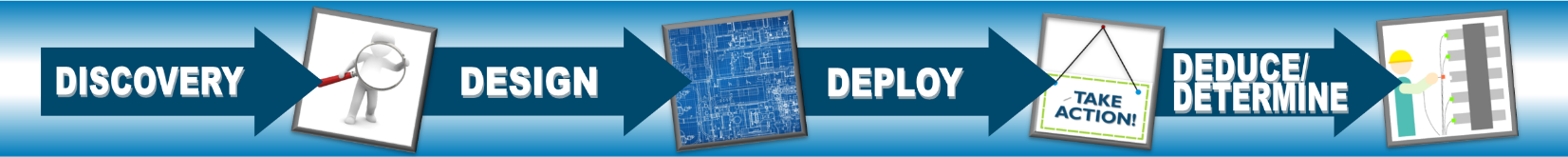
**Rapid Action Readmission Reduction Collaborative Plan**

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| **Timeline** | |
| 12/16 | 1 month prior to collaborative kick-off | Email participant invitations noting RSVP deadline |
| 12/27 | 3 weeks prior to kick-off event | Email welcome packet with prework assignment and calendar invitation to confirmed participants |
| 01/07 | 2 days prior to Event #1 | Send Event #1 email |
| 01/09 | Collaborative Week 1 | Host Event #1 |
| 01/14 | 2 days prior to Event #2 | Send Event #2 email |
| 01/16 | Collaborative Week 2 | Host Event #2 |
| 01/21 | 2 days prior to Event #3 | Send Event #3 email |
| 01/23 | Collaborative Week 3 | Host Event #3 |
| 01/28 | 2 days prior to Event #4 | Send Event #4 email |
| 01/30 | Collaborative Week 4 | Host Event #4 |
| 02/16-27 | 2-3 weeks following last event | Initiate check-in calls |

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| **Prework** |
| * Accept invitation * Discovery Tool * Capture information for last three or six month’s readmissions * Assemble a Team |

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| **Events** | |
| Format   * Intro * Data * Didactic * Peer-to-Peer sharing (Mentoring Hospital) * Discussion | |
| **Event #1 | Discovery** | |
| * State specific data * Discussion: Common causes of avoidable readmissions * Discussion on Discovery Tool: Share findings * Developing an internal goal/AIM * Homework: Complete and submit the discovery tool * [*Discovery* PowerPoint](https://www.qualityhealthnd.org/wp-content/uploads/1-RARRC-Discovery-Final.pptx) | Facilitator Notes  To help participants explore their data ask:   * # of days to readmission? * Where are the patients coming from (home/nursing home/home health)?     If < 7 days to readmit ask probing questions about the hospital discharge process and the patient’s condition on discharge   * Attention to activity level on admit/discharge: Were they being mobilized at least 3 times a day?   If > 7 days to readmission, ask probing questions about the patient’s social determinants of health and available community resources to accommodate the patient’s needs. |
| **Event #2 | Design** | |
| * National/CMS Data * Share tried and proven prevention strategies and correlating tools * Mentor hospital(s) share best practices * Use analysis of discovery tool to create the action plan * Homework: Create and action plan with at least two priority interventions completely fleshed out; submit action plans for feedback   + *[Design](https://www.qualityhealthnd.org/wp-content/uploads/2-RARRC-Design-Final.pptx)* [PowerPoint](https://www.qualityhealthnd.org/wp-content/uploads/2-RARRC-Design-Final.pptx) | Facilitator Notes  To help participants utilize a portfolio approach to readmissions   * Cumulative Complexity Model * 5:2:1 approach * Communicate effectively across staff/facility   Participants share discovery tool findings  Questions to run on: What plans do you have to address the challenges revealed through your discovery tool? What are your wishes – if you could have anything you wanted to address this issue what would it be? What would be the first step toward making that happen? |
| **Event #3 Deploy** | |
| * Data: Care Coordination Report by disease and discharge location * Teams share discovery tool findings/innovative ideas * Solicit feedback to develop ideas, invite mentor hospitals to participate * Homework: Submit refined Action Plan * [*Deploy* PowerPoint](https://www.qualityhealthnd.org/wp-content/uploads/3-RARRC-Deploy-Final.pptx) | Facilitator Notes  To assure participants are ready to implement action plan interventions  Deployment assumptions/Deployment checklist/Team Readiness  Age Friendly  Question to run on: What are your two highest priority interventions identified in your action plan, your plans for deployment, and your concerns? |
| **Event #4 Deduce/Determine** | |
| * Data: PFE/HIE * Follow-up to Action: Barriers/Challenges * Mentor Hospital: Evaluating interventions: adapt, adopt, discard; and hardwiring for sustainability * [*Deduce/Determine* PowerPoint](https://www.qualityhealthnd.org/wp-content/uploads/4-RARRC-Deduce_Determine-Final.pptx) | Facilitator Notes  To hardwire for sustainability  Process checklist  Keys to sustainability  7 Spreadly Sins (IHI)  Question to run on: What are your plans to thread patient and family engagement into each of your action plan interventions (think: what matters to the patient)? |
| **3-Month Follow-up Visit** | |
| Following the first collaborative, we did site visits at each hospital, which turned out to be the best part of the collaborative. They were very excited to show us what they were doing – much beyond our expectations at the end of the web-event series. In our 2nd cohort, however, we are running into the end of the HIIN contract so that isn’t feasible. Follow-up calls will be completed instead. Time will tell how that will compare. | |

