New York State Partnership for Patients

Readmission Reduction Through Partnership with Skilled Nursing Facilities

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

Introduction

The Centers for Medicare & Medicaid Services' (CMS) Partnership for Patients' goals for the Hospital Improvement and Innovation Network program are to reduce readmissions and avoidable hospital-acquired conditions. The New York State Partnership for Patients (NYSPFP)—a partnership of Greater New York Hospital Association (GNYHA) and the Healthcare Association of New York State (HANYS), in collaboration with IPRO, the State's Quality Improvement Organization—has been working with hospitals since 2012 to achieve these goals using a multifaceted approach to quality improvement (QI).

In 2016, NYSPFP piloted a Skilled Nursing Facility (SNF) Readmission Reduction Program to support hospitals' efforts to reduce avoidable readmissions by establishing and sustaining a foundation for ongoing collaboration with SNF partners.

The following section describes NYSPFP's suggested strategies for a readmission reduction partnership with post-acute care partners.

NYSPFP's SNF Readmission Reduction Approach

NYSPFP's approach to reducing readmissions between hospitals and SNFs focuses on four key strategies that impact transitions of care:

1. Building and strengthening relationships across care settings
2. Developing standardized processes for communication and information transfer between facilities
3. Engaging patients, families, and care partners* in care transitions
4. Understanding the use and capabilities of emergency departments and observation status

* NYSPFP uses the "care partner" term intentionally to highlight a family member, friend, or caregiver as an extension of the health care team; this term is also promoted by the Institute for Patient and Family-Centered Care, Planetree, and CMS. The term is interchangeable with "caregiver," as defined by the New York State Caregiver Advise, Record, and Enable Act, as defined in the New York State Caregiver Advise, Record, and Enable (CARE) Act.

How to Use the Toolkit

This toolkit helps hospitals collaborate with SNF partners to develop and tailor a hospital-specific strategy for reducing readmissions from SNFs. Each chapter contains various tools that can be adapted and used by hospital and SNF readmission reduction partnerships to reduce variation in processes, establish a process for obtaining feedback on care transitions, apply QI principles to identified trends, and obtain the perspective of patients, families, and care partners when SNF readmissions occur. Each tool complements existing NYSPFP resources, education, tools, and resources from national organizations such as the INTERACT® Toolkit.

With internal QI department and NYSPFP project manager support, hospital and SNF teams can use all the tools in sequence, or select and modify specific tools that meet the team's QI needs.

INTERACT® Toolkit
http://www.pathway-interact.com/interact-tools/interact-tools-library/interact-version-4-0-tools-for-nursing-homes/

Who Should Use the Toolkit?

The toolkit supports hospital operational and physician champions who lead an initiative to reduce readmissions among participating SNF partners.

What is in the Toolkit?

Chapter 1: Getting Started: How to Improve
Contains tools describing the overarching QI philosophy behind the toolkit and helps teams develop project goals.

Chapter 2: Planning and Implementing a Hospital and SNF Readmission Reduction Collaborative
Contains tools for planning and implementing your collaborative team approach.

Chapter 3: Maintaining Momentum and Sustaining Change: Keeping your SNF Readmission Reduction Project Alive
Contains tools to sustain progress and spread improvements for enduring change.

Chapter 1. Getting Started: How to Improve

NYSPFP suggests that hospital teams use the "Model for Improvement" framework to guide their work as recommended by the Institute for Healthcare Improvement (IHI). This toolkit closely follows the model's Plan-Do-Study-Act (PDSA) cycle. Additional tools, resources, and considerations from outside of the IHI QI essentials toolkit[1] are also included in the NYSPFP toolkit and are clearly noted in each tool's description.

Hospital teams should review the Model for Improvement and the tools in the following chapters, and select those that best suit their needs.

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 to accelerate process change. A simple but transformative model, it is not intended to replace existing change models adopted by organizations.[2]

The model has two parts:

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

When should the tool be used?

