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ASHNHA ALASKA STATE **HOSPITAL & NURSING HOME** ASSOCIATION

Washington State Hospital Association

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, please go to
http://www.wsha.org/quality-safety/projects/readmissions/

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OVERVIEW

WSHA Readmissions Origin and Timeline

WSHA has embraced the work of Dartmouth, which states that readmissions are a measurement of health care fragmentation. Based on this concept, we have set up community forums to implement the WSHA toolkit and to look at ways to integrate care. 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 our region, similar gaps exist at the intersections of care regardless of the type of providers. Together, providers in Washington, Alaska, and parts of Oregon are working to design effective processes for transitions.

Washington State Care Transitions Improvement Initiative began in 2005 as a regional 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 the 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 local 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.

In 2011, the Washington State Legislature established the Dr. Robert Bree Collaborative so that public and private health care stakeholders would have the opportunity to identify specific ways to improve health care quality, outcomes, and affordability in Washington State. These stakeholders are appointed by the Governor as Collaborative members and represent public health care purchasers for Washington State, private health care purchasers (employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations.

From May 2012 to March 2013, the Bree Collaborative convened a workgroup to address potentially preventable hospital readmissions. This body reconvened with new membership from April to June 2014. The Washington State Hospital Association participated as a member of this workgroup. In November of 2013, a report titled "30-day, All-cause Rehospitalization Rates at Washington Hospitals from 2011 CHARS Data" was published and in July of 2014, a follow-up report was published titled "Potentially Avoidable Hospital Readmissions Report and Recommendations."

Together, these working collaborations provide a powerful foundation for reducing potentially preventable readmissions throughout the Northwest region.

WSHA Readmissions Program Strategies

The Washington State Hospital Association has seen 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, WSHA has focused on 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.

In February of 2016, our Steering Committee met to identify the areas of focus for 2017 that would result in the greatest value through collaboration and synergy. Strategies central to our work moving forward will include:

1. **Advancing equity by identifying and mitigating disparities in care. Disparities within readmissions will be identified based on race, ethnicity, age, and language (or REAL) data.**

2. **Highlighting system-level innovations, including continued education and the dissemination of tools designed to decrease fragmentation and improve care coordination around transitions of care. As well as maintaining support for utilization of the Warm Handover Tool as a means to standardize transitions of care and discharge planning.**

3. **Highlighting individual interventions for high utilizers of care, including the coordination of social support services, medication reconciliation, provider communication, case management, and clinical care planning.**

4. **Aligning with Honoring Choices Pacific Northwest and other organizations that seek to honor patients' wishes in end-of-life care through culture change that includes normalizing advance care planning conversations, documentation, and review of values and goals of care, as well as supporting initiatives to increase identification of health care proxies for individuals who may be unable to communicate in the future.**

5. **Supporting education around sepsis diagnosis, treatment, and innovative care within readmissions.**

All of these areas will develop in alignment with and include Person and Family Engagement.

From 2011 through 2015 our region has achieved a 27.9% reduction in readmissions per 1,000 eligible Medicare beneficiaries – resulting in 23,459 fewer patients being readmitted, saving $223.8 million. Transforming the culture of patient care by erasing the borders between conventional hospital care to patient-centered care in the community has enhanced this work. Engaging health care providers, organizations, and stakeholders in collaborative initiatives is an important element in sustaining this work. Partnering with national leaders such as the Institute for Health Care Improvement and the Centers for Medicare and Medicare Services, we are building upon national best practices.

National Alignment with Best Practices

Our work is aligned with recommendations by the IHI, AHRQ, CMS, Support and Alignment Networks (SANs), and Practice Transformation Networks (PTNs) and our network is guided by Community Coalition Action Theory (CCAT) CCAT or Community Coalition. This is a type of Interorganizational Relationship approach used to build consensus and actively engage diverse organizations and constituencies in addressing community issues or problems. This approach allows our steering committee to know the community, establish positions and strategies, build and sustain networks, and mobilize constituencies. Our Regional Readmissions Steering Committee is comprised of the WA (DOH), Qualis Health (QIN-QIO), payors, providers, representatives from hospitals and skilled nursing facilities, home health, area centers on aging, and various other regional stakeholders to coordinate and advance reduction in potentially preventable readmissions.

Local Leadership

This work is being guided by the WSHA Regional 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.

Thank you to the many national and local organizations that contributed to this work.

