Reducing Medicaid Readmissions

Webinar 2: Updating your Avoidable Utilization Strategy - 2015

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Agenda: Updating Your Strategy for 2015

- Your readmission RCA: write it down, make it known

- Know who is doing what
  - Overview of Medicaid-relevant efforts to reduce readmissions in Maryland
  - Conduct your own local inventory

- Design your hospital’s readmission portfolio
  - Identify and fill gaps, avoid duplication in service or in target populations

- Model the impact of portfolio of efforts

- Tools 3, 7, 8, 12, 13 of the Guide
Objectives

- Codify & circulate your readmission root cause analysis & use it to engage, educate internal and external staff, leadership, partners

- Specify the “readmission-related” efforts occurring within your hospital across departments and service lines

- Specify the “readmission-related services” that post-acute, community based providers & agencies offer in your area

- Categorize existing activities across the continuum; model the impact of those activities; identify gaps in services offered or in target populations prioritized
Hospital Guide to Reducing Medicaid Readmissions
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• Why focus on Medicaid Readmissions?
• How to Use This Guide
• Roadmap of Tools
• Know Your Data
• Inventory Readmission Efforts
• Develop a Portfolio of Strategies
• Improve Hospital-based Processes
• Collaborate with Cross Setting Partners
• Provide Enhanced Services

http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/
Tools

1. Readmission Data Analysis
2. Readmission Interview
3. **Data Analysis Synthesis**
4. Hospital Inventory
5. Cross-Continuum Team Inventory
6. Conditions of Participation Checklist
7. **Portfolio Design**
8. **Readmission Reduction Impact**
9. Readmission Risk
10. Whole-Person Assessment
11. Discharge Information Checklist
12. **Forming a Cross-Continuum Team**
13. **Community Resource Guide**

http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/
Your readmission root cause analysis:

*Write it down, make it known, use it!*
Summarize the Data to Tell the Story
Tell your all-payer story with payer-specific detail

- 10,000 adult non-OB discharges in past 12 months
- 1000 readmissions, for overall 10% all payer readmission rate
  - 600 of the readmissions were Medicare – 15% readmission rate
  - 250 of the readmission were Medicaid – 12.5% readmission rate
  - 85% of the readmissions were either Medicare or Medicaid
- **Discharge disposition:**
  - 50% of Medicare patients discharged to PAC
  - 8% of Medicaid patient discharged to PAC
- **Diagnoses:**
  - 50% had a primary or secondary BH diagnosis
  - Top 10 diagnoses accounted for only 250 (25%) of all readmissions
  - Sickle cell, behavioral health and cellulitis unique to Medicaid list
- **High Utilizers:**
  - 500 people had 4 or more discharges in past 12 months;
  - This group accounted for 33% of all readmissions; had 40% readmission rate

Patient Interviews:
- Rushed
- Confused
- Uncertain
- Couldn’t get…
- Told to return…
- Comfortable here
A Picture is Worth a Thousand Words

Source: Presentation to HSCRC Care Coordination Workgroup December 2014
Tool 3: Data Analysis Synthesis Tool

[Hospital Name] Readmission Analysis

General Summary
From [month, year] to [month, year], there were [#] total adult, nonobstetric discharges from [Hospital Name], excluding those who were discharged deceased or transferred to another acute care hospital. Of this total, there were [#] Medicare discharges (% of total), [#] Medicaid discharges (% of total), [#] commercial discharges (% of total), and [#] uninsured/self-pay discharges (% of total).

There were [#] 30-day readmissions. This yields an all-payer, all-cause 30-day readmission rate for [Hospital Name] of %. The Medicaid readmission rate is %, the Medicare readmission rate is %, and the uninsured readmission rate is %. Note, the [payer, likely Medicaid] population has the highest 30-day readmission rate of all payer-defined subgroups. Of all of the readmissions at Hospital Name, % (n=#) were Medicaid readmissions; % (n=#) were Medicare readmissions; and % (n=#) readmissions were among uninsured patients.

