IHI Expedition
Reducing Readmissions by Improving Care
Transitions Session 1

Peg Bradke, RN, MA
Saranya Loehrer, MD, MPH

Thursday, June 6, 2013
These presenters have nothing to disclose.

Expedition Coordinator
Kayla DeVincentis, CHES, Project Coordinator, Institute for Healthcare Improvement, currently manages web-based Expeditions and the Executive Quality Leaders Network. She began her career at IHI in the event planning department and has since contributed to the State Action on Avoidable Rehospitalizations (STAAR) Initiative, the Summer Immersion Program, and IHI’s efforts for Medicare-Medicaid enrollees. Kayla leads IHI’s Wellness Initiative and has designed numerous activities, challenges, and educational opportunities to improve the health of her fellow staff members. In addition to implementing the organization’s first employee health risk assessment, Kayla is certified in health education and program planning. Kayla is a graduate of Northeastern University in Boston, MA, where she obtained her Bachelors of Science in Health Science with a concentration in Business Administration.
WebEx Quick Reference

- Welcome to today’s session!
- Please use chat to “All Participants” for questions
- For technology issues only, please chat to “Host”
- WebEx Technical Support: 866-569-3239
- Dial-in Info: Communicate / Join Teleconference (in menu)

When Chatting…

Please send your message to All Participants
Chat Time!

What is your goal for participating in this Expedition?

Join Passport to:

- Get unlimited access to Expeditions, two- to four-month, interactive, web-based programs designed to help frontline teams make rapid improvements.
- Train your middle managers to effectively lead quality improvement initiatives.

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What is an Expedition?

ex·pe·di·tion (noun)
1. an excursion, journey, or voyage made for some specific purpose
2. the group of persons engaged in such an activity
3. promptness or speed in accomplishing something

Expedition Support

- All sessions are recorded
- Materials are sent one day in advance
- Listserv address for session communications: ReadmissionsExpedition@ls.ihi.org.
- To add colleagues, email us at info@ihi.org
Where are you joining from?

Expedition Director

Saranya Loehrer, MD, MPH. Director, Institute for Healthcare Improvement (IHI), aligns care transitions related programming within IHI and provides coaching and facilitation to teams within the STAAR initiative. She also contributes to IHI’s efforts to adapt promising practices to better care for Medicare-Medicaid beneficiaries and serves as one of IHI’s “content curators” to ensure IHI’s publications and resources are reflective of the most recent innovations and best practices in the field. Saranya received her medical degree from Loyola University Chicago’s Stritch School of Medicine and her Master of Public Health degree from the Harvard School of Public Health, where she served as a Zuckerman Fellow.
Today’s Agenda

- Ground Rules & Introductions
- Building the Team You Need to Reduce Readmissions
- Content In Action
  - Holyoke Medical Center
- IHI’s Model for Improvement
- Action Period Assignment

Ground Rules

- We learn from one another – “All teach, all learn”
- Why reinvent the wheel? – Steal shamelessly
- This is a transparent learning environment
- All ideas/feedback are welcome and encouraged!
Overall Program Aim

The aim of this Expedition is to share strategies for hospitals and their cross-continuum partners to co-design care processes to improve the transition of patients from the hospitals to the next care setting.

Expedition Objectives

At the end of the Expedition each participant will be able to:

- Assess current challenges in reducing avoidable rehospitalizations and identify opportunities for improvement
- Explain how to build an effective improvement team including patients and families as well as acute, post-acute and community care providers
- Describe how to use the patient story to build an individualized plan of care.
- Use appreciative inquiry and Teach Back to better understand a patient’s post-acute care needs and capabilities
- Develop processes with post-acute care providers and community partners to ensure the timely transfer of critical information during patient transitions
Schedule of Calls

Session 1 – Building the Team You Need to Reduce Readmissions
Date: Thursday, June 6, 12:00-1:30 PM ET

Session 2 – Capturing the Patient Story
Date: Thursday, June 20, 12:00-1:00 PM ET

Session 3 – Assess for Success: Appropriate Post-Acute Follow-up
Date: Thursday, July 11, 12:00-1:00 PM ET

Session 4 – Passing the Baton: The Handover of Critical Information
Date: Thursday, July 25, 12:00-1:00 PM ET

Session 5 – Putting it All Together: Orchestral Testing and Implementation
Date: Thursday, August 8, 12:00-1:30 PM ET

