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Classifying and Comparing Hospital-to-Community Care Transition Strategies in Real-World Settings: Lessons from Project Achieve

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Classifying and Comparing Hospital Care Transition Strategies in Real-World Settings:

Project ACHIEVE's Retrospective Analysis

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Key Questions

- How do hospital care transition strategies vary in their core components?
- Which combinations of transitional care components lead to superior outcomes?

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Methodological Approach

- Recruit diverse national cohort of 400 hospitals
- Survey hospital personnel about transitional care strategies and components used
- Use principal components and cluster analysis to identify clusters of TC components commonly used together
- Compare patterns of care and patient outcomes across TC clusters using 5 years of Medicare claims data

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Variation in hospital use of specific TC components (1)

Transitional Care Components	Percent of Hospitals
1. **Risk Assessment:** Uses a protocol to identify patients who are at high risk of readmission:	
Identify medical risks only.	**23.3%**
Identify medical and social risks.	**16.0%**
2. **Patient Needs Assessment:** Conducts assessment of each patient's post-discharge needs.	**54.7%**
3. **Caregiver Needs Assessment:** Conducts assessment of each caregiver's post-discharge needs.	**38.2%**
4. **Shared Decision-Making:** Uses shared decision-making protocol with patient and caregiver.	**20.9%**
5. **Risk Factor Screening:** Screens all patients using explicit criteria to identify post-discharge risks	**31.0%**
6. **Risk-specific Interventions:** Implements risk specific interventions tailored to a patient's risks	**39.4%**
7. **Medication Reconciliation:** Contacts with outside pharmacies and/or primary care providers for clarifying current medication list; Uses designated person responsible for conducting medication reconciliation at discharge.	**35.0%**
8. **Skills Assessment:** Uses teach-back techniques with patients & caregivers for all of the following: **(a)** Discharge instructions/summary; **(b)** Action plan for patients and caregivers to help them manage changes in condition; **(c)** Personal health record; Signs/symptoms that should prompt PCP call or a return to the hospital; **(d**) Emergency plan with direct contact information for a specific provider; **(e)** Names, doses, frequency, and purpose of each medication; **(f)** Information about new, modified, and stopped medication.	**37.1%**
9. **Follow-up Appointment:** Ensures patients leave the hospital with an outpatient follow-up appointment already arranged.	**72.9%**
10. **Social Needs:** Identifies social service needs and makes referrals to community-based services; Asks patients whether they can afford their medications at discharge.	**51.9%**

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Variation in hospital use of specific TC components (2)

Transitional Care Components	Percent of Hospitals
11. Transition Team: Use a specific transition team to coordinate TC plans across hospital and post-home sites of care.	**30.9%**
12. Timely Communication/Alerts: Organization has process to alert outpatient providers within 24 hours of patient admission; Organization completes a patient's discharge summary and available for viewing within 72 hours.	**30.6%**
13. Information Exchange:	
Sends discharge summary directly to the patient's PCP.	**84.2%**
Ensures outpatient providers have access to inpatient electronic records.	**31.5%**
14. Pending Test Results: Assigns someone to follow up on test results that return after the patient is discharged.	**53.0%**
15. Lay-person Follow-up: Uses layperson to follow up with patients in person post-discharge	**27.8%**
16. Follow-Up Calls: Calls after discharge to either follow up on post- discharge needs or to provide additional education.	**74.2%**
17. Post-Acute Care Coordination:	
Conducts a nurse-to-nurse report prior to transfer.	**60.3%**
Provides a direct contact number to reach the inpatient treating physician.	**24.5%**
Average number of TC components used	**7.3**

