



# Reflection on Year 1 and Planning for Year 2

*Marie Schall and Rebecca Steinfield*

**February 3, 2011**

*These presenters have nothing to disclose.*

# Objectives

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- Assess progress to date
- Discuss key Issues for teams in coming year: What do you need to/want to learn about that will help you reach your goals?

# Reflections on Progress to Date

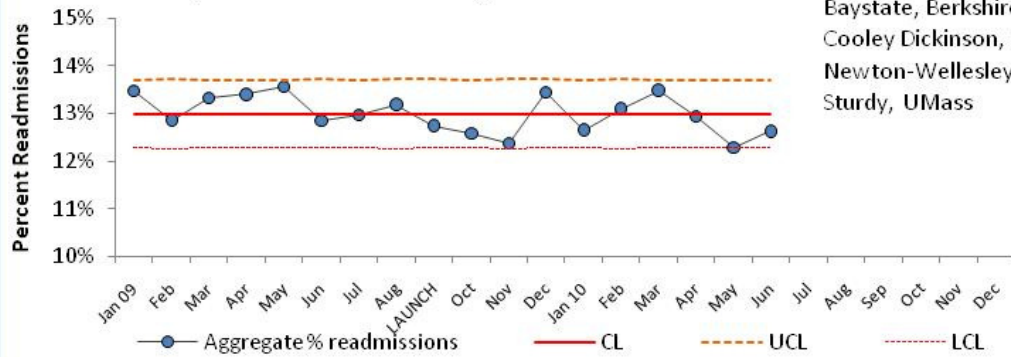
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Looking at readmissions and patient experience trends over time...

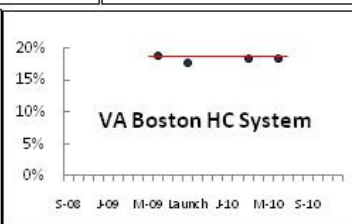
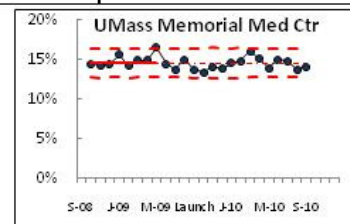
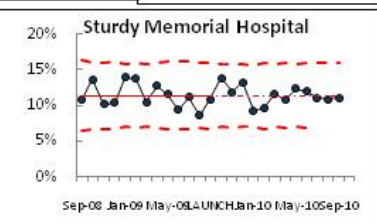
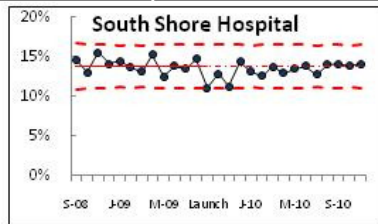
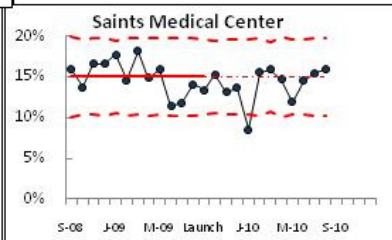
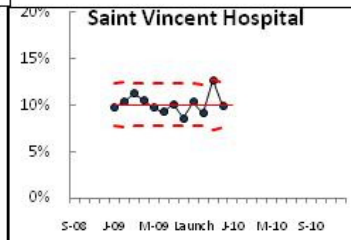
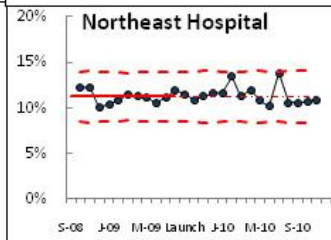
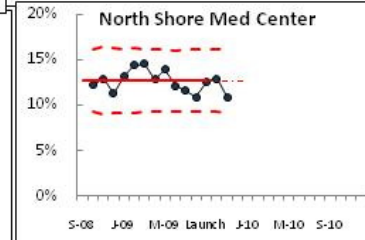
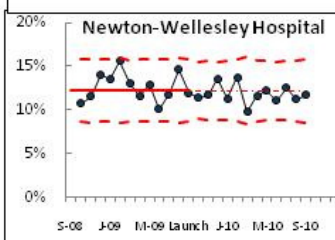
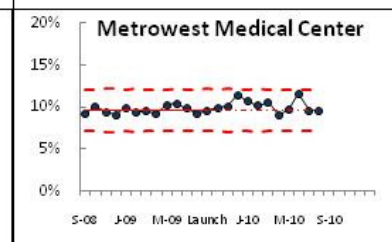
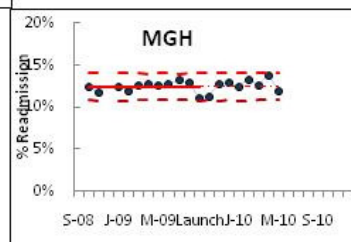
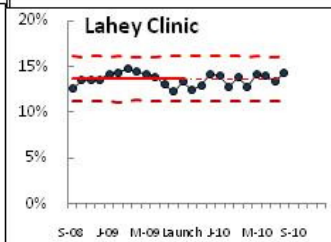
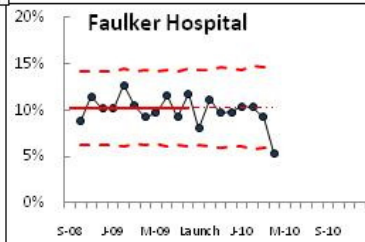
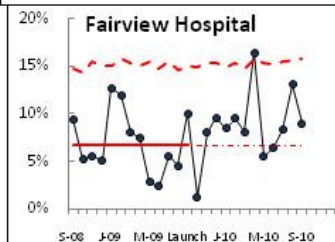
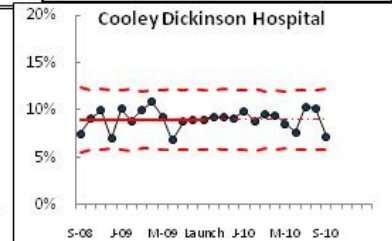
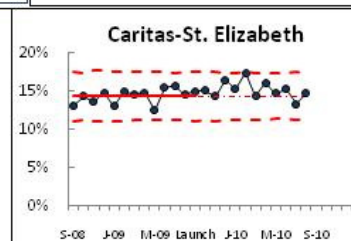
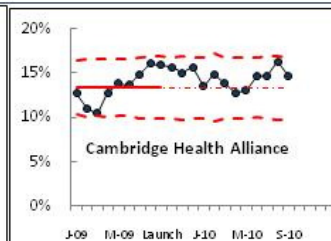
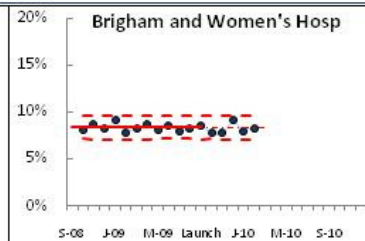
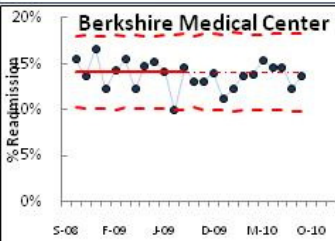
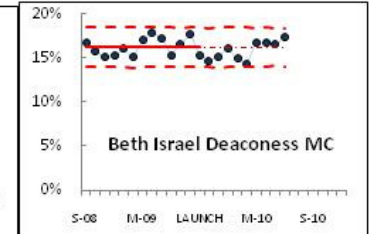
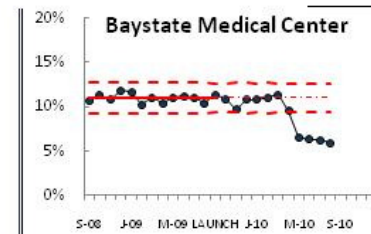
- A few hospitals are reporting data that shows improvement
- Aggregate data (from reporting hospitals) does not yet show improvement

Few teams are reporting process measures on the extranet, but some are reporting in storyboards and anecdotally.

