Reducing Readmissions: Care Transitions Toolkit©

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Right Care at the Right Time in the Right Setting
Reducing Readmissions: Care Transitions Toolkit

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To download a copy of this toolkit, go to http://www.wsha.org/partnershipforpatients.cfm

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OVERVIEW

Background

Readmission rates are increasingly seen as markers of a local community’s ability to deliver coordinated care and access to needed services for the community\(^1\). We are proud in the Northwest of our low admission and readmission rates and short length-of-stay. By working together, communities in Washington have lowered readmissions in the state from 10.27 per 1000 Medicare beneficiaries to 8.3 per 1000 Medicare beneficiaries, which is a 19 percent reduction since 2010.\(^2\)

While some readmissions are necessary and appropriate, it was estimated in 2011 that nationally approximately 12 percent of readmissions are avoidable according to an analysis conducted by the Medicare Payment Advisory Committee (MedPAC).\(^3\)

The literature found the following regarding the degree of the effectiveness of current care transitions processes:

- The availability of a discharge summary at the first post-discharge visit is only 12-34 percent.\(^4\)
- Nearly 20 percent of discharged patients experience an adverse event within three weeks of leaving the hospital; two-thirds of these are adverse drug events.\(^5\)
- At admission or discharge from the hospital, regularly used medications were erroneously discontinued in 46.4 percent of cases; 38.6 percent of these had the potential to cause moderate or severe discomfort or clinical deterioration.\(^6\)
- In Washington State, an estimated 15 percent of Medicare patients discharged from a hospital to a skilled nursing facility were readmitted to a hospital within 30 days in Q2 2013. It was 16.7 percent in Q3 2010 for a relative improvement rate of 10.2 percent.\(^2\)

The lack of a systematic approach to transitions not only impacts patients, it makes delivery of safe care more difficult and impacts the morale of the care providers.\(^7\)

- “Handoffs and Transitions” of important patient care information across hospital units and during shift changes had the second lowest average percent positive response (45 percent) on the 2012 Hospital Survey of Patient Safety Culture (Agency for Healthcare Research and Quality), indicating it is an area with potential for improvement for most hospitals.\(^7\)
- “Information Exchange with Other Settings” ranks the second lowest on the medical office version of the 2010 Survey of Patient Safety Culture (Agency for Healthcare Research and Quality).\(^7\)

National Linkage

This work is part of Washington’s work in the Centers for Medicare & Medicaid Services’ Partnership for Patients initiative and Institute for Healthcare Improvement and Commonwealth Funds’ STate Action on Avoidable Rehospitalizations (STAAR) program. Thank you to both of these organizations for their support.
Local Leadership

This work is being guided by the Washington State Readmissions Steering Committee. This committee, organized by the Washington State Hospital Association, is comprised of providers throughout the continuum, insurance companies, governmental agencies, and groups representing hospitals, physicians, and purchasers.

Washington State Readmissions Steering Committee

Washington State Care Transitions Improvement Initiative

Washington State Care Transitions is a state-wide initiative to foster safe, timely, effective and coordinated care as patients move between settings. Several initiatives have helped advance this work including a five year partnership between Washington State Hospital Association, the Institute for Healthcare Improvement and the Commonwealth Fund as Washington was one of three states selected to participate in the STate Action on Avoidable Readmissions (STAAR) initiative. The work was also strengthened through Qualis Health’s care transitions community coalition efforts initiated in 2008 with the Centers for Medicare & Medicaid Services (CMS) pilot community. Since then many Washington communities have begun or continued cross-continuum collaborations intended to improve and standardize care transitions processes and prevent avoidable readmissions on a community level. It is
coordinated and synergistic with the work that is happening through efforts such as Aging and Long-Term Support Administration (ALTSA) trainings in Care Transitions Intervention (CTI) coaching and Community-based Care Transitions Programs (CCTP) in many Northwest communities. This edition of the toolkit builds on first edition by including learnings from the work that has occurred through February 2014.

Washington saw a paradigm shift with facilities and providers acknowledging and understanding the importance of working together as a community to ensure patients experience seamless, safe care transitions.

Recognizing the complexity of preventing avoidable readmissions, this toolkit is focused on an important aspect – care transition processes from the time a patient visits the Emergency Department or is admitted to the hospital to the time the patient is discharged home or to a skilled nursing facility.

Much has been published on the fragmentation in care during transitions between hospital, home and other community-based care settings. It is clear that in Washington, similar gaps exist at the intersections of care regardless of the type of providers. Together, providers in Washington are working to design effective processes for transitions.

Carol Wagner, Washington State Hospital Association

Thank you to the many national and local organizations that contributed to this work.
RECOMMENDED CARE TRANSITION PROCESSES
FOR EMERGENCY DEPARTMENT VISITS AND INPATIENT ADMISSIONS

“I’ve got 10 doctors and 20 nurses. You’re all wonderful. Could you please talk with each other?”

-Patient

American patients see an average of 18.7 different doctors in their lifetime. Patients need care providers to communicate and coordinate care with the patient and with each other.

Lack of standardized processes within settings in a community, lack of patient/family activation, and poor communication often result in unplanned readmissions. It is important that the care transition improvement work begins with standard processes being implemented within settings in the community and then extends to cross-setting work. This toolkit is intended as a resource for hospitals and all other organizations involved in care transitions to support your efforts to reduce unplanned readmissions and to improve the quality of care transitions for patients and families.

The flow map on the next page summarizes the recommended care transition processes as patients transition across the care continuum. The flow map was developed through collaboration between hospitals, physicians, ambulatory care, pre- and post-acute care, and payors. These processes are applicable if the patient received care in the Emergency Department or was admitted to the hospital.

The recommended processes are listed below and described in the following pages of this toolkit.

1. Readmission Risk Assessment
2. Outpatient Provider Communication
3. Plan of Care
4. Medication Reconciliation
5. Social/Resource Barriers Assessment
6. Patient and Family/Caregiver Engagement and Teach Back
7. Advanced Care Planning at the End-of-Life
8. Scheduling the Follow-up Appointment
9. Discharge Communication - Verbal Handover/ Send Discharge Summary
10. Follow-up Phone Call
11. Follow-up Appointment - Primary Care Visit
12. Feedback to Hospital for Improvement
13. Community Forum
Care Transitions to Reduce Unplanned Readmissions

**During Hospitalization**
- **Patient Arrives at Hospital/Emergency Department**
- **Complete Risk Assessment**
  - For Moderate or High Risk, Discuss Plan of Care with Outpatient Care Providers
- **Reinforce/Revise Plan of Care**
- **Medication Reconciliation**
- **Social/Resources Barrier Assessment**
- **Assess Understanding/Teach Back**
- **End of Life Planning**
- **Schedule Follow-up Appointment**
- **Verbal Handover Send Discharge Summary**

**Post Discharge**
- **Follow-Up Phone Call**
- **Patient Follow-Up Appointment**
  - Reinforce/Revise Plan of Care
  - Medication Reconciliation
  - Social/Resources Barrier Assessment
  - Patient Coaching
  - End of Life Planning
- **Feedback to Hospital/ED for Quality Improvement**

**Hospital**

**Outpatient Care Provider**
The following sections describe the components of the Care Transitions flow map. Tools corresponding to each section are included at the end of the toolkit. The toolkit aims to provide one best practice resource or set of data elements whenever possible. In cases where a best practice has not yet been determined, more than one example has been provided. Tools and resources have been hyperlinked throughout the document for easy navigation.

1. **Readmission Risk Assessment**

**Process**

- Select a risk assessment tool and implement consistently in the community.
- Complete a risk assessment on every patient within 48 hours of admission.
- Develop a set of recommended interventions for each risk level.
- Update the risk assessment during the hospitalization as needed and adjust the interventions based on new findings.
- Include the identified risks in the discharge summary sent to the outpatient providers upon discharge.
- For continuous quality improvement, review randomly sampled readmission cases to validate the tool’s predictions and assess if the tool is correctly identifying the high risk patients. Revise the interventions as needed.
- Examples of readmission risk assessment tools ([Tools 1.1 to 1.5](#)) are included in the Tools section of this document.

