Care Transitions: Success Stories and Lessons Learned

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Objectives

• Learn strategies for implementation of successful care transitions initiatives
• Understand lessons learned from evaluation of care transitions initiatives
• Identify the steps to getting started with similar initiatives in your community
Reducing Avoidable Readmissions Effectively (RARE) campaign

Improving Transitions of Care Communities

Care Coordination for Rural Accountable Care Organizations

Health Information Technology for Post-Acute Care Providers (HITPAC) project
Reducing Avoidable Readmissions Effectively (RARE) campaign
What is the RARE Campaign?

- Campaign across the continuum of care to reduce avoidable hospital readmissions
- Statewide approach supported by hospitals, providers, health plans, other key stakeholders
- Collaborative approach led by Stratis Health, the Minnesota Hospital Association and the Institute for Clinical Systems Improvement
RARE Campaign

- Commitment from hospitals:
  - CEO signature on participation agreement
  - Willingness to share their readmission data with all other participating hospitals
  - Completion of an organizational readiness assessment
Supporting Work Teams

- Medication Management
- Mental Health
- Epic Users
- Measurement
- Long Term Care
- Health Plan Care Managers
How We Worked Together

• Leadership involvement
  – Every other month meetings

• Weekly Operations Meetings
  – In person events
  – Webinar series
  – Communications

• Coordinated efforts
  – Learning collaborative coordination
  – Resource consultants for hospital participants
**Campaign Design**

**RARE Campaign Implementation Overview 2011-2012**

- **Hospitals with Community Partners focus improvement in one of Five Key Areas:**
  - Medication Management
  - Transition Care Support
  - Patient and Family Engagement
  - Comprehensive Discharge Planning
  - Transition Communication

- **Options for Collaborative Support**
  - Care Transitions
  - Project Red
  - SAFE Transitions

- **Exploring Innovative Strategies - TBD**

- **Support for each RARE organization**

- **Individual support and assistance from RARE Resource Consultants**

- **Quarterly PPR data reports starting in October 2011**

**Triple Aim Goals:**
1. Prevent 4,000 avoidable readmissions with in 30 days of discharge by December 31, 2012
2. Patients and their families will spend 16,000 nights of sleep in their own beds and improve HCAHPS discharge preparation scores by 5%
3. Decrease health care costs by avoiding 4000 readmissions.
Results

• Eighty-four of 147 hospitals participated
• Accounted for 85% of MN readmissions
• Achieved a 19% reduction in 30-day, all cause readmissions by December 2013
• 7000+ readmissions prevented
• Received 2013 John M. Eisenberg Patient Safety and Quality Award
Improving Transitions of Care Communities
Improving Transitions of Care

• Three communities across the state
• Spanned the continuum of care (hospitals, nursing homes, assisted living facilities, home care agencies, hospice programs, clinics and others)
• Focused on improving care transitions and preventing avoidable hospital readmissions
• Hospitals were required to participate in the RARE campaign
• Hospitals given their readmission data including which nursing homes & home health agencies discharged to most frequently
• Root cause analysis was done at each organization and for the community
• Shared aim statements were developed to address RCA findings
Improving Transitions of Care

- Received technical assistance and education
- Received readmissions data throughout
- Each community met regularly (at least quarterly)
- Conducted multiple PDSA cycles
Implemented evidence-based interventions:

- Project RED (Re-Engineered Discharge)
- Care Transitions Initiative
- Interventions to Reduce Acute Care Transfers (INTERACT)
Results

- All three communities achieved improvement as measured by their goals
- All of the participating communities continue to collaborate to work on improving care coordination
Care Coordination for Rural Accountable Care Organizations
Care Coordination for Rural Accountable Care Organizations

- Initiated in nine rural Accountable Care Organization (ACO) communities in three states
- Designed to establish community-based care coordination programs in rural communities
Care Coordination for Rural Accountable Care Organizations

• Coaching, support, and training to care coordinators
• Education and technical assistance
• Research and testing to make the tools relevant and practical
Results

