• 680 bed tertiary care referral center (~1M)
• Flagship of Baystate Health
• 42,000 admissions/year
• Annual surgical volume: 29,043
• Western Campus of TUFTS
• Member CoTH, 9 residency programs/244 PGs
• 1,200 member medical staff, 206 faculty MDs
• Level 1 Trauma Center
• IHI Mentor Hospital (SCIP/AMI/HF/HAPU/VTE)
• Magnet facility – re designated 2010
Quality Accomplishments

**U.S. News & World Report**
- America’s Best Hospitals
- Baystate Medical Center
- Endocrinology

**Thomson Reuters**
- Top 50 Hospital System
  - Baystate Health

**Thomson Reuters**
- Top 100 Hospitals
  - Top 100 Cardiovascular Hospitals
  - Baystate Medical Center

**LeapFrog Group 2010**
- Top Hospitals
  - Baystate Medical Center

**SDI Top 100**
- Integrated Health Networks
  - Baystate Medical Center

**Magnet Hospital**
- Nursing Excellence
  - Baystate Medical Center

**Beacon Award**
- Baystate Medical Center
  - Adult ICU Critical Care Excellence
  - D68 Surgical Intermediate Care

**HIMSS Analytics**
- Top One Percent for Adoption of
  - Electronic Medical Records
  - Baystate Medical Center

**Premier HQID**
- Top Performers
  - Baystate Medical Center
  - Total Joint Replacement Care

**Institute for Healthcare Improvement**
- Mentor Hospital
  - Baystate Medical Center

**PRC**
- Patient Satisfaction Awards
  - Baystate Health

**Blue Distinction**
- For Total Joint Replacement & Cardiac Care
  - Baystate Medical Center
STAAR Collaborative Aims

• Reducing re-hospitalizations was selected as an clinical quality and patient safety organizational goal for 2010
  • **Threshold**: Implement a standardized discharge process for heart failure patients
  • **Target**: Decrease heart failure re-hospitalizations by 15%
  • **Maximum**: reduce heart failure re-hospitalizations by 30%

• Makes business sense to be proactive in light of:
  • Upcoming changes regarding healthcare
  • Throughput and capacity issues
  • Right thing to do for patients & families
BMC STAAR Collaborative Team

- Deb Hawkes RN - Unit Manager Splfd 3 Onc
- Laurie Kaeppel RN / Rosemary Rudloff RN - Splfd 3 M
- Carol Morrison RN – S4 Case Manager
- Brenda Krumpholz RN – S3 MCase Manager
- Bonnie Geld MSW - Director Care Management
- Deb Meyer RN - Assistant Director Medical Nursing PCS
- Carlo Real RN / Jodi Kashouh RN - Splfd 4 Short Stay Cardiology
- Gini Staubach RN - Assistant Director Critical Care & Cardiology PCS
- Ann Maynard RN - Director ED
- John Santoro MD - Vice Chair, Chief Emerg Svcs
- Surinder Yadav MD - DHQ / Attending Hospitalist
- Carol Richardson MD - Associate Med Director Hospital Medicine
- Mihaela Stefan MD – Hospitalist/Director Med Consult Service
- Donna Borah RN Director Hospital Medicine Program
- Ruth Odgren RN President BVNA&H
- Aaron Michelucci PharmD, Assistant Director, Clin Pharm
- Regional Western Mass Cross Continuum Partners
- Jan Fitzgerald MS, RN, CPHQ - Director Quality
- Chris Pouliot RN
Diagnostic Findings

- Lack of standardization
  - Admission process
  - Rounds
  - DC visit by physician to recap/clarify
  - Patient education
    - Content
    - Use of teach back; key points
  - Communication to post DC provider
    - Report, information, 1:1, PCP

- Passive follow-up
  - ask pts to make appointment rather than make appointment

- “Risk assessment” for readmission not done
Implementing Process Improvement

GAME PLAN
Reliability principles
Interventions to provide failure free care over time

COACH (Quality)
- Provide support
- Measurement

TEAM
Clinical champions ready, willing, and eager

Pt Centered Care

SCIENCE
Evidence based practice

How to start
Changes Implemented

- **Assessment of high risk:**
  - Readmission
  - Discharge needs (by HCM/RN)
- **Enhanced discharge preparation:**
  - Focused teaching to patient and family caregivers
- **Pt Education Redesign:**
  - Ask Me 3, Teach-back, medication management
- **Structured/organized Multidisciplinary Rounds:**
  - “Care Coordinator” role
Enhanced Admission Assessment for Post-Discharge Needs

- A *standardized assessment* is done on admission by RN and hospital case manager.

- List of *current meds* is collected on every patient to expedite the hospital reconciliation process.

- Plan is customized and started to meet each patient and their family members’ needs. It is reviewed and revised based on the course of the illness and care while the patient is in the hospital.
Heart Failure Zones

Heart Failure Zones

Every Day:
- Weigh yourself in the morning before breakfast, write it down and compare it to yesterday's weight.
- Take your medicines as prescribed.
- Check for swelling in your feet, ankles, legs and stomach.
- Fat low-salt foods.
- Balance activity and rest periods.

