Preventable Readmissions Initiative
Action Planning Resource Guide

2013
# Table of Contents

3 Introduction  
5 Identifying the Causes of Readmissions  
7 Developing and Implementing an Action Plan  
9 Readmissions Reduction Opportunities Across the Care Continuum  
   9 Pre-Admission  
   10 Emergency Department  
   10 Hospital Admission  
   12 Hospital Stay  
   13 Discharge Day  
   14 Post-Hospital Care  
   15 Primary Care  
17 CMS Community-Based Care Transitions Program and Other Initiatives  
19 Additional Resources  
21 Appendices  
   21 Appendix A. Gap Analysis for Best Practices to Reduce Readmissions  
   23 Appendix B. NYSPFP Readmission Action Plan Worksheet  
   25 Appendix C. High-Risk Factors for Readmission  
   29 Appendix D. Successful Practices for Medication Reconciliation  
   31 Appendix E. Successful Practices During the Hospital Stay  
   35 Appendix F. Successful Practices on Discharge Day  
   37 Appendix G. Successful Practices for Post-Hospital Care  
   39 Appendix H. Post-Hospital Care Interventions/Supports to Consider
Introduction

This resource is designed to guide hospitals through the process of planning and implementing a targeted, individualized preventable readmissions reduction program. By focusing on key drivers of readmissions, hospitals can organize their approach to assessing risk for readmission, prioritizing areas for intervention, and developing and applying strategies for prevention.

The Centers for Medicare & Medicaid Services’ (CMS) Partnership for Patients goal is to reduce hospital readmissions by 20% by December 2013. The NYS Partnership for Patients (NYSPFP) seeks to achieve this goal by comprehensively analyzing the underlying causes of readmissions, designing hospital-specific work plans to target those causes, and providing education on successful readmission reduction strategies. NYSPFP is tracking aggregate improvement beginning with December 2010 Potentially Preventable Readmission (PPR) data.
Identifying the Causes of Readmissions

NYSPFP has a number of tools to support hospitals’ efforts to identify and understand the underlying causes of their readmissions:

**Readmissions Diagnostic Report**
Hospital-specific readmission diagnostic reports are regularly updated and can be downloaded through the NYSPFP Web site. The reports are interactive, Excel®-based tools that use the 3M Potentially Preventable Readmission (PPR) Software and calendar year 2011 Statewide Planning and Research Cooperative System (SPARCS) data. The reports identify readmissions attributable to each hospital, whether those readmissions occurred in that hospital or another, and drill down into the readmissions by product line, diagnostic-related group, admission source, discharge status, payer, and case level. The reports can assist in identifying target populations on which to focus an in-depth assessment of the causes and potential avoidance of readmissions.

**Hospital Assessment of Current Practices**
NYSPFP administered an assessment of current hospital practices to better understand hospital readmission reduction efforts and identify opportunities for improvement. The assessment results are serving as a baseline for post-intervention comparison and helping hospitals prioritize their needs as they develop work plans to reduce readmissions.

**Patient and Caregiver Interviews**
NYSPFP encourages hospitals to conduct interviews with a sample of at least five readmitted patients and/or their caregivers to provide insight into patients’ perceptions of why the readmission occurred. Hospitals may wish to expand the survey to include additional readmitted patients if no pattern is discernible from the initial sample.

**Medical Chart Abstraction**
To derive information about specific readmissions causes or trends, NYSPFP recommends that hospitals conduct retrospective chart reviews on a sample of at least 10 patients who experienced unplanned readmissions within 30 days. This review can provide important information on readmission risk factors.

Hospital diagnostic reports are available on the NYSPFP Web site under the myNYSPFP section at https://www.nyspfp.org/Members/myNYSPFP.aspx.

A template Patient and Family Caregiver Interview Tool is available on the NYSPFP Web site at https://www.nyspfp.org/Materials/Patient_Caregiver_Survey_09052012.pdf.

A template Medical Chart Abstraction Tool is available on the NYSPFP Web site at https://www.nyspfp.org/Materials/Readmission_Chart_Abstraction_Tools.zip.
Primary Care Provider and Other Community-Based Provider Feedback

Hospitals are encouraged to communicate with at least three outpatient and other post-hospital care providers to ascertain their perspectives on the causes of preventable readmissions. These discussions can be informal and can offer instructive feedback, as well as cultivate relationships among providers in multiple settings. Hospital staff may find it most convenient to identify one patient who has been readmitted to the hospital within 30 days and use that case to guide a broader discussion with the provider. A similar approach may also be beneficial for reaching out to high-volume skilled nursing facilities and home care agencies.

A template High-Volume Primary Care or Other Community-Based Provider Interview Tool is available on the NYSPFP Web site at https://www.nyspfp.org/Materials/High%20Volume_Community_Based_Provider_Interview_09192012.pdf.
Developing an Action Plan
Once the hospital readmissions team—an institutional-level group usually made up of key clinical and administrative leaders and stakeholders—reviews the findings from the readmissions diagnostic report, the NYSPFP assessment tools, and other available information, opportunities to reduce readmissions can be identified and an action plan can be developed. This resource guide provides evidence-based practices and examples of interventions to support your action plan. The information and evidence-based practices are organized to address patients’ needs across the continuum of care (see Figure 1, page 9). Examples of interventions that can be implemented on admission through post-hospital care are provided in the appendices.

To significantly impact readmission rates, the hospital action plan should include small tests of change within a comprehensive, detailed project plan that includes an analysis of gaps and corresponding changes in process and other interventions and measurement strategy, as well as an implementation timeline. NYSPFP has provided a hospital gap analysis (Appendix A) and readmission action plan worksheet (Appendix B) to further aid hospitals in developing the action plan.

