2012

Reducing Readmissions: Highlights from Massachusetts STAAR Cross-Continuum Teams

MHA Massachusetts Hospital Association

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Massachusetts Coalition for the Prevention of Medical Errors

Reducing Readmissions: Highlights from Massachusetts STAAR Cross-Continuum Teams

For the past three years, the Massachusetts Hospital Association (MHA) and the Massachusetts Coalition for the Prevention of Medical Errors (the Coalition) have been working with partner organizations and with cross-continuum teams to reduce avoidable readmissions within Massachusetts and improve care transitions for patients and families.

The initiative, STate Action on Avoidable Readmissions (STAAR), was launched in three states in May 2009 by the Institute of Healthcare Improvement (IHI), with a grant from the Commonwealth Fund. To date, fifty STAAR cross-continuum teams have been formed, comprised of hospitals, long-term care facilities, home health agencies, physician office practices, and others.

MHA and the Coalition have participated as state leads with the Massachusetts Department of Public Health and the Massachusetts Medical Society, and all have continued to work in close partnership with Masspro, Massachusetts Senior Care Association, Massachusetts Home Care Alliance and Community Care Partnerships. We continue to reach across organizational boundaries, engaging payers, state and national stakeholders, patients and families, and other key organizations in this effort.

In the pages that follow, MHA and the Coalition are pleased to present a sample of improvement stories from the Massachusetts STAAR Cross-Continuum teams. If you are a consumer, use this guide to see what hospitals and cross-continuum teams in your area are doing to prevent avoidable readmissions. If you are a provider, look for ideas that you can incorporate into your own efforts to reduce readmissions.

You can find a copy of this report on the MHA and Coalition websites at www.patientcarelink.org and www.macoalition.org. You will also find copies of the tools these cross-continuum teams have used which they have provided for others to use.

Congratulations and thanks are due to all of these cross-continuum teams for their commitment and continuing efforts to reduce avoidable readmissions, and to improve care for all of our patients and families within the Commonwealth.

Table of Contents: Cross-Continuum Teams

Baystate Franklin Medical Center

Contact Name:	Phone:	Email:
Nancy Woodring, RN, MBA	413-773-2616	nancy.woodring@baystatehealth.org

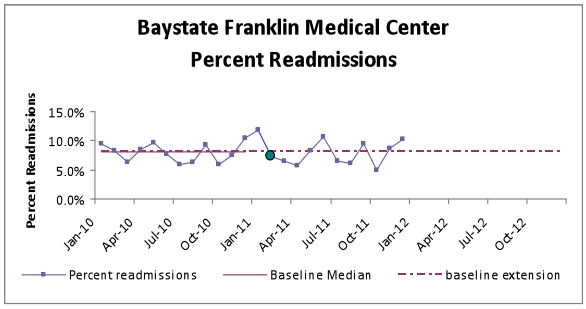
Aim Statement:

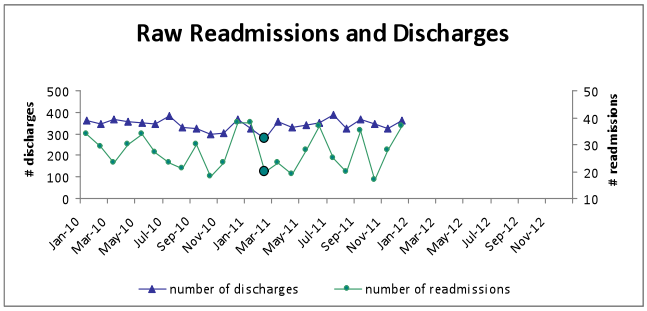
- Baystate Franklin Medical Center will reduce the 30-day readmission rate for heart failure patients by 10%
- Baystate Franklin Medical Center will achieve 4 of 8 domains at the 50th percentile or show improvement of at least 2 points over baseline period as measured by Hospital Consumer Assesment of Healthcare Providers and Systems

Organizations represented on our Cross-Continuum Team

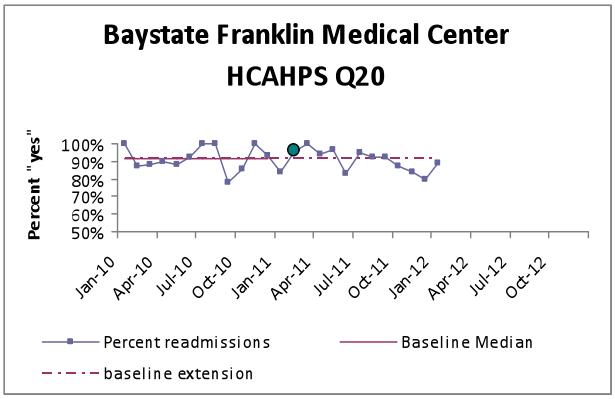
- Skilled nursing facilities
- Home care agencies
- Agencies on Aging
- Hospice
- Palliative care
- Medical home
- Physician practices
- Hospital physicians
- Case management
- Cardiopulmonary services
- Staff educators
- Information services
- Social work
- Pharmacist
- Hospital nurses
- Hospital quality improvement leaders

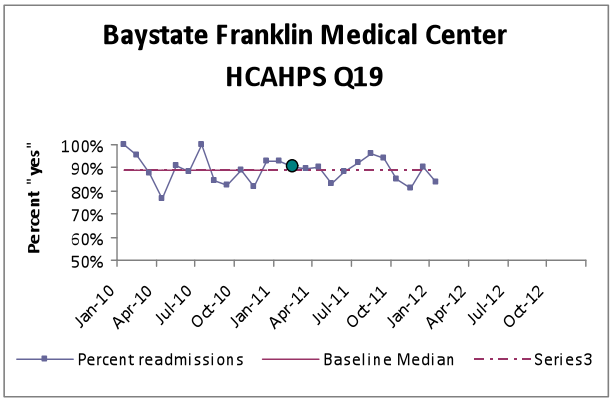
Readmissions:

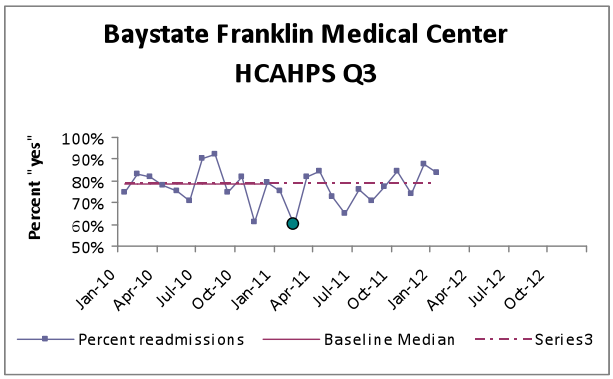


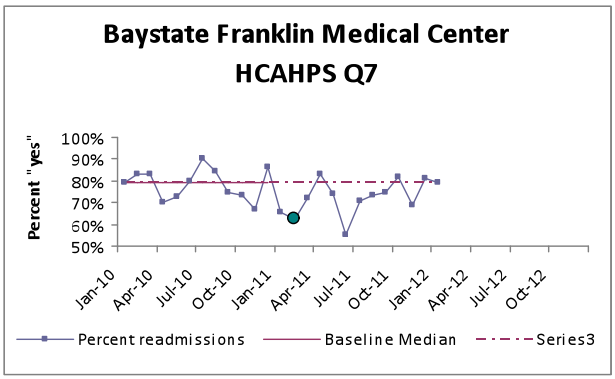


HCAHPS:









Changes we have made that we believe are helping achieve results in decreasing readmissions and improving the patient experience:

- Implementation of Zone teaching tool and calendar for recording daily weight across the Franklin County health care continuum
- Scheduling follow up appointments prior to discharge or first business day post discharge
- Baystate Health Insurance risk management grant "Improving Handoff Communication to Patients about Medication at Discharge"
- Community partner projects including discharged patient follow up calls to determine level of understanding regarding diagnosis and discharge instructions
- "Medication Safety Outreach and Collaboration Project" study by agency on aging

Key lessons learned

- Standardized teaching tools have been well received by the patients, families and the provider community
- Scheduled appointments help ensure patients follow up with the PCP
- Follow up appointments can almost always be made within the ordered time frame
- Monthly meetings of the cross-continuum team has made this work successful by building relationships and improving communication

Important tools used for these changes

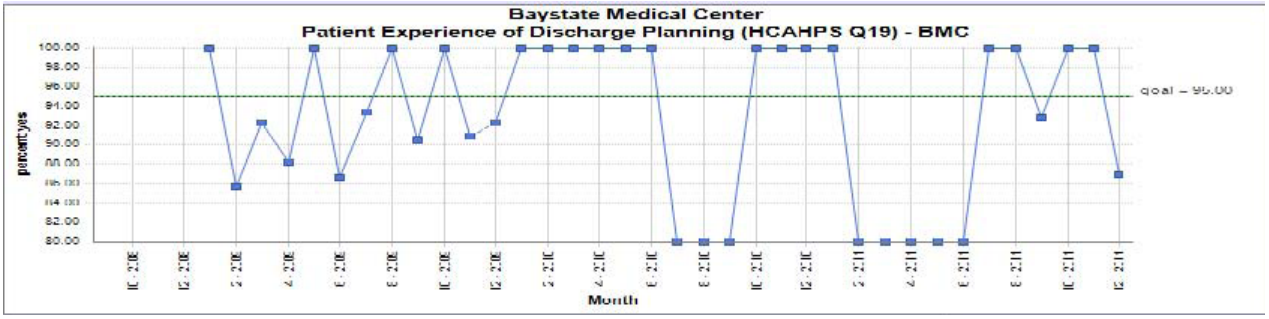
- Congestive Heart Failure zone teaching tool
- Calendar to record daily weight
- Caring for Your Heart: Living Well with Heart Failure teaching booklet
- Baystate Franklin Medical Center medication listing/side effects of common medications tool for nurses
- Risk stratification tool for determination of patients who are at high risk for readmission related to non-adherence to medication

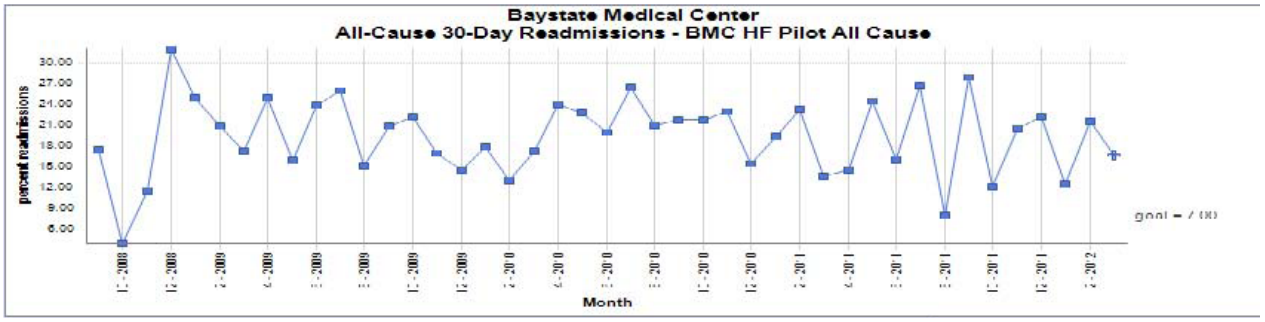
Baystate Medical Center

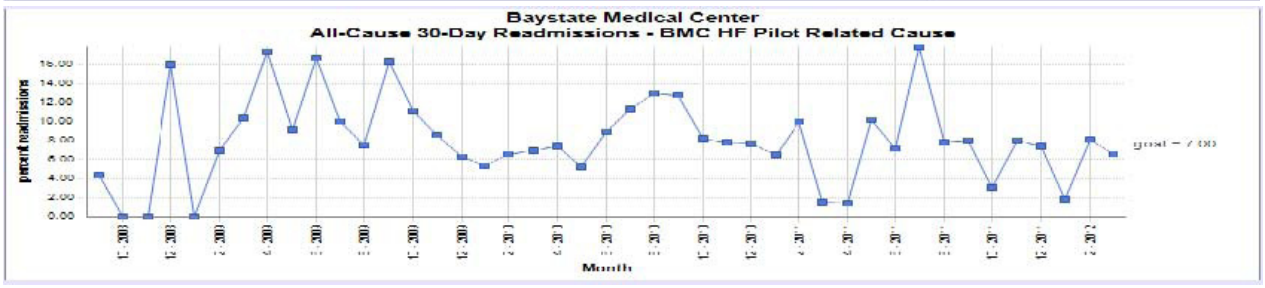
Contact Name:	Phone:	Email:
Stephanie Calcasola	413-794-2531	stephanie.calcasola@baystatehealth.org

Aim Statement:

Threshold: Continue to reduce re-hospitalization rates in all cause and related drivers for heart failure
Target: Spread STAAR model to patients with pneumonia and COPD. Reduce re-hospitalizations by 15%
Maximum: Reduce pneumonia and COPD re-hospitalizations by 25%







List the types of organizations represented on your Cross-Continuum Team

SNFs, ASAPS, Primary Care Practices, LTCs, VNA, Respiratory Infusion/DME Services, Subacute Facilities, Palliative care, care management organizations

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- Follow-up phone calls post discharge have been an intervention implemented on our heart failure pilot unit and three other units (S1, S3 and M 5).
- Daily rounds and warm handovers at the bedside with the patient involved are two other interventions which have been implemented.
- Within our cross-continuum teams, we have been having staff from outside agencies work with the inpatient team and then share their stories at our meetings. They dive into best practices and share opportunities for better handoff from hospital to agency and vice versa. They share what worked, and what didn't.
- On high-risk patients on HF unit, a pharmacist is now included in rounds and will provide medication teaching when the need is identified. Also, palliative care physician is part of HF unit daily rounds.
- Beginning to focus on a mixed medical unit for STAAR impact on readmissions (S3).

Key lessons learned

A key lesson we are learning is how to spread the STAAR interventions to other units which have different staffing matrices. Medical population is complex in needs and discharge education. We are beginning to develop ZONE teaching tools for disease specific topics like pancreatitis.

Important tools used for these changes

- Zone education
- Ask me 3 education tool

Beth Israel Deaconess Hospital - Milton

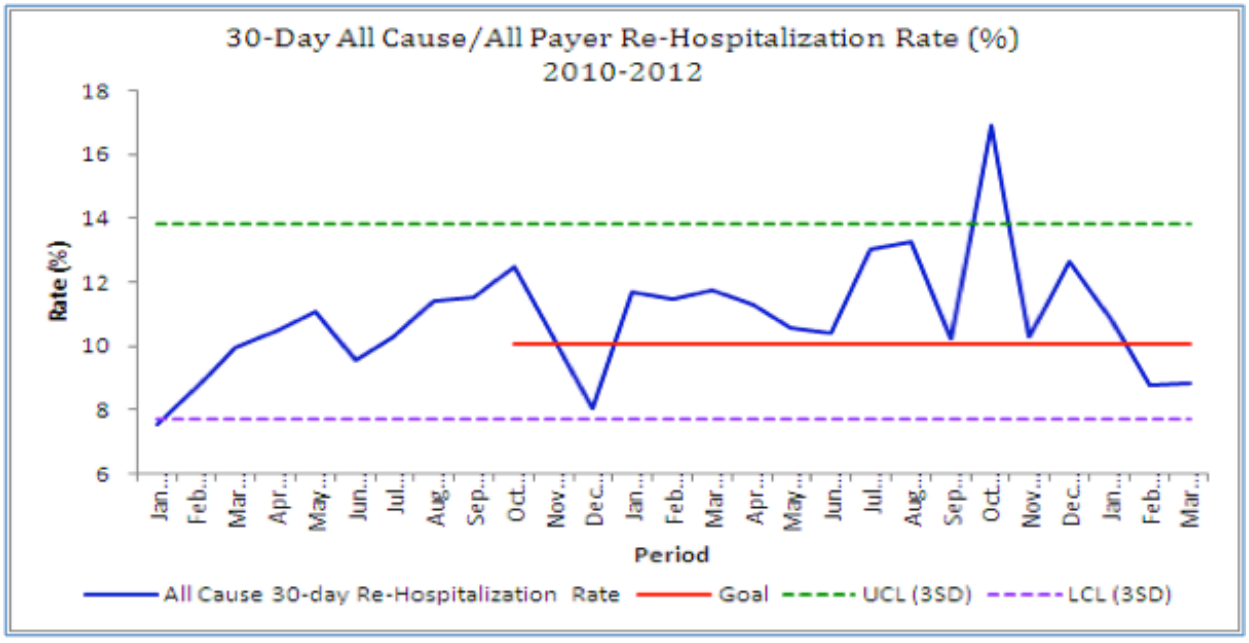
Contact Name:	Phone:	Email:
Alex Campbell	617-313-1053	alex_campbell@miltonhospital.org

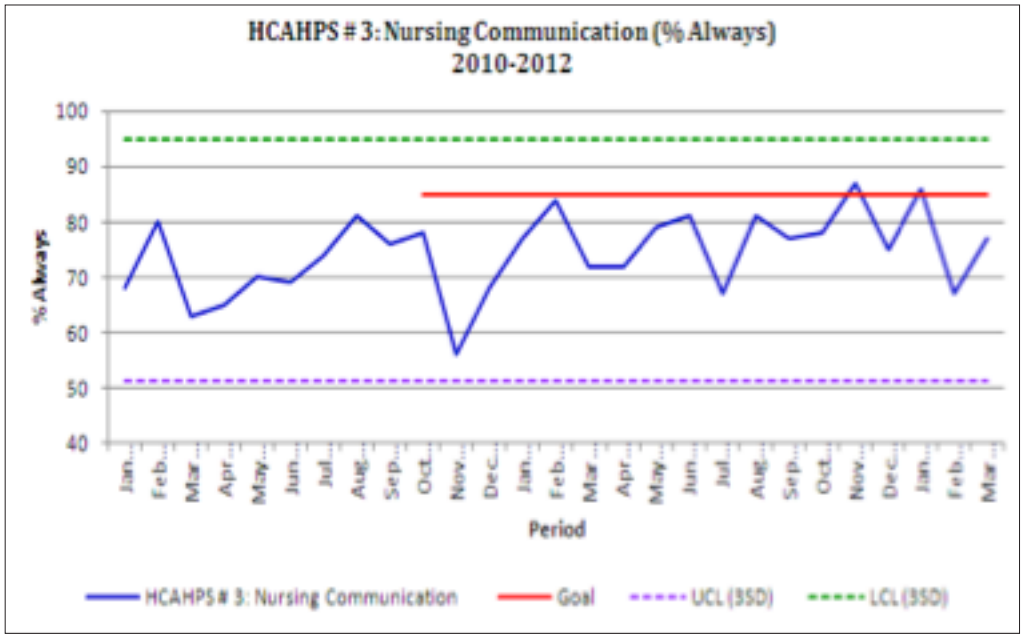
Aim Statement:

The Beth Israel Deaconess Hospital Milton (BIDH-M) will improve transitions for inpatients discharged from 2 North and 3North as measured by a decrease in 30-day all-cause readmission rate from 11.21% (FY 2011) to 10.09 % or less (10 % decrease) by the end of FY 2012.

There will be a focus on improving planning for discharge, patient centered handovers to community providers, post-acute follow-up, and improving patients' understanding of self-care.