The team can use the Model for Improvement tool when charged with improving a process. The model provides directions on how the team should set the project aim, select measures and changes, and test, implement, and spread interventions. Use of the model will lead the team through the steps required to achieve improvement results. It will guide teams to answer the following questions:

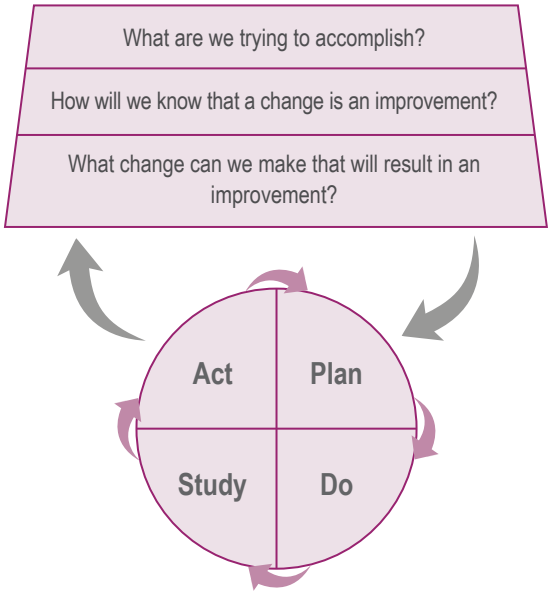
- What are we trying to accomplish? This is the improvement's aim. It should be specific, measurable, assignable, realistic, and time-based.
- How will we know if a change is an improvement? When answering this question, the team will identify the measures to be used to track the improvements.

1 "Quality Improvement Essentials Toolkit," *Institute for Healthcare Improvement,* (2017). **http://www.ihi.org/resources/Pages/Tools/Quality-Improvement-Essentials-Toolkit.aspx** (accessed on November 8, 2017).

2 "How to Improve," *Institute for Healthcare Improvement,* (2017). **http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx** (accessed on November 8, 2017).

- What change can we make that may result in improvement? This question will lead to the specific process changes that the team plans to test.

Model for Improvement



What are the Instructions for the Tool?

The Model for Improvement is available on the IHI website.

How to Improve

http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx

Chapter 2. Planning and Implementing a Hospital and SNF Readmission Reduction Collaborative

This chapter contains tools for planning and implementing a Hospital and SNF Readmission Reduction Partnership. The tools are organized to correspond with each of the four key strategies. Hospital and SNF teams can use all of the tools or they can select specific tools that best match their needs.

Suggested Tools for the Key Strategies of SNF Readmission Reduction

Building and Strengthening Relationships Across Care Settings

2.1 Utilizing an NYSPFP Project Charter to Define the Scope of Work
2.2 Readmission Reduction Through Partnership with SNF Resource Guide
2.3 SNF-to-Hospital Readmission – Data Abstraction Tool
2.4 Patient and Care Partner Interview Tool: Readmission from SNF
2.5 Process Mapping
2.6 Hospital/SNF Collaborative Evaluation

Developing Standardized Process for Communication and Information Transfer Between Facilities

2.7 Medication Discrepancies Data Collection Tool for Hospital-to-SNF Transitions
2.8 Circle Back Interview Tool

2.1 Utilizing an NYSPFP Project Charter to Define the Scope of Work

What is the tool?

The Hospital and SNF Readmission Reduction Through Partnership with SNF Project Charter is a document that ensures a shared understanding of the goals and activities to be undertaken as part of the project. It also ensures alignment with the hospital's overall readmission reduction work.

The Charter clarifies project direction and boundaries, and includes the following components:

- Aim
- Duration
- Executive sponsors from the hospital and SNF
- Goals
- Measurement
- Team members

When should the tool be used?

The charter should be completed at the beginning of the initiative to provide a structure for successful implementation by engaging hospital and SNF team members and ensuring leadership support for project aims, measures, and action plans. The charter also allows leadership to set expectations for the pace of the project by setting projected dates for completion of core activities.

Tips and considerations for using the tool:

- Select one or two SNF partners with the highest number of hospital readmissions
- Complete the charter with input and sponsors from both the hospital and the SNF(s)
- Review the *NYSPFP Readmission Reduction Through Partnership with SNFs Resource Guide* when completing the charter for an idea of what interventions could be undertaken as part of the project

What are the Instructions for the Tool?

Tailor the charter as needed to reflect your hospital-specific readmission reduction goals. Once reviewed and signed by hospital leaders, the charter should be referenced throughout the duration of the project to ensure the identified action plan steps continue to align with the project scope and aim statement.

https://www.nyspfp.org/Materials/SNF_hospital_charter.pdf

2.2 Readmission Reduction Through Partnership with SNF Resource Guide

What is the tool?

The Resource Guide provides sample tools and guides to assist in developing and tailoring a hospital-specific strategy for reducing readmissions from SNFs.