Implementing an Action Plan
The readmission team is responsible for implementing the action plan; prioritizing, aligning, and coordinating the tests of change; evaluating the progress; and communicating with the executive sponsor and senior leadership. The speed of change will depend on the hospital’s ability to commit resources, organize the change in processes, and test and measure parallel practices and processes. As the process changes become successful, the team will determine when to implement formal policy and procedure changes and ensure physician and staff education.
Readmission Reduction Opportunities Across the Care Continuum

While there are opportunities to implement interventions to reduce readmissions across the entire continuum of care, this resource guide will focus primarily on four stages: day of admission, the inpatient hospital stay, discharge day, and post-hospital care, which are identified in magenta in Figure 1 and have associated tables of interventions in Appendices C–G. Other points in the continuum of care, designated by grey boxes in Figure 1, are discussed in the following pages, but do not have specific interventions for consideration listed in an appendix.

**Pre-Admission**
Interventions implemented as part of the pre-admission process for planned admissions offer a number of opportunities to potentially reduce readmissions and will enable patients and caregivers to be more prepared for the hospital stay and post-hospital care.

**Pre-Admission Discharge Planning**
During the pre-admission testing visit(s), patients and caregivers are informed of the planned course of hospitalization and post-hospital care. This allows time for caregiver(s) to plan to be available, and to arrange for the patient’s transportation needs before the hospitalization. This time also provides an opportunity to prepare in advance for other services the patient may need post-hospitalization, such as home care, physical therapy, and nutritional counseling.

Reviewing planned post-discharge interventions during the pre-admission process can heighten the patient’s sense of readiness and control during a hospital stay and upon discharge. In complex post-hospital care situations, hospitals may consider coordinating with community-based organizations and health insurers to help organize the home and supports before the hospital admission. Some post-hospital care services, equipment, and supplies may be procured prior to hospital admission, which could simplify the discharge planning process during the hospital stay. Hospitals may also consider pre-registering patients for their post-hospital care services, such as transfers to a rehabilitative, sub-acute, or short-term nursing facility. This is especially effective when the hospital length of stay is predictable, as in orthopedic surgical cases. Pre-admission planning can mitigate some delays in post-hospital care services, particularly those with a waiting list.
Pre-Admission Patient and Caregiver Education
There is an opportunity to begin patient and caregiver education on post-hospital care during the pre-admission visit(s). Pre-admission education may include information to ease anxiety and reduce barriers to learning during the hospital stay. Hospitals may also consider developing standard protocols, which can range from meal planning to exercise programs, for pre-admission education based on reason for admission.

Emergency Department
The emergency department (ED) should provide a range of case management services tailored to the hospital’s specific patient population, ED volume, and available resources. Case management services in the ED can address the needs of patients who are admitted to the hospital and those who are transferred or discharged home directly from the ED. Patients returning to the ED within 30 days of discharge due to decompensation and potential failure of the previous post-hospital care plan should also have access to ED services and interventions that can reduce preventable readmissions.

Case Management
Hospitals are strongly encouraged to have a process for providing 24-hour, seven-day-a-week (24/7) case management in the ED. Models vary from 24/7 on-call services to having 24/7 case management/social work staff assigned to the ED. Most hospitals use a hybrid model based on ED volume, patient population, and hospital resources. In lieu of having case management staff assigned to the ED 24/7, hospitals may consider providing case management training to some ED providers.

If a patient meets criteria for case management services based on the risk assessment/screening (defined later in this guide), then case management can be consulted immediately and discharge planning can begin. If the patient has recently been discharged from the hospital, it is recommended that staff evaluate whether there was a failure in the post-hospital care plan that needs to be addressed. The ED case management services may be able to put a home care program in place prior to discharging the patient from the ED. Numerous adjunct services may also be available, such as disease management programs, specialty clinics/programs, intensive home care management programs, or palliative care. Additionally, many community-based and religious organizations have volunteers, support groups, patient advocates, or community health workers who can provide ongoing support and assistance.

Patient and Caregiver Education
Post-hospital care plans can be misunderstood as patients and caregivers are often overwhelmed with the self-care responsibilities required after discharge. ED staff should be mindful of the potential need for clarification and education that can effectively support the patient’s return home.

Alternatives to Hospital Readmissions
Observation services, when available, are particularly effective for patients that require treatment and a brief period of stabilization.

Hospital Admission
Identifying patients at risk for readmission and reconciling medications are two key interventions that can be implemented during the hospital admission process to help prevent readmissions.

Identifying High-Risk Patients and Appropriate Interventions
During the admission process, identifying risk factors (see Appendix C for high-risk factors and associated interventions) that may increase the likelihood of readmission provides the care team with the information necessary to initiate a patient-centered care plan with targeted interventions to reduce a preventable readmission. While NYSPFP does not recommend a specific risk assessment, hospitals are encouraged to select a risk assessment that is best suited for their institution.

The two primary methods for risk assessment are:
- **Risk Stratification.** An assessment using risk stratification can be a helpful strategy for targeting patients who would benefit from certain
types of interventions, including intensive case management. A unique scoring system assesses and categorizes patients into various risk levels. Each risk category has a corresponding set of suggested interventions to reduce the potential for a preventable readmission.

- **Any High Risk.** This method identifies evidence-based high-risk factors for readmission and recommends corresponding interventions to mitigate identified factors. It is a comprehensive, yet tailored, patient-centered approach that addresses all the patient’s high-risk factors for readmission.

**Medication Reconciliation**

Adverse events due to medication errors are a common reason for re-hospitalization. Medication reconciliation is a multi-step process aimed at reducing readmissions due to errors or complications in managing medications. The medication reconciliation process is ongoing throughout the hospital stay, occurring—at a minimum—on admission and at the point of discharge (though ideally during all transfers throughout the hospital stay). It is intended to reduce medication errors and patient harm, including adverse drug events (ADEs, see Appendix D for specific interventions related to medication reconciliation), and to establish continuity of the medication management plan of care. Research indicates that an effective medication reconciliation process can detect and eliminate a high percentage of medication discrepancies, leading to fewer ADEs and reducing the cost of care and preventable readmissions.¹

Medication reconciliation on admission is a formal process of comparing all medications a patient is taking (or should be taking) at admission with the medications that have been ordered by the attending physician. All discrepancies are identified and resolution is documented. Discrepancies may include omissions, duplications, discrepant or incorrect dose/frequency/route of administration, or discrepant or incorrect drug name. In one study, medication reconciliation on admission resulted in a 43% decrease in ADEs caused by errors in admission orders.²

A hospital may decide to assign various clinical staff members to the process, but it is critical that the hospital clearly assign roles and responsibilities, especially if it adopts a multidisciplinary team approach to medication reconciliation.