**In Practice**

A health system in Washington State adopted and implemented a risk assessment tool consistently throughout their health system. Within 48 hours of admission, all patients are assessed for their risk of readmission. Identified risk level and strategies carried out are documented in the patient’s electronic medical record and case management summary. Upon discharge, the case management summary is sent to the primary care provider’s office. When patients are readmitted, case management staff review previous admissions, risk score and strategies applied to determine if there were any missed opportunities and to validate the effectiveness of the risk assessment tool and strategies. Based on the findings, suggestions are made to modify the interventions.
2. **Outpatient Provider Communication**

Primary care providers (PCP) and outpatient care providers often provide valuable information for the plan of care and the transition back to the community. Early communication between hospitals and outpatient providers plays a critical role in preventing an unnecessary increase in length of stay, incomplete medication reconciliation, duplicative or unnecessary services, and reducing unplanned readmissions. It is important that patients’ outpatient care providers – including primary care providers (PCP), nursing homes and home health agencies – have been correctly identified upon admission as they will need to be contacted regarding the existing plan of care and ongoing treatment plan. Complete the notification to PCPs and other involved services (such as in-home services and skilled nursing facilities) when a patient receives treatment in the emergency department or is admitted to the hospital, especially for patients who are at a moderate or high risk for readmission.

**Process**

- Payors ensure hospital staff have easy access to information about the patient’s PCP as well as any in-home services received by the patient.
- Notify PCPs and other involved services (such as in-home services and skilled nursing facilities) of their patients’ emergency department visit or hospital admission via shared electronic medical records or by fax including the reasons for hospitalization in the notification. For patients who are at high or moderate risk for readmission, the involved physicians should communicate directly.
- Obtain the patient’s plan of care from the outpatient providers if a plan of care already exists.
- Often times, admission notifications that are sent in error to an incorrect provider are destroyed without any feedback to the sender. Adding a sentence such as “*If you are not this patient's Primary Care Provider or you believe you have received this notice in error, please call/fax to (xxxx) xxx xxxx*” at the end of the notification has helped ensure this feedback loop occurs. An example of this is shown in the Tools section (Tool 2).
- Communicate with the payor of the wrong PCP and work with the payor to identify the correct PCP if applicable.

**In Practice**

Some hospitals in Washington State notify the PCP via Epic in-basket notification if the provider is within the network and by fax if the provider is out of the network. PCP offices respond to the hospital using contact information provided on the notification if the patient is not their patient. This prompts the hospital staff/physicians to follow up with the patient to identify the patient’s correct PCP so that discharge and follow-up information is sent to the correct provider for post-discharge care.

**For patients without an established primary care provider:**
When patients do not have an established primary care provider (PCP), it can create significant challenges for them to receive appropriate post-discharge care. Establish processes for these patients to get registered with a PCP for continuity of care.

- Before exploring the options, confirm with the patient and family if they have a primary care provider the patient sees regularly. If this is not known, do the following:
  - If the patient is insured, contact the insurance carrier to identify the patient PCP.
  - If the patient is uninsured and if the hospital has a primary care clinic or affiliated primary care practice, register the patient at the clinic.
  - If the hospital does not offer a primary care clinic or have an affiliated primary care practice, identify the largest primary care practice in your community or safety net clinics and make arrangements so that the patient can be registered at their clinic. See Section 8.

3. **Plan of Care**

For high or moderate risk patients, a plan of care supports continuity of care. Often times, existing plans of care are not shared between involved providers, which may result in a missed opportunity for reinforcement and necessary modification of the plan of care. Seek input from the PCP, other involved services (such as in-home services and skilled nursing facilities) as described in Section 2, Outpatient Provider Communication. Tool 3 is a sample Plan of Care.

**Process**

- Obtain plan of care from the PCP and other involved services (such as in-home services, skilled nursing facilities and payors) when a patient is admitted to the hospital. Reinforce and revise the plan of care as necessary.
- If the patient is admitted for a new condition, develop a plan of care with input from the PCP and other involved services. Clearly state social and clinical issues that need to be addressed in addition to other important information such as discharge criteria, anticipated discharge barriers, proposed interventions, anticipated length of stay and possible discharge referrals.
- Involve the patient and family in creating and updating the plan of care.
- Ensure that the plan of care is accessible for all care providers such as the occupational therapist, respiratory therapist, dietician, social workers and discharge planners.

**In Practice**

A hospital in Washington State has developed a unit-based rounding process for care providers to review the patients’ care and needs at the patients’ bedsides with patients and families involved. Discharge criteria, discharge needs and anticipated discharge dates are documented on the whiteboard in the patient’s room and updated daily by care providers. Patients and families are also encouraged to write down questions and concerns on the patient bedside whiteboard. These questions are answered and the plan of care is reviewed and adjusted as necessary at daily rounds with the patient and/or family/caregiver.
4. Medication Reconciliation

Medication reconciliation is an important component of safe patient care at admission, during the hospital stay and immediately after transitioning from the hospital to another care setting or home. Accurate medication reconciliation reduces medication errors which could lead to increased patient harm and the possibility of a hospital readmission.

Process

- As an organization, create a standard process for reconciling patients’ medications upon admission, during transfer between units within the hospital and upon discharge home or transfer to another care setting. Identify which discipline(s) are primarily responsible for this reconciliation process.
- When taking the patient’s medication history, involve the patient, family, caregivers, appropriate care providers, and the patient’s local pharmacy to get complete and accurate medication record.
  - Consider that home health services and dialysis providers often have a list of current medications.
- Prior to discharge, review the reconciled medication list with the patient. Clearly identify each medication as newly added, unchanged, changed or discontinued during the patient’s hospital stay along with the purpose for the medication and reasons for the changes. Simple and easy to follow medication list tools should also be offered to the patients. (Tool 4).
- If the patient demonstrates an inability to understand or manage their medications, and is eligible for home health services, complete a referral to home health nursing services for medication management support.
- Use Tool 4 to provide a medication list to the primary care provider and the patient/care giver.
- During post-discharge follow-up phone calls (see Section 10), provide the patient or caregiver an opportunity to ask any question they may have regarding their medications.

The Agency for Healthcare Research and Quality (AHRQ)’s Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation is a good resource for acute care facilities.

In Practice

Working in partnership, a pharmacy and home health designed an inter-disciplinary, LEAN safe medication transition process for patients leaving the hospital and nursing homes and entering home health services. The admitting home health clinician verifies all medications in the home with the current orders, notes any discrepancies and sends a list with questions to pharmacy. The pharmacist at the pharmacy does a full reconciliation and communicates changes back to home health as needed. The prior process lacked efficiency, clarity and most importantly a quality and safety driven design. The ultimate goal was to maximize the scope of healthcare professionals through the design of a process to eliminate waste, resolve discrepancies thus preventing potential adverse drug events and hospital readmissions. Based on results, the estimated annual net savings range from $900,000 to $2.8 million.
5. Social/Resource Barriers Assessment

Addressing social and resource barriers early in the admission not only prevents unnecessary readmissions, but also proactively prevents delayed discharges and unnecessary increases in length of stay.

Process
- Evaluate and complete an assessment of the patient’s home-going needs and potential barriers to care including support requirements.
- If a patient falls in the high or moderate readmission risk category and is eligible for home health, provide the patient with a list of home health agencies to choose from and complete a referral.
- Request home health services early in the stay to assure time for the home health liaison to make contact, making it more likely that the services will be accepted by the patient.
- Incorporate the assistance of the patient’s preferred agency’s liaison in assessing and mitigating barriers to the home health plan.
- Whenever possible, connect patients with the available community resources in the area prior to discharge from the hospital.
- Ensure that all identified social and resource barriers are addressed appropriately and necessary arrangements are made before patient leaves the hospital (Tool 5).

6. Patient and Family/Caregiver Engagement and Teach Back

Research shows that providing patient-centered care through partnership and collaboration with patients and their caregivers:
- Improves patient safety and quality of care.
- Improves patient engagement and satisfaction.
- Reduces the cost of care.¹¹

Encouraging patients and family members to participate as members of their health care team is essential to ensuring a safe care transition process and reducing preventable readmissions. Not all patients are equally activated, and it is important to assess each patient’s activation level and tailor teaching approaches to the patient’s level. This can be done using either the Patient Activation Measure™ (PAM) or through observation of activated behaviors during interactions with the patient. On admission, establish the date and time for teaching and inform the support person and patient to be there. If the patient is too ill or unable to provide input, perform an assessment to determine who the primary caregiver will be for the patient post-discharge and/or who is most capable of understanding the education.
Institute for Patient-and Family-Centered Care identifies four core principles of patient-and family-centered care:
- Dignity and Respect
- Information Sharing
- Participation
- Collaboration

Each of these principles builds on the previous principle. Without trust, attained through treating patients with dignity and respect, and information shared in an unbiased, timely and accurate way, patients may not feel empowered to participate as partners in their care.

