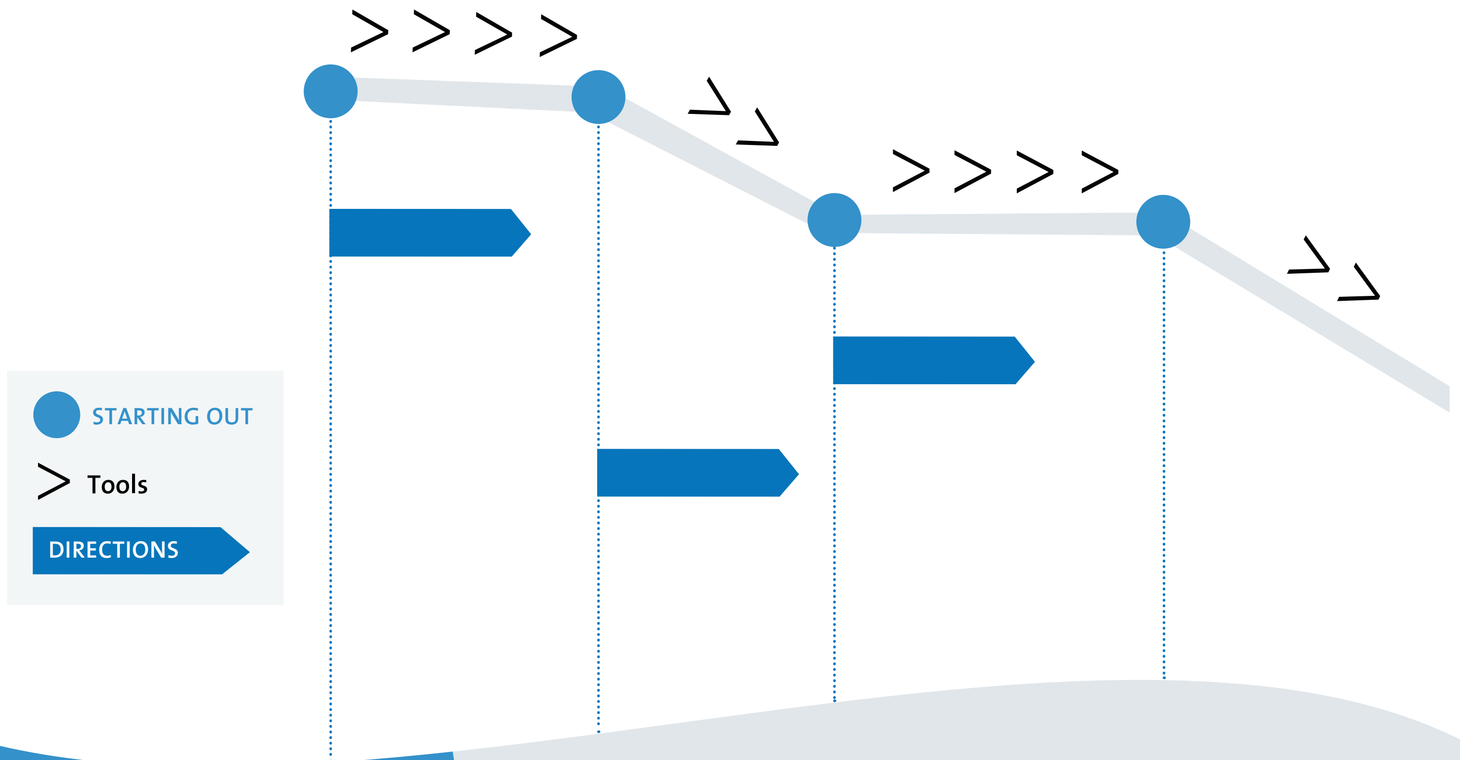
Reducing Readmissions TRAIL GUIDE



The improvement journey is rarely a straight line from start to finish. This guide will help you if you are just starting your journey or if you are on the way but may be lost and struggling to know which direction to turn. It is designed to help you find out where you are and jump right to ideas and tools that will help you get back on the trail and to your destination.