The full scope of the medication reconciliation process includes:

- completing medication reconciliation upon admission by obtaining, verifying, and documenting in the medical record the current prescription and over-the-counter medications the patient is taking;
- identifying and addressing unintended discrepancies between pre-admission medications and those ordered in the hospital with the ordering and/or attending physician;
- completing medication reconciliation at discharge, with attention to admission, inpatient, and post-discharge medications; and
- communicating post-discharge medication management information to the patient, the patient’s family, and providers in the next setting of care (i.e., primary care physician, home care provider, nursing home).


---


Hospital Stay

Despite recognizing the importance of planning for discharge starting on admission, planning for post-hospital care needs is often delayed until the day of discharge due to competing priorities and/or changes in the patient’s status during the hospital stay. This can result in inadequate discharge planning and patient education. Therefore, it is strongly recommended that a multidisciplinary hospital team embrace a patient-centered discharge planning process beginning on admission that is driven by the high-risk assessment, presenting condition and secondary chronic diagnoses, and post-hospital care services required (see Appendix E for associated interventions). Numerous issues can be addressed early in the hospital stay to help ensure the patient and caregiver’s readiness to self-manage upon discharge. Below are a few essential components to discharge planning that better support patients throughout the hospital stay and their ability to self-manage after discharge.

Engage a Multidisciplinary Clinical Team

Creating an effective discharge plan utilizing a dynamic multidisciplinary approach is vital to enabling the patient to successfully self-manage upon discharge from the hospital. Therapists, pharmacists, physicians, residents, physician extenders, nurses, technicians, nutritionists, pastoral care staff, social workers, and case managers can all play a role in patient-centered discharge planning throughout the hospital stay. Each discipline brings expertise and support to educate and prepare the patient and caregiver. It is recommended that the multi-disciplinary discharge preparation and planning be supported by reliable and consistent protocols for referrals, communication, and hand-offs between the entire team and the patient.

Patient and Caregiver Education and Empowerment

Patient and caregiver engagement is vital to the success of discharge and post-hospital care plans. Education is ideally provided throughout the hospital stay and is targeted to the patient’s needs, lifestyle, and health literacy level. Patients and caregivers can be engaged in the discharge planning process as advisors to ensure the post-hospital care plan meets their needs. For example, the patient and caregiver can be actively involved in updating the bedside white board, contributing to shift reports, and developing their home care schedule. Hospitals are encouraged to provide education in the patient’s language and at an appropriate literacy level to improve patient understanding and compliance with the post-hospital care plan. Visual cues and materials can be especially helpful if there are health literacy or language concerns. One successful practice is using a technique known as “teach-back,” which can help a provider evaluate and confirm comprehension, to ensure that patients understand their discharge plan. Assessing patient understanding using teach-back methods can involve providing verbal feedback, demonstrating techniques, seeking clarifications, using scenarios or role playing, viewing videos, and conducting simple tests.

The discharge plan can be a critically important tool for engaging and empowering patients, as well as ensuring successful patient self-management after discharge, particularly if the plan is written by the patient and caregiver. It is recommended that the written discharge plan include:

- medication list detailing dose, route, frequency (including time that meets patient’s lifestyle and would enhance compliance), and additional relevant information on side effects, drug-drug or drug-food interactions, or titration;
- diet and fluids, including relationship to medications, as needed;
- all diagnoses, including signs, symptoms management, and who to call;
- pending tests or test results that will need to be addressed;
- treatment and therapies;
- follow-up physician appointment(s), including date and time; and
- post-hospital care services, including date of first visit and services to be provided.

The Society of Hospital Medicine offers a five-step teach-back process: http://www.hospitalmedicine.org/Resource-RoomRedesign/RR_CareTransitions/PDFs/Teach_Back_.pdf.
Discharge Day
A successful discharge day is the culmination of effective practices throughout the patient’s episode of care, from pre-admission to the day before discharge. The key interventions for an effective discharge (see Appendix F for specific interventions) are appropriate patient and caregiver education using teach-back to assess patient understanding; accurate and comprehensive medication reconciliation from admission to discharge; and a post-hospital care plan based on the high-risk assessment and developed by a multidisciplinary team (more information on the post-hospital care plan is provided in the next section).

Validate Patient Understanding with Teach-Back
Staff should not assume patients fully understand what they have been taught. In fact, it is recommended that staff assume all patients have limited understanding—regardless of education level or language—as a hospital stay and the related emotional response can compromise their ability to process complex information. Therefore, for all patients, it is important that staff assess patient understanding of disease processes and post-hospital care need. Teach-back is an effective method to validate understanding. It is important that staff avoid “yes” or “no” or leading questions to confirm understanding. To better validate understanding, staff may ask patients to explain a treatment or diagnosis or demonstrate skills required for self-care. If staff cannot confirm the patient has learned the information, then it may need to be presented in a different way (e.g., using different words or another technique, such as drawing or demonstrating a skill for the patient), or you may need to consider bringing the caregiver into the process.

Medication Reconciliation
When completing the medication reconciliation process at discharge, staff compares the medication history given on admission with the admission, transfer, and discharge orders, as well as any associated reconciliation documentation, to identify any discrepancies. Once discrepancies are identified,
determine whether they are intended or unintended. Unintended differences require staff to follow up with the prescriber(s) and ensure that the discrepancy is resolved, which includes documenting the resolution in the medical record. The outcome of the medication reconciliation at discharge is the final discharge medication list. This is the list that will be shared with the patient, caregivers, and all post-hospital care providers.

Post-Hospital Care
A robust post-hospital care plan is a primary driver of supporting patient self-management after discharge and reducing preventable readmissions. The plan will ensure that the patient has the required level of care after discharge and that care has been coordinated between hospital and non-hospital providers. Specific components of a robust post-hospital care plan include scheduling all post-hospital appointments and ensuring information is transferred to all post-hospital providers (see Appendix G for additional interventions for consideration, and Appendix H for selected post-hospital care service options).