**Process**
The Institute for Healthcare Improvement (IHI) recommends using “Teach Back” and health literacy principles to assess the patients’ and their caregivers’ understanding of the discharge plan. Health literacy includes actual literacy (reading ability), cultural competency, appropriate language and many other factors. A well-educated person may function at a low level of health literacy when ill, stressed and vulnerable.

**Health Literacy**
In order to determine the best approach to communicate in a way that minimizes confusion for patients, families and caregivers, it is important to consider their health literacy. According to the Agency for Healthcare Research and Quality (AHRQ), “over a third of patients have limited health literacy, which results in their not understanding what they need to do to take care of their health. Limited health literacy is associated with poor management of chronic diseases, poor ability to understand and adhere to medication regimes, increased hospitalizations, and poor health outcomes.”

AHRQ and the University of North Carolina have developed a Health Literacy Universal Precautions Toolkit designed to provide all primary care providers with a systematic approach to reducing the complexity of medical care and ensure that patients can succeed in the health care environment.

**Teach Back**
Teach Back is one of the most effective methods for educating patients. Teach Back involves asking the patient or family and caregiver to recall and restate in their own words what they thought they heard during education or other instructions. Refer to Harrison Medical Center’s tool Tool 6.

Teach Back is used to assess patient and family understanding of information and education to improve their ability to perform self-care, take medications, recognize warning signs/symptoms, access help, and more. It includes the following:

- Explain needed information: Include the patient and family caregivers.
• Check for understanding: Ask in a supportive way for them to explain in their own words what was understood. For example, “I want to make sure I explained everything to you clearly. Could you explain to me in your own words...?”

• Check for understanding by the patient after each portion of the information. For example, after telling the patient how to take their water pill and again after explaining the reasons to call the doctor.

• Patients and caregivers should not feel Teach Back is a test. The emphasis is on how well you explain the concepts, placing the responsibility on the teacher not the learner.

• If a gap in understanding is identified, offer additional teaching or explanation followed by a second request for the patient to explain in their own words. Emphasize what they must do when they get home.

• Use multiple opportunities while the patient is in the hospital for review of important information to increase patient and family caregiver recall and confidence.

• If the patient or family caregiver cannot Teach Back, inform the care providers in the next care setting and adjust the transition plan accordingly.

• Use a standardized template to prompt nurses and other clinicians to document the patient’s understanding of what was taught, for example, a formatted Teach Back note in the patient’s chart.


7. Advanced Care Planning at the End-of-Life

The Agency for Healthcare Research Quality Research (AHRQ) has found that most patients have not participated in advanced care planning, yet many are willing to discuss what they want when encountering a serious illness and end-of-life care. A recent American Hospital Association study regarding patients’ wishes at the end of life revealed that 80 percent of patients wish to avoid hospitalization. Patients who have advance care planning involvement spend 10 fewer days in the hospital during their last two years and have fewer readmissions than those without as many elect to spend the time at home with family. When patients are involved with and educated on end-of-life care outside of the hospital, hospitalizations rates in the subsequent 30 to 180 days are decreased by 40 percent to 50 percent.

One way to determine patients' preferences for end-of-life care is to discuss hypothetical situations and find out their opinions on certain treatment options. These opinions can help clarify and predict their preferences if they should become incapacitated and unable to make their own decisions. In a nationwide public effort, The Conversation Project, co-founded by Pulitzer Prize winner Ellen Goodman, offers tools, guidance and resources necessary to start the conversation with their loved ones, in the home setting, about their wishes and preferences. In addition, the Institute for Healthcare Improvement (IHI) initiated the Conversation Ready Project to ensure that health care providers and systems are ready to incorporate these early and necessary conversations operationally. Piloting hospitals will be researching,
developing and testing processes. These early adopters will identify demonstrated methods including new tools and strategies to create a “Conversation Ready” package, which will be shared throughout.¹⁶

Palliative care, hospice care and advanced care planning are often confused with one another. Hospice care is typically delivered to patients (benefit and eligibility depends on insurer) who are expected to have limited survival. Palliative care consultation services can help as a resource either on an inpatient or outpatient basis to understand options. Training in advanced care and end-of-life planning, and in the ability to engage patients in these conversations, is encouraged for all primary care practitioners and all related care team members to improve their confidence in optimally understanding and following through on each patient's end of life wishes.

**Process**

Researchers sponsored by AHRQ have suggested a five-part process that physicians can use to structure discussions on end-of-life care:

- Initiate a guided discussion.
- Introduce the subject of advanced care planning and offer information.
- Prepare and complete advanced care planning documents.
- Review the patient's preferences on a regular basis and update documentation.
- Apply the patient's desires to actual circumstances.¹³

The most proactive approach is through standardization of three on-going conversations:

1. Initiating Advance Directive discussions while people are still healthy – encouraging conversations with family members and writing those wishes down
2. Discussing Advance Directives after terminal illness diagnosis and updating Advance Directives based on current diagnosis
3. Initiating **POLST** and updating Advance Directives as part of ongoing care for chronic conditions and aging
4. Ensuring that POLST moves with the patient between settings; helping patients understand the limitations of POLST (not the same as an Advanced Directive)

**8. Scheduling the Follow-up Appointment**

When discharged from the hospital, patients are at risk for complications as they adapt to a new activity level, diet, home environment, support system, updated treatment plan and changed medications. There is a relationship between early physician follow-up and 30-day readmission among Medicare beneficiaries hospitalized for heart failure. Patients who are discharged from hospitals with early follow-up appointment dates have a lower risk of 30-day readmission.¹⁷ Most Medicare readmissions occur in the first few days post-discharge, with half of all 30 day readmissions in Washington State occurring by the 11th day post-discharge from the hospital.² Therefore, it is critical to ensure that moderate and high risk patients have access to a prepared, effective post-discharge appointment within the first few days following discharge. A follow-up appointment should always be made after an emergency room visit or an unplanned hospitalization.
Process

For patients with an established PCP:

- Schedule discharge appointments based on the triage grid (Tool 1.1).
- For patients who are at a high or moderate risk for readmission, hospital staff schedules a follow-up appointment with the PCP prior to discharge.
- Work with the patient and their caregiver to determine and address existing barriers in attending their follow-up appointment such as transportation or availability of the caregiver to accompany them to the appointment. (Refer to Social/Resources Barrier Assessment)
- Ensure that the patient and their caregiver understand the purpose and importance of the follow-up appointment. Encourage the patient or their caregiver to reschedule the appointment if they are unable to make the scheduled time. In the discharge instructions, document the follow-up appointment date, time, provider and reason for the appointment.
- If in-home service referrals are made, include the date and time of the primary care follow-up appointment on the referral so the agency can support getting the patient to the appointment and can notify the physician of any significant findings prior to the appointment.
- Tool 8 is a list of data elements to include when scheduling a follow-up appointment.

For patients without an established PCP:

As described in Section 2, make attempts for the patient to get registered with a PCP for continuity of care if they do not currently have an established PCP. In addition, develop processes for those patients to receive necessary follow-up appointments within the recommended time frame.

