AMERICA'S ESSENTIAL HOSPITALS

A featured project from the Essential Hospitals Engagement Network (EHEN)

SANTA CLARA VALLEY HEALTH & HOSPITAL SYSTEM

Santa Clara Valley Medical Center *Preventable Readmission*

Problem Identified

Santa Clara Valley Medical Center was interested in looking at preventable readmissions where the drivers for readmission were identified as homeless, co-occurring diagnosis of substance use and mental health, and no connection to a primary care physician (PCP). By identifying those risk factors for readmission, the hospital was able to implement changes in discharge planning to decrease risk for readmission.

Interventions

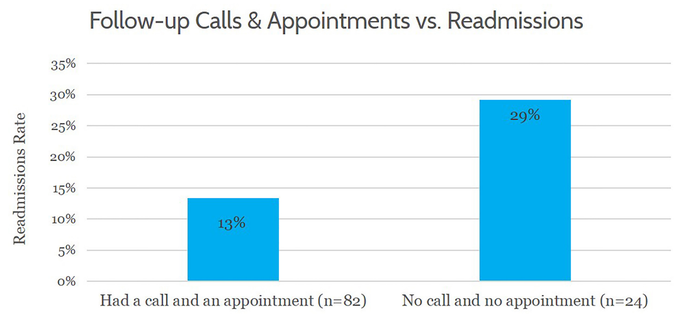
Santa Clara used the following tools: Better Outcomes by Optimizing Safe Transitions (BOOST), 8Ps risk assessment, Re-Engineered Discharge (RED) protocol for 72-hour follow up, and tracking if PCP appointments were made seven days after discharge. The hospital used Transition of Care (TOC) services from the pharmacy and public health nursing departments. Each of those programs has been shown effective in reducing readmissions with other patient populations at Santa Clara Valley Medical Center.

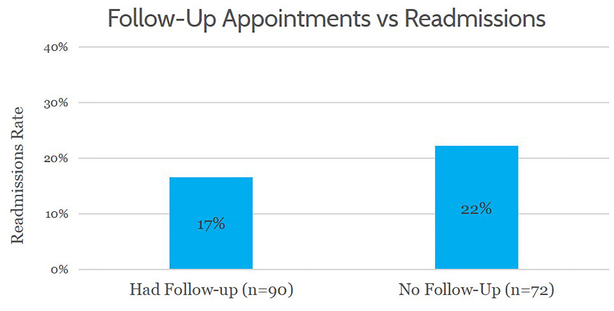
Leadership and Patient Engagement

The social worker staff integrated family and natural supports into treatment planning. As the project progressed, they were able to merge similar projects, like TOC services. The effort created a more integrative work model that discouraged working in silos.

Outcomes

The intervention team was able to reduce readmissions with the cohorts involved in the study by using the RED protocol and connecting with the primary care physician. (See figures below). The team also was able to demonstrate prevalence of substance use as a driver in readmissions.





Lessons Learned

Leadership involvement is key to any success of a program or innovation of new services. Santa Clara County Health and Hospital Systems have begun a Care Coordination and Transitions Work Group, which is part of a county leadership effort to utilize rapid transformation strategies toward Triple Aim efforts. (Triple Aim is a framework developed by the Institute for Healthcare Improvement, which advocates improved health system performance through better care, lower costs, and improved health.) Elements from the Preventable Readmission Project will be evaluated for integration as a change process to decrease risks for readmissions. During the intervention, the team faced the challenge of limited resources. Moving forward, Santa Clara Valley Medical Center will secure resources in advance, such as information services, direct service, and data analysis.

Strategies for Successful Replication

Strategies for successfully implementing a program for reducing readmissions include the following:

- Identify risk factors for readmissions, such as homelessness, co-occurring diagnosis of substance use and mental health.
- Coordinate internal services and external services from pharmacy, public health nursing, and social work to improve transition of care.