Table 1. Adult (nonobstetric) discharges and readmissions by Medicare and Medicaid

<table>
<thead>
<tr>
<th>Payer</th>
<th># Discharges</th>
<th>% (#/Total Discharges)</th>
<th>% (30-Day Readmissions)</th>
<th>% (Total Readmissions)</th>
<th>Readmission Rate (#Readm/#Discharges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients</td>
<td>100</td>
<td>100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicare</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid (adult, nonobstetric)</td>
<td></td>
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</tr>
</tbody>
</table>

Number of days between discharge and readmission
Of all readmissions, % (n=#) of all readmissions occurred within 4 days of discharge; and % (% (n=#) occurred within 10 days of discharge. This suggests [enter observation about the timing of posthospital followup and services].

Discharge disposition
% (%) of Medicaid patients were discharged to home; % (%) were discharged to home health care, and % (%) were discharged to SNF. In contrast, % (%) of Medicare patients were discharged to home, % (%) were discharged to home health care, and % (%) were discharged to SNF.

Table 2. Distribution of discharge disposition by Medicare and Medicaid

<table>
<thead>
<tr>
<th>Measure</th>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge to home</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge to home health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharge to skilled nursing facility</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Top diagnoses associated with readmissions
The diagnoses associated with the highest numbers of readmissions include: Diagnosis 1 (%), Diagnosis 2 (%); Diagnosis 3 (%); Diagnosis 4 (%); … and Diagnosis 10 (%). Together, the top 10 diagnoses account for a total of # readmissions, % of total readmissions. The top 10 readmission diagnoses by payer are listed below. Notable similarities include [list similar diagnoses here]; notable differences include [list differences here]. Chronic conditions, such as [heart failure, heart disease, diabetes, list] make up (%) on this list. Acute conditions, such as [sepsis, urinary tract infection, gastroenteritis, list] make up (%) on this list. Complications make up (%) on this list. There are (%) behavioral health-related diagnoses.

Table 3. Top discharge diagnoses resulting in readmission

<table>
<thead>
<tr>
<th>Medicare</th>
<th>Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>1.</td>
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<tr>
<td>2.</td>
<td>2.</td>
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<tr>
<td>3.</td>
<td>3.</td>
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<td>4.</td>
<td>4.</td>
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<td>5.</td>
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<td>6.</td>
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<td>7.</td>
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<td>8.</td>
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<td>9.</td>
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<tr>
<td>10.</td>
<td>10.</td>
</tr>
</tbody>
</table>

The top 10 diagnoses leading to readmissions accounted for (%) of all Medicare readmissions and (%) of all Medicaid readmissions. This suggests that [a small percentage of all readmissions are identified by relying only on primary diagnoses].

This template is used to create a narrative to describe the results from the quantitative data and readmission interviews.
Know Who is Doing What

Conduct a hospital-specific and cross-setting inventory of readmission efforts
Tool 4: Hospital Inventory Tool

It is likely that several complementary readmission reduction activities are underway at your hospital. As you embark on an effort to adapt and expand your readmission reduction efforts to the Medicaid population, it is helpful to inventory all the existing efforts at your hospital, across departments and service lines and among independent investigators (if applicable). An updated inventory of readmission reduction efforts may identify opportunities to align with or extend your Medicaid-specific efforts with other related efforts within your institution. This may help your team gain efficiency, obtain buy-in, and reduce redundancy or confusion among staff and patients.

<table>
<thead>
<tr>
<th>Department/Service Line</th>
<th>Initiative/Improvement</th>
<th>Point Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Executive Team (CEO, CFO, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
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<tr>
<td>Quality</td>
<td></td>
<td></td>
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<tr>
<td>Nursing</td>
<td></td>
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<tr>
<td>Social Work</td>
<td></td>
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<tr>
<td>Hospital Medicine</td>
<td></td>
<td></td>
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<tr>
<td>Emergency Department</td>
<td></td>
<td></td>
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<tr>
<td>Medical Specialties (Cardio, Neuro, etc.)</td>
<td></td>
<td></td>
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<tr>
<td>Psychiatry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgical Services (Ortho, General, Cardiothoracic, etc.)</td>
<td></td>
<td></td>
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<tr>
<td>Palliative Care</td>
<td></td>
<td></td>
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<tr>
<td>Pharmacy/Pharmacists</td>
<td></td>
<td></td>
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<tr>
<td>Patient Family Advisory Councils</td>
<td></td>
<td></td>
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<tr>
<td>Finance, Managed Care/Contracting</td>
<td></td>
<td></td>
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<tr>
<td>Informatics, IT</td>
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<tr>
<td>Research/Grants/Special Projects</td>
<td></td>
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<tr>
<td>Volunteer Services</td>
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</tr>
</tbody>
</table>

This tool prompts a comprehensive inventory of readmission reduction activity across departments, service lines, and units within the hospital.