Schedule Appointments
It is recommended that follow-up appointments with the patient’s primary care provider (PCP) be made within seven days of discharge or sooner, based on the patient’s medical condition. Follow-up appointments with specialty physicians or clinics may also be needed. Hospitals may also want to consider a process for pre-scheduling appointments during normal business hours, preferably the day before discharge, since patients frequently go home during “off” hours and on weekends.

Ensure Transfer of Materials and Services Are in Place
All outpatient providers need to be provided with timely and accurate care plan information in the post-hospital care hand-off. Ideally, both verbal and written communication will be provided to post-hospital providers. It is recommended that hospitals pre-plan and discuss patient care needs with the PCP and with home care, rehabilitative, and long term care providers to ensure capacity to meet the patient’s needs. Communication with all providers is essential prior to discharge and at the time of patient hand-off to ensure the services are in place and will meet the patient’s needs.

Post-Discharge Telephone Calls
Research increasingly demonstrates the benefits of a post-hospital phone call within 48–72 hours of discharge. It is recommended that staff use a scripted checklist to review high-priority items, such as compliance with medications, attendance at follow-up visits, signs and symptoms management, as well as identifying any change or deterioration in the patient’s condition. Many hospitals utilize or have supplemented these calls with a post-hospital care hotline.

See the MATCH toolkit for more information on the “one source of truth” medication list. Available at: http://www.ahrq.gov/qual/match/.

See the Project RED toolkit, which contains more information on facilitating the “Re-Engineered Hospital Discharge” to reduce preventable readmissions: https://www.bu.edu/fammed/projectred/toolkit.html.

Project RED provides additional information on the post-hospital care phone call: https://www.bu.edu/fammed/projectred/newtoolkit/5.%20How%20to%20Conduct%20a%20Post-discharge%20Follow-up%20Phone%20Call%204.15.11.pdf.

Additional Interventions for the Discharge Day

Inter-organizational Protocols
Informal and formal relationships with PCPs, agencies, and vendors are an important part of the process. Hospitals may want to consider developing proactive communication plans with receiving providers for clinical care delivery and/or possible sharing of programs. Many hospitals are reaching out to home care agencies and nursing homes to work together and enhance their readmission reduction efforts by identifying and sharing root causes of readmissions, and addressing patients’ unmet needs.

Transition Coaches
A number of hospitals, payers, home care, and community agencies have implemented transition coach models. The transition coach manages the patient’s transition from the hospital to home or other post-hospital care services. The coach usually meets the patient in the hospital to review the discharge plan, assesses the patient and caregiver’s self-management skills, and helps the patient transition from hospital to home. Once home, the coach intervenes by telephone and through home visits to ensure the post-hospital care plan is progressing as planned, and provides necessary adjustments as warranted.

For more information about using the transition coach model in your organization, see The Care Transitions Program by Eric Coleman, M.D., M.P.H., at: http://www.caretransitions.org/.

Read more about PCMHs and early evidence on associated outcomes.

National Committee on Quality Assurance PCMH Recognition: http://www.ncqa.org/Programs/Recognition/PatientCenteredMedicalHomePCMH.aspx.


Primary Care
PCPs are critical to preventing hospital readmissions. Prior to or shortly after discharge, it is recommended that the hospitalist or resident discuss the treatment plan with the PCP to ensure agreement and follow-up on care, tests, and medications. Because PCPs vary in their capacity to address patients’ comprehensive case management needs, it may be beneficial for the hospital case management staff to have a basic understanding of the capacity of their high-volume PCPs to handle complex case management issues. Hospitals may find it useful to identify patient-centered medical home (PCMH) practices within their community, since these practices enhance the continuity and quality of care for patients. Depending on the level of PCMH certification, these practices may offer varying intensity of case management services, electronic real-time communication between patients/caregivers and providers, and coordination of care between specialists and ancillary services.
CMS Community-Based Care Transitions Program (CCTP) and Other Initiatives

Hospitals are strongly encouraged to identify activities, programs, grants, or pilot projects available in their community that are focused on improving care transitions and reducing readmissions. New York State has received several Federal CCTP grants to facilitate the growth and development of effective care transitions through partnering with and integrating community-based services. The CCTP was created by Section 3026 of the Affordable Care Act and provides funding for community-based organizations (CBOs) or acute care hospitals partnering with CBOs to work together to improve care transitions for high-risk Medicare beneficiaries and create a more positive, patient-centered experience by implementing interventions that reduce readmissions.

In addition to the CCTP, there are other government-sponsored and managed care readmission reduction pilots occurring throughout New York State. Participation and/or learning from the results of these projects may have a positive impact on a hospital’s readmission reduction efforts. Some managed care organizations are paying incentive-based reimbursement tied to specific quality indicators, as well as sponsoring or contributing to costs associated with implementation of programs, electronic interventions, or key staffing positions targeted at reducing harm or reducing readmission.

Increasingly, pilot programs are bringing together multiple payers, hospitals, primary care providers, and others engaged in medical support services to achieve common goals focused on quality of care. Hospitals are encouraged to investigate these types of initiatives for potential participation or learning. These are excellent opportunities for hospitals to gain access to resources, education, and practices directed at reducing preventable readmissions or possibly to directly participate in a pilot program.

Learn more about CCTP at: http://innovations.cms.gov/initiatives/Partnership-for-Patients/CCTP/index.html.
Additional Resources

• Boston Medical Center (2012). Project RED (Re-Engineered Discharge).
  Available at: https://www.bu.edu/fammed/projectred/index.html.

• The Care Transitions Program. Available at: http://www.caretransitions.org/.

• Florida Atlantic University (2012). INTERACT—Interventions to Reduce Acute Care Transfers.
  Available at: http://interact2.net/.


  Available at: http://www.ihi.org/offerings/Initiatives/STAAR/Pages/default.aspx.