STAAR Data:




HCAHPS # 3: Nursing Communication (% Always)
2010-2012
100
90
80
70
60
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40
% Always
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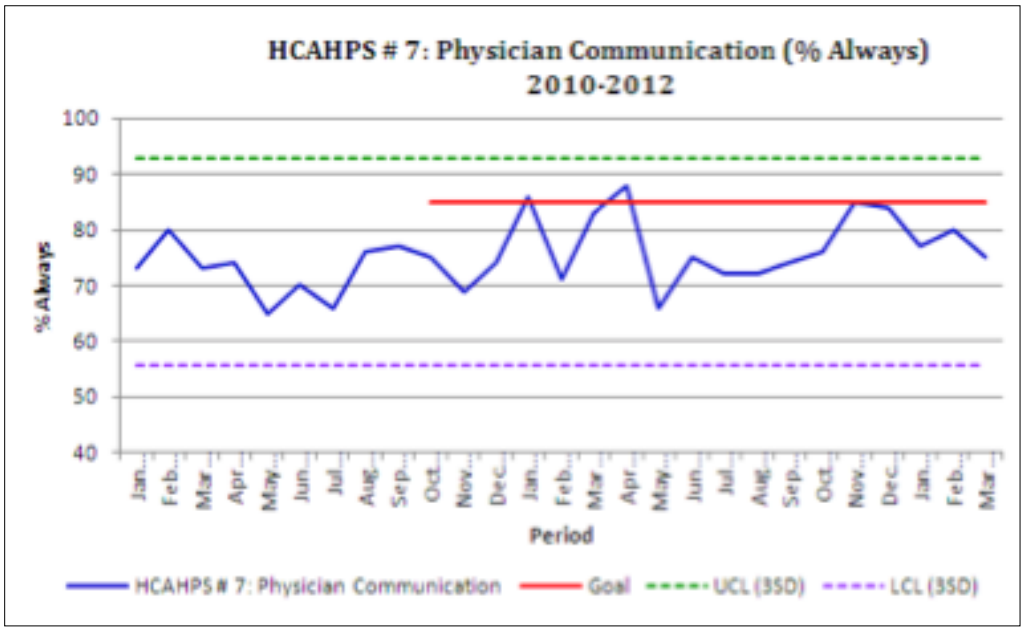
Period
HCAHPS # 3: Nursing Communication
Goal
UCL (3SD)
LCL (3SD)


HCAHPS # 7: Physician Communication (% Always)
2010-2012
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% Always
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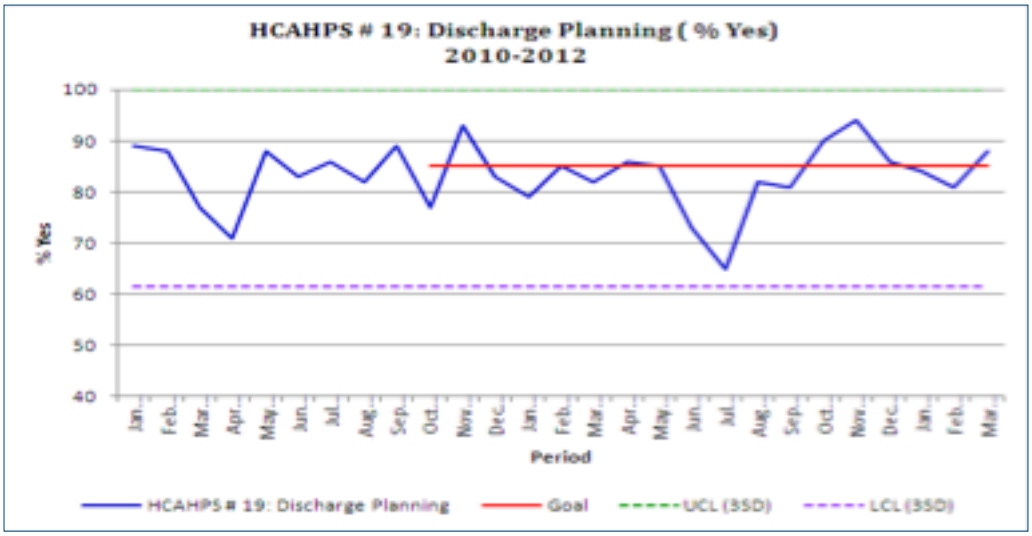
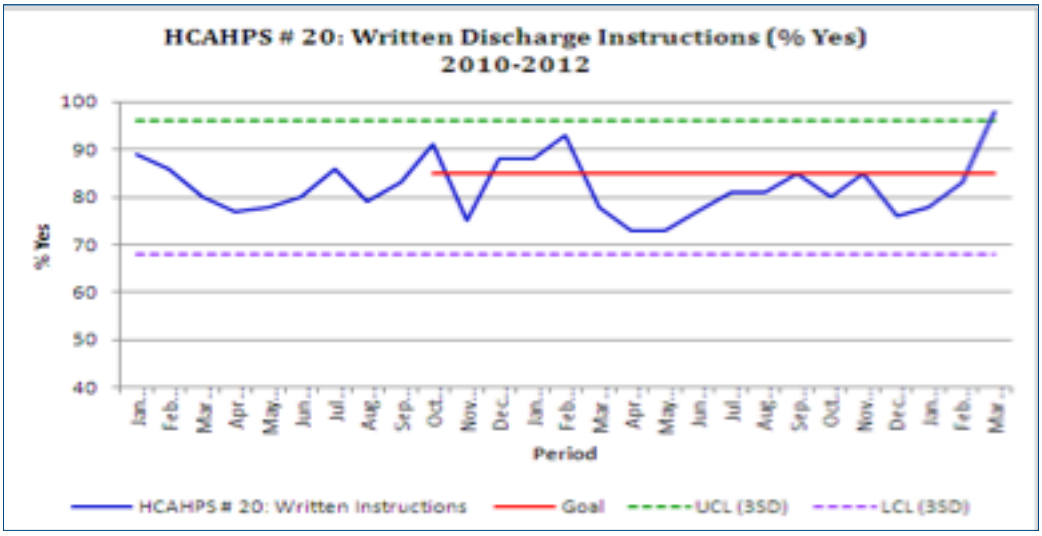
Period
HCAHPS # 7: Physician Communication
Goal
UCL (3SD)
LCL (3SD)





Types of organizations represented on BIDH-M's Cross-Continuum Team:

- Acute Care Hospital (multiple disciplines including medical staff)
- Skilled Nursing Facilities
- Visiting Nurses Associations
- Hospice/Palliative Care
- Acute/Long Term Rehab.
- Reinforced Care – post discharge patient monitoring
- Sheltered housing organization

Changes that have been made that we believe are helping us achieve results in decreasing readmissions and improving the patient experience?

- Implementation of patient teach-back methodology throughout organization
- New patient education tools (multi-language/appropriate reading level for patient population)
- Established process to ensure physician follow up appointments are made prior to discharge.
- Physician follow up visits made for no more than 7 days unless specifically indicated by physician.
- Post-discharge follow up calls for all inpatients from post discharge day 1 to post discharge day 30 (multiple days), with focus on key patient safety questions. An immediate escalation process is in place. Periodic interagency case review process used.
- Formation of patient experience quality team
- Staff education to enhance care provider/patient communication: AIDET methodology
- Cross-continuum team communication and opportunities for learning
- Ongoing participation in STAAR learning groups

Key lessons learned

- Importance of collaborative/open communication/relationship between hospital and community based care providers
- Need to implement small incremental process improvements to avoid overwhelming available resources
- Benefit of ongoing education/review of STAAR resource tools
- Importance of tracking measure outcomes
- Involvement of community based physician participant may be useful (TBD)
- Benefit of including former patient/family member in Cross-Continuum Committee (TBD)
- Next step – implementation of warm hand-off communication and finish re-designing medication reconciliation process

Important tools used for these changes

- Hospital purchased patient education software library

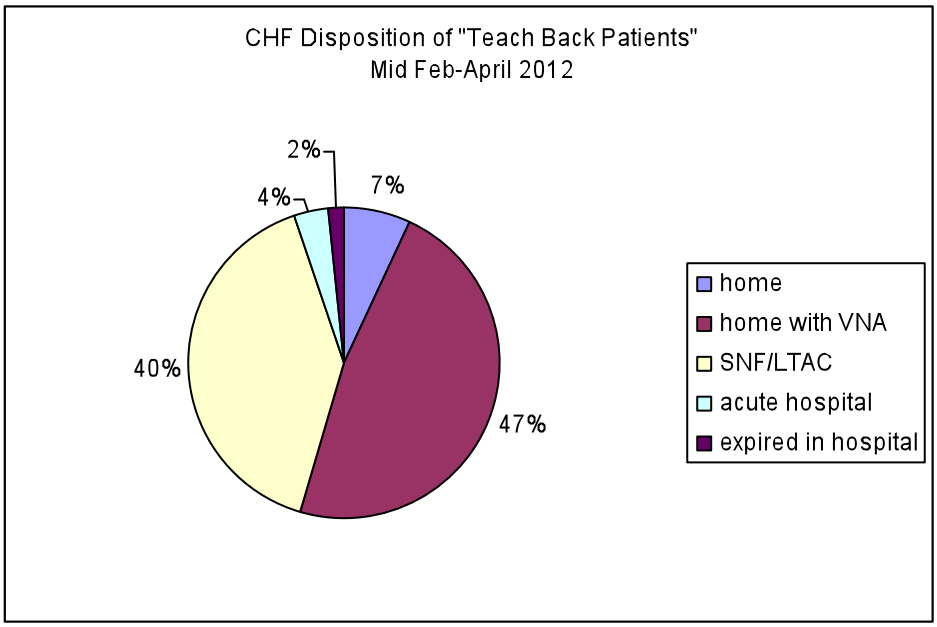
Beth Israel Deaconess Hospital - Needham

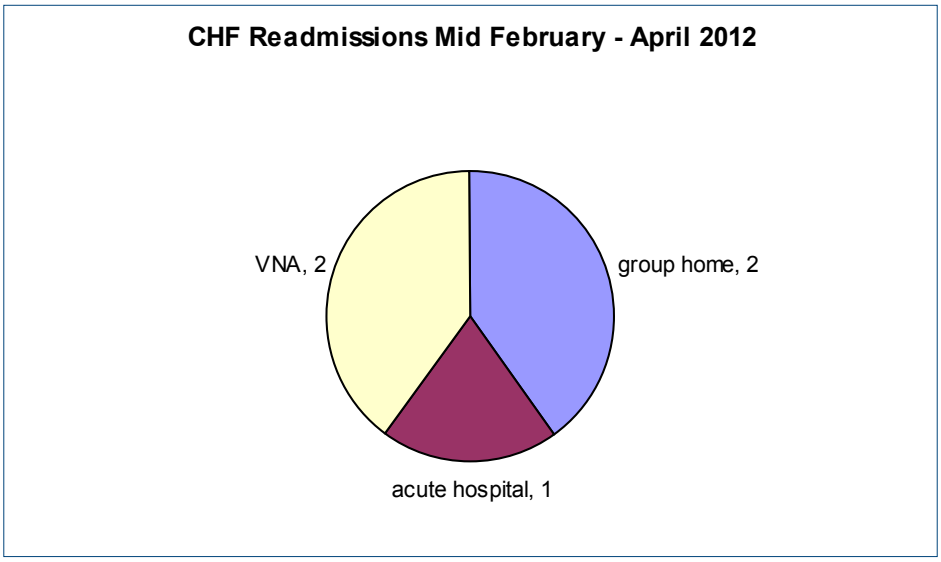
Contact Name:	Phone:	Email:
Merill Adler	781-453-5416	madler@bidneedham.org

Aim Statement:

To reduce readmissions of CHF patients

Results:





List the types of organizations represented on your Cross-Continuum Team

VNA, Area SNFs, ASAP and hospital staff

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

Development of Teach Back teaching tool and follow-up telephone calls

Key lessons learned

- Patients/family members appreciate interest/support
- We have been able to answer some patient/family questions in "real time"

Important tools used for these changes

- CHF Follow-up Call form

Cambridge Health Alliance

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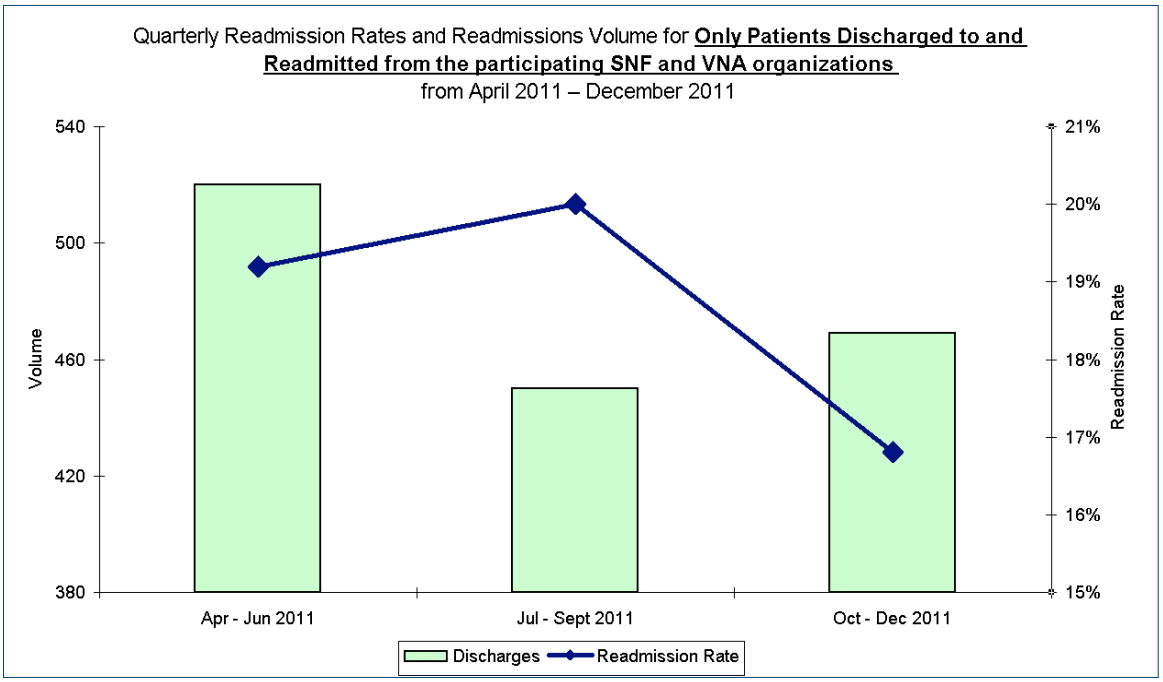
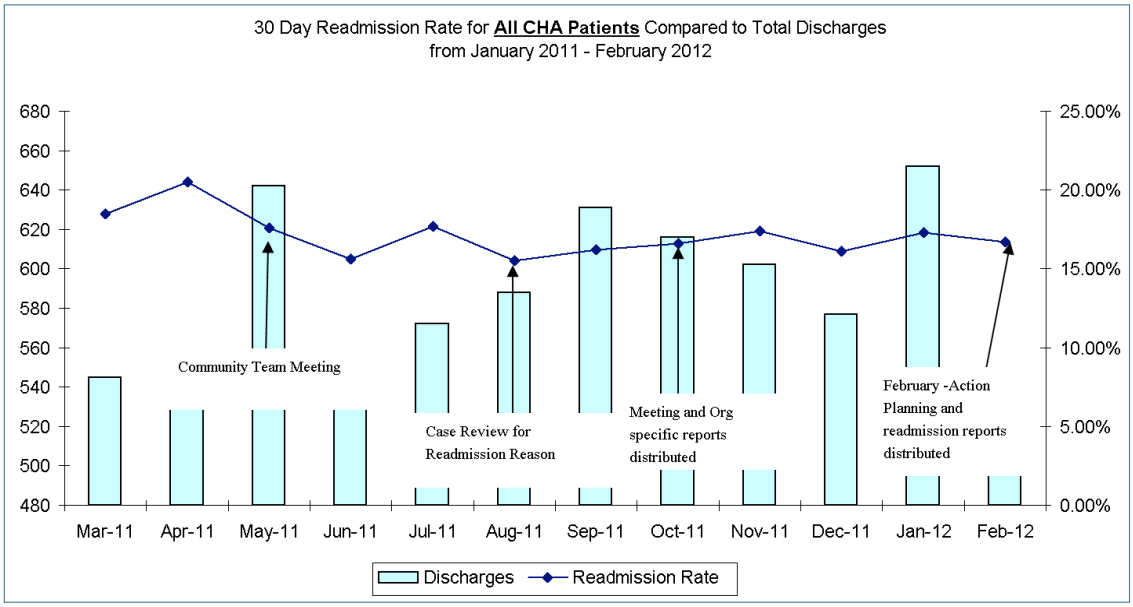
Deborah Ventresca	617-394-7617	dventresca@challiance.org
Kelly O'Connor	617-499-8355	koconnor@challiance.org
Cindy Reilly	617-499-8313	creilly@challiance.org

Aim Statement:

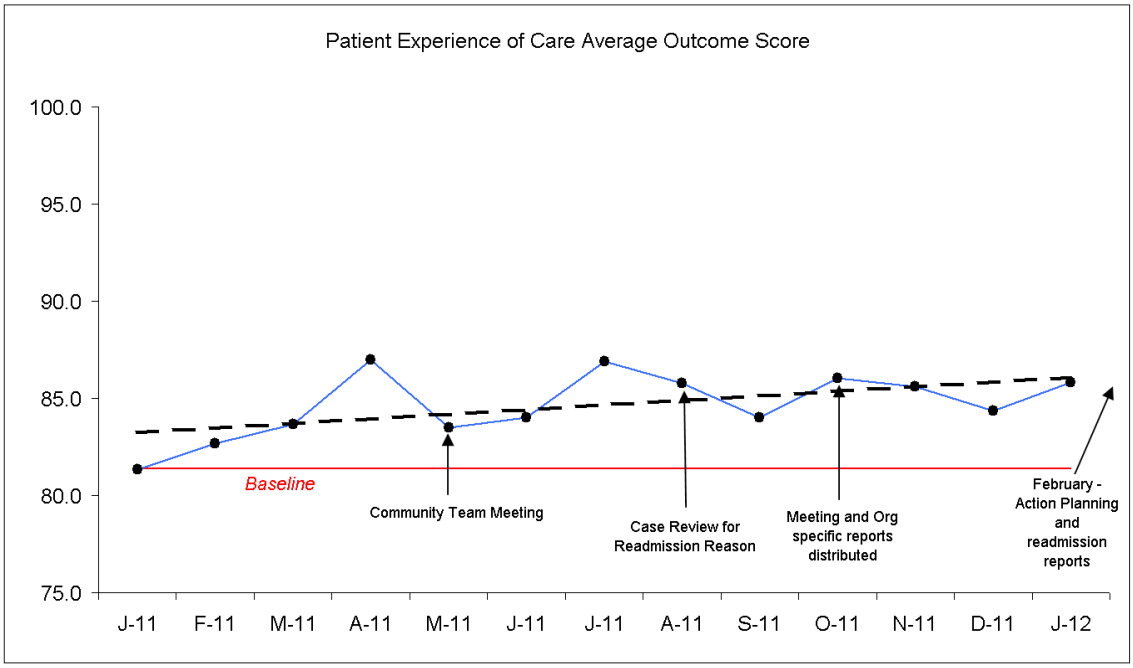
The overall aim is to reduce the rate of avoidable readmissions for patients using Visiting Nurse Association (VNA) and Skilled Nursing Facility (SNF) services. We hope to accomplish this by achieving engagement and communication among CHA and its community partners, facilitating Primary Care Physician engagement, and providing our shared patients with safe care and positive experiences across the continuum.

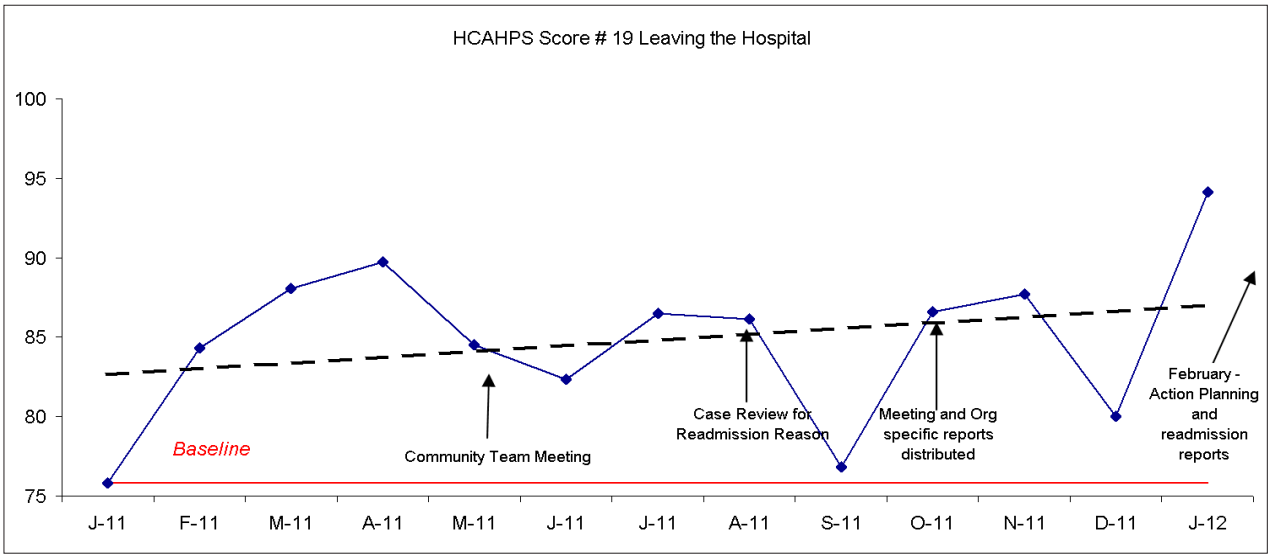
Results:



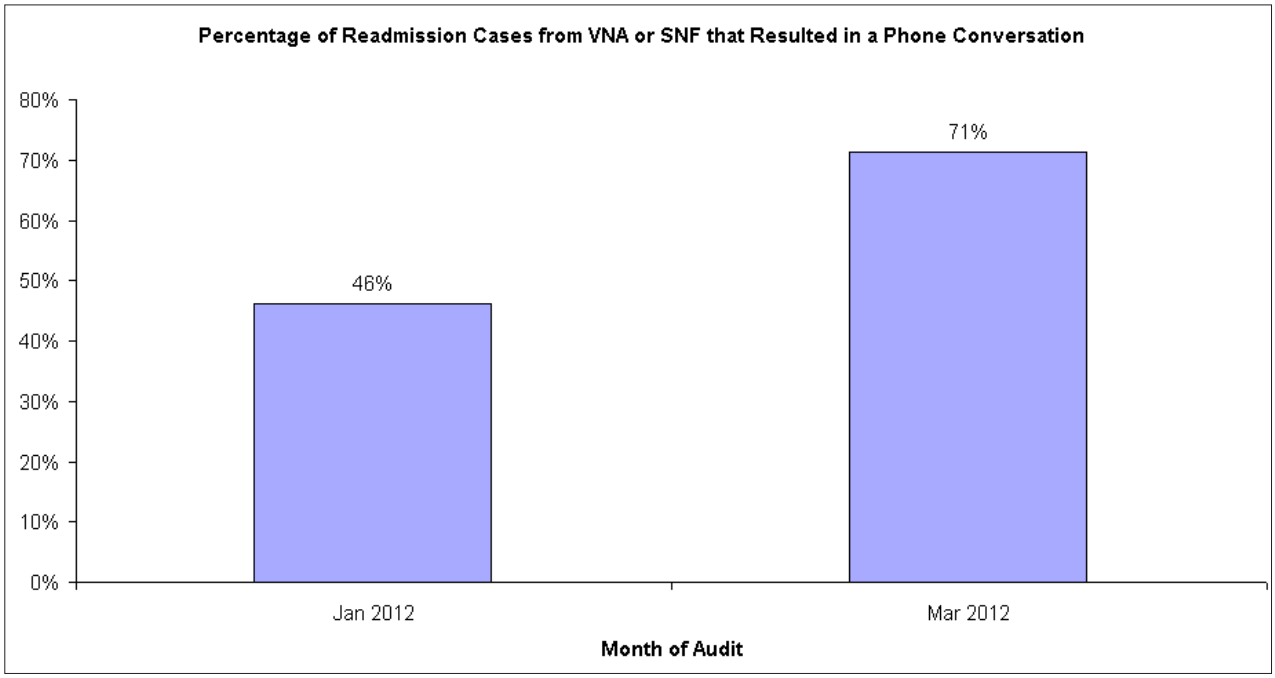


Patient Experience of Care Measures





Process Measure Results



List the types of organizations represented on your Cross-Continuum Team

We are working with a group of 14 Skilled Nursing Facilities, 4 Visiting Nurse Associations, and 2 Aging Service Access Points (ASAPs)

- All Care Visiting Nurse Association
- Cambridge Nursing and Rehabilitation
- Chelsea Jewish Nursing Home
- Chelsea Skilled Nursing and Rehabilitation Center
- Courtyard Nursing Care Center
- Golden Living – Dexter House
- Eastpointe Rehab
- Emerson Village Rehabilitation and Nursing Center
- Glenridge
- Mystic Valley Elder Services
- Cambridge Somerville Elder Services
- Greater Medford Visiting Nurse Association
- Leonard Florence Center for Living
- Lighthouse
- Manuel R. Grell Home Care Agency
- Mystic Valley Elder Services
- Neville Center for Nursing & Rehabilitation
- Sancta Maria
- Somerville-Cambridge Elder Services
- Visiting Nurse Association of Eastern Massachusetts

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- Cross-Continuum Team Collaboration:
  - + Beginning in May 2011, the CHA has hosted participating SNFs and VNAs at semi-annual Community Meetings where issues such as communications, investigating the root causes of readmissions, and understanding and impacting the patients' experience throughout their care and care transitions are discussed. General awareness has been raised and plans have been created for improving communication and improving the experience of our shared patients.