Use this tool to:

- identify readmission reduction efforts across departments
- Identify whether efforts are coordinated
- Identify whether there is duplication
- Identify gaps – in administrative support
- Identify gaps – in clinician engagement
- Identify gaps – in patient engagement
Tool 5: Cross-Continuum Team Inventory Tool

Forming and using a cross-continuum team is essential to meeting the innumerable posthospital needs of your diverse patient population. Partnering with postacute and community-based providers and agencies is a key part of optimizing the transition out of the hospital and into the next setting of care. Many hospitals have initiated cross-continuum teams composed primarily of postacute partners; additional partners will be needed to best meet the posthospital needs of adult Medicaid patients. Use this tool to identify which cross-continuum partners you currently engage in readmission reduction efforts and to identify additional partners to engage. As you complete this tool, capture services available and obtain a contact name.

<table>
<thead>
<tr>
<th>Cross-Setting Provider or Agency</th>
<th>Posthospital or Ongoing Services</th>
<th>Point Person/ Email/Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult day health</td>
<td></td>
<td></td>
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<tr>
<td>Adult protective services</td>
<td></td>
<td></td>
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<tr>
<td>Agencies on aging</td>
<td></td>
<td></td>
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<tr>
<td>Aging and disability resource centers</td>
<td></td>
<td></td>
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<tr>
<td>Behavioral health providers, crisis teams</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Behavioral health care-out providers</td>
<td></td>
<td></td>
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<tr>
<td>Community health centers, federally qualified health center</td>
<td></td>
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<tr>
<td>Community-based social workers</td>
<td></td>
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<tr>
<td>Community corrections system</td>
<td></td>
<td></td>
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<tr>
<td>Economic/financial counseling</td>
<td></td>
<td></td>
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<tr>
<td>High-volume Medicaid medical homes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>High-volume Medicaid pharmacies</td>
<td></td>
<td></td>
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<tr>
<td>Housing advocates and homeless services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Legal aid</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid agency (state) contact</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicaid managed care organizations</td>
<td></td>
<td></td>
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<tr>
<td>Substance abuse treatment providers</td>
<td></td>
<td></td>
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<tr>
<td>Skilled nursing facilities</td>
<td></td>
<td></td>
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<tr>
<td>Home health agencies</td>
<td></td>
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<tr>
<td>Hospice</td>
<td></td>
<td></td>
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<tr>
<td>Pain clinic</td>
<td></td>
<td></td>
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<tr>
<td>Physician practices</td>
<td></td>
<td></td>
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<tr>
<td>Public health nurses</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Long-term acute care hospitals</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This tool prompts a comprehensive inventory of community-based providers and agencies that provide services helpful in the post-discharge setting.

- Formal partnerships?
- Informal arrangements?
- Optimizing available resources?
- Is timely linkage as easy as it needs to be?
- Unknown gaps?
- Time to expand beyond “first phase”? 
Bon Secours Baltimore Health System

**Internal Inventory**
- Peer recovery coaches in the ED
- Outcomes Management
- Social Work
- Behavioral Health Program
- Clinics provide post-discharge follow up <7-10 days for anyone
- IT: ACO patients flagged
- IT: Use CRISP for notifications

**Community Inventory**
- Health Enterprise Zone
- The Coordinating Center
- Homeless Outreach Program
- Transitional Housing Providers
- Home Health Agencies
- Skilled Nursing Facilities
- Baltimore Area Agency on Aging
- Collaboration w UM Midtown

What’s needed next:
• Care coordination model for high risk patients
• Create care plans for high utilizers
• Integrate medical and behavioral health care clinical information
• Continue to innovate to meet need of patients

Source: presentation to HSCRC Care Coordination workgroup, Dec 2014
Community Inventory: Frederick Memorial

- Practice based care managers
- Breathing clinic - partnership with pulmonary group
- Way Station (Behavioral health)
  - Automated notifications of ADT through CRISP
  - ED High Utilizer Care Plans
  - Health Home Pilot Partnership
  - Monthly coordinating meeting
- Davita Dialysis Center
- Walgreens
- Department of Aging/Health Department – transportation
- Home care agencies
- Personal Care Agencies
- Assisted Living
- Bridges Program – medical-religious organization partnerships
- Chamber of Commerce

