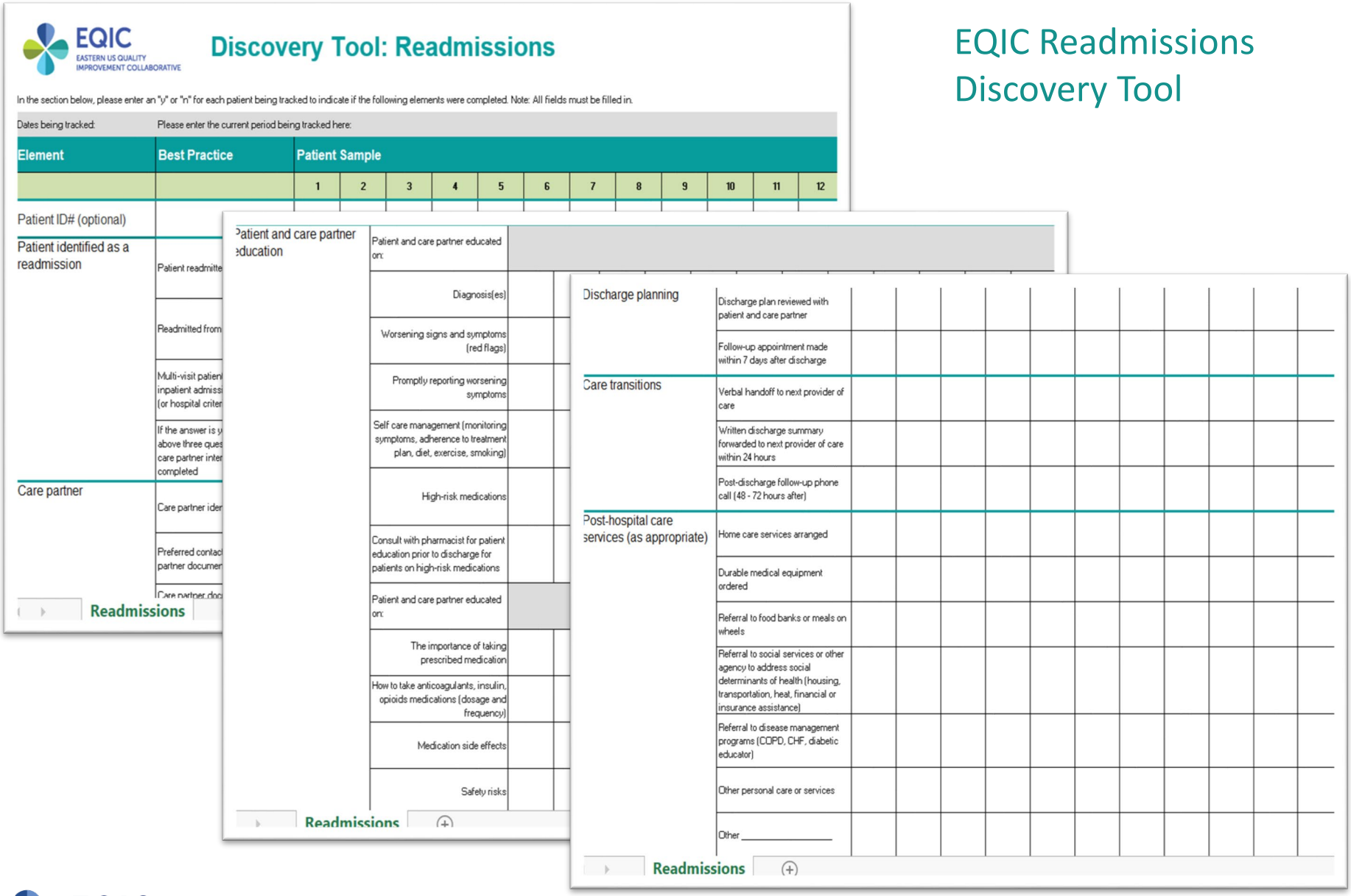

EQIC Readmissions Discovery Tool