Which Heart Failure Zone are you today? GREEN, YELLOW or RED?

Green Zone
All Clear — This zone is your goal
Your symptoms are under control. You have:
- No shortness of breath.
- No weight gain of more than 2 pounds in one day (it may change 1 or 2 pounds some days).
- No swelling of your feet, ankles, legs or stomach.
- No chest pain.

Yellow Zone
Caution — This zone is a warning
Call your doctor's office if you have any of the following:
- Weight gain of 3 pounds in one day or a weight gain of 5 pounds or more in one week.
- More shortness of breath than usual.
- More swelling of your feet, ankles, legs or stomach than usual.
- Feeling more tired than usual (lack of energy).
- A dry, hacking cough.
- Feeling dizzy.
- Feeling weak: you know something is not right.
- Harder to breathe when lying down (need to sleep sitting in a chair).

Red Zone
Emergency
Go to the emergency room or call 911 if you have any of the following:
- Struggling to breathe.
- Increased shortness of breath while sitting still.
- Chest pain.
- Confusion or unable to think clearly.

Baystate Heart & Vascular Program
Ask Me 3™
Good Questions for Your Good Health

Every time you talk with a doctor, nurse, or pharmacist, use the Ask Me 3 questions to better understand your health.

1. What is my main problem?
2. What do I need to do?
3. Why is it important for me to do this?

When to Ask Questions
You can ask questions when:
- You see your doctor, nurse, or pharmacist.
- You prepare for a medical test or procedure.
- You get your medicine.

What If I Ask and Still Don’t Understand?
- Let your doctor, nurse, or pharmacist know if you still don’t understand what you need to do.
- You might say, "This is new to me. Will you please explain that to me one more time?"

Who Needs to Ask 3?
Everyone wants help with health information. You are not alone if you find things confusing at times. Asking questions helps you understand how to stay well or to get better.

The Ask Me 3 questions are designed to help you take better care of your health. To learn more, visit www.npsf.org/askme3

Buenas preguntas para su buena salud

Cada vez que hable con un médico, enfermero o farmacéutico, use las preguntas de Hágame 3 Preguntas para comprender mejor su salud.

1. ¿Cuál es mi problema principal?
2. ¿Qué tengo que hacer?
3. ¿Por qué es importante que lo haga?

Cuando hacer preguntas
Puede hacer preguntas cuando:
- Vea a su médico, enfermero o farmacéutico
- Se prepara para una prueba o intervención médica.
- Compra sus medicamentos.

¿Qué pasa si pregunto e igualmente no comprendo?
- Ávisele a su médico, enfermero o farmacéutico si todavía no comprende lo que tiene que hacer.
- Puede decir "Esto es nuevo para mi. ¿Me lo podaste explicar una vez más?"

¿Quién debe hacer 3 preguntas?
Todos quieren obtener ayuda con información sobre su salud. Si a veces se confunde, no está solo. Al hacer preguntas podrán comprender cómo mantenerse sano o mejorar su salud.

Las preguntas de Hágame 3 Preguntas están diseñadas para ayudarle a cuidar más de su salud. Para obtener más información, visite www.npsf.org/askme3
Teach-Back Note

• **Nursing Identifies**: Primary Learner__________________________
  Primary Language__________________________
  
  Please enter above information in CIS, via RN to RN communication.

• **Patient education on importance of**: 
  • 2,000 mg or less NA restriction daily (500 mg a meal x3 meals, 250mg a snack x2 snacks daily; give restriction form) with ________% teach back
  • Reading labels with patient (give pre-printed nutrition labels)
  • **** Explain hidden salt, + 5 different types of salt (give patient info on “Why salt in harmful to patients with HF” and teach no salt shaker with ________% teach back.
  • 1500 cc Fluid Restriction daily (which is equal to 48 oz daily or (6)8ozcups) (give pre-printed restriction form) with ________% teach back.
Multidisciplinary Rounds for HF Patients

- MDR care/table top rounds
- MD/RN/Coordinator/HCM/PharmD/Rehab/Clin Nutrition
- **Focus: what missing? how are we doing?**
  - Discharge Plan (does it fit and make sense?)
  - Discuss weight difference daily
  - Fluid balance (goal is to match)
  - Core measures => EF; if <40% ACE/ARB; detailed DC Instructions
- 02 needs
- Diuretic Therapy (IV/PO)
- Teach back %

- **Issues (i.e. nursing concerns/EOL/$$)**
- **At risk for readmission?**
  - Needs in the community setting according to assessment (teach back and gaps)
Changes Implemented