Source: Presentation to HSCRC Care Coordination workgroup; Dec 2014
Know “Who is Doing What for Which Patients”
A partial inventory of Medicaid-relevant activities in Maryland
Medicaid-relevant readmission efforts in MD - 1

- **Anne Arundel Medical Center**
  - Co-located clinic at Morris Blum Senior Apartments to address high utilization from that specific location
  - Invested $185k of a $800k grant to establish clinic
  - Clinic appointments and home visits in the apartments
  - Reduced 911 calls by 13%
  - Reduced ED visits by 8%

- **Local Health Improvement Coalitions**
  - Allegany County – transportation assistance program

Source: Modern Healthcare; Dec 2014
Medicaid-relevant readmission efforts in MD - 2

- **St Agnes Hospital**
  - Transitional care navigators
  - Bedside delivery of medications prior to discharge

- **Doctors Community Hospital**
  - Identified frequent users of the ED
  - Developed new services to meet their needs
  - Free clinics for COPD, HF – with 4 week educational programs
  - Sickle cell clinic – dropped readmissions from 33% to <10%
  - Deployed RN transitional care navigators

Source: Modern Healthcare; Dec 2014
Medicaid-relevant readmission efforts in MD - 3

- Sinai Hospital of Baltimore
  - Looked at data, identified frequent users of the ED
  - Needs of frequent users were not well met in ED
  - Really needed connection to other resources
  - Partnered with community agency - HealthCare Access Maryland
  - Identify patients with >4 visits in 4 months – automated flag
  - Conducted weekly in-service sessions to engage / education ED staff
  - 3 care coordinators in the ED – contracted staff, have access to EMR
  - Home visits <1 week of ED visit; follow for 90 days
  - Comprehensive whole person needs assessment
  - Link patients to medical homes and other resources
  - Educate patient re: when to call PCP rather than go to ED
  - “we partner with many mental health organizations in the city”
  - Addresses housing needs
  - Excellent update – 75 of 90 patient accepted (as of 10/14)
  - 80% reduction in ED visits!

Source: ED Management; Oct 2014
Western Maryland Health System
- TPR hospital since 2010
- Added primary care practices
- Diabetes clinic
- Wound center
- Behavioral health clinic
- Admissions down 15%, readmissions down by 40%

Source: New York Times; Aug 27 2013
Medicaid-relevant readmission efforts in MD - 5

- Hopkins J-CHIP
  - 7 zip codes in East Baltimore
  - 7000 adult Medicaid patients targeted (& 14k Medicare)
  - 3000 patients will be targeted
  - Address mental illness, substance use, chronic illness
  - ED: assess risk and ease transition back to community
  - Bedside delivery of medications prior to discharge
  - Post-discharge outreach (phone, in person)
  - Patient “Anytime” Line
  - Create after hospital individual care plan
  - Community care teams with embedded BH specialists, CHWs
  - Establish ongoing relationship with community care

Source: Presentation to HSCRC Physician Alignment and Data & Infrastructure Workgroups; Mar 2014
Frederick Memorial
- Monthly meetings with community partners to re: patient care plans
- Identify high utilizers, develop / implement ED care plans
- Conduct revisit/readmission interview
- Care transition team engaged in-house for high risk patients; transition team follows for 30+ days, home / facility / provider visits
- If difficulty establishing PCP f/u then identify alternative way to achieve post-discharge follow up (urgent care, bridge clinic, etc)
- Readmission reviews found social determinants drive readmissions
- Community-based BH follow up with LICSW
- Next steps: community health workers
- Develop strategy to address communities with high ED utilization

Source: Presentation to HSCRC Care Coordination workgroup; Dec 2014
Health Care For the Homeless
- Hospitals – Mercy Medical Center, U of MD, Hopkins
- Staff – RN, CHW
- Patients: Frequent ED Utilizers, ~25 at each hospital = 75 total
- Past 6 months (May-Oct) 42 of 75 HU engaged
- Of patients engaged, 50% received multiple services
  - Medical
  - Mental health
  - Case management
  - Public benefits
  - Convalescent care
  - Addictions
  - Disability benefits assistance

Source: Hospital/Community Partnership Regional Forum; Nov. 17, 2014 Presentation
Medicaid-relevant readmission efforts in MD-8

1. **Annapolis/Morris Blum, Year One Budget: $200,000.** This Zone is utilizing HEZ funds to establish a new primary care health center in the Morris Blum public housing building.

