IHI’s Approach to Reducing Rehospitalizations in the STAAR Initiative

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Orlando, FL
December 10, 2012

Faculty Presenters

The Care Transitions Program

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Session Objectives

After this session participants will be able to:

- Describe the case for creating a more patient-centered transition from the hospital to post-acute care
- Identify promising approaches to reduce avoidable rehospitalizations
- Describe IHI strategies and key interventions utilized to improve care transitions and reduce avoidable rehospitalizations

Manifestations of Poor Transitions

- Medication errors
- Absence of follow-up care
- Greater use of hospital and emergency room
- Higher costs of care
Readmissions Among Patients in the Medicare Fee-for-Service Program

- 2007 Medicare data analysis finds:
  - One in five Medicare Beneficiaries are readmitted in 30 days
  - 67% are readmitted or deceased at 1 year
  - 24% of 30-day readmissions are to another hospital
- Among medical patients readmitted at 30 days:
  - 50% no bill for MD service between discharge and readmitted
- Among surgical patients readmitted at 30 days:
  - 70% are readmitted with a medical DRG


The Revolving Door Of Rehospitalization From Skilled Nursing Facilities

ABSTRACT Almost one-fourth of Medicare beneficiaries discharged from the hospital to a skilled nursing facility were readmitted to the hospital within thirty days; this cost Medicare $4.34 billion in 2006. Especially in an elderly population, cycling into and out of hospitals can be emotionally upsetting and can increase the likelihood of medical errors related to care coordination. Payment incentives in Medicare do not encourage providers to coordinate beneficiaries’ care. Revising these incentives could achieve major savings for providers and improved quality of life for beneficiaries.

Mor V, Intrator O, Feng Z, Grabowski DC. The revolving door of readmission from skilled nursing facilities. Health Aff (Millwood);29:57-64.
“The Billion Dollar U-Turn”

Readmissions are:

- **Frequent**
  - 20% Medicare beneficiaries readmitted within 30 days

- **Costly**
  - $17B in Medicare spending; est. $25B across all payers annually

- **Actionable for improvement**
  - 76% potentially avoidable
  - CHF, CAP, AMI, COPD lead the medical conditions
  - CABG, PTCA, other vascular procedures lead the surgical conditions

- **Highly variable**
  - Medicare 30-day readmission rate varies 13-24% across states
  - Variation greater within states

Commonwealth Fund State Scorecard on Health System Performance. June 2009
Confluence of National Attention

Medicare Payment Advisory Commission (MedPAC)

Policies to align incentives to reduce readmissions:

1) Public disclosure of hospital 30-day (risk-adjusted) readmission rates www.hospitalcompare.hhs.gov
2) Adjust payment based on performance (i.e., readmissions may not receive full payment)
3) Bundling payment across hospitals and MDs
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
Measuring Hospital Readmission: Far from a Perfect Science

- Numerator/denominator—what should count?
- Related/unrelated admissions?
- Planned/elective admissions?
- Risk adjustment?
- Observation status?
- Nursing home readmissions?

National Quality Forum

- Endorsed Care Transitions Measure
- Endorsed Hospital Consumer Survey HCAHPS
- Endorsed Hospital Discharge Safe Practices
- Out for public review: Best Practices in Care Coordination/Transitional Care
Administration for Community Living (formerly AoA)

- RFP though the Aging and Disability Resource Centers (ADRCs)
- National competition for funds to support community based discharge planning

Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine

Recent Evidence

- Gives us reason for pause
- Results are unimpressive and join growing number of mixed or negative studies in disease management/case management/care coordination
- We need to be careful not to over emphasize assessment, care planning, and patient education compared to patient/family caregiver engagement
- Time to shift from provider-centered care to patient-centered care

Determinants of Preventable Readmissions

- Patients with generally worse health and greater frailty are more likely to be readmitted
- There is a need to address the tremendous complexity of variables contributing to preventable readmissions
- Identification of determinants does not provide a single intervention or clear direction for how to reduce their occurrence
- 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

Effects of Care Coordination on Hospitalization, Quality of Care, and Health Care Expenditures Among Medicare Beneficiaries
15 Randomized Trials

Deborah Peikes, PhD
Arnold Chen, MD, MSc
Jennifer Schore, MS, MSW
Randall Brown, PhD

Context Medicare expenditures of patients with chronic illnesses might be reduced through improvements in care, patient adherence, and communication.

Objective To determine whether care coordination programs reduced hospitalizations and Medicare expenditures and improved quality of care for chronically ill Medicare beneficiaries.

Design, Setting, and Patients Eligible fee-for-service Medicare patients (primarily with congestive heart failure, coronary artery disease, and diabetes) who volunteered to participate between April 2002 and June 2005 in 15 care coordination programs each received a negotiated monthly fee per patient from Medicare and were randomly assigned to treatment or control (usual care) status. Hospitalizations, costs, and some quality-of-care outcomes were measured with claims data for 18,309 patients (n = 178 to 2657 per program) from patients’ enrollment through June 2006. A patient survey

Chronic illnesses pose a significant expense to the Medicare program and a major detriment to beneficiaries’ quality of life. The cost and complexity of care are greater for those patients with multiple chronic illnesses.

