AMERICA'S ESSENTIAL HOSPITALS

Essential Hospitals Engagement Network (EHEN)
2014 Best Practice Survey: Highlights and Responses

Readmissions

Background

- In May 2014, EHEN asked its hospitals to complete a survey of the interventions and practices they have implemented or plan to implement as part of their quality improvement efforts.
- Response rate: 12 of 22 hospitals responded (55 percent).

Report Information

- This report is not intended to recommend any one intervention or practice, nor is it intended to prove causation between interventions and outcomes.
- Hospitals were not necessarily able to answer every question.
- The highlight section provides comparisons between conditions and associations with relevant outcome data. The outcome data was collected though UHC's clinical database (CDB/CDB-lite). The remainder of the report is a full breakdown of responses to each question from the survey.
- For questions, please contact your improvement coach or e-mail EHEN@essentialhospitals.org.

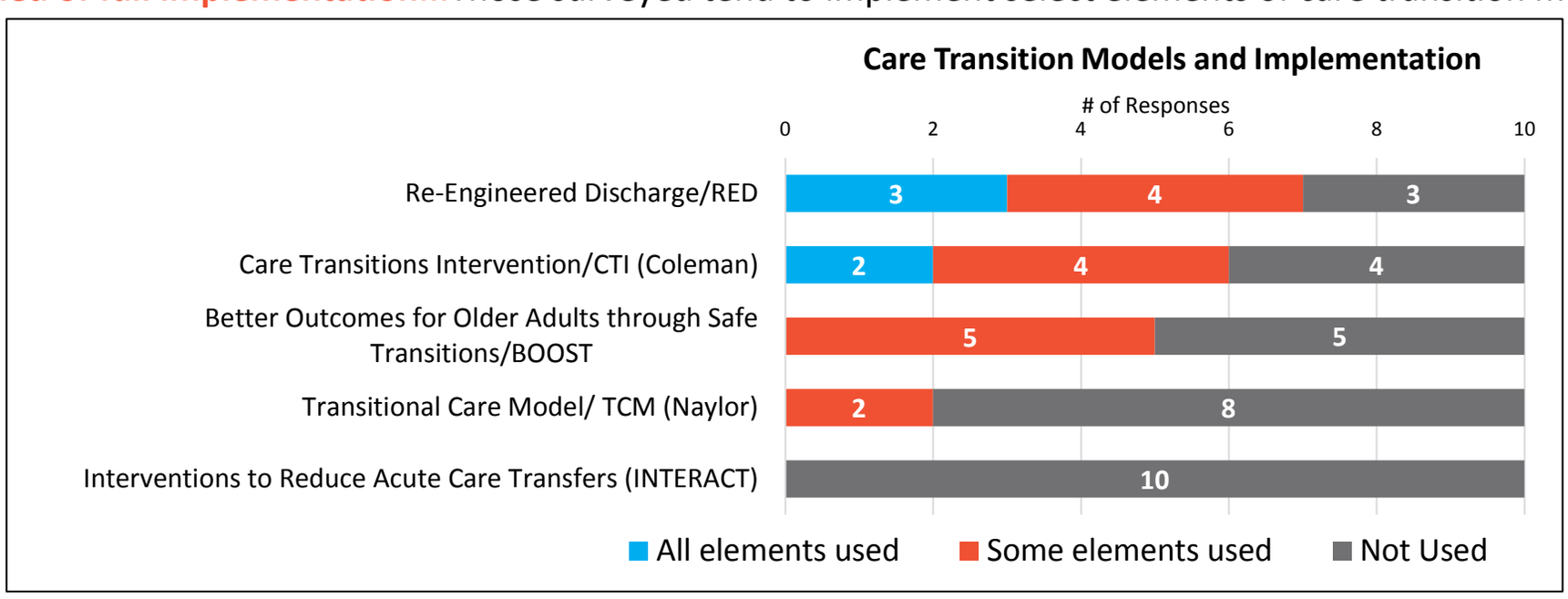
Readmissions: Best Practice Survey Highlights

In their own words... Top three effective Readmissions reduction strategies in the past 18 months from top performers.