2. **Caroline/Dorchester Counties (Rural), Year One Budget: $755,000.** The Zone is utilizing funds to support health care services teams that include peer recovery support specialists, community health outreach workers, mobile health care crisis teams, and school-based wellness programs. The goals of this HEZ include a reduction in behavioral health ED visits and hospitalization rates.

3. **Prince George’s County Health Department/Capitol Heights (Suburban), Year One Budget: $1,100,000.** This Zone focuses on expanding primary care access. The goals of this HEZ are to reduce hospitalization rates for asthma, diabetes, and hypertension.

4. **St. Mary’s County/Greater Lexington Park. (Rural), Year One Budget: $750,000.** The Zone is utilizing funds to expand access to primary and behavioral health services. The goals of this HEZ are to reduce emergency department and hospital admissions for behavioral health conditions and for key chronic conditions.

5. **West Baltimore Primary Care Collaborative (Urban), Year One Budget: $1,050,000.** This Zone recruitment of primary care providers, deploy community health workers, The goals of this HEZ are to reduce hospitalization rates for chronic illnesses.

Source: http://dhmh.maryland.gov/healthenterprisezones
70 Behavioral Health Homes in MD

The list below includes all Health Home sites approved by the Department as of January 23, 2013. A map of Health Home sites by county and provider type may be found at the Maryland Health Homes Map.

<table>
<thead>
<tr>
<th>Provider</th>
<th>Address</th>
<th>Provider Type</th>
<th>County</th>
<th>Contact Name</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ways of Life, LLC</td>
<td>2510 St. Paul Street, Baltimore, MD 21218</td>
<td>PRP (adult)</td>
<td>Baltimore City</td>
<td>Gwendolyn Tidewater</td>
<td>410-366-2101</td>
</tr>
<tr>
<td>Alliance, Inc</td>
<td>9201 Philadelphia Road, Baltimore, MD 21237</td>
<td>PRP (adult)</td>
<td>Baltimore County</td>
<td>John Hill</td>
<td>410-282-5900</td>
</tr>
<tr>
<td>Alliance, Inc</td>
<td>234 S. Broadway Street, Baltimore, MD 21231</td>
<td>PRP (adult)</td>
<td>Baltimore City</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance, Inc</td>
<td>4510 Wheat Point Court, Belcamp, MD 21017</td>
<td>PRP (adult)</td>
<td>Harford</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance, Inc</td>
<td>15 S. Park Avenue, Aberdeen, MD 21001</td>
<td>PRP (adult)</td>
<td>Harford</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Arcadian Lodge</td>
<td>2600 Solomons Island Rd, Edgewater, MD 21037</td>
<td>PRP (adult)</td>
<td>Anne Arundel</td>
<td>Michael J. Dresnow</td>
<td>443-433-5023</td>
</tr>
<tr>
<td>Care Connection</td>
<td>4419 Falls Road, Baltimore, MD 21201</td>
<td>PRP (adult)</td>
<td>Baltimore City</td>
<td>Lisa Monnin</td>
<td>410-319-1209</td>
</tr>
</tbody>
</table>
Inventory to Action:
Cross-continuum coordination is more than networking
Tool 12: Forming a Cross-Continuum Team

By definition, a transition involves a “sending” (referring) and “receiving” (accepting) provider. Remember that the best transition out of your setting is only as good as the reception into the next setting of care.

Forming a cross-continuum team has several concrete and practical benefits. Some of the immediate benefits include:

- Declare to your referral partners your organization’s readmission reduction goals;
- Describe the range of efforts your organization is implementing to reduce readmissions;
- Understand what your cross-setting referral partners are doing to reduce readmissions;
- Understand what information your receivers need to facilitate a safe and stable transition into their setting to avoid a readmission;
- Form and strengthen multidisciplinary relationships among providers who share the care of common patients (putting a face to a name); and
- Identify partners that will help your hospital achieve quality, satisfaction, and/or cost goals.

Forming a cross-continuum team does not need to represent a major new strategic business decision. Cross-continuum teams start with the providers with whom you commonly share high-risk patients. Acknowledge that not all possible partners are at the table, and allow the group to expand naturally over time. Once you start hosting cross-continuum team meetings, other providers will want to be included.