• Transitional Care Model. Available at: http://www.transitionalcare.info/.
## Appendix A. Gap Analysis for Best Practices to Reduce Readmissions

### During Hospitalization

<table>
<thead>
<tr>
<th>BEST PRACTICES</th>
<th>CURRENT STATUS</th>
<th>INTERVENTIONS FOR CONSIDERATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct high-risk assessment and implement related interventions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Coordinate patient care across multidisciplinary care team</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use teach-back or other method for ensuring understanding of education and discharge preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication reconciliation (at admission, all transitions, and discharge)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient and caregiver engagement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Address palliative or end-of-life care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Establish communication with PCP and other post-hospital care providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schedule PCP (and/or other providers, if needed) follow-up appointment(s) within seven days of discharge</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Post-Hospital Care

<table>
<thead>
<tr>
<th>BEST PRACTICES</th>
<th>CURRENT STATUS</th>
<th>INTERVENTIONS FOR CONSIDERATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct follow-up calls to patients and caregivers 48 to 72 hours after discharge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide timely and accurate transfer of verbal and written information to all post-hospital care providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ensure smooth transitions of care with post-hospital care providers</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Please complete the following grid as a guide for developing your work plan. List activities related to your team’s strategy for implementing this initiative in your hospital and achieving your stated goals. Assign team member roles, target objectives, and timeframes. Be as specific as possible.

<table>
<thead>
<tr>
<th>WHAT</th>
<th>HOW</th>
<th>WHO</th>
<th>TIMEFRAME</th>
<th>FEEDBACK/PROGRESS REVIEW PROCESS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Over the next month</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Over the next six months</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Over the next year</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C. High-Risk Factors for Readmission

<table>
<thead>
<tr>
<th>BEST PRACTICES</th>
<th>INTERVENTIONS FOR CONSIDERATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications</td>
<td>The higher the number of medications to be managed, the greater the risk for negative interactions, confusion, non-compliance, and post-hospital care medication mismanagement.</td>
</tr>
<tr>
<td>• Polypharmacy</td>
<td>• Examine the hospital population and set a hospital medication threshold trigger for polypharmacy based on internal findings.</td>
</tr>
<tr>
<td>• High-alert medications</td>
<td>* For example: Greater than 10 medications prompts specific medication management activities</td>
</tr>
<tr>
<td></td>
<td>• Ensure complete medication reconciliation on admission—consider working with the pharmacy and engaging pharmacists in this process.</td>
</tr>
<tr>
<td></td>
<td>• Identify patients admitted on high-alert medications (i.e., anti-coagulants, insulin, or opiates) as high risk.</td>
</tr>
<tr>
<td></td>
<td>• Evaluate patient’s management of high-alert medications during pre-admission or at admission for gaps in education and self-management training.</td>
</tr>
<tr>
<td>Psychosocial barriers</td>
<td>Begin patient and caregiver assessment on admission to identify psychosocial issue(s) and the impact on the patient’s ability to self-manage.</td>
</tr>
<tr>
<td></td>
<td>• Address urgent issues, such as concerns with violence, neglect, abuse, or homelessness.</td>
</tr>
<tr>
<td></td>
<td>• Assess for key triggers: frail, lives alone, and/or has limited support.</td>
</tr>
<tr>
<td></td>
<td>• Assess caregiver’s ability to meet the patient’s needs—conduct education and counseling as appropriate.</td>
</tr>
<tr>
<td></td>
<td>• Begin investigating community supports needed upon discharge.</td>
</tr>
<tr>
<td>Financial barriers</td>
<td>Identify financial barriers, such as those impacting a patient’s ability to comply with nutrition and dietary requirements, medications, follow-up medical care, transportation, and help to acquire necessary support systems.</td>
</tr>
<tr>
<td></td>
<td>• Complete application(s) for community assistance funding or programs.</td>
</tr>
<tr>
<td></td>
<td>• Determine use of county or other emergency funding for medications, food, and/or shelter.</td>
</tr>
<tr>
<td></td>
<td>• If needed, complete referral(s) to social service hospital personnel or community-based organizations.</td>
</tr>
<tr>
<td>Clinically complex/multiple chronic disease</td>
<td>Actively manage secondary co-morbid conditions, particularly chronic conditions, throughout the hospital stay and address them in the discharge plan.</td>
</tr>
<tr>
<td>or treatments</td>
<td>• Identify educational and self-management needs for secondary conditions.</td>
</tr>
<tr>
<td></td>
<td>• Arrange for post-hospital care services that address secondary conditions.</td>
</tr>
</tbody>
</table>
| Limited patient understanding and/or health literacy | Limitations to understanding can be caused by factors that include:  
  • having a disability;  
  • language barriers;  
  • hearing, vision, and speech limitations;  
  • health literacy limitations;  
  • cognitive problems; and  
  • being very young or very old.  
  • These factors may require more intensive caregiver management at discharge, including—but not limited to—24-hour care and safety provisions.  
  • Use teaching and discharge planning materials that accommodate patient language and health literacy.  
  • Offer visual or pictorial teaching and planning tools as needed. |
| Functional limitations | For patients with functional limitations, particularly new onset, in combination with living alone, a history of falls, issues with the physical home environment (For example: stairs), and/or the need for equipment/assistive device(s), hospital staff may consider the following actions:  
  • Try to prevent hospital-acquired deconditioning in ambulation, range of motion, need for walking aids, need for caregiver assistance, etc.  
  • Arrange for PT/OT evaluation in the context of identified challenges.  
  • Arrange for home evaluation while patient is still in the hospital to adapt to home environment.  
    • For example: Remove throw rugs, install a hospital bed and commode for first floor living, etc.  
    • Address functional limitations thoroughly with the post-hospital care providers. |
| Nutritional and/or dietary issues | Assess for dietary needs that require patient and caregiver education and preparation prior to discharge, such as diabetes, low salt, fluid restrictions, and drug-food interactions.  
  Potential dietary interventions include:  
  • Evaluate patient’s dentition or artificial dental work for impact on proper oral intake.  
    • For example: Dehydration  
  • Determine if nutritional or fluid deficiencies contributed to a readmission.  
    • For example: No way to get groceries  
  • Identify nutritional access issues.  
    • For example: No way to get groceries  
  • Assess potential issues with meal preparation, including functional and cognitive limitations.  
  • Arrange for nutrition services consultation. |
| **Unclear or unknown goals of care** | Readmission may occur because the patient, caregivers, and providers do not have a shared vision for addressing advanced care planning and handling palliative care issues (For example: recidivism between hospitals and nursing homes).

