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Overview of the MA STAAR Collaborative

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February 3, 2011

This presenter has nothing to disclose.

Session Objectives

Participants will be able to:

- Discuss key drivers of rehospitalization rates.
- Identify promising approaches to reduce avoidable readmissions.
- Describe the STAAR Initiative and lessons learned to date.
- Describe key activities in the MA STAAR Collaborative.

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Rebecca's Story

Rebecca Bryson lives in Whatcom County, WA and she suffers from diabetes, cardiomyopathy, congestive heart failure, and a number of other significant complications; during the worst of her health crises, she saw 14 doctors and took 42 medications. In addition to the challenges of understanding her conditions and the treatments they required, she was burdened by the job of coordinating communication among all her providers, passing information to each one after every admission, appointment, and medication change.

http://www.ihi.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/ImprovementStories/PursuingPerfectionReportfromWhatcomCountyWashingtononPatientCenteredCare.htm

Rebecca's Story

Rebecca said if she were to dream up a tool that would be truly helpful, it would be <u>something that would help her keep her care team all on the same page</u>. Bryson described typical medical records as being "location or process centered, not patient-centered." She also describes how difficult it can be for patients to navigate a large health care system. Rebecca summarizes her experience in this way – <u>"Patients are in the worst kind of maze, one filled with hazards, barriers, and burdens."</u>

http://www.ihi.org/IHI/Topics/PatientCenteredCare/PatientCenteredCareGeneral/ImprovementStories/PursuingPerfectionReportfromWhatcomCountyWashingtononPatientCenteredCare.htm

Continuum of Care for Heart Failure Patients

Patient

Inpatient care

- Emergency
- Inpatient
- Hospitalists
- Pharmacy
- Nutrition
- Care Mgmt / Social work
- Resource nurse

Homecare

- Evergreen Care Network
- Behavioral health
- Home health
- Hospice care
- Palliative care

Community care

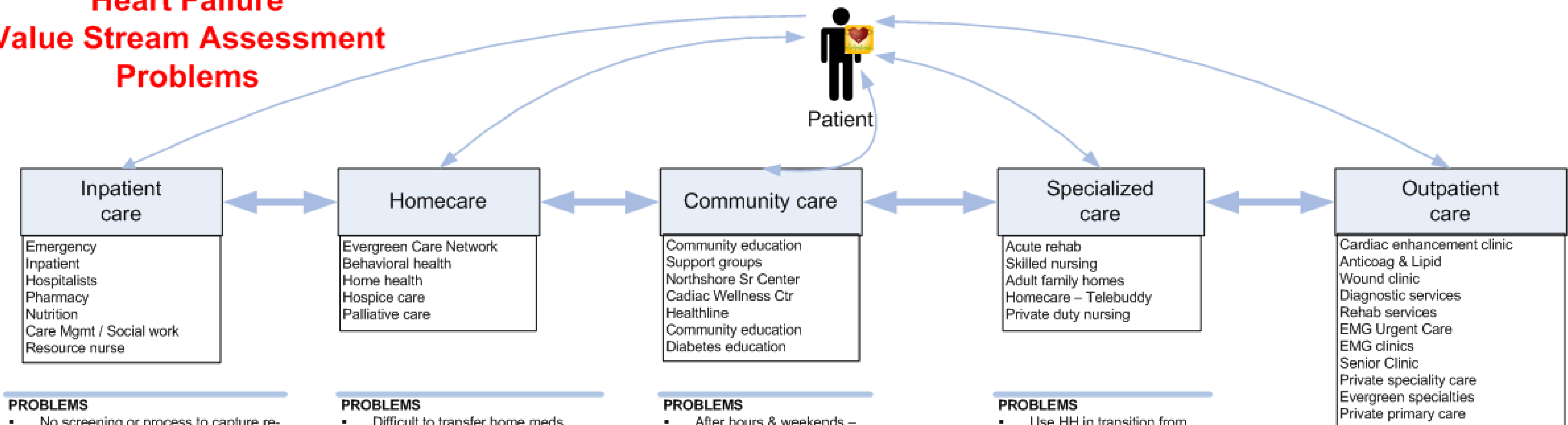
- Community education
- Support groups
- Northshore Sr Center
- Cadiac Wellness Ctr
- Healthline
- Community education
- Diabetes education

Specialized care

- Acute rehab
- Skilled nursing
- Adult family homes
- Homecare – Telebuddy
- Private duty nursing

Outpatient care

- Cardiac enhancement clinic
- Anticoag & Lipid
- Wound clinic
- Diagnostic services
- Rehab services
- EMG Urgent Care
- EMG clinics
- Senior Clinic
- Private speciality care
- Evergreen specialties
- Private primary care



PROBLEMS (Inpatient care)

- No screening or process to capture re-admit risk
- Patient not cared for by providers who know them
- Patient not get consistent message when bedside nurses train – nurses not trained in education
- Specialty consultations can be fragments and delayed (increase LOS)
- Problems with discharge med list and reconciliation
- Physicians have different hand-off from OP to ED (and reverse).
- Not always have discharge summary (not required)
- Patients refuse services
- Family/caregivers not included in education and care plan
- No connection between co-morbid conditions (Elenor's story – not always doing a baseline functional assessment).
- Person (visitor) in hospital; but there's not always a caregiver at home
- Inpatient info does not always get to HH (not good summary & process)
- Hospital does not have access to ECN
- Frequent readmits from PacMed, VM, GH, & others at UW.

PROBLEMS (Homecare)

- Difficult to transfer home meds when patient goes to hospital
- Payer determines when patient is well—this can happen before HH is completed
- Need to improve communication link between hospice/providers (not electronic)
- HH communicate with physicians only if a problem exists; this can be done by a phone call. No summary
- HH can work with many providers (EHMC only 30%). Also can be done with patients and other HH agencies
- Identify depression in 50% of HF patients. Evergreen Care network is value
- EHCS consists of: knowledge, insurance, county of residence, & age. It's a complex decision-qualification process
- ECN & EHCS have a disjointed communication and record access
- No formal pathway of care (Ex: patient options, also IP setting)
- Palliative care can be a transition to hospice. (expand to treatment, now-only decision making).

PROBLEMS (Community care)

- After hours & weekends – Healthline can expand to other groups. (Ex: Eastside Cardiology)
- Add Disease Mgt to VSA
- Improve link to Northshore Senior Center (for all patients)
- No consistency in education for co-morbidities
- Evergreen community education works well!

PROBLEMS (Specialized care)

- Use HH in transition from SNF to home. Patients do not get enough support and can be readmitted if needed.
- Educate family to ask questions
- Reimbursements to Evergreen covers costs only if ≥ 5 visits.
- Or you can send ARNP to home
- Can't share IP information with private duty and adult family home – education that's given at the hospital can be missed
- Link between telebuddy & cardiac enhancement center can encourage ED visits being needed
- Patients like service but time consuming for providers.
- Challenge is to get the right info at the right time.