An example email/letter of invitation for new members of your cross-continuum team is on the following page. Keep it simple, and send the emails today. Use Tool 5, the Cross-Continuum Inventory Tool, to identify providers and agencies to invite. As you expand your readmission reduction efforts to include adult Medicaid patients, consider reaching out to the following:

- Medicaid managed care organizations
- Medicaid behavioral health carve-out plans
- Medicaid agencies, especially in a fee-for-service market
- Behavioral health providers, community mental health, crisis teams
- Substance abuse treatment providers
- Home health agencies that serve high-volume Medicaid and/or behavioral health patients
- Physician practices that serve high-volume Medicaid patients, including community health centers
- Social service agencies, including those that provide social work services
- Elder service agencies, including those identified as aging and disability resource centers
- Pharmacies that provide bedside delivery and/or medication counseling services
- Adult day health programs
- Local emergency departments that share the care of common frequent users

Tool 13: Community Resource Guide

The first step to using community resources to address patients’ social and behavioral health needs is to identify community agencies and other organizations that can help meet those needs. Many hospitals perceive that there are limited or no community resources available, without ever having made a concerted effort to look for these resources. This tool will help you populate a resource guide to quickly and efficiently connect patients to the services they need.

Starting on the next page is a template to fill in the information about your community resources. This resource guide will be especially helpful to the discharge coordinators, community health workers, patient advocates, volunteers, or other people who will help patients address their basic needs. Once completed, an abbreviated version of the most common referrals/resources used can be added to the Whole-Person Assessment Tool.

To populate this resource guide, draw from the following information sources:

1. **Your cross-continuum team partners.** A highly useful function of your cross-continuum team is to ask them to help populate an inventory of community-based services that can meet the clinical and nonclinical needs of Medicaid patients after hospitalization. Their knowledge and experience with these services will help in creating efficient linkages to care from the hospital.

2. **Key contacts at Medicaid health plans.** Representatives from Medicaid health plans should be invited to the cross-continuum team meetings, but depending on geography, they may not be able to attend in person as the local service providers can. A clinical/quality leader at the hospital (e.g., director of quality) should identify a key contact at each Medicaid health plan who can update and clarify the types of supports and services the plan can provide and for which types of patients. Most important, the hospital and each plan should develop a clinical (not just utilization review) point of contact to facilitate time-sensitive discussions about posthospital supports and services to reduce readmissions.

3. **Your hospital social workers.** Social workers are trained to understand the comprehensive landscape of social services in a community. Over time, hospital-based social workers may benefit from in-services or networking with community-based colleagues to refresh connections and understanding of available programs and resources, as this is a continuously changing landscape in any community.

4. **A search engine.** Conducting an online search for community resources in your area can be a quick way to find potential partners and their contact information. This can be a useful research method in addition to what the social workers and cross-continuum team partners are aware of.

5. **211.** Most of the United States has access to 2-1-1, a telephone hotline that specializes in health and human services information and referral. This can also be a useful supplemental method of research for hard-to-find community resources.
Cross Continuum Coordination - Tips

If you are just getting started:

- Hold regularly scheduled monthly meetings
- Start with a “coalition of the willing” – doesn’t need to be perfect
- Invite new partners/ agencies as you learn about them
- Allow 3-4 months for the group to gel
- Start with common agenda items:
  - Readmission data
  - Readmitted patient stories
  - Readmission stories from “receiver” perspective
  - Handoff communication
  - What information do “receivers” need that they frequently don’t have?
Cross Continuum Coordination - Tips

If you have a team already:

- **Identify gaps in membership**
  - SNFs? Home Health? Hospice/Pall Care? ACOs? PCMH?
  - Behavioral Health? Health Homes?
  - Social service agencies? Healthcare for the Homeless?
  - Medicaid Managed Care Plans?

- **Consider subcommittees for transition-specific work**
  - SNFs, Home Health, Behavioral health, community agencies
  - Still hold periodic “cross continuum” meetings with all

- **Consider requiring everyone to bring data**
  - All cross continuum partners (especially clinical) should be able to measure readmission / return to acute for their patients
  - Use CRISP reports to facilitate best-available cross-setting information
Cross Continuum Coordination - Tips

If you have a high functioning group already:

- Consider establishing “shared expectations” for handoffs
  - What will “senders” commit to do, every time?
  - What will “receivers” commit to do, every time?
  - How will we measure and hold ourselves accountable?