- Improved Handoffs:
  - + External liaisons are now reviewing a letter of information about their service or facility with the patient during the screening process and leaving it in the patient's personal information folder. This is recorded in a track sheet by the liaison.

- Readmission Phone Call Conversations:
  - + Readmission Phone Call initiative began in January 2012. The readmission phone call is from the VNA or SNF caring for a patient to the hospital where the patient is being admitted. During this call the case manager and treating nurse discuss the patient's care plan and adjustments that need to be made based on the reasons for the readmission. We are currently undergoing the study phase of how this is working. We will continue to conduct PDSA cycles to reach the goal of having a conversation with the outside organization.

- Readmissions Data Feedback:
  - + Beginning in May 2011, participating organizations are receiving quarterly, organization specific reports of the rates of readmission of our shared patients. In this report, the numbers of patients that are discharged to a particular SNF or VNA are the denominator in this rate, and the numbers of patients that are readmitted within 30 days directly from that same SNF or VNA are the numerator.

- Readmission Root Cause Analysis and Case Review:
  - + Beginning in August of 2011, case mangers took an active role in investigating the root causes of readmissions. Using a standardized set of definitions for root cause helps the case manager to understand the reasons for the readmission. Reports of the causes help us understand themes and guides our routine case reviews.

- Action Planning with Community Team Participants:
  - + During Community Team meetings possible improvement ideas to reduce readmissions are discussed in breakout sessions. Of the 16 participating organizations, 11 (62%) submitted their action plans. CHA case management and quality staff will follow-up and coach their improvement efforts with guidance on measurement and shared learning. Using a Plan, Do, Study, and Act model for improvement organizations answered the questions:
    - What are we trying to accomplish?
    - How will we know that a change is an improvement?
    - What change can we make that will result in improvement?

- Expanding the Cross-Continuum Team:
  - + The Cross-Continuum Team has grown from its inception of 9 community partners to 19 community partners.
  - + Our newest additions are two area ASAPs: Mystic Valley Elder Services and Somerville-Cambridge Elder Services. We are eager to partner with them to tie in the transitions and services available to patients from these organizations.
  - + We have added a member of the Patient Family Advisory Council who is familiar with VNA work and a patient of Cambridge Health Alliance.

- Scales:
    + Patients with a diagnosis of CHF and without the means to purchase a body weight scale for the home will now be receiving a scale and education on how to use the scale. We will be integrating teach back techniques into this program.

- VNA visits within 24 – 48 hours:
    + Patients discharged home with visits from a VNA now receive a visit within 24 to 48 hours of discharge.

Key lessons learned

- We have found there were points of confusion around processes that were easily clarified. For example, if a patient did not speak English the external liaisons did not know that a nurse or unit secretary would help them call an interpreter.
- Real-time discussion of readmissions has helped us to understand the general causes as well as to work through issues on a case by case basis.
- We learned that community partner organizations distribute blue folders to patients which are similar to the ones given to patients at CHA. We plan to work together to alleviate any confusion that the patient or family may endure.
- There has been a noticeable heightened awareness and action by the case managers to coordinate and investigate the transitions of care to and from the hospital with our community partners.

Important tools used for these changes

- Readmission Root Cause guide

Cape Cod Hospital

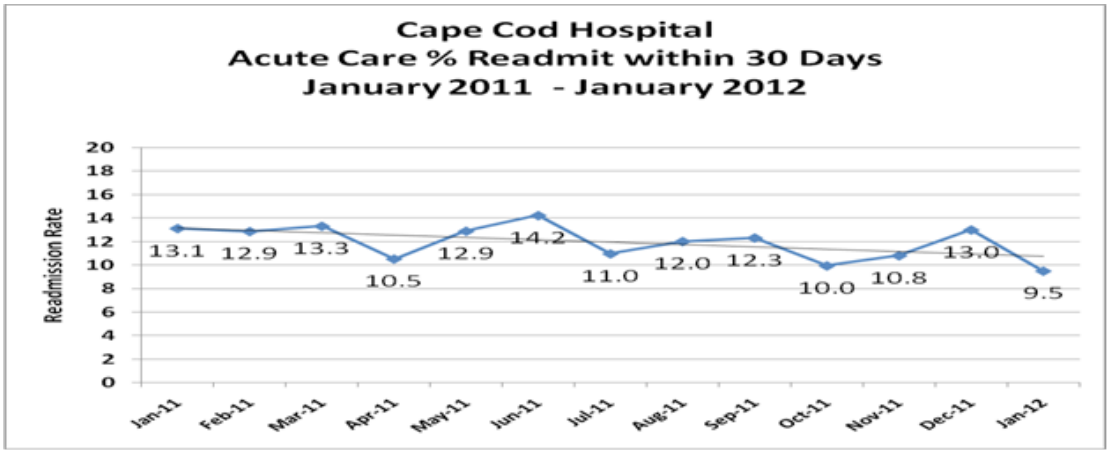
Contact Name:	Phone:	Email:
Molly Nadeau Cathy Bachert	508-862-7408 508-862-5116	mnadeau@capecodhealth.org cbachert@capecodhealth.org

Aim Statement:

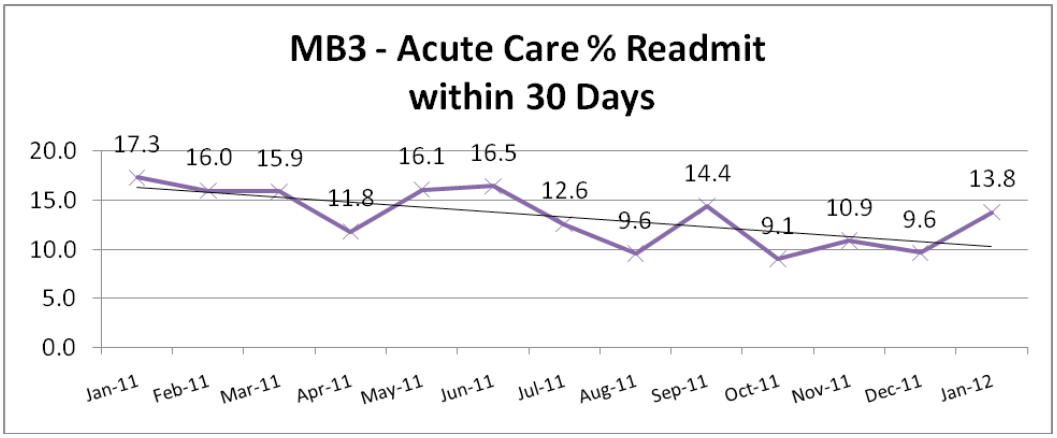
By December 2012, Cape Cod Hospital will improve care transitions for all inpatients as evidenced by a sustained reduction in 30 day all cause readmissions below 10%. In addition to the 30 day all cause readmission rate, other initiatives that contribute to this reduction will be measured. They include: Evidence of Teach Back Methodology employed, Nurse to Nurse communication occurs, Post Hospital Care Follow-up/ PCP appointment made prior to discharge, Enhanced High Risk Case Management Assessment applied.

Results:

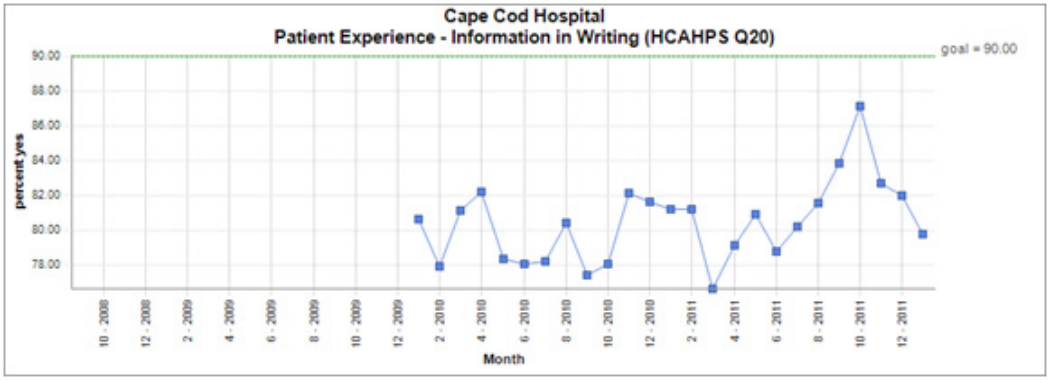
Cape Cod Hospital Pilot Unit (MB3) Readmission Rate Downward Trend
This unit represents the medical service Hospitalist patients.



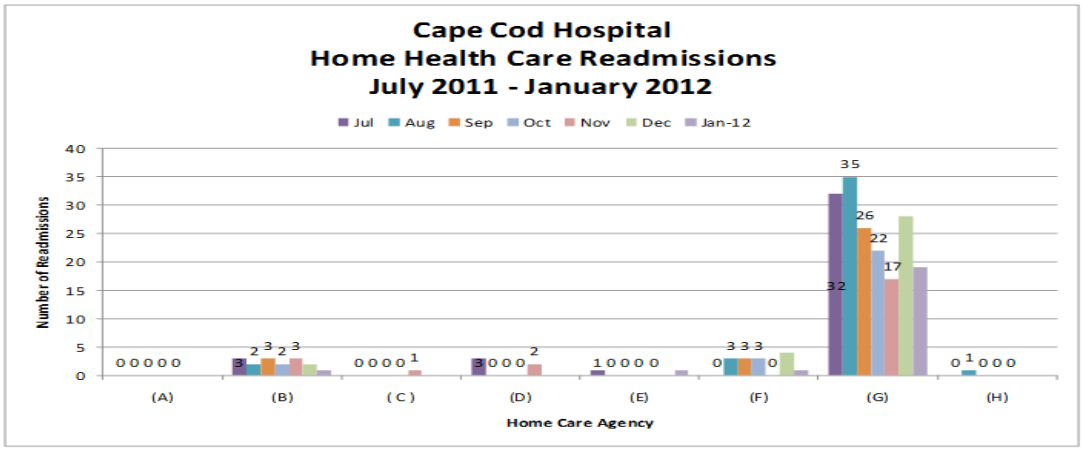
Cape Cod Hospital Pilot Unit – HF 30 Day Readmission Rate, downward decline.

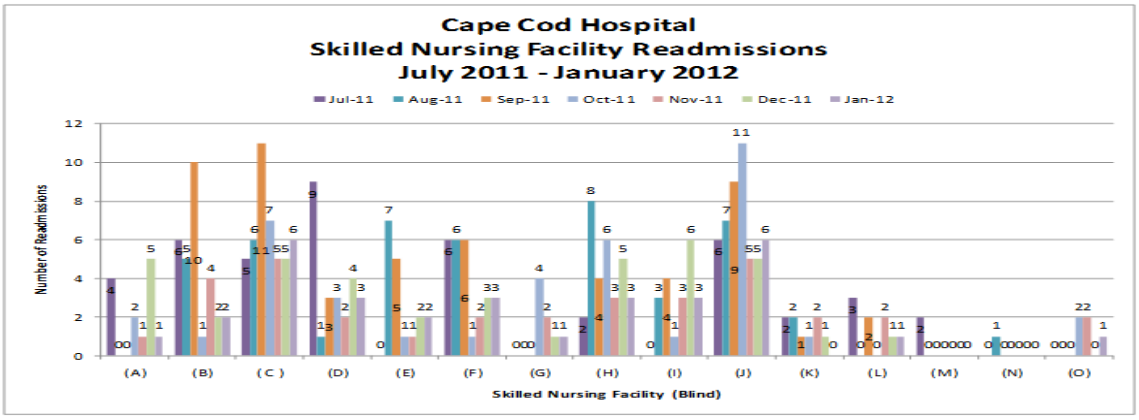


Cape Cod Hospital Patient Experience – Information in Writing



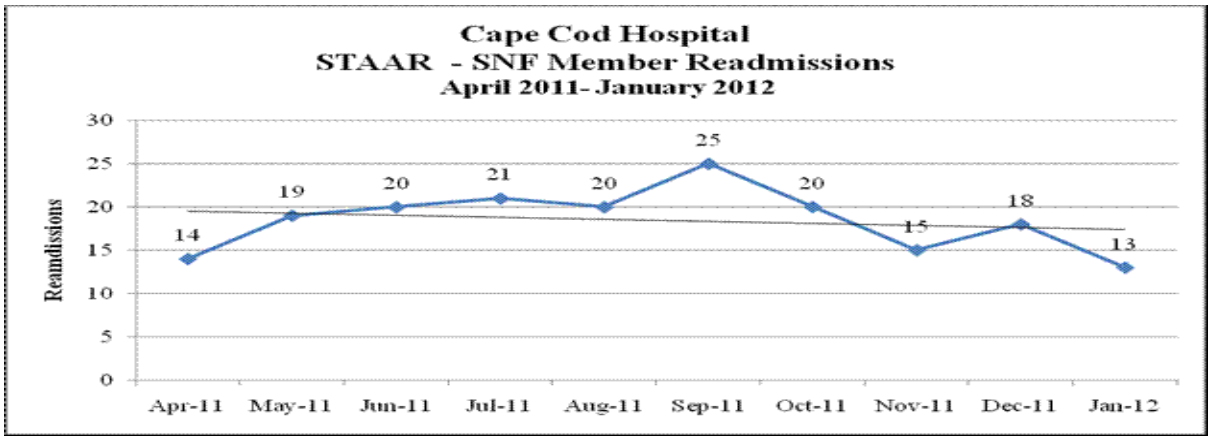
Home Care Readmission by Number of Readmits VNA = (G)
Steady downward trending with our VNA team member





SNFs are given the number of readmits to hospital within 30 days of discharge with corresponding names unblended for each facility. The patients are reviewed using an audit tool that the SNF developed during a STAAR meeting session. Trends and findings are identified.

Below you will find the total number of 30 day readmissions by STAAR Team SNFs. We are seeing a downward decline.



List the types of organizations represented on your Cross-Continuum Team:

Elder Services, Visiting Nurse Association, Director of Quality, 2 Patient Representatives, 5 Skilled Nursing Facilities, Hospital Director, Quality, Case Manager, Hospital Nurse Manager, Physician Practice, EMS Regional Director.

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- Nurse-to-Nurse Communication
- PCP Notification on Discharge
- PCP Appointment within 72 hours of Discharge
- Enhanced Assessment – Risk for Readmission (Pilot stage)
- Teach Back Methodology
- VNA / SNF Readmission Audits and Reporting on findings with action plans
- Hospital / SNF Medical Director Meetings
- "Dovetail" – CCHC "Helping Hands" Program for post-discharge patients who need additional help with medication reconciliation and education support
- HF – Standardization of Patient Teaching materials
- VNA – Offshoot STAAR committee and Readmission Studies
- Daily Patient Care Planning Rounds – Case Manager, Clinical Leader, PT, OT, Manager, MD

Key lessons learned

- PCP Follow Up Appointments – Physicians thanked us at first, but then felt burdened by the demand. This forced us to expedite our high risk assessment and increase our window for appointments from 72 hours to 5-7 days.
- The importance of all staff buy-in to these initiatives is key to their success: Enhanced Assessment, PCP Notification and Appointments, and Dovetail referrals.
- Dovetail referrals were slow in the beginning due to patient resistance and risk identification of the patients who would benefit from the program.

Important tools used for these changes

- "PCP Notification Form"
- Nurse to Nurse SNF Communication Worksheet and Audit tool
- Dovetail Referral Form
- Enhanced Reassessment Tool
- SNF Readmission Audit Tool and Report Template
- Teach Back – 5 Key Must Know Categories

Cooley Dickinson Hospital

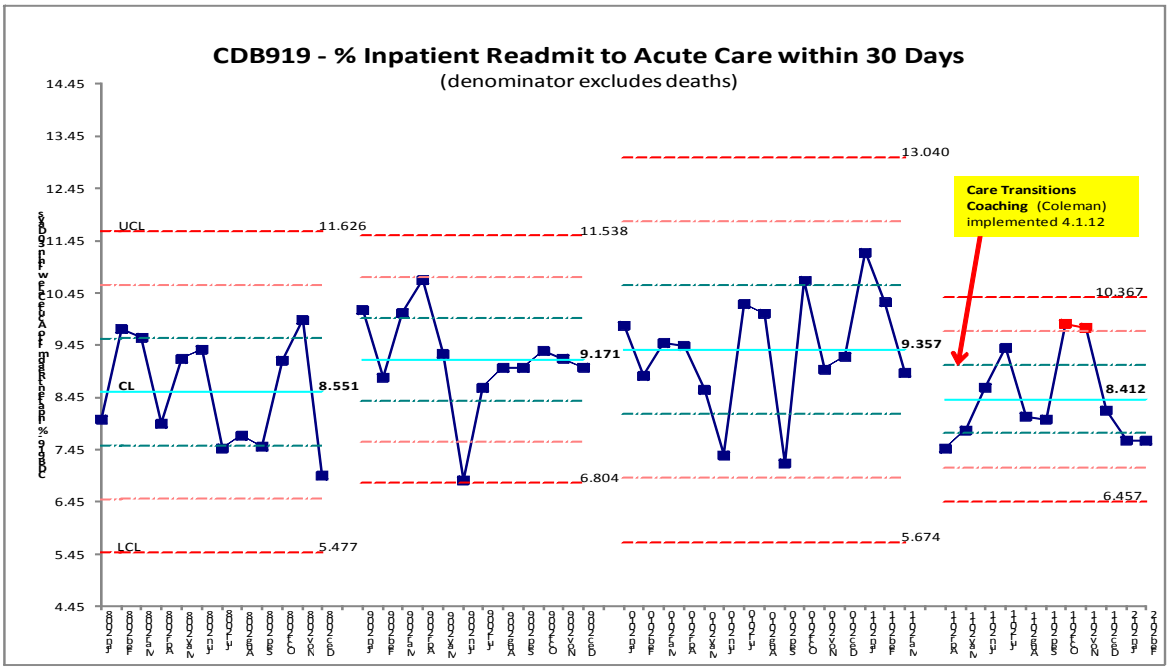
Contact Name:	Phone:	Email:
Tammy Cole-Poklewski	413-582-4736	tammy_cole-poklewski@cooley-dickinson.org

Aim Statement:

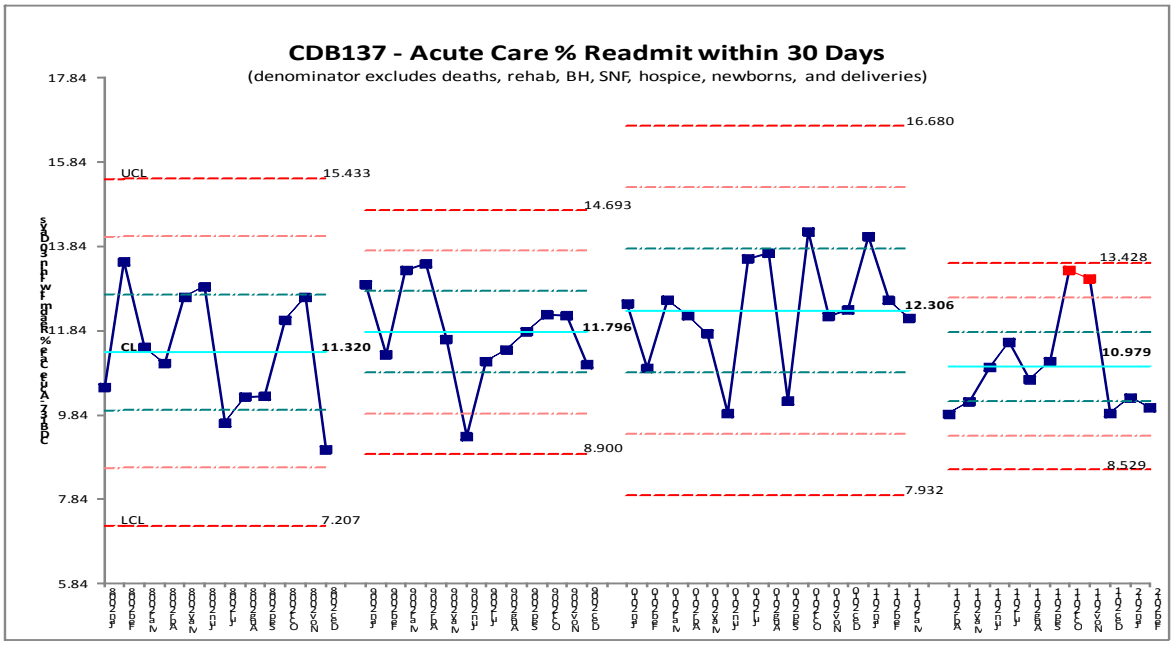
Cooley Dickinson Hospital will reduce all cause readmissions from 9.17% to 7.5% inpatient readmit to acute care (within 30 days) by December 2012. We will focus on improving the patient's disease self-management skills, improved communication on admission and discharge with community providers, and engaging patients and families in discharge planning.