PROBLEMS (Outpatient care)

- Cardiac enhancement center (20-30%).
- Enhanced cardiac care works well for patients (Goal: to cut 50% re-admissions)
- Not provided for all patients that are homebound.
- Caregivers do not always understand care

Overall Continuum of Care

PROBLEMS

- Reimbursement can be a barrier to continuum of care (learn from demo projects and benchmarks).

Determinants of Preventable Readmissions

- Patients with generally worse health and greater frailty are more likely to be readmitted
- Identification of determinants does not provide a single intervention or clear direction for how to reduce their occurrence
- There is a need to address the tremendous complexity of variables contributing to preventable readmissions
- Importance of identifying modifiable risk factors (patient characteristics and health care system opportunities)
- Preventable hospital readmissions possess the hallmark characteristics of healthcare events prime for intervention and reform > leading topic in healthcare policy reform

Determinants of preventable readmissions in the United States: a systematic review

Implementation Science 2010, 5:88 doi:10.1186/1748-5908-5-88

“The Billion Dollar U-Turn”

- Frequent
  - 17.6% of all Medicare hospitalizations are 30d *rehospitalizations*
- Costly
  - $12B in Medicare spending; est. $25B across all payers annually
- Actionable for improvement
  - 76% potentially avoidable
  - Heart Failure, Pneumonia, COPD, Acute MI (medical conditions)
  - CABG, PTCA, other vascular procedures (surgical conditions)
- Performance highly variable
  - Medicare 30-day rehospitalization rate varies 13-24% across states
  - Variation greater within states

MedPAC Report to Congress, Promoting Greater Efficiency in Medicare. June 2007
Mark Taylor, The Billion Dollar U-Turn, *Hospitals and Health Networks*, May 2008
Commonwealth Fund State Scorecard on Health System Performance. June 2009

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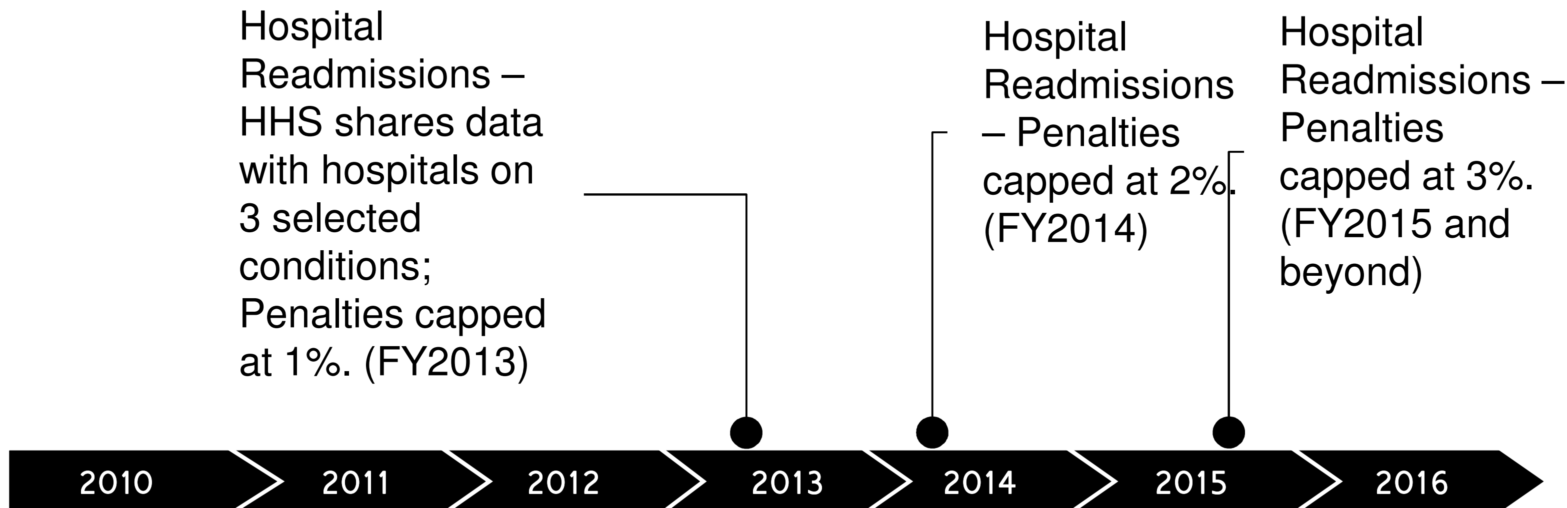
The Challenge

- Potentially preventable rehospitalizations are prevalent, costly, burdensome for patients and families and frustrating for providers
- No one provider or patient can “just work harder” to address the complex factors leading to early unplanned rehospitalization
- Problem is exacerbated by a highly fragmented delivery system in which providers largely act in isolation and patients are usually responsible for the own care coordination
- Most payment systems reward maximizing units of care delivered rather than quality care over time

Readmissions: Health Care Reform Provisions

- Up to 3% cut to <u>all DRGs</u> for readmissions over expected
- Up to 1% in FY 2013, 2% in FY 2014, not to exceed 3% in 2015 and beyond
- Initially AMI, CHF, Pneumonia
  - Expands to COPD, CABG, PTCA, and other vascular conditions in 2015
- 10 year savings: $7.1 B



The proposed prospective payment system begins October 1, 2012 (FY 2013)

The Chinese Symbol for Crisis

Danger

Opportunity

Opportunities

- Rehospitalizations are ***frequent ,costly and many are avoidable;***
- Successful pilots, local programs and research studies demonstrate that rehospitalization rates ***can be reduced;***
- Individual successes exist ***where financial incentives are aligned;***
- Improving transitions state-wide requires ***action beyond the level of the individual provider; systemic barriers*** must be addressed;
- ***Leadership at the provider, association, community, and state levels are essential assets*** in a state-wide effort to improve care coordination across settings and over time.

What can be done, and how?

There exist a growing number of approaches to reduce 30-day readmissions that have been successful locally

Which are high leverage?

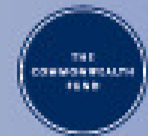
Which are scalable?

Success requires engaging clinicians, providers across organizational and service delivery types, patients, payers, and policy makers

How to align incentives?

How to catalyze coordinated effort?

STate Action on Avoidable Rehospitalizations



An initiative of The Commonwealth Fund & the Institute for Healthcare Improvement

http://www.ihi.org/IHI/Programs/StrategicInitiatives/STateActiononAvoidableRehospitalizationsSTAAR.htm

STate Action on Avoidable Rehospitalizations (STAAR) Initiative

The Commonwealth Fund-supported initiative to reduce avoidable 30-day rehospitalizations, taking states as unit of intervention.