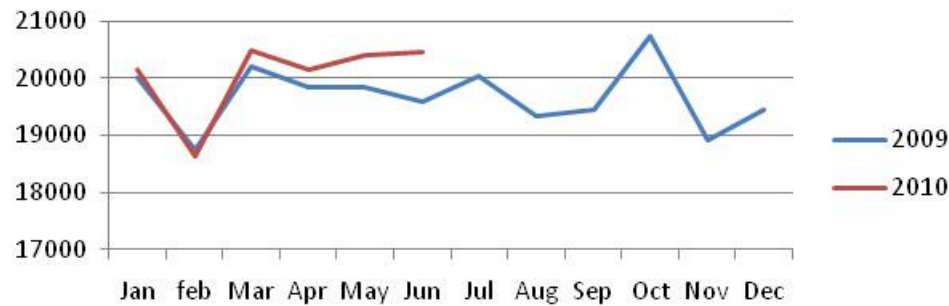
# MA Hospital All-Cause 30-Day Readmissions



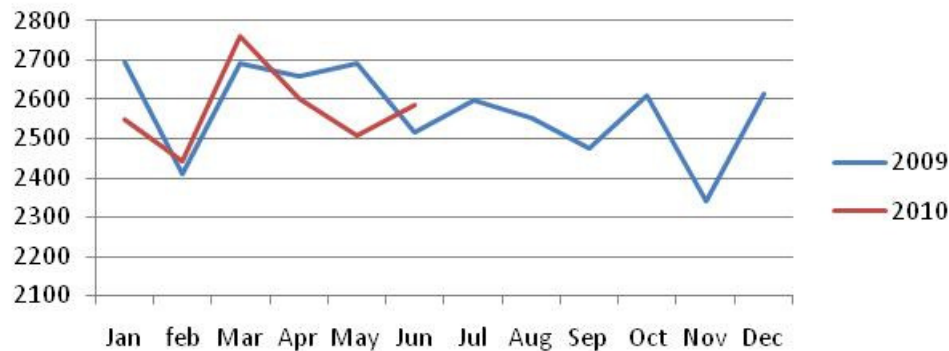
The 14 hospitals included in the roll-up are:  
 Baystate, Berkshire, BIDMC, CHA, Caritas/St. E,  
 Cooley Dickinson, Fairview, Lahey, Metrowest,  
 Newton-Wellesley, Northeast, Saints, South Shore,  
 Sturdy, UMass



### Number of Discharges



### Number of Readmissions



This data is the sum of the numerators and denominators for the 14 hospitals in MA who have consistently reported all-cause hospital readmissions from Jan 09 through Jun 2010

# Planning for Year 2

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- Get ideas to expand and deepen your work
- Place a “dot” next to the change on the wall that corresponds to your work to date:
  - Implementing and/or reliable = Green
  - Are testing = Yellow
  - Not started working = Red
  - Spreading to other units = Blue
- Be prepared to share your ratings



# Reliability and Sustainability

*Gail Nielsen, BSHCA, FAHRA, RTR*

*Pat Rutherford MS, RN*

February 2, 2011

*These presenters have nothing to disclose.*

# Session Objectives

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Participants will be able to:

- Describe strategies for designing reliable processes to achieve desired outcomes.
- Describe successful implementation plans utilized by STAAR Collaborative Teams.
- Discuss strategies for sustaining improvements and spreading successful changes to achieve system-wide results.
- Identify approaches for embedding new competencies and best practices into routine care processes.



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# Strategic Questions for Achieving System-Level Results (Improving Transitions & Reducing Rehospitalizations)

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- Is reducing the hospital's readmission rate a strategic priority for the executive leaders at your hospital? Why?
- Do you know your hospital's readmission rate for patients with HF and AMI?
- What is your understanding of the problem?
- Have you declared your improvement goals?
- What will help drive success in your quality improvement initiatives?
- What projects, when combined, will help you achieve your goals?
- Do you have the capability to make improvements?
- How will you provide oversight for the improvement projects, learn from the work and spread successes?

# Execution of Strategic Quality Improvement Initiatives

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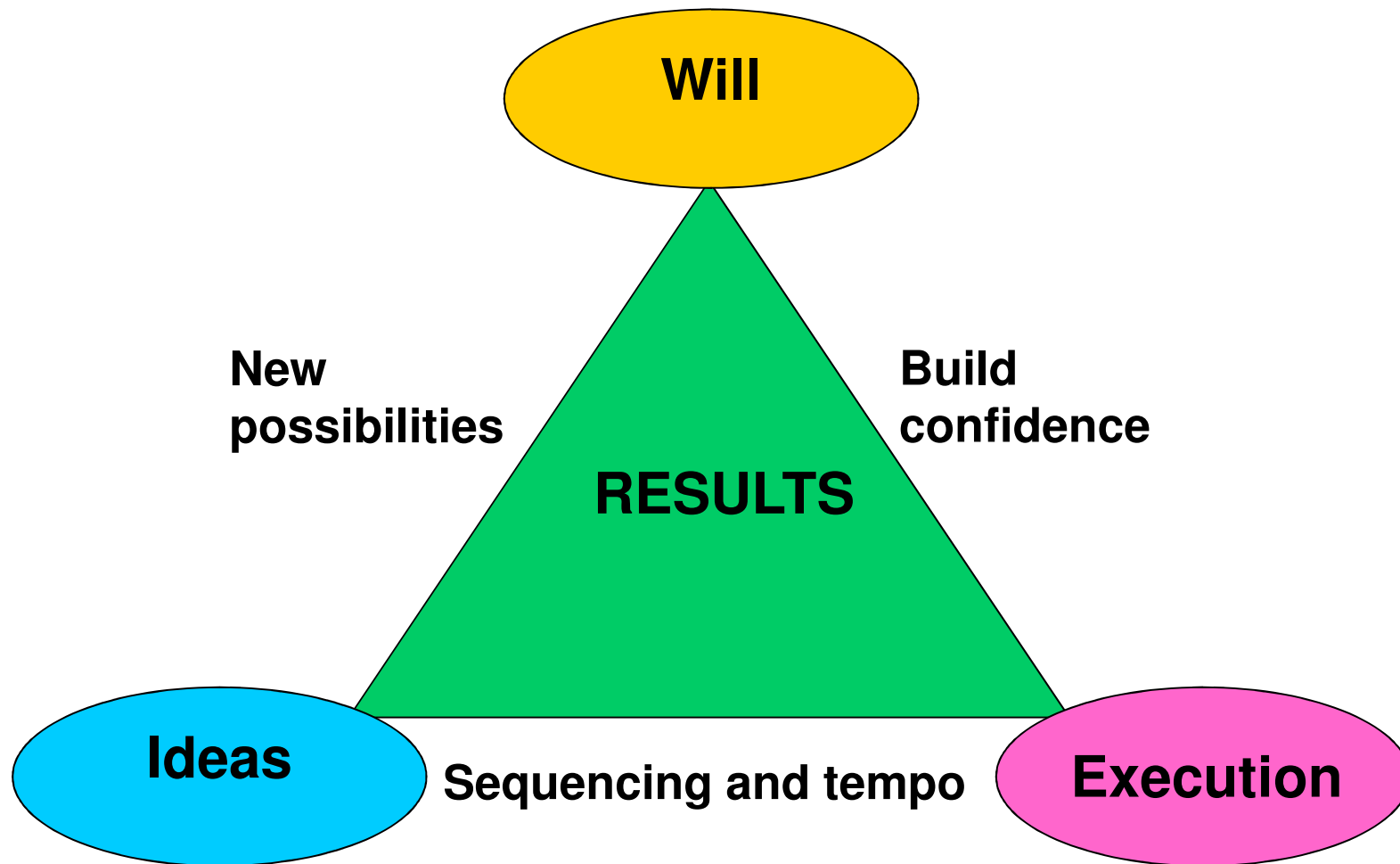
1. Setting Priorities and Breakthrough Performance Goals
2. Developing a Portfolio of Projects to Support the Goals
3. Deploying Resources to the Projects That Are Appropriate for the Aim
4. Establishing an Oversight and Learning System to Increase the Chance of Producing the Desired Change