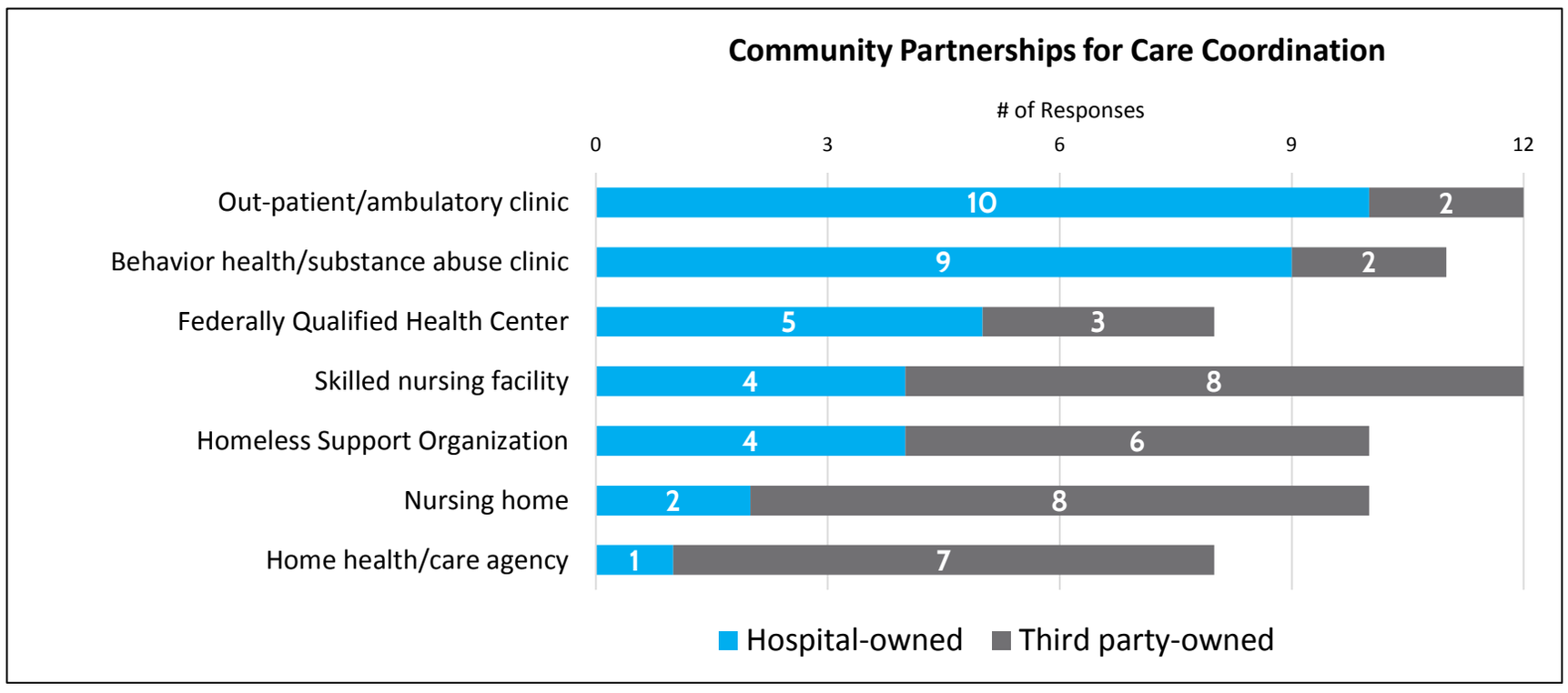
			Top Three Effective Strategies (Identified by the Hospital)		
	% Improvement	**Sparkline**	**#1**	**#2**	**#3**
Maricopa Integrated Health System	-17.3		Post discharge follow-up phone calls by hospital unit coordinators, which help determine patient compliance post discharge	Electronic risk assessment tool through EPIC that helps nursing assign appropriate score and trigger consult to care management when high risk.	Steps were recently outlined for ED physicians to make appointments for patients in the Transition Clinic. Hospital Unit Coordinators will be integrated into referral process.
MetroHealth System	-10.3		ACO care coordination/care navigation	Care Management/Social Work/Clinical Team discharge rounds	Transitional Care Program
Contra Costa Regional Medical Center	-5.5		SNF Care Managers	Pharmacy medication reconciliation and education prior to discharge	Structured follow-up phone calls within 72 hrs of discharge, and for select patients, a home visit and phone calls for 30 days after discharge.
Truman Medical Centers-Hospital Hill	-4.5		Outpatient infusions chairs for patients	Patients bringing all home meds with them to ED and/or outpatient clinic appointments	Follow-up appointments with next provider within 7-10 days post discharge