- May 1, 2009 launch
- Anticipated 4-year initiative
- Institute for Healthcare Improvement providing technical assistance and facilitating a learning system
- Multi-stakeholder coalitions in 3 states selected as partners in this initiative (Massachusetts, Michigan, Washington)

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STAAR Initiative: Two Concurrent Strategies

1. Provide technical assistance to front-line teams of providers working to ***improve the transition out of the hospital and into the next care setting*** with the specific aim of reducing avoidable rehospitalizations and improving patient satisfaction with care.
2. Create and support ***state-based, multi-stakeholder initiatives*** to concurrently ***examine and address the systemic barriers*** to improving care transitions, care coordination over time (policies, regulations, accreditation standards, etc.).

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What have we learned to date in the STAAR Initiative?

Varying Degrees of Will

- Hospitals
  - strategic goal (aligned with health care reform and integrated approach to care; “right thing to do”)
  - avoidance of reimbursement penalties
  - watchful waiting
- Primary Care and Specialists
  - aligned with the goals of the Patient-Centered Medical Home demos
  - cardiologists generally engaged in developing comprehensive heart failure care models
- Home Care
- Skilled Nursing Facilities
- Area Agencies on Aging

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Strategic Questions for Executive Leaders

- Is reducing the hospital's readmission rate a strategic priority for the executive leaders at your hospital? Why?
- Do you know your hospital's 30-day readmission rate?
- What is your understanding of the problem?
- Have you assessed the financial implications of reducing readmissions? Of potential decreases in reimbursement?
- Have you declared your improvement goals?
- Do you have the capability to make improvements?
- How will you provide oversight for the collaborative, learn from the work and spread successes?

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Cross Continuum Teams

- One of the most transformational changes in the STAAR Collaborative
- Reinforces that readmissions are not solely a hospital problem
- Need for involvement at two levels:
  1) at the executive level to remove barriers and develop overall strategies for ensuring care coordination
  2) at the front-lines -- power of "senders" and "receivers" co-redesigning processes to improve transitions of care
- New competencies in partnering across care settings will be a great foundation integrated care delivery models (e.g. bundled payment models, ACOs)

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Diagnostic Reviews

- Recommend that teams complete a formal review of the last five readmissions every 6 months (chart review and interviews)
- Members from the cross continuum team hear first-hand about the transitional care problems “through the patients’ eyes”
- Engages the “hearts and minds” of clinicians and catalyzes action toward problem-solving
- Opportunities for learning from reviewing a small sampling of patient experiences are innumerable

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Transformation is Needed

- Traditional focus on discharging patients > facilitating transitions in care & a shift from handoffs to handovers (senders & receivers co-design the processes)
- Focus on what clinicians are teaching > focus on what is the patient learning
- Health care has an effect on ~10% of health outcomes > shift from the focus on the immediate clinical needs to a focus on the whole person and their social needs
- Patient is the focus of the care team > patient and family members are essential members of the care team
- GPS location team > Cross Continuum Team with a focus on the patient's experience over time

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Promising Approaches to Reduce Avoidable Rehospitalizations

- Improved transitions out of the hospital for all patients
  - Project RED
  - BOOST
  - IHI's Transforming Care at the Bedside and STAAR Initiative
  - Hospital to Home "H2H" (ACC/IHI)
- Supplemental transitional care after discharge from the hospital
  - Care Transitions Intervention (Coleman)
  - Transitional Care Intervention (Naylor)
- Enhanced ongoing management for high risk patients
  - Evercare Model
  - VNSNY Home Care Model
  - Heart failure clinics
  - Intensive care management from primary care or health plan

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Improved Transitions after an Acute-care Hospitalization for all Patients

Hospitals

Ambulatory Care Clinics

Home

Skilled Nursing Facilities

Home Care &
Community Resources

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Improved Transitions from SNFs to Home

Hospitals

Ambulatory Care Clinics

Home

Skilled Nursing Facilities

Home Care &
Community Services

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Re-Engineered Discharge (RED)

- Discharge Advocate; *assigned* role to ensure all components are complete
- The intervention significantly reduced the combined endpoints of ED use and hospitalization within 30 days by 30% (incidence risk ratio 0.695, p=0.009)
- Intervention required approximately 1 hour for implementation
- National Quality Forum (NQF) adopted RED as one of their "Safe Practices" in 2006

Jack BW, Veerappa KC, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization. *Ann Intern Med.*. 2009;150:178-187.

BOOST Toolkit: Primary Components

- Tool for Identification of High-Risk Patients
- Patient and Family/Caregiver Preparation
  - Primary cause for hospitalization and other diagnoses
  - Test results and interpretation, pending tests
  - Treatment plan during and after hospitalization
  - Follow up plans including appointment
  - Principal care provider identification -- who to call?
  - Warning signs and how to respond
  - Medication reconciliation
- Discharge Summary Communication

BOOST Recommendations for Patients at Increased Risk for Readmission

- Direct communication with provider *before* discharge
- Telephone contact within 72 hours post-discharge to assess condition, discharge plan comprehension and adherence, and to reinforce follow-up
- Follow-up appointment with provider within 7 days
- Direct contact information for hospital personnel familiar with patient's course provided to patient/caregiver to raise questions/concerns *if unable to reach principal care provider* prior to first follow-up

- H2H is a national quality improvement initiative to reduce unnecessary readmissions for cardiovascular patients
- Goal is to reduce all-cause readmission rates among patients discharged with heart failure or acute myocardial infarction by 20% by Dec 2012
- Virtual Learning Community and H2H website

Excellence in Transitions

3 Question Framework

Medications + Appointment + Symptom Management = Transition

1. **Medication Management Post-Discharge:** Is the patient familiar and competent with his or her medications and is there access to them?
2. **Early Follow-Up:** Does the patient have a follow up appointment scheduled within a week of discharge and is he or she able to get there?
3. **Symptom Management:** Does the patient fully comprehend the signs and symptoms that require medical attention and whom to contact if they occur?

Transforming Care at the Bedside

How-to Guide:

Creating an Ideal Transition Home for Patients with Heart Failure

Transforming Care at the Bedside (TCAB) is a national program designed to improve the quality and safety of patient care on medical and surgical units, to increase the vitality and retention of nurses, and to improve the effectiveness of the entire care team. For more information, go to http://www.ihi.org/.

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How-to Guide:

Creating an Ideal Transition Home

Support for the *How-to Guide: Creating an Ideal Transition Home* was provided by a grant from The Commonwealth Fund.

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How to cite this document:
Nielsen GA, Rutherford P, Taylor J. *How-to Guide: Creating an Ideal Transition Home*. Cambridge, MA: Institute for Healthcare Improvement; 2009. Available at http://www.ihi.org.

