OREGON HEALTH CARE QUALITY CORPORATION
A nonprofit partnership for quality improvement

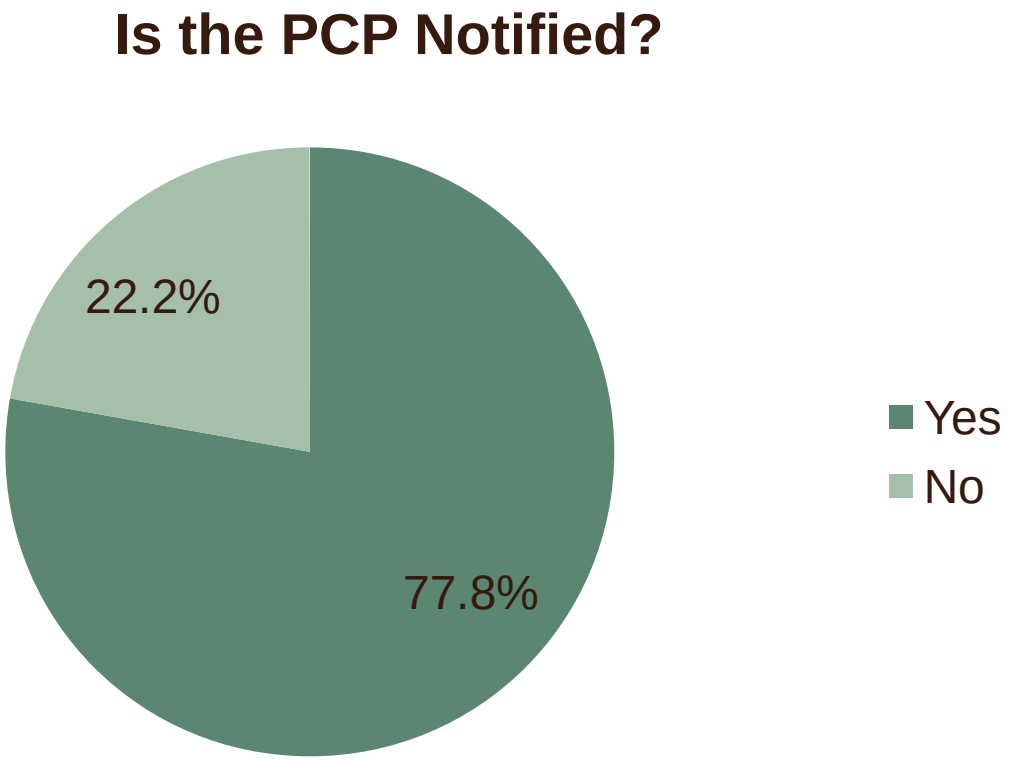
Transitions in Care Hospital Survey

September 2011

Survey Parameters

- 9 questions created by Diane Waldo, OAHHS
- Questions tested by Diane on 4-5 hospitals, modified based on results
- Questions loaded into SurveyMonkey
- Surveys distributed by Diane to sample of hospitals
- N=18 unique responses

#1: Regarding notification of PCP upon admission of their patient:



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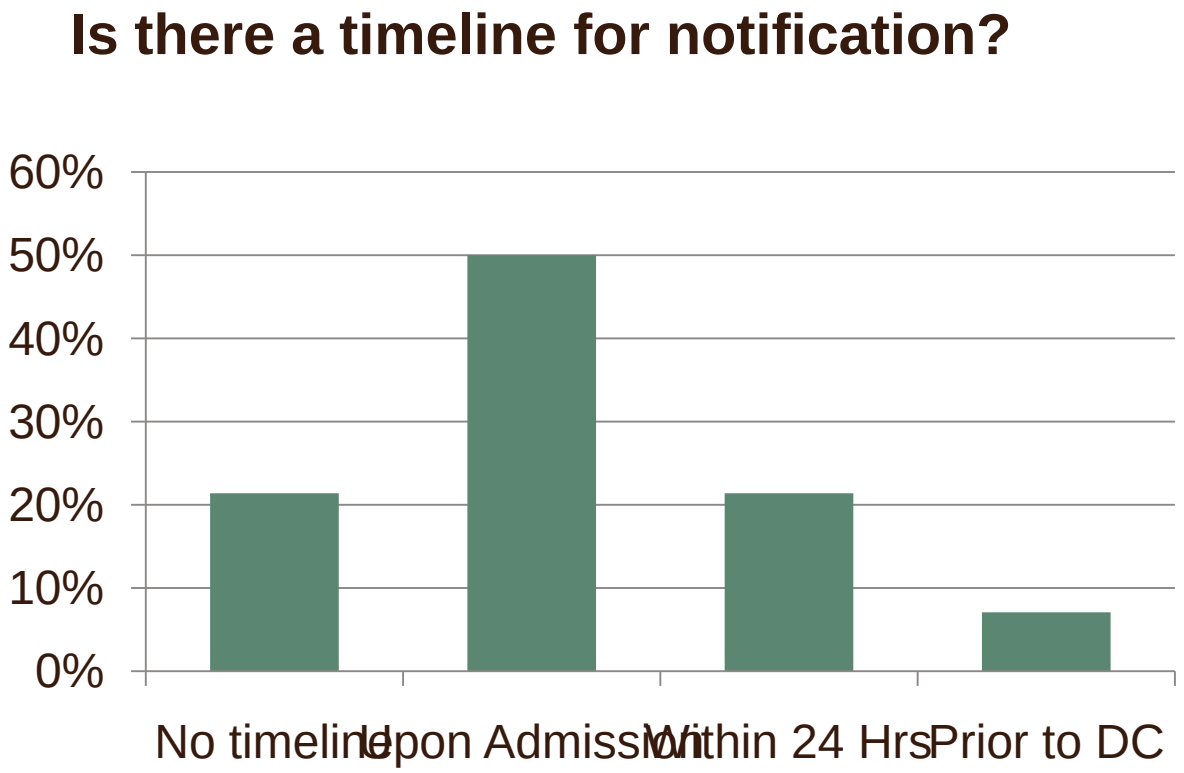