Nolan TW. *Execution of Strategic Improvement Initiatives to Produce System-Level Results*. IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2007.



# Achieving Desired Results in the MA STAAR Collaborative

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# Getting Started

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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

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

## PROS

- 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

## CONS

- Data may not be readily accessible by unit
- Busy units may need resources to accelerate testing and implementing changes



# Initial Population of Focus

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

## PROS

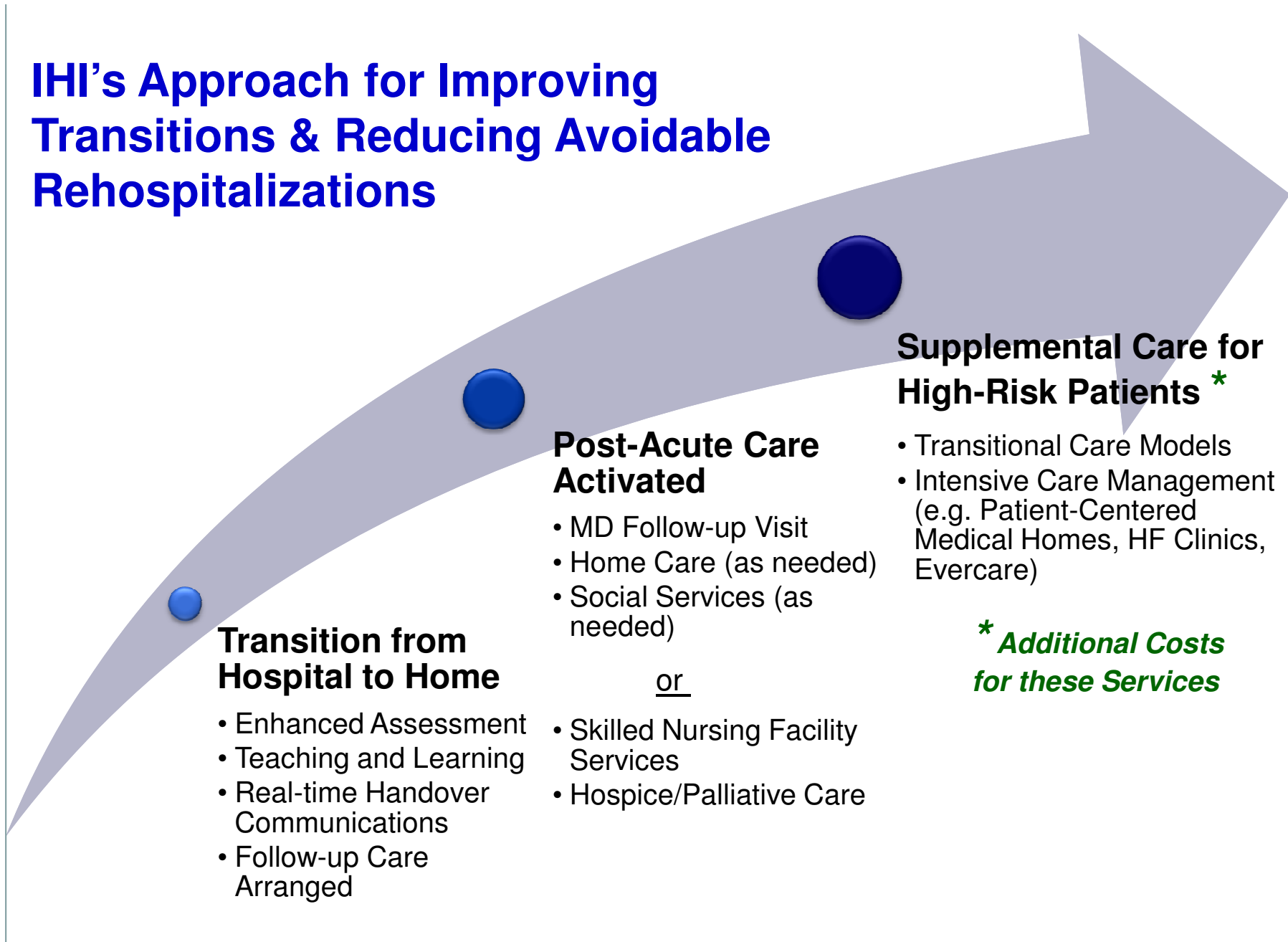
- Doesn't overburden busy front-line staff if specialty practices can add resources
- Relevancy for proposed reimbursement changes for patients with HF, AMI and pneumonia

## CONS

- 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



# IHI's Approach for Improving Transitions & Reducing Avoidable Rehospitalizations



# Key Changes to Achieve an Ideal Transition from Hospital to Home

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

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- 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 and spread successful changes

## Model for Improvement

What are we trying to accomplish?

How will we know that a change is an improvement?

What changes can we make that will result in improvement?