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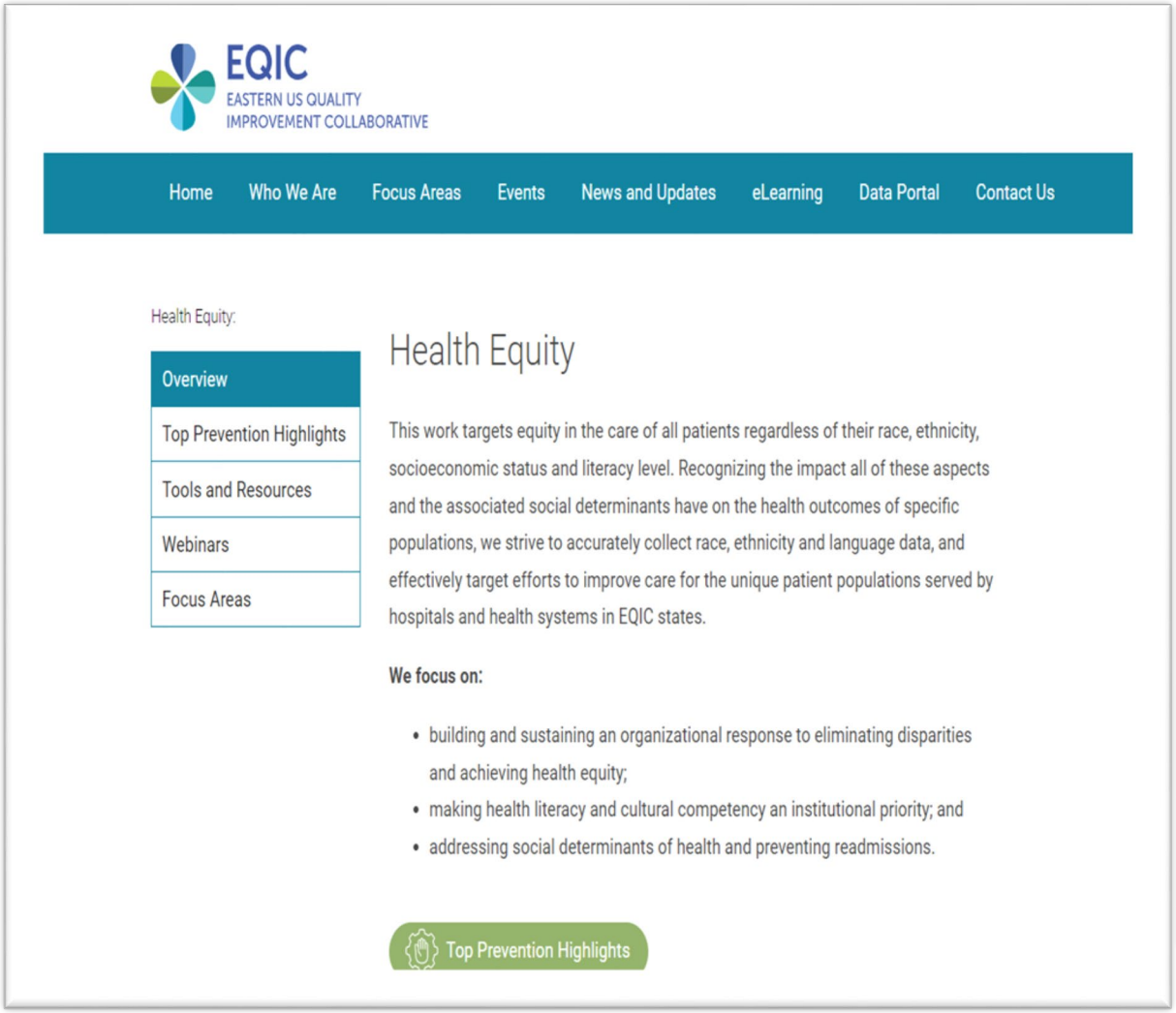