- If the patient is insured with a managed care plan, contact the plan to provide the patient with assistance getting the necessary follow-up appointments.
- If the patient is uninsured and if the hospital has a primary care clinic or affiliated primary care practice, work with the clinic to identify the number of appointments that should be reserved for post-hospital visits. Make arrangements between clinics and hospitals that if a slot has not been filled for a post-discharge visit by certain time/day before the appointment, it is released for general appointment scheduling by the clinic. This negotiation should involve hospital senior leadership in the discussions to set overall priorities.
- If the hospital does not have a primary care clinic or an affiliated primary care practice (or internal negotiations fail), identify other clinics in the community that provide primary care services. Discuss the need for primary care follow-up appointments for patients that are a high risk for readmissions and determine how many “slots” may be available for these patients. The discussion with the clinics will likely be more successful when the responsibility for creating the new-patient appointments is equitably spread across all of the clinics providing primary care services in the community. Make formal arrangements with each practice administrator to reserve a specific number of appointment slots per day. If a slot has not been scheduled by 3:00 p.m. the day before the appointment, it will be released to schedule appointments for others.
- In addition, some communities in Washington State have Project Access programs (http://projectaccessnw.org/) that have arrangements with primary care providers within the community to donate primary care for low-income uninsured people. It may be possible to make arrangements for these slots to be used for uninsured and underinsured patients that are at high risk for readmission to the hospital.
In Practice

A health system in Washington State has developed an internal process to ensure that patients without primary care providers receive proper follow up care when discharged from the hospital. Each primary care provider has 1-2 slots per week reserved for these patients. The provider is chosen on a rotational basis depending on where the patient would like to receive care. These slots, if not filled 48 hours in advance, will return to pre-book status and be available for other patients.

Evaluate these arrangements at least quarterly to ensure there are an adequate number of available slots without having reserved too many slots. Over time, strengthen these relationships with cooperative practices and remove arrangements where the partnerships are not working.


9. Discharge Communication – Verbal Handover/Send Discharge Summary

The discharge summary is completed when the patient is discharged from the hospital. It describes the reasons for admission, what procedures, investigations and treatments were done in the hospital and what follow-up is needed once discharged, including a list of reconciled medications and medication management needs. It is one of the most common methods used by hospital physicians to communicate with family doctors.\(^{18}\) Quality and timing of the discharge summary help prevent avoidable readmissions.

According to the Institute of Healthcare Improvement (IHI), “Approximately 20 percent of Medicare beneficiaries are discharged from the hospital to a skilled nursing facility. Poorly executed care transitions negatively affect patients’ health, wellbeing, and family resources as well as unnecessarily increase health care system costs. Continuity in patients' medical care is especially critical following a hospital discharge. Research highlights that nearly one-fourth of Medicare beneficiaries discharged from the hospital to a skilled nursing facility (SNF) are readmitted to the hospital within 30 days, costing Medicare $4.34 billion in 2006.”\(^{19}\) This excerpt highlights the importance of careful consideration, planning and handoff when transferring patients out of the hospital regardless of the discharge destination.

This section of the toolkit focuses on discharges from hospital to home with primary care provider follow-up and discharges from hospital to a skilled nursing facility.

Process

- Perform verbal handoff from clinician to clinician when a high risk patient is transitioned home or to a sub-acute care setting. Verbal handoff enables the providers to discuss the treatment plan in
detail, areas of concern that need attention in the post-discharge period, alert the receiving facility/provider to be prepared to accept the patient and ensure that they are capable of providing the recommended care for the patient. (Please refer to Tool 1.1 and IHI – How to guide – transition from hospital to SNF.)

- Complete a discharge summary (DC summary) that includes data elements shown on Tool 9.
- Establish reliable and sustainable processes to ensure that outpatient providers receive a document containing sufficient information to allow them to manage the patient on the day of the patient’s follow up appointment. Hospitals should create expectations that physicians and systems provide a complete DC summary to the PCP, SNF, or other follow-up care provider within 24-48 hours after discharge or prior to the patients’ scheduled follow-up appointment, whichever comes first.
- Provide the patient or caregiver a copy of the discharge instructions that includes the plan of care, specific signs and symptoms that warrant follow up with clinician, when to seek emergency care, how to contact the primary care physician, and a 24/7 phone number for advice about questions and concerns along with date and time of the follow-up appointment.

**In Practice**

A hospital in Washington State provides read-only electronic medical record (EMR) access for the outpatient providers such as PCP, skilled nursing facilities and home health agencies in the area. This expedites the receipt of necessary information by the PCPs and post-acute providers in time for the patients’ follow-up appointments.

**10. Follow-up Phone Call**

After the patient is discharged from the hospital and prior to seeing the outpatient provider for post-discharge care, it is important to communicate with the patient or caregiver via a phone call and/or visit to ensure that they are able to follow their plan of care. This is recommended for all patients but especially encouraged for high and moderate readmission risk patients. If the patient has been discharged home without any in-home services assistance, this follow-up phone call also serves as an opportunity to re-evaluate if a referral to an in-home service agency or other community resource might be beneficial. To avoid redundant calls or failure to call at all, communities should discuss and agree on who is accountable to make the follow up call.

**Process**

- Use the triage grid risk level to do follow-up call (see Triage Grid – Tool 1.1).
- Prior to discharge, ask the patient or their caregiver about the best time to call and best number to call. Include this information on the plan of care and discharge summary.
- During the follow-up call, it is recommended that the following items be discussed with the patient/caregiver:
  - Confirm that the transportation arrangements are made and the patient or their caregiver is aware of the date, time and provider they will see at the follow-up appointment.
o Offer assistance if the patient needs to change the appointment time or problem-solve through transportation options.

o Encourage the patient to arrive at the appointment on time, and to bring their medication in a bag or small box and a list of any questions they have for the primary care provider to the appointment.

o Offer the patient or caregiver an opportunity to ask any question they may have regarding the medication.

- Develop a process to transfer the calls to the appropriate provider if a patient or caregiver has specific questions. (e.g. medication-related questions should be redirected to a pharmacist),

Tools 10.1 and 10.2 include scripts that can be used by clinical and non-clinical staff when making the follow-up call.

**In Practice**

A hospital in Washington State has mechanisms and processes set up to make automated interactive follow up phone calls using a vendor. The patient’s staff nurse educates the patient/caregiver prior to discharge to expect this phone call within 48 hours of discharge. They provide the patient with verbal as well as written instruction explaining the call and its purpose. The automated call starts with a personal greeting from the Chief Nursing Officer with a brief introduction that the call is regarding the patient’s recovery and that a short series of questions will be asked. The prompts are user friendly using simple verbiage. If a clinical or satisfaction concern is identified, a designated hospital clinician is alerted to call the patient back to provide additional assistance. This is found to be well received by patients/caregivers.

**In Practice**

When high and moderate readmission risk patients are discharged from the hospital, case managers from a hospital in Washington State make verbal handoff calls to the case managers at the outpatient clinics. This ensures the outpatient provider is aware that the patient is discharged from the hospital, knows the follow-up appointment date/time and when to make the follow-up calls. It also provides an opportunity for a detailed discussion between the hospital and clinic case managers regarding the care plan and follow-up considerations.

### 11. Follow-up Appointment - Primary Care Visit

The post-hospital follow-up visit addresses clinical condition(s) that resulted in hospitalization to support and coach the patient and their caregiver regarding the condition. The PCP will perform medication reconciliation, discuss warning signs, when to call, diet, daily activities, and a list of things to follow and things to avoid. It is also an opportunity to discuss end of life planning, assess social barriers, reinforce...
and adjust the plan of care as necessary and also to perform medication reconciliation and medication management.

**Process**
- Allow sufficient appointment time for a thorough examination and to address post-discharge follow-up items.
- Utilize Teach Back and health literacy concepts; engage patients in goal setting and shared decision making.
- Provide opportunities for the patient/caregiver to ask questions. Use open-ended questions to create interactive discussions.
- Set up the appointments in a structured format so that the visit will cover all the important discussions.
- Utilize a checklist to ensure that all needed follow-up conversations and services occur (Tool 11).

**In Practice**
A hospital in Washington State includes “**Issues to be discussed at the follow-up appointment**” in their standard discharge summary. This usually includes repeat examinations or investigations, test results to follow up and medication adjustments. Outpatient providers find this particularly helpful as they can plan ahead prior to patient’s follow-up appointment.

**12. Feedback to Hospital for Improvement**

In the interest of continuous learning and improvement, PCPs and other pre- and post-acute care providers are encouraged to provide feedback to the hospitals regarding issues with the transition. This feedback will improve the process for future patients and could be discussed in the community forum (see **Section 13 Community Forum**). A sample feedback form is also included in the Tools section (Tool 12).

**Process**
- Pre- and post-acute care providers, patients and their families should provide feedback to the hospitals using a form such as the sample (Tool 12), at a community forum, using patient and family resource phone number or provider feedback phone number.
- The community comprised of leadership from the hospitals, pre- and post-acute care providers, patients and their families should review the feedback together in their forum and establish process to improve transitions.
In Practice

A clinic in Washington State tracks and follows up with high and moderate readmission risk patients who did not come for their follow-up appointment. The information gathered from the patient is provided to the hospital staff so the hospital staff is able to identify missed opportunities and improve the process as needed.

