IHI’s Approach to Reducing Rehospitalizations in the STAAR Initiative: Overview

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Orlando, FL
December 10, 2012

Minicourse Objectives

After this session, participants will be able to:

• Describe common problems that contribute to rehospitalizations and identify promising approaches to reducing them
• Describe the STAAR initiative’s two concurrent strategies to reduce avoidable rehospitalizations
• Compare and contrast case studies from sites that have implemented improvements to dramatically reduce avoidable rehospitalizations
• Identify strategies to remove systemic barriers and policy implications
Saints Medical Center
Lowell General Hospital

Janet Liddell, RN, MSN/MBA

Orlando, Florida
December 10, 2012

Lowell, Massachusetts
Saints Medical Center

- Community Hospital – Lowell, MA
- Served Greater-Lowell and Merrimack Valley since 1839
- Licensed 157 beds with more than 8,856 admissions and 223,605 outpatient visits per year
- Primary and Acute care services to 315,000 residents from 25 communities

Lowell General Hospital

- Lowell General Hospital acquired Saints Campus - July 1, 2012
- Combined 374 bed community hospital
- Located on two campuses on either side of the Merrimack River
- 2010 – Magnet Designation
- Level III Trauma Center
- Level IIB Special Care Nursery
Why is Reducing Avoidable Rehospitalizations Important?

In 2009:

- Publicly reported CMS Data
- 27.9% Heart Failure 30-Day Readmission Rate (Among Highest Readmission Rates in the Country)
- Talk of Financial Penalties
- Executive Leader “We can’t just flip a switch”

In September, 2009, Saints joined the Institute for Health Care Improvement (IHI) STAAR initiative

- 20 Hospitals each from MA, MI, WA, +OH
- Learning Collaborative
- 4 Key Changes and a Cross Continuum Team (CCT)
- Concentrated on Heart Failure Population
- Conducted a Diagnostic Workup (Baseline) of care for our Heart Failure Population
- Formed our Front Line Team
- Focused work on Two Pilot Units

STAAR CCT: Community Partners

- Elder Services of Merrimack Valley - Mary DeRoo, Home Care Director
- Home Health VNA - Patricia Finocchiaro, Clinical Director
- VNA of Greater Lowell – Cindy Roche, Director of Clinical Services
- CareTenders - Michael Guarnieri, Executive Director
- Blaire House of Tewksbury – John Tryder, Executive Director
- D’Youville Senior Care - Cynthia Thornton, RN, Director of Nursing
- Fairhaven Healthcare Center – Alex Struzziero, Administrator
- Wingate at Lowell - Diane Tessier-Efstathiou, Administrator
- Heritage Nursing Care Center - Elizabeth Rozzi, Administrator
- Palm Manor - Frank McGuire, Administrator
- Willow Manor - Robin Fortin, Administrator
- Radius Northwood HealthCare Center – Karen Koprowski, Executive Director
- Life Care Center of Merrimack Valley - Colleen Lovering, Executive Director
- NEQCA – Tufts - Jennifer Mercier, RN, Case Manager
- Amedisys HHA – Kimberley Brown, RN
STAAR CCT: Saints Medical Center

- Debbie Staniewicz, RN Day-to-Day Leader STAAR, Nurse Manager, 3E
- Deborah McCrady, Dir. Case Management
- Ellen Scott, RN, Nurse Manager, ICU
- Christine Helie, RN, Nurse Manager, IMC
- Janet Liddell, RN Day-To-Day Leader STAAR, Quality Improvement Manager
- Kim Richardson, RN, Dir. Outpatient Satellites

- Dr. S. Ramya, Hospitalist, Executive Leader STAAR
- Helene Thibodeau, CNO, VP Q&PS, Executive Leader STAAR
- Judith Casagrande, COO
- Heather Barry, RPh, Clinical Pharmacist
- Jennifer Braga, Dietician
- Donna Buckley, RN, Director Dialysis
- Christina Breault, BS, CPHQ, Data Analyst

Early Cross Continuum Team Work

First Year:

- Recognized need to standardize care
  - Shared and Compared Best Patient Teaching/Education Tools
  - HHA developed Hospital to Home Pathway
  - SNF held Regional Session INTERACT
- MOU with ESMV for Transition Coaching
Readmissions Root Cause Analysis

