February 20, 2015

Dear Readmission Leader,

Thank you for participating in the Maryland Hospital Association's Learning Network to Reduce Medicaid Readmissions. We are thrilled you are interested in identifying opportunities to expand and adapt your readmission reduction efforts to better serve the needs of adult Medicaid patients.

The Learning Network consists of a 3-part, action-oriented, webinar series and one face-to-face meeting. Each webinar will cover different parts of the Guide, and active participation in the pre-work and webinar series will accelerate your readmission reduction work early in 2015. The 3 webinars will be held on **February 25, March 11, and March 25** at 1:00 p.m. The in-person meeting will be held on **April 1** – detailed information forthcoming.

The webinar series will feature Amy Boutwell, MD, MPP and James Maxwell – developers of the AHRQ *Hospital Guide to Reducing Medicaid Readmissions*. During the Learning Network we will go through the Guide in detail, focusing on the 13 customizable online tools to help develop your Medicaid readmission reduction strategy. Please download the Guide and Toolkit for free from the AHRQ website: http://www.ahrq.gov/professionals/systems/hospital/medicaidreadmitguide/.

The objectives of the webinar series are three-fold:
- Identify 3 reasons why your readmission reduction efforts should be expanded to better address the transitional care needs of Medicaid adults;
- Identify 3-5 practical ways in which to expand your hospital's efforts to reduce Medicaid readmissions; and
- Provide feedback to the Guide developers on the Guide, Tools, and webinar series.

To maximize your participation in the Learning Network please consider using the attached a "pre-work" packet for *Webinar 1: Updating Readmission Strategies for 2015 – A Focus on Medicaid*. The objective of Webinar 1 is to specifically describe the importance of using your own hospital's data to understand how Medicaid readmission patterns are similar to- and different from- those in the Medicare population. We encourage you to look at your own data (Tool 1), interview a small number of recently readmitted Medicaid patients (Tool 2), and interpret these findings to craft an updated understanding of the opportunities to reduce Medicaid readmissions, specific to your hospital (Tool 3). In recognition of the fact that all Maryland hospitals have been working on readmissions over the past several years, please also utilize the Hospital Inventory Tool (Tool 4).

We are thankful for your commitment to patient care and to improve care transitions for all patients.

Please do not hesitate to contact us with any questions or feedback.

Sincerely,

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Vice President, Policy & Data Analytics   Analyst, Policy & Data Analytics
Maryland Hospital Association   Maryland Hospital Association

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Hospital Guide to Reducing Medicaid Readmissions
Toolbox

Tool 1: Readmission Data Analysis

Purpose: Analyze hospital administrative data to evaluate readmission patterns.

Description: Extensively vetted 10-point analysis of data to facilitate a compare and contrast view of readmissions by payer to identify differences between Medicare, Medicaid, commercial, and all-payer rates.

Staff: Data analysis, business analyst, staff able to run administrative data.

Time required: 4 to 6 hours.

Tool 1: Readmission Data Analysis

Use the most recent 12 months of data available, calendar or fiscal year. Count readmissions as any return to the inpatient setting for any reason within 30 days of discharge from the inpatient setting. This analysis is for nonobstetric, nonpediatric, adult medical/surgical/behavioral health patients. Exclude discharges that are coded as deaths or transfers to another acute care hospital.

Data Element	Medicare	Medicaid	Self-Pay	All Payer
1. Total number of discharges alive (exclude transfers, deceased, <18yrs, obstetric)				
2. Total number of individual patients				
3. Total number of 30-day readmissions				
4. Overall readmission rate (#3/#1)				
5. Discharge disposition (from #1): a. Home (no home health) (#, %) b. Home with home health (#, %) c. Skilled nursing facility (#, %)				
6. Average number of days between discharge and readmission for all readmissions, days 0-30 (or #, % of readmissions within 0-6, 7-14, 15-30 days, respectively)				
7. Top 10 discharge diagnoses resulting in readmission (based on *index* DRG) a. List top 10 diagnoses b. Report number of readmissions per diagnosis c. Report readmission rate per diagnosis (readmissions for diagnosis/discharges for diagnosis)				
8. Top 10 readmission discharge diagnoses (based on *readmission* discharge DRG) a. List top 10 diagnoses b. Report number of readmissions per diagnosis c. Report % of all readmissions accounted for by each top 10 readmission diagnosis				
9. Proportion of top 10 readmission diagnoses as a percentage of all readmissions (sum of readmissions in top 10/total readmissions)				
10. High-utilizing population (H.U.) a. Number of people hospitalized three or more times in past 12 months (H.U.) b. Number of hospitalizations among H.U. c. Discharge disposition of H.U. (home, home health, skilled nursing facility) d. Top 10 discharge diagnoses among H.U. e. 30-day readmission rate among H.U.				