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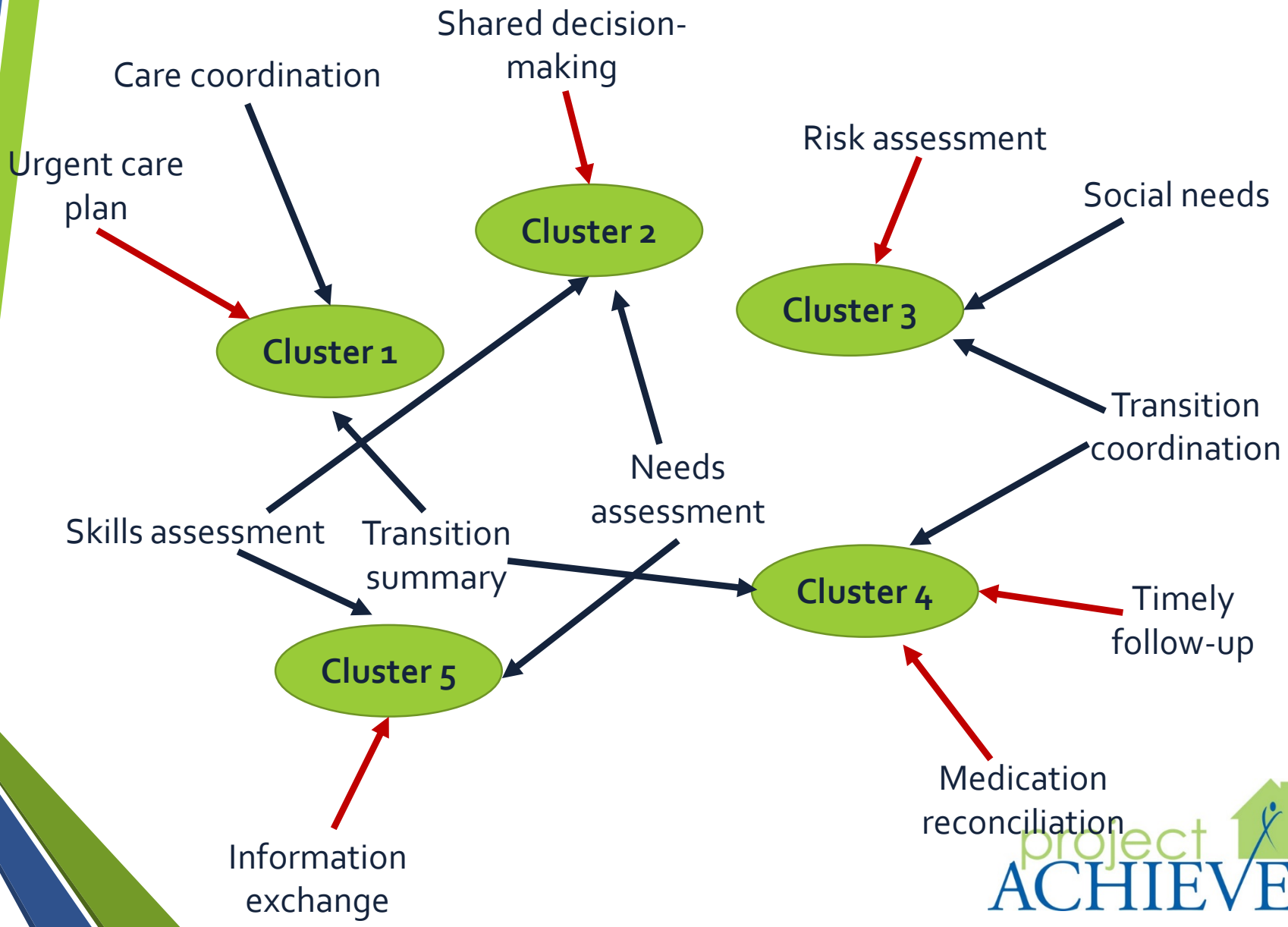
Clusters of TC Components Delivered Together (Program Signatures)