- Consider evolving from informal collaborations to formal relationships
  - Preferred providers
  - Contracted services
  - Co-located services
  - Collaborate on developing/ updating individual care plans
Design a Data-Driven Portfolio of Strategies
Tool 7: Portfolio Design

Develop a Portfolio of Strategies

**Improve Hospital-Based Transitional Care Processes for Medicaid Patients**

- Flag discharge <30d in chart
- ED-based efforts to treat & return
- Broaden view of readmission risks; assess “whole-person” needs
- Develop transitional care plans that consider needs over 30 days
- Ask patient & support persons what help they need; share with them their needs/risk assessment
- Use teach-back, target the appropriate “learner”
- Customize information
- Arrange for posthospital follow-up
- Use a checklist for all patients

**Collaborate With Cross-Setting Partners**

- Use ADT notifications with medical and behavioral health providers
- Ask community providers what they need and who they want to receive it
- Collaborate to arrange timely follow-up
- Perform “warm” handoffs and opportunity for clarification
- Form a cross-continuum team that can access resources your staff are unaware of
- Constantly refresh your awareness of social and behavioral health resources
- Broaden partners to include Medicaid health plans and their care managers
- Identify community partners with social work and behavioral health competencies

**Provide Enhanced Services for High-Risk Patients**

- Segment “high risk”—varying types of service & levels of intensity
- Strategy for high utilizers
- Strategy for navigating care
- Strategy for accessing resources
- Strategy for self-management
- Strategy for frailty/medically complex
- Strategy for end-of-life trajectory
- Strategy for recurrent stable symptoms, etc., individual care plans
## What is your hospital portfolio of efforts?

<table>
<thead>
<tr>
<th>Setting</th>
<th>Target Population</th>
<th>Action(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>Identify HU</td>
<td>Avoid recurrent admission using individual care plan</td>
</tr>
<tr>
<td>ED</td>
<td>Identify all 30-day returns</td>
<td>Prompt provider assessment</td>
</tr>
<tr>
<td>ED</td>
<td>All patients from SNF</td>
<td>Treat and Return process</td>
</tr>
<tr>
<td>Hospital</td>
<td>High risk = Medicaid, frail, BH comorbidity and/or &gt;3 hospitalizations</td>
<td>Palliative care consult, pharmacist med optimization, bedside delivery of meds, appointment &lt;7 days</td>
</tr>
<tr>
<td>Hospital</td>
<td>All d/c to SNF</td>
<td>Warm RN-RN handoff</td>
</tr>
<tr>
<td>Post-Discharge</td>
<td>All High risk</td>
<td>Transitional care team contact x 30 days (BH, SW, RN)</td>
</tr>
<tr>
<td>Post-Discharge</td>
<td>Patients who can’t get follow up &lt; 7 days</td>
<td>Urgent care, retail clinic, hospital bridge clinic, NP visit</td>
</tr>
</tbody>
</table>
## What is the portfolio of efforts in the community?

<table>
<thead>
<tr>
<th>Provider</th>
<th>Target Population</th>
<th>Action(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day</td>
<td>X criteria</td>
<td>Clinical monitoring, meds, meals, social</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>Established or new patients</td>
<td>Care management, integrated care</td>
</tr>
<tr>
<td>Public Health</td>
<td>Adults with active SUD</td>
<td>Peer recovery specialists</td>
</tr>
<tr>
<td>Senior Housing</td>
<td>Residents of facility/site</td>
<td>On-site clinical care</td>
</tr>
<tr>
<td>HEZ</td>
<td>Residents with HTN, DM</td>
<td>New access to primary care</td>
</tr>
<tr>
<td>Competing hospital’s effort</td>
<td>HF, COPD, BH</td>
<td>90 day TOC outreach team</td>
</tr>
<tr>
<td>Sickle Cell Clinic</td>
<td>Any patient with SCD</td>
<td>Urgent non-ED care</td>
</tr>
<tr>
<td>Social Services</td>
<td>X criteria</td>
<td>Transportation to appointments</td>
</tr>
</tbody>
</table>
Go back to your data & needs – gaps?