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| **Resources** | | |
| **Mentor Hospitals** | **1:1 Coaching** | **Tools** |
| * Identify 3-4 mentor hospitals * Decide whether to participate in all calls; share ad hoc and as designated on three calls * Feedback and suggestions to struggling teams | Offer coaching with individual hospital teams on request*.* | * Readmission Discovery Tool * Post discharge call-back scripts * ASPIRE * Readmission interview * Ask Me Three * CMS Discharge Checklist * Teach-Back * Crucial Conversations – Developing a plan * ACP * Getting There Guide * PMC Admission Packet: * Questions to ask before discharge * Your daily routine * Community resource guide * PMC Med-Surg/Swg rounding guide * Deployment Checklist |

**Considerations for future events:**

1. Site Visits:Incorporate site visits into virtual events (host sites with teams)
2. Support post collaborative: Listserv? Think Tank events? Office Hours?

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| **Email Templates** |
| **Initial Invitation** |
| Your hospital is among a select group of [name of state program] participating hospitals [who we strongly encourage to join our Rapid Action Readmission Reduction Collaborative **or** whom we invite to consider joining our Rapid Action Readmission Reduction Collaborative].  Information provided in the HRET HIIN data repository (CDS) suggests that your hospital [continues to experience a higher than expected **or** has recently experienced an increase in 30-day all cause readmissions]. 30-day all cause readmissions are considered a national and local HRET HIIN priority topic where we strive to affect a HIIN-wide 12% reduction.  [insert hospital specific 30-day readmission graph here]  *Note, your hospital’s 30-day all cause readmission rate, depicted in blue, is above the state and all-project median and your trend line is flat, suggesting minimal to no improvement since the inception of HIIN in October 2016.* [this statement will be individualized for each hospital]  **Four Part Series**  Please join us for 4 highly interactive virtual events where we will:   * Address common (and not-so-common!) causes of avoidable readmissions * Help participating hospitals analyze their data to identify readmission root cause(s) * Highlight nationally touted tried and proven strategies to prevent avoidable readmissions * Host ND mentor hospitals who will share their best practices that helped them achieve their readmission reduction goals * Explore innovative ideas and concepts to prevent avoidable readmissions * Learn how patient and family engagement in the discharge process can minimize the probability of avoidable readmissions   **Who should attend?**  We strongly encourage a team approach. If possible, plan for at least 2 persons from your hospital attend the virtual Readmission Reduction Collaborative events.   * Hospital HRET HIIN Lead * Case Managers/Care Coordinators * Social Worker(s) * Patient Representative(s) * Quality Improvement/Process Improvement Staff * Risk Manager(s) * Community healthcare partners, e.g., nursing homes, clinics, home care, public health, senior living, food pantry, churches, etc.   **Schedule of Events**  Virtual events will be held from [list time]  [Day/Date] Discovery  [Day/Date] Design  [Day/Date] Deploy  [Day/Date] Deduce/Determine  *Note, coaching with individual hospital teams will be available on request.*  Please RSVP your intent to join this collaborative by responding to this email no later than [RSVP date]. Come prepared to make a difference!!! |
| **Email to RSVPs** |
| Thank you for joining HRET HIIN Rapid Action Readmission Reduction Collaborative. You’re on your way to a great opportunity for customized education and peer-driven learning and action! Over the next four weeks we will:   * Address common (and not-so-common!) causes of avoidable readmissions * Help participating hospitals analyze their data to identify readmission root cause(s) * Highlight nationally touted, tried and proven strategies to prevent avoidable readmissions * Host ND mentor hospitals who will share their best practices that helped them achieve their readmission reduction goals * Explore innovative ideas and concepts to prevent avoidable readmissions * Learn how patient and family engagement in the discharge process can minimize the probability of avoidable readmissions   In preparation for the first virtual meeting   1. Position your hospital to approach readmission reduction from a team perspective. Begin by assembling a small team of individuals who are involved in the discharge process. (Suggestions noted below.) Appoint a lead who will assume responsibility for the day-to-day tasks associated with this rapid improvement initiative and who has demonstrated leadership abilities.   