- **Physician education/interventions:**
  - Zone/geographical model
  - Conferences/MDR/Tracer/Standardized DC encounter
- **Post DC Follow up (standardized):**
  - “Call back”
  - Subsidized VNA Home visits (Telehealth, protocols)
  - Appointments for office visits made before discharge
  - Follow up Clinics
Post Discharge Follow-Up for HF Patients

- Automatic VNA follow up day after discharge
- Call back 1-2 days after DC
- Reviews discharge notes/summaries and contacts patient
  - Reads last teach-back note to see level of understanding
  - Ask patient if they have F/U MD appt/plan
  - Medication management
  - “Ask Me Three
  - Heart failure specific education (what are they doing at home?)
- Document Teach-Back% => gaps for other providers to view and follow up on
- Know HIGH RISK READMITS, and collaboratively strategize to make them successful
Patient-Centered Care Planning at the End of Life

- Early referral => end of life care
  - Resource to start difficult conversation
  - Consistent face
- Education to physician partners
  - “Sooner rather then later”
  - NYHA class 4…..=> too late
- Palliative care team
  - Approved and to be implemented
- Documentation of true end of life decision making increase to 70%
Patient-Centered Medical Home

- Physician practices strengthen the patient / physician relationship
- Promote coordinated care and long term healing relationships
- Provide comprehensive primary care
  - **Personal physician**: ongoing relationship for continuous and comprehensive care
  - **Physician directed practice**: physician leads team of non-physician care providers that take responsibility for all ongoing care
  - **Whole person orientation**: provide or arrange for all care: acute, chronic, preventive, end of life.
  - **Care is coordinated and integrated** across the health care system including community-based services
  - **Quality and Safety**: Evidence based medicine, clinical decision support, continuous quality improvement, patient engagement, IT
  - **Enhanced Access**: open scheduling
Partnership Meetings

Cross Continuum
Regional Meetings
STAAR Presentation to the Patient Family Advisory Council

Patient and Family Advisory Councils Give Voice to Patients

What can we do to help ??
Springfield 4 Cardiac Short Stay

- 34 bed acute care unit specializing in caring for heart failure and short stay cardiac patients

- **Aim:** BMC will reduce the readmission rate for HF patients on S 4 by 30% (22%- 16%) by October 31 2010.
Baystate Medical Center Springfield 4 (MA)
PILOT UNIT: Patient Experience/Discharge Readiness - S4

Higher is Better

goal = 95.00

Baystate Medical Center Springfield 4 (MA)
PILOT UNIT: Patient Experience/Self Care at Home - S4

Higher is Better

goal = 98.00
Baystate Medical Center Springfield 4 (MA)
PILOT UNIT: Percent of Patients Receiving Self Care Instructions in Writing - S4

% patients who answer yes

90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00

Month

Higher is Better

Baystate Medical Center Springfield 4 (MA)
PILOT UNIT: Teach Back - S4

% Successful Teachback

100.00
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
0.00

Month

Higher is Better
Springfield 3M

- 34 bed acute care nursing unit specializing in caring for general medical populations
- **Aim:** BMC will decrease all 30-day readmissions for medical patients on Springfield 3M by 30% (16% to 11%) by October 2010
Baystate Medical Center Springfield 3 M (MA)

PILOT UNIT: Patient Experience/Discharge Readiness - S3M

Higher is Better

Baystate Medical Center Springfield 3 M (MA)

PILOT UNIT: Percent of Patients Receiving Self Care Instructions in Writing - S3M

Higher is Better
Barriers and Breakthroughs

- Slow to start; tentative as to how much autonomy to redesign processes
- “Patient centered” (really?)
- Hampered by past experiences (micro-management)
- New leadership and mind set
- Positive feedback and freedom
- Support to try anything
- First hints of success
  - Energized teams
  - Willing to do more
Effective Leadership & “Boards on Board”

• Senior Leadership
  • Keep readmissions on the front burner; annual measurable goals
  • **Active (How’s our work on re admissions going?)**
  • Be visible and supportive
  • Message is crisp and consistent
  • Humility

• Clinical Leadership
  • Visible (walk rounds)
  • **Active (How’s our work on re admissions going?)**
  • Model desired behaviors
Keys to Success

- Persistence and reinforcement/high visibility
- Senior leader support
- Multidisciplinary cooperation & collaboration
  - Accurate, timely and relevant data
  - Communicate – flexibility
  - Right people
- Willing to try changes and take a risk
- Develop reliable systems (strive for $10^{-2} > 90\%$)
  - Incorporate into workflow
  - Make changes easy => transparent => meaningful

Make The Right Thing The Easy Thing
Ongoing Focus of Work

- Sustain the energy and interest
- Change mind set from DC to transition
- Timely communication between clinicians at times of transfer /Improved knowledge transfer
  - Revised post DC report
  - Standardized DC note/ DC Checklist
  - Key few vs. numerous many
- Spread “MDR” to all units
- Clinical Coordinator role to be expanded
- Integrated Care Management Model
- Spread redesigned patient education model
- Follow up (transition) Clinics