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
A New Partnership For Detroit

January 1, 2011

- Investing $850 million in DMC hospitals in the next 5 years with $500 million going to major projects
- Brand new 4 story Pediatric Specialty Center and 175,000 square foot Tower*
- New Heart hospital - The Cardiovascular Institute
- Expanded and modernized facilities at Detroit Receiving**, Rehabilitation Institute*, Huron Valley-Sinai *
- New ER at Sinai Grace and Harper/Hutzel **
- $350 million for ongoing equipment and capital needs **

Projected renovations
*Completed
**In process

Employees 2286
Beds 394
Adult/Peds Patient Days 99,420
Adult/Peds Discharges 18,414
Births 1,512
Emergency Visits 100,762
Average LOS 5.06
Ambulatory/Professional Visits 104,331

2011 Data
Comparison of Cities with High Percentage of Diverse Populations


Percentage of Population Living Below Poverty

Sources: U.S. Census Bureau, 2011 American Community Survey, and 2010 Census, Profile of Demographic Characteristics.
Burden of Heart Disease for Racial and Ethnic Minorities

• Blacks have a higher heart disease death rate than whites or Hispanics.
• Blacks have a higher prevalence of cardiac disease than whites or Mexican Americans.
• Mexican Americans are more likely to have higher cholesterol than whites or blacks.
• Blacks and Mexican Americans are more likely than whites to be diagnosed with diabetes.

Heart Disease Death Rates Among 35+ Population by Race, United States, 1996-2000

Deaths per 100,000 Residents

- Whites 529
- Blacks 662
- Hispanics 348

Source: Centers for Disease Control and Prevention, Heart Disease and Stroke Maps. The data are age-adjusted heart disease mortality deaths per 100,000 between the years 1996-2000 for adults ages 35 years and above.

Source: American Heart Association, Heart Disease and Stroke Statistics – 2006 Update.

MI STA*AR Collaborative Aims

Sinai Grace Hospital will implement interventions that:

☆ Improve self-management of chronic diseases by patient or caregiver

☆ Improve post-discharge follow-up

☆ Improve coordination of care between providers and across the continuum of care by promoting seamless transitions from the hospital to home, skilled nursing care, home health care or other providers to prevent avoidable readmission to the hospital

☆ Improve medication reconciliation and management
Why is the MI STA*AR Collaborative strategic to your organization?

❖ **Patient Satisfaction**
   Patient should be the focus of the full team from admission to post transition out of the hospital. That would be ideal patient centered care. Each TX plan is individualized with the patient being the most important member of the team.

❖ **Quality**
   Evidence based care is pivotal to the outcome of the health of the patient. As ACO’s are developed, the care of the patient will no longer stop at the hospital doors and we must find a way to partner with the PCP, the SNF, and the Home Care agencies that will be part of our ACO.

❖ **Financial**
   CMS changes in the reimbursement formula for unplanned admissions will be present in the next two years that will impact the reimbursement (revenue) to the hospital.

❖ **Market Share**
   Establishing significant partnering relationships with our patients through regular scheduled calls should help us be their Hospital of choice.

Most Importantly Because It’s The Right Thing To Do!
4 Key Changes to Improve the Transition from Hospital to Home

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

Enhanced Admission Assessment for Post-Discharge Needs

- Emergency Department Case Manager identifies patients & starts assessment and plan of care with family
- Case Manager places note in the EMR
- Social Workers and Case Managers use ECIN risk assessment tool and the report is placed in chart.
- Daily multidisciplinary rounds assess patient discharge needs and follow-up recommendations.
- Upon discharge, Social Worker provides patient with community based service information
HCAHPS Question 19

Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?

HCAHPS Question 20

Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
Enhanced Teaching and Learning

- Bedside RN identifies learner upon admission
- Educational materials were developed for heart failure
- Educational materials are available on through the intra-web and on each unit
- Bedside RN taught how to provide teach back education during unit roll-out
- New RN employee orientation contains Teach Back learning
- Teach back yearly competencies on Net Learning

Nursing Education:
Learn to use Teach-Back

Research shows that the use of “Teach Back” is beneficial to patients and families, although few clinicians actually use it every day. The main reason that clinicians do not use teach-back is their unfamiliarity with the teach-back method or may find it difficult to change their communication style.
Nursing Education:
Example of Orientation Materials

Transitions In Care

Role Play
Groups of 3

Allotted Time: Role Play 15 min; Group Reflection 5-10 min

Role Play Instructions:
1) Groups of 3 (Nurse/ Patient-Identified learner /Monitor person)
2) Identify your role Nurse, Patient, or Monitor
3) Nurse will provide simple directions on how to get to where they (Nurse) live from Sinai Grace Hospital to the Patient
4) The monitor will observe to see if the Nurse provided easy instructions and then listen to the “teach-back” from the Patient
5) Then switch roles: Patient will become Monitor, Nurse will become Patient and Monitor will become Nurse (follow step 3)
6) Then switch roles again: Patient will become Nurse, Nurse will become Monitor, and Monitor will become Patient (follow step 3)

*Assuming patient is the identified learner, if not then it should be the identified learner who receives the teach back information
Transitions In Care

Group Reflection: Role Play Lessons:
- What did you learn?
- Did the learner provide accurate teach back?
- Was the nurse aware if the education was successful or unsuccessful?
- Did the nurse (clinician) take responsibility for the education?