Results:

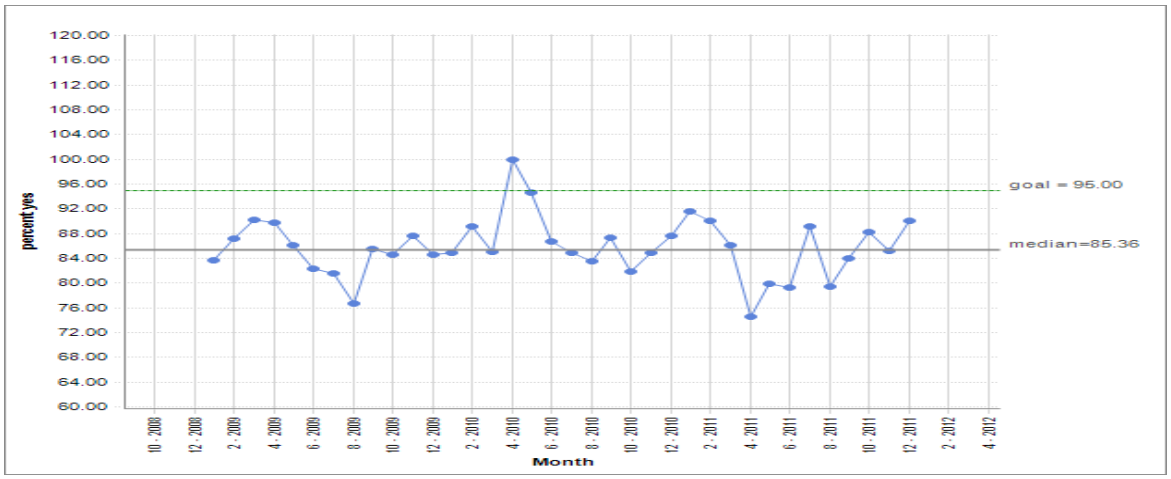
Percent Inpatient Readmit to Acute Care Within 30 Days (denominator excludes deaths)



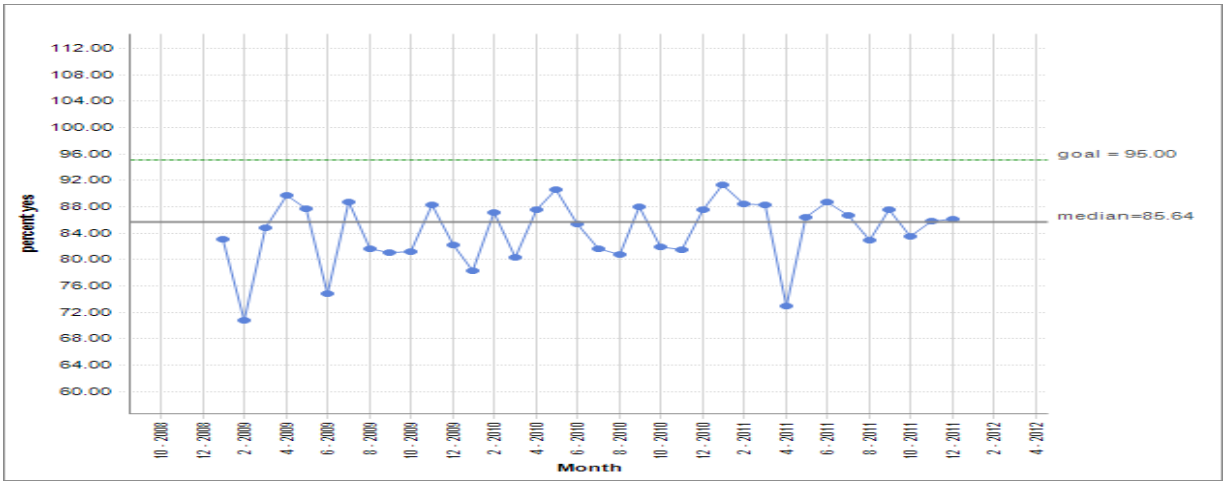
Acute Care Percent Readmit within 30 days (denominator excludes delivery, newborn, BH, hospice, rehab, deaths)



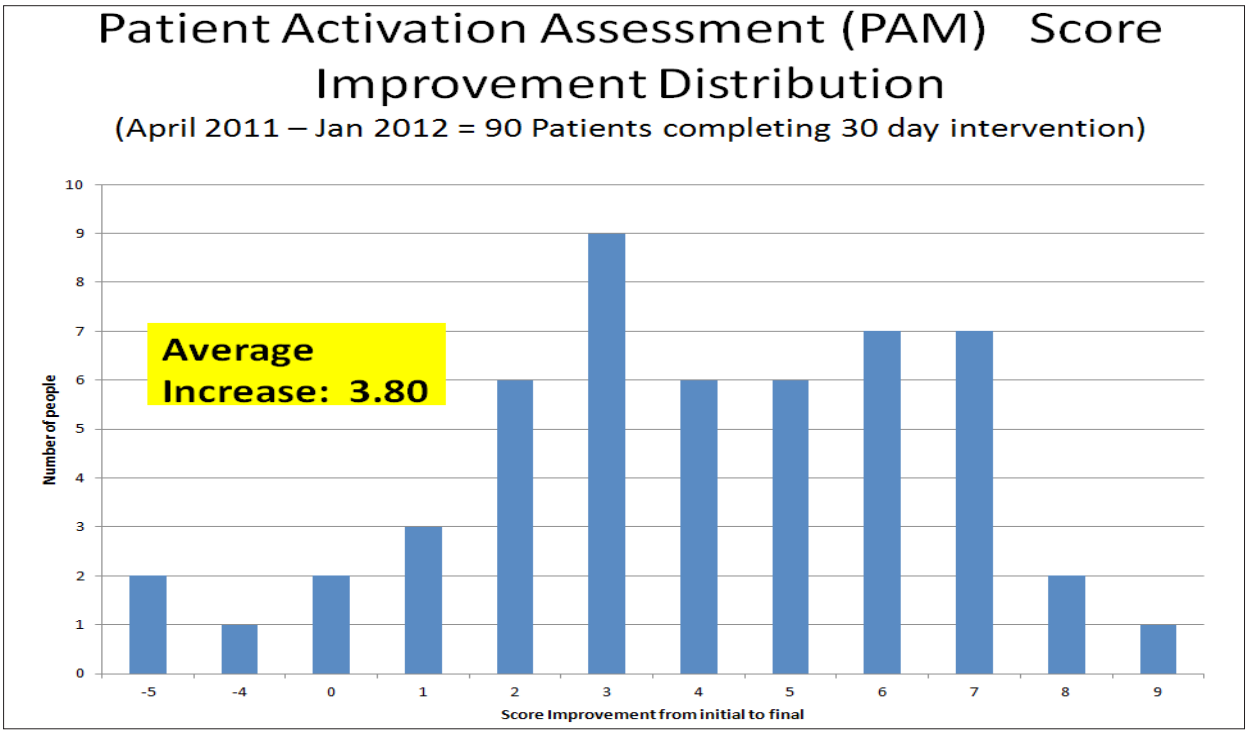
HCAHPS - "Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?" (Q19)



HCAHPS -"Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?" (Q20)



Patient Activation Assessment Score – administered prior to Care Transition Coaching and after completing 30 day intervention.

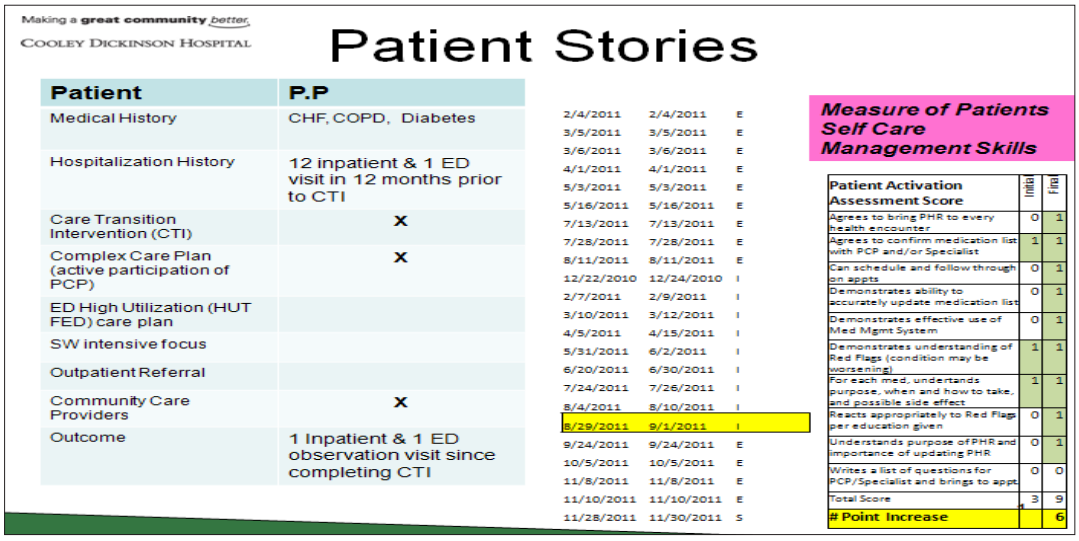


CTM-3 Interview Questions

Profile: CASE MANAGEMENT - POST DC FOLLOW UP

Indicator	Total	% of Total
Total # Post Disch Phone Calls Made	333	
CTM-3 Hosp staff took my pref into account re needs post disch	337	
Strongly Agree	**128**	**38%**
Agree	**173**	**51%**
Disagree	9	3%
Don't know/Don't remember/NA	27	8%
CTM-3 When left hosp I had good understanding responsible managing hlth	336	
Strongly Agree	**130**	**39%**
Agree	**184**	**55%**
Disagree	12	4%
Strongly Disagree	2	1%
Don't know/Don't remember/NA	8	2%
CTM-3 When left hosp I clearly understood purpose taking each med	335	
Strongly Agree	**123**	**37%**
Agree	**175**	**52%**
Disagree	16	5%
Strongly Disagree	4	1%
Don't know/Don't remember/NA	17	5%

Summarized Patient Specific Stories to share with cross-continuum members, hospital staff, medical staff, and board of trustees



Making a **great community** *better*

COOLEY DICKINSON HOSPITAL

Patient Stories

Patient	P.P
Medical History	CHF, COPD, Diabetes
Hospitalization History	12 inpatient & 1 ED visit in 12 months prior to CTI
Care Transition Intervention (CTI)	x
Complex Care Plan (active participation of PCP)	x
ED High Utilization (HUT FED) care plan	
SW intensive focus	
Outpatient Referral	
Community Care Providers	x
Outcome	1 Inpatient & 1 ED observation visit since completing CTI

2/4/2011	2/4/2011	E
3/5/2011	3/5/2011	E
3/6/2011	3/6/2011	E
4/1/2011	4/1/2011	E
5/3/2011	5/3/2011	E
5/16/2011	5/16/2011	E
7/13/2011	7/13/2011	E
7/28/2011	7/28/2011	E
8/11/2011	8/11/2011	E
12/22/2010	12/24/2010	I
2/7/2011	2/9/2011	I
3/10/2011	3/12/2011	I
4/5/2011	4/15/2011	I
5/31/2011	6/2/2011	I
6/20/2011	6/30/2011	I
7/24/2011	7/26/2011	I
8/4/2011	8/10/2011	I
8/29/2011	9/1/2011	I
9/24/2011	9/24/2011	E
10/5/2011	10/5/2011	E
11/8/2011	11/8/2011	E
11/10/2011	11/10/2011	E
11/28/2011	11/30/2011	S

Measure of Patients Self Care Management Skills

Patient Activation Assessment Score	Initial	Final
Agrees to bring PHR to every health encounter	0	1
Agrees to confirm medication list with PCP and/or Specialist	1	1
Can schedule and follow through on appts	0	1
Demonstrates ability to accurately update medication list	0	1
Demonstrates effective use of Med Mgmt System	0	1
Demonstrates understanding of Red Flags (condition may be worsening)	1	1
For each med, understands purpose, when and how to take, and possible side effect	1	1
Reacts appropriately to Red Flags per education given	0	1
Understands purpose of PHR and importance of updating PHR	0	1
Writes a list of questions for PCP/Specialist and brings to appt	0	0
Total Score	3	9
# Point Increase		**6**

List the types of organizations represented on your Cross-Continuum Team

Hospital staff – case managers, social work, respiratory care, nursing

Home care	ASAP	PFAC	SNF
eDischarge (Curaspan)	VAMC	Community	Assisted Living
PCP	Hospitalists	Palliative physicians	VNA & Hospice

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- We implemented the Care Transitions Coaching Program (Coleman Model) in February 2011 and began enrolling patients in April 2011.
- In May of 2011 we began the Coaching Networking Breakfast at the VNA & Hospice of Cooley Dickinson in order to closely coordinate the services of the Coleman trained coach, the VNA Home Care Services, the local ASAPs, and several Nursing Facilities
- In February 2012 nine additional members of our Hampshire County Cross-Continuum Team were trained by our Care Transition Coach Trainer (3 ASAP, 1 AIDS care, 2 VNA, 2 Social Work inpatient, 1 HF telemetry nurse) in order to expand Coleman Coaching
- Focused attention on the high risk patients returning to the Emergency Department:
    + Increased medical social work coverage in the ED focusing on the underserved population: uninsured, under insured, homeless, disabled, and patients with complex psychosocial issues
    + Participation on the multi-hospital ED "high utilization task force" facilitated the development of patient specific care plans and standardizing of the approach to this high risk group. These complex care plans helped "break the cycle of returns to the ED" for some high risk patients
- Establishing Complex Case Management & Social Work plans for patients and developing standardized computer documentation to provide necessary information to all providers caring for the patient
    + Daily complex Case Manager & Social Work rounds on the medical/surgical units
- Involvement of patients and family members on teams and seeking out feedback from patients and families on how to improve our processes
- Patients present their experiences to the Board of Trustees

Key lessons learned

When we focused on listening to the voice of the patient it was easier to keep everyone focused on improving processes

- Involvement and coordination of the entire healthcare team (across the continuum) in the care of the patient improved the patient's experience and the staff involvement
- We created seamless transitions for the patient from one setting to the next
- Participation in the multi-hospital ED "high utilization task force" facilitated the development of patient specific care plans and standardizing the approach to this high risk group. These complex care plans helped "break the cycle of returns to the ED" for some high risk patients

Important tools used for these changes

Medication Discrepancy Tool (Coleman)
Personal Health Record (Coleman)
Standardized Eclipsys documentation for high risk patients

- ED high utilize plan
- Complex care plan
- Case Management Discharge Plan note
- OASIS Data to measure improvement in management in oral medication and decrease in acute care hospitalization
- SNF post discharge feedback survey (how did the discharge go?)

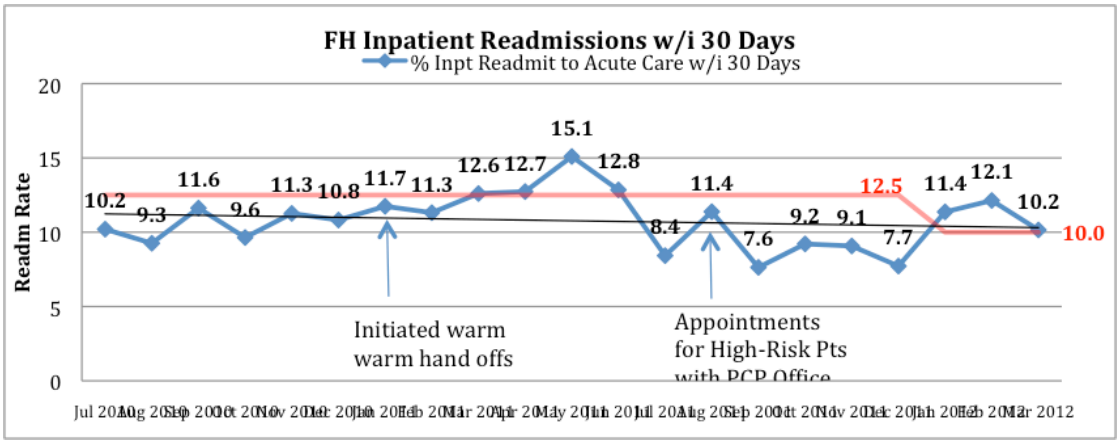
Falmouth Hospital

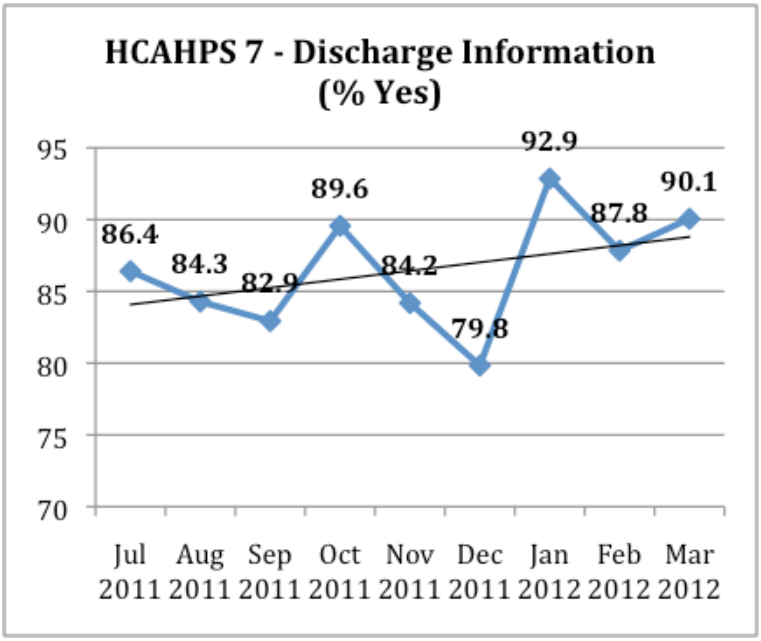
Contact Name:	Phone:	Email:
Deborah Byrne Pamela Kendrick	508-457- 3520 508-457-3517	djbyrne@capecodhealth.org pkendrick@capecodhealth.org

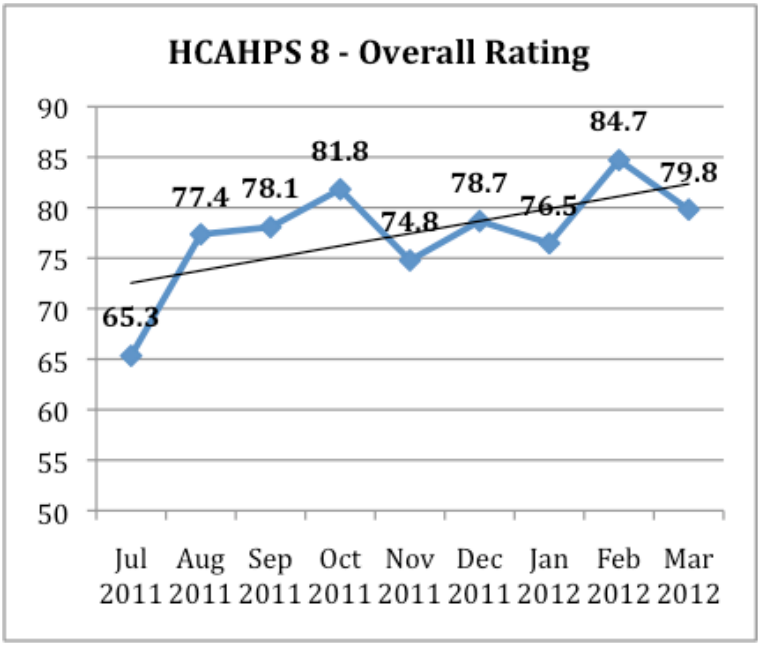
Aim Statement:

By December 2012, Falmouth Hospital will improve transitions for all inpatients as evidenced by a sustained reduction in 30-day all-cause readmissions below 10.0%. In addition to 30-day all-cause readmission rate, other initiatives that contribute to this reduction will be measured. They include: evidence of teach-back methodology employed, nurse to nurse communication occurs, post hospital care follow up/PCP appointments made prior to discharge, multidisciplinary daily review to identify and treat high-risk cases.