- Are you targeting Medicare patients?
- Are you addressing Medicare patients needs?
- Are you targeting Medicaid patients?
- Are you addressing Medicaid patients needs?
- Are you targeting behavioral health (BH) patients?
- Are you addressing BH patient needs?
- Are you targeting high utilizers (HU)?
- Are you addressing HU patient needs?
- Are you addressing medication issues?
- Are you addressing chronic recurrent symptomatic presentations?
- Do you have an approach for addressing housing issues?
- What gaps in addressing target populations or services exist?
Calculate the size of the target population (each target population)
- Program A: 150 high utilizers accounted for 600 hospitalizations
- Program B: 1000 patients used 2000 ED BH visits

Identify how many patients per week/month/year the service (hospital-based or community based) can accommodate
- Program A: Transitional care team serves all 150 patients per year (100%)
- Program B: agency-based CHW service will enroll 10 patients per week, or 10 x 50 = 500 patients per year (50% of target population)

Estimate the expected impact of the service for the patients
- Program A: Reduce hospitalizations by 30% (180 fewer d/c)
- Program B: Reduce ED BH visits by 30% among patients served (500 patients, 1000 visits less 30% = 300 fewer ED BH visits which will be 15% overall reduction in ED BH visits)
## Tool 8: Readmission Reduction Impact and Financial Analysis Tool

### Tool 8: Readmission Reduction Impact and Financial Analysis Tool

<table>
<thead>
<tr>
<th>BASIC DATA</th>
<th>Total</th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Source of Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Number of (non-OB, adult) discharges, past year (#)</td>
<td>5,000</td>
<td>2,000</td>
<td>750</td>
</tr>
<tr>
<td>B</td>
<td>Number of (non-OB, adult) readmissions, past year (#)</td>
<td>625</td>
<td>360</td>
<td>150</td>
</tr>
<tr>
<td>C</td>
<td>(non-OB, adult) readmission rate (calculation)</td>
<td>12.5%</td>
<td>18.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>D</td>
<td>Average cost (reimbursement) per (non-OB, adult) admission ($)</td>
<td>$8,500</td>
<td>$10,000</td>
<td>$6,500</td>
</tr>
<tr>
<td>E</td>
<td>Total cost of readmissions, past year (calculation)</td>
<td>$5,312,500</td>
<td>$3,600,000</td>
<td>$975,000</td>
</tr>
</tbody>
</table>

### IMPACT OF READMISSION REDUCTION STRATEGIES

**Strategy 1 (example): Improve Standard Hospital Based Care for All**

| G | Target population strategy 1 will serve (#) | All | All | All | Based on your strategy |
| H | Number of admissions strategy 1 will serve (#) | 5,000 | 2,000 | 750 | Input your data |
| I | Readmission rate among target population (%) | 12.5% | 18.0% | 20.0% | Input your data |
| J | Readmissions among target population (calculation) | 625 | 360 | 150 | Calculate: HxI |
| K | Estimated impact of strategy 1 in reducing readmissions (%) | 10% | 10% | 10% | Based on your estimation |
| L | Number of readmissions averted (calculation) | 63 | 36 | 15 | Calculate: JxK |
| M | Estimated savings of strategy 1, ($, calculation) | $531,250 | $360,000 | $97,500 | Calculate: LxD |

**Strategy 2 (example): Intensive community social service support for high utilizers**

| N | Target population strategy 2 will serve (#) | 250 | 175 | 75 | Based on your strategy |
| O | Number of admissions strategy 2 will serve (#) | 650 | 490 | 360 | Input your data |
| P | Readmission rate among target population (%) | 30% | 30% | 30% | Input your data |
| Q | Readmissions among target population (#, calculation) | 255 | 147 | 108 | Calculate: OxP |
| R | Estimated impact of strategy 2 in reducing readmissions (%) | 30% | 30% | 30% | Based on your estimation |
| S | Number of readmissions averted (calculation) | 77 | 44 | 32 | Calculate: QxR |
| T | Estimated savings strategy 2, ($, calculation) | $650,250 | $441,000 | $210,600 | Calculate: SxD |

continued
Upcoming Webinars & Meetings

Upcoming Webinars:
- March 25: High Impact Medicaid-Specific Strategies

In-Person Learning Session:
- April 1, Turf Valley
- Register here: https://www.surveymonkey.com/r/April1Readmissions

See MHA Transitions: Handle With Care
- Slides
- Registration link for April 1 meeting
Thank you!

We welcome your feedback on the webinars and Guide/Tools!

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