• Lack of skills in chronic disease self-management
• Lack of knowledge regarding warning signs
• Lack of patient teaching
• Lack of standard follow-up care with PCP

Key Changes

• Enhanced Assessment / Risk Assessment
• Teach Back
• Handover Communication
• Follow-up Care
• Transition Coaching
Enhanced Assessment

• Identify Heart Failure Patients
  – Therese’s List

• Use Principles of Health Literacy
  – Identifying Primary Learner

• Conduct Enhanced Assessment

• Conduct Risk Assessment For Readmission

Daily STAAR List

<table>
<thead>
<tr>
<th>STAAR - CURRENT IN-PATIENTS</th>
<th>9/14/12</th>
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<tr>
<td>Name</td>
<td>Acct #</td>
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<tr>
<td>Mr. Smith</td>
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<tr>
<td>Mrs. Peabody</td>
<td>57575756</td>
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<tr>
<td>Col. Mustard</td>
<td>57575760</td>
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<tr>
<td>Ms. Peacock</td>
<td>57575761</td>
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<tr>
<td><strong>Mr. Redford</strong></td>
<td>57575763</td>
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**PNEUMONIA**

| Mr. Willis | 45454455 | 666998 | 9/10/12 | 3E 330-2 | 10/17/11 |
| Ms. Carey | 45454456 | 666980 | 9/13/12 | 3E 322-2 | None |
| Mr. Jaems | 45454460 | 666984 | 9/12/12 | 4A 412-2 | 03/23/12 |
| Ms. White | 45454462 | 666986 | 9/10/12 | 8P 514 | 11/23/11 |

**COPD**

| Mr. Green | 98765435 | 780137 | 09/06/12 | 3E 335-2 | 2010 |
| Ms. Monroe | 12345678 | 741167 | 09/10/12 | 3E 323-1 | None |
| Mr. Hughes | 57877767 | 553482 | 09/03/12 | 3E 322-2 | 01/04/12 |
| Mr. Hall | 98076578 | 848719 | 09/08/12 | 4A 409-1 | None |

**STROKE**

| Ms. Potter | 65566566 | 878787 | 9/1/12 | 4A 409-1 | 2010 |
| Mr. Truman | 65566567 | 878787 | 9/10/12 | 3E 322-1 | 3/1/2012 |
| Ms. Horace | 65566568 | 878790 | 9/12/12 | 3E 334-1 | None |
| Ms. Balboa | 65566570 | 878792 | 9/8/12 | IMC 309-1 | None |

**Indicates re-adm within 30 days**

***Not real patient data. Names and numbers have been changed!!!***
STAAR
(State Action on Avoidable Rehospitalization Initiative)
Enhanced Assessment
Interviews with Patients, Family Members, and Care Team Members

1. "Can you tell me what symptoms you were experiencing before you came into the hospital?"
   "When did these symptoms start?"

2. "Did you call your doctor or the doctor's nurse in the office before you came (back) to the hospital?"
   "If not, why not?"

3. "Do you weigh yourself everyday?" "Do you track your weight?" "Do you have a scale?"
   "What is your current weight?"
   "Do there any barriers to buying a scale?"

4. "Can you tell me what your heart pills are?"
   "How do you take your medicine and set up your pills each day?"

5. "Describe your typical meals since you got home."

6. "Who takes care of you at home?" (i.e., nursing, meals, meds, refills)

Family/Caregiver Name: ___________________________ Phone Number: ___________________________

Case Manager: ___________________________ DAF: ___________________________

02/2010 Enhanced Assessment Roll 1

Discharge Risk Assessment (to be completed 2 days prior to discharge)

PATIENT NAME: ___________________________

CHECK ALL THAT APPLY:

- Lives at home with limited or no community support
- Requires assistance with medication management
- Psychosocial greater than 2 medications
- History of mental illness
- Needs with health literacy
- Requires assistance with ADLs
- Cognitive impairment
- End stage condition
- Diagnosis of CHF/OD/DM/ARDS
- Incontinence
- Ambulatory wound or pressure ulcer
- History of falls
- Decreased adherence to treatment plan
- Previous hospitalization/ED visits
- Requires assistance in management of Oxygen and nutrition

TOTAL # CHECKED: ___________________________

SCORE 0 - 4 LOW RISK for rehospitalization. Discharge to community.