Areas of Focus for Collaboration and Synergy

Innovations in Community Care – Advancing Equity

Advancing equity by identifying and mitigating disparities in care. Disparities within readmissions will be identified based on race, ethnicity, age, and language (or REAL) data.
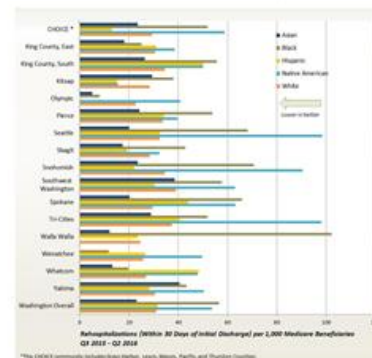

There are several excellent resources for identifying and mitigating disparate populations within readmissions. Primary resources should include the [Guide to Preventing Readmissions among Racially and Ethnically Diverse Medicare Beneficiaries](#) produced by the Disparities Solution Center for the Centers for Medicare & Medicaid Services (CMS) Office of Minority Health. This report can be found at https://www.cms.gov/About-CMS/Agency information/OMH/Downloads/OMH_Readmissions_Guide.pdf

Another set of resources include the [Qualis Health Community Performance Reports](#). These reports use Medicare Part A Fee for Service claims data to assess hospital readmission rates and healthcare utilization for Medicare beneficiaries residing in the defined community. These are intended to support efforts within each community to improve care transitions and reduce rehospitalizations. These community reports can be found at http://medicare.qualishealth.org/projects/care-transitions/news-and-progress/specific-communities/performance-reports

Additionally, the [Qualis Health report on Readmission Disparities](#) is an essential guide allowing each community to identify unique opportunities in addressing equity of care. This report can be found at http://medicare.qualishealth.org/sites/default/files/medicare.qualishealth.org/CommunityDisparities_WA.pdf

While the racial disparities may be due to numerous reasons, it should be remembered that there is at least one constant across all the patients included in these data: everyone has the same insurance coverage—Medicare. Numerous studies have shown that even when issues such as income are accounted for, racial disparities in healthcare are apparent nationwide. As of January 1st, 2017, our region's 30-day readmission rate of 31.3 per 1,000 Medicare beneficiaries is better than the national average (52.5 per 1,000).

Innovations in Organizational Care

Highlighting system-level innovations, including continued education and the dissemination of tools designed to decrease fragmentation and improve care coordination around transitions of care. As well as maintaining support for utilization of the Warm Handover Tool as a means to standardize transitions of care and discharge planning.
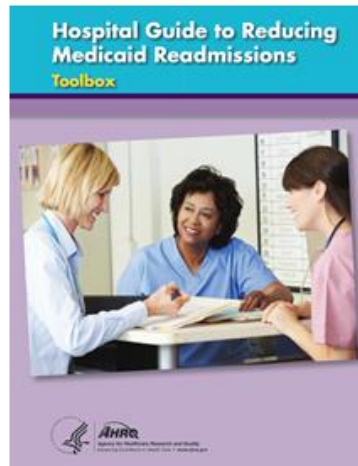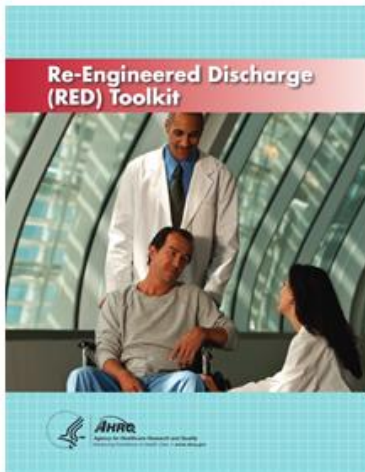
Additional resources exist for decreasing fragmentation and improving care coordination around transitions of care at and between organizations of care delivery. Primary resources should include the Agency for Healthcare Research and Quality (AHRQ) Re-Engineered Discharge (RED) Toolkit. The RED Toolkit can be found at http://www.ahrq.gov/sites/default/files/publications/files/redtoolkit.pdf and a companion resource, the AHRQ Guide to Reducing Medicaid Readmissions Toolbox, can be found at http://www.ahrq.gov/sites/default/files/publications/files/medread-tools.pdf

While a newer version is available for purchase, The Society of Hospital Medicine offers a free project BOOST (Better Outcomes for Older Adults through Safe Transitions) Toolkit, which is found at http://tools.hospitalmedicine.org/Implementation/Workbook_for_Improvement.pdf

The Institute for Healthcare Improvement (IHI) offers tips on Process Improvement and SMART Discharge Protocols.

Look for these resources at:
http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx
http://www.ihi.org/resources/Pages/Tools/SMARTDischargeProtocol.aspx
https://www.ncqualitycenter.org/wp-content/uploads/2013/01/staar-readmissions-diagnostic-tools.pdf

IHI also offers a structure for chart reviews and interview questions for readmitted patients to identify probable causes for readmissions. Utilization of standardized tools creates a framework in which innovations in organizational care can be built on best practices.