Results:







List the types of organizations represented on your Cross-Continuum Team

Elder Services, VNA, CCHC Director of Quality, CCHC Dietary, CCHC Community Benefit & Partnerships, CCHC Physician Hospital Organization, CCHC Physician Organization, Skilled Nursing Facilities (9), Acute Rehabilitation Facility – Spaulding, Medical Affiliates of Cape Cod, Cardiovascular Specialists, Home Care Agencies, SNF Group Administration-Royal, Falmouth Hospital Departments of Nursing, Quality Management and Case Management, Hospice

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- Nurse-Nurse Communication
- PCP Notification on Discharge
- PCP Appointment within 72 hours of discharge for high-risk patients
- SNF and VNA facility specific patient readmission list by month, reviewed and findings reported to Facilities
- Follow-up phone calls (home discharges) within 24 hours
- Dovetail (CCHC Helping Hands) Program for post discharge patients who need additional pharmaceutical support
- Heart Failure – standardization of patient teaching material across the continuum
- Education of ED and Hospitalist staffs to not always admit SNF patients who can be treated in the ED and returned to their facility
- Approval for SNF communicated to VNA in case of failure at home and patient returning to ED can be admitted to SNF directly
- Enhanced VNA communication to reduce/remove/minimize potential barriers for returning home
- Redesigning our Clinical Decision Unit: incorporating cross-continuum collaboration, and tools developed through STAAR, to improve assessment, treatment and discharge of observation patients

Key lessons learned

The collaboration with the PCP office staff on a regular basis has made implementation of the follow-up 72 hour appointments a success. In fact, some offices have reserved one appointment each day for this purpose. Our multidisciplinary daily rounds focus has been changed to not only think about what the acute care plan is, but also what the future needs of the patient may be. Open and consistent communication across the continuum of care allows for rapid and effective changes.

Important tools used for these changes

- Nurse to Nurse communication
- PCP Discharge Notification Form
- Discharge Follow up phone call

Good Samaritan Medical Center

Contact Name:	Phone:	Email:
Joanne O'Donnell Jerilyn Thomas Marcy Carty	508-427-3000 508-427-3000 508-427-3000	joanne.O'Donnell@steward.org jerilyn.Thomas@steward.org marcy.Carty@steward.org

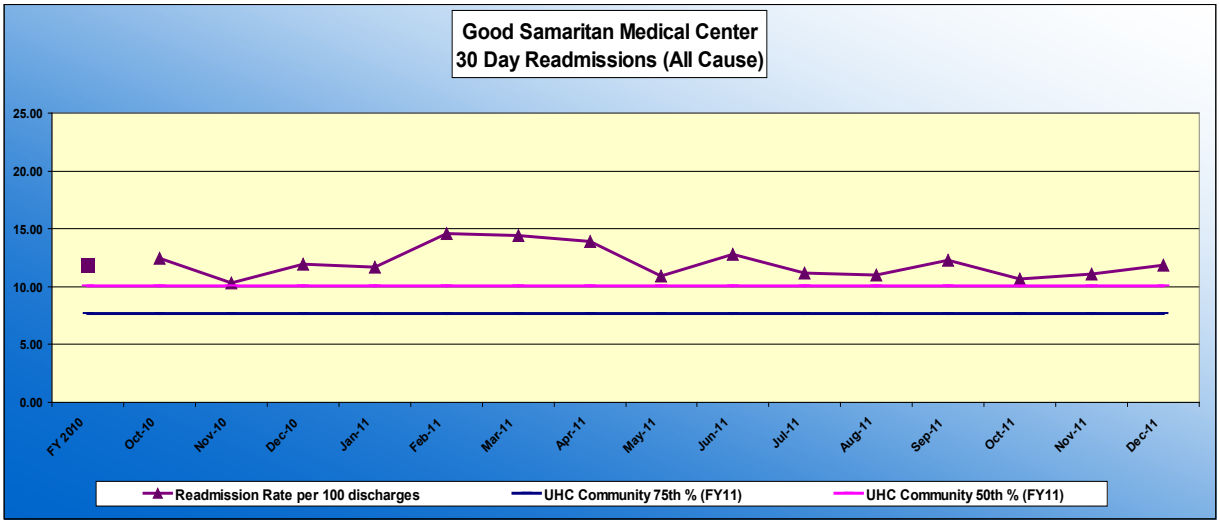
Aim Statement:

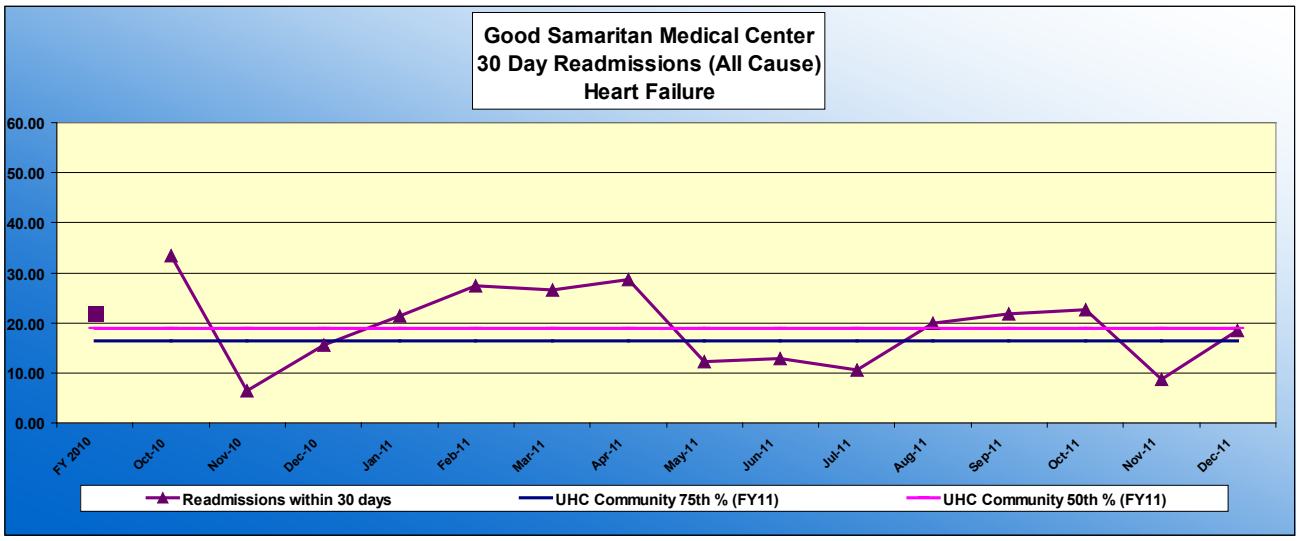
To reduced the GSMC unplanned 30 day readmission rate for Heart Failure Patients (CHF) by 10%.

Actual Rates by FY				
	FY 2009	FY 2010 (Baseline)	FY 2011	FY 2012 YTD
All Cause	12.0	11.8	12.3	11.2
HF	21.7	21.8	20.3	16.3

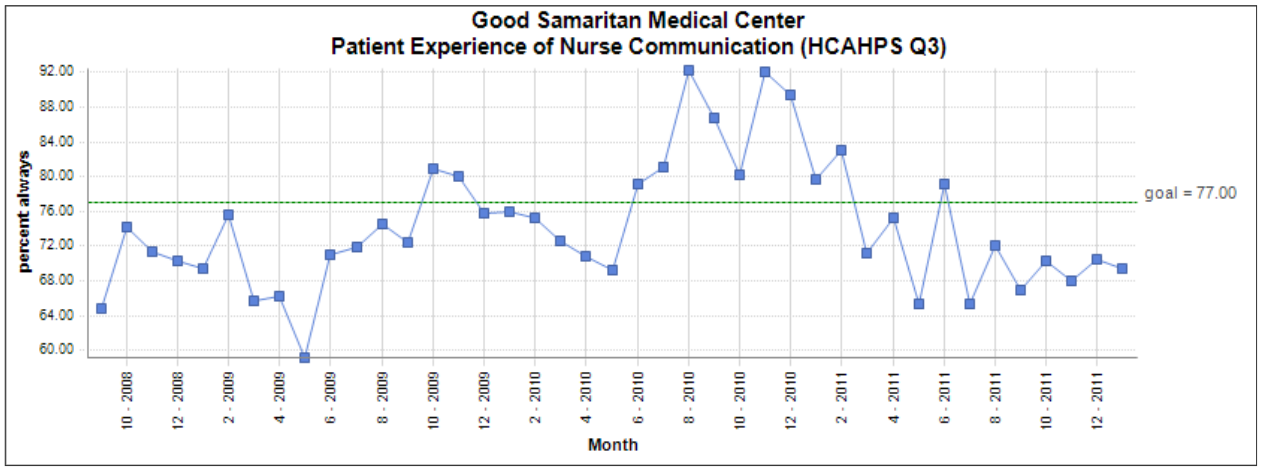
Goals	
UHC 50th % (FY 2010 Community Cohort)	UHC 75th % (FY 2010 Community Cohort)
10.1	7.6
19.0	16.3

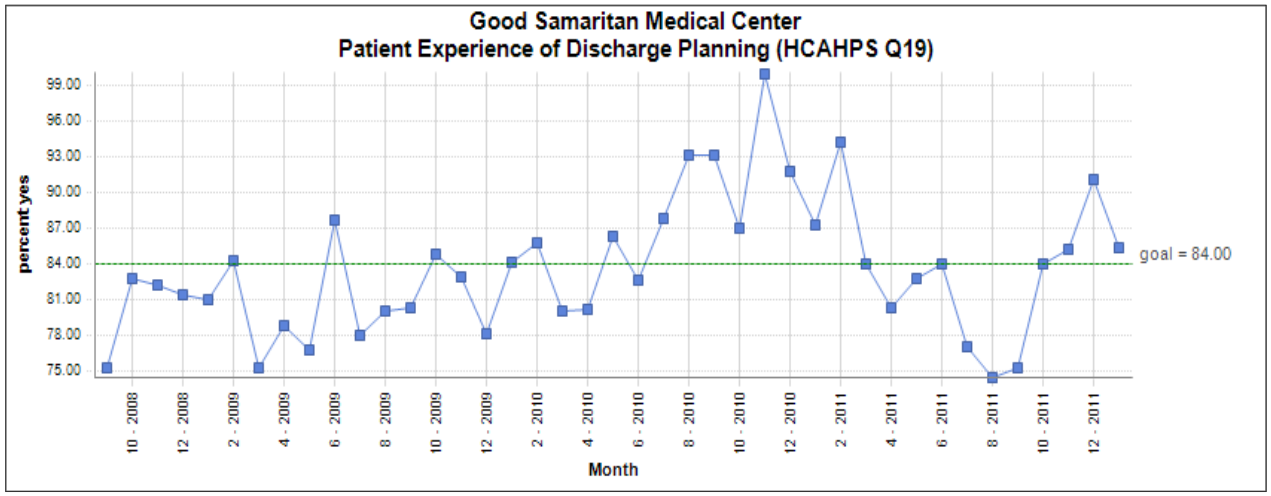
Clinical results





Patient Experience Results:





List the types of organizations represented on your Cross-Continuum Team:

Multi-disciplinary GSMC Internal Team

- Nursing
- CNO
- VPMA
- Quality
- Hospitalist
- Case Management
- Pharmacy
- Nutrition
- Respiratory Therapy

STAAR Cross-Continuum & Post Acute Care Team (PACT)

- SNFs
- LTACs
- VNA
- Old Colony Elderly Services
- Steward Health Care Network, Inc.

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- Enhanced Readmission Assessment: now electronic and completed on all readmissions, not just the pilot floors
- Identification of the learner
- Involving the family in planning the patient's care
- Discharge Callback Nurse conducting Teach Back
    + Ensures patient understands his/her diagnosis
    + Conducts teach back where needed
    + Sets up doctor's appointments if needed
- Dovetail Referrals
- Warm Handoff on the pilot floors and to the ED on patient arrival and discharge
- CHF Patients receive nutrition consult and education
- Pharmacy students will be helping with Teach Back education, providing another layer of education for our patients

Challenges:

- Discharge
    - + PCP follow-up appointments within 48 hours
    - + Ensuring the patients make their appointments
    - + Warm Handoff every time with a documentation tool to be created. Our goal is to spread to all locations in Spring 2012
- Identifying the services that each SNF/LTAC/VNA can provide allowing patients to discharge earlier
- Palliative Care
    - + Developing an internal program and learning from our cross-continuum partners
- Active Record Review
    - + Identifying the readmissions in house
    - + Identifying who our readmissions are for trends
- Multi-disciplinary Rounds

GSMC Next Steps for 2012:

- Identify risk of readmission on admission
- Spreading Warm Handoffs to all Nursing Floors
- Spreading/Sharing Teach Back & Zone Education Information to the SNFs/LTACs/VNAs/PCPs
- Multi-disciplinary Rounds that work for GSMC
- Discharging Patients earlier in the day
- Care Mapping for CHF & Pneumonia
- Explore the Steward Homecare Care Map
- Review readmission data more closely
    - + Identify the source of the readmission
- Request a report to pull data from Meditech to help us analyze data for our readmitted patients
- Request a report that displays a flag on the census to easily locate readmissions

Holyoke Medical Center

Contact Name:	Phone:	Email:
Cherelyn Roberts	413-534-2521	Roberts_cherelyn@holyokehealth.com

Aim Statement:

Holyoke Medical Center will maintain all cause readmissions for heart failure patients below 24% (National Average 2010). Our focus is on communication, education and standardized patient teaching across the continuum.

All-Cause 30-Day Readmissions

Time Period	Value	Number of Readmissions	Number of Discharges	Annotation Type
Oct-10	15.1	61	404	None
Nov-10	16.1	62	385	None
Dec-10	14.29	57	399	None
Jan-11	13.54	57	421	None
Feb-11	14	63	450	None
Mar-11	22	77	350	None
Apr-11	15.89	61	384	None
May-11	11.9	50	420	None
Jun-11	13.35	51	382	None
Jul-11	18.45	69	374	None
Aug-11	13.13	47	358	Change
Sep-11	11.8	42	356	Change
Oct-11	11.39	46	404	None
Nov-11	11.74	50	426	None
Dec-11	13	49	377	Event
Jan-12	13.89	50	360	Change
Feb 12	10.9	39	387	

List the types of organizations represented on your Cross-Continuum Team

- Community Health Clinic
- Community Agencies (Housing Corporation)
- Home health Agencies
- SNF
- Office Practices
- Dialysis Center
- Insurance Companies
- Patient Family Advocate (new addition)
- Outpatient Mental Health Providers

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

We started in the Fall of 2011:

- The changes we have made that we feel are helping us achieve our goals are in communication. We have identified key contacts in the community who share our vision.
- We continue to include any community member or facility who wants to make a difference in people's lives.
- Interviewing patients, caregivers and anyone who is involved in a patient's care when a patient gets readmitted has given us clues to what we are missing and need to work on.
- Listening to everyone on the cross-continuum team to hear what the barriers are for each facility and how we can help each other overcome them is key.
- Sharing information and visiting facilities. We assigned a "resource RN" to a SNF to work with staff to develop a CHF program in the facility to care for CHF patients in the SNF environment. We are planning to spread lessons learned to other SNFs in our area. We are using Teach Back.
- 3 tools have been developed: CHF Monitoring Tool, CHF Education Record and MAR with daily orders for 2GM sodium diet, I&O, daily weight same time, same clothing, and notify physician per parameters of heart zones. These tools were adapted by the SNF to be used for long term care or short term rehab for the CHF patient.
- Holyoke Health Center Clinic developed a plan that included: assigning their patients to be seen the day after discharge to review medication reconciliation, a physical assessment by an RN or NP, and include education.
- A transition team (RN and SW) was assigned to the ER to assist physicians with placement of patients in appropriate settings when acute care was not necessary. This is treat and release. (January 2012)
- Presently working with the Case Management Deptartment to assign a risk level to each patient and refer high risk patients to either a transition coach already established for the patient in the community or refer to one on day of admission.

- Notification of PCP patients seen in the ER for early follow up. The transition team in the ER does not hesitate to call PCP offices or providers in the community for high-risk patients seen in the ER.
- Follow up phone calls

Key Lessons Learned:

- When you keep the focus on the patient providers are on board
- Teach Back works, patients are bringing their daily calendars and I&O sheets to the ER
- Awareness is the first step. Keeping staff informed is hard work but key to the success of any new process. This requires constant checking in, updating, feedback and monitoring in order to sustain what we have started.
- It is easy to get overwhelmed; sometimes figuring out who is "driving the bus" is confusing.

Important tools used for these changes

- CHF Monitoring Tool for SNF
- CHF Education Tool for SNF
- MAR for the CHF Patient in a SNF

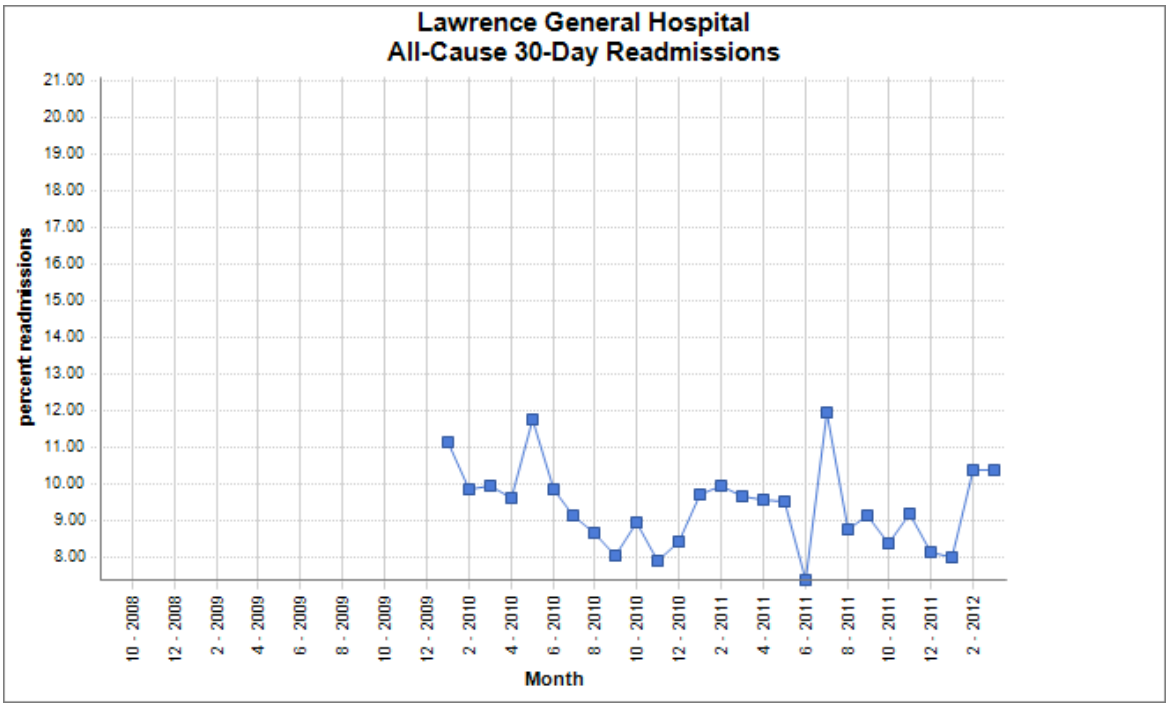
Lawrence General Hospital

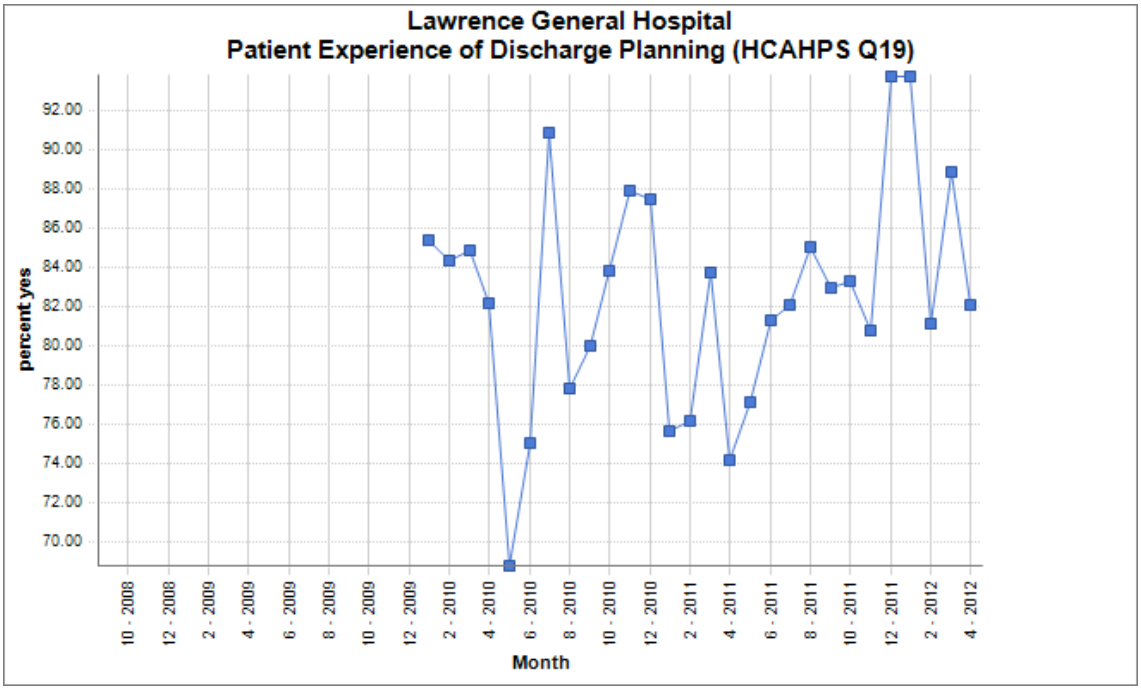
Contact Name:	Phone:	Email:
Robin Hynds	978-946-8264	Robin.Hynds@LawrenceGeneral.org
Mary Wiggin Loux	978-683-4000 x2303	Mary.E.Wiggin@LawrenceGeneral.org

Aim Statement:

Decrease unplanned 30 day all cause readmissions on target unit, Hamblet 5, by 10%. This project will be based on the four pillars of the Coleman (STAAR) framework: Enhanced Admission Assessment of post hospital needs, Effective Patient Education, Improved (real time) Handoffs communication, and Ensuring post hospital care follow up. In addition, this project intends to build on the Coleman (STAAR Model) by adding a fifth pillar focused on enhancing communication from post-acute providers back to the hospital.