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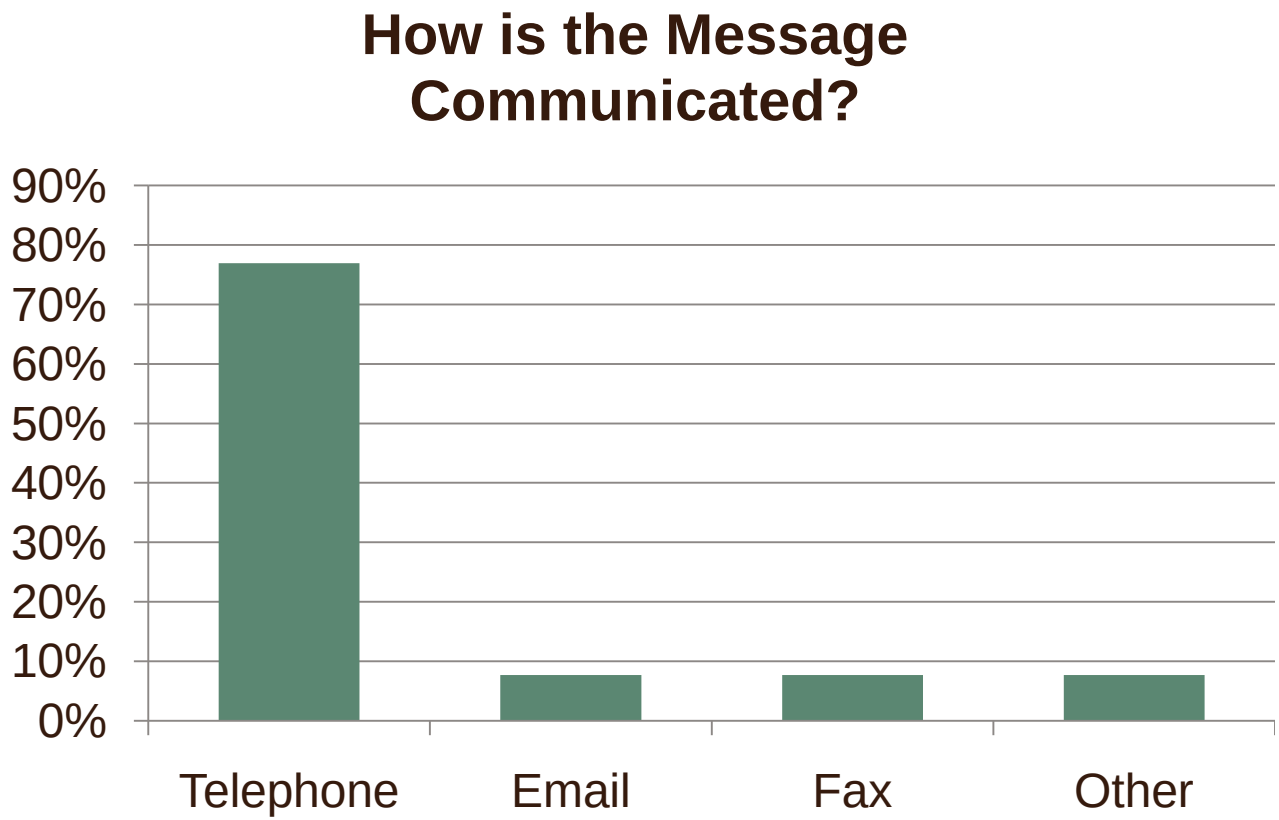