Innovations in Individual Care

Highlighting individual interventions for high utilizers of care, including the coordination of social support services, medication reconciliation, provider communication, case management, and clinical care planning.

The Robert Wood Johnson Foundation (RWJF) has partnered with several other organizations including the Camden Coalition of Healthcare providers (CCHP) in coordinating enhanced care for those who need it, as evidenced by their utilization of emergency and hospital services. This work is based on observations made by Dr. Jeffrey Brenner, MD, who pioneered a model for improving care while reducing costs for complex patients who are "super-utilizers" of the health care system. After using claims data to identify these patients, teams offered personalized care management. Please visit the Camden Website (https://www.camdenhealth.org/) for more information.

"In many regions across the country, robust 'super-utilizer' programs that provide intensive outpatient care management to high-need, high-cost patients are beginning to emerge. The term 'super-utilizer' describes individuals whose complex physical, behavioral, and social needs are not well met through the current fragmented health care system. As a result, these individuals often bounce from emergency department to emergency department, from inpatient admission to readmission or institutionalization — all costly, chaotic, and ineffective ways to provide care and improve patient outcomes." More information: Robert Wood Johnson page on super-utilizers (http://www.rwjf.org/en/library/collections/super-utilizers.html) and Improving Management of Health Care Super-utilizers (http://www.rwjf.org/en/library/articles-and-news/2014/02/improving-management-of-health-care-superutilizers.html)

A local organization engaged in this model of care is CHI Franciscan Health. Visit their website for information about Highline Health Connections (https://www.chifranciscan.org/Highline-Foundation/Current-Fundraising-Initiatives/Care-Navigation-for-Vulnerable-Populations).

Care planning is also an effective method for streamlining care and decreasing fragmentation of care, as well as a component of the RWJF and CCHP models. A care plan is a succinct yet detailed physician's note summarizing the medical, behavioral, social, and other issues that make this patient's care complex with evidence-based provider consensus and recommendations specific to those issues which may be driving unnecessary or inappropriate care. Samples of care plans are available from Swedish Medical Group and the University of Washington Medical Center.

Furthermore, Providence has developed a Transition of Care (TOC) Pharmacy program designed to facilitate safe, smooth and effective transitions from one setting of care to the next through high risk medication reconciliation services. The goals of this program are to (1) reduce readmissions, (2) reduce financial penalties to hospitals, (3) increase compliance with CMS and JACHO requirements, and (4) increase the quality of care for patients. Please contact WSHA for more information about any of these innovations.

Innovations in End-of-Life Care

Aligning with Honoring Choices Pacific Northwest and other organizations that seek to honor patients' wishes in end-of-life care through culture change that includes normalizing advance care planning conversations, documentation, and review of values and goals of care, as well as supporting initiatives to increase identification of health care proxies for individuals who may be unable to communicate in the future.

Careful planning for end-of-life care is essential for making sure patients receive care that aligns with their wishes and values. Many patients are admitted or readmitted towards the end of their life for care that is not consistent with their wishes or care planning. Honoring Choices Pacific Northwest (HCPNW) is engaged in moving the important conversation of advance care planning upstream to healthy individuals or those with well managed chronic illnesses. In doing so, HCPNW is helping to change the culture of health care and make having this conversation a part of routine care. HCPNW can be found at the Honoring Choices Pacific Northwest Website (http://www.honoringchoicespnw.org/)

HCPNW is a joint venture between the Washington State Hospital Association (WSHA) and the Washington State Medical Association (WSMA). Additional resources for starting the conversation and end-of-life planning are available from the Honoring Choices website. (http://www.honoringchoicespnw.org/get-started/start-the-conversation/)

The Washington State Hospice & Palliative Organization (WSHPCO) is also involved in improving end-of-life care through education and advocacy efforts. WSHPCO is dedicated to promoting and maintaining quality, compassionate care for those facing life-threatening illnesses. They do this by providing information and referral services to the public and by providing professional services for Washington State's hospice and palliative care programs. (https://wshpco.org/).

Innovations in Sepsis Identification and Education

Supporting education around sepsis diagnosis, treatment, and innovative care within readmissions.

Safety Action Bundle: Sepsis

Sepsis has been identified as a major contributor to readmissions, as well as a frequent diagnosis in end-of-life care. Various toolkits are available online, including the WSHA Sepsis Safety Action Bundle found at WSHA (http://www.wsha.org/quality-safety/projects/infections/sepsis/). Additional resources, including a Sepsis Card, Badge, and Clock are available from the University of Washington.

