Before you set your strategy, understand why readmissions occur at your hospital

Much has changed in our collective understanding of why readmissions happen and how we can prevent them. Hospitals with successful strategies regularly reassess their data and their understanding of what drives readmissions within their patient populations. You may learn, for example, that avoiding readmissions is more about logistics, navigation, and communication than clinical protocols or medical complexity.

Review your data for yourself

Analytics partners can be valuable, but some readmissions reports from external sources are done with a pre-determined "cut" of the data, such as limited reporting of predetermined diagnostic categories, or for certain payers, and more. As a result, it's preferable to examine your own raw data. A sample data analysis that has proven feasible for hospital finance or quality analysts to conduct in-house is in the Appendix.

In addition to basic administrative data analysis, your clinical, financial or information technology staff may be aware of potential additional analyses based on your organization's unique data assets. For example, your administrative data may have a reliable primary care provider field, or "admission source" field, or your case management software may capture the specific discharge facility, or whether a person-to-person "warm handoff," as opposed to an email or voice mail handoff, was completed. Or, your nursing documentation may contain information about readmissions risk assessment. All of these sources go well beyond billing data but are important to place on your hospital's readmissions reduction dashboard. Taking advantage of data you are already collecting to drive improvement is a good first step.

Ask your patients, their families and their providers why readmissions occur

While it is important to have a good understanding of your organization's readmissions data, data alone do not help us understand the kinds of barriers patients, families and providers face during the post-hospital transitional care period, or the circumstances leading patients to return to the hospital soon after discharge. Drawing from the Institute for Healthcare Improvement's STate Action on Avoidable Rehospitalizations (STAAR) initiative,* we recommend your readmissions team conduct ***10 "readmission interviews."*** These can uncover the "story behind the story:" going well beyond chief complaint, discharge diagnosis or other clinical parameters to understand the communication, coordination, or other logistical barriers in the days following discharge that resulted in a readmission.

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If you're worried that conducting patient interviews will be time-consuming, try using a simple script at the beginning of the interview. Readmission teams uniformly report that these interviews yield valuable information not found in chart reviews or data analyses.

While this document's Appendix includes a sample script, the most important thing is to provide the patient, family member or provider an opportunity to detail why the patient had to return to the hospital. The prompts are only meant to help elicit the stories from the individuals you interview.

**See Appendix for additional information on the STAAR initiative*

Inventory your current readmissions reduction efforts

Revisiting your readmissions reduction strategy is a good time to specifically inventory the various efforts your team has put into place over the past several years. This inventory should include:

- Completed efforts (i.e. trained staff on Teach-Back to ensure patients understand instructions and information, or had information technology staff place a high-risk flag in electronic medical records)
- Current efforts (i.e. refer high-risk patients to care transitions team; warm handoffs to skilled nursing facilities)
- Planned efforts that have gone undone (i.e. make appointments prior to discharge, hire staff)
- Attempted but abandoned efforts (be sure to know why)

Revisit your readmissions reduction strategy

Armed with an updated understanding of the readmissions patterns at your hospital, the reasons that patients, family and providers have offered for readmissions, and a comprehensive review of the completed, current, and intended but incomplete readmissions reduction efforts at your hospital, we invite you to revisit your readmissions reduction strategy. This strategy should be optimized to achieve immediate, measurable readmissions reductions this year and each year thereafter for the five years of the new waiver demonstration.

Know your hospital's readmissions reduction goal in context of the "waiver test"

As of April 2014, the Maryland Hospital Association and the state's Health Services Cost Review Commission are discussing how to quantify the annual readmissions reduction goals, and to design policies that meet the milestone performance requirements of the waiver. While the readmissions reduction goal a hospital sets for itself should be closely aligned with targets and payment policies set by the Health Services Cost Review Commission, your hospital's internal performance improvement goal may be more aggressive and more tailored to the hospital's own strategic goals than a readmissions target tied to a payment policy.

Recent Medicare data indicate that, from July 2012 through July 2013, there were 45,244 Medicare readmissions among 235,532 Medicare admissions in Maryland, for an all-cause readmission rate of 19.2 percent. The current U.S. national average is 17.4 percent, which is expected to continue decreasing at a steady rate. Current calculations estimate that Maryland will need to improve 5-10 percent per year, every year, to meet the U.S. national average by 2018. While there is no consensus on how low a hospital's readmissions rate should be, you are encouraged to set attainable goals that are tied to the statewide reduction goal.