

No Place Like Home –  
A California Campaign to Reduce Readmissions



**Quality Improvement Organizations**  
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CENTERS FOR MEDICARE & MEDICAID SERVICES

**No Place Like Home –  
A California Campaign to Reduce Readmissions**

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Health Services Advisory Group of California, Inc.  
(HSAG-California)

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***“If you want to go quickly, go alone.  
If you want to go far, go together.”***  
**—African proverb**



**No Place Like Home  
C A M P A I G N**  
... reducing hospital readmissions because  
there really is no place like home.

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**No Place Like Home Campaign**

- Started in Arizona and has spread to California, Florida, and Nevada
- Features a one-stop shop statewide readmissions  
Web site <http://www.noplacelikehomeca.com/>
- Seeks to engage hospitals, rehabilitation and skilled nursing facilities, hospices, home health agencies, community pharmacies, clinician offices, community-based organizations, payers, and other care providers in an intense 24-month collaborative effort to reduce readmissions

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# No Place Like Home – A California Campaign to Reduce Readmissions

## Campaign Goals

- Prevent 30,000 avoidable readmissions within 30 days of hospital discharge by July 2014
- Reduce the overall readmission rate for Medicare beneficiaries by 20 percent (based on claims data from Medicare 2010)
- Decrease healthcare expenditures related to readmissions—saving \$240–\$390 million in California each year

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## No Place Like Home CAMPAIGN

... reducing hospital readmissions because there really is no place like home.

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Welcome to the **No Place Like Home Campaign!** 2012

When a person leaves the hospital, the last thing he or she wants to do is to go back again anytime soon. Yet, one in five Medicare patients are readmitted to the hospital within 30 days\*—and three-quarters of those readmissions could have been prevented.\*

In California, this adds up to more than 133,000 Medicare patients being readmitted to the hospital each year—at a cost of \$8,000–\$13,000 per readmission.\*

The **No Place Like Home Campaign** brings together hospitals, rehabilitation and skilled nursing facilities, hospices, home health agencies, community pharmacies, clinician offices, community-based organizations, and other care providers in a robust, intense collaborative effort to reduce avoidable hospital readmissions that occur within 30 days of hospital discharge.

**Our Goals**

1. Prevent 30,000 avoidable readmissions within 30 days of hospital discharge by July 2014.
2. Reduce the overall readmission rate for Medicare beneficiaries by 20 percent (based on claims data from Medicare 2010).
3. Decrease healthcare expenditures related to readmissions—saving \$240–\$390 million in California each year.

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## About Us

2012

Medicare patients report a greater dissatisfaction in discharge-related care than in any other aspect of care that CMS measures.\* The California Campaign seeks to engage hospitals, rehabilitation and skilled nursing facilities, hospices, home health agencies, community pharmacies, clinician offices, community-based organizations, and other care providers in a robust, intense collaborative effort to reduce avoidable hospital readmissions that occur within 30 days of hospital discharge.

**Our Goals**

1. Prevent 30,000 avoidable readmissions within 30 days of hospital discharge by July 2014. In doing this, we increase patient satisfaction and wellness in the community and reduce costs associated with readmissions.
2. Reduce the overall readmission rate for Medicare beneficiaries by 20 percent (based on claims data from Medicare 2010).
3. Decrease healthcare expenditures related to readmissions. With the estimated average cost of a readmission ranging from \$8,000 to \$13,000,\* there is an opportunity to save \$240–\$390 million in California.

In addition to improving the patient experience and the health of Californians, the Campaign has the potential to save hundreds of millions of dollars, making healthcare more affordable—achieving the Triple Aim identified in the U.S. Department of Health and Human Services (HHS) National Strategy for Quality Improvement in Health Care. On April 20, 2012, HHS released the National Quality Strategy 2012 Annual Progress Report.

The **No Place Like Home Campaign** recognizes that avoidable hospital readmissions are the result of a fragmented healthcare system. The Campaign will initially recruit hospitals, which will then engage other groups in the care continuum that contribute to avoidable readmissions. The Campaign seeks commitment from all hospitals in California, but particularly those that account for approximately 50 percent of annual hospital readmissions. Participating hospitals commit to meet aggressive but realistic goals and partner with care delivery organizations to achieve them. Participating hospitals will receive support to implement the interventions most likely to accelerate their work and achieve success.

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# No Place Like Home – A California Campaign to Reduce Readmissions

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Statewide Progress 2012

Under Construction

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**Partners**

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Partners 2012

The No Place Like Home Campaign is supported by a broad and growing base of stakeholders in the California healthcare community. Its goal is to engage hospitals and care providers across the continuum of care in order to prevent 30,000 avoidable hospital readmissions in the state and surrounding areas between June 2012 and July 2014.

As a healthcare community that is deeply committed to its patients and prides itself in being at the forefront of quality improvement, it is our responsibility to reduce avoidable readmissions in California. We can accomplish this by better coordinating patient care across our fragmented healthcare system.

The No Place Like Home Campaign will be one of the largest coordinated improvement initiatives undertaken by the California healthcare community. We are confident we can attain our aggressive goals because of our community's dedication to patient health and our known willingness to collaborate. The needs of our patients and the challenges facing healthcare require this statewide concerted effort.