Sepsis Resources

Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization project (HCUP)
- Readmissions Trends High Volume Conditions (https://www.hcup-us.ahrq.gov/reports/statbriefs/sb196-Readmissions-Trends-High-Volume-Conditions.jsp)
- National Inpatient Hospital Costs: The Most Expensive Conditions by Payer, 2011 (http://www.hcup-us.ahrq.gov/reports/statbriefs/sb160.jsp)

Health Research and Educational Trust (HRET) Change Package
(http://www.hret-hen.org/topics/sepsis/13-14/2014-SEPSISChangePackage.pdf)

News 2015 – Sepsis survivors return to hospital for preventable reasons
(http://www.infectioncontroltoday.com/news/2015/03/sepsis-survivors-return-to-hospital-for-preventable-reasons.aspx)

News 2016 – Number one cause of readmissions (Sepsis)
(http://www.sepsis.org/news/2016/number_one_cause_of_readmissions/)

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?

American patients see an average of 18.7 different doctors in their lifetime.[i] 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

Hospital | **Outpatient Care Provider**

During Hospitalization

Patient and Family/Caregiver Engagement

Patient Arrives at Hospital/Emergency Department → Notify Primary Care Provider

↓

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

Community Forum

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Washington State Hospital Association

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

Complete Risk Assessment

Multiple factors are believed to be associated with increased risk of readmission to the hospitals and repeat emergency room visits. Understanding these factors and identifying the most appropriate transitional care interventions to address them will enhance the efforts to reduce unnecessary readmissions. It is recommended that hospitals utilize a readmission risk assessment tool and deliver the needed interventions for the appropriate risk group.[ii]

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 local health system 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.

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2. Outpatient Provider Communication

Notify Primary Care Provider	For Moderate or High Risk, Discuss Plan of Care with Outpatient Care Providers

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 (xxx) 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 our region 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

Reinforce/ Revise 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 local hospital 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

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.

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5. **Social/Resource Barriers Assessment**

Social/Resources Barrier 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

Teach Back	Patient and Family/Caregiver Engagement

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.[iii]

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[iv]

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."[v] 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.[vi]

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.

Adapted from: Rutherford, P. et al. *How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2012. www.IHI.org.

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

End of Life Planning

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.[vii] A recent American Hospital Association study regarding patients' wishes at the end of life revealed that 80 percent of patients wish to avoid hospitalization.[viii] 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.[vii]

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.[ix] 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.[ix]

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.[vii]

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

- o Initiating Advance Directive discussions while people are still healthy – encouraging conversations with family members and writing those wishes down.
- o Discussing Advance Directives after terminal illness diagnosis and updating Advance Directives based on current diagnosis.
- o Initiating POLST and updating Advance Directives as part of ongoing care for chronic conditions.
- o 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**

<div align="center">

Schedule Follow-up Appointment

</div>

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.[x] Most Medicare readmissions occur in the first few days post-discharge, with half of all 30 day readmissions in our region occurring by the 11th day post-discharge from the hospital.[xi] 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 our region 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 local health system 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.

Adapted from: Schall M, Coleman E, Rutherford P, Taylor J. *How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

9. Discharge Communication – Verbal Handover/Send Discharge Summary

> 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.[xii] 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."[vi] 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 our region 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.

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10. Follow-up Phone Call

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.
  - Offer assistance if the patient needs to change the appointment time or problem-solve through transportation options.
  - 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.
  - 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.
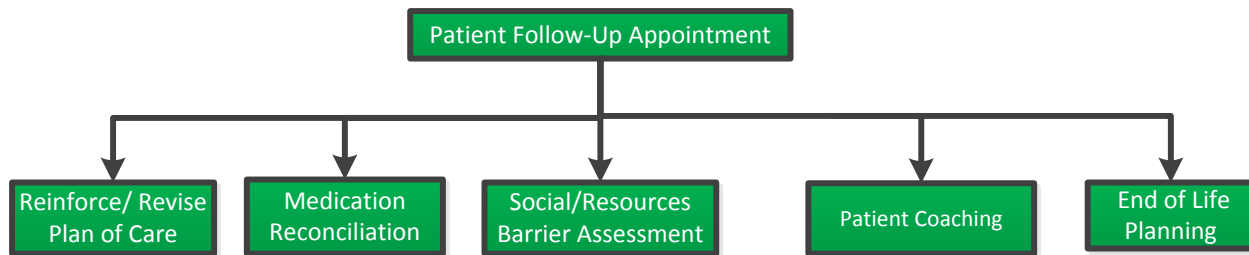

In Practice

A local hospital 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 our 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.