# Suggestions for Conducting PDSA Cycles

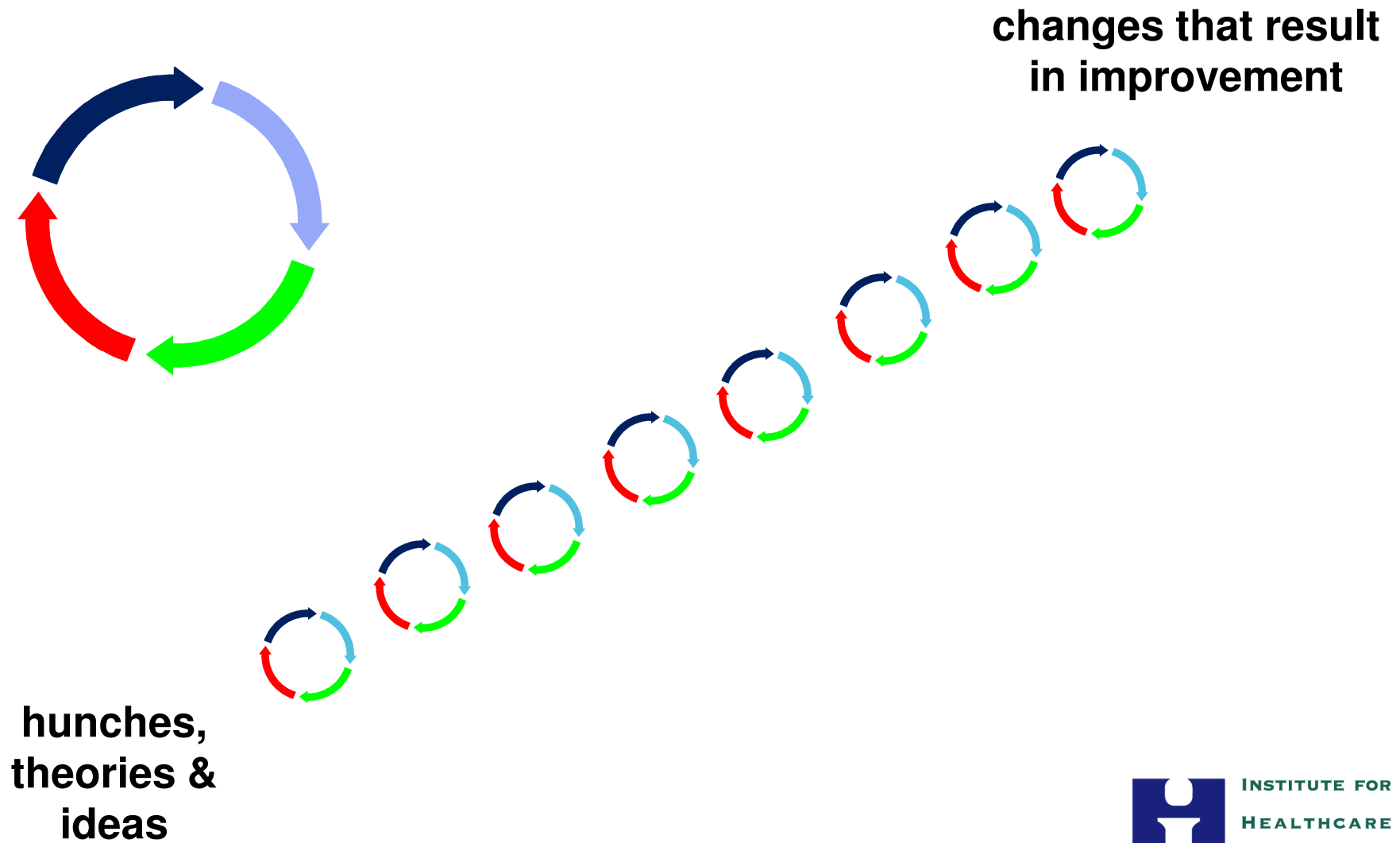
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- Remember that one test of change informs the next.
- Keep tests small; be specific.
- Refine the next test based on learning from the previous one.
- Expand test conditions to determine whether a change will work at different times of day (e.g., day and night shifts, weekends, holidays, when the unit is adequately staffed, in times of staffing challenges).
- Continue the cycle of learning and testing to improve process reliability.
- Collect sufficient data to evaluate whether a test has promise, was successful, or needs adjustment.
- For more information on the Model for Improvement and on selecting and testing changes, explore this link

<http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/HowToImprove/>.

# Testing and Implementing Changes

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**WOULD YOU BE SATISFIED IF:**

Your car started  
70% of the time?

You received a paycheck  
80% of the time?

The light-switch worked  
90% of the time?

clean.



**Hand Hygiene...**  
**What Are You Satisfied With?**

# Levels of Reliability

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- 80% or less
  - chaotic processes
    - > failures greater than 20%
    - > no articulated process
- 80%
  - lacks consistent process
    - > failures in 1 or 2 out of 10 opportunities
    - > fewer than 5 staff can accurately describe the process
- 95%
  - reliable, not perfect
    - > 5 failures in 100 opportunities
    - > some variation but 5 staff can easily describe the process

*Intent, Vigilance and Hard Work*  
(will generate performance with < 95% reliability)

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Process Design to Prevent Basic Failures:

- Common equipment, standard orders
- Personal check lists
- Working harder next time
- Feedback of information on compliance
- Awareness and training

# *Use of Human Factors and Reliability Science*

(will generate performance with > 95% reliability)

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## Design Sophisticated Failure Prevention, Identification and Mitigation

- Standardize work processes
- Build job aides and reminders
- Take advantage of preexisting work and habits
- Make the desired the default rather than the exception
- Create redundancy
- Bundle related tasks



# Creating Standard Work

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- Current best, easiest and safest way to do a job
- Clarifies the value of the work
- Specifies:
  - who does what, when, why
  - delineates roles and relationships for handoffs
  - methods for “how”

# Specify the Standard Work

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*Ask yourself, “What would I see if I could observe this being done?”*

Select a process and precisely describe the standard work, including information regarding:

- Who does it;
- What do they do;
- When do they do it (and for which patients);
- Where do they do it;
- How do they do it (include tools that are used);
- How often do they do it; and
- Why do they do it.

# Specification of Work

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- 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

# Signaling Failures

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- For each testing cycle, study the results and learn about failures
  - Was the test successful? Yes or No
  - If it failed, how do staff report the failure
- Examples: failure to make the follow-up MD visit appointment before patients are discharged
  - Clerical staff tell the unit manager whenever they could not make an appointment and describe why they weren't successful
  - Notations on the unit manager's office door

# Review Every Failure

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Once the test/process is 85% reliable, review every failure:

- Review ASAP -- same shift, same day
- Observe the process and get input from staff
  - Is the process being followed as specified?
  - Ask 5 staff to articulate the aim of the process design and the “specified” process
- Look for workarounds

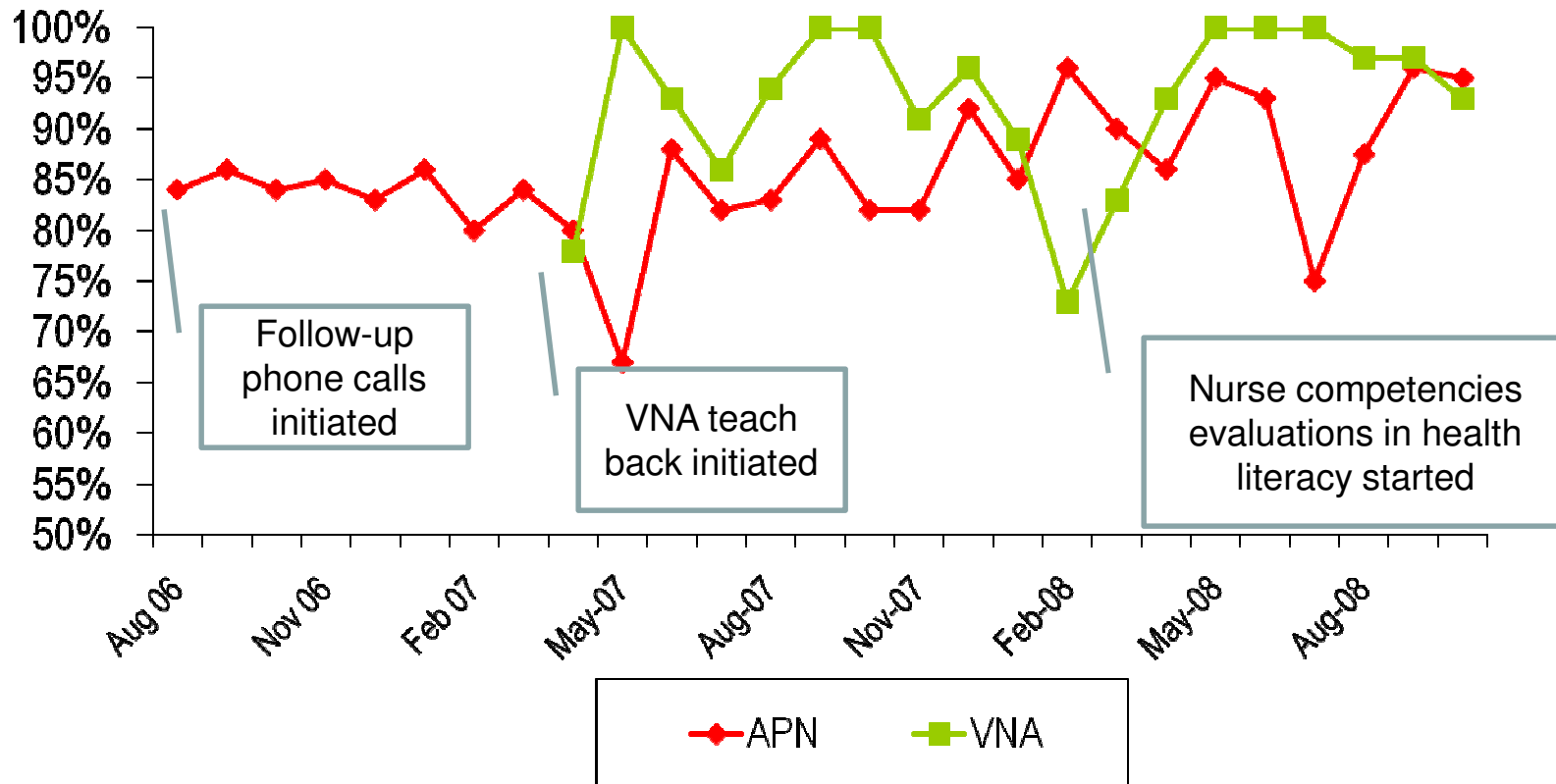
# Using Process Measures to Evaluate the Reliable Implementation of Changes