Key Changes to Achieve an Ideal Transition from Hospital (or SNF) to Home

1. Perform an Enhanced Assessment of Post-Hospital Needs
2. Provide Effective Teaching and Facilitate Learning
3. Provide Real-Time Handover Communications
4. Ensure Post-Hospital Care Follow-Up

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Number of Process Changes Related to the 4 Key Changes

Key Changes	CMWF/IHI STAAR Initiative	SHM Project BOOST	Project RED	ACC/IHI Hospital to Home (H2H)
	All Patients	Geriatric Patients	All Patients	Patients with HF or AMI
I. Perform Enhanced Admission Assessment for Post-Hospital Needs	1 → 2 → 3	1 → 2	1	
II. Provide Effective Teaching and Facilitate Learning	1 → 2 → 3	1 → 2 → 3	1 → 2 → 3 → 4	1 → 2
III. Conduct Real-Time Patient and Family-Centered Handoff Communication	1 → 2 → 3 → 4	1 → 2 → 3 → 4	1 → 2 → 3	
IV. Ensure Post-Hospital Care Follow-Up	1 → 2	1	1 → 2 → 3	1

Completing the Transition into Care Settings within the Community

Office Practices	Home Care	Skilled Nursing Facilities
• Provide timely access • Reconcile meds and plan of care • Coordinate care with other community clinicians	• Reconcile meds • Reinforce self-care plan • Communicate as indicated with primary care provider and specialists	• Assure staff are capable to care for patient's needs • Reconcile meds and plan of care • Provide timely consultation when patient's condition changes

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The NEW ENGLAND JOURNAL of MEDICINE

SPECIAL ARTICLE

The Quality of Health Care Delivered to Adults in the United States

Elizabeth A. McGlynn, Ph.D., Steven M. Asch, M.D., M.P.H., John Adams, Ph.D., Joan Keesey, B.A., Jennifer Hicks, M.P.H., Ph.D., Alison DeCristofaro, M.P.H., and Eve A. Kerr, M.D., M.P.H.

Adults in the US received 54.9% of recommended care

- Acute Care – 53.5%
- Care for Chronic Conditions – 56.1%
- Preventive Care – 54.9%

Reliable, Evidence-based Care in all Care Settings

Hospitals

Ambulatory Care Clinics

Home

Home Care & Community Resources

Skilled Nursing Facilities

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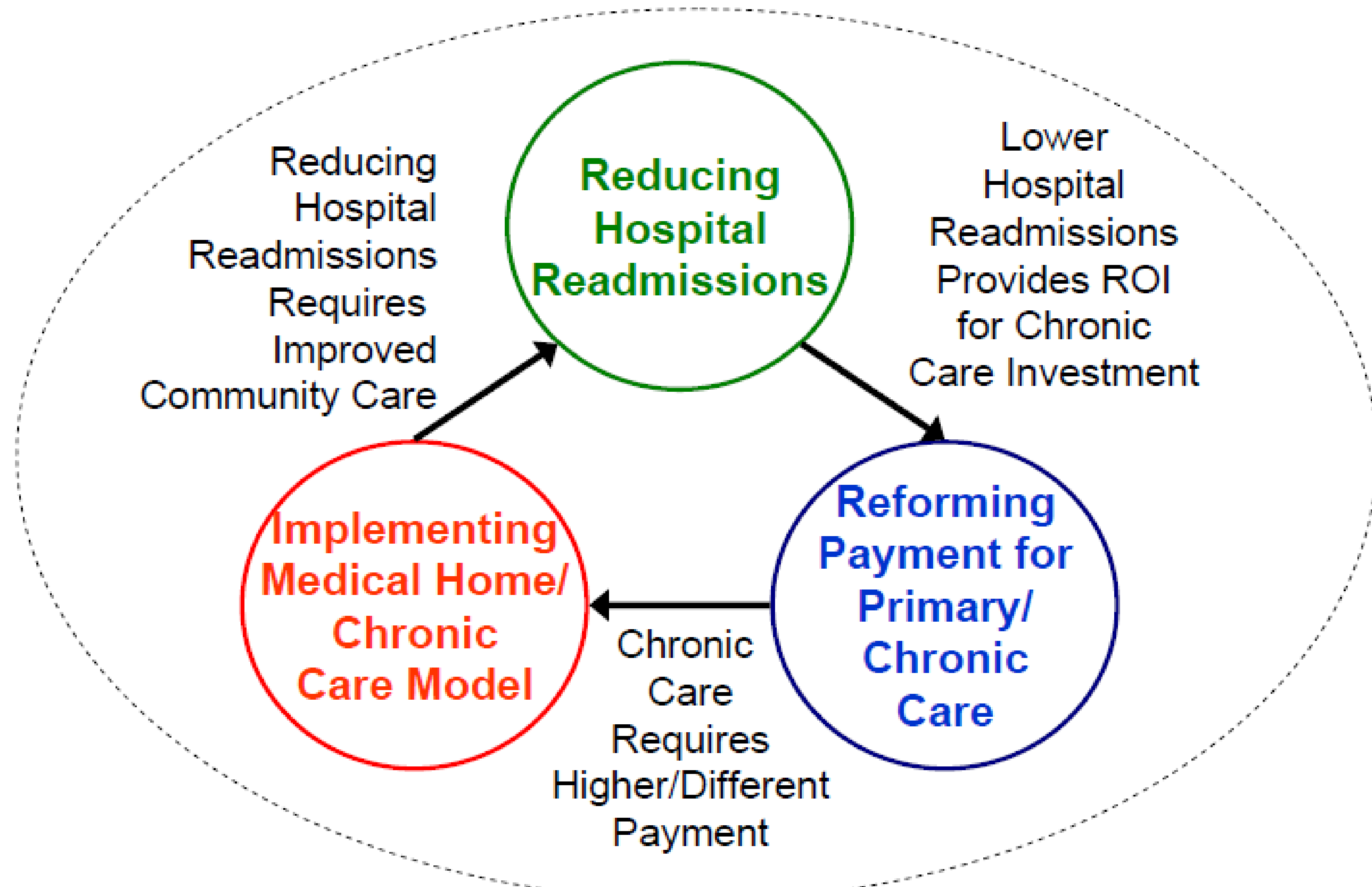
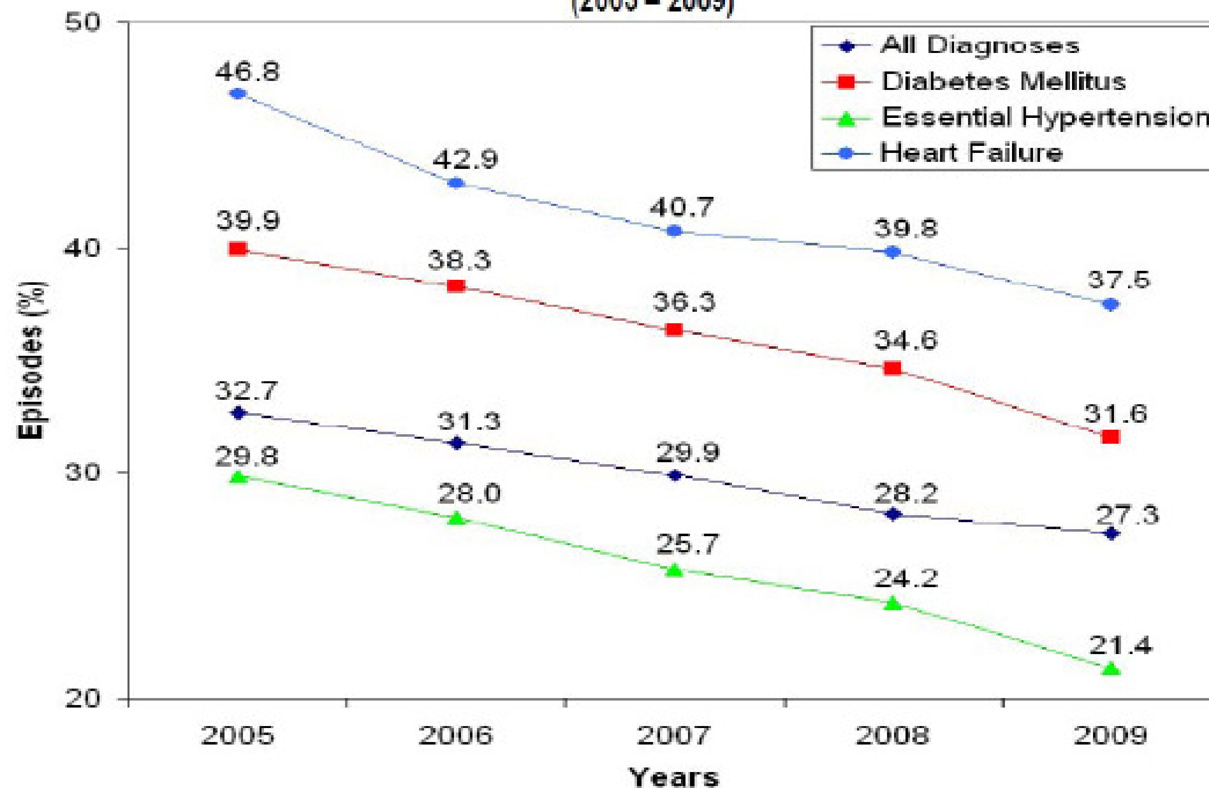
Marrying the Medical Home and Hospital Readmissions