When should the tool be used?

Select key strategies that the partnership would like to focus on. Review corresponding interventions and consider using identified resources to enhance your discharge process.

Tips and considerations for using the tool:

Prior to selecting tools and strategies, you may wish to complete the project charter to help:

- Identify and recruit the internal hospital readmission team
- Select teams from one or two SNFs with a high volume of readmissions to your hospital
- Clarify the project's scope and goals

NYSPFP Readmission Reduction Through Partnership with SNF Resource Guide
https://www.nyspfp.org/Materials/SNF_hospital_resource_guide.pdf

2.3 SNF-to-Hospital Readmission – Data Abstraction Tool

What is the tool?

This tool aids hospitals and SNFs in performing root cause analyses and tracking contributing factors on readmissions from SNFs to hospitals. Data on causes for readmissions entered into this tool will be automatically aggregated and displayed on the "Results – Charts" and "Results – Tables" sheets of this workbook. These results can then be used to identify opportunities to review and modify processes across care transitions to reduce readmissions.

When should the tool be used?

This tool should be used as part of the pre-work for the partnership team meetings to optimize the team's understanding of your readmission patient population and any correlation between processes and readmission outcomes.

Tips and considerations for using the tool:

- NYSPFP recommends that the SNF-To-Hospital Readmission Data Abstraction Tool be completed for at least the 10 most recent medical records of patients who were readmitted from the SNF within 30 days of inpatient hospital discharge and/or are identified from high-volume readmission diagnoses, services, or other areas of concern.
- You may alter this criteria or questions in the tool to meet your hospital's needs.
- Hospitals are encouraged to communicate with SNF(s) to ascertain their perspectives on the causes of potentially preventable readmissions. These discussions can be informal, offer instructive feedback, and cultivate relationships among leaders and frontline staff across the care continuum.
- Hospital staff may find it beneficial to identify a patient who has been readmitted within 30 days and use that case to guide a broader discussion.

What are the Instructions for the Tool?
The specific steps to complete the SNF Readmission Medical Chart Abstraction tool are specified on the "Introduction" tab of the workbook.

https://www.nyspfp.org/Members/Initiatives/Readmissions/Tools.aspx

2.4 Patient and Care Partner Interview Tool: Readmission from SNF

What is the tool?

This tool helps hospitals gather information from the patient and care partner on non-medical factors that may have contributed to the readmission. The questions facilitate a deeper understanding of the patient and care partner's perspectives and challenges to help hospitals better optimize discharge plans to ensure they address patient concerns and identify commonly recurring opportunities for improvement in current discharge processes.

When should the tool be used?

This tool should be used in the planning phase of the project to incorporate the perspectives of the patient and care partner into the improvement plan. Teams should refer to the tool to identify opportunities to engage patients, families, and care partners in designing the intervention, gathering ideas for opportunities for improvement, and assessing the progress of the initiative. Once identified, these opportunities can be added to the project's action plan.

Tips and considerations for using this tool:

- Identify at least 10-15 patients readmitted within 30 days of hospital discharge
- Identify cases from SNF partners or service lines with a high volume of readmissions
- Complete the interview with the patient and the care partner or family member to help you obtain more robust information
- Ensure that you interview enough patients to observe trends and opportunities for improvement. NYSPFP encourages you to interview the patient when the patient's care partner or family member is present to provide more complete information.

Note: This tool is not meant to be given to a patient or care partner to complete and return to staff.

NYSPFP Patient and Care Partner Interview Tool: Readmission from SNF
https://www.nyspfp.org/Materials/Readmissions_Interview_Tool.pdf