The Bad News:
There are No “Silver or Magic Bullets”!

.....no straightforward solution perceived to have extreme effectiveness

Conclusion: “No single intervention implemented alone was regularly associated with reduced risk for 30-day rehospitalization.”

Interventions to Reduce 30-Day Rehospitalizations: A Systematic Review


The Major Challenges

- 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

The Chinese Symbol for Crisis

危机
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?
The Good News: There are Promising Approaches to Reduce Rehospitalizations

- Improved transitions out of the hospital
  - Project RED
  - BOOST
  - IHI’s Transforming Care at the Bedside and STAAR Initiative
  - Hospital to Home “H2H” (ACC/IHI)
- Reliable, evidence-based care in all care settings
  - PCMH, INTERACT, VNSNY Home Care Model
- Supplemental transitional care after discharge from the hospital
  - Care Transitions Intervention (Coleman)
  - Transitional Care Intervention (Naylor)
- Alternative or intensive care management for high risk patients
  - Proactive palliative care for patients with advanced illness
  - Evercare Model
  - Heart failure clinics
  - PACE Program; programs for dual eligibles
  - Intensive care management from primary care or health plan

Immediate Steps Your Organization Is Well-Positioned to Take…

(c) Eric A. Coleman, MD, MPH
All Arenas

- Include patients and family caregivers as partners in the care team
- Identify their specific learning needs and limitations (language, literacy, cognition)
- Support them in their self-care roles—build confidence and skills through simulation

(c) Eric A. Coleman, MD, MPH

Hospital Arena

- Do away with term “discharge”
- Facilitate opportunity for receiving care providers to engage in 2-way communication
- Set expectation that summaries be available within 72 hours
Ambulatory Arena

- Provide clear instructions on how to access after hours care
- Create access for hospital follow-up visits

Home Health Care

- Consider making first visit before patient has left the hospital or nursing home
- Within rules and regulations, try to have one home care nurse work with a given ambulatory practice
Medications

- Support patients in medication reconciliation
- Encourage use of a single pharmacy
- Provide the indication for each medication
- Print a copy of the medication list after each encounter or modification/reconciliation

(c) Eric A. Coleman, MD, MPH

Timely/Accurate Information Transfer

- Review and understand HIPAA
- Develop community standards for the content and format for information transfer
- Information transfer should proceed the patient’s physical transfer to the next setting

(c) Eric A. Coleman, MD, MPH
Health Information Technology to Support Care Transitions

- Identify baseline cognitive and physical function
- Identify advance directives
- Identify family caregivers

Measure Performance

- Identify opportunities for improvement
- Include metrics on recidivism
- Include patient perspective
- Reward performance

(c) Eric A. Coleman, MD, MPH
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.).

Harold D. Miller, President and CEO, Network for Regional Healthcare Improvement and Executive Director, Center for Healthcare Quality and Payment Reform
Strategy 1. Improve the transition out of the hospital and into the next care setting.
Contemporary Evidence about Hospital Strategies for Reducing 30-day Readmissions

- Study sought to determine prevalence of practices being implemented (for patients with HF or AMI)
- Cross-sectional study of hospitals enrolled in the Hospital to Home (H2H) initiative
- Although most hospitals had a written objective of reducing preventable readmissions, the implementation of recommended practices varied widely
  - 49.3% of hospitals had partnered with community MDs
  - Inpatient and outpatient prescription records were electronically linked in 28.9% of hospitals
  - Discharge summary was sent to the primary care doctor in 25.5% of hospitals
  - On average, 4.8 of 10 recommended practices were implemented


“We can’t solve problems by using the same kind of thinking we used when we created them.”

*Albert Einstein*
## Changing Paradigms

<table>
<thead>
<tr>
<th>Traditional Focus</th>
<th>Transformational Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immediate clinical needs</td>
<td>Comprehensive needs of the whole person</td>
</tr>
<tr>
<td>Patients are the recipients of care and the focus of the</td>
<td>Patient and family members are essential and active members of the care team</td>
</tr>
<tr>
<td>care team</td>
<td></td>
</tr>
<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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</table>

## Changing Paradigms

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<tr>
<td>Length of stay in the hospital and timely discharges of</td>
<td>Initiating a post-acute care plan to meet the comprehensive needs of patients</td>
</tr>
<tr>
<td>patients</td>
<td></td>
</tr>
<tr>
<td>“Handoffs”</td>
<td>Senders &amp; receivers co-design “handover communications”</td>
</tr>
<tr>
<td>Clinician teaching</td>
<td>What are the patient and family caregivers learning?</td>
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</tbody>
</table>
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 improvement initiatives, learn from the work and spread successes?