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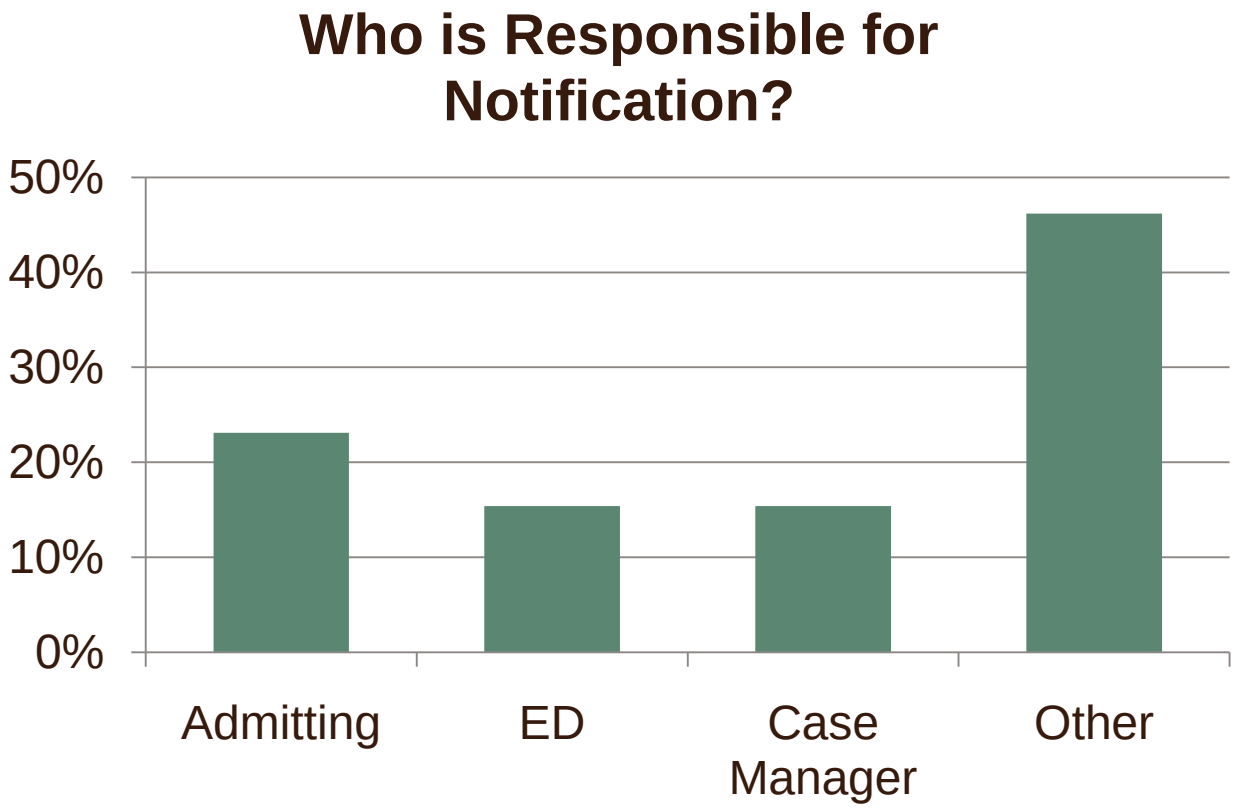
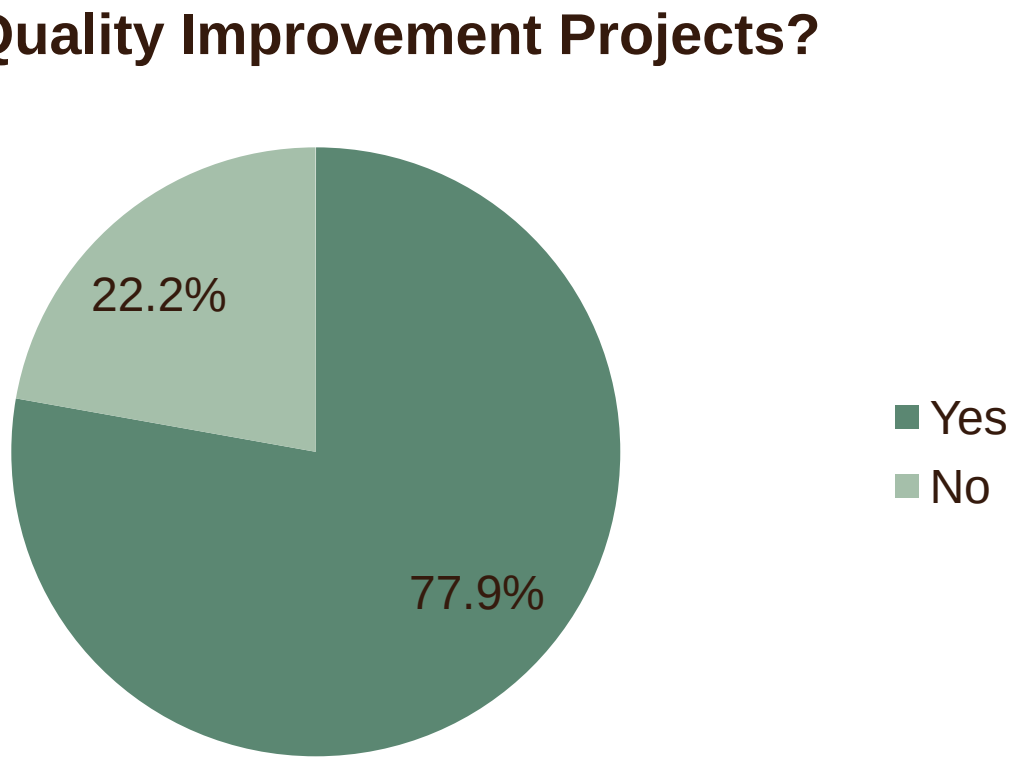


#2: Are you participating in internal or external QI projects to reduce readmissions?