Additional Resources

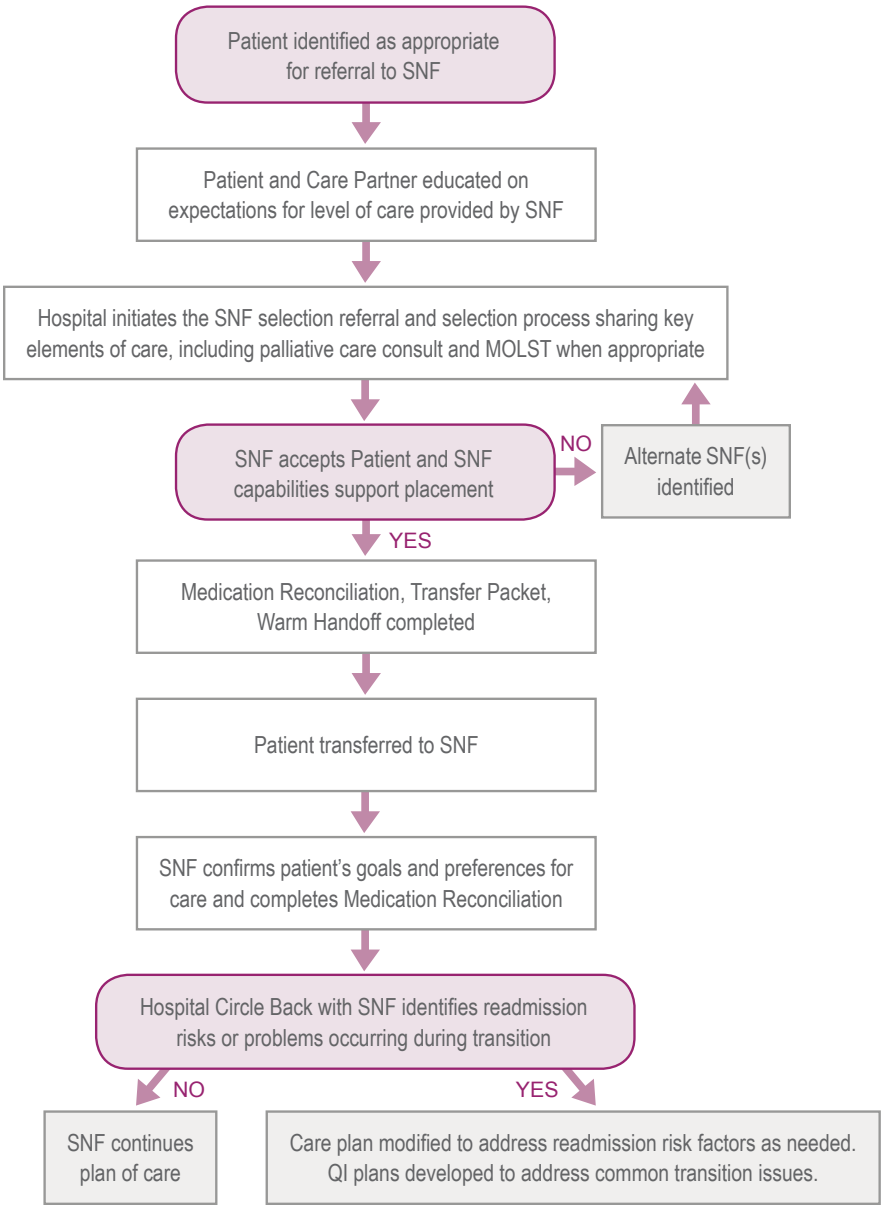
NYSPFP Patient and Family Engagement Resource Guide
https://nyspfp.org/Materials/NYSPFP_PFE_Guide_2014.pdf

Guide to Patient and Family Engagement in Hospital Quality and Safety (AHRQ)
http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/index.html

2.5 Process Mapping

Process Map Example

Note: Patient, family, and care partner engagement is a key element of each step in the process. Upon admission the patient identifies a care partner(s) who is engaged throughout the discharge process.



What is the tool?

Process maps (flowcharts) visually convey the steps in a process.[3] This tool helps teams gather information from line staff across the care continuum on processes related to care transitions that can impact readmissions.

When should the tool be used?

Process maps should be used in the pre-work stage of the partnership to document existing processes, identify process gaps or opportunities to improve, or to hardwire existing processes.

Tips and considerations for using this tool:

- Obtain feedback from all stakeholders, preferably onsite at participating facilities
- Incorporate feedback to ensure that the process map reflects actual practice rather than expected behavior based on current policy
- Process maps should be modified as new processes are implemented to reflect new process flow

What are the Instructions for the Tool?

The specific steps to create a flowchart are available on the AHRQ website.

https://healthit.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/flowchart

Additional Resources

Many types of flowcharts and more sophisticated visual representations of processes can be helpful to teams. Other visual representations that can be used include, but are not limited to, value stream mapping, value-added analysis, and workflow diagrams.