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Tool 2: Readmission Review

Purpose: Obtain qualitative insights in to why readmissions occur.

Description: Adapted from the well-known STAAR approach, this one-page interview guide prompts clinical or quality staff to elicit the patient, caregiver, and provider perspective about the causes of readmissions.

Staff: Quality improvement, nursing, case management staff.

Time required: 15 minutes per interview; 10-20 interviews suggested to start; many teams review ALL readmissions when the patient is readmitted.

Tool 2: Readmission Review

Ask your patients, their caregivers, and providers "why?"

While it is important to have a good understanding of your organization's quantitative readmission data, these data do not help you understand the kinds of barriers patients, families, and providers face during the posthospital transitional care period or the circumstances leading patients to return to the hospital soon after discharge. Adapting from a popular approach from the Institute for Healthcare Improvement's State Action on Avoidable Rehospitalizations (STAAR) Initiative (www.ihi.org/staar), we recommend your readmission team conduct **5-10 "readmission interviews**."

These reviews are designed to elicit the **"story** behind the **story": going** well beyond chief complaint, discharge diagnosis, or other clinical parameters to understand the communication, coordination, or other logistical barriers experienced in the days after discharge that resulted in a readmission.

Some teams may be concerned that patient interviews will be time consuming. You can address time constraints by using a simple framing script at the beginning of the interview (see next page). Readmission teams uniformly report that these reviews yield valuable information that would otherwise be difficult to obtain from charts or data.

While we provide a script, the most important principle of conducting these interviews is to give patients, family members, and providers an opportunity to provide detail about why they/their loved one/their patient had to return to the hospital. The prompts are only meant to help elicit the stories from the individuals you interview.

The readmissions interview has three main parts:

- Brief chart review of the first admission and the readmission.
- Patient/family caregiver interview.
- Provider interview.

Drawing on an innovation to the readmission interview developed by Feigenbaum and colleagues at Kaiser Permanente, we recommend capturing all the reasons patients, caregivers, and/or providers cite that factored into the readmission event. As Feigenbaum and team discovered, an average of 9 factors spanning the domains of hospital-care, predischarge preparation, the discharge process, and posthospital time period contributed to each potentially preventable readmission they reviewed.

Implementation tip: these interviews should take no more than 40 minutes each. It is often easiest to find one or two patients currently in your care who were recently readmitted and interview them. Remember to call the relevant cross-continuum partners (physician, home health nurse, discharging physician, community based case worker, mental health provider, etc.) to get their perspective.

Section 1: Brief chart review (10-15 minutes)

Elicit the following basic information:

- Date of first admission
- Date of first discharge
- Active medical issues during first hospitalization
- Discharge disposition
- Comments on first transitional care plan (i.e., whether teaching/written instructions given/ referrals made/ appointments scheduled)
- Date of readmission
- Number of days between discharge and readmission
- Site of care readmitted from (home, skilled nursing facility, etc.)
- Readmission chief complaint, as recorded in the chart
- Active medical issues during the second hospitalization
- Discharge disposition (if they are no longer in the hospital)
- Comments on documented transitional care plan (was anything done differently?)

Section 2: Patient/family caregiver interview (10-15 minutes)

(Suggested script: "We are working to improve the discharge process and noticed that you have been in the hospital twice recently. I'd like to ask you for about 10 minutes of your time to give us some feedback about what happened between the time you were discharged and the time you returned to the hospital. This will help us understand what we might be able to do better for you and what we might be able to do better for our patients in general. Would that be o.k. with you?")

- What brought you to the hospital the first time? [insert reference to date of first hospitalization]
- Did you think the doctors, nurses and other staff helped you get ready to leave the hospital?
- Did you understand what the plan was for your care when you left the hospital?
- Did you receive information about whom to call if you had questions or problems?
- Tell me about anything that was unclear or confusing for you when you left the hospital.
- I see you went to (discharge disposition). How did it go once you got there?
- Did any new symptoms or issues come up after you were discharged?
- Did you see a doctor, nurse, or other provider after you were discharged? Who?
- Why do you think you needed to come back to the hospital?
- Was there anything that could have been done differently [so you didn't develop that symptom or issue]?
- Do you have any other suggestions for us? Thank you.