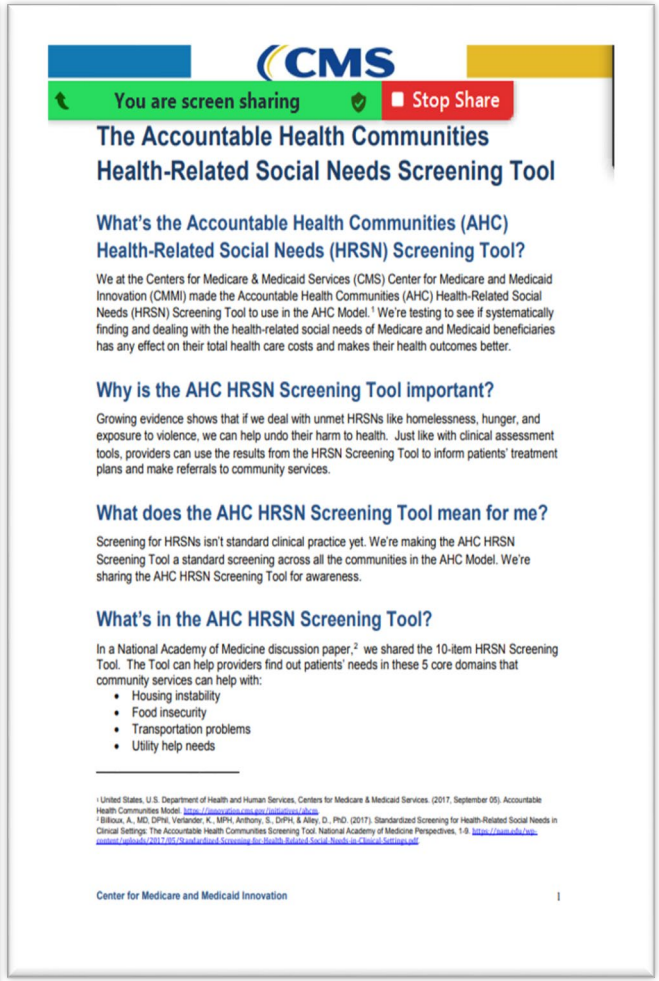
Health Equity