Notes: Performance based on 30-day All-Cause, All-Payer Readmissions data collected through UHC's CDB/CDB-lite. The baseline is 2010 for all, except Contra Costa, whose baseline is Q3'12-Q2'13). The performance period is Q2'14 for all, except MetroHealth, whose performance period is Q4'13). Sparklines show trend over time.

In lieu of full implementation... Those surveyed tend to implement select elements of care transition models.



Through partnerships... Hospitals surveyed can not make meaningful reductions in readmissions acting alone.



Essential Hospitals Engagement Network (EHEN)

Best Practices Survey 2014 - Readmissions/Care Transitions (CT)

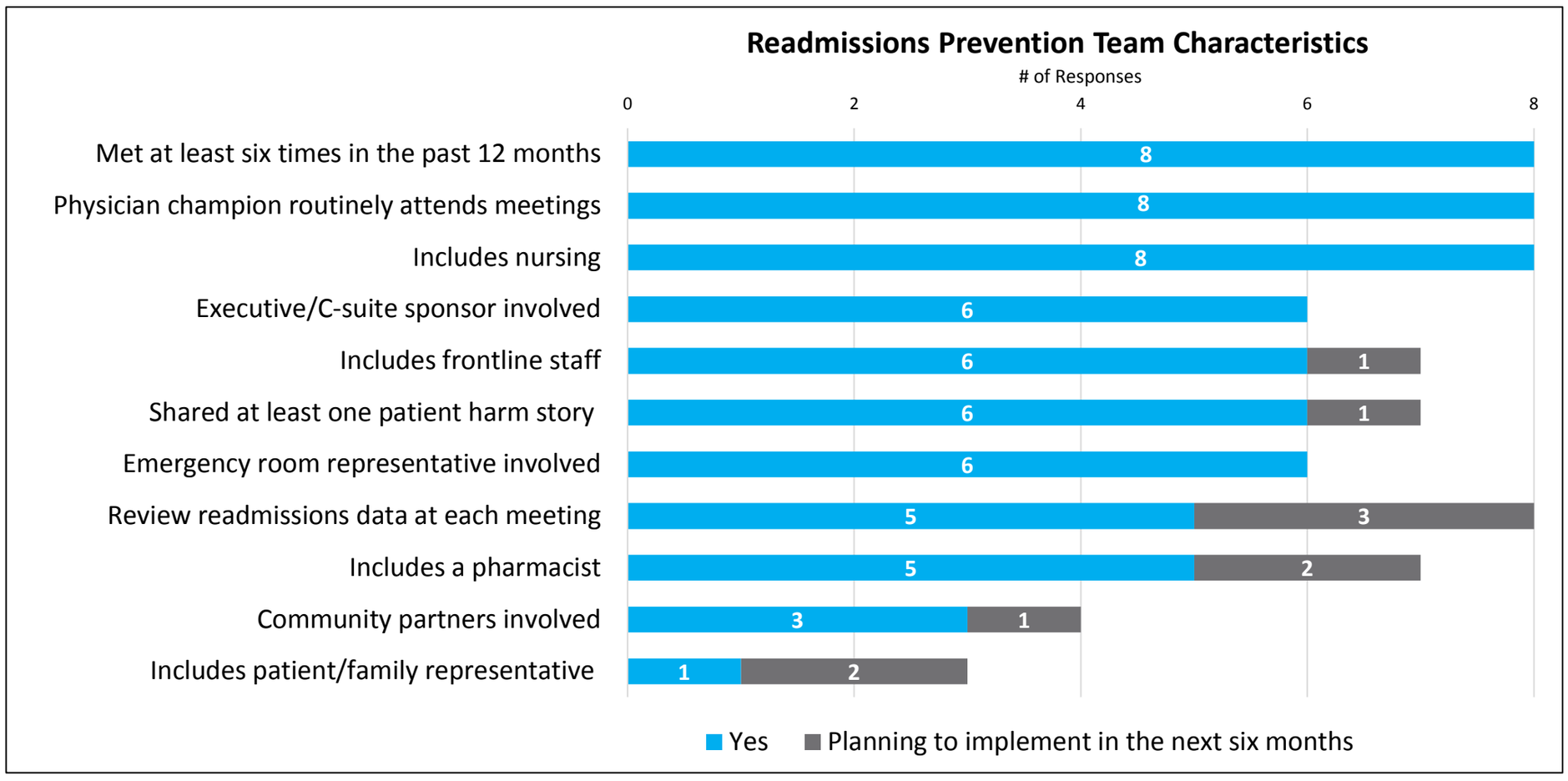
Red Numbers Represent Responses (n=12)