**Our Partners**

- Health Services Advisory Group of California, Inc. (HSAG California)
- Aging Services of California
- The California Association of Health Facilities
- The California Association for Health Services at Home
- California Association of Long Term Care Medicine
- California Culture Change Coalition
- Coalition for Comprehensive Care of California
- California Hospital Association

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**Getting Involved**

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Join 2012

Get involved with the No Place Like Home Campaign and be part of its broad and growing base of stakeholders.

**Why Join?**

**The Right Thing to Do**  
Most of us have likely had a loved one—parent, spouse, child, or friend—who returned to the hospital soon after being discharged. We can identify with the anxiety, worry, and burden felt by all of those involved when this occurs. Patients and their families would much prefer to remain in their homes and be surrounded by the things that bring them comfort, such as their pets, their food, and their own bed. We have a great opportunity to prevent avoidable readmissions and ensure our loved ones enjoy better health at home because there really is no place like home.

**Costs**  
The estimated average cost of a readmission ranges from \$8,000 to \$13,000,<sup>1</sup> so there is an opportunity to save \$40 to \$70 million in California.

**It Can Be Done**  
Individual hospitals in the country have already significantly reduced avoidable readmissions in the past year using evidence-based best practices that can be easily replicated.<sup>2</sup>

**Avoid Bad Outcomes**  
Nearly one in five Medicare patients discharged from hospitals is readmitted within 30 days. Only 10 percent of those were planned. For 30 percent of the patients who were readmitted within 30 days after a medical discharge to the community, it appears there was no visit to a physician's office between the time of discharge and readmission.<sup>3</sup>

**Penalties**  
Hospitals with higher than expected, risk-adjusted 30-day readmission performance can incur penalties of 1 percent of their total quarterly Medicare payments beginning in fiscal year 2013 (October 2012–September 2013). The penalty increases each year after that until it reaches a maximum. Some activities on the bottom line.

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# No Place Like Home – A California Campaign to Reduce Readmissions

**Upcoming Events**

2012 Care Transitions Webinar Series Calendar of Events  
This Webinar series will provide you with tools and resources you can use to reduce readmissions in your communities and improve care for patients.

- **The Role of the Patient's Experience of Care in the Value-Based Purchasing Program**  
June 26, 2012  
10-11 a.m.  
[Registration Link](#)
- **Patient and Family Education**  
July 19, 2012  
10-11 a.m.  
*Registration information coming soon!*

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**Past Events**

Care Transitions Webinar Series

- **Strategies to Improve Medication Management Processes**  
Recorded Webinar Presentation
- **Strategies to Improve Compliance with the Physician Follow-Up Visit**  
April 19, 2012  
Recorded Webinar Presentation
- **Discharge Planning: Is Your Patient RED?™?**  
March 15, 2012
- **Root Cause Analysis (RCA): Identifying the Drivers of Hospital Readmissions**  
February 16, 2012  
Recorded Webinar Presentation

CCTP, Health Care Innovation Challenge Grant and Overview of Provider Penalties Webinar  
Tuesday, January 24, 2012  
11:00 a.m. to 12:00 p.m. MST  
[Recorded Webinar Link](#)

Care Transitions Coaching Intervention Webinar  
Thursday, January 19, 2012  
11:00 a.m. to 12:30 p.m. MST  
[Recorded Webinar Link](#)

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**5 Key Areas**

The No Place Like Home Campaign builds upon and expands work that has been going on for several years by many hospitals, medical groups, health plans, and the Supporting and Community Partners. The Campaign will focus on five key areas that, if not managed well, are known to be main contributors to avoidable hospital readmissions:

1. **Comprehensive discharge planning**  
Focus on ensuring that all of a patient's needs are considered and included in a comprehensive discharge plan with input from the patient and family. Interventions may consist of written, visual, or recorded discharge plans that include and consider follow-up appointments, medications, nutritional needs, family support, transportation, health literacy, knowing whom to call, social problems, and red flags.
2. **Medication management**  
Focus on improving the use of medications for the patient's condition and ensuring that the patient understands the purpose of the medications and is taking them in the correct manner at the correct time. This includes a review of over-the-counter medications and nutritional/herbal supplements, in addition to prescription medications. Interventions may include medication reconciliation, patient/family education on medications, medication therapy management, and medication set-up simulations for the patient/family.
3. **Patient and family engagement**  
Focus on ensuring that processes are in place to empower and engage patients/family, elevate and acknowledge the status of family caregivers as essential members of the team, and prepare the patient and family to manage care at home. Interventions may include such methodologies as teach back, collaborative conversations and communication, and simulations with the patient and family member.
4. **Transition care support**  
Focus on ensuring that transition plans are in place and followed so that the patient's care is coordinated among caregivers. Interventions may include the role of care coach, transition coordinator, and post-transition follow-up care.
5. **Transition communications**  
Focus on ensuring that effective communication occurs between sending and receiving caregivers working with the hospital (e.g., home care, home, primary/specialty care, skilled nursing facility, or rehab). Interventions may include processes for transferring information, providing discharge summaries in a timely manner, defining accountability for care, communication of the plan of care, and follow-up care.