To improve palliative/end-of-life care, palliative care teams can:
- Provide support and address fundamental quality-of-life issues, and offer education for providers.
- Develop symptom management care plans.
- Review options for end-of-life care (i.e., home, hospice, hospital) with the patient and caregivers. |

| **Mental health or substance abuse history** | Identify mental health and substance abuse issues as conditions that can impact the patient’s ability to self-manage. To manage these conditions, hospital staff can:
- Use screening tools and diagnostic testing to identify mental health/substance abuse issues.
- Prevent decompensation and address inpatient interventional needs. Make appropriate follow-up appointments/referrals for post-hospital care. |
Appendix D. Successful Practices for Medication Reconciliation

<table>
<thead>
<tr>
<th>BEST PRACTICES</th>
<th>INTERVENTIONS FOR CONSIDERATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct medication reconciliation on admission</td>
<td>• Engage a multidisciplinary team, but ensure roles and responsibilities are clearly defined.</td>
</tr>
<tr>
<td></td>
<td>• Review pre-admission medications (including OTC) with hospital admission medications and reconcile any discrepancies.</td>
</tr>
<tr>
<td></td>
<td>• Use a standardized process for collecting pre-admission medications.</td>
</tr>
<tr>
<td></td>
<td>• Document intended differences.</td>
</tr>
<tr>
<td></td>
<td>• Contact physician to discuss clarifications and unintended discrepancies.</td>
</tr>
<tr>
<td></td>
<td>• Ensure updated orders are in place.</td>
</tr>
<tr>
<td></td>
<td>• Document medication reconciliation in the patient record.</td>
</tr>
<tr>
<td>Conduct medication reconciliation at all transitions and at discharge</td>
<td>• Review the pre-admission medications (including OTC) against the medications used during the hospitalization, and the medications prescribed at discharge.</td>
</tr>
<tr>
<td></td>
<td>• Consider tools or information technology solutions that automatically provide pre-admission and hospital medication comparisons for discharging physician writing post-hospital medication orders.</td>
</tr>
<tr>
<td></td>
<td>• For example: Use an EHR with a split screen to do a side-by-side comparison of medications prior to admission, during admission, and those planned for post-hospital care.</td>
</tr>
<tr>
<td></td>
<td>• Consider the role of pharmacy in this process, either as consult or the direct staff managing the medication reconciliation process.</td>
</tr>
<tr>
<td></td>
<td>• Consider using a pharmacist for patients at high risk for adverse drug events.</td>
</tr>
<tr>
<td></td>
<td>• For example: Patients on high-alert medications</td>
</tr>
<tr>
<td></td>
<td>• Ensure a system to capture prescription medications written by more than one physician at discharge.</td>
</tr>
<tr>
<td></td>
<td>• Address all medications at discharge, not just those ordered by the discharging physician(s). This may require a call between the discharging and primary care physician.</td>
</tr>
<tr>
<td></td>
<td>• Ensure there is a plan of action for a situation in which the primary care physician disagrees with the medication choices. Consider having the primary care physician order the post-hospital care medication.</td>
</tr>
<tr>
<td></td>
<td>• Address formulary issues.</td>
</tr>
<tr>
<td></td>
<td>• For example: Medications that are ordered, but not covered by the patient’s insurer, are problematic. Patient will not be able to afford them, or there could be a two- to three-day delay in medication compliance before it gets resolved.</td>
</tr>
</tbody>
</table>
### Appendix E. Successful Practices During the Hospital Stay

<table>
<thead>
<tr>
<th>BEST PRACTICES</th>
<th>INTERVENTIONS FOR CONSIDERATION</th>
</tr>
</thead>
</table>
| **Engage a multidisciplinary clinical team** | • Create a structured multidisciplinary forum for ongoing patient-specific information exchange, goal setting, and plan development.  
  - For example: Multidisciplinary rounding or daily team meetings  
  • Designate team leaders and participants and clearly define roles and responsibilities.  
  • Apply an accountability process to ensure team participation and that deliverables are met.  
  • Ensure there is a documentation system (preferably an electronic health record, or EHR) in place for care coordination and discharge planning activities.  
  • Establish user-friendly methods for continuous communication among the team.  
  - For example: Use white boards, concise discharge planning summary document either in EHR or readily identifiable on the patient’s chart. |

| **Conduct continuous and effective patient and caregiver education and empowerment** | • Include the patient, family, and/or caregiver as an active member of the team.  
  • Schedule teaching in advance to ensure caregiver availability whenever possible.  
  • If the caregiver is unable to participate in person, arrange for telephone participation.  
  • Identify who should be present for any teaching. The primary caregiver may not be the person who visits the patient in the hospital.  
  • Educate patients/caregivers about their diagnosis, medications, and treatments; encourage self-management throughout the hospital stay.  
  • Assess the patient and caregiver level of understanding of what is being taught by using the teach-back method.  
  • Set up a system to validate patient readiness and understanding of education from all staff on the multidisciplinary team.  
  • Incorporate simple, visual tools, such as red-yellow-green stoplights for various stages for discharge readiness.  
  • Have the patient and caregiver(s) complete his or her own discharge instructions under the guidance of the care team.  

A discharge plan, at minimum, should include:  
• Simple-to-use materials and tools (pictures and symbols can be very effective);  
• Materials in the patient’s primary language and literacy level;  
• Post-hospital care agency and vendor information (For example: home health, durable medical equipment), including name, address, and telephone number of each vendor;
### Conduct continuous and effective patient and caregiver education and empowerment (continued)

- Disease-specific signs and symptoms, including what to look for, how to monitor, and who to call;
- Pending test results, including the expected time of results and potential actions that may be needed;
- Outstanding tests needed, including the appointment day, time, location, and provider;
- Frequency of ongoing lab/diagnostic testing
  - For example: Anti-coagulant blood draws;
- Medication lists with dosage, drug purpose, frequency, and generic and brand names, including drug-drug and drug-food interaction(s) as appropriate;
- Comprehensive education and written material on high-alert medications, especially those titrated at home;
- Nutrition/dietary information, including fluid restrictions and/or provisions for post-hospital care nutritional counseling
  - For example: Renal disease or diabetes self-management education; and
- Supplemental teaching tools, information, materials, and other guides related to diagnoses, surgical recovery, and ongoing care.

