Hospital Engagement Network
Strategies to Enhance Care Transitions

Physicians Consortium for Performance Improvement
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David Schulke
Vice President, Research Programs
Health Research and Educational Trust
Session Overview

1) Describe HRET
2) Outline HRET role as a Hospital Engagement Network (HEN) contractor.
3) Examine several key drivers of hospital readmissions.
4) Review emerging strategies hospitals are using to improve care transitions.
5) Review typical initiatives of hospitals in the HRET HEN to reduce readmissions.
About HRET

• **Mission:** Transform health care through research and education.

• **Vision:** Leveraging research and education to create a society of healthy communities, where all individuals reach their highest potential for health.

• Established in 1944

• 501(c)(3) supporting organization of the American Hospital Association

• 70+ staff

• ~$50 million annual revenue
HRET National Improvement Projects

**Strategic Priorities**

- Leadership/Culture
- Teamwork
- CLABS
  - [Public Reporting 1/12; HAC Financial Penalty 2014]
- CAUTI
  - [Public Reporting Now; HAC Financial Penalty 2014]
- Readmissions
  - [Financial Penalty Now]
- HCAHPS
  - [Value Based Purchasing Now]
- ED Wait Time
  - [Public Reporting 1/13]
- VTE
  - [Public Reporting 1/13]

**HRET Projects**

- All HRET Projects
  - **TeamSTEPPS**
    - 3 years, $3.3 million
- **CUSP CLABS**
  - State Hospital Associations
  - 1 year, $7 million
- **CUSP CAUTI**
  - State Hospital Associations
  - 4 years, $19 million
- **Patient Safety Learning Networks**
  - State Hospital Associations, Systems
  - 2 years, $1.5 million
- **Hospital Engagement Contractor**
  - State Hospital Associations
  - 3 years, $98 million

**Obstetrical Harm**
**Surgical Complications**
**Adverse Drug Events**
**Patient Falls**
**Pressure Ulcers**
**VAP**
Partnership for Patients (PfP)

• Created and funded through Center for Medicare and Medicaid Innovation (CMMI--Sec. 1907 of House bill; Sec. 3021 of Senate bill)

• PPACA provides $1 Billion/year to “to test innovative payment and service delivery models to reduce program expenditures under the applicable titles while preserving or enhancing the quality of care furnished to individuals under such titles.”

• CMS established PfP as a private-public partnership

• Hospital Engagement Networks (HENs) are one part of the PfP
Aims of the Partnership for Patients

The 40/20 Goal

Keep patients from getting injured or sicker.
Reduce preventable hospital-acquired conditions by 40%.

1.8 million fewer injuries to patients, with more than 60,000 lives saved over the next three years.

Help patients heal without complication.
Reduce all hospital readmissions by 20%.

1.6 million patients will recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.
Scope of the HRET HEN: 
~1,600 Hospitals in 31 States
Hospitals in the HRET HEN

- Teaching: 45%
- Rural Referral: 18%
- Critical Access: 32%
- Community: 6%
HEN Hospitals: We Need Help with Readmissions
Overview of HEN Support

• Fund State Hospital Associations (SHAs) to recruit and support their members
• Training and coaching for hospitals and SHA leads
• State and national topic-specific collaboratives
• Improvement Leaders Fellowship for nearly 1,000 hospital leaders over a year
• Speakers bureau of subject matter experts, frequent national and State presentations
• Hospitals report process and outcome measures
• AHA/HRET HEN provides resources--
  ➢ Library of presentations on improvement strategies
  ➢ Topic specific change packages
  ➢ Bibliography of relevant literature
Five change packages (bundles of interventions) have been shown to work in controlled trials—

1) Coleman’s Care Transitions Intervention
2) Evans’ early, systematic discharge planning
3) Jack’s Reengineered Hospital Discharge (Project RED)
4) Koehler’s pharmacist patient education, medication reconciliation, phone follow-up
5) Naylor’s Transitional Care Model

Individual parts of these change packages have not been proven to work by themselves—to increase likelihood of a beneficial effect, implement the whole bundle

1) Medication reconciliation
2) Early inpatient education
3) Set follow-up appointments with PCP
4) Identify outstanding tests and who is following up
5) Arrange post-discharge services
6) Reconcile discharge plan with national guidelines
7) Teach what to do if problem arises
8) Provide written discharge plan
9) Assess patient understanding
10) Send discharge summary to PCP
11) Telephone reinforcement with patient
Figure 2. Cumulative hazard rate of hospital utilization for 30 days after index hospital discharge.
RED Components a Plurality of Hospitals in State “X” Report having Implemented

- Post-DC services identified, contact information given to patient (52%)
- Medication reconciliation (50%)
- Make follow-up appointment for patient (46%)
- Review with patient what to do if problem arises post DC (46%)
- Educate patient early and often during inpatient stay (43%)
- Assess patient understanding of plan (32%)
- Written AHCP to patient (26%)
RED Components that a Plurality of Hospitals in State “X” Report they have not yet Started

- Post DC calls to patient (54%)
- Alignment with national clinical process guidelines (50%)
- Expedite transmission of DC summary to PCP (48%)
- Discuss follow up tests with patient (44%)
- Assess patient understanding of plan (32%--equal share of hospitals as those who have already “implemented”)

American Hospital Association

HRET
Arkansas Hospital Progress Report

- Care “gaps continue to occur following discharge to other healthcare entities …Challenge now is coordination with clinic, HHAs and [LTCFs], seeing readmissions from these providers. Planning for meetings with them.”

California Hospital Progress Report

- “Post-Discharge phone calls must provide higher concentration on actual discharge instructions and assist patient with follow-thru”
- “Tracking not only Medicare but all-payer readmission rates and also readmissions from SNF”
- “Aiming to improve patient satisfaction while reducing readmissions”
• “CHF informational booklet is being distributed on PCU North and South and 10 CHF patients will be participating in the test phase. Results will be evaluated in 30 days.

• “Next Step: Evaluate feedback from CHF patients that are participating in the test phase and adjust information in the CHF booklet.”
Post discharge phone calls (Project RED)

- 100% of our patients are called post discharge, 81% successfully reached by a nurse
- Discuss with the patient—
  1. Pain
  2. Medications
  3. Follow Up Appointment
  4. Discharge Instruction Clarity
- Seeing improved satisfaction, improved compliance with discharge plan
• Discharge teaching with “teach back,” follow up appointments made before discharge, electronic medication reconciliation, written instructions (elements of both Project RED & “BOOST”)
• Despite teaching patients about activity level, diet, discharge medications, follow-up appointment, and weight monitoring …
• Some patients still present with large, unrecognized weight gain and distress. WHY?
• Patients are told to weigh themselves daily, but … can’t see the scale, don’t own a scale, can’t interpret change in weight (due to poor math skills, cognitive decline)

• We decided to use structured, formal shoes (“Sunday Shoes”) to assess pedal edema

• Did not want physicians receiving puzzling calls – “My shoes don’t fit” – so reviewed new approach with Medical Staff over two months

• Passed information to the office staff working on the phones
In Sum

- Some movement and improvement
- Enormous opportunities for improving hospital-physician practice cooperation
- Those seeking improvement are challenged by resistance over definitions of what number of readmissions are “avoidable”
- Multiple proven approaches; questions about full change packages vs. individual interventions
- Social factors are significantly greater challenge to some hospitals
Questions and Comments?

dschulke@aha.org