Cross Continuum Teams

A team of staff in the hospital, skilled nursing facilities, home health care agencies, office practices, and patients and family members:

- Provide oversight and guidance
- Help to connect hospital improvement efforts with partnering community organizations
  - Identifies improvement opportunities
  - Facilitates collaboration to test changes
  - Facilitates learning across care settings
- Provide oversight for the initial pilot unit work and establishes a dissemination and scale-up strategy
Cross Continuum Teams

- CCTs is one of the most transformational changes in IHI’s work to improve care transitions
- CCTs reinforces the idea that readmissions are not solely a hospital problem
- There is a 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-designing processes to improve transitions of care
- The new competencies developed in CCTs (where team members collaborate across care settings) will be a great foundation integrated care delivery models (e.g. bundled payment models, ACOs)

Quotes from Cross Continuum Team Members

“It is a lot of work to establish this team, but it is worth it.”

“The conversations change when everyone is at the table. It feels good to have us all in the room with the patient at the center of our work.”

“Even if we haven’t moved the numbers, we have moved the mindset.”

“Staff at different sites of care pick up the phone; they didn’t before.”

“We make more referrals to home care as a result of the improved communications.”

“The CCT will last beyond STAAR. All future initiatives will benefit from the open communications and less siloed care.”

“We are making great strides in opening the communication of patient care between our diversified organizations. It is truly encouraging after 40+ years in health care to see this transformation.”
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”

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/offerings/Initiatives/STAAR/Pages/Materials.aspx#videos
Systems of Care

“The quality of patients’ experience is the “north star” for systems of care.” – Don Berwick

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?”

Systematic Review of Risk Prediction Models

**Conclusions:** Most current readmission risk prediction models that were designed for either comparative or clinical purposes perform poorly. Although in certain settings such models may prove useful, efforts to improve their performance are needed as use becomes more widespread.

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>
</tr>
</thead>
<tbody>
<tr>
<td>Patient has been admitted two or more times in the past year</td>
<td>Patient has been admitted once in the past year</td>
<td>Patient has had no other hospital admissions in the past year</td>
</tr>
<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>
<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>
<td>Patient or family caregiver has a high degree of confidence and can Teach Back how to carry out self-care at home</td>
</tr>
</tbody>
</table>


When are patients being readmitted?

- Initial readmissions spike within 48 hours of discharge
- 66% of readmissions occur within 15 days

Dianne Feeney is associate director of quality initiatives for the Maryland Health Services Cost Review Commission (HSCRC).
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
Co-Design of Handover Communications

http://www.ihi.org/explore/Readmissions/Pages/default.aspx
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
  - 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

Ohio Hospital Association Work Results in Hospital Readmission Reductions

AUGUST 2, 2012

OHA’s Quality Institute worked to decrease hospital readmissions through the Ohio State Action on Avoidable Rehospitalizations (STAAR) Initiative. Eighteen hospitals participated, and results showed an eight percent greater reduction in STAAR hospitals’ readmissions than other Ohio hospitals’. The Columbus Dispatch reported that hospital readmissions in Ohio dropped six percent in 18 months and accredited the STAAR program as a factor in the decrease.
prepared at the request of the Center for Medicare and Medicaid Innovation (CMMI)

UCSF Heart Failure Program

Case Study
INNOVATIONS IN CARE TRANSITIONS
November 2012

University of California, San Francisco Medical Center: Reducing Readmissions Through Heart Failure Care Management

DOUGLAS McCARTHY

http://www.commonwealthfund.org/Publications/Case-Studies/2012/Nov/University-of-California-San-Francisco.aspx
Strategy 2. **State-based, multi-stakeholder initiatives to concurrently examine and address the systemic barriers**

STAAR State Level Strategy

- **Hospital-level**
  - Improve the transition out of the hospital for all patients
  - Measure and track 30-day readmission rates
  - Understand the financial implications of reducing rehospitalizations

- **Community-level**
  - Engage organizations across continuum to collaborate on improving care, partner with non-clinical community-based services, address lack of IT connectivity, clarify who “owns” coordination, engage patient advocates
  - Ensure post-acute providers are able to detect and manage clinical changes, develop common communication and education tools

- **State-level**
  - Develop state-level population-based rehospitalization data
  - Convene all payer discussions to explore coordinated action
  - Link with efforts to expand coverage, engage patients, improve
    - HIT infrastructure, establish medical homes, contain costs, etc.
  - Establish state strategy, use regulatory levers
MA Care Transitions Initiatives

Michigan’s Portfolio of Projects

MPRO (QIO 10th Scope of Work)

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
Care Transitions Resources

- www.caretransitions.org
- www.NTOCC.org
- www.nextstepincare.org
- www.hospitalmedicine.org/BOOST
- http://www.ihi.org/explore/Readmissions/Pages/default.aspx
- www.pacdemo.rti.org
- www.hospitalcompare.hhs.gov
- www.teachbacktraining.com

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http://www.ihi.org/IHI/Programs/StrategicInitiatives/STateActiononAvoidableRehospitalizations/STAAR.htm