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Step 4: Customize interventions

- Create an individualized plan for each patient
- Coordinate a discharge plan with the MAP program team
- Engage emergency department staff in MAP program
- Ensure follow-up communication with post-discharge provider(s) occurs
- Provide post-discharge support and follow up

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Step 4 tools

- EQIC Circle Back Interview Tool
- EQIC Transitional Care Community Resource List
- AHRQ RED toolkit: How to Conduct a Post-discharge Follow-up Call
- AHRQ Whole-Person Transitional Care Planning
- AHRQ IDEAL Discharge Process

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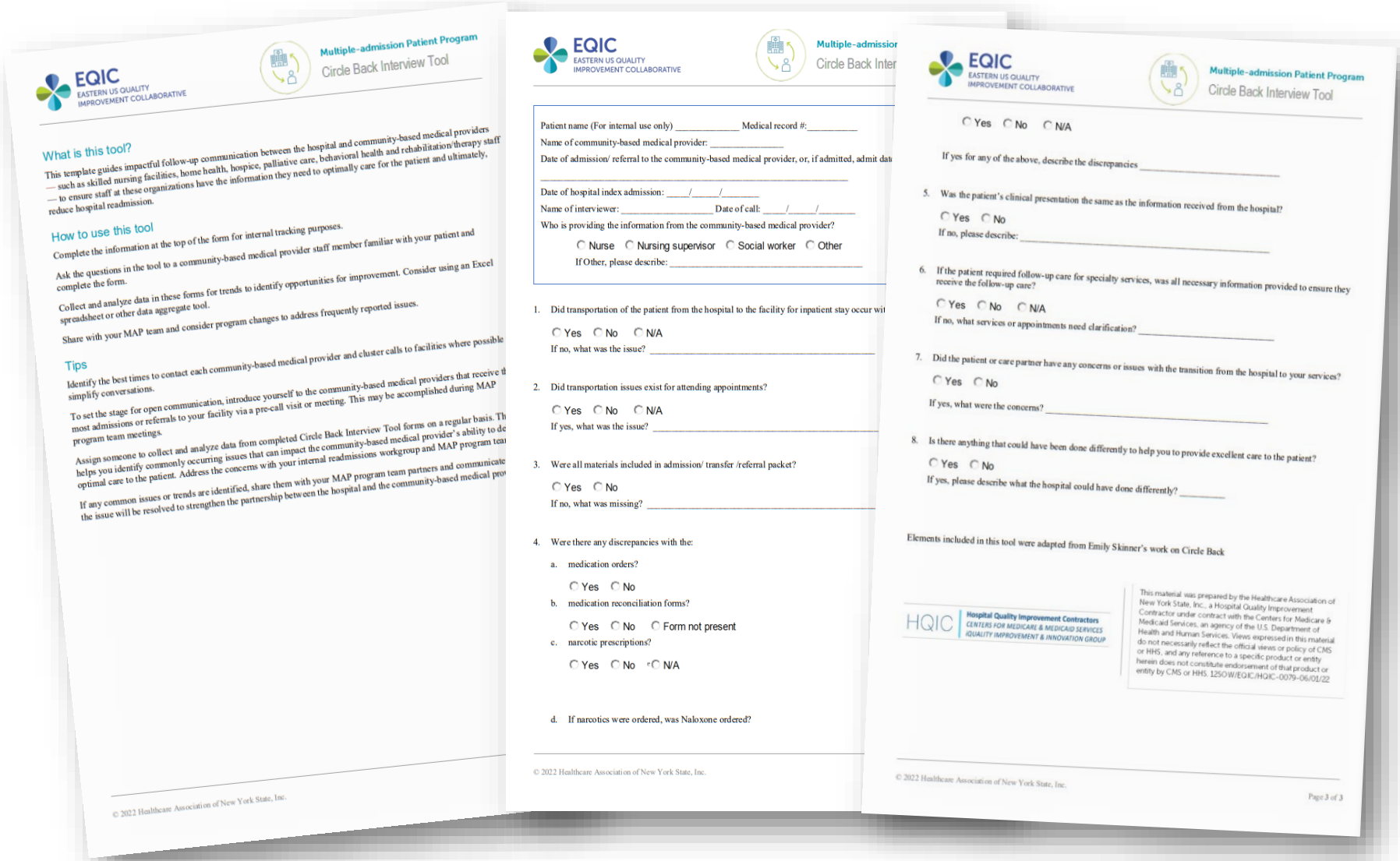
EQIC Circle Back Interview Tool



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Multiple-admission Patient Program
Circle Back Interview Tool

What is this tool?

This template guides impactful follow-up communication between the hospital and community-based medical providers — such as skilled nursing facilities, home health, hospice, palliative care, behavioral health and rehabilitation/therapy staff — to ensure staff at these organizations have the information they need to optimally care for the patient and ultimately, reduce hospital readmission.

How to use this tool

Complete the information at the top of the form for internal tracking purposes.

Ask the questions in the tool to a community-based medical provider staff member familiar with your patient and complete the form.

Collect and analyze data in these forms for trends to identify opportunities for improvement. Consider using an Excel spreadsheet or other data aggregate tool.

Share with your MAP team and consider program changes to address frequently reported issues.

Tips

Identify the best times to contact each community-based medical provider and cluster calls to facilities where possible simplify conversations.

To set the stage for open communication, introduce yourself to the community-based medical providers that receive th most admissions or referrals to your facility via a pre-call visit or meeting. This may be accomplished during MAP program team meetings.

