Greater New York Hospital Association/United Hospital Fund Quality Initiative

# *IMPACT* TO REDUCE READMISSIONS

**Follow Up Hospital Assessment**

## Overview and Instructions

As part of your participation in the GNYHA/UHF ***IMPACT* to Reduce Readmissions Collaborative**, please complete this follow up survey regarding your experience and progress made to date.

The survey is designed to: (1) Assess the interventions implemented and activities underway; (2) Understand what your hospital found particularly challenging or effective; and (3) Identify additional areas for improvement going forward into 2015.

Hospitals only need to submit one survey. Your participating nursing homes will be asked to complete a similar survey. Please email Melissa Miller (mmiller@gnyha.org) or Kelly Donohue (donohue@gnyha.org) if you have any questions. Please click **"Next"** to begin.

**NEXT>>**

Greater New York Hospital Association/United Hospital Fund Quality Initiative

# IMPACT TO REDUCE READMISSIONS

**Follow Up Hospital Assessment**

## IMPACT to Reduce Readmissions - Hospital Information

***Please select your hospital:**

*****

**Please enter in the name and email address of the person completing the survey (in case we have any follow up questions):**

**Name:**

**Email Address:**

***Please select the number of nursing homes you are working with for the IMPACT Collaborative:**

- 1
- 2
- 3
- 4

**Follow Up Hospital Assessment**

## Nursing Home (1 Facility)

Please select the nursing home you are working with for the IMPACT Collaborative from the dropdown menu:

***Nursing Home #1**

**Follow Up Hospital Assessment**

## GOAL 1: Build and strengthen relationships across care settings (1 Facility)

**Approximately how often does your facility's IMPACT team meet with the nursing homes below (in person and/or over the phone)?**

| | Once a week or more | Every other week | Once a month | Every other month | Once a quarter or less | Do not meet |
|---|---|---|---|---|---|---|
| Nursing Home | ○ | ○ | ○ | ○ | ○ | ○ |

**Which of the following <u>have you implemented</u> with the nursing home below? Please check all that apply.**

| | Nursing Home |
|---|---|
| Review of data or cases to identify root causes of readmissions | ☐ |
| Hospital staff visit(s) to the nursing home | ☐ |
| Nursing home staff visit(s) to the ED | ☐ |

**If applicable, please describe how any of the interventions listed above have contributed to any changes in clinical and/or administrative processes in your hospital and your partner nursing home(s)?**

(Example: Our hospital and nursing home team developed a process for when a nursing home requires hospital assistance with reinserting catheter but the patient does not require to be readmitted.)

**Follow Up Hospital Assessment**

## GOAL 2: Develop standardized processes for communication and information transfer between facilities

**Which of the following <u>have you implemented</u> with the nursing home below? Please check all that apply.**

| | Nursing Home #1 |
|---|---|
| Maintaining hospital and nursing home contact lists | ☐ |
| A communication/ information sharing process for hospital discharge to nursing home admission | ☐ |
| A communication/ information sharing process for nursing home transfer to hospital emergency department (ED)/ unit | ☐ |
| "Warm" handoffs/ proactive outreach post-discharge and post-transfer | ☐ |
| Ongoing review of patient information and forms shared between facilities to ensure essential, actionable information is included | ☐ |
| Medication reconciliation process between facilities at hospital discharge | ☐ |
| Medication reconciliation process between facilities at nursing home transfer | ☐ |
| A process to address differences in medication formularies | ☐ |
| Usage of a standardized transfer tool (e.g., INTERACT) to communicate between facilities | ☐ |

**Follow Up Hospital Assessment**

**Describe which of these standardized processes you have found to be particularly useful in improving communication and information transfer with [Nursing Home #1], and why?**