13. Community Forum

As hospitals work to standardize their internal processes for improving care transition-related work, they also begin to focus on improving cross-continuum care transition practices. A community forum is a meeting of stakeholders in the continuum of care to focus on ways to enhance care transitions in that community. These may be led by hospitals but are often more effective if the leadership is across the continuum and facilitated by neutral parties. The community forum should include patients, physicians, hospital staff, clinical and operational staff from skilled nursing facilities, home health, mental health, palliative care/hospice programs, home care providers, acute and sub-acute care providers, representatives from community agencies, patient and family representatives and payors. The community forum should meet at least quarterly to identify gaps and propose potential solutions with a goal of improving care transitions. Using the discussions to uncover and understand the challenges and barriers each area is experiencing will create opportunities to review and negotiate how the community as a whole can implement reliable and sustainable system change processes and practices that work for all patients for better population health.

Process

- Review data on the population health status in the community, readmission rates, services provided by the hospitals and clinics in the area and relationships between care settings to understand the issues.
- Align and collaborate with existing community groups and initiatives to avoid duplication of efforts.
- Identify the key players including engaged and committed leaders who are able to get buy-in from the community.
- Identify the motivating issues and make the urgency clear, concise and visible.
- Develop charters, memorandums of agreement and understanding.
- Set clear goals and create common value.
- Start with small and specific focused processes.
- Be mindful of distractions and shifting priorities.
- Monitor the improvement with data and adjust the process improvement implementation as needed.
- Share learnings through the Washington State Hospital Association Safe Tables.

Colorado Foundation for Medical Care (CFMC)’s Community Care Transitions Toolkit provides additional information, resources and tools needed to start your own community care transitions initiative.
### Tool 1.1: Triage Grid: Follow-up and Interventions Based on Patients' Readmission Risk

<table>
<thead>
<tr>
<th>Risk Categories</th>
<th>High</th>
<th>Moderate</th>
<th>Low</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admitted 2 or more times in the past year</td>
<td>• Admitted once in the past year</td>
<td>• No other admission in the past year</td>
<td></td>
</tr>
<tr>
<td>Unable to Teach Back</td>
<td>Moderate likelihood to follow treatment plan</td>
<td>Able to Teach Back</td>
<td></td>
</tr>
<tr>
<td>Low likelihood to follow treatment plan</td>
<td>Moderate likelihood patient readmitted within 30 days</td>
<td>Low likelihood patient readmitted within 30 days</td>
<td></td>
</tr>
<tr>
<td>High likelihood patient readmitted within 30 days</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Appointment Needed w/in</th>
<th>48 hours</th>
<th>5 – 7 days</th>
<th>As Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handoff</td>
<td>Doctor to Doctor</td>
<td>Hospital to PCP team</td>
<td>Hospital to PCP team</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DC Summary</th>
<th>Phone AND Fax</th>
<th>EHR or Fax</th>
<th>EHR or Fax</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Interventions Prior to discharge</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Schedule a face-to-face follow-up visit within 48 hours of discharge. Care teams should assess whether an office visit or Home Health care is the best option for the patient.</td>
<td>• Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit within 5-7 days.</td>
<td>• Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit.</td>
<td></td>
</tr>
<tr>
<td>If a Home Health care visit is scheduled in the first 48 hours, an office visit might be slightly later but must also be scheduled within 5 days.</td>
<td>• Initiate in-home services (home health, palliative/ hospice care or home care) or transitional care services as needed.</td>
<td>• Provide 24/7 phone number for advice about questions and concerns.</td>
<td></td>
</tr>
<tr>
<td>• Initiate supportive care management programs as indicated (if not provided in primary care or in outpatient specialty clinics (e.g. heart failure, stroke clinics)</td>
<td>• Provide 24/7 phone number for advice about questions and concerns.</td>
<td>• Initiate a referral to social services and community resources as needed.</td>
<td></td>
</tr>
<tr>
<td>• Provide 24/7 phone number for advice about questions and concerns.</td>
<td>• Initiate a referral to social services and community resources as needed.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Initiate a referral to social services and community resources as needed.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

This Triage Grid above was adapted by local physicians and hospitals with evidence from the Institute for Healthcare Improvement (IHI) toolkit.

# Tool 1.2: The 8Ps: Assessing Your Patients Risk for Adverse Events after Discharge

## The 8Ps:
Assessing Your Patient’s Risk For Adverse Events After Discharge

<table>
<thead>
<tr>
<th>Risk Assessment: 8P Screening Tool (Check off what apply.)</th>
<th>Risk Specific Intervention</th>
<th>Signature of individual responsible for insuring intervention administered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Problem medications</strong> (cardiovascular, insulin, oral hypoglycemic agents, aspirin &amp; clopidogrel dual therapy, digoxin, narcotics)</td>
<td>□ Medication specific education using Teach Back provided to patient and caregiver</td>
<td>□ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin)</td>
</tr>
<tr>
<td>□ Specific strategies for managing adverse drug events reviewed with patient/caregiver</td>
<td>□ Follow-up phone call at 72 hours to assess adherence and complications</td>
<td></td>
</tr>
</tbody>
</table>

| Psychological depression screen positive or low depressive diagnosis | □ Assessment of need for psychiatric aftercare if not in place | □ Communication with aftercare providers, highlighting this issue if new |
| □ Involvement/awareness of support network insured |

| Principal diagnosis (cancer, stroke, IBD, COPD, heart failure) | □ Review of national discharge guidelines, where available | □ Disease specific education using Teach Back with patient/caregiver |
| □ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms | □ Discuss goals of care and chronic illness model discussed with patient/caregiver |

| Polypharmacy (≥5 more active meds) | □ Elimination of unnecessary medications | □ Simplification of medication scheduling to improve adherence |
| □ Follow-up phone call at 72 hours to assess adherence and complications |

| Poor health literacy (inability to do Teach Back) | □ Committed caregiver involved in planning/administration of all general and risk specific interventions | □ Aftercare plan education using Teach Back provided to patient and caregiver |
| □ Link to community resources for additional patient/caregiver support | □ Follow-up phone call at 72 hours to assess adherence and complications |

| Patient support (absence of caregiver to assist with discharge and home care) | □ Follow-up phone call at 72 hours to assess condition, adherence and complications | □ Follow-up appointment with aftercare medical provider within 7 days |
| □ Involvement of home care providers of services with clear communications of discharge plan to those providers |

| Prior hospitalization (readmitted in last 6 months) | □ Review reasons for re-hospitalization in context of prior hospitalization | □ Follow-up phone call at 72 hours to assess condition, adherence and complications |
| □ Follow-up appointment with aftercare medical provider within 7 days |

| Palliative care | □ Patient not expected to live more than 6 months. | □ Patient not expected to live more than 6 months. |
| □ Identify goals of care and therapeutic options | □ Communicate prognosis with patient/family/caregiver |
| □ Assess and address bothersome symptoms | □ Identify services or benefits available to patients based on advanced disease status |
| □ Discuss with patient/family/caregiver role of palliative care services and benefits and services available |
Tool 1.3.a: LACE Readmission Risk Assessment Tool

Step 1. Length of Stay
Length of stay (including day of admission and discharge): __________ days

<table>
<thead>
<tr>
<th>Length of stay (days)</th>
<th>Score (circle as appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>4-6</td>
<td>4</td>
</tr>
<tr>
<td>7-13</td>
<td>5</td>
</tr>
<tr>
<td>14 or more</td>
<td>7</td>
</tr>
</tbody>
</table>

Step 2. Acuity of Admission
Was the patient admitted to hospital via the emergency department?
If yes, enter “3” in Box A, otherwise enter “0” in Box A

