State Action on Avoidable Rehospitalizations (STAAR) Initiative

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

- May 1, 2009 launch
- Now in the 4th year of the initiative
- Institute for Healthcare Improvement providing technical assistance and facilitating a learning system
- Multi-stakeholder coalitions in 3 states selected as partners (Massachusetts, Michigan, Washington)
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.).
"We can’t solve problems by using the same kind of thinking we used when we created them.”

Albert Einstein

Diagnostic Case Reviews

- Provide opportunities for learning from reviewing a small sampling of patient experiences
- Engage the “hearts and minds” of clinicians and catalyzes action toward problem-solving
  - 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”
### Changing Paradigms

<table>
<thead>
<tr>
<th>Traditional Focus</th>
<th>Transformational Focus</th>
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<tbody>
<tr>
<td>Immediate clinical needs</td>
<td>Comprehensive needs of the whole person</td>
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<tr>
<td>Patients are the recipients of care and the focus of the care team</td>
<td>Patient and family members are essential and active members of the care team</td>
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<tr>
<td>GPS location team (teams in each clinical setting)</td>
<td>Cross Continuum Team with a focus on the patient’s experience over time</td>
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<tr>
<td>Length of stay in the hospital and timely discharges of patients</td>
<td>Initiating a post-acute care plan to meet the comprehensive needs of patients</td>
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<tr>
<td>“Handoffs”</td>
<td>Senders &amp; receivers co-design “handover communications”</td>
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<tr>
<td>Clinician teaching</td>
<td>What are the patient and family caregivers learning?</td>
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Transition from Hospital to Home

Post-Acute Care Activated

Evidence-based Care in Community Care Settings (Better Models of Care)

Improved Transitions and Coordination of Care

Reduction in Avoidable Rehospitalizations

Alternative or Supplemental Care for High-Risk Patients

* Additional Costs for these Services

Key Design Elements

Patient and Family Engagement

Cross-Continuum Team Collaboration

Health Information Exchange and Shared Care Plans

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

1. “How can we gain a deeper understanding of the comprehensive post-discharge needs of the patient through an ongoing dialogue with the patient, family caregivers and community providers?”

2. “How can we gain a deeper understanding of patient and family caregiver understanding and comprehension of the clinical condition and self-care needs after discharge?”

3. “How can we develop a post-acute care plan based on the assessed needs and capabilities of the patient and family caregivers?”

4. “How can we effectively communicate post-acute care plans to patients and community-based providers of care?”

IHI’s Approach: Assess the Patients Medical and Social Risk for Readmission

Figure 13: Categories of a Patient’s Risk of Rehospitalization

<table>
<thead>
<tr>
<th>High-Risk Patients</th>
<th>Moderate-Risk Patients</th>
<th>Low-Risk Patients</th>
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<tbody>
<tr>
<td>• Patient has been admitted two or more times in the past year</td>
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<tr>
<td>• Patient or family caregiver is unable to Teach Back, or the patient or family caregiver has a low degree of confidence to carry out self-care at home</td>
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<tr>
<td>• Patient has been admitted once in the past year</td>
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</tr>
<tr>
<td>• Patient or family caregiver is able to Teach Back most of discharge information and has a moderate degree of confidence to carry out self-care at home</td>
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<tr>
<td>• Patient has had no other hospital admissions in the past year</td>
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<tr>
<td>• Patient or family caregiver has a high degree of confidence and can Teach Back how to carry out self-care at home</td>
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Post-acute Plan of Care for Residents Transitioning to SNFs or Rehab

- A reliable transition of care after the resident is discharged from the hospital (review plan of care, medication reconciliation, etc.)
- Continuity of care with an MD or APN
- Proactive advanced illness planning with the patient and family members
- Reliable evidence-based care in the SNFs (fall prevention, care of patients with HF, etc.)
- Timely assessment of changes in clinical status of residents and a plan to address common conditions

Key Design Elements

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Improved Transitions and Coordination of Care

Reduction in Avoidable Rehospitalizations

* Additional Costs for these Services
Evidence-based Care in Community Settings

Alternative or Supplemental Care for High-Risk Patients

The Transitional Care Model (TCM)
What are we learning about Reducing Avoidable Readmissions?

- Local learning about the process failures and problems that exist is core to success
- Knowledge of patients’ home-going needs emerges throughout hospitalization
- Family caregivers and clinicians and staff in the community are important sources of information about patients’ home-going needs
- Through Teach Back we learn what patients comprehend about their conditions and self-care needs

What are we learning about Reducing Avoidable Readmissions?

- Cross-continuum team partnerships design transformational changes together
- Senders” and “receivers” partnerships agree upon and design the needed local changes, e.g.
  - Vital few critical elements of patient information that should be available at the time of discharge to community providers
  - Written handover communication for high risk patients is insufficient; direct verbal communication allows for inquiry and clarification
What have we learned about Reducing Avoidable Readmissions?

- Appropriate and timely follow-up care is dependent on availability and payment for services
- There are no universally agreed-upon risk assessment tools
  - We need a much deeper understanding of how best to meet the needs of high-risk patients
  - Use practical methods to identify modifiable risks

Analysis of Results-to-Date

- Reducing readmissions is dependent on highly functional cross continuum teams and a focus on the patient’s journey over time
- Improving transitions in care requires co-design of transitional care processes among “senders and receivers”
- Providing intensive care management services for targeted high risk patients is critical
- Reliable implementation of changes in pilot units or pilot populations require 18 to 24 months
All-Cause 30-Day Readmissions
- Incomplete medical management
- Wrong site of post-acute care
- Socio-economic factors
- Physician follow-up
- Medication
- Patient compliance with regime
- Disease trajectory

Histogram of Days between Initial Discharge Date and Readmission Date
Heart Failure as Initial Admission

Frequency

Days between

Mean 15.10
SD 8.773
N 49

Improvements in Care Transitions: A Case Study of St. Luke’s Hospital

Prepared at the request of the Center for Medicare and Medicaid Innovation (CMMI)
30 Day All-Cause Readmissions

30 Day Readmissions for HF Pilot Nursing Units: Any Dx of HF

- 2009 Average = 24%
- 2010 Average = 19%
- 2011 Average = 13%

Goal Line: 16% (30% reduction)

90-Day All Cause Readmissions

90 Day Readmissions for Heart Failure Patients

- Average for 2009 = 40.2%
- Average for 2010 = 31%
- Average for 2011 = 26%

30% Reduction from 2006 (45.2%) to 2010

Goal Line: 31% (30% reduction)
UCSF Heart Failure Program

Summary

- Rehospitalizations are frequent, costly, and actionable for improvement
- The STAAR Initiative acts on multiple levels – engaging hospitals and community providers, communities, and state leaders in pursuit of a common aim to reduce avoidable rehospitalizations
- Working to reduce rehospitalizations focuses on improved communication and coordination over time and across settings
  - With patients and family caregivers;
  - Between clinical providers;
  - Between the medical and social services (e.g. aging services, etc.)
- Working to reduce rehospitalizations is one part of a comprehensive strategy to promote patient-centered care and appropriate utilization of health care resources
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http://www.ihi.org/IHI/Programs/StrategicInitiatives/STateActiononAvoidableRehospitalizationsSTAAR.htm