Results:




Lawrence General Hospital
Patient Experience of Discharge Planning (HCAHPS Q19)
percent yes
92.00
90.00
88.00
86.00
84.00
82.00
80.00
78.00
76.00
74.00
72.00
70.00
10 - 2008
12 - 2008
2 - 2009
4 - 2009
6 - 2009
8 - 2009
10 - 2009
12 - 2009
2 - 2010
4 - 2010
6 - 2010
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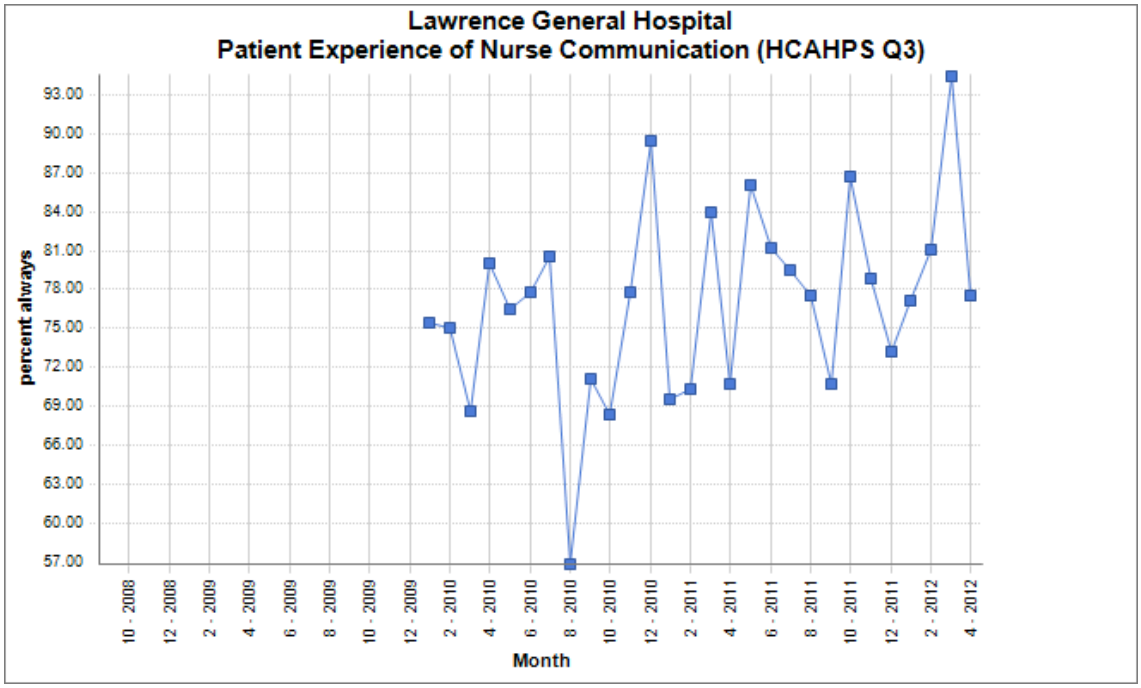
10 - 2010
12 - 2010
2 - 2011
4 - 2011
6 - 2011
8 - 2011
10 - 2011
12 - 2011
2 - 2012
4 - 2012
Month


Lawrence General Hospital
Patient Experience of Nurse Communication (HCAHPS Q3)
percent always
93.00
90.00
87.00
84.00
81.00
78.00
75.00
72.00
69.00
66.00
63.00
60.00
57.00
10 - 2008
12 - 2008
2 - 2009
4 - 2009
6 - 2009
8 - 2009
10 - 2009
12 - 2009
2 - 2010
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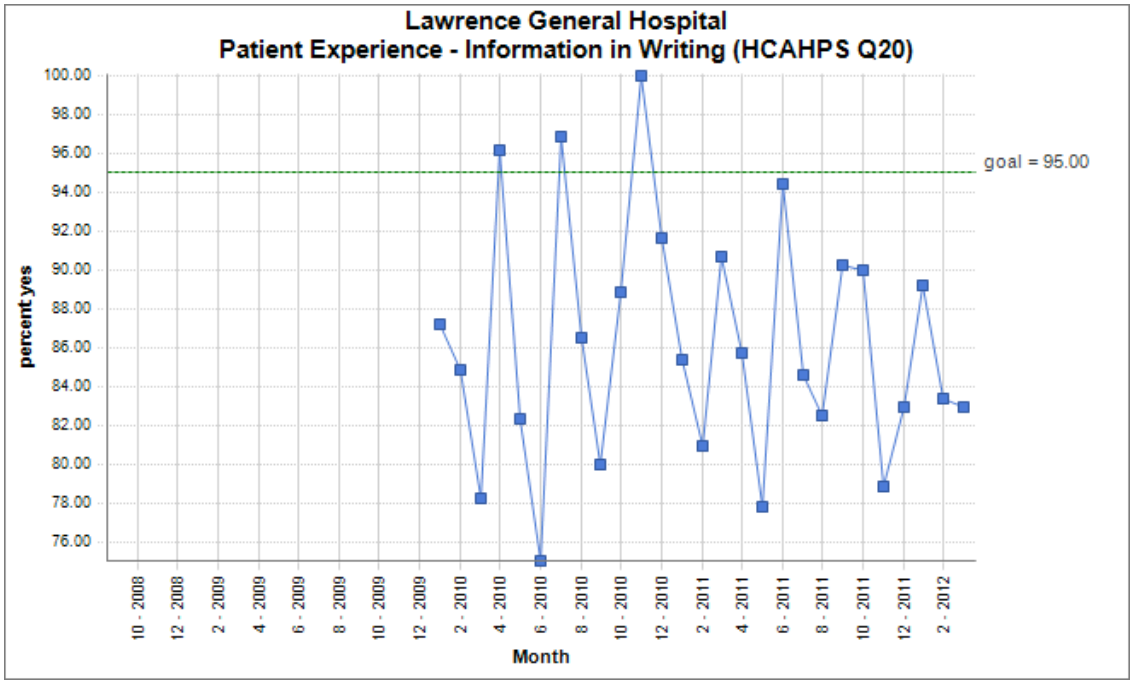
4 - 2012
Month


Lawrence General Hospital
Patient Experience - Information in Writing (HCAHPS Q20)
percent yes
100.00
98.00
96.00
94.00
92.00
90.00
88.00
86.00
84.00
82.00
80.00
78.00
76.00
goal = 95.00
10 - 2008
12 - 2008
2 - 2009
4 - 2009
6 - 2009
8 - 2009
10 - 2009
12 - 2009
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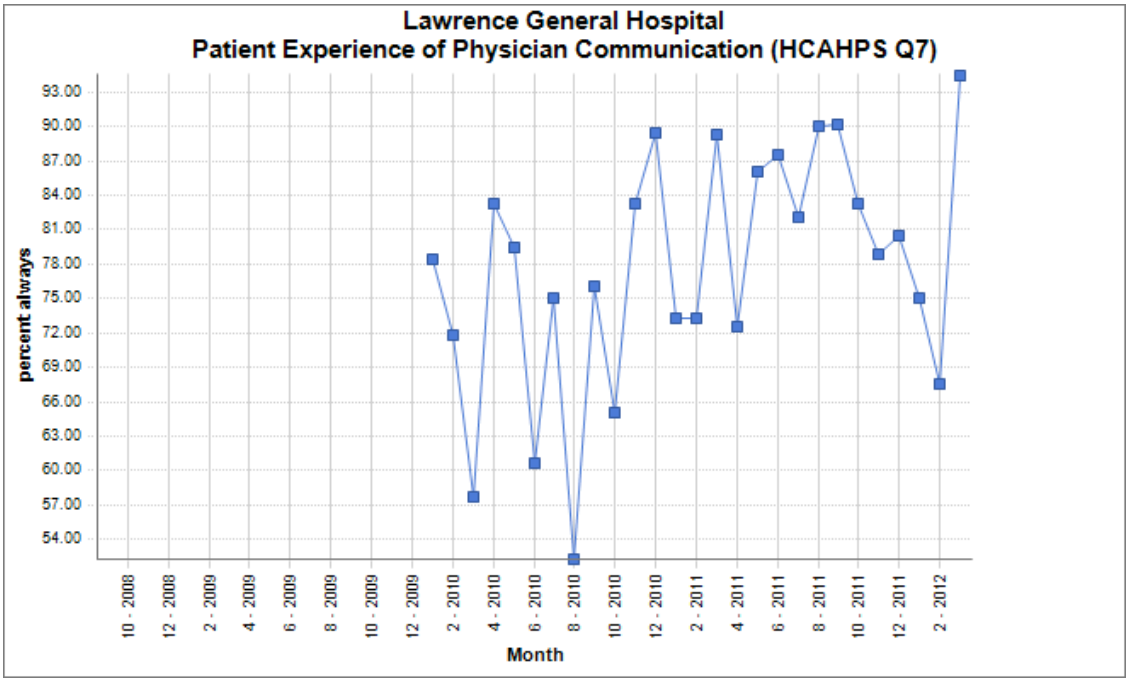
2 - 2012
Month


Lawrence General Hospital
Patient Experience of Physician Communication (HCAHPS Q7)
percent always
93.00
90.00
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4 - 2011
6 - 2011
8 - 2011
10 - 2011
12 - 2011
2 - 2012
Month

List the types of organizations represented on your Cross-Continuum Team:

- Visiting Nurses Association
- Skilled Nursing Facilities
- Long Term Acute Care Hospitals
- Acute Rehabilitation Hospitals
- Elder Service Organization
- Members of Patient Family Advisory Committee
- Patient Centered Medical Home Physicians

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- Provide Enhanced Admission Assessment for Post-Hospital Needs:
- Instituted use of tool which was a combination of all Merrimack Valley area hospital's tools, in combination with McKesson Interqual transition tool, which provides assessment to identify patient's risk for readmission- centered on evidenced based literature and research.
- Current use of transition coach from Merrimack Valley elder services through awarding of 3026 grant- providing a visit in the hospital, follow up phone calls and home visits for care coordination and navigation for patients identified as high risk for readmission
    + LICSW use tool and make referrals to the coaches who are in house
    + Weekly meetings with ASAP to discuss progress and/or issues of patients referred
    + Coaches are seen as an extension of LGH services to help high risk patients navigate in complex health care system
- Enhanced assessment interview tool created and being performed on patients that are readmitted within 30 days by RN Case Managers
- Provide Effective Teaching and Enhanced Learning
- Working with Transition coaches and outside Home Health agencies to enforce teaching and learning that was initiated within the hospital
- Institution of teach back method on Pilot unit
    + Goal is to provide educational sessions for greater than or equal to 80% of hospitalists and nursing staff on this method and institute use of method hospital wide by 2013
- Early identification of the learner upon admission- working with ED staff and floor nurses on pilot unit during admission process to identify the person best utilized to help patient upon discharge
- Instituting easy to understand teaching tools upon discharge
    + Hospitalists borrowing from BOOST strategies have instituted use of discharge forms that cater to patients and trialing it on pilot unit
- Will be in both English and Spanish
- Formulated to be understood at 4th grade level for health literacy reasons
- Plan to embed in electronic system

- Provide Real-time Patient- and Family- Centered Handoff Communication
- Current cross-continuum work with partners to establish warm handover communication between accepting agencies (SNF, Rehab, etc).
    + Pilot unit nurses and Skilled Nursing Facility nurses worked together in 1 day workshop to formulate best practice scope of work and a script.
    + Started on Pilot unit in November 2011 and now spreading throughout hospital
- Provide Post-Hospital Care Follow Up
- PCP and Specialist appointments are being made for patients prior to leaving hospital on pilot unit
    + Plan for continued work with Physician offices to identify best practice processes
    + All patients sent home with transition coach are ensured PCP follow up appointments are made and psychosocial, economic, environmental, and cultural factors that create barriers to care are addressed and managed as needed
    + Shared hospitalized patients with primary care at PCMH-Greater Lawrence Family Health Center have follow up appointments being made upon discharge
- Plan to gather baseline data on how many of these patients who are diabetics and are discharged home are referred to a certified diabetic educator
- Discharge phone calls currently being done within 24-48 hours on all patients discharged to home from pilot unit
- Enhancing communication from post-acute providers back to the hospital
- Working with care managers directly from PCMH practice to identify strategies to facilitate exchange of up-to-date clinical information related to the specified medical care plan of our shared patients. Information to be communicated will include: treatment plans and other medical interventions; disease-specific education administered; medication reconciliation; and psychosocial, economic, environmental, and cultural factors that are identified as impacting our shared patients' health.
- Weekly meetings with elder services transition coaches who provide follow up to cases that are referred to them and they provide home visits on.

Key lessons learned

- Ongoing learning and process development to optimize utilization of transition coaches
    + Invited to ongoing learning session with CMS to share best practices and learn from one another across country
    + Creation of a Merrimack Valley Collaborative Care Team was essential
    + Need for key stakeholders such as SNFs, Rehabs and VNAs to coordinate efforts and maximize results.
- Warm Handoff process improves transitions and initial results seem to indicate it decreases bounce backs to the emergency room
- Collaboration with physicians in devising discharge education tools is extremely valuable

Important tools used for these changes

- Script for warm handoffs

Massachusetts General Hospital

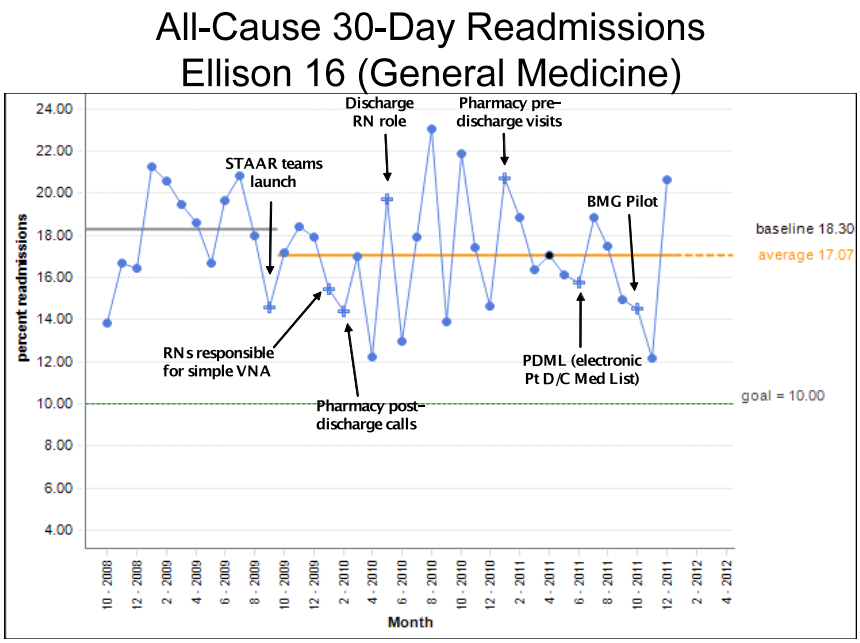
Contact Name:	Phone:	Email:
Jane Murray	617-643-6468	jmurray15@partners.org

Aim Statement:

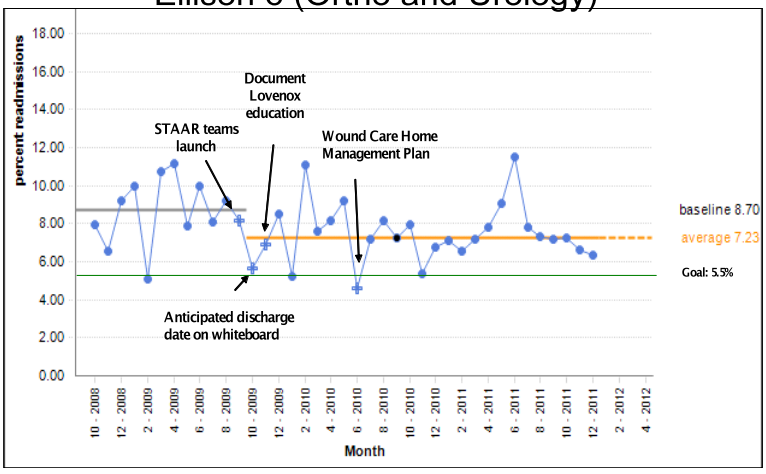
MGH will reduce 30-day all-cause readmissions for patients discharged from the three pilot units. On Ellison 16 (General Medicine) we will reduce the rate from 20% to 10%; on Ellison 6 (Ortho/Urology) we will reduce the rate from 8% to 5.5%; and on White 6 (Ortho) we will reduce the rate from 6.5% to 5.5%.