Faculty

Peg M. Bradke, RN, MA, is Director of Heart Care Services at St. Luke’s Hospital in Cedar Rapids, Iowa. She received her Bachelor’s Degree in Nursing from Mount Mercy College and her Master’s Degree in Nursing Administration from the University of Iowa, College of Nursing. In her 25-year career, she has had various administrative roles in the cardiac care areas. She currently coordinates the Heart and Vascular Service line which includes two intensive care units, two step-down telemetry units, the Cardiac Cath Lab, Electrophysiology Lab, Diagnostic Cardiology, Vascular and Interventional Lab, Respiratory Care, Cardiopulmonary Rehabilitation and Heart Failure and Coumadin Clinics. In addition, Peg is serving as faculty with the Institute for Healthcare Improvement (IHI) on the Transforming Care At the Bedside (TCAB) Initiative and STAAR (STate Action on Avoidable Rehospitalizations Initiative).
**Context Setting**

- Readmissions are frequent, costly and actionable for improvement
- 20% of Medicare beneficiaries are readmitted within 30 days. The cost across all payers is roughly $25 billion annually ($17 billion for Medicare)\(^1\)
- CMS Hospital Readmission Reduction Program began penalizing hospitals in 2012 for “excess” readmissions
- Hospitals held fiscally responsible although transitions also often involve community sites of care
- Patients and families often left to navigate fragmented system of care delivery on their own


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**Hospital Readmission Reduction Program**

- CMS authorized to reduce payments to IPPS hospitals with excess readmissions beginning October 1, 2012
- Up to a 1% reduction for all DRG’s but based on 3 clinical conditions: Heart Failure, AMI and Pneumonia
- Data based on a 3 year rolling average (2008-2011)
- Penalties may increase to a maximum of 2% in FY2014 and 3% in 2015. Clinical conditions evaluated may also increase
- 2,217 hospitals impacted in FY2013
Pre-Work Assignment

Survey Responses

| Reasons why patients are readmitted          | Lack of family and community support |
|                                            | Lack of timely and adequate follow-up care |
|                                            | Poor discharge planning and execution |
|                                            | Medication management                 |
|                                            | Challenges with patient education and ability to self-manage |

| Organizational challenges to reducing readmissions | Limited resources to devote to addressing care transitions |
|                                                    | Multiple competing demands             |
|                                                    | Lack of coordination within and across care settings |
|                                                    | Difficulty communicating with community care settings |
|                                                    | Difficulty in obtaining needed post-acute care services |

| What you are most proud of at your organization | Obtaining executive and organizational commitment |
|                                                | Creating an action team to help facilitate transitional care |
|                                                | Developing partnerships with post-acute care settings |
|                                                | Teamwork!                                      |
|                                                | Making progress and seeing results             |
Deep Dive Readmission Diagnostic

**REVIEWs**
- MD INTERVIEWS
- PATIENT OR CAREGIVER INTERVIEWS

**RN/M D Team FINAL ASSESSMENTS**
Synthesis of 3 different data sources

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**Diagnostic Results**

**Patient Perspective**
What Factors Led to Readmission

- None mentioned
- Hard to get in touch with someone at KP
- Hard to get appointments
- Did not receive clear explanation of what to do at home
- Did not understand medications

<table>
<thead>
<tr>
<th>Percent of Patients</th>
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<tr>
<td>0</td>
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<tr>
<td>20</td>
</tr>
<tr>
<td>40</td>
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<tr>
<td>60</td>
</tr>
<tr>
<td>80</td>
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<tr>
<td>100</td>
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</tbody>
</table>

| Access to Palliative Care Services | 7 |
| Multiple Readmissions             | 6 |
| Failed to identify Frail Living Situation | 5 |
| F/U Appointment Too Late | 4 |
| CHF Medications | 3 |
| # of Patients | 2 |

**System Perspective**
Where we can work on transition care?

* From Patient Interview, n=115
What did you learn?

- Did you have any “a-ha” moments?
- What surprised you?
- Did you identify any opportunities for improvement?
Vision for Cross-Continuum Teams

Understanding mutual interdependencies, the hospital-based teams co-design care processes with their CCT partners and collaborate to solve problems to improve the transition out of the hospital and reception into community settings of care.