Step 3. Comorbidities

<table>
<thead>
<tr>
<th>Condition (definitions and notes on reverse)</th>
<th>Score (circle as appropriate)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous myocardial infarction</td>
<td>+1</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>+1</td>
</tr>
<tr>
<td>Peripheral vascular disease</td>
<td>+1</td>
</tr>
<tr>
<td>Diabetes without complications</td>
<td>+1</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>+2</td>
</tr>
<tr>
<td>Diabetes with end organ damage</td>
<td>+2</td>
</tr>
<tr>
<td>Chronic pulmonary disease</td>
<td>+2</td>
</tr>
<tr>
<td>Mild liver disease</td>
<td>+2</td>
</tr>
<tr>
<td>Any tumor (including lymphoma or leukemia)</td>
<td>+2</td>
</tr>
<tr>
<td>Dementia</td>
<td>+3</td>
</tr>
<tr>
<td>Connective tissue disease</td>
<td>+3</td>
</tr>
<tr>
<td>AIDS</td>
<td>+4</td>
</tr>
<tr>
<td>Moderate or severe liver disease</td>
<td>+4</td>
</tr>
<tr>
<td>Metastatic solid tumor</td>
<td>+6</td>
</tr>
</tbody>
</table>

If the TOTAL score is between 0 and 3 enter the score into Box C. If the score is 4 or higher, enter 5 into Box C

Step 4. Emergency department visits
How many times has the patient visited an emergency department in the six months prior to admission (not including the emergency department visit immediately preceding the current admission)? __________
Enter this number or 4 (whichever is smaller) in Box E

Add numbers in Box L, Box A, Box C, and Box E to generate LACE score and enter into box below. If the patient has a LACE score greater than or equal to 10 the patient can be referred to the virtual ward

If you have questions about the use of this tool, please contact Dr. Irfan Dhalla at dhallai@smh.toronto.on.ca or by pager through St. Michael’s Hospital locating (416-864-5431)
<table>
<thead>
<tr>
<th>Condition</th>
<th>Definition and/or notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Previous myocardial infarction</td>
<td>Any previous definite or probable myocardial infarction</td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>Any previous stroke or transient ischemic attack (TIA)</td>
</tr>
<tr>
<td>Peripheral vascular disease</td>
<td>Intermittent claudication, previous surgery or stenting, gangrene or acute ischemia, untreated abdominal or thoracic aortic aneurysm</td>
</tr>
<tr>
<td>Diabetes without microvascular complications</td>
<td>No retinopathy, nephropathy or neuropathy</td>
</tr>
<tr>
<td>Congestive heart failure</td>
<td>Any patient with symptomatic CHF whose symptoms have responded to appropriate medications</td>
</tr>
<tr>
<td>Diabetes with end organ damage</td>
<td>Diabetes with retinopathy, nephropathy or neuropathy</td>
</tr>
<tr>
<td>Chronic pulmonary disease</td>
<td>??</td>
</tr>
<tr>
<td>Mild liver disease</td>
<td>Cirrhosis but no portal hypertension (i.e., no varices, no ascites) OR chronic hepatitis</td>
</tr>
<tr>
<td>Any tumor (including lymphoma or leukemia)</td>
<td>Solid tumors must have been treated within the last 5 years; includes chronic lymphocytic leukemia (CLL) and polycythemia vera (PV)</td>
</tr>
<tr>
<td>Dementia</td>
<td>Any cognitive deficit??</td>
</tr>
<tr>
<td>Connective tissue disease</td>
<td>Systemic lupus erythematosus (SLE), polymyositis, mixed connective tissue disease, moderate to severe rheumatoid arthritis, and polymyalgia rheumatica</td>
</tr>
<tr>
<td>AIDS</td>
<td>AIDS-defining opportunistic infection or CD4 &lt; 200</td>
</tr>
<tr>
<td>Moderate or severe liver disease</td>
<td>Cirrhosis with portal hypertension (e.g., ascites or variceal bleeding)</td>
</tr>
<tr>
<td>Metastatic solid tumor</td>
<td>Any metastatic tumour</td>
</tr>
</tbody>
</table>
Tool 1.4.a: MultiCare Health System Readmission Risk Assessment and Strategies

MultiCare Health System
Readmission Risk Tool
Intended to guide discharge processes and interventions
v2.0 2013

<table>
<thead>
<tr>
<th>Check the following that are true.</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 80 or older</td>
<td>1</td>
</tr>
<tr>
<td>No funding source</td>
<td>1</td>
</tr>
<tr>
<td>More than 4 Chronic Conditions</td>
<td>1</td>
</tr>
<tr>
<td>Active Behavioral / psychiatric health issue</td>
<td>1</td>
</tr>
<tr>
<td>Six or more prescribed medications</td>
<td>1</td>
</tr>
<tr>
<td>Two or more hospitalizations within the past 6 months</td>
<td>1</td>
</tr>
<tr>
<td>Readmitted within 30 days</td>
<td>1</td>
</tr>
<tr>
<td>Inadequate support system</td>
<td>1</td>
</tr>
<tr>
<td>Low health literacy</td>
<td>1</td>
</tr>
<tr>
<td>Documented history of non-adherence to the therapeutic regimen</td>
<td>1</td>
</tr>
<tr>
<td>Require assistance with ADL’s</td>
<td>1</td>
</tr>
<tr>
<td>Substance / ETOH abuse</td>
<td>1</td>
</tr>
<tr>
<td>CM / MSW / Physician determination</td>
<td>6</td>
</tr>
</tbody>
</table>

Take the sum of the points and enter the total

<table>
<thead>
<tr>
<th>Score</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>0 to 2</td>
</tr>
<tr>
<td>Medium</td>
<td>3 to 4</td>
</tr>
<tr>
<td>High</td>
<td>5 to 6</td>
</tr>
<tr>
<td>Intensive</td>
<td>above 6</td>
</tr>
</tbody>
</table>

If you have questions regarding this MHS Readmission Risk Assessment Tool please contact:
Stephanie Mudd
MultiCare Health System
Care Management
253-403-1794

*MHS Readmission Tool based from Mary Naylor’s transition care model

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### MultiCare Health System

**Care Management Department**

<table>
<thead>
<tr>
<th>Tool 1.4.b: MultiCare Health System Readmission Risk Assessment and Strategies (cont.)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Care Management Strategies for Risk of Readmissions</strong></td>
</tr>
</tbody>
</table>

#### Intensive Risk

1. Care Conference
2. Evaluate SNF vs HH
3. Referrals
   - Palliative
   - MSW
   - Pharmacy Med Rec
   - Community Referrals
   - HF Clinic, RCCP, COPD Focus, Pulmonary Clinic etc
4. Follow up appointment with PCP
5. Goal: Appointment within 2 days
5. CM Discharge Summary Completed

#### High Risk

1. Care Conference Recommended
2. Evaluate SNF vs HH
3. Referrals to consider
   - Palliative
   - MSW
4. Follow up appointment made with PCP
5. Goal: Appointment within 2 to 4 days
5. CM Discharge Summary Completed

#### Medium Risk

1. SNF vs HH
2. Community Referrals
   - HF Clinic, RCCP, COPD Focus, Pulmonary Clinic etc
3. Follow up appointment made by patient unless cognitively impaired
   - Goal: Appointment within 5-7 days
4. CM Discharge Summary suggested

#### Low Risk

1. SNF vs HH
2. Community Referrals
   - HF Clinic, RCCP, COPD Focus, Pulmonary Clinic etc
3. PCP appointment made by patient
   - Goal: Appointment within 7 - 10 days
4. CM No Discharge Summary Required

---

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# Tool 1.5.a: Rockwood Health System Care Coordination Risk Assessment