Section 10: Readmissions/Care Transitions (CT)

1. Does your facility have a multidisciplinary team *actively* working to reduce readmissions/improve CT?

8	Yes
3	No (Go to question 3)

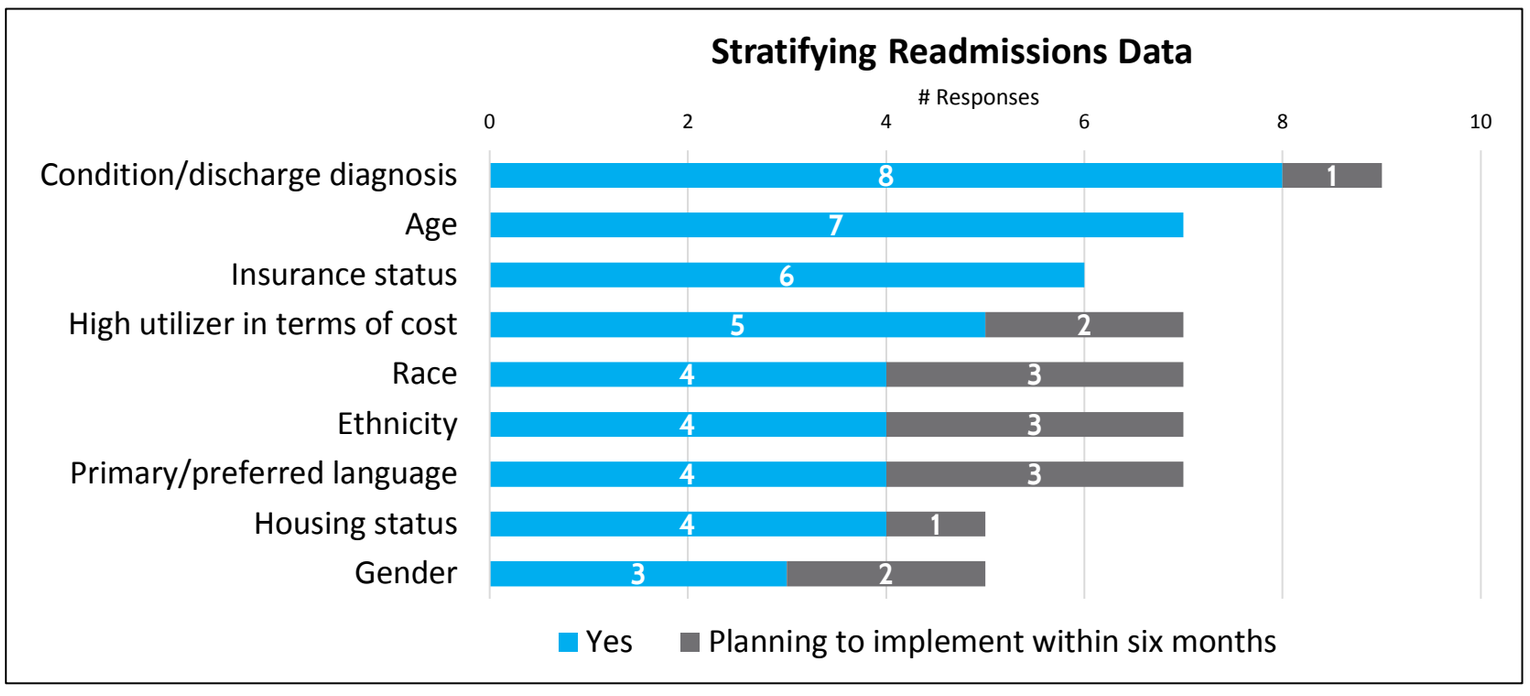
2. Please answer the following for your readmissions/CT team:



3. We have done an inventory of all internal and external initiatives/projects/programs currently working to reduce readmissions/improve CT within our hospital system.

4	Yes
5	Currently in process
2	No

4. Readmissions data are routinely stratified by which of the following patient characteristics:



Section 10: Readmissions/Care Transitions (CT)

5. Does your readmissions/CT committee routinely track and review the following outcomes data? Select the best response.

Outcome measures	All discharges	Only specific discharge diagnoses	Do not track
Seven days or less post discharge readmissions	4	2	3
15 days post discharge readmissions	3	2	3
30 days post discharge readmissions	8	2	
60-90 day post discharge readmissions	5	2	1
Return to the emergency room visits within seven days post discharge	1	5	2
Readmissions related to adverse drug events		3	5
Other: CCRMC- 30 day return to ED	1		

6. Do you routinely collect and monitor data on the following process measures for discharged patients? Select the best response.

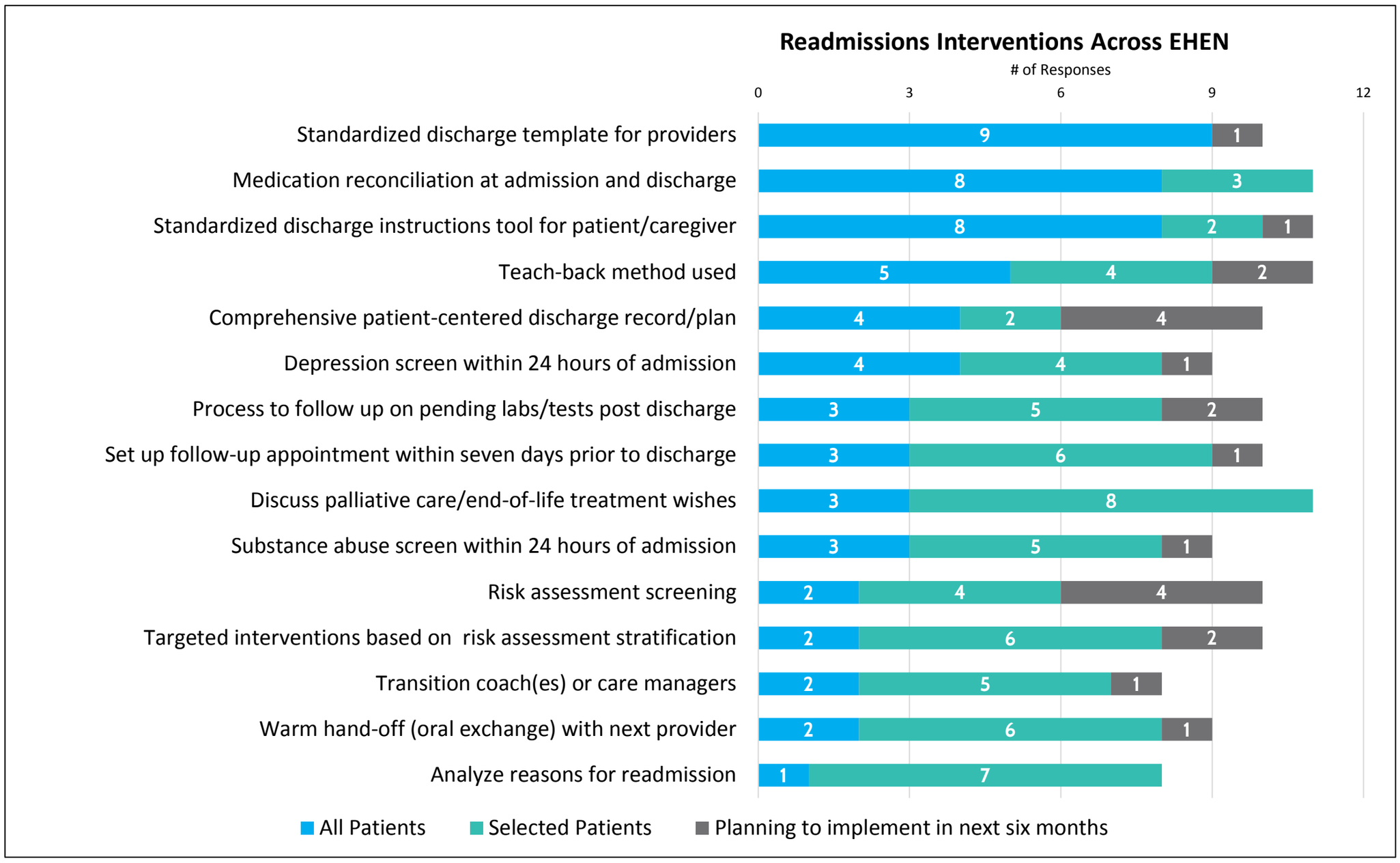
Practice	All discharges	Only selected discharges	Plan to do within next six months
Number of cases with completed discharge summary transmitted/made available to post care provider within 72 hours post discharge	4	4	2
Number of cases with documented follow-up appointment with post care provider within seven days post discharge	5	3	2
Number of cases with documented follow-up phone call within 72 hours of discharge	4	2	3
Number of cases for which defined and separate lists of discontinued, new, and continued medications are present in the medical record	5	1	3
Other: Rancho- F/U Medical Appt		1	