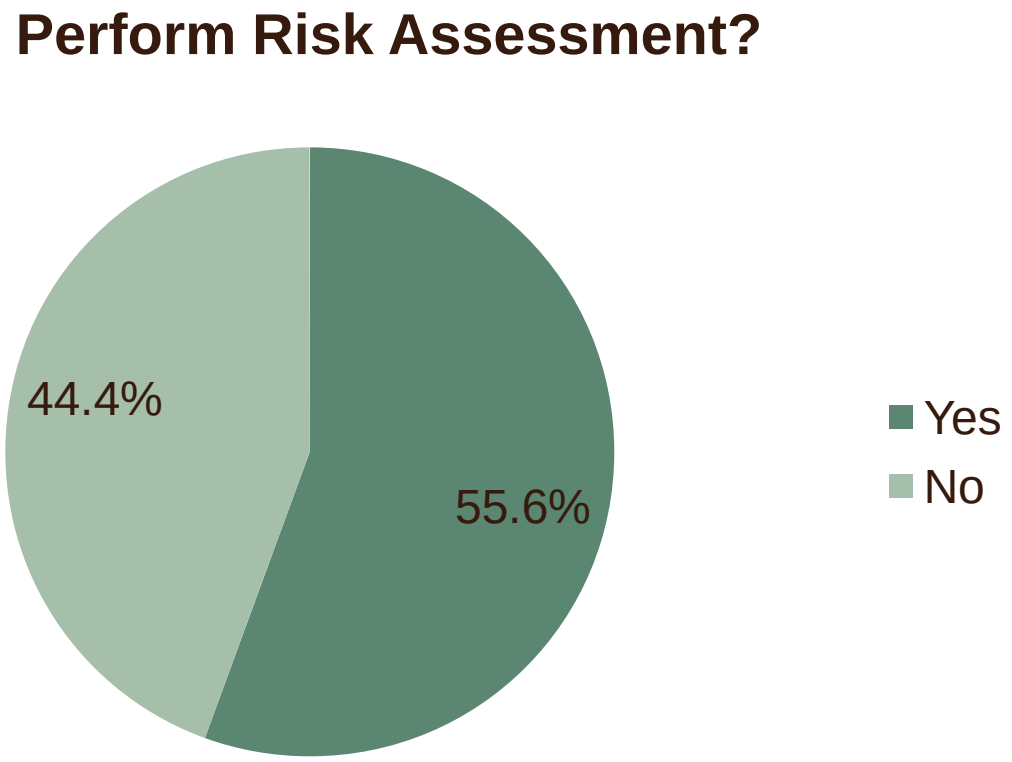
#2: Types of QI Projects

- Mult. Co. Care Transitions Program; also starting corporate wide Care Transitions program
- Readmission task force, meeting with outside sources, i.e. SNF, HH, Hospice and the State
- Reduce the rate for patients readmitted with a primary diagnosis of heart failure
- Community CHF education
- Focus on high risk diagnoses with case management and discharge phone calls

#2: Types of QI Projects*, continued*

- Person Centered Discharge grant through CMS; Coleman's Care Transitions Intervention model (also grant funded); post discharge phone calls
- Oregon State project
- We are working with the Robert Woods Foundation to reduce readmissions
- A4Q Heart Failure
- AF4Q Heart failure project; Internal investigation of case review of readmitted patients.
- TCAB *(Transitional Care at the Bedside)*

#3: Do you perform risk assessment to identify patients at risk of readmission?



