

STAAR Issue Brief: Reducing Barriers to Care Across the Continuum - Working Together in a Cross-Continuum Team

Amy Boutwell, MD, MPP and Marian Bihrlé Johnson, MPH

Overview: Reducing Avoidable Rehospitalizations

Avoidable rehospitalizations are frequent, costly, burdensome for patients and families, and fortunately, actionable for improvement. Many rehospitalizations within 30 days of discharge are considered potentially avoidable if communication was more effective and care better coordinated. Opportunities abound to improve transitions out of the hospital and into the next setting of care, and efforts to improve care transitions and reduce rehospitalizations are proliferating in the US in response to signals from local, state, and federal payers and policymakers.

Lessons from Track and Field

The best transition out of the hospital is only as good as the reception into the next setting of care. Hospitals can not improve care transitions in isolation. Consider the techniques of track and field athletes in relay races: each partner has practiced, ***defined roles*** in either passing or receiving the baton. Each athlete must ***iteratively adjust within those roles*** to ensure a completed handoff is successfully executed. At different times in the race, the athlete may be a sender or a receiver. Similarly, improving transitions in care involves clarifying roles, establishing norms of communication, practicing, and receiving feedback.

Forming the Team and Changing the Conversation

In the Fall of 2009, 67 hospitals and their cross-continuum partners enrolled in the first cohort of the STAAR Initiative to reduce 30-day rehospitalizations. A unique aspect of the STAAR Initiative is the requirement of every participating hospital to form a cross-continuum team. The composition of each team is slightly different, but includes representatives from ***skilled nursing facilities, home health agencies, ambulatory practices, community services, and patient and family advocates***.

At the front line, the enthusiasm of the post-acute providers at skilled nursing facilities, long-term acute care facilities, and home health agencies presents a valuable asset for the STAAR cross continuum teams; many want to be more active in work to reduce rehospitalizations and seek guidance on where to focus their efforts.

STAAR (STate Action on Avoidable Rehospitalizations)

An Initiative of the Commonwealth Fund and the Institute for Healthcare Improvement

Composition of STAAR Cross Continuum Teams

STAAR cross continuum teams include representatives from the following categories:

	Percent
Patients and Family	32.6%
Hospital Staff Nurses	71.7%
Hospital Nurse Managers	95.7%
Pharmacists	50.0%
Hospital Physicians or Hospitalists	82.6%
Case Managers	91.3%
Hospital Quality Improvement Leaders	91.3%
Staff from Skilled Nursing Facilities	65.2%
Clinicians and Staff from Office Practice Settings	52.2%
Staff from Home Care agencies	82.6%
Staff from other Community or Public Health Services	30.4%

In Massachusetts, **22 STAAR cross-continuum teams** include an **average of seven** organizational partners, involving over **150 organizations** in the state in improving care transitions.

The experience of forming a cross continuum team has provided valuable insight into the very practical ways that the fragmentation of the current healthcare delivery system can be mitigated. STAAR's cross continuum team recommendation revealed an unanticipated finding: active, engaged partners across disciplines and organizations with a desire to meaningfully engage in improving the care of shared patients across settings. STAAR teams now ask, **"what is the benefit to patients of optimizing 'siloed' processes?"** This is a novel query from the field, one reinforces a central improvement principle of handoffs: iterative co-design between senders and receivers.

"If we haven't moved the numbers, we have moved the mindset"

Establishing a team of senders, receivers, patients, and caregivers to improve care transitions has been embraced by providers, payers, and policymakers. Examples include:

- The recommendation to form a cross-continuum team has been incorporated into voluntary pay-for-performance contracting at Blue Cross Blue Shield of Massachusetts; and
- The Massachusetts Department of Public Health plans to incorporate assessment of nursing homes' cross-continuum partnerships in their safety inspections.

STAAR (State Action on Avoidable Rehospitalizations)

An Initiative of the Commonwealth Fund and the Institute for Healthcare Improvement

Infrastructure for State-level Reform

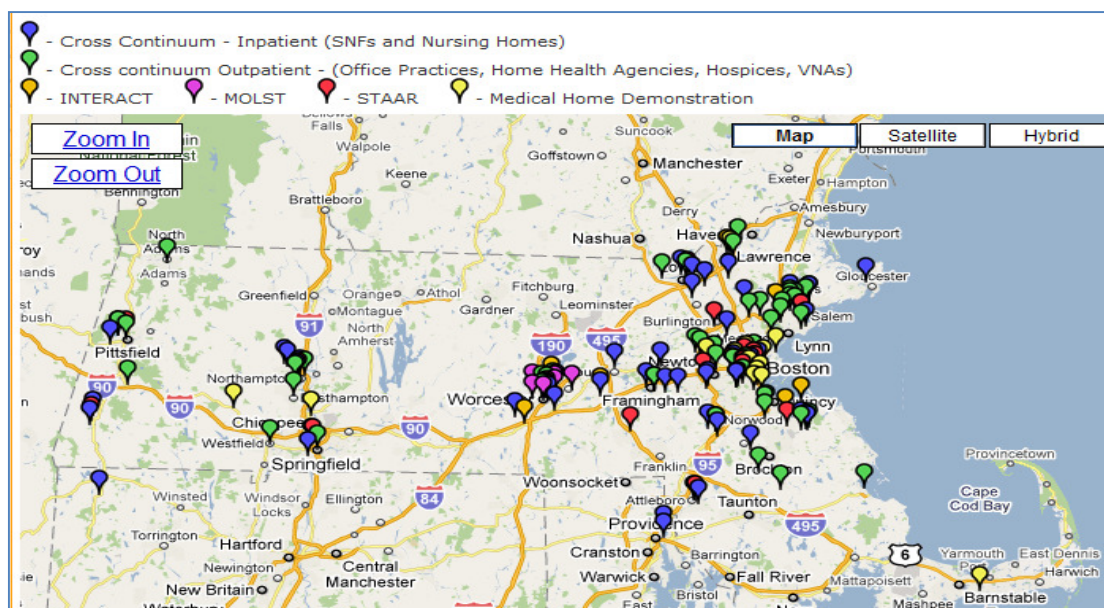
Working across the continuum of care is a strategy for **both front-line quality improvement** in care transitions as well as an important **leverage mechanism for state-wide delivery system reform**.