© 2008-2010 Pittsburgh Regional Health Initiative and Center for Healthcare Quality and Payment Reform

VNSNY Overall Hospitalization Rate by Diagnosis



* Includes all CHHA cases for which an OASIS was completed. Diagnosis taken at beginning of patient episode.

- *communication tools*
- *clinical care paths*
- *advanced care planning tools*

EARLY WARNING TOOL

"Stop and Watch"

If you have identified an important change while caring for a resident today, please circle the change and discuss it with the charge nurse before the end of your shift.

Name of Resident ___________________________________

S eems different than usual
T alks or communicates less than usual
O verall needs more help than usual
P articipated in activities less than usual

A te less than usual (Not because of dislike of food)
N
D rank less than usual

W eight change
A gitated or nervous more than usual
T ired, weak, confused, or drowsy
C hange in skin color or condition
H elp with walking, transferring, toileting more than usual

Staff____

Reported to ______________________________________

Date _____ / _____ / _______ Time _______________

Supplemental Transitional Care or Intensive Care Management for High-risk Patients

Hospitals

Ambulatory Care Clinics

Home

Home Care & Community Resources

Skilled Nursing Facilities

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The Care Transitions Intervention

- 750 community-dwelling adults 65 years or older admitted to the study hospital with 1 of 11 selected conditions
- Intervention:
  - Tools to promote cross-site communication
  - Encouragement to take a more active role in their care
  - Guidance from a "transition coach"
- Resulted in lower rehospitalization rates at 30d and 90d
- Reduced odds of rehospitalization by about **40%**
- Reduced hospital costs at 180d from **$2500 to $2000**
- Care Transitions Intervention adopted in over 150 settings

Coleman Eric A; Parry Carla; Chalmers Sandra; Min Sung-Joon. The care transitions intervention: results of a randomized controlled trial. Archives of internal medicine 2006;166(17):1822-8.

Transitional Care Model

- Nurse Practitioners provide inpatient assessment
- NPs review medications and goals
- Design and coordinate care with patients and providers
- Attend first post discharge MD office visit
- Direct home care for 1-3 months
- Conduct home intervals
- Results:
  - Decreased the total number of rehospitalizations at 6 months by **36%** (37% v. 20% p<0.001)
  - Decreased average total cost of care by **39%**

Naylor, M.D. et al. 2004. *J Am Geriatr Soc* 52:675–84.

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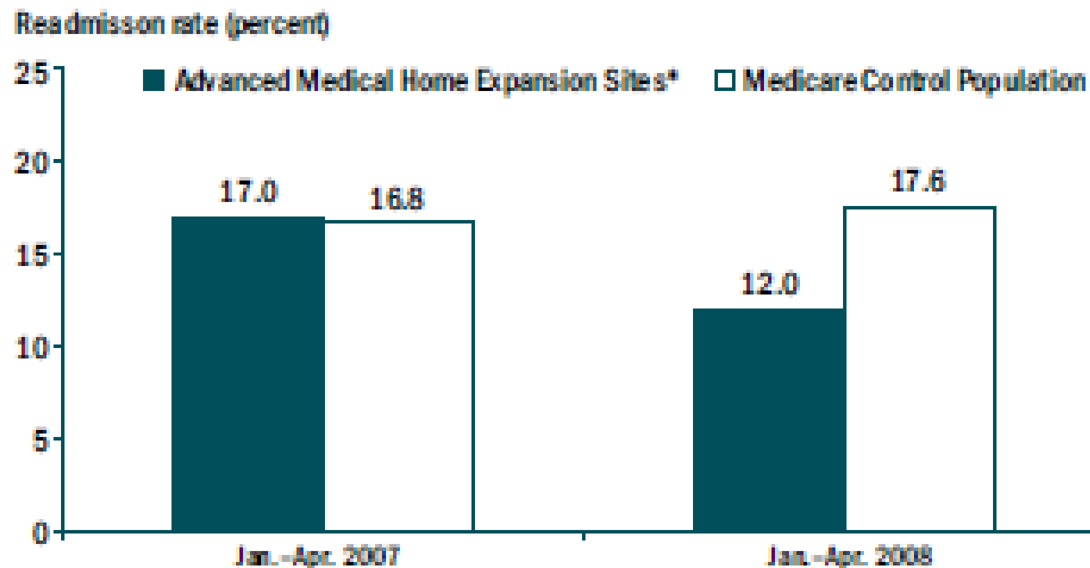
ProvenHealth[SM] *Navigator:* Advanced Medical Home Model



GEISINGER

Comprehensive Discharge Planning With Postdischarge Support for Older Patients With Congestive Heart Failure

A Meta-analysis

JAMA 2004; 291:1358-67

Christopher O. Phillips, MD, MPH
Scott M. Wright, MD
David E. Kern, MD, MPH
Ramesh M. Singa, MPH
Sasha Shepperd, MS, DPhil
Haya R. Rubin, MD, PhD

Context Comprehensive discharge planning plus postdischarge support may reduce readmission rates for older patients with congestive heart failure (CHF).

