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
Expedition Director

Saranya Loehr, 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

- Action Period Report Out
- Looking Back
- Looking Forward
- Staying in Touch
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: Orchestrated 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).
Looking Back: A Wordle

Please take a moment to chat in one word that describes how you were feeling about your readmissions work **prior to the Expedition**

Action Period Report Out

- Discuss a recent handover with a post-acute or community partner.
  - Did the community partner get the information they needed in a format they desired? Were there unresolved issues?
  - How could the handover be improved?
  - What could be tested as a result of this assignment going forward?

- Review the INTERACT Hospital to Post-Acute Care handover tool with one or two of your community partners to determine if this could be utilized as the handover tool.

- Design and test a warm handover (phone call) to a post-acute care setting.
Action Period Report Out

What did you do?

What surprised you?

What will you do next as a result?

Action Period Assignments To Date

- **Session 1: Build the Team You Need**
  - Reach out to 2 potential CCT partners to discuss opportunities to improve information transfer
  - Call patients and caregivers post-discharge to learn what went well and identify opportunities for improvement

- **Session 2: Capture the Patient Story**
  - Observe rounds/huddles where patient transitions are discussed

- **Session 3: Assess for Success**
  - During rounds/huddles, ask “what is the likelihood that this patient will be readmitted in the next 30 days and why?”
  - Observe 1-2 patient transitions
**Action Period Assignments To Date**

What did you do?

What surprised you?

What will you do next as a result?

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**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
- Co-morbid conditions
- Challenges with patient education and ability to self manage
Survey Responses
Looking Back: Challenges

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
- Working in silos
- Physician engagement

Looking Back: Insights

- **Session 1** – Building the Team You Need to Reduce Readmissions
- **Session 2** – Capturing the Patient Story
- **Session 3** – Assess for Success: Appropriate Post-Acute Follow-up
- **Session 4** – Passing the Baton: The Handover of Critical Information
Session 1 Learning:  
Building the Team You Need to Succeed

- Reducing readmissions requires partnerships between patients and families and providers across all care settings
- Cross-Continuum Teams are a great avenue for creating transformational change
- To build will:
  - Spend time early on building trusting relationships
  - Focus on process/system failures (don't place blame on individual patients, providers, or care settings)
  - Use Diagnostic Reviews and reviews of recently readmitted patients to surface processes that work well across care settings and identify opportunities for improvement

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.

From Holyoke Medical Center Cross-Continuum Team
Session 2 Learning: Capturing the Patient Story

- The importance of Appreciative Inquiry
  - Are we using all team members to get to the patient story?
- Ask “the 5 whys” to surface the root causes of what may be contributing to a patient’s readmission
- Ask the patient and family, “What are you most worried about going home?”

Session 3 Learning: Assess for Success

- Ensure providers can set up patients and families for success by:
  - Specifying what information each member of the care team will bring to rounds/huddles
  - Building relationships with post-acute care providers to ensure timely follow-up appointments and services are in place prior to discharge
    - Histograms can help guide your work and build will with community partners
- Ensure patients and families are set up for success post-discharge by:
  - Ensuring the discharge process highlights and focuses on the importance of the follow-up appointments and self-care
  - Making sure the patient and family have a follow up number to call with questions (specifying who to call for what)
- Use Teach Back as a teaching and diagnostic tool and communicate the status of a patient’s ability to Teach Back during handovers
  - Teachbacktraining.com is a helpful resource
Session 4 Learning: 
Communicating Across Care Settings

- Cross-continuum teams are a great place to begin identifying ways in which to improve care transitions and communication related processes
- When conducting warm handovers with community partners:
  - Have a direct phone line available
  - Always include information on what matters to the patient
  - When providing patient education information, remember to include their ability to Teach Back
- Involve pharmacy in Medication Reconciliation for high risk patients

Putting It All Together

Saranya Loehr, 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

Source:
How Will We Know That a Change Is An Improvement?

- MEASURE
- 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>
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| - Determine if change(s) should be made  
- Plan for next test  
- Act to hold gains, continue to improve | - Plan 1 small change to test  
- Predict what will happen  
- Decide on data to evaluate test |

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<tr>
<th>Study</th>
<th>Do</th>
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| - Analyze the data  
- Compare results to predictions  
- Summarize what was learned | - Run the test  
- Document problems and observations  
- Begin data analysis |
Determining the Pace of Spread of Innovations

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<thead>
<tr>
<th>Current Situation</th>
<th>Resistant</th>
<th>Indifferent</th>
<th>Ready</th>
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<tr>
<td>Low Confidence that current change idea will lead to</td>
<td>Cost of failure</td>
<td>Very Small Scale</td>
<td>Very Small Scale</td>
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<td>Improvement</td>
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PDSA Worksheet

Team Name:_________________  Cycle start date:________  Cycle end date:________

PLAN: 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

DO: 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?
Evaluating Results

Coverage and Completeness
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.mri.org.

PDSA Example: Teach Back

- Cycle 1: One nurse, on one day, tests whether using Teach Back with one patient who has heart failure (HF) helps the patient learn the reasons to call the physician for help after discharge. The nurse learned that materials were confusing to the patient.
- Cycle 2: Nurse revises the teaching materials to identify key points by circling them for the patient on the teaching handout. The nurse runs a second PDSA cycle with the same patient the next day and the patient can Teach Back the signs and symptoms, when and how to call his doctor.
- Cycle 3: The nurse expands Teach Back to two more patients, one has a designated learner, his daughter.
- Cycle 4: The nurse tries a cycle of setting a learning appointment with a designated learner. This cycle is later abandoned due to complexity.
PDSA Example: Teach Back

- **Cycle 5:** Nurse expands Teach Back to all patients with heart failure and spreads out the Teach Back sessions over several days during the stay.
- **Cycle 6:** Nurse expands Teach Back to all her patients and designated learners.
- **Cycle 7:** Teach Back is introduced to the weekend staff and two nurses from each shift are trained. Nurses begin sharing results of learning in shift report to coordinate who teaches what.
- **Cycle 8:** The nurse manager observes that staff struggle with how to ask the patients to Teach Back and develops 3 alternative scripts for testing.
- **Cycle 9:** Staff try the scripts and like two of the three, they adopt those two.

IHI How-to Guides

- Improving Transitions from the Hospital to Community Settings
- Improving Transitions from the Hospital to Home Health Care
- Improving Transitions from the Hospital to the Clinical Office Practice
- Improving Transitions from the Hospital to Skilled Nursing Facilities

[http://www.ihi.org/offerings/Initiatives/STAAR/Pages/Materials.aspx#guides](http://www.ihi.org/offerings/Initiatives/STAAR/Pages/Materials.aspx#guides)
Degree of Confidence

Before the Expedition

Not confident  Very confident

After the Expedition

Not confident  Very confident

Looking Forward: Another Wordle

Please take a moment to chat in one word that describes how you were feeling about your readmissions work moving forward.
Follow Up

- The listserv will remain active.
  - To use the listserv, address an email to ReadmissionsExpedition@ls.ihi.org

- Instructions to receive Continuing Education Credits will be sent with the follow-up email for today’s session
  - Please complete the instructions within 30 days

- Please take 5 minutes to complete the Expedition evaluation survey

Staying in Touch

Thank you for being such passionate and committed providers, participants, and partners. We wish you, your colleagues, and your patients tremendous success. Please stay in touch and let us know how you are doing!

Saranya: sloehrer@ihi.org
Peg: Peg.Bradke@unitypoint.org