Examples of regional and state-wide action coming from the cross-continuum infrastructure include:

- The **Ticket to Ride** project in Michigan, focuses on designing a regionally-adopted transfer form;
- As part of the **Massachusetts Care Transitions State Strategy**, the Division of Healthcare Safety and Quality is spearheading an effort to standardize transfer forms across the state;
- The **Detroit CARR** (Community Action to Reduce Rehospitalizations) effort aims to address caring for socially complex patients as a community priority, not only a hospital priority; and
- The **Care Transitions Forum** in Massachusetts coordinates with stakeholders from over 125 different organizations align and accelerate improvement efforts across the state.

The STAAR Initiative generated a map of participating cross-continuum teams and other related care transitions improvement projects. This map is a valuable tool to plan future work at the state level.

Mapping Care Transitions Communities



Note: Community providers of non-clinical services such as the AAAs (Area Agencies on Aging) are not included in this map but have joined several cross continuum teams.

STAAR (STate Action on Avoidable Rehospitalizations)

An Initiative of the Commonwealth Fund and the Institute for Healthcare Improvement

Co-designed Transition at Cambridge Health Alliance, Cambridge, MA

Cambridge Health Alliance co-designed an improved transition process with hospital physicians and nurses and outpatient physicians and nurses. The redesigned transition system includes:

- A **Home Care Plan** with essential information and patient education materials clearly displayed in accordance with health literacy guidelines and translated, when needed;
- A **hospital nurse** carefully reviews the Home Care Plan with the patient prior to discharge;
- The plan is electronically transmitted to the patient's **primary care site**;
- Receipt of the form at the primary care office **signals to the primary care nurse** that the patient had been discharged;
- The primary care nurse contacts the patient the next business day following discharge, **reviewing the care plan and resolving issues**;
- The **physician reviews** the Home Care Plan following the nurse outreach call, making any needed modifications.

For patients receiving this process, CHA has seen a greater than 25 percent reduction in rehospitalizations and improved outpatient follow-up. In addition, outpatient nursing outreach has been crucial to correct misunderstandings about medication use, call in needed prescriptions, and arrange transportation to ensure arrival at outpatient appointments.

"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."

"Staff at different sites of care pick up the phone, where they didn't before."

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

"The cross-continuum team will last beyond STAAR. All future initiatives will benefit from the open communications and less silo-ed care."

'Care Plan Partners' at South Shore Hospital, Weymouth, MA

South Shore Hospital has instituted a standardized procedure where every admitted patient is asked to identify a **Care Plan Partner**. The Care Plan Partner can be a family member, friend, neighbor, or any other person of significance to the patient. The South Shore STAAR team asks patients to consider the following questions when choosing a Care Plan Partner:

- Who helps you with your day to day needs?
- Who would you call if you were not feeling well?
- Who would you ask to get your prescriptions or groceries?

The Care Plan Partner signifies an important recognition by hospital staff that **many causes of rehospitalization lie outside the walls of the hospital** and are as often related to **challenging aspects of daily life** as to clinical need. The Care Plan Partner is also formally recognized and respected among all post-acute providers through the collaborative efforts of the STAAR Cross Continuum Team.

"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."

STAAR (STate Action on Avoidable Rehospitalizations)

An Initiative of the Commonwealth Fund and the Institute for Healthcare Improvement

Observations

- The cross-continuum team concept is **uniformly attractive way** to improve care transitions.
- The cross continuum team provides a **valuable infrastructure** on which to coordinate activity at the organizational level, the community level, and the state level.
- Payers and policymakers are **encouraging** providers to form cross continuum teams.
- State leaders recognize an opportunity to mobilize cross continuum teams to achieve the goals of several current delivery system reform efforts, including **medical home** demonstrations, and **community-based care transitions** efforts.
- The **organizational relationships and norms** emerging from work on cross-continuum teams will be an asset for regions or organizations considering ACO pilots or bundled payment pilots.

Recommendations for Providers:

1. **Form a cross continuum team** to aid in care transitions efforts.
2. **Codesign, then standardize** transfer information and patient education material between senders and receivers.
3. **Codesign, then standardize** the communication strategy between the hospital and the next setting of care.
4. Ask members of the cross-continuum team **visit each other's care settings** to observe patient care processes during transitions.
5. **Include patients and family members** on the cross-continuum team to enhance the focus on the patient's experience and to harvest their unique perspective for improving care processes.

Recommendations for Policy Makers:

1. **Encourage** providers to work with partners across the continuum, as in Massachusetts.
2. **Look for** natural communities of activated providers across settings when evaluating care transitions proposals.
3. **Consider** incorporating the concept of a cross continuum team in forthcoming pilots and demonstrations; ensure that care transitions are coordinated across multiple agencies in the public and private sectors.
4. **Recommend** hospitals implement requirements to form patient and family advisory councils using the cross-continuum team as a starting point.