SCORE 5 - 7 MODERATE RISK for rehospitalization. Refer to home care services immediately.

SCORE > 7 HIGH RISK for rehospitalization. Discharge to day hospice facility.

*If patient has an end stage/life limiting condition and any of the following consider a hospice evaluation or referral:
- Recent decline in functional status, as evidenced by unplanned weight loss of ≥ 10%, or ≥ 6 months of severe albumin < 2.5
- Recent decline in functional status (Karnofsky score < 50)
- Unexplained physical symptoms and/or Symptoms proving difficult to manage
- Poor response to optimal treatment
- Frequent ER visits and/or hospitalizations

TO QUALIFY FOR MEDICARE HOME HEALTH SERVICES:

- This patient is under the care of a physician (community physician willing to sign home care orders).
- The patient requires skilled nursing, physical therapy or speech therapy services or has a continuing need for occupational therapy on an intermittent basis. (If so, then there is a signed plan of care.)
- Services are provided in the patient's home.
- Services must be reasonable and necessary.
- The patient is homebound.

DEFINITION OF HOMEBOUND:
- Homebound means the condition of the patient results in a considerable and lasting effort for the patient to leave his home.

TO REFER TO HOME HEALTH SERVICES:

- Skilled Nursing: Observation and assessment, Teaching and training, Performance of skilled treatment of procedures
- AND/OR Physical/occupational and/or speech therapy
- AND/OR Home health aide service for personal care and/or transport
- AND/OR Transportation
- AND/OR To receive medical day care services

If patient referred to receive home health care prior to discharge, please include name of agency below:

City/State: ___________________________
Enhanced Learning

• Use Principles of Health Literacy
  – Teach Primary Learner
  – Heart Failure Packet (Zones, Simple Anatomy & Physiology, Nutrition)

• Teach Back Methodology
  – Nurse Competency
  – Annual Skills Demonstration

• Developed Tool with CCT Sub-Group
  – Learning Issues and HF Weights – Passing the Baton
  – Spread – PN, COPD and Diabetes
Handover Communication

- Hospitalists emailing or texting PCPs with information regarding acute care episode
- RN to Receiving RN telephone communication
- Goal: Physician D/C Summary leaves the hospital with the patient
  - SNF – Yes
  - HHA – Long way to go
Post Acute Follow-up Care

- Mod/High Risk for Readmission
  - Multiple Re-hospitalizations
  - Lives alone / Lack of Social Supports
  - Low Health Literacy
- Schedule Follow-up Appointment within 3–5 days after discharge
  - Outreach
    - Office Practice Managers – shared goals, teamwork
    - Medical Staff - Dept Medicine, Family Medicine, CMEs
  - Unit Coordinators scheduling appointments
- Transition Coaching – since summer 20: 

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Complete Connected Care

First Encounter

Lasting Impressions

Quality/Outcomes

Healing Environment

Touchpoints

Transitions

Lowell General Hospital

Complete connected care™
Affordable Care Act – Section 3026

Medicare Demonstration Projects:
Partnership for Patients & Community Based Care Transitions Program

Goals:
- Reduce HACs by 40%
- Reduce Hospital Readmissions by 20% by 2013

Community-Based Care Transitions Program

Goals
- Reduce hospital readmissions
- Maintain or improve quality of care
- Document measurable savings to the Medicare program
Merrimack Valley Care Transitions: A Collaborative Approach

Elder Services of Merrimack Valley (CBO)
In Partnership with 5 area hospitals:

- Anna Jaques – High Readmission
- Lawrence General – Medically Underserved
- Saints Medical Center – Care Transitions Experience (STAAR 2009): now campus of Lowell General Hospital
- Holy Family
- Merrimack Valley

Merrimack Valley Root Cause Analysis

Inadequate Care Coordination
- inadequate home care support
- Inability to access follow-up care