**Patient Name**

**MR#**

**DIRECTIONS:** Complete this assessment at Start of Care, at Resumption and at Recertification

<table>
<thead>
<tr>
<th>Emergent Care</th>
<th>Points</th>
<th>Emergent Care</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>use during the previous 6 months</td>
<td>0</td>
<td>No emergent care use of a hospital ED</td>
<td></td>
</tr>
<tr>
<td>(Related to the primary or co-morbidity diagnosis for home health services)</td>
<td>1</td>
<td>1-2 emergent visits to a hospital ED</td>
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<tr>
<td></td>
<td>2</td>
<td>3-4 emergent visits to a hospital ED</td>
<td></td>
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<tr>
<td></td>
<td>3</td>
<td>5 or more emergent visits to a hospital ED</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hospitalizations</th>
<th>Points</th>
<th>Hospitalization</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>within the past 6 months</td>
<td>0</td>
<td>No hospitalizations</td>
<td></td>
</tr>
<tr>
<td>(Related to the primary or co-morbidity diagnosis for home health services)</td>
<td>1</td>
<td>1-2 hospitalizations</td>
<td></td>
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<tr>
<td></td>
<td>2</td>
<td>3-4 hospitalizations</td>
<td></td>
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<tr>
<td></td>
<td>3</td>
<td>5 or more hospitalizations</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>High Risk Diagnosis</th>
<th>Points</th>
<th>High Risk Diagnosis</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary / secondary Diagnosis</td>
<td>1 point for each</td>
<td>• CAD/AMI</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• CHF</td>
<td></td>
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<tr>
<td></td>
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<td>• COPD</td>
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<td></td>
<td></td>
<td>• DM</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pneumonia</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Co-Morbidity Diagnosis</th>
<th>Points</th>
<th>Co-Morbidity Dx</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No co-morbidities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1-2 co-morbidities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>3-4 co-morbidities</td>
<td></td>
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<tr>
<td>3</td>
<td>5 or more co-morbidities</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Severity of Illness-Impact on ADL</th>
<th>Points</th>
<th>Co-Morbidity Dx</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Asymptomatic: No limitations on activities of daily living</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Minimal Severity: Symptoms present but little limitations on activities of daily living</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Mild Severity: Symptoms present daily and cause limitations on activities of daily living</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>High Severity: Symptoms present most of the day and cause a significant impact on activities of daily living</td>
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</tbody>
</table>
### Tool 1.5.b: Rockwood Health System Care Coordination Risk Assessment (cont.)

<table>
<thead>
<tr>
<th>Risk Characteristics</th>
<th>Points</th>
<th>Risk Characteristics</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specific to the patient’s mental and physical status, home environment, social support, lifestyle and use of the health care system</td>
<td>1 point for each characteristic</td>
<td>• Lives alone (MO340)</td>
<td></td>
</tr>
<tr>
<td>CHECK ALL THAT APPLY</td>
<td>Maximum = 13</td>
<td>• No primary caregiver identified (MO360)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Home environment not conducive to home health</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Discharge from an acute care hospital (MO175)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Patient demonstrates confusion (3 or above on MO570)</td>
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<td></td>
<td></td>
<td>• Severe anxiety level (2 or above on MO580)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Surgical wounds (MO440, MO476, MO484)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Stage 3-4 pressure ulcer (MO440, MO476)</td>
<td></td>
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<td></td>
<td></td>
<td>• Urinary catheter (MO520)</td>
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<tr>
<td></td>
<td></td>
<td>• Treatment regime complex for patient’s ability to manage</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Takes more than 8 medications (prescribed and OTC)</td>
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<td></td>
<td>• 3 or more physicians ordering medications or treatments</td>
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<tr>
<td></td>
<td></td>
<td>• History of inconsistent follow-up with medical provider</td>
<td></td>
</tr>
</tbody>
</table>

### TOTAL SCORE

**High Risk: Score: >11**
- *Enrolled in care coordination*
  - **Phone Calls**
    1. Post discharge call within 12-24 hrs. following discharge
    2. Following provider visit
    3. 2-3 times per week as needed for 30 days
  - **Provider Follow up**
    1. Post discharge office visit within 24-48 hrs. following discharge
    2. Additional follow up visits every 1-2 weeks as needed per provider discretion
    3. Re-assess after 30 days

**Moderate Risk: Score: 8-10**
- *Enrolled in care coordination if needed*
  - **Phone Calls**
    1. Post discharge call within 18hrs following discharge
    2. Following provider visit
    3. 1-2 times per week as needed
  - **Provider Follow up**
    1. Post discharge office visit within 5 days following discharge
    2. Additional follow up visits as needed per provider discretion
    3. Re-assess after 30 days

**Low Risk: Score: 0-7**
- *Enrollment in care coordination and reassessment per clinician discretion*
  - **Phone Calls**
    1. Post discharge call within 7 days following discharge
    2. Follow up calls as needed
  - **Provider Follow up**
    1. Post discharge visit as needed per provider discretion
Tool 2: Primary Care Provider Notification

Patient Information
Patient Name: ___________________ Date of Birth: ___/___/___ Gender: Male/Female

Admission Information
Visit/Admission Date: ___/___/___
Admit reason/Anticipated diagnosis/Admit diagnosis: __________________
Attending Name and Number: __________________________ Location: ______________________
Additional Contact Name and Number: ___________________________

“If you are not this patient's Primary Care Provider or you believe you have received this notice in error, please call/fax to (xxxx) xxx xxxx.”

Tool 3: Plan of Care

Name: ___________________________________________________________________________
Date of Birth: _____________________________________________________________________
Address: _________________________________________________________________________

Code Status: _______________________________________________________________________
Language: _________________________________________________________________________
Interpreter required: Yes/No

Primary Care Provider: _______________________________________________________________
Other Providers Involved in Care:  ______________________________________________________

Hospitalizations in last 12 months: _______________________ ER Visits in last 6 months: _________

Diagnoses: _________________________________________________________________________
Allergies: _________________________________________________________________________
Medications: _______________________________________________________________________
Significant Medical Problems and Clinical History: _________________________________________
___________________________________________________________________________________

Social History: ______________________________________________________________________
Barriers to Self-Care: __________________________________________________________________

Living situation: _____________________________________________________________________
Lives with: _________________________________________________________________________
Housing situation concerns – Yes/No
Have dependable transportation – Yes /No
Have someone who can help – Yes/ No

Safety/Risk Assessment: __________________________________________________________________
Mental health status including cognitive function: __________________________________________
Cultural needs, preferences or limitations: _____________________________________________
Caregiver and/or support system: ____________________________________________________

Plan of Care
- Problems:
- Barriers:
- Short and Long Term Goals with Target Dates:
- Interventions Planned:
- Progress toward Goal:
- Goal Achieved Date:

### Tool 4: My Medication List

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Comment Continued/Altered/Now/Discontinued</th>
<th>Reason for Taking Medication</th>
</tr>
</thead>
<tbody>
<tr>
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### Tool 5: Social/Resource Barriers Assessment

- Number of Admissions: __________________________________________________________
- Advance Care Plan: _____________________________________________________________
- Current Living Situation: _____________________________________________________
- Recent Mental Health Services: ________________________________________________
- Recent Housing: ________________________________________________________________
- Current Employment: __________________________________________________________
- Source of Income: _____________________________________________________________
- Social Background: __________________________________________________________
- Education: __________________________________________________________________
- Substance Abuse Brief Assessment: _____________________________________________
- Patient’s Functional Limitations: ______________________________________________
- Assessment of Social Functioning: _____________________________________________
- Anticipated Social Work Needs/Interventions: __________________________________________________________________________
- Potential Discharge Issues; preliminary discharge plan: _____________________________________________________________________
- Patient’s biggest concerns post-discharge: _____________________________________________________________________________
Tool 6: Harrison Medical Center Teach Back Education Tool

Teach-back should be used with ALL patients to ensure that they understand information, changes, and instructions.

Teach back is not just repeating back or saying “Yes, I understand”.

Teach-back Questions to ask your patient:

- How would you explain that to... (your wife, your children)?
- Tell me what you know about... (your diabetes, asthma)?
- How would you know... (when to call the doctor, if you had an infection)?
- Show me how you would... (take this insulin, use your inhaler)?
- What would you do if... (you are on insulin but you get sick, have chest pain)?
- Who would you call if... (you have a temp over 102, your arm swells)?
- What are 2 side effects of your medication?

Teach Back Tips:

- Do not ask “Do you understand?”
- Ask your patients to repeat in their own words what they need to do when they leave the hospital/the doctor’s office.
- Let the patient know that you will be asking them questions after you review the information with them (they will pay more attention). Use phrase like: “I want to be sure that I did a good job explaining”
Tool 7: Physician Orders for Life-Sustaining Treatment (POLST)

Available for download at https://www.wsma.org/POLST#download

Tool 8: Scheduling Follow-up Appointments

Discharged On: (Date) with (Diagnosis)

Appointments made: ☐ Yes ☐ No

If no, why not? _____________________________________________

Has transportation ☐ Yes ☐ No

If no, document intervention __________________________________

Any barriers to completing appointments? ☐ Yes ☐ No

If yes, what are barriers?