### Conduct medication reconciliation at all transitions

See Appendix D, Successful Practices for Medication Reconciliation.

### Plan for palliative or end-of-life care

- The palliative care and end-of-life plan should be clearly documented in the medical record, and be readily visible to all providing patient care.
- Enable patients/caregivers to make informed decisions by educating them about their disease.
- Assist the patient/caregiver with Advance Directive or Medical Orders for Life-Sustaining Treatment (MOLST). Have trained palliative and end-of-life staff available for inpatient consultation and planning.
- Palliative care clinical competencies are basic skills for all clinical staff, hence the need to better equip professionals to provide standardized and evidence-based primary palliative care services, reserving specialists for truly difficult problems.
- To facilitate palliative, end-of-life referrals, consider a screening process, palliative care rounds in critical care and other appropriate units, or automatic protocols for palliative care input.
- A working relationship with community providers is essential.
- Policies and procedures should be in place to specify transition protocols across care site.
  - For example: Hospital to home hospice or palliative care.
- Explore inpatient options, including hospice inpatient services, for patients who are unable to return home.
| Consider cultural or spiritual needs | • Identify patient cultural and spiritual needs and special requests.  
• Identify health care–related religious beliefs.  
  • For example: Bloodless care  
Potential cultural/spiritual interventions may include:  
• A referral for spiritual support (hospital or patient’s own congregation).  
• Ensuring communication of patient preferences/beliefs with post-hospital care providers that may affect medical/treatment care. |
| Verify history to ensure safe discharge | Presence of the following factors may indicate the need for supplemental and supportive patient and caregiver education and post-hospital care services:  
• history of any formal post-hospital care services;  
• history of use of home care supplies, durable medical or respiratory equipment, as well as any support services, such as transportation, Meals on Wheels, or social service agency support;  
• history of medication non-compliance;  
• frequent emergency department visits; and  
• history of readmission within 30 days of discharge.  
• Potential interventions include providing education, support, and referral for post-hospital care for all identified risk factors. |
| Conduct a final check the day before discharge | • Assess patient/caregiver understanding utilizing teach-backs and provide additional education, as needed.  
• Ensure post-hospital care appointments are made, especially if discharge will occur on a weekend or after office hours.  
• Finalize the discharge plan. |
| Schedule post-hospital care appointments | • Schedule post-hospital care appointments with the primary care provider and specialists/clinics (as appropriate) within seven days of the discharge target.  
• Ensure appointments are made during PCP office hours to accommodate evening or weekend discharges.  
• Consult the patient and caregiver about the best times for appointments and secure transportation, if needed.  
• Ensure the discharge summary is available to the post-hospital care provider at the time of the follow-up visit.  
• Arrange for automatic or automated appointments when available. |
| Ensure transfer of materials and services are in place | • Ensure timely implementation of home care services.  
• Ensure timely transfer to long term care or institutional transfer protocols, including pre-planning, if needed, and timely verbal and written transition of care information.  
• Ensure that services and equipment are available at receiving facility.  
• Secure transportation between facilities and specify time of arrival (early transfers are usually better for the receiving facility). |
<table>
<thead>
<tr>
<th>Create inter-organizational protocols</th>
</tr>
</thead>
<tbody>
<tr>
<td>• All providers, facilities, social service agencies, and clinics providing post-hospital care for the patient should receive standardized verbal and written information to enable a smooth transition.</td>
</tr>
<tr>
<td>• Formally agree upon communication methods:</td>
</tr>
<tr>
<td>• Consider creating or using existing standardized forms for communicating about a patient.</td>
</tr>
<tr>
<td>• Consider participation in electronic transfers of information.</td>
</tr>
<tr>
<td>• Patients with complex post-hospital care and/or high risk for readmission will likely require pre-discharge communication and/or a series of discussions.</td>
</tr>
<tr>
<td>• Standardize and share educational tools/materials across settings.</td>
</tr>
<tr>
<td>• Consider the timing of discharge or transfer as an important factor to ensure services are in place.</td>
</tr>
<tr>
<td>• Hold intermittent workgroup meetings with top referral organizations to monitor/measure outcomes.</td>
</tr>
<tr>
<td>• Create partnerships with community resources—tapping into Office for Aging, county public health, adult services, and maternal-child programming.</td>
</tr>
</tbody>
</table>
## Appendix F. Successful Practices on Discharge Day

<table>
<thead>
<tr>
<th>BEST PRACTICES</th>
<th>INTERVENTIONS FOR CONSIDERATION</th>
</tr>
</thead>
</table>
| Confirm self-management with patient teach-back | • Patient and/or caregiver should be able to demonstrate the physical and cognitive skill needed to self-manage their diagnosis and care plan, as well as perform any complex treatment or care—confirm this by using the teach-back technique.  
• If patients are not independent with self-management caregiver, education is essential.  
• If patient and caregiver cannot perform certain therapies or treatments, ensure home health care is engaged.  
• Consider teach-backs as a clinical competency for all staff. |
| Conduct medication reconciliation at discharge | See Appendix D, Successful Practices for Medication Reconciliation.                                                                                                                                                                |
### Appendix G. Successful Practices for Post-Hospital Care