Section 3: Provider interview (3-5 minutes)

(Suggested script: We are working to improve care transitions and reduce avoidable readmissions. One of your patients was recently readmitted to our hospital and we'd like to ask for your thoughts on how we can improve our transitional care processes. It will take no more than 5 minutes of your time.)

- Did you know [insert patient name] was admitted on (first hospital date)?
- Did you know the patient was discharged to (setting) on (date)?
- Did our hospital contact you at all about the admission or discharge plan? If so, describe the interaction or information you received.
- Did the patient contact you after discharge with questions or issues, or for followup?
- Did you have contact with the patient after discharge? If so, were there points of confusion about the plan, symptoms, or other issues we should be aware of?
- Why do you think the patient ended up being readmitted?
- Do you think there was anything that could have been done for this patient, or others like him/her (socially or clinically) to prevent readmissions?

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Tool 3: Data Analysis Synthesis Tool

Purpose: Summarize and interpret the findings from data and interviews.

Description: This template creates a written narrative to describe the results from the quantitative data and readmission interviews.

Staff: Quality improvement staff.

Time required: 2 hours.

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

Payer	# Discharges	% (#/Total Discharges)	# 30-day Readmissions	% (#/Total Readmissions)	Readmission Rate (#Readm/#Discharges)
All Patients		100		100	
Medicare					
Medicaid (adult, nonobstetric)					

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 post-hospital follow-up 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

Measure	Medicare	Medicaid
Discharge to home		
Discharge to home health		
Discharge to skilled nursing facility		

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

Medicare	Medicaid
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.
6.	6.
7.	7.
8.	8.
9.	9.
10.	10.

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

High-utilizing population

There were # people hospitalized three or more times at our hospital in the past 12 months. These # people used # hospitalizations, which is an average of # per person. There were # readmissions, yielding a readmission rate of #%. Among the high-utilizing population, #% were discharged to home without services, #% were discharged to home health, and #% were discharged to a skilled nursing facility. [Make observation about diagnoses, whether similar or different than overall readmission population].

Table 4: High utilizers

	# People	# Hospitalizations
People hospitalized 3 times		
People hospitalized 4 times		
People hospitalized 5 times		
People hospitalized 6 times		
People hospitalized 7 times		
Continue until max		
Total	Total # people	Total# hospitalizations
Average hospitalizations/person (# hospitalizations/# people)		

Readmission interview findings

To supplement the insights derived from data analyses, we interviewed # recently readmitted Medicaid patients. The table provides a summary of the patients' readmission circumstances.

Table 5. Summary of readmission interviews

1st Hospitalization	2nd Hospitalization	# Days to Readmission	Notes
Age, sex, chief complaint, length of stay, discharge diagnosis, discharge disposition	Patient's words why returned, whether he/she had post-hospital follow-up	Days between discharge and readmission	Opportunities for improvement
Patient 2			
Patient 3			
Patient 4			
Patient 5,, etc.			

Summary of patient perspectives about being readmitted:

[Summarize what patients said about why they returned to the hospital, whether it is disappointing/reassuring to them, whether this represents "good" care or not, whether they felt rushed, confused, had questions after discharge, whether their doctor told them to return, etc.]

Analysis of patients' perspectives about being readmitted:

What do the patient comments suggest about:

- The discharge process, including timing and perceived readiness?
- The educational or written materials?
- Whether teach-back is being targeted effectively (e.g., target to caregiver)?
- Whether "whole-person" needs are being identified?
- Whether referrals for supports and follow-up are being made before discharge?
- Whether there is any collaboration with post-acute or community providers?
- Whether patients view readmissions as "bad" or "o.k."? What does that suggest for our efforts to educate patients, caregivers, and the public about effective transitions in care?

Summary of family/caregiver perspectives about being readmitted:

[Summarize the family/caregiver perspectives about returning to the hospital. You may note that often family/caregivers are more able/willing to offer criticism.]

Analysis of family/caregiver perspectives about being readmitted:

[What did you learn from this feedback that can inform improvement activities?]

Summary of providers' perspectives about readmitted patients:

[Summarize what providers said about readmitted patients, including whether the provider knew the patient had been readmitted, whether the provider had any insights about what could have avoided a readmission, and whether the provider had any suggestions for general improvement.]

Analysis of provider feedback:

What does the provider feedback suggest about:

- Whether providers know when their patient is readmitted?
- Whether providers view readmissions as potentially preventable?
- Whether provider education or engagement is warranted?

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Tool 4: Hospital Inventory Tool

Purpose: Understand your hospital's current readmission reduction efforts.

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

Staff: Quality improvement, readmission reduction team members.

Time required: 2-4 hours.

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.

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