Assign someone to collect and analyze data from completed Circle Back Interview Tool forms on a regular basis. Th helps you identify commonly occurring issues that can impact the community-based medical provider's ability to de optimal care to the patient. Address the concerns with your internal readmissions workgroup and MAP program tea

If any common issues or trends are identified, share them with your MAP program team partners and communicate the issue will be resolved to strengthen the partnership between the hospital and the community-based medical pro

Patient name (For internal use only) _____ Medical record #:_____
Name of community-based medical provider: _____
Date of admission/ referral to the community-based medical provider, or, if admitted, admit dat
_____
Date of hospital index admission: ____/_____/_____
Name of interviewer: _____ Date of call: ____/_____/_____
Who is providing the information from the community-based medical provider?
○ Nurse ○ Nursing supervisor ○ Social worker ○ Other
If Other, please describe: _____

1. Did transportation of the patient from the hospital to the facility for inpatient stay occur wit
○ Yes ○ No ○ N/A
If no, what was the issue? _____

2. Did transportation issues exist for attending appointments?
○ Yes ○ No ○ N/A
If yes, what was the issue? _____

3. Were all materials included in admission/ transfer /referral packet?
○ Yes ○ No
If no, what was missing? _____

4. Were there any discrepancies with the:
   a. medication orders?
   ○ Yes ○ No
   b. medication reconciliation forms?
   ○ Yes ○ No ○ Form not present
   c. narcotic prescriptions?
   ○ Yes ○ No ○ N/A
   d. If narcotics were ordered, was Naloxone ordered?

○ Yes ○ No ○ N/A
If yes for any of the above, describe the discrepancies _____

5. Was the patient's clinical presentation the same as the information received from the hospital?
○ Yes ○ No
If no, please describe: _____

6. If the patient required follow-up care for specialty services, was all necessary information provided to ensure they receive the follow-up care?
○ Yes ○ No ○ N/A
If no, what services or appointments need clarification? _____

7. Did the patient or care partner have any concerns or issues with the transition from the hospital to your services?
○ Yes ○ No
If yes, what were the concerns? _____

8. Is there anything that could have been done differently to help you to provide excellent care to the patient?
○ Yes ○ No
If yes, please describe what the hospital could have done differently? _____

Elements included in this tool were adapted from Emily Skinner's work on Circle Back

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Preventable Readmissions:

- Overview
- Top Prevention Highlights
- Tools and Resources
- Webinars
- Focus Areas

Preventable Readmissions

EQIC offers education and interventions to assist hospitals with implementing strategies to identify patients at risk for preventable readmissions and improve care transitions. This work is designed to assist hospitals with a wide range of targeted interventions addressing the complex and multi-factorial nature of readmissions and implementing focused interventions related to those areas. EQIC addresses a wide variety of issues, including SNF and home care readmission, high-utilizer readmission, specific diagnostic or delivery of care readmission, health equity implications and the most important aspect of empowering the patient and family through a Care Partner Program.

Goal: Reduce hospital readmissions by 5%.

Top Prevention Highlights

https://qualityimprovementcollaborative.org/focus_areas/readmissions

Discussion

- What information can you leverage to help expand opportunities in your facilities and communities?
- What impactful actions can you take as a result of the information shared today?
- Where can you begin with your facility to continue to ensure safety, and a true patient-centered approach as you engage collaboratively with others?
- What activities do you have underway that will allow for you to expand and push forward in action over the next 30, 60 or 90 days?

Final Thoughts

Join Us for the Next Community of Practice Call!

Join us for the next
Community of Practice Call on September 15, 2022
from 1:00 – 2:00 p.m. ET

We invite you to register at the following link:
https://zoom.us/webinar/register/WN_ASl_l3p_TEyx_VY_YYFFeA

You will receive a confirmation email with login details.

Thank You!

Your opinion is valuable to us. Please take 4 minutes to complete the post assessment.

We will use the information you provide to improve future events.