Objective To evaluate the effect of comprehensive discharge planning plus post-discharge support on the rate of readmission in patients with CHF, all-cause mortality, length of stay (LOS), quality of life (QOL), and medical costs.

Data Sources We searched MEDLINE (1966 to October 2003), the Cochrane Clinical Trials Register (all years), Social Science Citation Index (1992 to October 2003),

- Meta-analysis; 18 RCTs from 8 countries
- Interventions generally began in hospital with post-discharge support
- Follow-up ranged from single home visit to extensive visiting and phone support
- Results: 25% reduction in readmissions**;** 13% reduction (p=.06) in all-cause mortality; Net savings $359-536 per month of intervention

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Blue Shield of CA

- Health plan partnership with disease management service
- Patient Centered Management (PCM) protocol
  - Patients toward end of life, late stage cancer, neurologic conditions
  - Patient education, coordination, end-of-life management
  - **PCM Complex Care Team- care manager, coordinator, consulting MD**
  - Low caseloads, intensive interaction
  - PCM RN communicates with **inpatient team , pt/family** to ensure smooth transition
  - **Care manager home visit** to establish goals, review medications
  - **Twice weekly** phone contact
  - 10 hours/pt, average of 10 calls per patient/month, average intervention **5.5 months**
  - Cost-effective for "outlier" patients
- Results: **38% fewer hospitalizations;** 36% fewer hospital days, 30% fewer ED visits, 26% lower costs ($18,000 per patient)

Kanaan SB. Homeward Bound: Nine Patient-Centered Programs Cut Readmissions. CHCF, Sept 2009.

Evercare Model

- Nurse Practitioners and Care Managers develop and manage personalized care plans
  - coordinate multiple services
  - help facilitate better communication between physicians, institutions, patients and their families
  - help ensure effective integration of treatments
- Four levels of care, with each level involving different priorities and focus of care provided by the NP or CM
- Results:
  - Reduced hospitalizations by 45% with no change in mortality
  - Reduced emergency room visits by 50%

Kane, R. L., G. Keckhafer, et al. (2003). "The effect of Evercare on hospital use." *Journal of the American Geriatric Society* 51(10):1427-34.

IHI's Approach for Improving Transitions & Reducing Avoidable Rehospitalizations

Transition from Hospital to Home

- Enhanced Assessment
- Teaching and Learning
- Real-time Handover Communications
- Follow-up Care Arranged

Post-Acute Care Activated

- MD Follow-up Visit
- Home Care (as needed)
- Social Services (as needed)

or

- Skilled Nursing Facility Services
- Hospice/Palliative Care

Supplemental Care for High-Risk Patients *

- Transitional Care Models
- Intensive Care Management (e.g. Patient-Centered Medical Homes, HF Clinics, Evercare)

* *Additional Costs for these Services*

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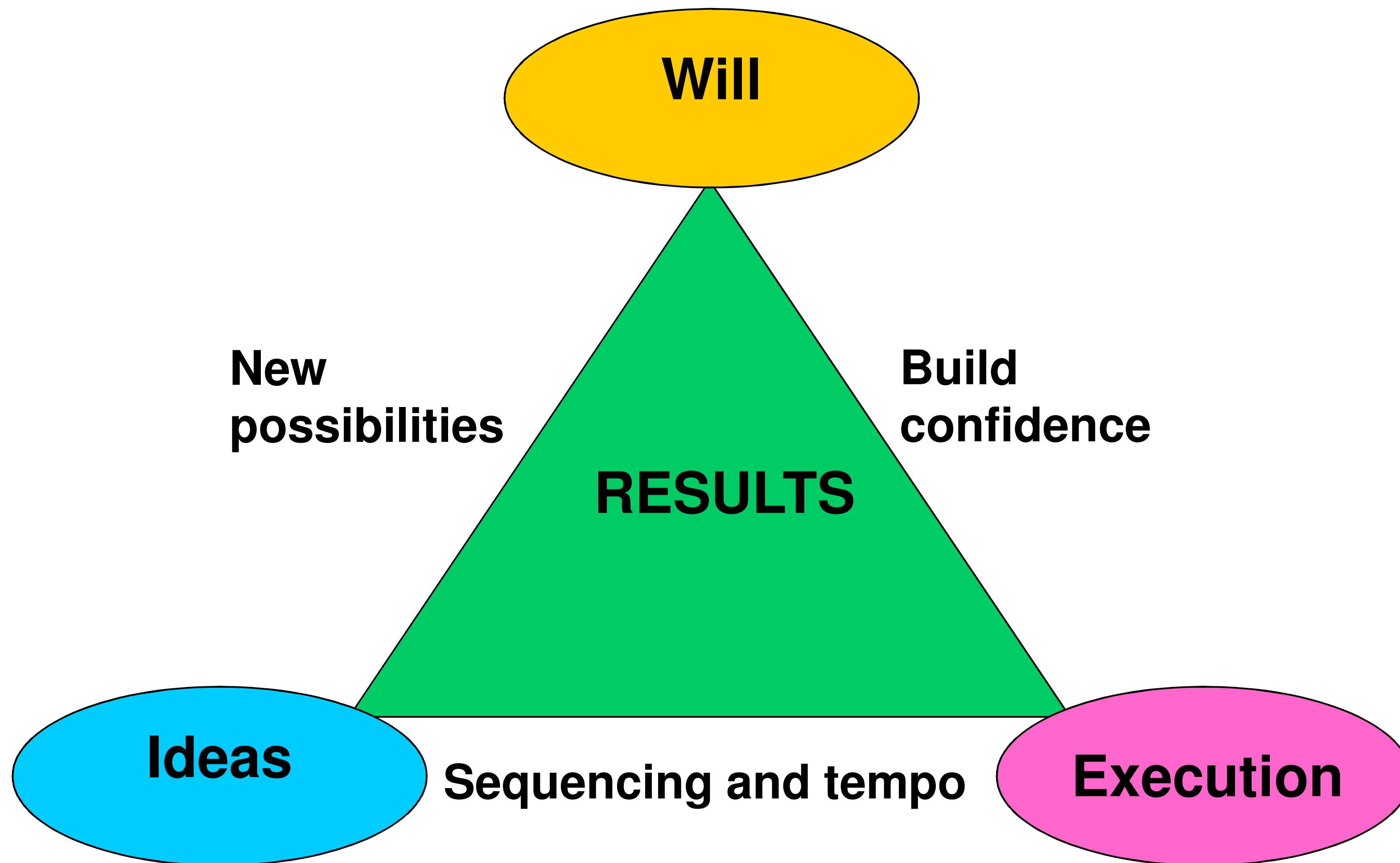
MA STAAR Collaborative

