Reducing Readmissions Preparation Program

HOME HEALTH READMISSION ASSESSMENT (PRE & POST)

Facility Name: _____ CCN:* _____ ☐ Pre-Assessment Date: _____

Survey Completed By: _____ ☐ Post-Assessment Date: _____

Work with your Reducing Readmissions Committee to complete the following assessment. Each item relates to prevention elements that should be in place for a successful readmissions program in your organization. Select one of the implementation status options on the right for each assessment item.

Assessment Items	Yes, In Place With Consistent Use	Yes, In Place With Partial Use	Under Development	No, Not Doing at All
Operational Processes				
1. Do you track and trend transfers using a readmission dashboard? Rationale: "A dashboard is an ideal way to prioritize the most important indicators for home health and encourage regular monitoring of the results. Home Health should include readmission as one of the measures in your dashboard." Source: Instructions to Develop a Dashboard, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/QAPI/downloads/InstrDevDshbddebedits.pdf.	☐	☐	☐	☐
2. Do you discuss readmissions that occurred in the last 24 hours during daily stand-up meetings? Rationale: Daily stand-up meetings provide an opportunity to review all patients readmitted from the previous day to determine the root causes for the readmission and the plan to prevent them in the future.	☐	☐	☐	☐
3. Do you conduct case reviews for patients who return to the hospital? Rationale: Conducting case reviews on patients who return to the hospital is an integral part of root cause analysis. This will provide a comprehensive review of the resident's condition and other factors contributing to the transfer. See the INTERACT Quality Improvement Tool for a Review of Acute Care Transfers (chart audit tool) at http://www.pathway-interact.com/.	☐	☐	☐	☐
4. Do you use the INTERACT chart audit tools (or other evidence-based tools) for your readmission case reviews on patients that return to the hospital? Rationale: Reviewing a small sample of readmitted patient charts aids in identifying patterns or trends in data and provides opportunities for improvement. Data analyzed include key clinical information, such as changes in condition, vital signs at the time of transfer, new or worsening symptoms, etc. See the INTERACT Quality Improvement Tool for Review of Acute Care Transfers (chart audit tool) at http://www.pathway-interact.com/.	☐	☐	☐	☐

**CCN is your six-digit CMS Certification Number from the Centers for Medicare & Medicaid Services.*

Assessment Items	Yes, In Place With Consistent Use	Yes, In Place With Partial Use	Under Development	No, Not Doing at All
5. Do you have at least one Performance Improvement Project (PIP) specific to readmission prevention? Rationale: A project establishes the goals, scope, timing, milestones, and team roles and responsibilities for an improvement project. Develop a PIP specific to readmission prevention.	☐	☐	☐	☐
6. Do you have annual competencies with your nurses related to effective team communication? Rationale: Adding standardized communication tools in the annual competencies is a method to validate that staff members know how to use the communication tools. Provide training for those that are not using the tools or using them inconsistently. Consider using INTERACT Situation-Background-Assessment-Recommendation (SBAR) and the "Stop and Watch" warning tool. See the INTERACT forms at http://www.pathway-interact.com/.	☐	☐	☐	☐
7. Do you have a Case Conference that meets weekly? Rationale: A team that meets to review data, case studies, and improvements for current processes. The case conference should include the interdisciplinary team. Having a dedicated review committee will assist in identifying system failures that exist, trends in data, and opportunities for improvement.	☐	☐	☐	☐
8. Do you report on readmissions, including data, to your Quality Assurance and Performance Improvement (QAPI) committee quarterly? Rationale: As part of feedback, data systems, and monitoring for QAPI, it is important to keep the QAPI leadership in your organization informed of readmission-related issues and data so that they can support and provide resources to drive improvement efforts.	☐	☐	☐	☐
Pre-Admission				
9. Does your primary transferring hospital know your capabilities? Rationale: A capabilities checklist in the emergency department or case management department is used by hospital staff members in the decision-making process to determine whether the patient should be admitted to the hospital or referred back to the home health. The checklist is a quality improvement tool that educates hospital staff members and improves confidence in their home health partners.	☐	☐	☐	☐

Assessment Items	Yes, In Place With Consistent Use	Yes, In Place With Partial Use	Under Development	No, Not Doing at All
10. Does your primary transferring hospital share all necessary medical history and documents when the patient transfers to your services? Rationale: Sharing patient medical history, physician orders and discharge summary, among other important information, is critical to receive from the acute care provider. See the INTERACT Acute Care Transfer Document Checklist at http://www.pathway- .	☐	☐	☐	☐
Admission/Transfer From Hospital				
11. Do you have a process for measuring if a patient is at risk for readmission? Rationale: A risk-assessment tool is an evidence-based approach to stratify patients who are at high risk for readmission. Patients identified as high risk should be "flagged" to receive targeted interventions throughout their care and before discharge. Source: https://quality.allianthealth.org/wp-content/uploads/2023/11/Home-Health-Rehospitalization-Risk-Assessment-Tool-FINAL_508.pdf	☐	☐	☐	☐
12. Do you always have telephone access to medical providers (Dispatch Health, Telemedicine) (24/7) to ensure timely responses to urgent clinical needs? Rationale: Home health members need access to medical providers (Dispatch Health, Telemedicine) to ensure timely responses to urgent clinical needs.	☐	☐	☐	☐

Assessment Items	Yes, In Place With Consistent Use	Yes, In Place With Partial Use	Under Development	No, Not Doing at All
Discharge to Home				
13. Do you ensure patients have a plan for obtaining medications post-discharge? Rationale: Medication errors during patient transitions are prevalent and contribute significantly to readmissions. A comprehensive medication plan in place at the time of discharge should include: the discharge medication list, indication and duration of new medications, and changes in medication (if any), and must be communicated to and understood by the resident and family upon discharge.	☐	☐	☐	☐
14. Do you use the teach-back method to validate patients' and families' understanding of their medications, medical condition and/or discharge plans? Rationale: Teach back is a communication tool to confirm that a healthcare provider has explained to the patient what they need to know in a manner that the patient understands. Source: https://quality.allianthealth.org/wp-content/uploads/2023/02/Transitions-of-Care-Make-Teach-back-and-Always-Event-FINAL_508.pdf	☐	☐	☐	☐
15. Do you conduct post-discharge follow-up phone calls to patients/families within 1 week of discharge? (Subsequent calls within seven days are also recommended). Rationale: Follow-up phone calls are essential because they provide an opportunity to reinforce the discharge plan, problem solve, and resolve post-discharge issues such as challenges obtaining medications, new or worsening symptoms, and barriers to getting to physician follow-up appointments. Phone calls also help maintain a positive connection with your patients and let them know you care about them.	☐	☐	☐	☐

This material was prepared by Health Services Advisory Group (HSAG) and modified by Alliant Health Solutions, a Quality Innovation Network – Quality Improvement Organization (QIN – QIO) under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. Publication No. 12SOW-AHS-QIN-QIO-TO1-PCH-5391-03/07/24