Cross-Continuum Teams

- Comprised of acute and post-acute care partnerships to co-design care transitions processes
- Emphasize that readmissions are not solely a hospital problem and require a community solution
- Have built the foundation for many care settings participating in ACO development, Patient Centered Medical homes and the Community-based Care Transitions Program
Cross-Continuum Team Charter

- Provide oversight and guidance
- Review data (process and outcome measures)
- Help to connect improvement efforts between hospitals and partnering community organizations
  - Identifies improvement opportunities
  - Facilitates collaboration to test changes
  - Facilitates learning across care settings

Poll Question

- Do you have a Cross-Continuum Team (CCT)?
- Which of the following people, roles, or organizations are represented on your CCT? (Check all that apply)
  - Patients and family caregivers
  - Hospital clinicians and staff
  - Quality improvement staff
  - Information technology
  - Finance
  - Skilled nursing facilities
  - Office practice settings
  - Home health care agencies
  - Community or Public health services
  - Outpatient Clinic Centers (Dialysis, Diabetes, Rehabilitation)
  - Public and private payers
  - Other (if selected, please chat in your responses)
Cross-Continuum Team Membership Recommendations

- Executive Sponsor
- Day-to-Day Leader
- Patients and family caregivers
- Hospital clinicians and staff
- Supporting staff (QI, IT, Finance, etc.)
- Clinical and administrative staff and/or leaders from the community
  - Skilled nursing facilities
  - Office practice settings
  - Home health care agencies
  - Community or Public health services
  - Outpatient Clinic Centers (Dialysis, Diabetes, Rehabilitation)
- Public and private payers

CCT – Capacity for Improvement

- 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
Fostering Cross-Continuum Collaborations

- Start your meetings with a patient story
- Before all else, build trust
- Convene meetings in various care settings
- Do a “deep-dive” into a series of recently readmitted patients to identify opportunities for improvement across care settings
- Use the power of observation - have members of various care setting shadow critical processes such as admission, discharge and patient education
- Members from the CCT hear first-hand about the transitional care problems “through the patients’ eyes”

Diagnostic Reviews: Charts

Institute for Healthcare Improvement
How to Guide: Improving Transitions from the Hospital to Community Settings to Reduce Avoidable Rehospitalizations

Step 3a. An in-depth medical record review of the last five rehospitalizations yields rich information. The Diagnostic Worksheet helps make sense of these findings (Figure 25).

Figure 25: Diagnostic Worksheet (Part 1) (How to Guide Resources, page 122)

Engages the “hearts and minds” of clinicians and catalyzes action toward problem-solving

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 health care as a result of the improved communications.”
“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.”

CCT collaboration moving into ACO

“The CCT will last beyond STAAR. All future initiatives will benefit from the open communications and less siloed care.”
“Our organization has expressed appreciation for the relationships we have developed with our CCT. “
“They see these relationships as critical to the development and success of the ACO model going forward.”
Cherelyn Roberts, RN, BSN, is the STAAR Initiative Program Manager and Pilot Lead for the Care Transitions Project at Holyoke Medical Center. She began involvement with IHI in 2004, working on FLOW Innovations and Transforming Care at the Bedside (TCAB). These projects provided the groundwork for the redesign of the medical-surgical unit which included POD formation, allowing nurses to stay closer to their patients, and the institution of multidisciplinary rounds. Ms. Roberts began STAAR work while at WING Memorial in 2010, collaborating with the Home Care Agency caring for heart failure patients. Since returning to Holyoke in 2011, she instituted the CHF and COPD programs while concentrating efforts on reducing readmissions and developing relationships with providers in the community with the ultimate goal of improving the lives of patients and communication among providers.

Ms. Roberts began her career as a Medical-Surgical/Pediatric nurse at Holyoke Medical Center in 1995. She obtained her BSN from Elms College in Chicopee, Massachusetts in 2005.
The Team We Need To succeed

OUR TEAM

Holyoke Medical Center
YOUR REGIONAL HEALTH RESOURCE
OUR AIM STATEMENT:

HMC will decrease the monthly readmission rate by 20% from 12.8% and maintain that rate by Dec 2013 by improving the handoff of critical information at the time of discharge for the identified high risk for readmit patient on the Telemetry Unit going home with Home Health.