• Care Coordination Toolkit now publically available on the Stratis Health web site
• Toolkit has three experience levels
• Provides tools for different stages for development
• Tools focus on people, functions, policy, and processes to achieve successful care coordination programs
Health Information Technology for Post-Acute Care Providers (HITPAC) project
HITPAC

- Three hospitals, 10 nursing homes, two pharmacies
- Improve care transitions and medication management through the use of an electronic health record (EHR)
- Test health information exchange
• Agree upon standardized assessment content that is needed with hospitals and nursing homes
• Process map current and future state workflows in information exchange and medication reconciliation
HITPAC

- Network of committees and workgroups formed to focus on each of the components
- Technical assistance and education provided to participants
- Developed a pilot to move medication reconciliation upstream
Results

• Successful test exchanges between hospitals, nursing homes, pharmacy
• Achieved real health information exchange between nursing home and pharmacy
• Collected analytics of potential issues for Prospective Medication Review Pilot
• Developed and disseminated white paper
RARE Collaborative

• Established RARE Team (Sept. 2011)
• Completed Organizational Assessment
• Reviewed 30-day Readmissions (Jan.-July 2011)
RARE Toolkit

• Chart Review Questions
  • # days from discharge to readmit
  • Follow-up appointment scheduled
  • ER/urgent care visits
  • Clear discharge plan
  • Teach-back documentation
Redwood Area Hospital (RAH)

RAH Improvement Areas

- Teach-back Education
  - Patients/Family
  - Staff
  - Documentation
- Follow-up Appointments
Teach-Back Implementation

- Patient/Family Discharge Observations/Interviews
- Updated RAH Education Policy
- Mandatory Staff Teach-Back Education
- Documentation to Include Teach Back Method
Safe Transitions

- RAH Administration Support
  - Buy in from local long term care providers
  - 7 SNF’s, 4 assisted living facilities
- Focus on Transfer Communication
  - Interagency Transfer Form
    - 1 page form with key patient information
    - Collaborative effort to determine key items
- ED Transfer Form
Redwood Area Hospital (RAH)

GAP Analysis
• Hosted Monthly Meetings
• Universal Interagency Form
• Discharge Order Sets per Disposition
• 1 Week PCP Post Hospital Follow-up
Redwood Area Hospital (RAH)

Patient/Resident Transfer Form

Follow-up Appointments/Referrals:

Basic Information:

Emergency contact name: __________________ Phone: __________________

Reason for transfer/transfer to:

Current Patient Status:

Patient's social history and key family information/support systems:

Chief Complaint/History:

Present with no history of:

Interventions:

Financial Status:

Additional Safety Concerns:

Activity/Identify Restrictions:

Activities of Daily Living:

Summary:

Risk Level:

Form Completed By: __________________ Date: ________________ Time: ________________

Physician Signature: __________________

Redwood Area Hospital (RAH)

Patient/Resident Transfer Form
Care Transitions

- Transitional Coach Program
  - Collaborative with RAH Home Care
  - One Designated Nurse
  - Follow-up Contacts Occur in First 30 Days of Discharge
Transitional Coach Program

- CHF – Dec. 2013
- Pneumonia – Apr. 2014
- COPD – Oct. 2014
Redwood Area Hospital (RAH)
Redwood Area Hospital (RAH)

RARE Continued Collaboration

• Significant Decline in Rate
• Quarterly QI Reports
• Host Biannual Meeting with Long Term Care Providers
• Continued Collaboration with Transitions to EMR
Lessons Learned

• Strong, collaborative leadership compels action
• Trust and transparency among participants increases innovation
• Organizational structure and culture must support the charge
• A stepwise approach to change and improvement generates positive outcomes
Steps to Getting Started

- Display strong, visible, consistent leadership
- Identify champions and use them to foster buy-in
- Find and employ evidence-based interventions – but don’t shy away from innovation
- Engage patients and families in meaningful ways
- Get to know your partners
Steps to Getting Started

• Be purposeful about learning the role that each partner plays in care transitions
• Continue to advance the use and optimization of the electronic health record
• Use your data
Questions?

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