Interventions to address those barriers ___________________________

Follow up with ***. Appointment with (Provider) on: (Date) at: (Time) been scheduled. Transportation plan discussed.
Tool 9: Discharge Summary

Patient Name: ___________________ DOB: ________________________________

Admission Date: _________________________________________________________

Discharge Date: _________________________________________________________

Admitting Diagnoses: ______________________________________________________

Discharge Diagnoses: ______________________________________________________

Attending Physician: Name/Contact: _______________________________________

Primary Care Physician: ___________________________________________________

Referring Physician: _______________________________________________________ 

Consulting Physician(s): ___________________________________________________

Condition on Discharge: ___________________________________________________

Allergies: __________________________________________________________________

Code status: ___________________________________________________________________

Readmission Risk: ___________________________________________________________

History of MDRO or C. diff: Yes/ No. If yes, list. ________________________________

Reason for Admission: _____________________________________________________

Final diagnostics: (list primary diagnosis first) __________________________________

Disposition: (Home, home w/HH/hospice, SNF, Transfer to another facility) ______

Procedures During Hospitalization: (list dates, complication) ___________________

Pertinent Laboratory/Data: ___________________________________________________

Discharge Instructions: (diet, activity, restrictions) ______________________________

Follow-up Appointments: PCP and specialists ___________________________________

Issues to be Addressed at Follow Up: (pending labs, unresolved problems, follow up needed):

_____________________________________________________________________________

Hospital Course: ____________________________________________________________

Discharge Reconciled Medication List: __________________________________________

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Dose</th>
<th>Frequency</th>
<th>Comment (Continued/Altered/New/Discontinued)</th>
<th>Reason for Taking Medication</th>
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Tool 10.1: Follow-up Call by Clinical Staff

Hello Mr. /Ms. _____________ I am (caller’s name), a (title) from (name of facility). I am calling to see how you are doing after your discharge and if there is anything I can do to help you. We will also review your medications during this call. Can you bring all of your medications including non-prescription medicines and herbal supplements to the telephone, please?

HEALTH STATUS:
1. Before you left the hospital, your main medical problem during your hospital stay was explained to you. Can you explain to me your main problem or diagnosis?
   a. **Yes** – Confirm the patient’s knowledge of the discharge diagnosis.
   b. **No** – Use this opportunity to provide patient education about the discharge diagnosis.
2. Do you have any questions for me about your diagnosis?
   a. **Yes** – Explain again.
   b. **No** – Continue.
3. Since you left the hospital, do you feel your main problem has improved, worsened or not changed? What does your family or caregiver think?
   a. **Worsened** – Refer to an appropriate provider.
   b. **Improved/No change** – Continue.
4. Have you experienced any new medical problems since you left the hospital?
   a. **Yes** – Ask what has happened?
   b. **No** – Continue.

WARNING SIGNS:
- **What did the medical care team tell you to watch out for to make sure you are okay?** Review specific symptoms to watch out for and things to do for this diagnosis e.g. weigh self, blood sugar, blood pressure, peak flow chart, etc.
- **Do you have any questions about what to do if a problem arises?**

FOLLOW-UP:
1. Can you please tell me what appointments are scheduled? Who is it with? If it is a lab/test, what is it for? When is it? Are you going to be able to make it to your appointment?
   a. **Yes** – Continue.
   b. **No** – Help with the issues or get appointment rescheduled.

   **Note:** If there is no appointment scheduled already, set up an appointment based on the discharging provider’s request and according to the triage grid.
2. Please remember to bring **all** your medications, including non-prescription medicines and herbal supplements, with you to your visit.

MEDICATIONS:
- **What questions do you, your family, or caregiver have regarding your medications?**

EDUCATION PROVIDED:
- **Do you have any other questions for me?**

ADDITIONAL ACTIONS TAKEN:

Adapted from Project RED
Tool 10.2: Follow-up Call by Non-Clinical Staff

Hello Mr./Ms. _____________ I am (caller’s name), a (title) from (name of facility). I am calling to see how you are doing after your discharge and if there is anything I can do to help you.

FOLLOW-UP:
1. Can you please tell me what appointments are scheduled? Who is it with? If it is a lab/test, what is it for? When is it? Are you going to be able to make it to your appointment?
   a. Yes – Continue.
   b. No – Help with the issues or get appointment rescheduled.

Note: If there is no appointment scheduled already, set up an appointment based on the discharging provider’s request and according to the triage grid.

2. Please remember to bring all your medications, including non-prescription medicines and herbal supplements, with you to your visit.

WARNING SIGNS:
- What did the medical team tell you to watch out for to make sure you are okay?
- Do you have any questions about what to do if a problem arises?
  a. Yes – Continue.
  b. No/Have questions – Refer to a clinician.

HEALTH CARE STATUS:
- Before you left the hospital, someone spoke to you about your main problem during your hospital stay. Can you explain to me your main problem or diagnosis?
  a. Yes – Continue.
  b. No – Refer to a clinician.
- Since you left the hospital, do you feel your main problem has improved, worsened or not changed? What does your family or caregiver think?
  a. Worsened – Refer to a clinician.
  b. Improved/No change – Continue.
- Have any new medical problems occurred since you left the hospital?
  a. Yes – What has happened? Refer to a clinician.
  b. No – Continue.

MEDICATIONS:
- What questions do you/your family or caregiver have regarding your medications?
  (Refer to a clinician if there are questions)

EDUCATION PROVIDED:
- Do you have any other questions that I can forward to the clinical team?

ADDITIONAL ACTIONS TAKEN:

Adapted from Project RED
Plan of Care and Medication Reconciliation

☐ Ask the patient to explain:
  ✔ Goals for the visit
  ✔ What factors contributed to hospital admission or ED visit
  ✔ Medications patient is taking and schedule.

☐ Perform medication reconciliation with attention to the pre-hospital regimen. Define the need to:
  ✔ Adjust medications or dosages
  ✔ Follow up on test results
  ✔ Monitor or test
  ✔ Discuss end-of-life planning
  ✔ Discuss patient preferences for specific future treatment and advance care planning. The Physician Orders for Life-Sustaining Treatment (POLST) form may be used as a tool.

☐ Instruct patient in self-management; ask the patient to repeat back.
☐ Explain warning signs and steps to take; ask the patient to repeat back.
☐ Provide instructions for seeking emergency and non-emergency after-hours care.

☐ At the End of the Visit:
  ✔ Print reconciled dates, medication list and provide a copy to the patient, family caregiver, home health, palliative/hospice or home care nurse and case manager, if appropriate.

Communicate any revisions of the care plan to family caregivers, home health, palliative/hospice or home care nurse and case manager, if appropriate.

Adapted from: Coleman, Eric, MD. The Post-Hospital Follow-Up Visit: A Physician Checklist to Reduce Readmissions
Tool 12: Primary Care Provider Feedback to Hospital

Date: _______________________________________________________________________________
Primary Care Provider: _________________________________________________________________
Contact Information ___________________________________________________________________

Patient Name: ________________________________________________________________________
Admission Date: __________________________________________________________________________
Discharge Date: _________________________________________________________________________

Patient had a post-discharge appointment on: ________________________________________________

Did patient keep the scheduled appointment? Yes/No
If no, describe
• Patient was unaware of the appointment date and time
• Patient was unclear of the reason why they need the follow-up appointment
• Patient has no transportation to go to the appointment
• Appointment date and time is inconvenient for the caregiver to accompany the patient

Did the patient remember the two most important elements for self-care? Yes / No
If no, describe: _______________________________________________________________________

Were medications being taken as prescribed?  Yes / No
If no, describe: _______________________________________________________________________

What if there needs to be a medication change? _____________________________________________

Suggestions that would be helpful for the hospital to know when caring for future patients: ________

Please contact primary care at (xxx) xxx-xxxx if you have questions.
REFERENCES


2. Data provided by Qualis Health, derived from Medicare Part A data under the 10th Statement of Work Quality Improvement Organization (QIO) contract for Washington State.


17. Adrian F. Hernandez; Melissa A. Greiner; Gregg C. Fonarow; et al. Relationship between Early Physician Follow-up and 30-day Readmission Among Medicare Beneficiaries Hospitalized for Heart Failure. JAMA. 2010;303(17):1716-1722 http://www.aahfn.org/2010annualmeeting/pdf/annualMeetingResource/Marie_Jama_article.pdf.


23. IHI – STAAR Initiative http://www.ihi.org/offerings/Initiatives/STAAR/Pages/Improvement.aspx