January 2011 thru May 2013

30-Day % All-Cause Readmissions
Hospital
How We Established Our Cross-Continuum Team (CCT)

- Networking
- Visiting Facilities
- Offering to introduce the STAAR program at the health clinic, PCP, offices, VNAs and SNFs
- Asked for front-line staff to join us as they have the most access to our patients

Open Invite

- Anybody who has any contact with our patients in our community needs to be on the CCT
- We desire to reach the patient at every “touch point” in the community
- Listening to ALL providers and service providers, find out what matters to them and to the patient
Current Members

- Home Health Agencies:
  1. Holyoke VNA
  2. Amedisys Home Health
  3. Chicopee VNA
  4. Trinity Home Care
  5. Noble VNA
  6. Overlook VNA
  7. Mercy Homecare

SNFs

- Holyoke Geriatric Authority
- Mount Saint Vincent
- Wingate
- Loomis Communities
- Birch Manor
- Calvin Coolidge
- Redstone
- Holyoke Health Care Center
- Renaissance Manor
- Mary’s Meadow
- Holyoke Rehab Center
- Holyoke Soldier’s Home
Acute Rehab

- Healthsouth
- Kindred Hospital (Parkview)

Other
- AMR
- Diabetes Center of Western Mass
- Commonwealth Care Alliance
- Holyoke Community College
- American Renal Dialysis Center
- 2 Patient Family Advisory Council Members
- Food and Fitness Policy Council

PCP/Medical Home Providers

- WMPA (Western Mass Physician Associates)
- Holyoke Health Center
- Valley Medical PCP Offices, Amherst
Meetings

- ALL members meet monthly
- We discuss case reviews, each organization presents a readmit and the group brainstorms on “why the patient returned?” “why did the discharge fail? Until we find the reasons and possible solutions

Rules of Engagement

1. Throw out your old attitudes about work
2. Don’t think of reasons Why it Won’t Work, Think of Ways to Make the New Ideas Work
3. Don’t Make excuses, and Don’t Accept Excuses. Don’t say, “We can’t”
4. Don’t wait for perfection; 50% is fine for starters
5. Correct Problems Immediately
6. Wisdom Arises from Difficulties
7. Ask “Why” at least 5 times until you find the root cause.
8. Better the “Wisdom” of Ten people then the “Knowledge” of One.
9. Improvements are Unlimited. Don’t Substitute Money for Brains.
10. Improvement is Made at the Workplace NOT from the Office.
Cross-Continuum Team Branches

- COPD team
- Pulmonary Rehab Team
- Partnering with RT and Pharmacy
- Heart failure program
- Community partners
- Resource Nurse
- Tobacco education committee
- PCMH
- Chronic Disease Patient Education Tools
- Care Transitions Project

Accomplishments

- Heart Failure and COPD Redesigned Educational Tools shared across the Continuum
- Teach Back taught and used across the Continuum
- Heart Failure Protocol established in One SNF with Resource RN and spreading to other SNFs
- Identification for High Risk For Readmit
- Warm Handoffs
- Care Transitions Education Project
- Pharmacy Education at the Bedside of HF patients
- PCMH work
- Appts prior to discharge
- Follow up calls
- Priority to HF and COPD patients for Home Health Visits
Accomplishments

• Key Contacts for follow ups
• RT teaching inhaler use at the bedside prior to discharge
• Teach back being used by Pharmacy, RT, Nursing, MD, Case Management etc.
• Patient Interviews
• Pulmonary Rehab revised, more hours, more days, multidisciplinary approach
• Currently revising Smoking Cessation Protocol to include more frequent assessments and training of Smoking Cessation Counselors

How can we sustain our work?

• Updates to staff at staff meetings and through the use of Bulletin Boards and Outcome results of the work going on
• Continue CCT meetings to stay in the loop on PCMH progress, waiver, COPD and CHF programs, Diabetes
• Coming in the Fall, Monthly Update Meetings for all staff to keep them engaged
Questions?

- Raise your hand
- Use the Chat

The Model for Improvement

Saranya Loehrer, MD, MPH
Three Fundamental Questions for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What changes can we make that will result in improvement?

The Model for Improvement

The three questions provide the strategy

The PDSA cycle provides the tactical approach to work

What are we trying to accomplish?

- Can be answered with a good Aim Statement
- A good Aim Statement succinctly answers three critical questions:
  - How Good?
  - For Whom?
  - By When?
- Example: General Hospital will reduce its readmission rate for heart failure patients on unit 5W from a baseline of 17% to 10% by December 31, 2013

- Please chat in your team’s Aim Statement!

How will we know that a change is an improvement?

- Measure...
- Measure...
- And…
How will we know that a change is an improvement?

- Use run charts to track your progress over time
- Track your process measures, outcome measures and balancing measures
- Annotate your run charts so your team can easily identify how the changes you are making (or external factors) are impacting your results
- Review your data with your team and senior leaders to identify, drive and sustain improvement

What change can we make that will result in improvement?