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11. Follow-up Appointment - Primary Care Visit

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            ┌──────────────────────────────┐
            │ Patient Follow-Up Appointment │
            └──────────────────────────────┘
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| Reinforce/ Revise Plan of Care | Medication Reconciliation | Social/Resources Barrier Assessment | Patient Coaching | End of Life Planning |

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 our region 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.

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12. Feedback to Hospital for Improvement

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┌────────────────────────────┐
│  Feedback to Hospital/ED    │
│  for Quality Improvement    │
└────────────────────────────┘
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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 our region 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.

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13. Community Forum

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 analyze gaps.
- 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

Risk	High	Moderate	Low
Categories	• Admitted 2 or more times in the past year • Unable to Teach Back • Low likelihood to follow treatment plan • High likelihood patient readmitted within 30 days	• Admitted once in the past year • Moderate likelihood to follow treatment plan • Moderate likelihood patient readmitted within 30 days	• No other admission in the past year • Able to Teach Back • Low likelihood patient readmitted within 30 days
Appointment Needed w/in	48 hours	5 – 7 days	As Needed
Handoff	Doctor to Doctor	Hospital to PCP team	Hospital to PCP team
DC Summary	Phone AND Fax	EHR or Fax	EHR or Fax
Interventions Prior to discharge	• 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. • 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. • Initiate supportive care management programs as indicated (if not provided in primary care or in outpatient specialty clinics (e.g. heart failure, stroke clinics) • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.	• Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit within 5-7 days. • Initiate in-home services (home health, palliative/ hospice care or home care) or transitional care services as needed. • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.	• Schedule a follow-up phone call within 48 hours of discharge and schedule a physician office visit. • Provide 24/7 phone number for advice about questions and concerns. • Initiate a referral to social services and community resources as needed.

This Triage Grid above was adapted by local physicians and hospitals with evidence from the Institute for Healthcare Improvement (IHI) toolkit. Adapted from: Rutherford, P. et al. *How-to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2012. www.IHI.org.

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

| Risk Assessment: 8P Screening Tool (Check all that apply.)	Risk Specific Intervention	Signature of individual responsible for insuring intervention administered
Problem medications (anticoagulants, insulin, oral hypoglycemic agents, aspirin & clopidogrel dual therapy, digoxin, narcotics) ☐	☐ Medication specific education using Teach Back provided to patient and caregiver ☐ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) ☐ Specific strategies for managing adverse drug events reviewed with patient/caregiver ☐ Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or h/o depression 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, DM, 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 routine 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 (non-elective; 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 (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?) Yes to either: ☐	☐ Assess need for palliative care services ☐ 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

Length of stay (days)	Score (circle as appropriate)
1	1
2	2
3	3
4-6	4
7-13	5
14 or more	7
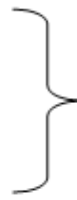
⟹ **L**

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

A

Step 3. Comorbidities

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

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

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

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

LACE

Tool 1.3.b: LACE Readmission Risk Assessment Tool (cont.)

Condition	Definition and/or notes
Previous myocardial infarction	Any previous definite or probable myocardial infarction
Cerebrovascular disease	Any previous stroke or transient ischemic attack (TIA)
Peripheral vascular disease	Intermittent claudication, previous surgery or stenting, gangrene or acute ischemia, untreated abdominal or thoracic aortic aneurysm
Diabetes without microvascular complications	No retinopathy, nephropathy or neuropathy
Congestive heart failure	Any patient with symptomatic CHF whose symptoms have responded to appropriate medications
Diabetes with end organ damage	Diabetes with retinopathy, nephropathy or neuropathy
Chronic pulmonary disease	??
Mild liver disease	Cirrhosis but no portal hypertension (i.e., no varices, no ascites) OR chronic hepatitis
Any tumor (including lymphoma or leukemia)	Solid tumors must have been treated within the last 5 years; includes chronic lymphocytic leukemia (CLL) and polycythemia vera (PV)_
Dementia	Any cognitive deficit??
Connective tissue disease	Systemic lupus erythematosus (SLE), polymyositis, mixed connective tissue disease, moderate to severe rheumatoid arthritis, and polymyalgia rheumatica
AIDS	AIDS-defining opportunistic infection or CD4 < 200
Moderate or severe liver disease	Cirrhosis with portal hypertension (e.g., ascites or variceal bleeding)
Metastatic solid tumor	Any metastatic tumour