Process Mapping (AHRQ)

https://healthit.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/process-0

3 "Health Information Technology Flowchart," *Agency for Healthcare Research and Quality*. **https://healthit.ahrq.gov/health-it-tools-and-resources/evaluation-resources/workflow-assessment-health-it-toolkit/all-workflow-tools/flowchart** (accessed on November 8, 2017).

2.6 Hospital/SNF Collaborative Evaluation

What is the tool?

This tool help teams evaluate the extent to which specific program objectives were met and the overall satisfaction of partnership participants. Evaluation forms also provide a forum for collecting input from team members on suggestions for future readmission reduction initiatives and outstanding questions or concerns.

When should the tool be used?

This tool should be used at the end of the chartered project.

Tips and considerations for using this tool:

- Evaluation questions can be modified to meet the needs of your specific readmission reduction partnership
- Teams can decide to conduct evaluations more frequently (e.g., midway through the project or following each meeting)

What are the Instructions for the Tool?

Distribute the evaluation forms to team members, allowing sufficient time for robust and thoughtful responses.

Analyze feedback for variances in satisfaction levels between hospital and SNF participants and for planning future meetings.

https://www.nyspfp.org/Materials/Readmissions_Eval_SNF.pdf

2.7 Medication Discrepancies Data Collection Tool for Hospital to SNF Transitions

What is the tool?

This tool helps SNFs collect data on medication discrepancies found upon admission to the SNF for patients discharged from the hospital. The tool helps SNFs categorize and record different types of medication discrepancies affecting patients. The categorized data can inform a discussion with the hospital, aggregated and presented as a chart (e.g., a Pareto chart) to help the hospital and SNF Collaborative team identify specific processes with opportunities for improvement.

When should the tool be used?

The tool should be used with all admissions received by the SNF for an agreed-upon period of time.

Tips and considerations for using the tool:

- Establish a standard timeframe to provide feedback from the SNF to the hospital for discrepancies identified (e.g., daily, weekly, or monthly). The interval for updates will depend on the volume of admissions to the SNF(s) and should be agreed upon by both the SNF and the hospital, with regular time to meet and discuss how these issues could be resolved.
- Track rate or percentage of patients admitted to the SNF from the hospital with a medication discrepancy for the specified interval (e.g., daily, weekly, or monthly) for which data is collected
- Identify a contact person at the SNF and at the hospital who will work closely together to identify solutions and connect regularly to review the data collected in the log

What are the Instructions for the Tool?

Complete the log every time a medication discrepancy is discovered. Data to collect includes patient name, category of discrepancy/cause, specific medication, name of prescriber, and date of admission to SNF.

When "other" is selected as the cause of the discrepancy, ensure that the reason is recorded, and that the list of "other" and frequency of each "other" reason recorded are reviewed regularly. Consider adding the new reasons to the list of causes if they appear regularly for your facility.

https://www.nyspfp.org/Materials/Readmission_MedDisc_Tool.pdf

2.8 Circle Back Interview Tool

What is the tool?

This tool is a template to guide conversations between the hospital and SNF staff to follow up or "circle back" to ensure staff at the SNF have all the information needed to continue to optimally care for the patient.[4]

4 The elements included in this tool were adapted from Emily Skinner's work on Circle Back, which is accessible at the following link: **http://www.hqi.solutions/wp-content/uploads/2018/02/ITW-toolkit_template_web.pdf?utm_source=HQI+Master+List&utm_campaign=f7adde4e3a-EMAIL_CAMPAIGN_2017_10_09&utm_medium=email&utm_term=0_e5aad4f842-f7adde4e3a-64605931&utm_source=HQI+Master+List&utm_campaign=655543eb81-EMAIL_CAMPAIGN_2017_10_09&utm_medium=email&utm_term=0_e5aad4f842-655543eb81-64605931**.

When should the tool be used?

This tool should be used within 24–72 hours of the patient's transfer to the SNF to enable the hospital and SNF to collaborate on the development of care plan revisions for any newly identified readmission risk factors.

Tips and considerations for using the tool:

- It will facilitate conversations if the hospital team identifies the best times for each SNF to receive calls, and will cluster calls to facilities where possible
- In the early stages, a pre-call visit to introduce yourself to the SNFs that receive the most admissions can set the stage for open communication
- Assign someone to collect and analyze data from completed forms on a regular basis to help you identify commonly occurring issues that can impact the SNF's ability to provide optimal care for the patient, and address them with your internal readmission team
- If any common issues/trends are identified, share them with your SNF partners and communicate to them how processes will be modified to strengthen the partnership between the hospital and the SNF

What are the Instructions for the Tool?