Results:

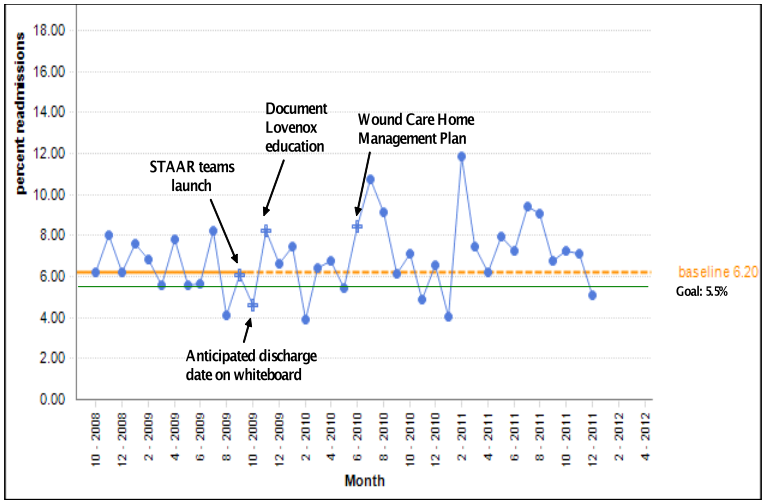
Readmission and patient experience graphs

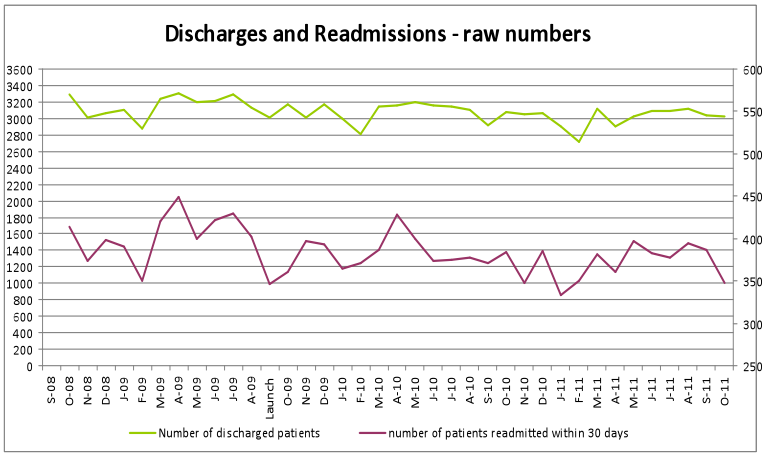


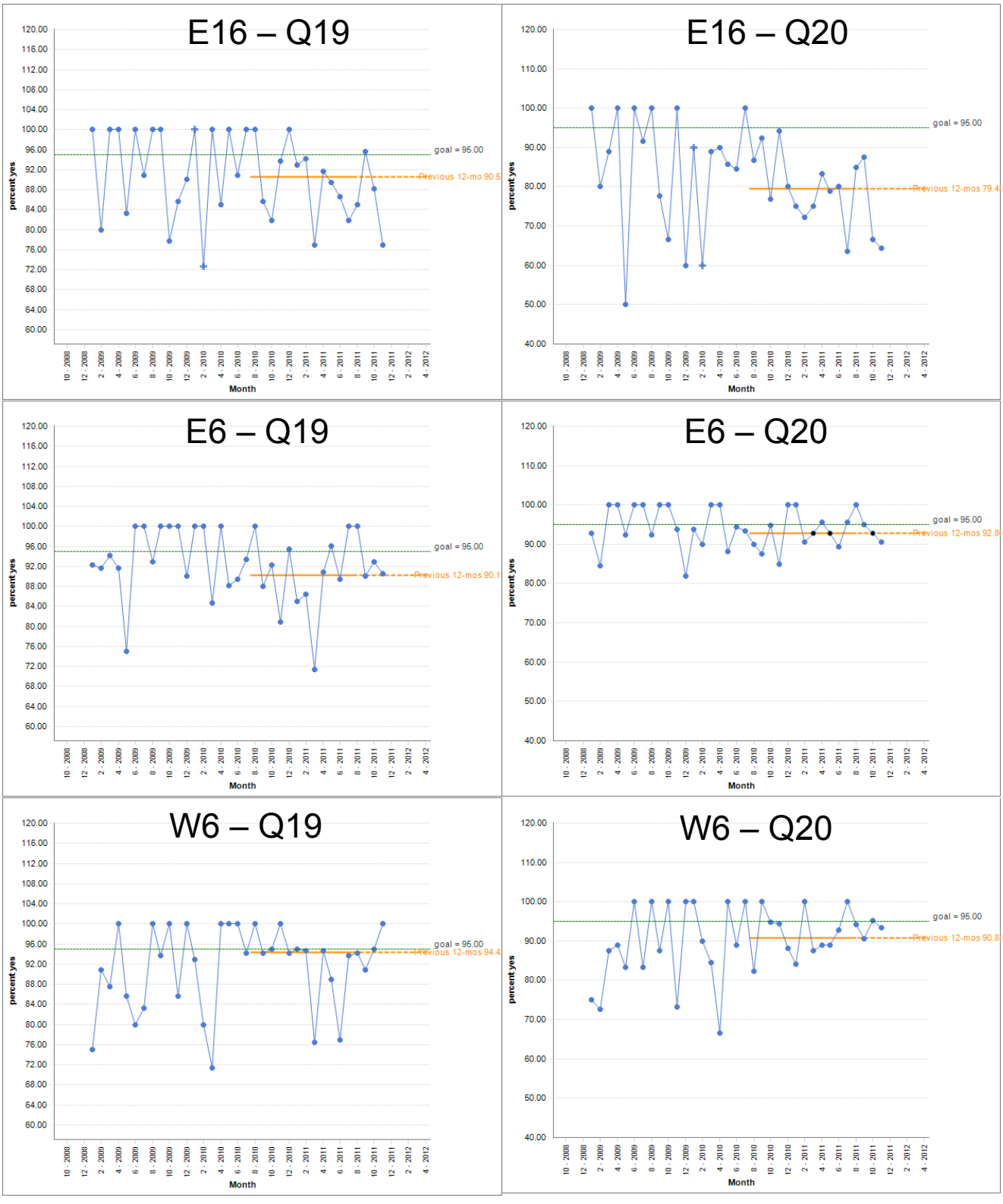
All-Cause 30-Day Readmissions
Ellison 6 (Ortho and Urology)



All-Cause 30-Day Readmissions
White 6 (Ortho)






E16 – Q19
E16 – Q20
E6 – Q19
E6 – Q20
W6 – Q19
W6 – Q20
percent yes
Month
goal = 95.00

List the types of organizations represented on your Cross-Continuum Team

- Acute care hospital (MDs, RNs, CMs, RPh, QI Specialists)
- Non-acute care facilities (Rehab and LTCAH network)
- Home care
- Office practice (primary care)
- Heart failure clinic
- CMS demo group

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- Implementing the Discharge Nurse Role (DC RN) has been an invaluable addition on our medicine pilot unit. Patients find the continuity with teaching, discharge planning, and post-hospital follow up very helpful. All of the staff (MDs, RNs and CMs) agree that the position has helped with information flow and communication on the floor. The role continues to evolve according to feedback from patients and staff to make the process as efficient and patient-friendly as possible.

- Pharmacist interventions, both pre-discharge counseling and post-discharge phone calls, have played a big part in reducing readmissions. Additionally, the pharmacist found that 52% of the patients she called post-discharge had a medication related issue.

- Multidisciplinary rounds have improved communication between RNs, MDs, CMs, PT/OT, SWs and RPhs to determine an effective care plan for patients.

- We are in the process of creating more patient friendly education materials VNA patient education sheet.

- Our Cross-Continuum team has become a forum (beyond the pilot units) to share best practices, lessons learned, and develop a hospital-wide strategy to prevent readmissions.

Key lessons learned

- Hardwiring processes takes time and commitment from staff and leadership. You must also build in measures to hold people accountable to ensure they are following the process all of the time.
- Need to link up senders and receivers to discuss the critical information. Receivers need a chance to ask questions in order to have successful hand-off communication so nothing falls through the cracks.
- Keep the patient as the focus for all readmission reduction efforts. We have found sharing a brief case study is a great way to start off our Cross-Continuum Team meetings (we borrowed this from another CC team).

Important tools used for these changes

- Wound Care Home Management Plan (patient education sheet)
- MGH post-discharge medication reconciliation program worksheet (and script)
- What to expect with VNA home care services (patient education sheet)

Merrimack Valley Hospital

Contact Name:	Phone:	Email:
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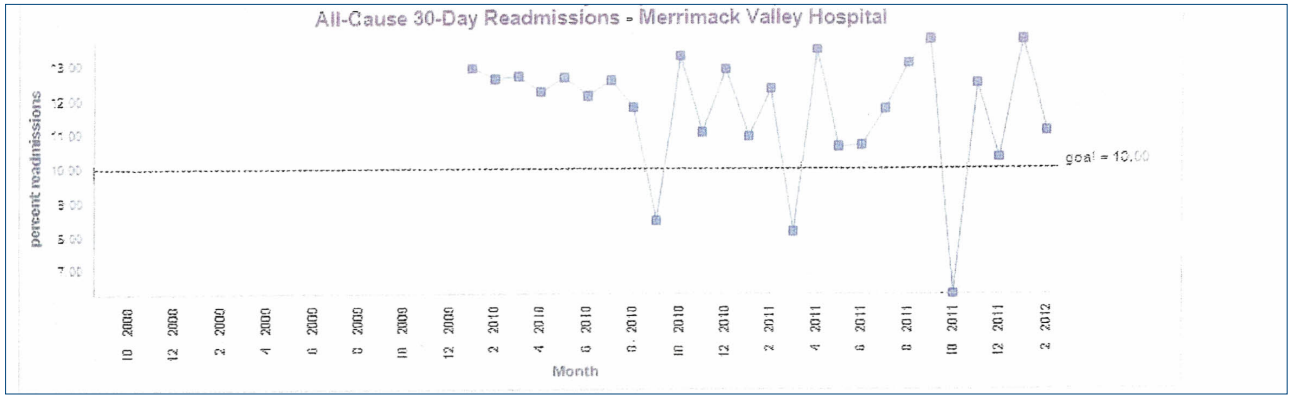
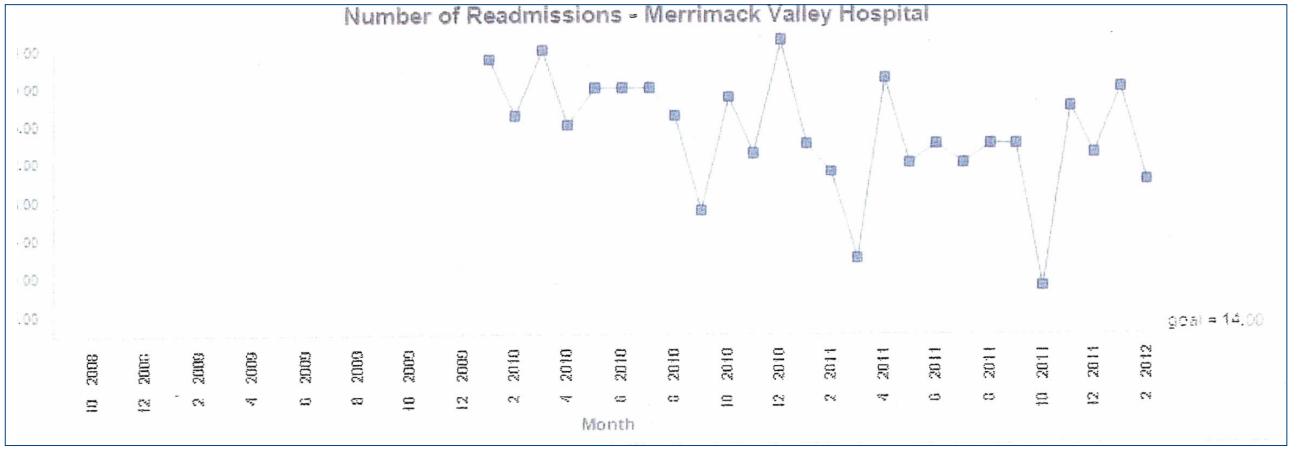
Robin McIntosh	978-521-1160	robin.Mcintosh@steward.org

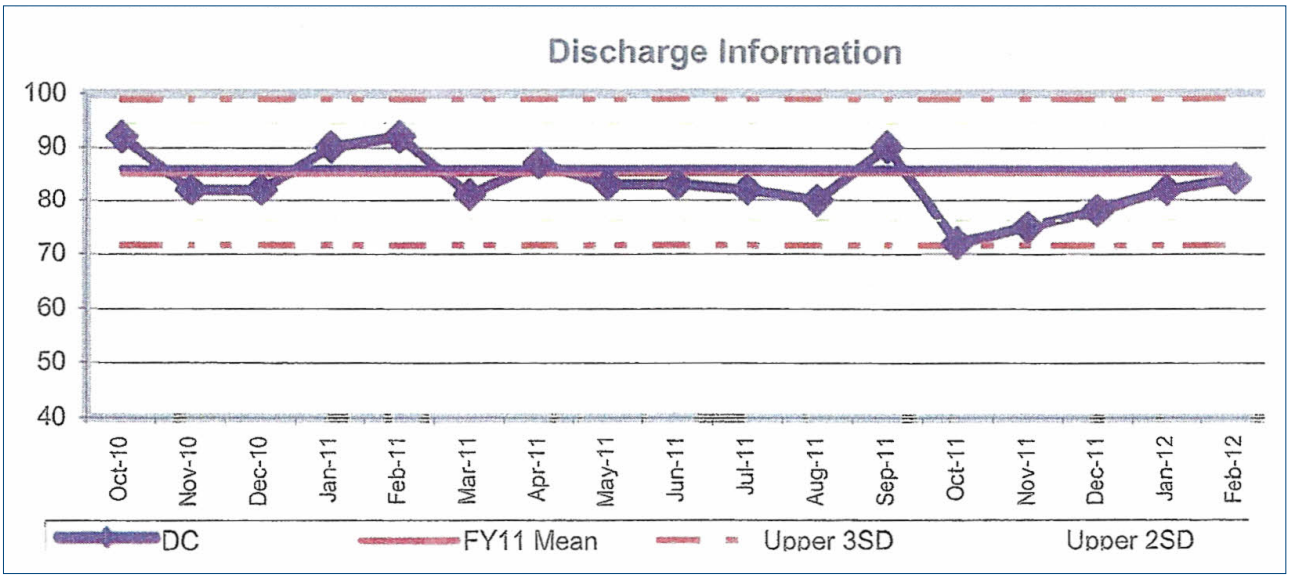
Aim Statement:

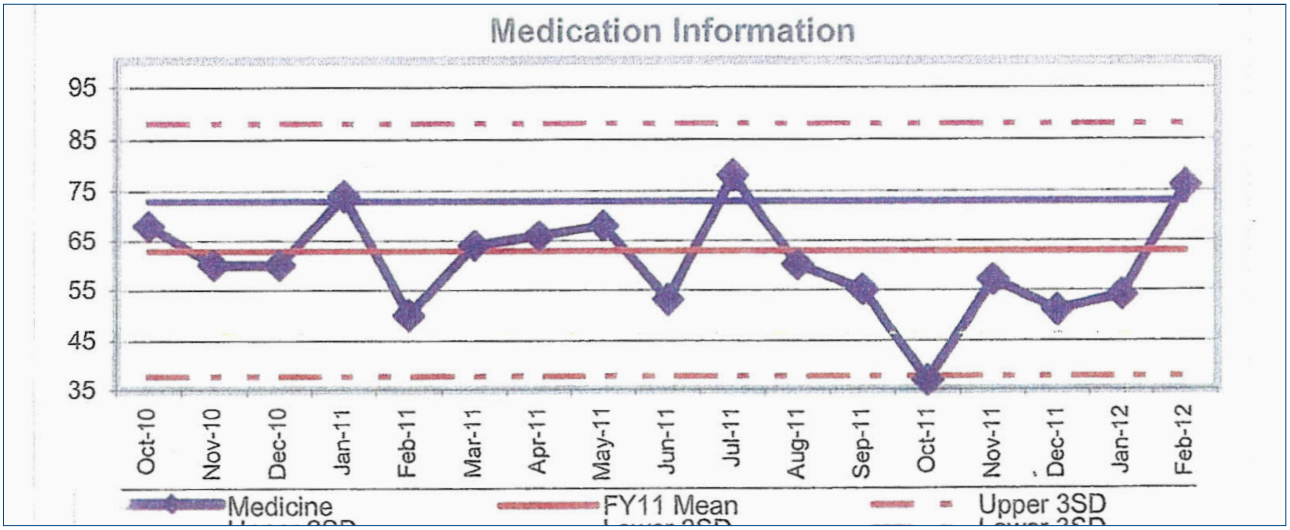
Merrimack Valley Hospital will endeavor to reduce the rate of 30-day avoidable readmissions. Processes to assist in this endeavor include engaging with our Community Partners to provide transitions that are safe and meet the continued needs of our patient populations.

Results:









List the types of organizations represented on your Cross-Continuum Team

The following organizations are part of our Cross-Continuum Team and provide Rehab services, SNF services, and Home Care services to our patients:

- Elder Services of Merrimack Valley
- Steward Home Care / Healthy Transitions
- VNA Home Health Agency
- Wingate Health Care
- Penacook Place
- Whittier Health Care
- Whittier IPA

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

Cross-Continuum Team Collaboration:

- Beginning in 2011 a Cross-Continuum Team was established between Merrimack Valley Hospital and the agencies and facilities in the community that provide care to our patients after discharge. The team is multidisciplinary with representation not only from the community, but also the hospital disciplines including: Medical Staff, Pharmacy, Nursing, Education, Quality, Case Management, and Nutritional Services. This collaborative allows for open discussion and communication in what works best for our patients, both while inpatients and after discharge.

Improved Communication through Handoffs:

- Communication tools have been developed and implemented at many levels during the patient's stay at the hospital. Improved communication tools between the members of the collaborative and the hospital, both prior to admission and after discharge, allow for a smoother transition and reduce the risk of missing important factors in their disease process and care needs.

- INTERACT document used for transfers, including the SBAR documentation methodology, to inform the next caregiver of the patient's condition and needs.

SNF Resource Guide:

- Development of a resource guide listing all of the services that the SNFs are able to provide. This resource document is now available in the Emergency Department and on the inpatient units.

Education Packets:

- Education packets for patients and families have been revised to include the necessary after discharge information the patient will need to maintain his/her health at home. Included in the packets are "Zone" sheets with color bars that alert the patients based on their symptoms when they need to either call the physician or nurse for guidance or when they need immediate intervention.

Scheduling Physicians Follow up Appointments:

- Nursing staff are calling the PCP or consulting physician to schedule the next appointment after discharge for patients that are discharged home. This assures that the patient will be seen when recommended and assures that the patient will be followed immediately.

Discharge Phone Calls:

- Phone calls to patients are made by the nursing/case management staff to assure those patients' needs are being met and that the patient is able to cope with being at home. Barriers to a successful discharge are identified and addressed immediately.

Pharmacist Education:

- Prior to discharge a pharmacist is visiting the patient and providing education on new medications. There is also a program provided by Steward Health Care that sends a pharmacist into the homes of patients receiving visiting nurse services.

Elder Services of Merrimack Valley Coaching Program:

- Based on a grant from CMS, a coach visits patients at home within 24-48 hours of discharge. The Coach reviews the discharge instructions and the medication regime with the patient and/or family. The Coach also makes sure the patient has a follow up appointment and the means to get to the appointments. A booklet is prepared and left with the patient/family addressing all of the patient's health care needs and history. This booklet is available for the patient to share with physicians and other caregivers.

A checklist is being drafted to place in the Patient Education packet as a prompt for all disciplines to include their data.

Key lessons learned

- The primary reason(s) for readmissions within 30 days is not limited to PN, CHF and MI but a number of reasons. It has been beneficial to streamline and improve our processes for all patient populations.
- Making follow up appointment with physicians' offices is difficult for late discharges and impossible to achieve during the weekends. A scheduling form is being developed to fax to the offices when they are closed requesting a follow up appointment for the patient. This process is in the draft stage.

Important tools used for these changes

- Hand off tool
- Interact / SBAR tool (hand off from SNF to acute)
- Total Revision of the Patient Admission packet to Patient Education Packet
- Pharmacy Discharge Counseling Brochure
- SNF Resource Guide

Milford Regional Medical Center

Contact Name:	Phone:	Email:
Michelle Barry	508-422-2107	mibarry@milreg.org
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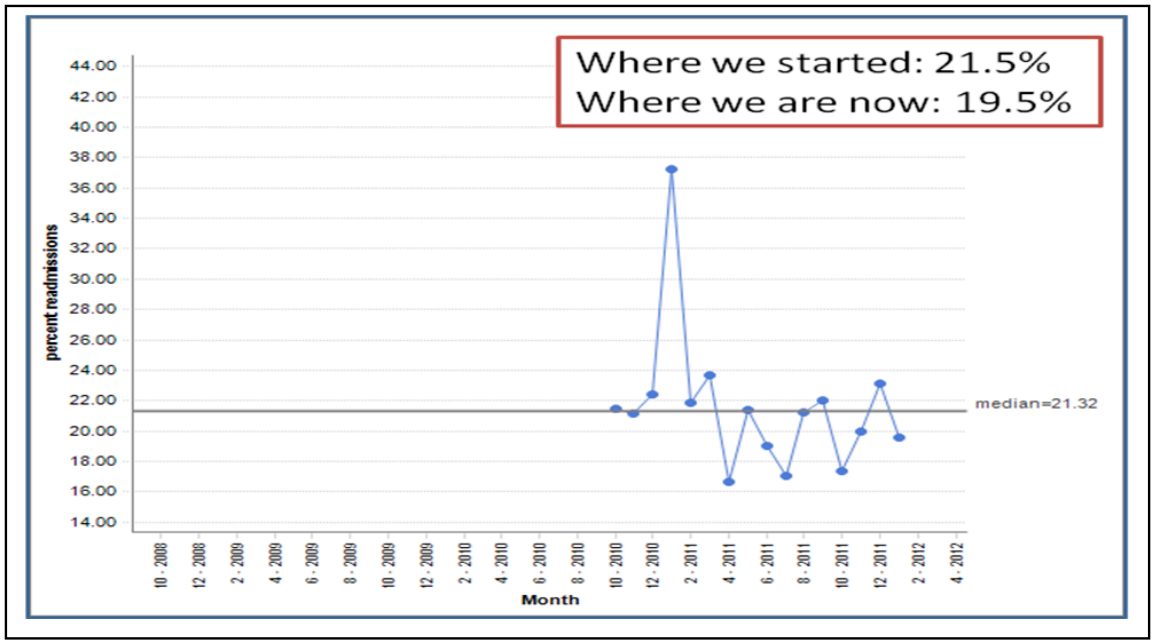
Tina Robakiewicz, MD	508-422-2305	trobakiewicz@milreg.org
Donna Saul	508-422-2302	dsaul@milreg.org

Aim Statement:

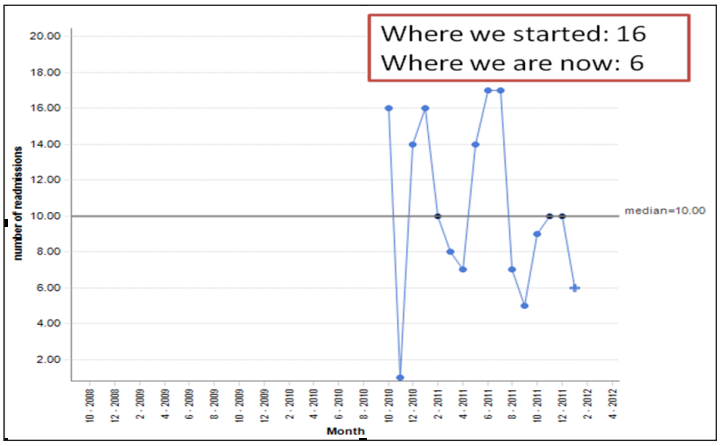
A 20% decrease in the number of patients with a diagnosis of heart failure that are readmitted to Gannett and 2-Tele within 30 days of discharge.