Tool 1.4.a: MultiCare Health System Readmission Risk Assessment & Strategies

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

MultiCare ✚
BetterConnected

Check the following that are true.	Points
Age 80 or older	1
No funding source	1
More than 4 Chronic Conditions	1
Active Behavioral / psychiatric health issue	1
Six or more prescribed medications	1
Two or more hospitalizations within the past 6 months	1
Readmitted within 30 days	1
Inadequate support system	1
Low health literacy	1
Documented history of non adherence to the therapeutic regimen	1
Require assistance with ADL's	1
Substance / ETOH abuse	1
CM / MSW / Physician determination	6
Take the sum of the points and enter the total	

Score

Low	0 to 2
Medium	3 to 4
High	5 to 6
Intensive	above 6

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

MultiCare Health System
Care Management Department

MultiCare
BetterConnected

Care Management Strategies for Risk of Readmissions

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

Medium Risk	Low Risk
1. SNF vs HH	1. SNF vs HH
2. Community Referrals	2. Community Referrals
HF Clinic, RCCP, COPD Focus, Pulmonary Clinic etc	HF Clinic, RCCP, COPD Focus, Pulmonary Clinic etc
3. Follow up appointment made by patient unless cognitivaly impaired	3. PCP appointment made by patient
Goal : Appointment within 5-7 day	Goal: Appointment within 7 - 10 days
4. CM Discharge Summary suggested	4. CM No Discharge Summary Required

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

Emergent Care	Points	Emergent Care	SCORE
use during the previous 6 months	0	No emergent care use of a hospital ED	
	1	1-2 emergent visits to a hospital ED	
(Related to the primary or co-morbidity diagnosis	2	3-4 emergent visits to a hospital ED	
for home health services)	3	5 or more emergent visits to a hospital ED	
Hospitalizations	**Points**	**Hospitalization**	**SCORE**
within the past 6 months	0	No hospitalizations	
	1	1-2 hospitalizations	
(Related to the primary or co-morbidity diagnosis	2	3-4 hospitalizations	
for home health services)	3	5 or more hospitalizations	
High Risk Diagnosis	**Points**	**High Risk Diagnosis**	**SCORE**
	1 point for each	• CAD/AMI	
		• CHF	
Primary / secondary	Diagnosis	• COPD	
		• DM	
		• Pneumonia	
Co-Morbidity Diagnosis	**Points**	**Co-Morbidity Dx**	**SCORE**
	0	No co-morbidities	
	1	1-2 co-morbidities	
	2	3-4 co-morbidities	
	3	5 or more co-morbidities	
Severity of Illness- Impact on ADL	**Points**	**Co-Morbidity Dx**	**SCORE**
	0	**Asymptomatic:** No limitations on activities of daily living	
	1	**Minimal Severity:** Symptoms present but little limitations on activities of daily living	
	2	**Mild Severity:** Symptoms present daily and cause limitations on activities of daily living	
	3	**High Severity:** Symptoms present most of the day and cause a significant impact on activities of daily living	

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

Risk Assessment Follow up

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 visit every 1-2 weeks as needed per provider discretion
Re-assess after 30 days

Moderate Risk= Score: 8-10
Enrolled in care coordination if needed
Phone Calls
1. Post discharge call within 48hrs 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
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 (xxx) 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

Tool 3: Plan of Care (cont.)

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

Medication Name	Dose	Frequency	Comment Continued/Altered/New/Discontinued	Reason for Taking Medication

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

"This is what I *heard!*"

"This is what I *meant*"

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".

It is having patients **demonstrate** they understand what is required in **their own words, related to their life.** This is a way for us to confirm their understanding and identify areas of need.

<u>Teach Back Questions to ask your patient:</u>

- **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

- <u>Do not ask</u> "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: _____

Medication Name	Dose	Frequency	Comment (Continued/Altered/New/Discontinued)	Reason for Taking Medication

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

Tool 11: Checklist for Post-Hospital Follow-up Visits

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.

Tool 13: Hospital to Skilled Nursing Facility (SNF) Warm Handover Guide

Hospital to Skilled Nursing Facility Nurse to Nurse "Warm Handover" Verbal Report Guideline