Health System Failures
- poor communication among providers
- unrealistic expectations of provider’s capabilities
- inappropriate SNF or home care placement

Low Health Literacy
- patient and/or caregiver do not understand care plan
- patient and/or caregiver do not know how to identify warning signs
- patient and/or caregiver do not know the appropriate response

Behavioral Risks
- anxiety or mental health conditions
- cognitive impairment
- non-adherence with medications or follow-up care
Merrimack Valley Root Cause Analysis

Environmental Risks
- Unsafe physical structure (home)
- Insufficient financial capability for meds
- Abuse/neglect
- Lack of access to providers and services

Clinical Risks
- Multiple and complex comorbidities
- Poly-pharmacy
- Developmental impairments

Cultural Barriers
- Lack access to information and education in language or context they understand re: discharge, care plan instructions or use of medications

Transition Coach
- A Healthcare Professional Trained in the Coleman Care Transitions InterventionSM (CTI)
- Hospital Based Lead Coaches
  - 3 Field Coaches
    - Assigned to all Mod/High Risk for Readmission
    - Medicare FFS
    - Patient Consent
Transition Coaches

- Assist patients across all care settings
- Conduct Home Visit within 24 – 48 hours post hospital discharge
- Maintain ongoing communication over four week period
- Assist with routine referrals and special interventions
- Encourage adherence to prescribed treatment plan
- Help patient ID “red flags”
- Promote self-management
- Conduct Medication review
- Develop Personal Health Record
- Ensure PCP follow-up and care coordination

Case Review: George

- 51 year old male with
  - Primary Medical History: COPD, CKD, advanced cardiomyopathy, EF 15%, tobacco/cocaine abuse, MI x2
- Medicare FFS
- Hospitalized four times in seven months
- Consented to CCTP Transition Coaching
Case Review: George

Enhanced assessment:
- Single, with roommate
- High risk behavior i.e., tobacco and cocaine
- Medication non-compliant
  - Reports taking meds 1x/week
- Poor diet
- Progression of heart failure symptoms

Risk assessment:
- High risk for readmission
- Nutrition education consult ordered

Case Review: George

Teach Back:
- Primary Learner
- Able to teach back 2/3 of content
- Poor understanding of sodium content in food
Front Line Team Meeting

George was readmitted within 19 days post discharge, however, the Case Manager reports:

• Gaining chronic disease management knowledge
• Able to identify cause-effect relationship between dietary indiscretion and readmission
• Patient reports SOB X 2 days after eating chips and ham and cheese sub
• Patient gained 10 pounds due to better diet
• More compliant in taking daily meds
• Affect improved due to daily social engagement

Front Line Team Meeting

Transition coach reports that George:

• Moved in with brother
• Eating better due to S-I-L meal prep
• Attending follow-up appointments
• Walks to social day program
All-Cause 30-Day Readmissions
Success/Achievements

- Engaged Cross Continuum Team
- High Risk for Readmission patients are identified on Admission
- Staff beginning to look at whole person and their social situation over time
- Patients are becoming more knowledgeable about self managing chronic disease
- High Risk patients receiving timely follow-up care
- High Risk Medicare FFS patients benefit from Transition Coaching
Success / Achievements

- Implemented Transition Coaching Program
- Conduct enhanced assessments to identify discharge needs on admission
- New health literacy heart failure educational booklet
- Teach back training and implementation
- Enhanced Electronic Transition Record
- Scheduling of timely follow up MD appointments for heart failure patients
- Warm phone handover to SNF’s and Rehabs

Ongoing Challenges

- Medication reconciliation continues to be a major challenge across the continuum of care
- Discomfort among staff in referring patients to Palliative Care Services
- End-of-life preparation goes largely unaddressed across the continuum of care
Next Steps

- STAAR/IHI Intensive focus on the transition of residents between the Hospital and SNF
- Implement MOLST
- Enhance collaboration with Palliative Care Services
- Improve Discharge Medication Reconciliation

STAAR and CCTP COLLABORATIVES

Executive Leader:
Amy Hoey, RN, MS, BSN, CCRN, VP/CNO

Day-to-Day Leaders:
Janet Liddell, RN, MSN/MBA
Cindy Crowe, RN, BSN, CPHQ