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Process Measures tell us whether the specific changes we are making are working as planned. When displayed in annotated run charts, they give us shorter cycle feedback on the relationship between our theory (the changes we are making) and the outcomes for our patients (readmissions and overall experience).

The following slide is an example of an annotated run chart for the process measure for “Enhanced Teaching and Learning”

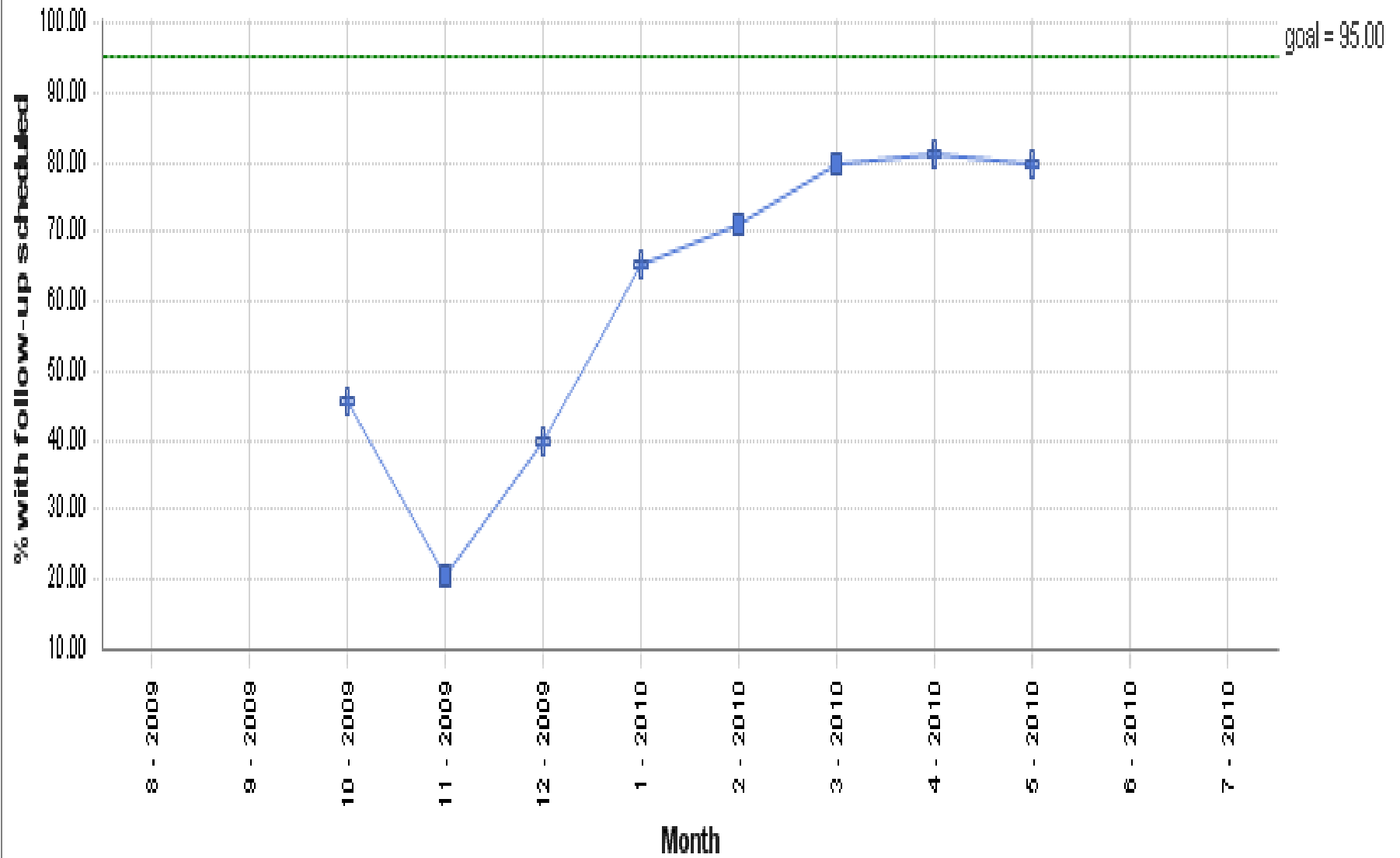
# Process Measure: Patient Responses Using Teach Back\*



\*Percent of complete patient responses in Teach Back conducted by VNA at 24 to 48 hours post-discharge home visit and the follow-up phone call by hospital-based APN 7 days after discharge