Complete the information at the top of the Circle Back Interview Tool for internal tracking purposes. Ask a SNF staff person(s) the questions in the tool and complete the form.

https://www.nyspfp.org/Materials/Readmissions_CircleBack_Tool.pdf

Chapter 3. Maintaining Momentum and Sustaining Change: Keeping your SNF Readmission Reduction Project Alive

This chapter contains tools to help hospitals and nursing homes maximize their improvement efforts. Hospital and SNF teams should use these tools to plan for sustainability from the beginning of a new initiative. Teams should also be prepared to spread successful interventions to new hospital units or new SNF partners once they prove effective following small tests of change.

3.1 Sustainability Checklist

What is the tool?

Sustainability refers to locking in the progress that has been made and continually building upon it.[5] This tool is a checklist of items to help teams ensure their interventions are sustained. The checklist includes items to prompt teams to:

- Identify a process owner
- Establish key leadership for support and buy-in, tool assessment, and development
- Monitor results
- Identify and communicate project milestones to celebrate the teams' successes

When should the tool be used?

Teams should complete the sustainability checklist before implementing a new intervention and review it periodically or during each new PDSA cycle. The checklist can also be used once the interventions have been successfully trialed and teams are hardwiring them into daily workflow.

What are the Instructions for the Tool?

This sustainability checklist template helps teams identify and take steps to lock in gains already made. Use the checklist to consider ideas that address particular factors, then plan next steps for the team to achieve sustainability. Efforts to achieve sustainability will be more successful if many ideas are implemented. Use the checklist to build on prior success by evaluating ongoing improvement and seeking opportunities for continued improvement and innovation.

https://www.nyspfp.org/Materials/NYSPFP_PatientSafety_Toolkit.pdf (Section 3.1, page 18)

5 "How-to Guide: Sustainability and Spread," *Institute for Healthcare Improvement.* **http://www.ihi.org/resources/Pages/Tools/HowtoGuideSustainabilitySpread.aspx** (accessed on November 8, 2017).

Additional Resources

The sustainability checklist is adapted from the following materials:

Sustainability Checklist (Center for Public Health Quality)
http://www.astho.org/Accreditation-and-Performance/Quality-Improvement/QI-Plan-Toolkit/Home

Sustainability Planning Guide & Sustainability Planning Workbook (IPRO)
https://atlanticquality.org/download/hospital-safety-ny/508_IPRO-Sustainability-Planning-Guide-and-Workbook_Web-Version_20170217.pdf

3.2 Spreading Improvements

What is the tool?

Spread refers to the process of "actively disseminating best practice and knowledge about every intervention and implementing each intervention in every available care setting."[6] This tool is a guide to considerations a team should address when it starts spreading the successful intervention. Spreading innovations and best practices maximizes the initial team's investment and provides the benefit of improved care to a broader group of patients.

When should the tool be used?

Once the team has tested the change/intervention on a single unit and has established that it affects the outcome in the desired direction, the intervention can spread to other relevant parts of the hospital. Likewise, once an intervention has successfully been tested with a single SNF partner, it can be spread to other SNFs or other post-acute care partners.

Tips and considerations for using the tool:

As teams prepare to spread their successfully trialed intervention, it is important to plan ahead and:

- Prepare for spread
- Establish an aim for spread
- Develop, execute, and refine a plan for spread

In addition, unit-based teams should consider adopting improvements successfully trialed on other units, and improvements or processes that could be successfully adapted and adopted or spread from other units.

6 "How-to Guide: Sustainability and Spread," *Institute for Healthcare Improvement.* **http://www.ihi.org/resources/Pages/Tools/HowtoGuideSustainabilitySpread.aspx** (accessed on November 8, 2017).

What are the Instructions for the Tool?

Specific instructions for the tool can be found on the IHI website.

http://www.ihi.org/resources/Pages/Tools/HowtoGuideSustainabilitySpread.aspx

Additional Resources

A Framework for Spread: From Local Improvement to System-Wide Change (IHI)

http://www.ihi.org/resources/Pages/IHIWhitePapers/AFrameworkforSpreadWhitePaper.aspx

The Seven Spreadly Sins (IHI)

http://www.ihi.org/resources/Pages/Tools/IHISevenSpreadlySins.aspx

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