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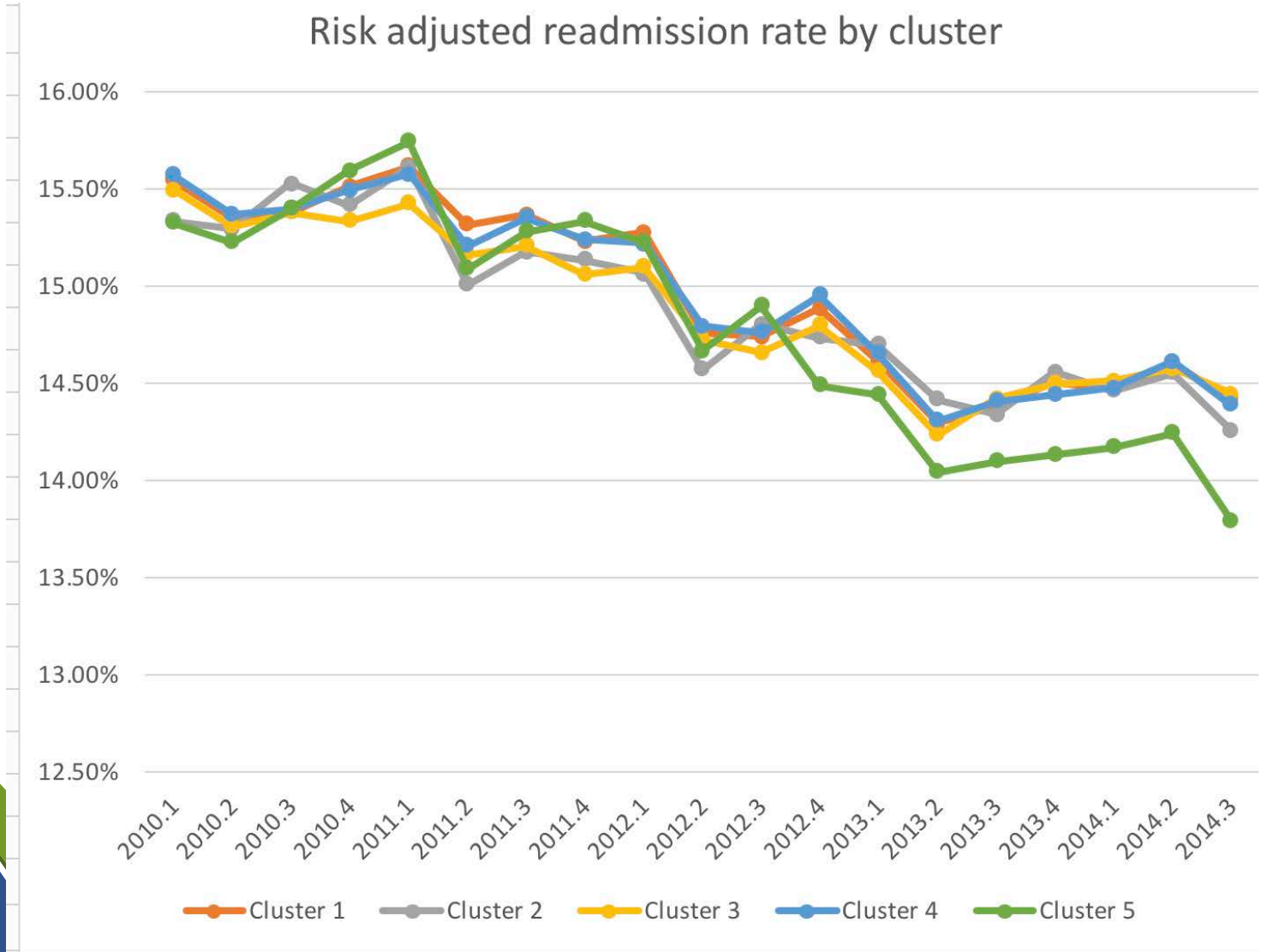
30-day Readmission Trends Among Hospitals Implementing Different TC Clusters

Adjusting for patient, hospital and community characteristics



Key Lessons for Policy and Clinical Practice

- Care transition strategies **vary widely** across hospitals
- **Five** general clusters of TC components are evident in current practice patterns
- Hospitals appear to adopt TC clusters preferentially based on **high baseline readmission rates**.
- Hospitals that adopt TC clusters experience significantly **larger reductions** in readmissions than non-adopters.
- TC strategies that include **information exchange with post-acute providers** are associated with the largest reductions in readmissions.

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Next Steps: ACHIEVE Prospective Analysis

- Granular examination of TC components in 46 hospitals using qualitative & quantitative measures
- Collection of patient-reported and caregiver-reported outcomes and experiences for 9000 patients following discharge.
- Refined estimates of the comparative effectiveness of TC components in improving patient-centered outcomes.

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