# Detroit Medical Center - Sinai Grace (MI)

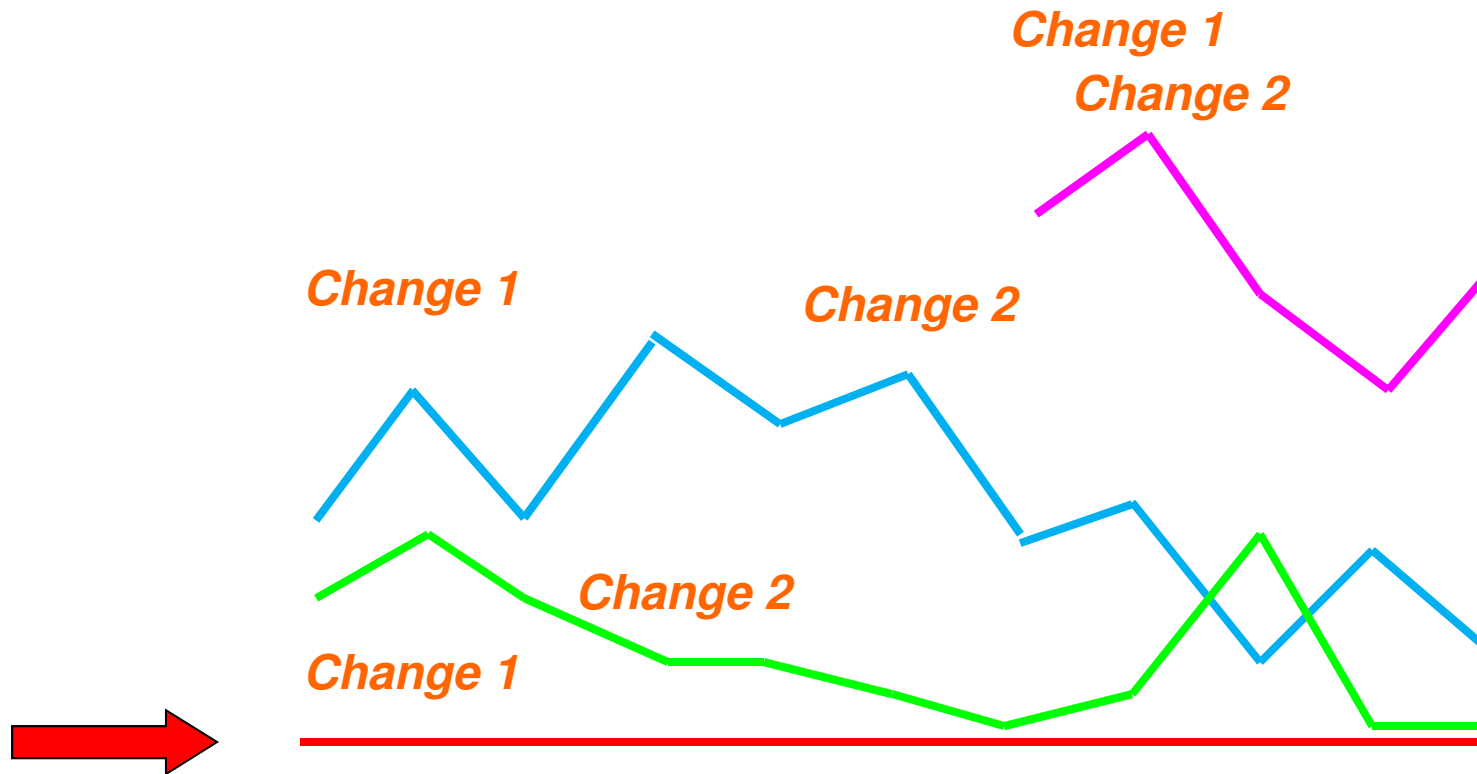
## PILOT UNIT: Percent of Patients with Follow-up Appointment Before Discharge





# Evaluating Results and Spreading Successes

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Pilot Unit #1  
Pilot Unit #2  
All Med/Surg Units

# Sustaining Improvements

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- Communicate aims and successful changes that achieved the desired results (e.g. newsletters, storyboards, patient stories, etc.)
- Improvements must be “hard-wired” so that the new processes are difficult to reverse (e.g. IT templates, yearly competencies, role descriptions, policies and procedures)
- Assign ownership for oversight and ongoing quality control to “hold the gains”
- Embedding ongoing measurement of processes and outcomes will aid in sustaining the gains



# Examples of Successful Strategies to Design Reliable Processes

*(MA STAAR Collaborative Teams)*

# STAAR Trek: New Frontiers

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Since all patients experience fragmented care, implement successful interventions for **ALL** patients:

- Full-scale implementation of successful changes (embedding changes as standard practices)
- Initial focus on condition-specific interventions (mostly HF patients) >> sequential spread to patients with high-risk clinical conditions is not practical
- Will require a robust improvement infrastructure and learning organization culture



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INSTITUTE FOR  
HEALTHCARE  
IMPROVEMENT

100%



	Green	Green	Green	Green	Green
	Green	Yellow	Green	Yellow	Green
	Green	Green	Yellow	Yellow	Yellow
	Green	Yellow	Red	Green	Red
	Green	Red	Red	Yellow	Red
	Green	Red	Red	Red	Red

100%

# CMS Prospective Payment System

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Beginning on or after October 1, 2012 (FY 2013), payments for hospitals paid under the inpatient prospective payment system will be reduced based on each hospital's ratio of payments for actual risk-adjusted readmissions to payments for expected risk-adjusted readmissions.

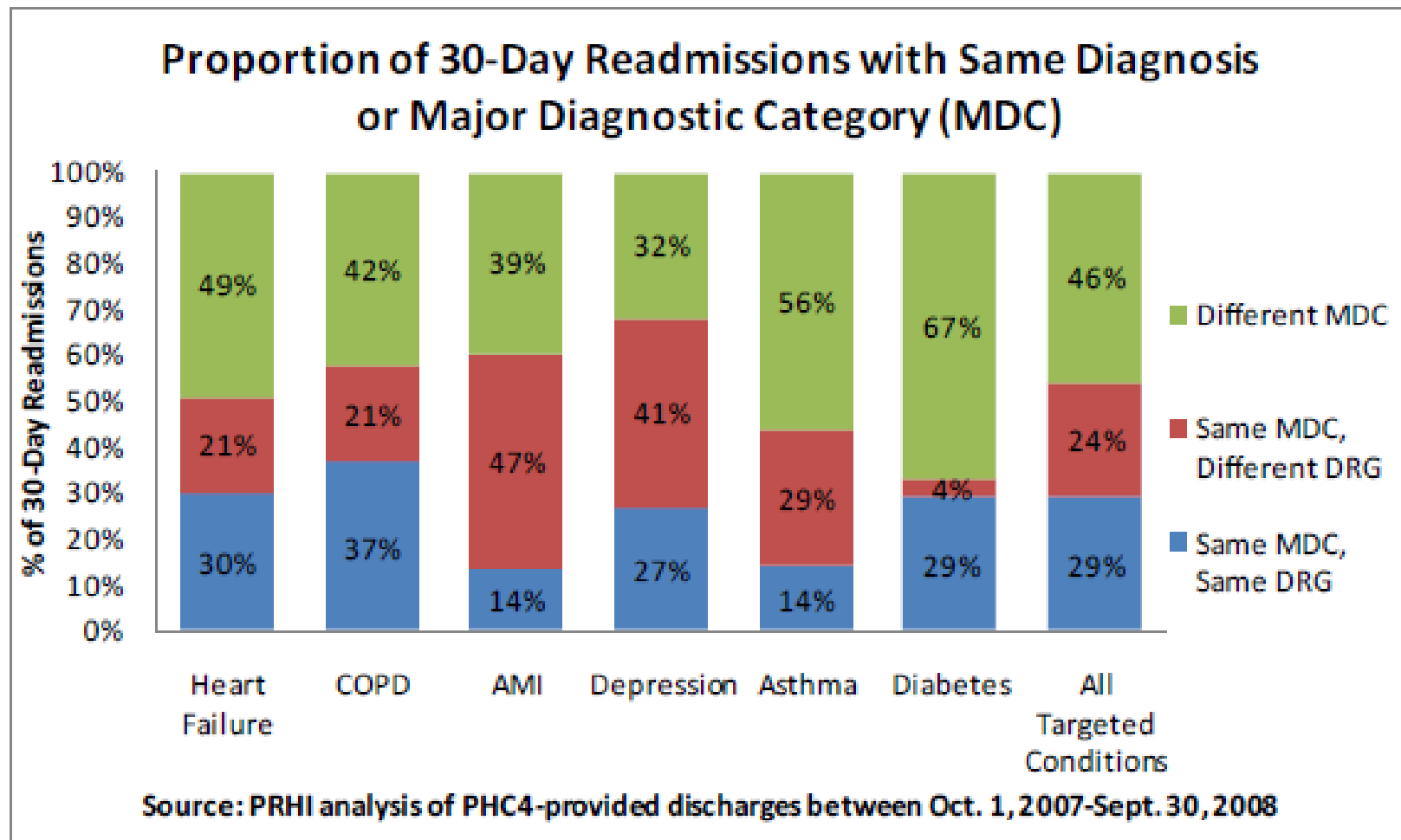
## Initial clinical conditions:

- Heart failure
- AMI
- Pneumonia

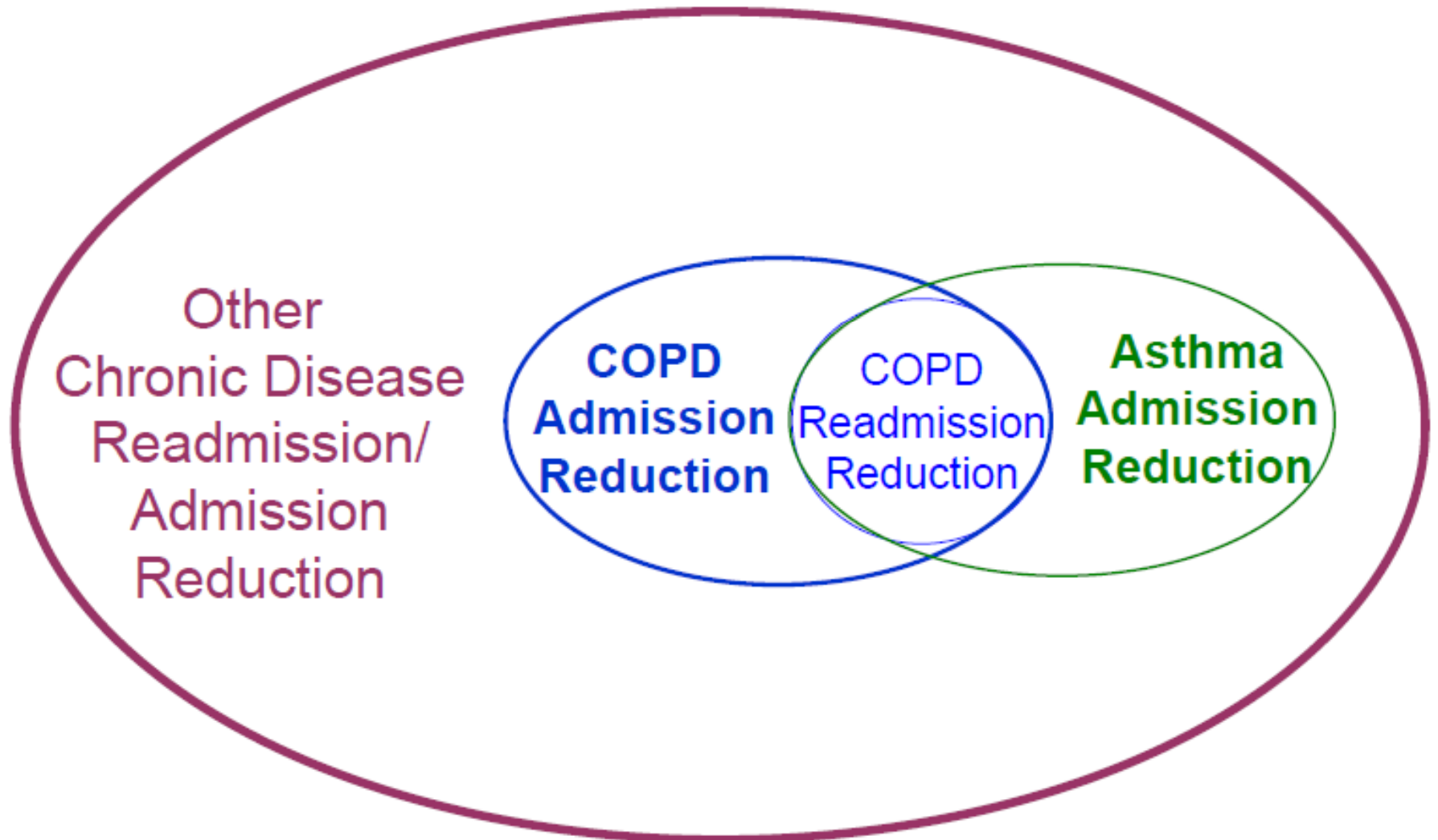
frequent co-morbidities: COPD, stroke, diabetes, renal failure, congestive heart failure, malignancy

# Complexity of Chronic Disease Management

- Over half of 30-day readmissions are for the same MDC
- 70% of 30-day readmissions are for a different diagnosis



# Similar Approach Likely Applicable to Other Chronic Diseases

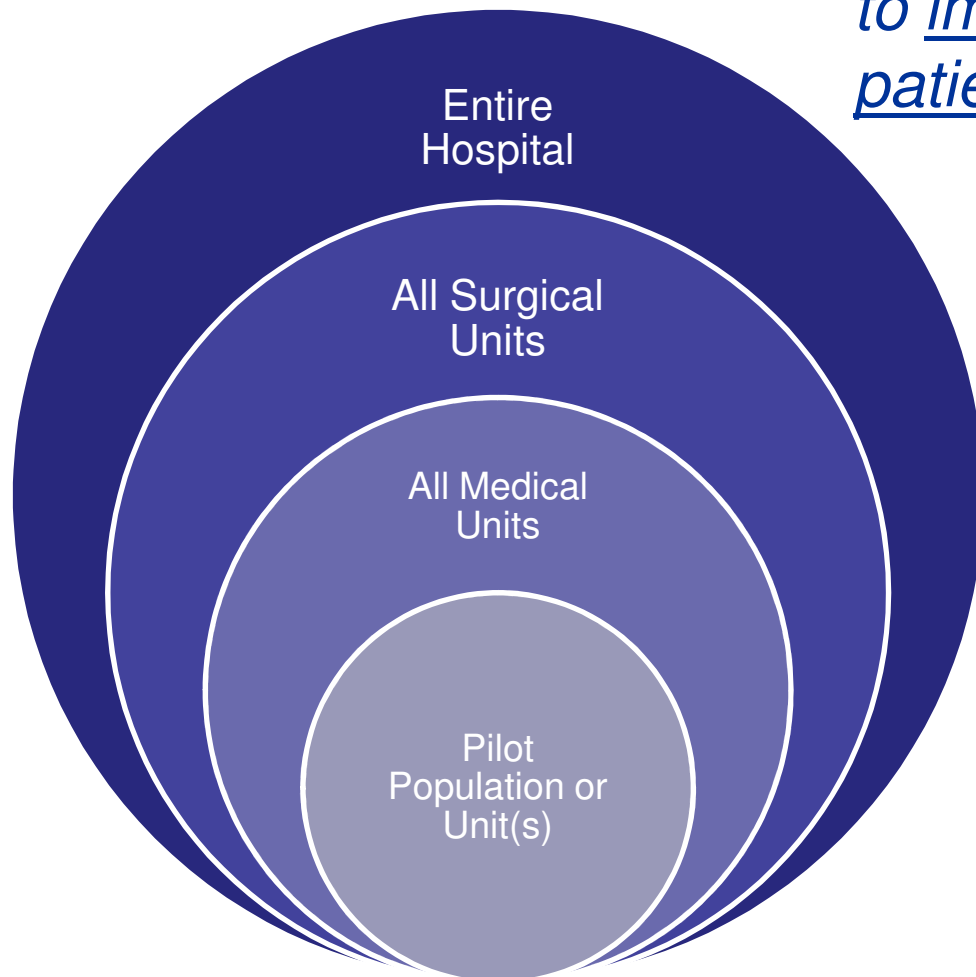




# Spread from Pilot Units to Clinical Departments to Entire Hospital

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*....redesigning care processes to improve transitions for all patients*