STARTING OUT This section contains the items you will need for a successful journey. Think of it as the provisions you will need for your hike. If you are not making any improvements or you are going backwards with your results, examine the components in this section because you may not have all the items that you need to be successful.

DIRECTIONS ALONG THE TRAIL This section contains ideas and tools that can help your team determine what next steps to take to get to your destination. Think of this section as referring to your GPS to understand where to go next. Sometimes you forgot something and may have to go back to the beginning and obtain it. If this is the case, be sure to also review the Starting Out section. You might not be able to find your way otherwise!

ENJOY THE JOURNEY!

STARTING OUT	Where are you?	Tools
Leadership	Is there *organizational will and support* to reduce all-cause readmissions from your 2014 baseline rate by 12% by September 2018? > Alignment with organizational priorities > Executive sponsorship > Accountability: • Who is on point to make this happen? • Is leadership ensuring staff's adoption of change processes? • Are leaders reviewing progress and encouraging transparency?	> **Hospital Readmissions Reduction Program: Fiscal Year 2017 Fact Sheet** > **Hospital Readmissions Reduction Program Measures and Dates** > **Hospital Value-Based Purchasing (VBP) Program Fact Sheet**
Team	Do you have an *effective* team? > According to Yale health science research, hospitals who are more successful in reducing and maintaining lower readmission rates have teams that work both across departments and across the continuum.	> **Yale School of Health Science Research Center Publication Summary** > **Readmissions Reduction Team Guide**
Science of Improvement	> Have you done an analysis to understand where you are and what gaps you have? > Have you set your aim? > Have you selected what you want to test? > Are you running effective PSDA cycles? > Have you reviewed the HRET HIIN Change Package and Top 10 checklist?	> **Readmissions Data Drill Down** > **Readmissions Reduction Gap Analysis** > **Readmissions Reduction Ideas to Test** > **Institute for Healthcare Improvement PDSA Worksheet for Testing Change**
Measurement	> Are you reviewing your readmission data at least monthly? > Are you monitoring your key processes?	> **HRET HIIN Encyclopedia of Measures (refer to pages 21-22)** > **Sample Readmissions Dashboard**

DIRECTIONS

DIRECTIONS	Where are you?	Tools
PFE	Are you struggling with what you consider to be *"non-compliance"* or are you actively working to improve Patient Family Engagement? > How are you including patients and families in planning? > Are you using teach back to validate understanding? > How are you finding out directly from patients why they were readmitted? > Are you considering patient activation (the patient's ability to self-manage) & health literacy? > Are you asking patients what matters to them in addition to what is the matter with them?	> CMS Discharge Planning Checklist for Patients > ASPIRE Tool 2: Readmission Review Tool > Next Step in Care Website > Patient Activation Measure (PAM) > ODPHP Quick Guide to Health Literacy > AHRQ Health Literacy Measurement Tools > Teach-back training
Learning Loop	> Are you continuously determining why your patients are coming back? > Are you aggregating these reasons and selecting priorities for you to focus on?	> Readmissions Case Review and Analysis
High Leverage Approaches	> *ED pause* — Are you pausing when a previously discharged patient comes to your ED to determine if an alternative for an acute care admission is appropriate? > *Highest utilizers* — Do you know who your highest utilizers are and are you providing them additional support? > *Community collaboration* — Are you collaborating with your clinical and non-clinical partners to improve care transitions across the continuum?	> ED Pause- Emergency Department Opportunity Tool > ASPIRE Tool 13: ED Care Plan > Community Collaboration Tool

This trail guide was designed to help you identify opportunities and provide tools to improve your readmissions reductions efforts. It is only one of many HRET resources. For additional information, visit the HRET HIIN resource library or Huddle for Care.

STAY THE COURSE!