Patient name: _____ Date of birth: _____

Report given by: _____ to: _____

Contact number for additional questions: _____

Time expected to transfer and route of transportation: _____

Date/Time of the report: _____

Primary language: _____ Allergies: _____

Palliative care consult: ☐Yes ☐No Code status: _____ POA: _____

Isolation precautions: ☐Yes ☐No Type: _____ POLST: _____

Admitting diagnosis: _____ 1:1 Status ☐Yes ☐No

Brief hospital course: _____

Vital signs within last hour: _____

Personal preferences: _____

Patient / Family issues: _____

Mental status / Mood: _____

Ambulatory status: _____

Assistive device: ☐Yes ☐No   IV lines / tubes: ☐Yes ☐No

Fall / Safety issues: ☐Yes ☐No   Skin Issues: ☐Yes ☐No

Swallowing issues: ☐Yes ☐No   Hearing Aid: ☐Yes ☐No

Enteral feeding: ☐Yes ☐No   Eye Glasses: ☐Yes ☐No

Oxygen needs: ☐None ☐Mask ☐Cannula ☐Nebulizer ☐BiPap Liters: _____

Wound issues: ☐Yes ☐No   Last dressing change (Date/Time): _____

Pain issues: ☐Yes ☐No   Last pain med given: _____

Diabetes: ☐Yes ☐No   Next glucose draw due: _____

Anticoagulation: ☐Yes ☐No   Type: _____ Next draw due: _____

On IV medication: ☐Yes ☐No   Next IV med due at: _____

Last void / Last bowel movement: _____

Therapy concerns / Orders: ☐PT ☐OT ☐ST ☐Others

Follow up test / appointment: _____

Hard copy prescriptions included in packet (OR sign each page of electronic orders)

- For a list of medications requiring the written prescription to accompany patient to the facility, see back of form

Adapted from Pierce Co. and KC4TP Warm Handover Guide
Please contact wshapatientsafety@wsha.org for more information.

Hospital to Skilled Nursing Facility Nurse to Nurse "Warm Handover" Verbal Report Guideline

Please see list of Class II – IV narcotics that require a script that includes quantity and physician DEA# for transfer to a SNF.

CLASS II NARCOTICS	CLASS III - IV
Fentanyl	Acetaminophen/Codeine 300-30 mg (Tylenol #3)
Actiq	Alprazolam (Xanax)
Duragesic	Androderm Patch
Hydromorphone	Androgel Gel Packets
Dilaudid	Carisoprodol (Soma)
Morphine	Chlordiazepoxide (Librium)
Roxanol	Clonazepam (Klonopin)
Oxycodone containing products	Clorazepate (Tranxene)
Endocet	Diazepam (Valium)
Oxycodone/Apap	Diphenoxylate/Atropine (Lomotil)
Oxycontin	Dronabinol 2.5 mg (Marinol)
Oxyfast	Flurazepam (Dalmane)
Percoset	Guafenesin/Codeine)Robitussin AC) Cough Syrup
Roxicet	Hydrocodone/Acetaminophen 10-325 (Norco)
Roxicodone	Hydrocodone/Acetaminophen 5 -500 Tab (Vicodin)
Methylphenidate	Hydrocodone/Acetaminophen 7.5-325 mg (Norco)
Ritalin	Hydrocodone/Guaifenesin (Hydromet) Cough Syrup
Dextroamphetamine	Lorazepam (Ativan)
Dexedrine	Lunesta
Adderall	Lyrica
	Nuvigil
	Phenobarbital
	Provigil
	Temazepam (Restoril)
	Tramadol
	Triazolam (Halcion)
	Vimpat
	Zolpidem (Ambien)

Adapted from Pierce Co. and KC4TP Warm Handover Guide
Please contact wshapatientsafety@wsha.org for more information.