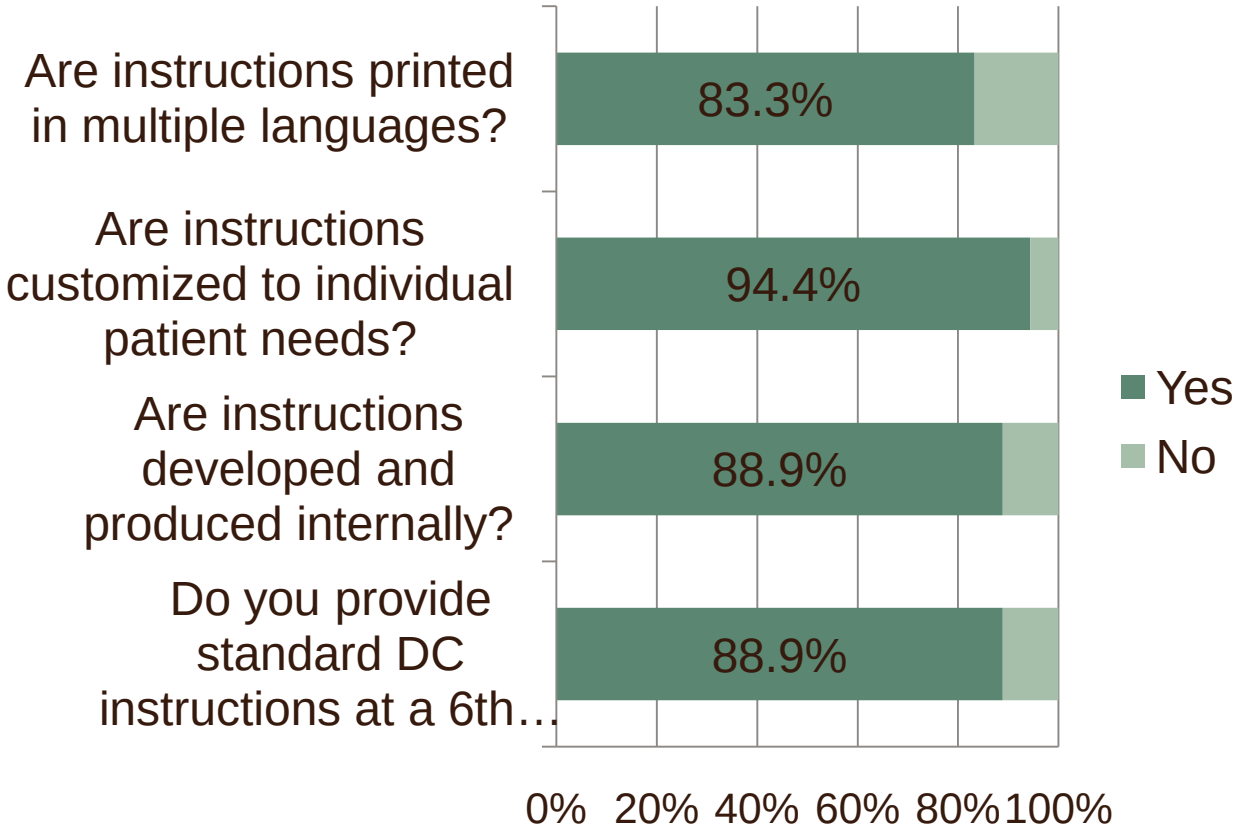
#3: Please describe the tool

- Set of questions regarding home life, concerns and watch for certain dx that are frequent readmissions and try to address them upon the first admission...setting up with resources as needed
- risk assessment tool in EMR to meet HFAP standards
- Criteria for high risk is one or more of the following: Pneumonia, CHF, HF or frequent admissions for any diagnosis
- STAAR risk assessment

#3: Please describe the tool, *continued*

- The case manager assess each patient for needs
- We are restructuring our case management model to better assess several parameters, readmission will be one of them
- Criteria are multiple chronic health conditions, poly-pharmacy, low health literacy, lack of social support, financial barriers

#4: When giving discharge instructions to patients:



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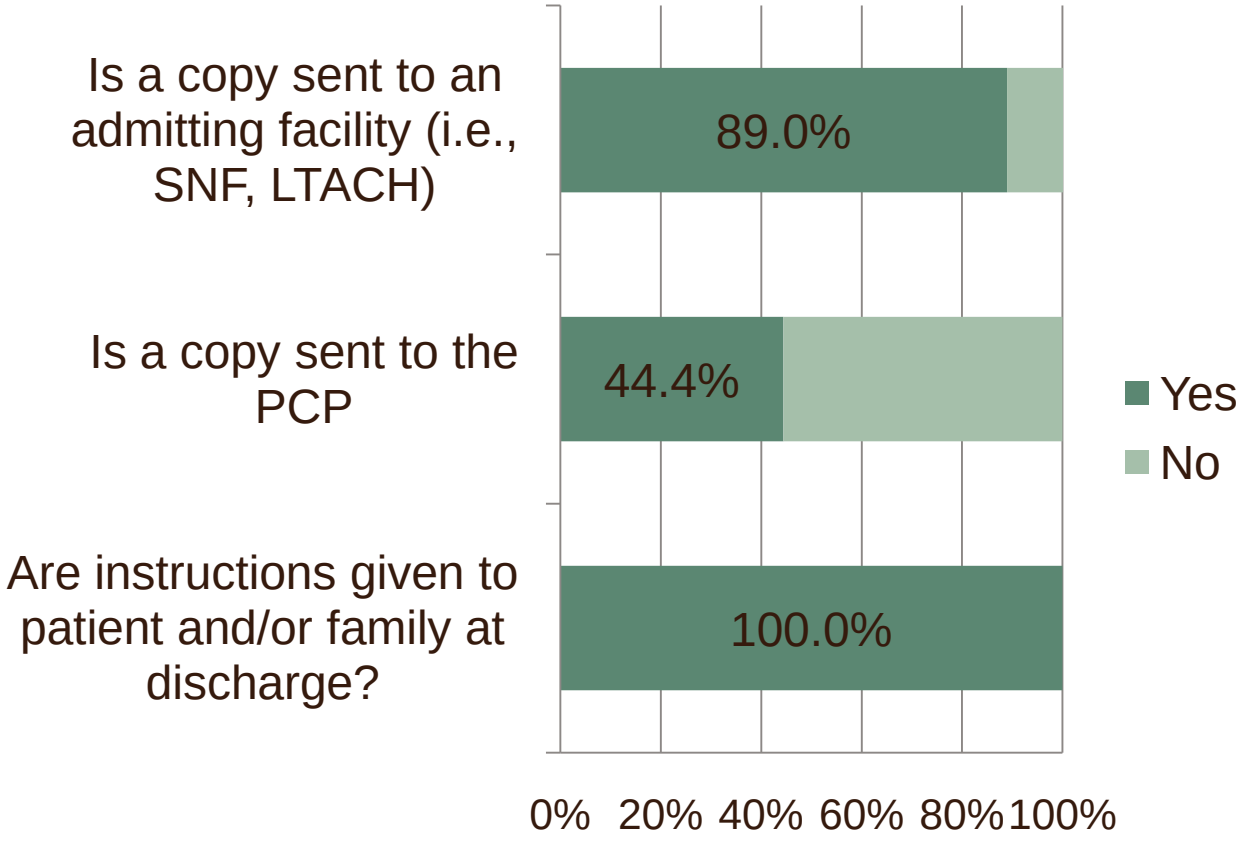
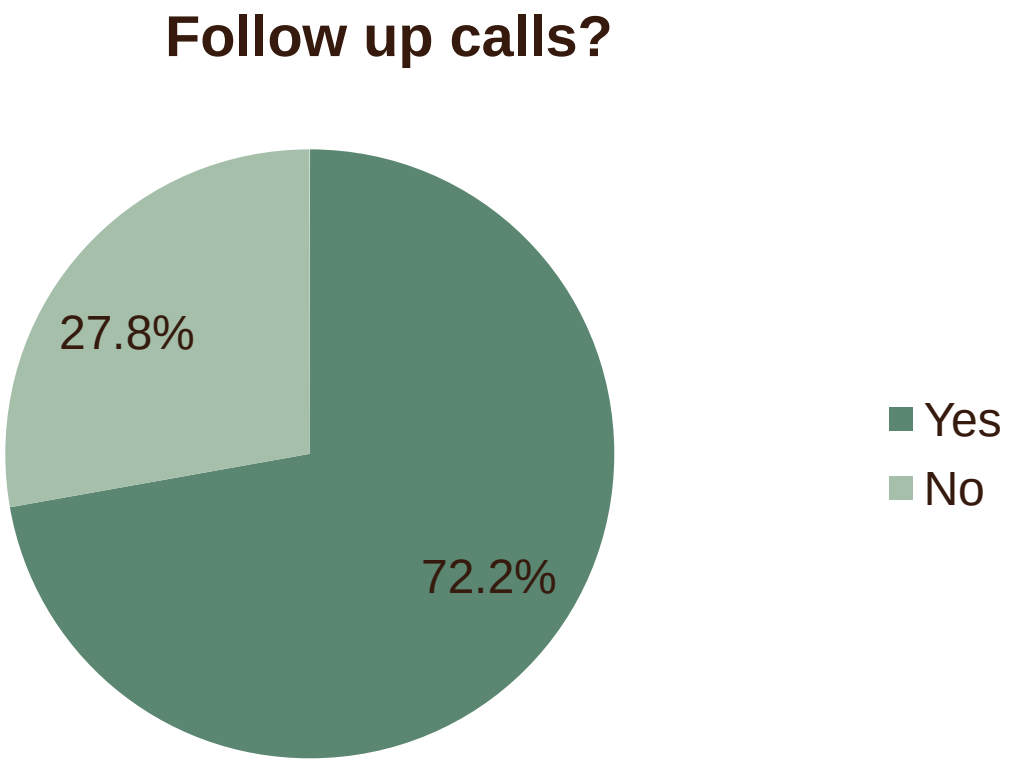