Achieving Desired Results in the MA STAAR Collaborative



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Getting Started

1. The Hospital CEO Selects an Executive Sponsor and a Day-to-Day Leader to lead the improvement work
2. Executive Sponsor convenes a Cross-Continuum Improvement Team
3. Team Identifies opportunities for improvement using:
   a. In-depth review of the last five rehospitalizations
   b. 30-day all-cause readmission rates
   c. Patient experience data on communications and discharge preparations
4. Select one or two pilot units or a pilot population and develop an aim statement

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Initial Population of Focus

- Select one or two pilot units where readmissions are frequent
  - Will require individual tracking of patients using medical record numbers to assess progress

PROS	CONS
• Changes easier to implement when a unit becomes part of the improvement team • Interventions are universal except which meds and self-care activities patients need to understand • Easier to see progress faster on one unit rather than across a facility	• Data may not be readily accessible by unit • Busy units may need resources to accelerate testing and implementing changes

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Initial Population of Focus

- Select a high-risk population
  - MDC and DRGs are useful in tracking data to assess population trends

PROS	CONS
• Doesn't overburden busy front-line staff if specialty practices can add resources • Relevancy for proposed reimbursement changes for patients with HF, AMI and pneumonia	• Case-finding is often difficult and time-consuming • Spreading to more conditions may require adding additional expert resources • Identifying which patients need which interventions takes time • Many patient have multiple conditions –teaching needs to be customized

Executive Sponsor's Role

- Leads the CCT, provides oversight and guidance and removes obstacles and barriers as necessary
- Meets with the Day-to-Day Leader and other senior managers to connect this work with the organization's strategies and goals
- Meets monthly with the Front-Line Improvement Team to review standard progress reports
- Ensures that sufficient resources (data support, QI staff, etc.) and time is allocated for the initiative
- Communicates what is learned from the improvement work to motivate and mobilize the entire organization to adopt and spread successful changes

Tips for Executive Sponsor

- Schedule time for the initiative meetings
- Meet monthly with Day-to-day Leader
  - Ask about progress, barriers and “how can I help?”
  - Ask for monthly short briefing reports
- Help the CCT break down silos
- Assure resources and support the development of a specified, rigorous spread plan within the hospital and across the continuum

Day-to-Day Leader's Role

- Participate in the Cross-Continuum Improvement Team
- Coordinate, guide and support improvement activities of the Front-line Improvement Team
- Provide or assist with the timely submission of monthly reports
- Meet at least monthly with the Executive Sponsor

Cross-Continuum Improvement Team

The CCT is a multi-stakeholder team (e.g., staff in the hospital, skilled nursing facilities, home health care agencies, office practices, and patients and family members):

- Provides oversight and guidance; helps connect hospital improvement efforts with partnering community organizations
  - Identifies improvement opportunities
  - Facilitates learning across care settings
  - Facilitates collaboration to test changes
- Provides oversight for the initial pilot unit work and establishes a dissemination strategy
- Convenes at least monthly

Front-line Improvement Team: Testing Changes and Designing Reliable Processes

- Start by focusing on one of the key changes
- Identify the opportunities/failures/successes in the current processes and select a process to work on
- Conduct iterative PDSA cycles (tests of change)
- Specify the who, what, when, where and how for the process (standard work)
- Understand common failures to redesign the process to eliminate those failures
- Use process measures to assess your progress over time (aim is to achieve > 90% reliability)
- Implement successful changes

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Specification of Work

- Allows less than perfect design in the initial specifications (we do not have to plan for every possible contingency)
- No need to spend months coming up with the perfect design
- Assumes that the observation of failures in the process will lead to further redesign of the process
- Build knowledge of how to design the process over time

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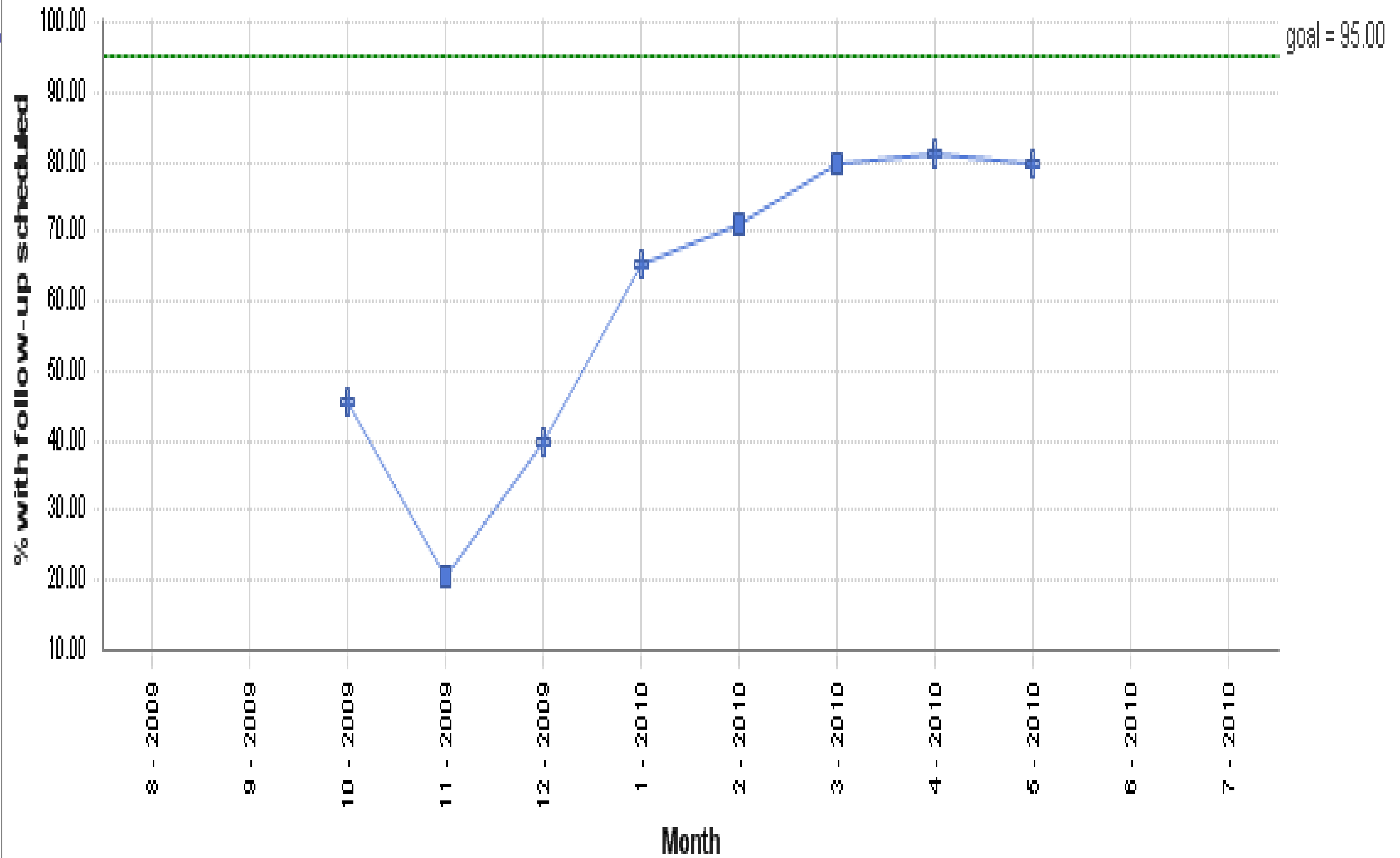
Enhanced Teaching and Learning