# STAAR Trek: New Frontiers

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Adding staffing resources (in hospitals, home care, office practices):

- Not a scalable, sustainable solution
- Need to remove waste and inefficiencies from front-line clinicians' daily work and reliably embed new competencies and best practices into routine care processes



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# Transforming Care at the Bedside

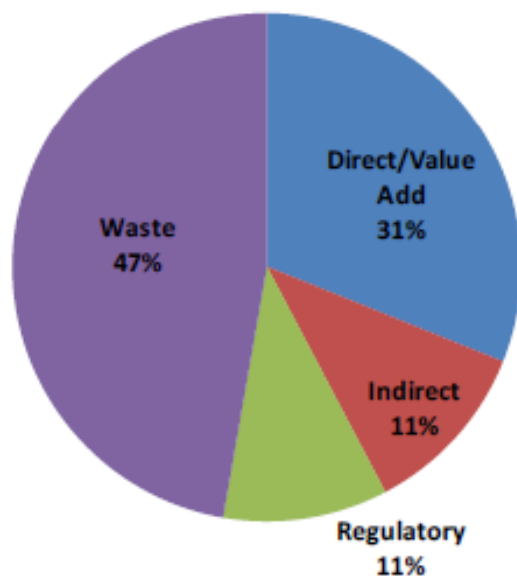
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TCAB Goal: Nurses spend 60% of their time in direct patient care

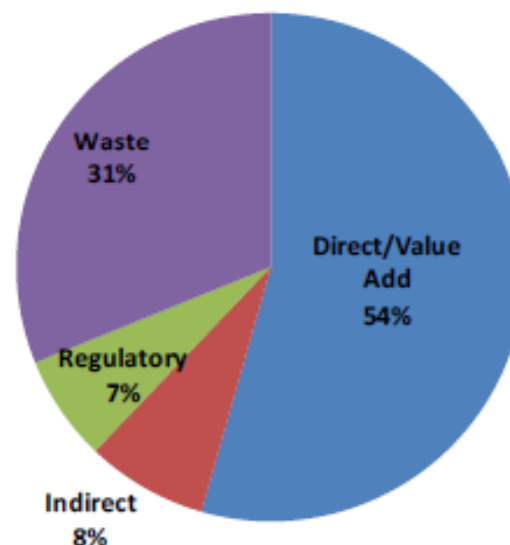
- Eliminate waste in (hunting and gathering, inefficiencies and re-work, workarounds, etc.)
- Nurses' time is reallocated to direct patient care activities that create value for patients and family members
  - Customization of care to meet needs and preferences of patients
  - Creating an "Ideal Transition Home"
    - ✓ Enhanced Assessment
    - ✓ Patient Teaching using Teach Back and Ask Me 3
    - ✓ Customized home care plans
    - ✓ Arranging Follow-up

# How Do Staff Find Time to Do New Things? By Reducing Waste

Respiratory Therapist  
6<sup>th</sup> Floor  
08/19/2008, 1st Shift



Respiratory Therapist  
6<sup>th</sup> Floor  
08/18/2008, 2nd Shift



**Analysis Done Using Perfecting Patient Care<sup>SM</sup> Techniques Showed 1/3 – 1/2 of Respiratory Therapists' Time Was "Wasted" on Inefficient Processes; 1 FTE "Created" by Redesigning Processes**

# Redefining and Redesigning Hospital Discharge to Enhance Patient Care: A Randomized Controlled Study

*Richard B. Balaban, MD<sup>1,2</sup>, Joel S. Weissman, PhD<sup>3,4,5</sup>, Peter A. Samuel, BS<sup>2</sup>,  
and Stephanie Woolhandler, MD<sup>1,2</sup>*

**JGIM 2008**

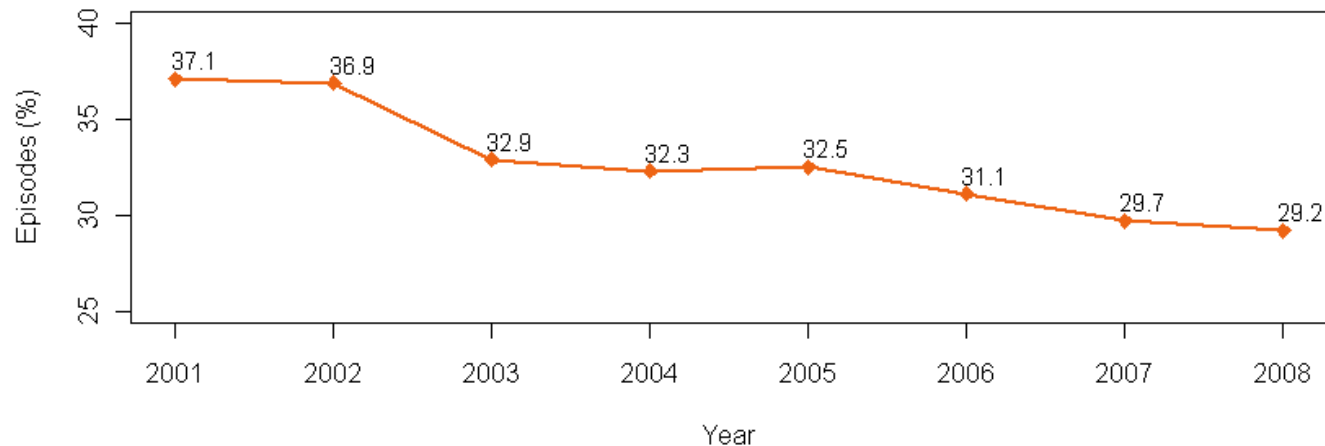
- User-friendly patient discharge form, emailed to PCP
- **Telephone outreach from a PCP nurse post-discharge**
- 4-part combined endpoint “undesirable outcome”
  - No outpatient f/u within 21 d (15% v. 41%)
  - Readmission w/in 31d
  - ED visit w/in 31d
  - Failure by PCP to complete recommended outpatient w/u
- 25% intervention v. 55% control had  $\geq 1$  undesirable outcome
- Effect on rehospitalization alone not significant

# Visiting Nurse Service of NY

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- Focus on the first 30 days of a patient's transition from one care setting to another aimed at reducing the number of hand offs
- Include all settings: referrer (hospital, hospitalist, discharge planners) VNSNY Care Teams, the primary MD and patient/family, community, LTC setting
- Create efficient and effective processes for embedding transitional care practices into daily work.

**Percent of VNSNY Patient Episodes Resulting in Hospitalization per Year for All Payors \*  
(2001 - Present)**



# Planning for Year 2

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- Place a “dot” next to the change on the wall that corresponds to your work to date:
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- Be prepared to share your ratings