#5: Does the hospital do follow up calls with discharged patients?



#5: Which patients get calls, what timeframes?

- Automated by Hospital within 24 hrs post discharge. By Multnomah ADS Care Transitions Coaches within 24 hrs post discharge f/u by 1 visit and 2 f/u calls
- Inpatients within 48 hours of DC ED Patient within 24 hours
- We are in the process of starting that
- OB, Surgical, and some ED within 48 hours
- Per HFAP standards we do this and generally it is within 3 days. Also, there are the HCAPPS calls. The patients have expressed that they are being called too much

#5: Which patients get calls, what timeframes?

Continued

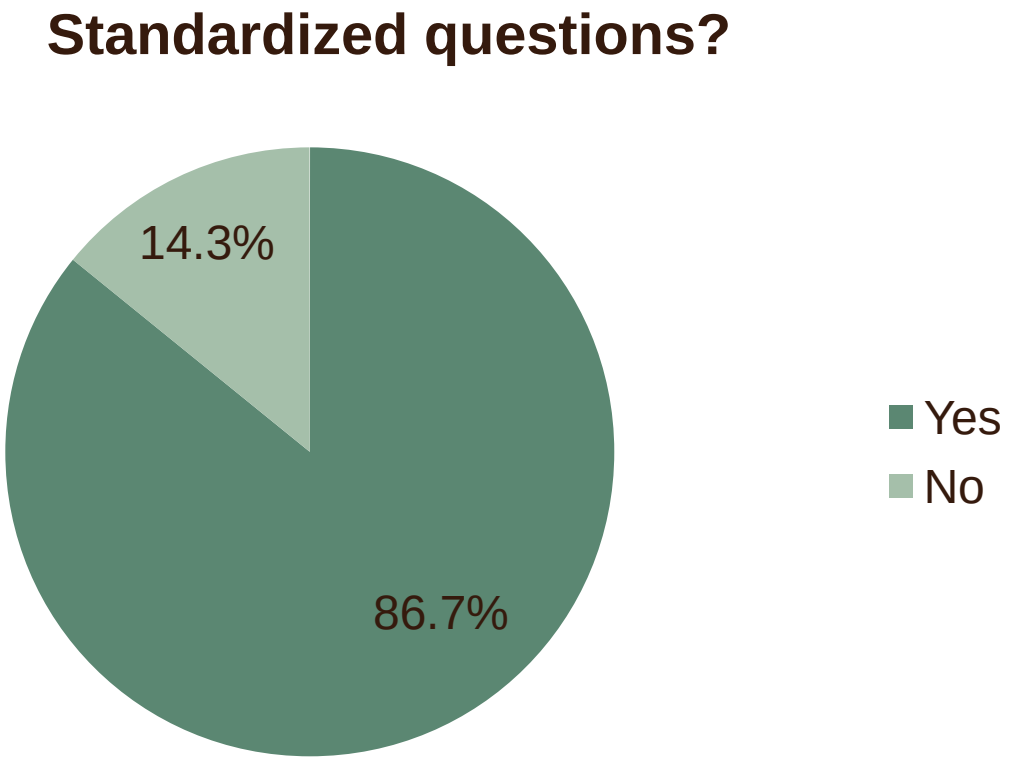
- All inpatients are called post discharge. Some ED patients are written on a list if there is a concern or if the condition was not clearly identified - such as abd pain. These patients receive a follow up phone call.
- currently our case manager tries to call all discharges within 3 days
- All patients within 48 to 72 hours
- All patients discharged to home as soon after discharge as possible (after 48hrs)
- Pt's at risk for re-admission; goal is within 48-72 hours