Baystate Medical Center Springfield 4 (MA)
PILOT UNIT: Teach Back - S4

% Successful Teachback
100.00
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00
goal = 95.00
8 - 2009
9 - 2009
10 - 2009
11 - 2009
12 - 2009
1 - 2010
2 - 2010
3 - 2010
4 - 2010
5 - 2010
6 - 2010
7 - 2010
8 - 2010
9 - 2010
Month


Detroit Medical Center - Sinai Grace (MI)
PILOT UNIT: Percent of Patients with Follow-up Appointment Before Discharge
% with follow-up scheduled
100.00
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
goal = 95.00
8 - 2009
9 - 2009
10 - 2009
11 - 2009
12 - 2009
1 - 2010
2 - 2010
3 - 2010
4 - 2010
5 - 2010
6 - 2010
7 - 2010
Month

MA STAAR Collaborative Activities

- Conduct regular team meetings to plan sequential tests of change, design reliable processes and share learning.
- Actively participate in regional meetings and during monthly collaborative conference calls and WebEx sessions to share learning about successful changes and to discuss how to overcome barriers to progress.
- Submit process and outcome data on a monthly basis.
- Submit an updated MA STAAR Collaborative Storyboard each quarter that describes the changes the improvement team has tested, implemented and spread and describes ongoing learning.

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IHI's Faculty Team for the MA STAAR Collaborative

Peg Bradke, RN, MA

Peg M. Bradke, RN, MA, Director of Heart Care Services, St. Luke's Hospital, coordinates services for two intensive care units, two step-down telemetry units, the Cardiac Catheter Lab, Electrophysiology Lab, Diagnostic Cardiology, Interventional/Vascular Lab, and Cardiopulmonary Rehabilitation. In her 25-year career, she has had various administrative roles in critical care areas. Ms. Bradke works with the Institute for Healthcare Improvement on the Transforming Care at the Bedside initiative and Transitions Home work. She is President-Elect of the Iowa Organization of Nurse Leaders.

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Eric Coleman, MD, MPH

Eric A. Coleman, MD, MPH, is Professor of Medicine within the Divisions of Health Care Policy and Research at the University of Colorado at Denver and Health Sciences Center. He is the Director of the Care Transitions Program that aims to improve quality and safety during care "handoffs" across care settings.

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Gail Nielsen, BSHCA, FAHRA, RTR

Gail A. Nielsen, BSHCA, FAHRA, RTR, Director of Learning and Innovation, Iowa Health System, building infrastructure and capability across the 26-hospital enterprise for innovation and process improvement to achieve ideal patient care delivery. She is a George W. Merck Fellow, Patient Safety Scholar and faculty of the Institute for Healthcare Improvement .

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Marie Schall, MA

Marie W. Schall, MA, Senior Director, Institute for Healthcare Improvement (IHI), leads innovation and improvement projects including the STate Action on Avoidable Rehospitalizations (STAAR) initiative. She also serves as senior faculty for IHI's Breakthrough Series College and is responsible for the ongoing development of IHI's spread methodology and use of virtual learning methods. Prior to joining IHI in 1995, Ms. Schall designed and led improvement projects for the New Jersey Quality Improvement Organization) and was Director of Research for the Health Research and Educational Trust of New Jersey.

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Rebecca Steinfield, MA

Rebecca Steinfield, MA, Improvement Advisor, Institute for Healthcare Improvement (IHI), serves in this capacity both internally and externally. She has been with IHI for thirteen years in numerous capacities, including coordinating Breakthrough Series Collaboratives, establishing and coordinating hiring and orientation processes, managing the development of the Breakthrough Series College and serving on its faculty, establishing and coordinating the Institute's continuing education accreditation systems, managing IHI's Breakthrough Series coaching and mentoring services, and establishing and coordinating IHI's business development processes.

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Jeff Wetherhold, MEd

Jeff Wetherhold, M.Ed., Project Manager, Institute for Healthcare Improvement (IHI), is responsible for managing IHI's state and regional work to reduce avoidable rehospitalizations through the STAAR Initiative. He has experience managing state policy and organizational quality improvement projects in both healthcare and higher education. Prior to joining IHI, Mr. Wetherhold managed a national initiative focused on aligning state and institutional efforts to improve student outcomes in community colleges.

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Pat Rutherford MS, RN

Patricia A. Rutherford MS, RN is a Vice President at the Institute for Healthcare Improvement (IHI). She is leads innovations in the following areas: Transforming Care at the Bedside; Optimizing Care Coordination and Transitions in Care; Improving Efficiency and Flow in Hospitals, Office Practices and Outpatient Settings; and Innovations in Patient-Centered Care. She is currently the co-investigator for the STate Action on Avoidable Rehospitalizations (STAAR) initiative, funded by The Commonwealth Fund.

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MA Learning Session Agenda

Day 1

- 10:00 AM Table Rounds
- 10:55 AM Breakout Sessions
  – Option 1: Collaborative Improvement Method: The Model for Improvement
  – Option 2: Reliability and Sustainability
  – Option 3: Stakeholders
- 12:00 PM Lunch - Storyboard Review and Networking

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MA Learning Session Agenda

Day 1 (continued)

- 12:45 PM Key Change 1: Perform an Enhanced Admission Assessment for Post-Hospital Needs
- 2:15 PM Key Change 2: Provide Effective Teaching and Facilitate Learning
- 3:30 PM Engaging Patient and Family Members
- 4:15 PM Team Meetings and Consultation

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MA Learning Session Agenda

Day 2

- 7:00 AM Breakfast and Storyboard Viewing
- 8:00 AM Debrief from Day 1 – Key Issues and Questions
- 8:30 AM Key Change 3: Conduct Real-Time Patient and Family-Centered Handover Communications
- 10:00 AM Key Change 4: Ensure Post-Hospital Care Follow-Up
- 11:15 AM Completing the Transition: Role of Community Care Settings

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MA Learning Session Agenda

Day 2 (continued)

- 12:45 PM Networking Lunch
- 1:30 PM New and Emerging Ideas
- 2:15 PM Breakout Sessions
  - Option #1: Setting the Pace and Infrastructure for Getting Results: The Front-line Improvement Team on Pilot Units
  - Option #2: The Cross-Continuum Project Team
- 3:00 PM Breakout Sessions
  - Option 1: Collaborative Plans and Team Report Outs
  - Option 2: Stakeholder Meeting
- 3:45 PM Next Steps and Action Period Activities!

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