Hospital HRET HIIN Lead  Case Managers/Care Coordinators  Social Worker(s)  Patient Representative(s)  Quality Improvement/Process Improvement Staff  Risk Manager(s)  Community healthcare partners   1. Using the attached *Readmission Discovery Tool,* review and record data for the 6 most recent readmissions **or** the most recent 6-months [add dates] of readmissions to your hospital, whichever comes first. Please note, there are three pages in this tool; the first page (Preliminary) will collect data for each readmission; the second and third pages are continuations of the first page and will collect data according to the time that elapsed from the original admission to the readmission.   As noted in the invitation, our first event is scheduled on [date/time]. We’re referring to this event as the Discovery event – time will be spent discussing common causes of avoidable readmissions; interpreting the information recorded in the Readmission Discovery Tool; and, developing goals and a plan of action.  Attachments: Readmissions Collaborative Toolkit, Readmissions Discovery Tool Template |
| **Pre-event #1 Email** |
| Good morning Readmissions Reduction Collaborative Participants!  I am very excited to get this party started!  [Meeting access instructions]  If possible, please join the meeting a few minutes early so we can start on time.  **Attachments**: Slide-deck handout (6 per page) |
| **Pre-event #2 Email** |
| Hello Readmission Champions!  I am very much looking forward to tomorrow’s event, where we will focus on Designing your course of action now that you have had time to complete and study your discovery tool. Please find the slide deck for tomorrow’s call, #2 RARRC Design, and a copy of the Action Plan Template attached. I will follow this general email with a separate email to each hospital who submitted their discovery tool to me, with feedback.  We want our calls to be as interactive as possible. Please be prepared to address the following during tomorrow’s event:   1. During the Discovery call on [date], several common challenges were identified:  * Appropriate level of care * Chronic disease management * Super-utilizers * End of life care * Patients struggling with ADLs, yet resistant to moving to next level of care * Transitions/lack of community resources/lack of USE of community resources   Please be prepared to share how your hospital is addressing, or has successfully resolved, one of these issues.   1. What plans do you have to address the challenges revealed through your discovery tool? Don’t be afraid to think far outside the box and dream big! What are your wishes – if you could have anything you wanted to address this issue what would it be? What would be the first step toward making that happen?   If you were not able to be on last week’s call, or would like share with others, you may access the recording here:  Link: [recording link]  Password: [recording password]  Note: Only hospitals who are participating in the collaborative are given this link and password. In respect of the privacy for all hospitals involved, please do not share this with non-participating hospitals.  **Attachments**: Readmissions Collaborative Toolkit, Action Plan Template, Slide-deck handout (6/page) |
| **Pre-event # 3 Email** |