Tool 14: Hospital to SNF Transition Process, Best Practices and Tools

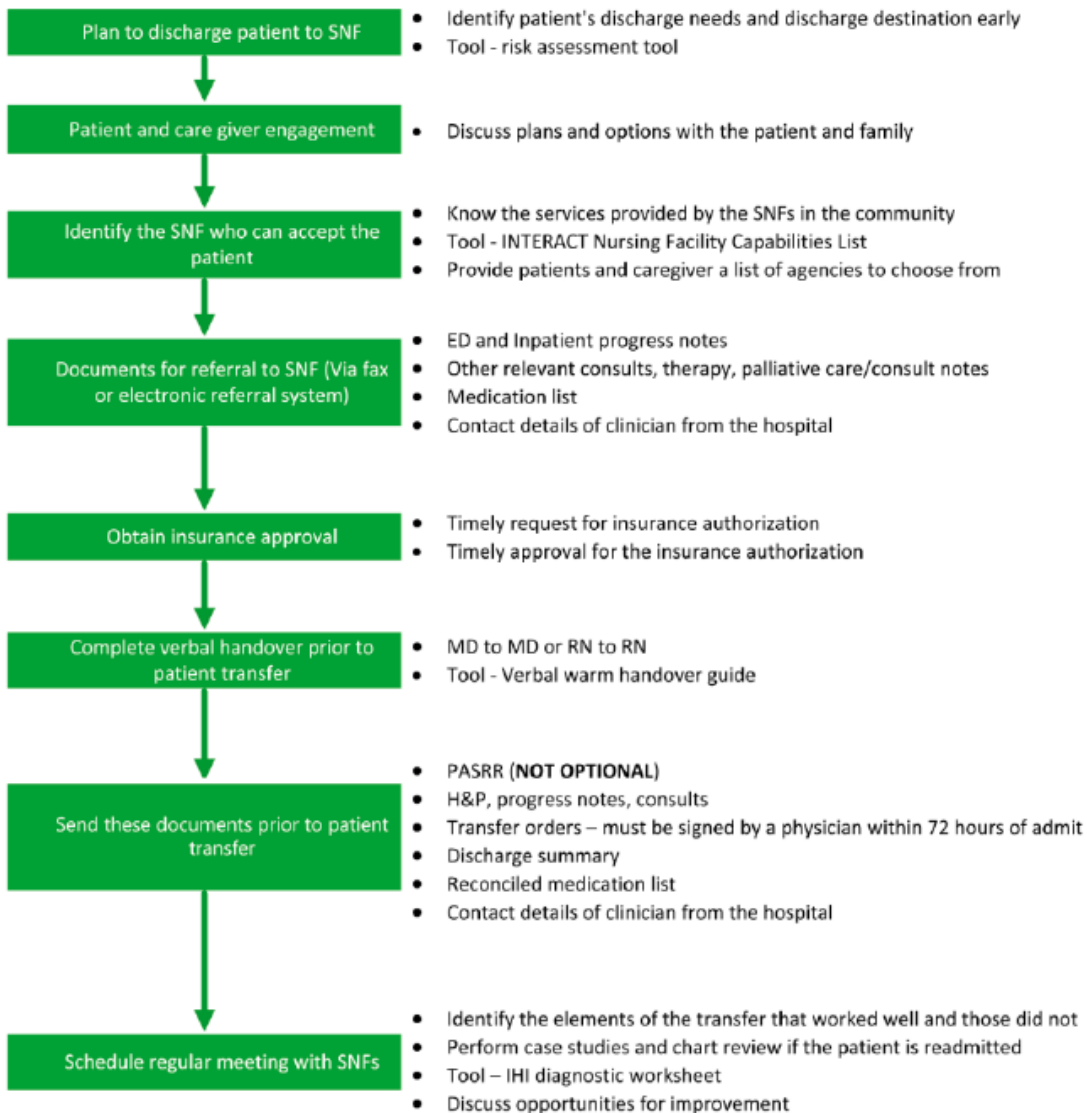## Partnership for Patients

ASHNHA — ALASKA STATE HOSPITAL & NURSING HOME ASSOCIATION | **Washington State Hospital Association**

Transitions from the Hospital to Skilled Nursing Facilities Process Steps, Best Practices and Tools

Plan to discharge patient to SNF
- Identify patient's discharge needs and discharge destination early
- Tool - risk assessment tool

Patient and care giver engagement
- Discuss plans and options with the patient and family

Identify the SNF who can accept the patient
- Know the services provided by the SNFs in the community
- Tool - INTERACT Nursing Facility Capabilities List
- Provide patients and caregiver a list of agencies to choose from

Documents for referral to SNF (Via fax or electronic referral system)
- ED and Inpatient progress notes
- Other relevant consults, therapy, palliative care/consult notes
- Medication list
- Contact details of clinician from the hospital

Obtain insurance approval
- Timely request for insurance authorization
- Timely approval for the insurance authorization

Complete verbal handover prior to patient transfer
- MD to MD or RN to RN
- Tool - Verbal warm handover guide

Send these documents prior to patient transfer
- PASRR (**NOT OPTIONAL**)
- H&P, progress notes, consults
- Transfer orders – must be signed by a physician within 72 hours of admit
- Discharge summary
- Reconciled medication list
- Contact details of clinician from the hospital

Schedule regular meeting with SNFs
- Identify the elements of the transfer that worked well and those did not
- Perform case studies and chart review if the patient is readmitted
- Tool – IHI diagnostic worksheet
- Discuss opportunities for improvement

Tool 15: Qualis Health Care Transitions Assessment (CTA) Tool

Qualis Health
Care Transitions Assessment

The purpose of this tool is to help hospitals:

- Assess the organization's current activity related to care transitions and avoidable rehospitalizations
- Identify opportunities for improvement
- Measure progress over time

www.Medicare.QualisHealth.org/CTA

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