<table>
<thead>
<tr>
<th>BEST PRACTICES</th>
<th>INTERVENTIONS FOR CONSIDERATION</th>
</tr>
</thead>
</table>
| Coordinate care with primary care provider (PCP)    | - PCP should receive verbal and written information (electronic, fax notification, and copies of records) from the hospital in a timely manner to ensure their ability to address patient problems that arise after discharge.  
- Key components that need to be readily available to the PCP include medication and plans for titration, pending tests and results, treatments, and other service providers.  
- A verbal discharge report to the PCP is ideal.  
- Ensure follow-up appointments within seven days of discharge.  
- PCP should conduct medication reconciliation and address discrepancies at the first post-hospital care visit.  
- Coordinate care with specialist(s).  
- Provide ongoing orders and guidance to post-hospital care agency providers.  
- Work closely with allied providers, such as Coumadin clinics, AADE or ADA Diabetes Self Management Programs, pain management clinics, etc.  
- For patient-centered medical home practices, ensure the patient has access to the appropriate level of case management.                                                                                                                                                                                                                     |
| Conduct a post-discharge follow-up telephone call    | - Determine the staff model for follow-up calls (may vary based on needs of the patient)—various staff can make these calls, including the primary discharging RN, case management, community worker/navigation staff, or pharmacists. Some hospitals are training and using staff on light duty, or those with intermittent down time, such as labor and delivery nurses.  
- Determine the protocols for follow-up calls, including scripts, check lists, scheduling session or triggers, documentation plan, and data tracking plan.  
- Call the patient within 72 hours of discharge.  
- Use a checklist and script for follow-up phone calls.  
- Assess medication management, health and recovery status, follow-up with tests/appointments, effectiveness of the post-hospital care plan, current self-management abilities, and barriers to success.  
- Coach the patient and caregiver on navigating the system to contact providers or services.  
- Consider setting up a post-hospital care hotline.                                                                                                                                                                                                                                     |
### Have clinical and non-clinical transition coaches available, as appropriate

- The transition coach models focus on coaching to promote patient self-management and patient and caregiver empowerment. Some of these models exclusively utilize advance nurse practitioners to provide a level of clinical intervention and education.
- Key program details include:
  - **Hospital visit with patient and caregiver:** Transition coach performs comprehensive needs assessment and defines goals and services with patient and hospital discharge team.
  - **Home visits:** Coaches usually visit each patient within 24–48 hours of discharge. A planned telephone contact and return visit are scheduled based on protocols and patient needs.
  - **Telephone contacts:** Additional telephone calls are scheduled based on protocols and patient needs to ensure medication and treatment compliance, follow up with PCP, identify barriers to self-management, and provide education on ways to manage care needs.
  - Coaches intervene in any decompensation or complication scenario.
  - Coaches accompany patient to physician (an option for complex patients).
### SELECTED SUMMARY OF NYS POST-HOSPITAL CARE SERVICES

- **Home care:**
  - **Certified Home Health Agency (CHHA):** Patient may also require intermittent, time-limited skilled care (nursing, physical, occupational, and/or speech therapies).
  - **Licensed Home Care Services Agencies (LHCSAs):** These agencies provide home health services to persons who pay privately or have private insurance coverage. They may also contract with CHHAs to provide Medicaid-covered services, such as private duty-approved nursing services.

- **PACE:** The PACE model of care is established as a provider in the Medicare program and enables states to provide PACE services to Medicaid beneficiaries as a state option as follows:
  - ages 55 or older;
  - live in the service area of a PACE organization;
  - be eligible for nursing home care; and
  - be able to live safely in the community.

- **Home Care Waiver programs:** Medicaid Home- and Community-Based Services (HCBS) are available through waiver programs to groups of individuals who would be eligible for Medicaid if institutionalized and who would be institutionalized, if not for the home- and community-based services provided.

- **Traumatic Brain Injury (TBI) Program:** Regional Resource Development Specialists (RRDSs) are responsible for assisting family members and potential waiver participants by furnishing lists of approved providers and information about the waiver services. RRDSs facilitate the selection of and referral to service coordinators for potential waiver participants.

- **Long Term Home Health Care Program (LTHHCP):** Also known as “Nursing Home Without Walls,” this home care mirrors skilled nursing facility care. The provision caps the home care expenses at a percentage of the county’s nursing home rate.

- **Personal Care:** Also referred to as Home Attendant Services.

- **Consumer-Directed Personal Assistance Program (CDPAP):** May provide aides performing “skilled” medical services otherwise performed by a nurse (e.g., tracheostomy suctioning, insulin injection, or medication delivery that the patient may not be able to perform).

- **Hospice:** Provides comprehensive services to patients needing end-of-life care and support services.

- **Community Alternative Systems Agency (CASA):** Patient may be eligible for additional non-skilled, personal care services, assistance services, or other waivered program.

- **Office of Aging (OOA)**

- **Community organized support agencies:** Home support services and transportation may be available through neighborhood/community organizations, religious organizations, or municipalities, either for a cost or offered by charitable organizations.
• **Medical and Social Adult Day Care Models:** For patients that live in the community. Types of day care include:
  - **Medical day care:** daytime supervision and skilled services in an RN-monitored setting up to five days per week;
  - **Social day care:** aimed at cognitively impaired adults with minimal personal care needs five days per week;
  - **Specialized day care program:** Alzheimer’s disease, dementia, mental health, developmentally delayed;
  - **Transportation; and**
  - **Flexible scheduling.**

Residential/congregate care includes:
• **Acute Rehabilitation:** Multidisciplinary therapy model (i.e., physical therapy, occupational therapy, speech therapy, orthotic or prosthetic services) that requires the intensive treatments to meet criteria and coverage.
• **Long Term Acute Care Hospitals (LTACH):** Must require daily monitoring and complex medical interventions (ventilators, complex wounds, TPN, etc.) delivered daily.
• **Sub-acute:** May be provided in swing beds, short-term hospitals, or in nursing home.
• **Skilled Nursing Facility (SNF):** For those patients who require short or long term assistive care, medical care, and medical support ancillary services. There are a number of SNFs that provide specialized services, such as dialysis and ventilator care.
• **Adult Home/Assisted Living:** Provides supervision, room, board, medication administration, and light personal care and social opportunities. Levels of services vary among facilities. Careful evaluation of services offered should be done to meet patient’s needs. Many facilities offer choices in the level of support and services.
• **Specialized Residence Homes:** AIDS homes, veteran’s homes, mental health homes, etc.