| Hello Readmission Champions!  Our next call will occur on [date/time] focusing on Deployment of your Action Plan. The slide deck for the call is attached (disclaimer: minor adjustments may be made), along with the Readmissions Collaborative toolkit which has been distributed a number of times already, and a Deployment Checklist. There are also two new resources that will be mentioned on the call, both attached, that were just published last week. The “[Getting in” Guide](http://www.hret-hiin.org/resources/display/getting-in-guide-a-roadmap-to-successful-partnerships) is a field guide for quality improvement leaders at the state level that provides guidance and suggestions for how to build successful partnerships with hospitals when connection is difficult – but the strategies apply to your attempt to connect with other entities in your community. The “[Getting there” Guide](http://www.hret-hiin.org/resources/display/getting-there-guide-engage-the-right-people-on-your-performance-improvement-journey) dives into engagement of staff within the hospital and understanding who to engage and how to connect in an effective way. I hope you find these resources helpful.  Thank you to those who have already submitted their action plans. I will be reviewing those before the call.  Please be prepared to share the two highest priority interventions identified in your action plan, your plans for deployment and your concerns about deployment on the call. Please also feel free to respond to others with ideas that you have to address their concerns.  [Meeting access instructions]  If you were not able to be on last week’s call, or would like share with others, you may access the recording here:  Link: [recording link]  Password: [recording password)]  **Attachments:** Slide-deck handout (6/page), Deployment Checklist, Readmissions Collaborative Toolkit |
| **Pre-event #4 Email** |
| Greetings Readmission Reduction Advocates!  Our 4th and final web-event will be on [date/time] titled Deduce and Determine. The slide deck for the call is attached.  Most of you have submitted your action plans, but if your hospital has not, please do so by COB tomorrow, so that I can update the slide deck to reflect your work. Remember, although I would love to see your entire plan, only two interventions are required to be fleshed out at this time. I welcome updated plans if you have done more work since your first submission.  Please be prepared to participate in the call:   1. Come with Fresh and innovative ideas of how to thread patient and family engagement into each of your action plan interventions (think: what matters to the patient). 2. If you are feeling stuck on an issue and would like help to brainstorm ideas to resolve it please be ready to bring it up including a succinct problem statement so that we can quickly get the ideas rolling. If possible please send these to me ahead of time and I can integrate these right into the slide deck. 3. Come with any ideas you have to help us keep this work moving forward. What could Innovate-ND do to support you?   [Meeting access instructions]  If you were not able to be on last week’s call, or would like share with others, you may access the recording here:  Link: [recording link]  Password: [recording password]  Following Thursday’s event, I will send another email with a link to an evaluation in SurveyMonkey. I would appreciate it if each person who participated on your team *each* completed it. I want to have as much feedback as possible and I invite you to be candid with what you liked and didn’t like. I can’t make it better if I don’t know what is wrong.  **Attachments:** slide-deck handout |
| **Post 4th Event Email** |
| Readmission Reduction Champions,  Thank you for your participation in today’s call and the entire Rapid Action Readmission Reduction Collaborative.  If you were not able to be on today’s call, or would like share with others, you may access the recording here:  Link: [recording link]  Password: [recording password]  Please take a moment to give me your feedback by completing the survey monkey evaluation: [evaluation link]. Each person has a different perspective, so please encourage every member of your team to complete it.  The final step to completing the collaborative, and be credited with an Innovate-ND fellowship (Platinum Milestone requirement), is to complete the follow-up call. This will be a call between myself and your hospital team. Each hospital is to select ONE date/time that will work best for your team in this doodle poll: [poll link]. Your selection of a date and time will be your hospital’s appointment with me, and I will provide a calendar invite with conference call number for that date and time. Once you made your selection, no other hospital will be able to select that time slot. Please complete the doodle poll by [date/time].  I look forward to our follow-up calls and learning of your progress! |