The PDSA Cycle

<table>
<thead>
<tr>
<th>Act</th>
<th>Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine if change(s) should be made</td>
<td>Plan 1 small change to test</td>
</tr>
<tr>
<td>Plan for next test</td>
<td>Predict what will happen</td>
</tr>
<tr>
<td>Act to hold gains, continue to improve</td>
<td>Decide on data to evaluate test</td>
</tr>
</tbody>
</table>

Study

- Analyze the data
- Compare results to predictions
- Summarize what was learned

Do

- Run the test
- Document problems and observations
- Begin data analysis
What measure will you use to learn if this test is successful:
- Describe the change you are testing and state the question you want this test to answer (If I do x will y happen?)
- What do you predict the result will be?
- What measure will you use to learn if this test is successful or has promise?
- Plan for change or test: who, what, when, where
- Data collection plan: who, what, when, where

What do you predict the result will be:
- Report what happened when you carried out the test. Describe observations, findings, problems encountered, special circumstances.

STUDY:
- Compare your results to your predictions. What did you learn? Any surprises?

ACT:
- Modifications or refinements for the next cycle; what will you do next?

Suggestions for Conducting PDSA Cycles

- Keep tests small, be specific
- Remember- one test of change informs the next
- Refine the next test based on learning from the previous test
- Expand test conditions to determine whether a change will work at different times (e.g., day and night shifts, weekends, holidays, when the unit is adequately staffed, in times of staffing challenges)

For more information please visit the “How to Improve” link within the Knowledge Center at www.ihi.org
Iterative Testing

Cycle 6: the nurses begin teaching teach-back on another unit
Cycle 5: All nurses on the unit use teach-back
Cycle 4: The nurse teaches teach-back to her colleague and they both use it all week
Cycle 3: The same nurse tries teach-back with all her patients for one week
Cycle 2: The same nurse tries teach-back with three patients on her next shift
Cycle 1: 1 nurse tries teach-back with 1 patient on 1 shift on 1 day

Determining the Pace of Testing and Implementation

<table>
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<th>Indifferent</th>
<th>Ready</th>
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<td>Cost of failure</td>
<td>Cost of failure</td>
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<td>small</td>
<td>small</td>
</tr>
<tr>
<td>Low Confidence that current change idea will lead to</td>
<td>Very Small Scale Test</td>
<td>Very Small Scale Test</td>
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<tr>
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<td></td>
<td></td>
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<tr>
<td>High Confidence that current change idea will lead to</td>
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<tr>
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<td>Very Small Scale Test</td>
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<td>High Confidence that current change idea will lead to</td>
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<tr>
<td>improvement</td>
<td>Small Scale Test</td>
<td>Large Scale Test</td>
<td>Implement</td>
</tr>
</tbody>
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Model for Improvement Resources

Two excellent resources for learning (or refreshing your memory) about the Model for Improvement and how to run PDSA cycles:

- **On-Demand Video: [free]**
  - For the video, please visit On Demand: An Introduction to the Model for Improvement, listed under the Virtual Program section at [www.ihi.org](http://www.ihi.org)

- **Open School Module: [free for students]**
  - For the module, please visit QI 102: The Model for Improvement: Your Engine for Change, listed under the Open School course list at [www.ihi.org](http://www.ihi.org)

- **Domestic Lean Goddess: [free]**
  - For the module, people visit the Colorado Foundation for Medical Care website at [http://www.cfmc.org/lanncc/files/dlg_5-10-13.html](http://www.cfmc.org/lanncc/files/dlg_5-10-13.html)

Questions?

- Raise your hand
- Use the Chat
Action Period Assignments

- If you have not done so already, complete 1 or 2 diagnostic reviews

- Reach out to 2 potential CCT partners to assess the current process for transfer of information

- Call 2 patients or caregivers 24-48 hours after they have returned home to learn what went well and also to identify opportunities for improvement.

  Some questions to consider:
  - What has been your greatest concern since you went home?
  - Did we miss anything in your discharge instructions?
  - Were you confused by any of the instructions you were given?
  - Now that you are home, what would you tell us is the most important thing we could have done for you to prepare you for your care at home?

Chat Time!

Chat in one thing you learned during today’s session.
Expedition Communications

- Listserv for session communications: ReadmissionsExpedition@ls.ihi.org
- To add colleagues, email us at info@ihi.org
- Pose questions, share resources, discuss barriers or successes

Next Session

Thursday, June 20, 12:00 PM – 1:00 PM ET
Session 2 – Capturing the Patient Story