7. In the past 12 months, for which populations have you tried to improve CT/reduce readmissions? Check all that apply.

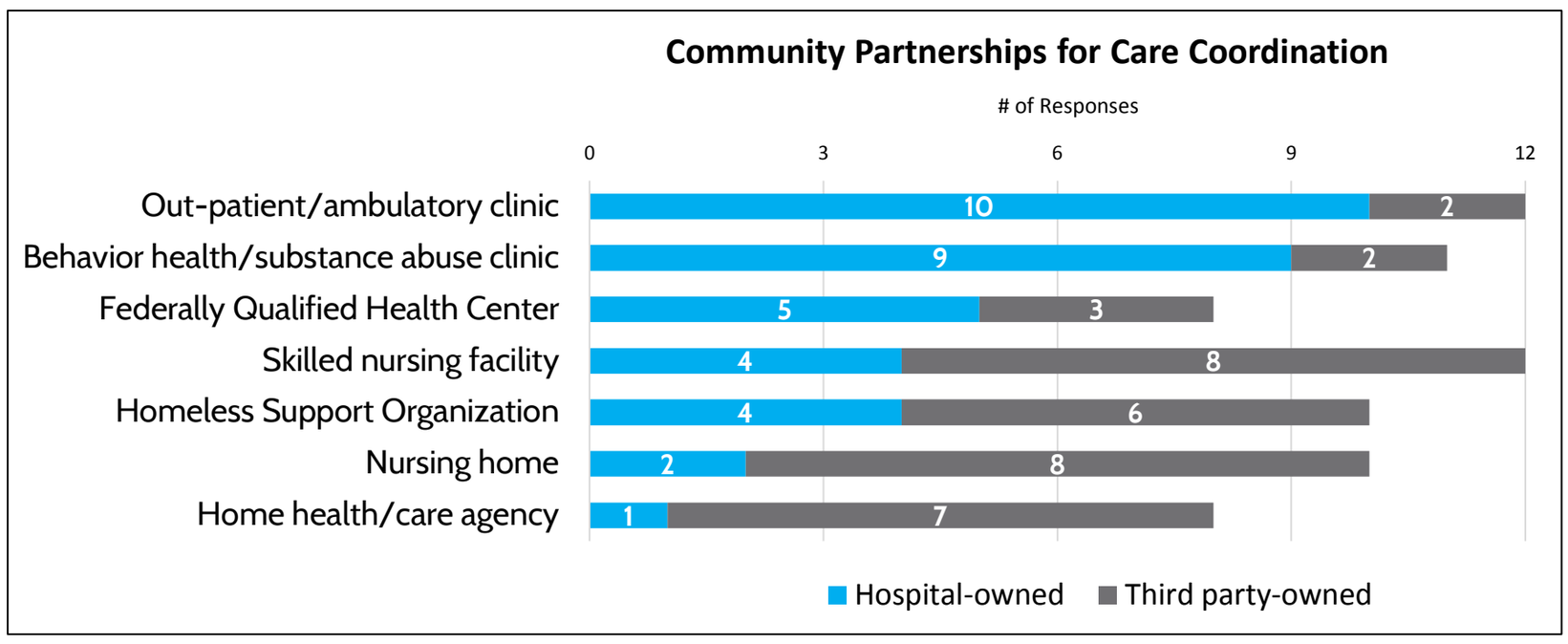
- 6 Specific patient diagnostic groups (e.g., heart failure, AMI, pneumonia, COPD, etc.)
- 7 All-cause, all-payer readmissions
- 5 Patients with behavioral health issues (e.g., mental health, substance abuse)
- 3 Other: MetroHealth- Uninsured, Patients on Waiver and ACO Medicare FFS; Alameda- Frequent Fliers; CCRMC- All Med/Surg excluding Psych and Perinatal

Section 10: Readmissions/Care Transitions (CT)

8. **Common interventions have been shown to positively impact care transitions and lead to a reduction in readmissions. Which of the following do you routinely and consistently use? Select the best response.**



9. **Do you have active partnerships with community organizations/post-care providers to improve care coordination? Check all that apply.**



10. **Effectiveness is defined as the degree to which a tool or strategy produced the desired result or impact on the intended goal. Using this definition, please list the three top interventions/strategies for reducing readmissions/improving care transitions you have implemented in the past 18 months**

Section 10: Readmissions/Care Transitions (CT)

11. Which multidimensional models do you use improve care transitions? Select the best response.

Models to improve transitional care	All elements	Some elements but not all	Have not used this model
Care Transitions Intervention/CTI (Coleman)	2	4	4
Transitional Care Model/ TCM (Naylor)		2	8
Better Outcomes for Older Adults through Safe Transitions/BOOST		5	5
Re-Engineered Discharge/RED	3	4	4
Interventions to Reduce Acute Care Transfers (INTERACT)			10

12. Does your hospital have a process for post discharge phone calls as part of follow-up care? Check all that apply.

- 6 Calls are made within 24-72 hours of discharge
- 2 Calls are made through a call center
- 4 Calls are made by a nurse, care manager, or pharmacist
- 7 A scripted interview tool is used and includes re-enforcement of discharge plan
- 5 All medications are discussed
- 6 We have a protocol/process for following up with medical issues identified on the call
- 3 We do not make post discharge phone calls

13. Which of the following post discharge interventions does your care transitions/readmissions program include? Check all that apply.

