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Understanding the groups of care transition strategies used by U.S. hospitals: an application of factor analytic and latent class methods.

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*RESEARCH methodology
*PATIENT readmissions
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*EVALUATION research
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*MEDICARE

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Abstract: <bold>Background: </bold>After activation of the Hospital Readmission Reduction Program (HRRP) in 2012, hospitals nationwide experimented broadly with the implementation of Transitional Care (TC) strategies to reduce hospital readmissions. Although numerous evidence-based TC models exist, they are often adapted to local contexts, rendering large-scale evaluation difficult. Little systematic evidence exists about prevailing implementation patterns of TC strategies among hospitals, nor which strategies in which combinations are most effective at improving patient outcomes. We aimed to identify and define combinations of TC strategies, or groups of transitional care activities, implemented among a large and diverse cohort of U.S. hospitals, with the ultimate goal of evaluating their comparative effectiveness.<bold>Methods: </bold>We collected implementation data for 13 TC strategies through a nationwide, web-based survey of representatives from short-term acute-care and critical access hospitals (N = 370) and obtained Medicare claims data for patients discharged from participating hospitals. TC strategies were grouped separately through factor analysis and latent class analysis.<bold>Results: </bold>We observed 348 variations in how hospitals implemented 13 TC strategies, highlighting the diversity of hospitals' TC strategy implementation. Factor analysis resulted in five overlapping groups of TC strategies, including those characterized by 1) medication reconciliation, 2) shared decision making, 3) identifying high risk patients, 4) care plan, and 5) cross-setting information exchange. We determined that the groups suggested by factor analysis results provided a more logical grouping. Further, groups of TC strategies based on factor analysis performed better than the ones based on latent class analysis in detecting differences in 30-day readmission trends.<bold>Conclusions: </bold>U.S. hospitals uniquely combine TC strategies in ways that require further evaluation. Factor analysis provides a logical method for grouping such strategies for comparative effectiveness analysis when the groups are dependent. Our findings provide hospitals and health systems 1) information about what groups of TC strategies are commonly being implemented by hospitals, 2) strengths associated with the factor analysis approach for classifying these groups, and ultimately, 3) information upon which comparative effectiveness trials can be designed. Our results further reveal promising targets for comparative effectiveness analyses, including groups incorporating cross-setting information exchange. [ABSTRACT FROM AUTHOR]

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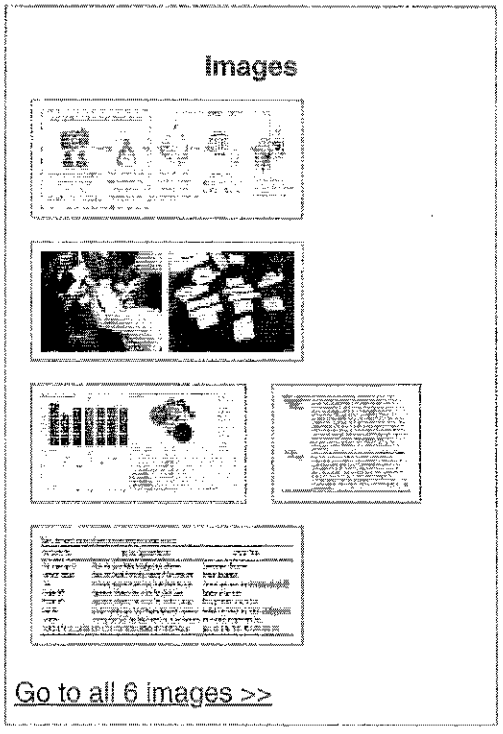
Dashboards to Support Operational Decision Making in Health Centers: A Case for Role-Specific Design.



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Subject Terms: *USER-centered system design
*HEALTH information technology
*HUMAN-computer interaction

*HEALTH facilities
*MEDICAL informatics

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Abstract: Applying a user-centered design (UCD) process within the framework of a learning healthcare system (LHS), this study unearths role-specific performance measures to support operational and financial decision making in community health centers (CHCs). We first built a multidimensional EHR/Practice Management data warehouse through a large collaborative of seven CHCs in the state of Indiana aimed at improving efficiency and access to care. A UCD process that comprised contextual interviews, card sorting and high fidelity dashboard prototyping was used to uncover over 45 different operational performance measures, many of which were unique and hitherto unknown measures of relevance to different individual roles within a CHC that included frontline staff, providers, clinical support, and executive management. Within the LHS paradigm, the study highlights the value of role-specific performance measurement and their delivery through interactive user-centered visualizations, while continuing to guide the development of future informatics tools. [ABSTRACT FROM AUTHOR]

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Can integrated care improve the efficiency of hospitals? Research based on 200 Hospitals in China.

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*DESCRIPTIVE statistics
*INTEGRATED health care delivery
*DATA analysis
*WORKING hours

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Abstract: Background: The shift towards integrated care (IC) represents a global trend towards more comprehensive and coordinated systems of care, particularly for vulnerable populations, such as the elderly. When health systems face fiscal constraints, integrated care has been advanced as a potential solution by simultaneously improving health service effectiveness and efficiency. This paper addresses the latter. There are three study objectives: first, to compare efficiency differences between IC and non-IC hospitals in China; second, to

examine variations in efficiency among different types of IC hospitals; and finally, to explore whether the implementation of IC impacts hospital efficiency. Methods: This study uses Data Envelopment Analysis (DEA) to calculate efficiency scores among a sample of 200 hospitals in H Province, China. Tobit regression analysis was performed to explore the influence of IC implementation on hospital efficiency scores after adjustment for potential confounding. Moreover, the association between various input and output variables and the implementation of IC was investigated using regression techniques. Results: The study has four principal findings: first, IC hospitals, on average, are shown to be more efficient than non-IC hospitals after adjustment for covariates. Holding output constant, IC hospitals are shown to reduce their current input mix by 12% and 4% to achieve optimal efficiency under constant and variable returns-to-scale, respectively, while non-IC hospitals have to reduce their input mix by 26 and 20% to achieve the same level of efficiency; second, with respect to the efficiency of each type of IC, we show that higher efficiency scores are achieved by administrative and virtual IC models over a contractual IC model; third, we demonstrate that IC influences hospitals efficiency by impacting various input and output variables, such as length of stay, inpatient admissions, and staffing; fourth, while bed density per nurse was positively associated with hospital efficiency, the opposite was shown for bed density per physician. Conclusions: IC has the potential to promote hospital efficiency by influencing an array of input and output variables. Policies designed to facilitate the implementation of IC in hospitals need to be cognizant of the complex way IC impacts hospital efficiency. [ABSTRACT FROM AUTHOR]

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