Something to think about:
- If you were a patient or family member of a patient that received this type of education would you be happy or feel that you were educated in the appropriate way?
- Would you be able to get to the house by the directions you were provided or would you need a GPS??

Food for thought as they say............ Let this guide your practice on how to educate your patients.

HCAHPS Question 3

How often did the nurses explain things in a way you could understand?

Detroit Medical Center - Sinai Grace - Q3
CHF Patients: Discharges & Readmissions

All-Cause 30 Day Readmissions CHF Patients
Patients discharged home receive a magnet, calendar pages for weight tracking, 24-7 Nurse Triage number for emergent needs/questions.

Patient will also be enrolled into the heart failure corporate call center, which will provide weekly contact with patient and nurse for 6 months after discharge.
Patient and Family-Centered Handoff Communication/Discharge

☆ Medication Reconciliation completed on admission, transfer to another unit, and at discharge.
☆ Any credentialed provider has the ability to access EMR from any computer.
☆ Hospitalist Groups fax discharge summary faxes to primary care physicians office.
☆ Social Workers and Case Managers transmit information to Skilled Nursing Facilities and Home Care Agencies through ECIN.
☆ Discharge paperwork and medication reconciliation accompany patient at discharge with instructions to take to primary care physician at follow-up appointment.

Community Partner Activities/Involvement

☆ Bi-Monthly multi-disciplinary meetings with local Skilled Nursing Facilities regarding admissions, readmissions, and transfers
☆ Education provided to facility staff on how to implement Interact II tool in a effort to decrease inappropriate transfers
☆ Open communication with these facilities regarding any variance from the 'ideal' transition.
☆ Developed processes that facilitated non-emergent patient needs to avoid patients being sent to ER (e.g. Peg Tube Placement, Blood Transfusion)
☆ Physician-to-Physician education provided to illicit ‘buy in’ on using the established protocols/interventions from Interact II
☆ Up-skilled nursing and support staff on assessment and implementation of INTERACT II tools
Transitions in Care: Partnering Together to Reduce Unnecessary Readmissions

- Interdisciplinary meetings started weekly with facility
- Discussed unplanned discharges and identified barriers or causes that contributed to patient being sent to ER
- Established a ‘hotline’ to schedule a peg tube replacement.
- Provided direct contact number at SGH in the event the facility received resistance with scheduling case
- Provided staff development on the use of SBAR
- The nurses and physicians have developed a relationship of trust regarding patient care.
Transitions in Care: Partnering Together to Reduce Unnecessary Readmissions

Key Lessons Learned

☆ Small, rapid changes make big differences in outcomes.
☆ Allowing yourself to abandon a process that initially looked good on paper but does not work in the practice setting.
☆ New programs need to be embraced from top leadership and the commitment communicated to everyone including the physician network.
☆ One phone call to the patient at home post-discharge can change the patients outcome and prevent a readmission.
☆ Realizing that you can do everything right for some patients and due to social, medical, psychological issues some patients will still return within 30 days.
☆ Person-dependent processes will eventually fail! Hard wire your processes so that they become the responsibility of everyone, not just one person.
Key Lessons Learned

- Keep staff engaged. Keep them informed on the progress and recognize the effort that is made.
- Share your patient stories with the staff, good and bad. The bad stories can help improve future outcomes.
- Find unit champions who will keep the initiative fresh and the staff engaged.
- Remember to bring all members of the team together – even members that are not involved in direct patient care (i.e.: dietary staff, housekeeping) they have eyes and ears and sometimes have a different perspective that our bedside staff.
- Perform frequent root cause analysis on patients and events and use these valuable experiences to improve your process.
**Patient 2**

**Demographics**
- Black Female
- 47 years old
- Hx: HTN, CHF, Asthma, Diabetes
- Ejection Fraction 55%

**Prior Admissions/Readmissions**
- ED visits: 5/23/10
- Hospital admissions: 3/19 - 3/31/10

**Biggest Challenges**
- Managing health with limited resources
- Weight loss
- Low activity level
- Low self-esteem

**What We Did**
- Education using teach-back process regarding disease process, diet and the importance of following up with PCP 3-5 days after discharge
- Patient received post-discharge follow-up call and told nurse practitioner she was unable to afford $40 office visit fee for PCP
- Scheduled follow-up at clinic with nurse practitioner
- Four follow-up phone calls with patient to verify teach-back information, daily weights taken, medication adherence and any questions or concerns
- Monthly visits at clinic with patient
- Filled out prescription assistance forms for asthma medications
- Provided patient with meter to monitor blood sugar
- Provided letter to utility company to request no power shut-off due to health status

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**Where We Are Today**
- No readmissions within 30 days
- Continued contact with patient
- Patient keeping regular appointments with nurse practitioner
- Takes meds at scheduled time and correct doses
- Maintains all education obtained during admission
- Actively involved in plan of care
- Weekly appointments to assist with weight loss goals
- Assisting patient with obtaining insurance

**Patient Goal**
- To continue to lose weight
- Increase activity level
- Obtain insurance

**Healthcare Provider’s Goal**
- Continue open communication with patient
- Continue to provide education
- Patient to participate with Healthy Heart Support Group
- Maintain ejection fraction
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