- 3 Dedicated full-time transition coach/care manager/social worker
- 10 Medication reconciliation
- 7 Transportation to/from follow-up appointments
- 11 Inclusion of family/caregivers in transition care plan
- 9 Reminder call(s) for follow-up appointments
- 7 Home visit(s)
- 7 Post-discharge follow-up clinic/provider access for patients without a PCP
- 2 Telehealth or telemonitoring program
- 9 Referral to behavioral health and/or substance abuse services

14. Which tool(s) do you use to identify individuals most at risk for returning to the hospital? Check all that apply.

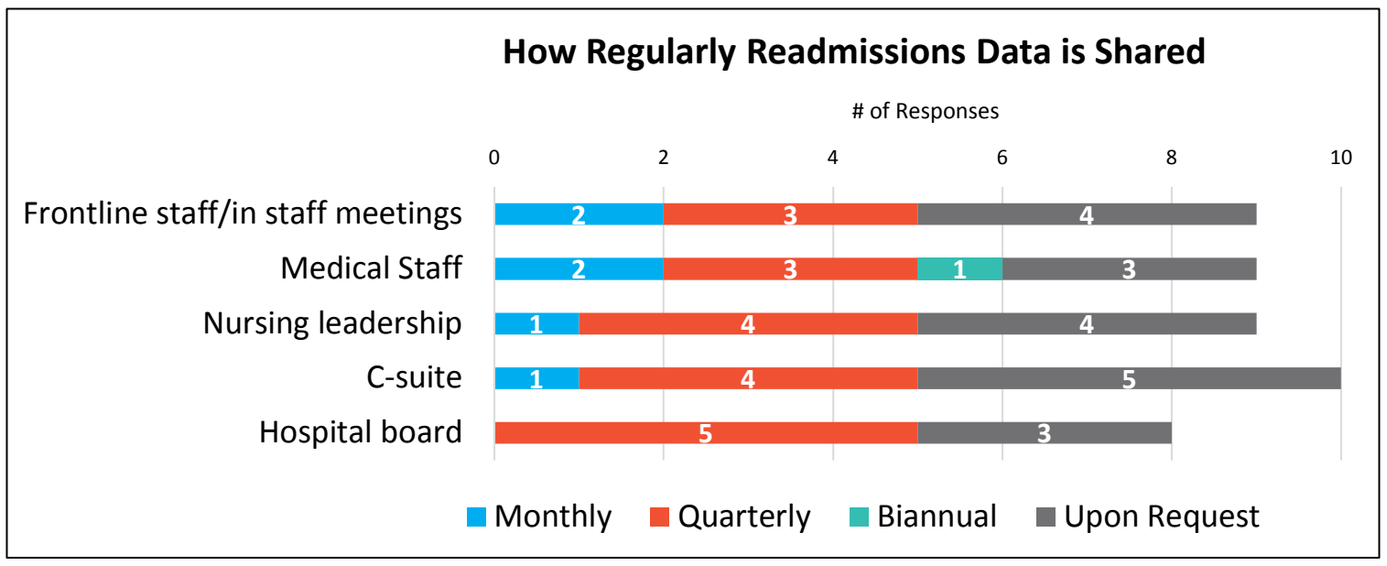
- 3 LACE/Modified LACE tool
- 3 BOOST 8Ps
- 0 CORE Readmission Risk Calculator
- 4 Chart review
- 5 Electronic Health Record
- 3 Predictive modeling
- 2 Registry
- 2 Transitional Care Model Discharge screen for high-risk older adults
- 1 Other: Rancho: PHQ2

15. How do you support patient attainment of prescriptions/medications at time of discharge? Check all that apply.

- 6 Medications delivered to/ Prescriptions filled for patient prior to discharge 7 days/week
- 4 Medications delivered to/ Prescriptions filled for patient prior to discharge 5 days/week
- 6 Electronic transmission directly to pharmacy
- 7 Prescriptions are faxed to or called into to pharmacy
- 10 Patients receive a hard copy prior to discharge
- 8 Provisions for interim medication supply
- 8 Co-pay support/low cost alternatives for medications
- Other:

Section 10: Readmissions/Care Transitions (CT)

16. How do you share data on hospital readmissions on a regular basis to promote system wide learning and transparency? Select the best response.



17. Which methods do you use to display readmission data in your hospital?

Method	Method used	Method *not* used
Run charts	**5**	**3**
Control charts	**2**	**6**
Bar graphs/pie charts	**4**	**4**
Harm counts	**2**	**5**
Days between readmissions	**2**	**5**
Other:		