**Please select the top three priority areas that require further improvement with the nursing home listed below. *(Select up to three items from the list below)***

| | Schulman and Schachne Institute |
|---|---|
| Maintaining hospital and nursing home contact lists | ☐ |
| A communication/ information sharing process for hospital discharge to nursing home admission | ☐ |
| A communication/ information sharing process for nursing home transfer to hospital emergency department (ED)/ unit | ☐ |
| "Warm" handoffs/ proactive outreach post-discharge and post-transfer | ☐ |
| Ongoing review of patient information and forms shared between facilities to ensure essential, actionable information is included | ☐ |
| Medication reconciliation process between facilities at hospital discharge | ☐ |
| Medication reconciliation process between facilities at nursing home transfer | ☐ |
| A process to address differences in medication formularies | ☐ |
| Usage of a standardized transfer tool (e.g., INTERACT) to communicate between facilities | ☐ |

## GOAL 3: Incorporate patient, family members, and caregivers

**How often do each of the following activities take place with patients, family members, and caregivers in your facility?**

| | Never | Rarely | Sometimes | Often | Always |
|---|---|---|---|---|---|
| Discussion of patient's goals of care | ○ | ○ | ○ | ○ | ○ |
| Discussion of patient's anticipated outcomes upon admission and transfer | ○ | ○ | ○ | ○ | ○ |
| Discussion of advance care planning needs of patients upon admission and transfer | ○ | ○ | ○ | ○ | ○ |
| Continually inform and include patients, family and caregivers in discussions about their care | ○ | ○ | ○ | ○ | ○ |
| Collection of information from patients, family members, and caregivers on reasons why a patient was transferred and/or readmitted to better understand reasons for readmission | ○ | ○ | ○ | ○ | ○ |

**Describe any specific activities your facility has used to incorporate patients, family members, and caregivers that you found to be particularly useful in improving the care coordination process, and why?**

**Follow Up Hospital Assessment**

**Please select the <u>top three priority areas</u> that require further improvement in your facility. *(Select up to three items from the list below)***

- ☐ Discussion of patient's goals of care
- ☐ Discussion of patient's anticipated outcomes upon admission and transfer
- ☐ Discussion of advance care planning needs of patients upon admission and transfer
- ☐ Continually informing and including patients, family and caregivers in discussions about their care
- ☐ Collection of information from patients, family members, and caregivers on reasons why a patient was transferred and/or readmitted to better understand reasons for readmission

**Follow Up Hospital Assessment**

## Tools Adopted

**Does your facility use any INTERACT Tools to improve communication and information transfer with your nursing homes**

- ○ Yes
- ○ No

**If YES:**

## INTERACT

**If your facility has adopted any of the following INTERACT tools to improve communication and information transfer with your nursing homes, please rate the effectiveness of the tools.**

| | Not at all Effective | Somewhat Effective | Effective | Very Effective | Extremely Effective | N/A or Do Not Use |
|---|---|---|---|---|---|---|
| SBAR (Situation, Background, Assessment, Recommendation) | ○ | ○ | ○ | ○ | ○ | ○ |
| Early Warning Tool | ○ | ○ | ○ | ○ | ○ | ○ |
| Stop and Watch | ○ | ○ | ○ | ○ | ○ | ○ |
| Standardized Transfer Form/Checklist | ○ | ○ | ○ | ○ | ○ | ○ |
| Nursing Home Capability Checklist | ○ | ○ | ○ | ○ | ○ | ○ |
| Hospitalization Tracking Tool | ○ | ○ | ○ | ○ | ○ | ○ |
| Quality Improvement Tool | ○ | ○ | ○ | ○ | ○ | ○ |

**Follow Up Hospital Assessment**

**Has your facility adopted any other tools to improve communication and information transfer with the nursing homes you are working with? (Please select all that apply)**

☐ Has your facility adopted any other tools to improve communication and information transfer with the nursing homes you are working with? (Please select all that apply) Medication Reconciliation Tools

☐ MOLST or other Palliative Care Tools

☐ Standardized Communication Tools

☐ Case Review Tools (other than INTERACT QI tool)

☐ Tools to incorporate the patient, family/ caregivers into the care coordination process

Other (please specify)

**For any of the items selected above, please describe which tools your facility has adopted in more detail and describe their effectiveness:**

## Additional Comments

**What educational programming would you like GNYHA to host in the future?**

Please click on the "Submit" button to submit your survey.