#5: Which patients get calls, what timeframes?

Continued

- We try to reach all discharged patients within 3 days of discharge to clarify instructions and confirm follow up appointments are made.
- This is currently being implemented.
- Heart Failure, unknown time frame
- All same day surgical patients (within 24-48 hours); heart failure patients and have just started with total joint replacement patients.

#6: If you do follow up calls with patients, are they asked standardized questions?



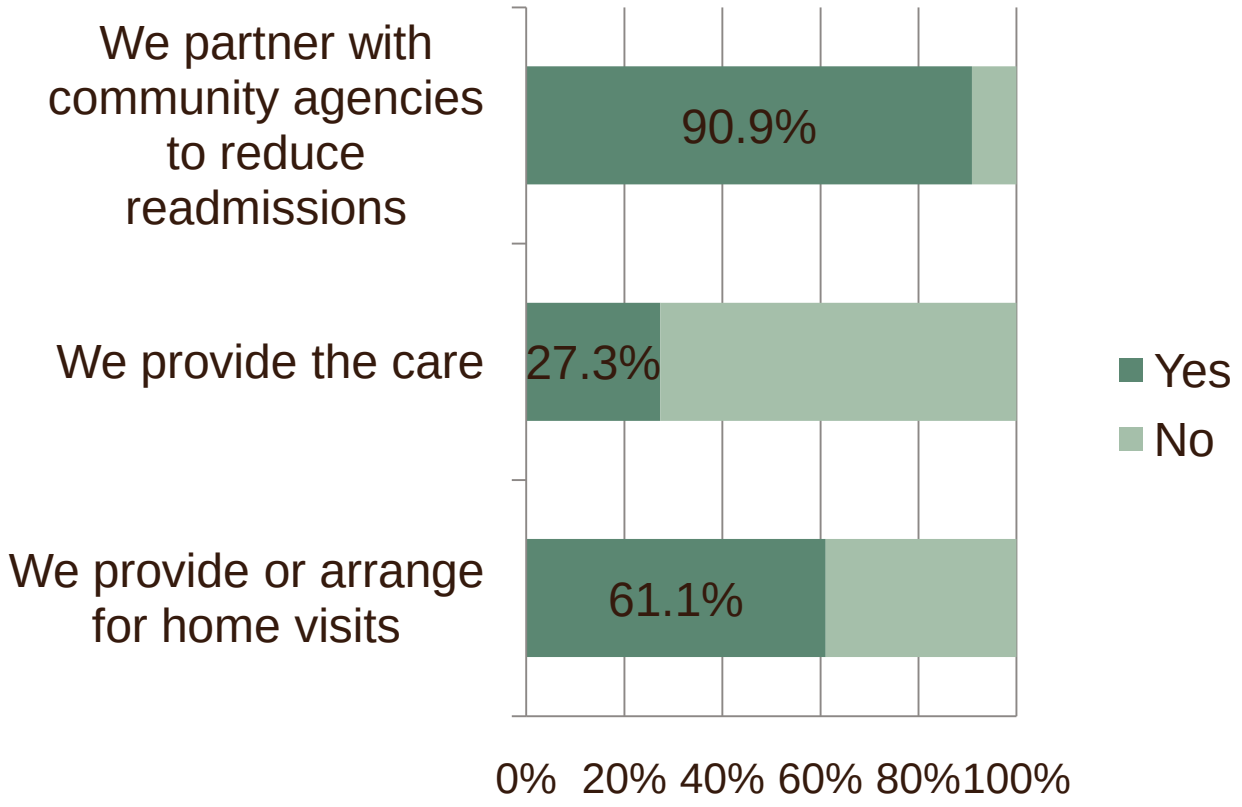
#6 What standardized questions are asked?

- Any Questions about you meds? Have you made an appointment with your PCP? Are you having any problems? Did you get all of your prescriptions filled? Can I help you with anything today?
- How was your stay? Do you have a follow up appt made? Did you fill all of your prescriptions? Was your pain controlled while you were here? Do you have any questions concerning your discharge instructions? Is there anything that we could have done differently to have made your stay better?