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# No Place Like Home – A California Campaign to Reduce Readmissions

**Root Cause Analysis Toolkit** 2012

**Introduction**

The goal of the No Place Like Home Campaign is to prevent 30,000 readmissions within 30 days of hospital discharge by June 2014, thus reducing avoidable hospital readmissions by 25 percent. To accomplish this goal, we need to understand the processes involved in readmissions and identify the basic or causal factors that lead to unnecessary readmissions; we need to conduct an RCA.

An RCA typically allows us to identify the "root" of the problem in a process including how, when, and why a problem, adverse event, or trend exists. Healthcare organizations conduct RCAs whenever there is a sentinel event, adverse outcome, or near miss event. The principles used in those situations can also be used to determine the root cause for readmissions.

An RCA focuses primarily on systems and processes, not individual performance. To begin, identify the underlying functions leading to poor outcomes. Then, determine the primary cause(s) and contributing factors. An RCA is generally broken down into the following steps:

- Collecting data
- Analyzing data
- Developing evaluating corrective actions, using PDCA (Plan-Do-Study-Act) cycles
- Implementing successful corrective actions

The resources below will assist you in conducting an RCA. If you need technical assistance conducting your RCA, please contact us.

**RCA Tools & Resources**

Coming soon!

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**Readmission Toolkits** 2012

**Toolkits**

**Health Literacy Toolkit**

- **Simply Put:** A guide for creating easy-to-understand materials—This guide helps you transform complicated scientific and technical information into communication materials your audience can relate to and understand. This guide will be useful for creating fact sheets, FAQs, brochures, and other materials.
- **AHRQ Health Literacy Universal Precautions Toolkit:** This toolkit provides step-by-step guidance and tools for assessing your practice and making changes so you can connect with patients of all literacy levels.
- **CDC's Guide to Social Media:** This guide contains information to help you write more effectively using multiple social media channels.

**Institute for Healthcare Improvement (IHI) How-To Guides**

- **How-to Guide: Improving Transitions from the Hospital to Post-Acute Care Settings to Reduce Avoidable Rehospitalizations**  
This guide is designed to support hospital-based teams and their community partners in redesigning and reliably implementing improved care processes to ensure that patients who have been discharged from the hospital have an ideal transition to the next setting of care.
- **How-to Guide: Improving Transitions from the Hospital to Skilled Nursing Facilities to Reduce Avoidable Rehospitalizations**  
This guide focuses on the transfer of residents from the hospital to the skilled nursing facility (SNF) setting and the associated transfer of responsibility from the hospital to the SNF care team. (SNF is an umbrella term that includes nursing homes, long-term care facilities, acute rehabilitation facilities, and post-acute care facilities.)

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**Web Links and Articles** 2012

**Web Links**

- Integrating Care for Populations and Communities National Coordinating Center
- National Transitions of Care Coalition (NTCCC)
- Partnership for Patients

**Articles of Interest**

The following articles provide an opportunity to gain a broader depth of knowledge of care transitions.

**Integrated Care Cuts Hospital Admissions by a Fifth:**  
Integrated care cuts hospital admissions for elderly patients by at least one-fifth, according to a new report from RAND Europe, Ernst & Young, University of Cambridge, and the Wellfield Trust.

**Hospital Checklists Cut Readmissions, Medicare Costs:**  
In another win for its hospital checklists, new research finds that a simple, one-page checklist can keep heart patients out of the hospital, as well as save Medicare billions of dollars, according to a presentation given at the American College of Cardiology's (ACC) annual scientific session.

**Affordable Care Act Update: Implementing Medicare Cost Savings:**  
The Affordable Care Act reforms the Medicare program's payment and delivery systems to help drive system-wide cost savings and quality improvement. Cost containment strategies resulting in six-year projected savings are included in the article.

**Hospital Readmissions Among Participants in a Transitional Care Management Program:**  
The following article describes a study on the implementation of a telephone transitional care management program (TCM) designed for patients discharged from an acute care facility. Results indicate an effective

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Funding Opportunities 2012

Community-Based Care Transitions Program (CCTP) Application  
Centers for Medicare & Medicaid Services (CMS) Web site Resources

- Details for the CCTP
- Solicitation for Applications—CCTP
- Medicare CCTP Application

Other Resources

- The CCTP Overview Presentation

Health Care Innovation Challenge Grant  
Visit <http://innovations.cms.gov> for more information.

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**Contact Us**

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Contact Us 2012

Please contact us if you have any questions regarding the No Place Like Home Campaign.

**Program Team Contacts**

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**Thank You!**

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# No Place Like Home – A California Campaign to Reduce Readmissions



**Quality Improvement Organizations**  
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**HSAG** HEALTH SERVICES ADVISORY GROUP

We convene providers, practitioners, and patients to build and share knowledge, spread best practices, and achieve rapid, wide-scale improvements in patient care; increases in population health; and decreases in healthcare costs for all Americans.

[www.hsag.com](http://www.hsag.com)

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