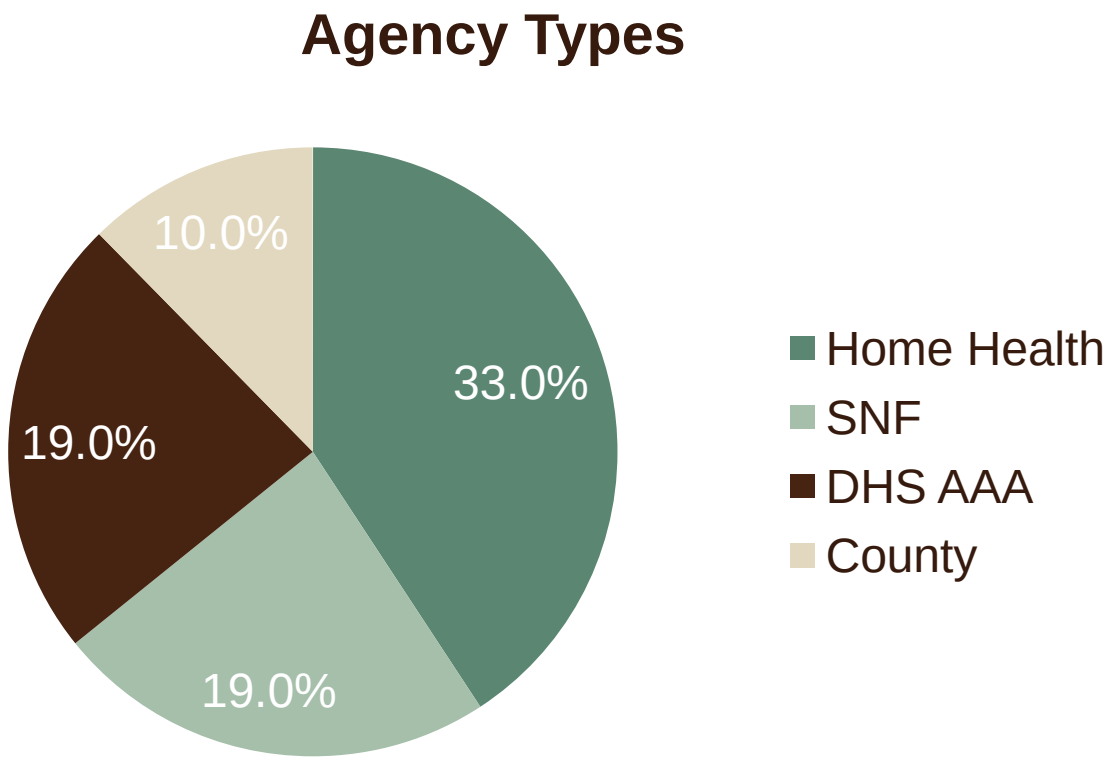
#6 What standardized questions are asked?*Continued*

- Template used asking about any new medications they are taking, follow up with PCP, specific questions re: weight and diet for CHF patients.
- Do they have outstanding tests? Do they have any concerns? When is their next appt with their PCP?
- Medications Follow up Diet Problems

#7: Regarding home visits to patients at high risk:



#7: What agencies do you partner with?



#8 What are your plans to address readmissions?

- Piloting the Care Transitions program at this time; expanding it to more counties (besides Multnomah Co. patients) and include patients with other high risk readmit diagnoses
- Within the next 3 months will have addressed many of these issues- 6 months for many to be resolved and within a year hope to have readmissions down to a science.... :)
- We will continue to study the data and work on a comprehensive program which focuses primarily on outpatient management to prevent readmissions

#8 What are your plans to address readmissions?*Continued*

- We have very few admissions and so readmissions are rare. We watch for any readmit for patients seen in ED and in Med-Surg
- Implement "teach-back" methodology for DC instructions. Timeline is Jan 1st 2012.
- Continue to monitor

#9 What do you need to be successful in avoiding readmissions?

- Health literacy education at the bedside staffing level; initiated with case management but that needs to be hospital wide knowledge
- Better identify those at high risk and extend care into the community to support health
- Communication with all the agencies we work with, being on the same page, and continuing to monitor the situation and address changes and situations as they arise
- Data and information on how others are meeting evidenced based care

#9 What do you need to be successful in avoiding readmissions? *Continued*

- Financial support and education
- Better coordination with PCP, better access to PCP
- Our readmission rate is very low, but more staffing for follow-up phone calls would improve care
- More interactions with non-compliant pts
- Post discharge phone calls are tremendously important but very difficult to resource
- Case Manager for outpatient coordination of care

#9 What do you need to be successful in avoiding readmissions? *Continued*

- The ability to influence noncompliant pts
- Some help in providing services to those who do not qualify for HH, yet are not compliant with meds. Support for families, etc. It's called money! for help. We are a poor county with no or little public transportation. We need jobs and health ins. for workers.
- Don't know
- Ideally, the PCP should be more involved with patient's aftercare and follow up. That being said, the hospitals are charged with this which means more overhead to follow up on "out of hospital" care and follow up.