Results:

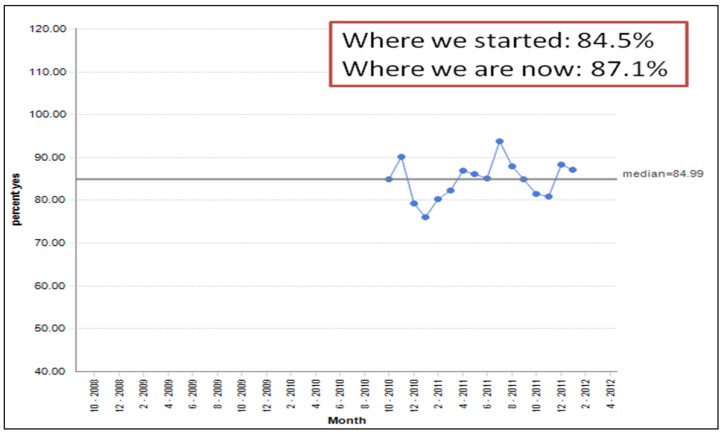
30 Day All Cause Readmission



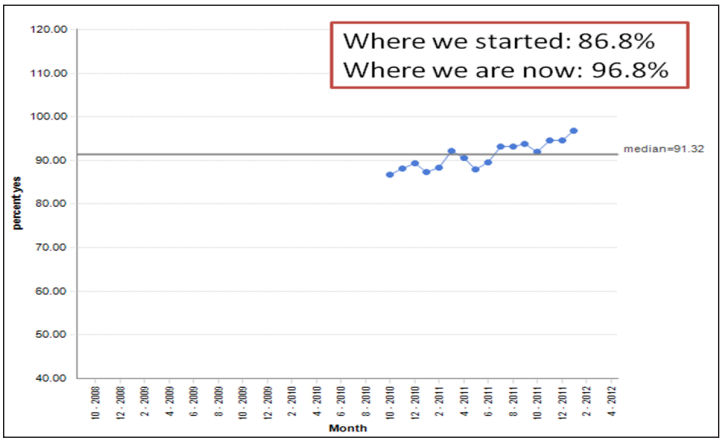
Number of Heart Failure Readmissions



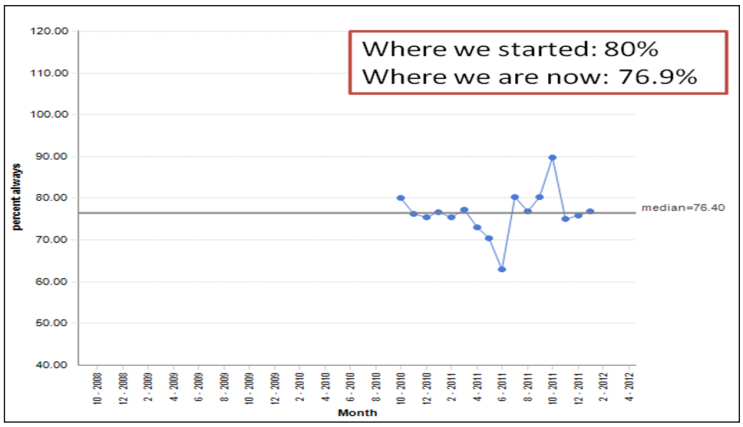
Patient Experience of Discharge Planning



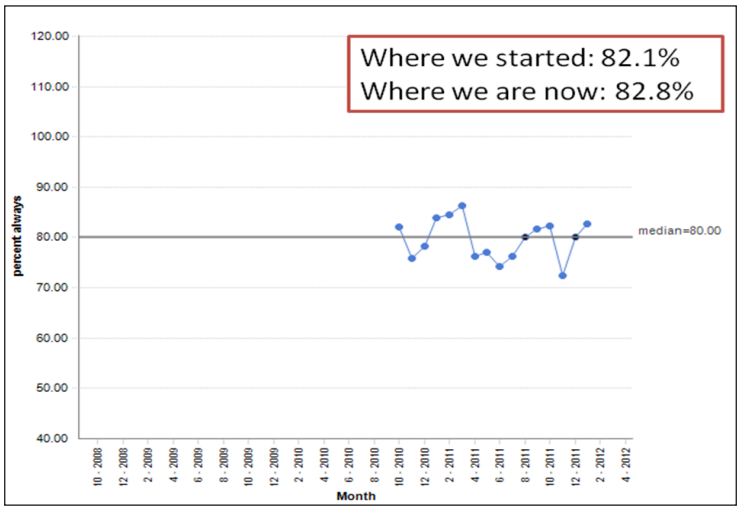
Patient Experience — Information in Writing



Patient Experience — MD Communication



Patient Experience — RN Communication



List the types of organizations represented on your Cross-Continuum Team

- Skilled Nursing Facility
- VNA
- Aging Service Access Points
- Long Term Care
- Private Home Care
- Patient Family Advisory Council
- Assisted Living
- Milford Regional Medical Center Staff
- Senior Centers

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- Care Partners to whom we can speak and who are easily accessible
- High Risk Assessment
- Discharge faxes on CHF and dialysis patients

Key lessons learned

- Applying our efforts across the continuum from the pre-admission process through discharge and beyond to provide what is best for patient and family
- Success in applying our efforts across the continuum with focus on the patient
- Revising teachback tool for ease of portability to follow the patient and be more user friendly
- Determine where communication breakdowns are
- Care Partners give us another contact person to help with planning
- Incorporating documents into electronic record improves access to all staff
- Streamlining and portable format for teachback tool for ease of implementation and ensures consistency across settings

Important tools used for these changes

- LACE
- Teachback
- Care Partner Brochure
- Community Resource Guide and Check List
- 5 Steps to Wellness

Newton-Wellesley Hospital

Contact Name:	Phone:	Email:
Bert Thurlo-Walsh	617-243-6341	bthurlo@partners.org

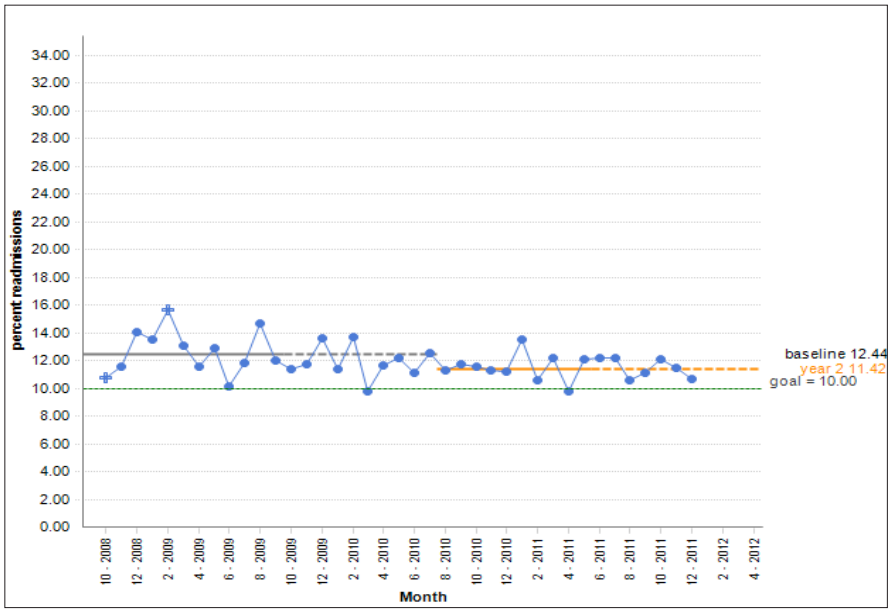
Aim Statement:

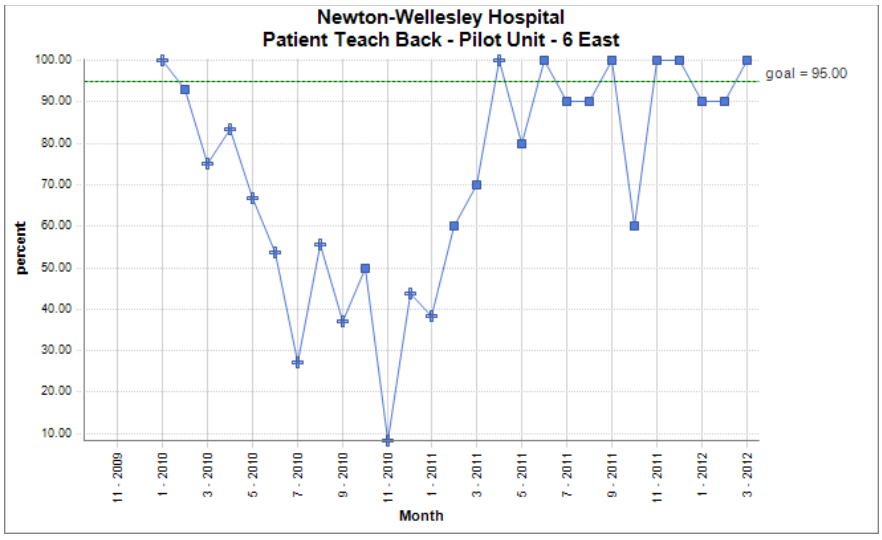
Newton-Wellesley Hospital will:

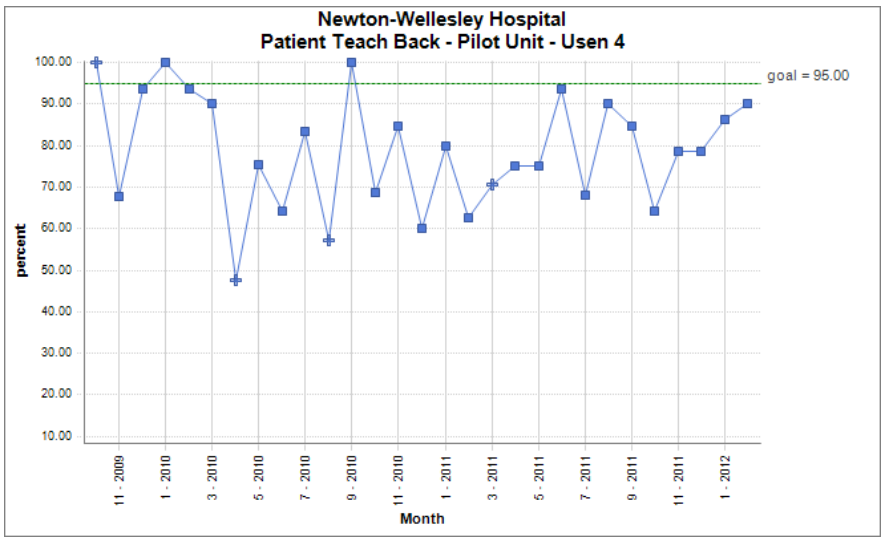
- Decrease 30-day All-Cause Readmissions by 10%
- Reduce 30-day readmissions of patients with knee replacements from 9 percent to 7 percent or less
- Reduce 30-day readmissions of patients with heart failure from 18 percent to 14 percent or less

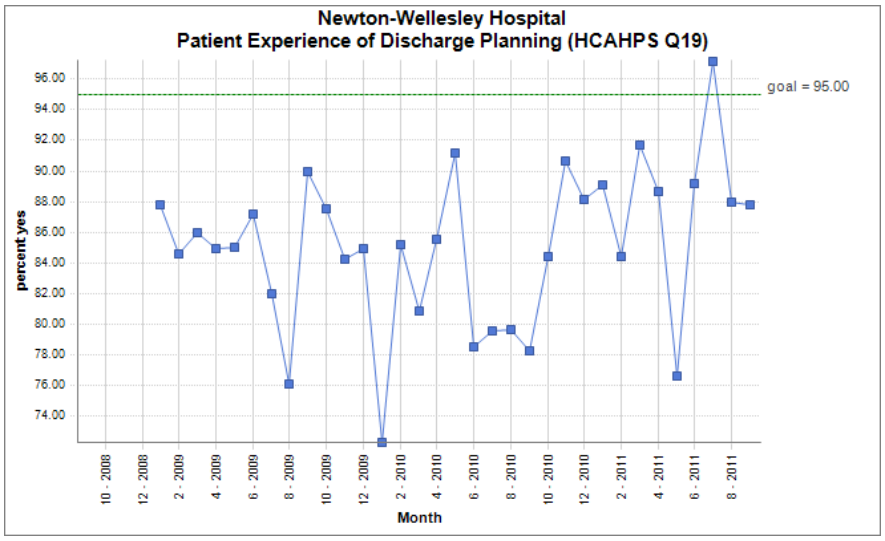
Results:

NWH All-Cause Readmission Rate, October 2009 – December 2011




Newton-Wellesley Hospital
Patient Teach Back - Pilot Unit - 6 East
goal = 95.00
percent
Month


Newton-Wellesley Hospital
Patient Teach Back - Pilot Unit - Usen 4
goal = 95.00
percent
Month


Newton-Wellesley Hospital
Patient Experience of Discharge Planning (HCAHPS Q19)
goal = 95.00
percent yes
Month

List the types of organizations represented on your Cross-Continuum Team

- Community Elder Service Agency
- Heart Failure Clinic
- Home Care
- Office Practice – Cardiology, Medicine
- Palliative Care
- Patient/Family
- SNF/Rehab

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- Spread teach back to all medical and surgical inpatient units
- Consistent discharge phone calls with targeted questions
- Readmissions reviewed at Surgical M&M conference
- Follow up appointments prior to discharge – Acute MI, Heart Failure, Pneumonia
- Partners Health Care at Home Heart Failure Program
- Cardiology- increased access for post-acute appointments
- Staff education re: readmissions in multiple forums
- Addition of complex case manager
- Identification of care plan partner – nursing assessment, patient education, and patient handbook
- Transition Coach program with Elder Services partner (Springwell)

Key lessons learned

- Staff engagement/buy in
- Staff STAAR Champions
- Consistent team meetings/huddles
- Patient/family feedback and participation
- Sharing patient stories at all transitions of care
- Many complex and multivariable transitions of care
- TEST, TEST, TEST

Important tools used for these changes

- Teach back – Medical and Surgery
- Discharge phone call script

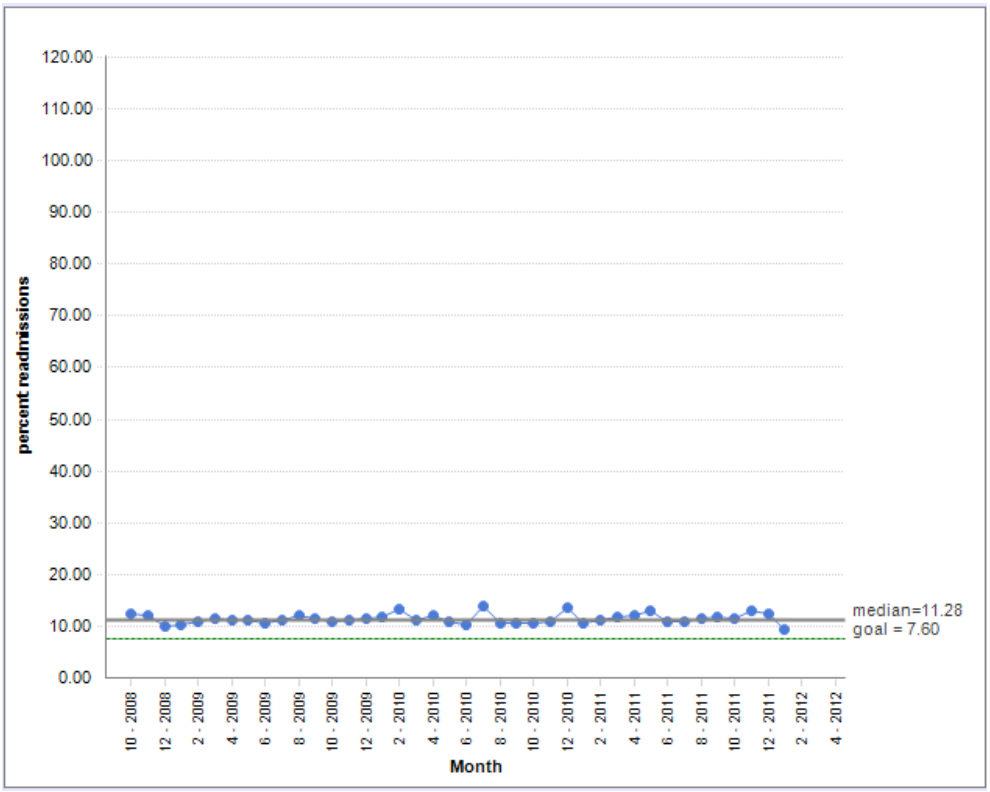
Northeast Health System

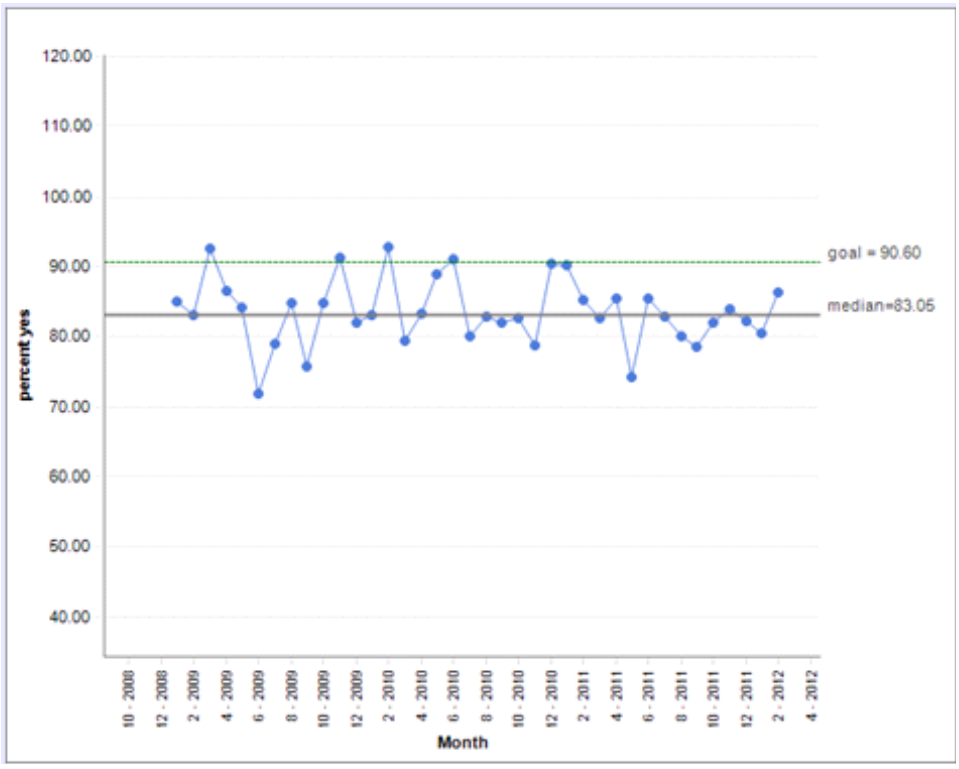
Contact Name:	Phone:	Email:
Cheryl Merrill RN	978-922-3000 x 2243	cmerrill@nhs-healthlink.org

Aim Statement:

Northeast Health System 2012 Corporate Goal:
Improve care transition to and from the hospital as measured by reduced 30-day all cause readmission rate by 2 percent.

NHC 30-day all cause readmissions





List the types of organizations represented on your Cross-Continuum Team

- Acute care
- Physician office practice
- Home health
- Skilled nursing
- ASAPs
- Primary care provider
- Hospitalist Program

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

We have created a "HRRT Team" (High Risk Readmission Team) to pilot some interventions with patients who meet specific criteria for risk of readmission (polypharmacy, progressive chronic condition, comorbidities) who are identified during daily 10 am rounds on our pilot unit. Once the patient is identified, an interdisciplinary team meets to provide input in the patient's care. Pharmacy input has been critical in identifying medications that have side effects and medications that should be added.

We have piloted a "discharge advocate role" on our pilot unit. We started the pilot with our targeted population, Congestive Heart Failure, but now are spreading to all patients who meet the HRRT Criteria. The discharge advocate started interviewing patients who were going to be discharged. Her findings included many patients had overestimated their ability to function independently at home. In addition, she found many unrecognized/untreated depression issues. Now she is utilizing a discharge tool adapted from several sources. She has begun to contact selected patients post discharge. As part of the HRRT Team she attends the HRRT huddles and the 10 am daily rounds.

- We are moving from a disease management approach to a more holistic approach to prevent readmissions.
- The PHO, as a member of our team, has had focus groups to provide input on patient education. They are now using the "zones" approach in teaching their patients.
- The VNAs are also using "zones" tools.
- The non- acute providers are using the INTERACT 11 tool for communication between the non-acute and acute care providers.
- We have identified that some readmissions could be prevented if we addressed the end of life issues ideally in the outpatient setting, but otherwise before discharge.

Key lessons learned

- Developing the insight to partner with patients on an individual basis to help them stay at home. Because we don't have infrastructures to provide this intense one-to-one navigation we need to find creative ways to meet the need for a navigator role.
- The impact of the polypharmacy issue and the need to have the pharmacist involved in the process.
- The understanding that there are a lot of efforts being made by many providers. The education and interventions need to be consistent so that patients are not confused.
- The importance of not overlooking the possible cognitive and emotional contributors to the patients overall condition.
- We need to have a patient centered cross-continuum approach to identify what the patient needs and where the patient needs to go to meet those needs to stream line effective care.

Important tools used for these changes

- High Risk Readmission Criteria
- Discharge checklist
- Mini cognitive assessment
- Depression screening tool

Northshore Medical Center

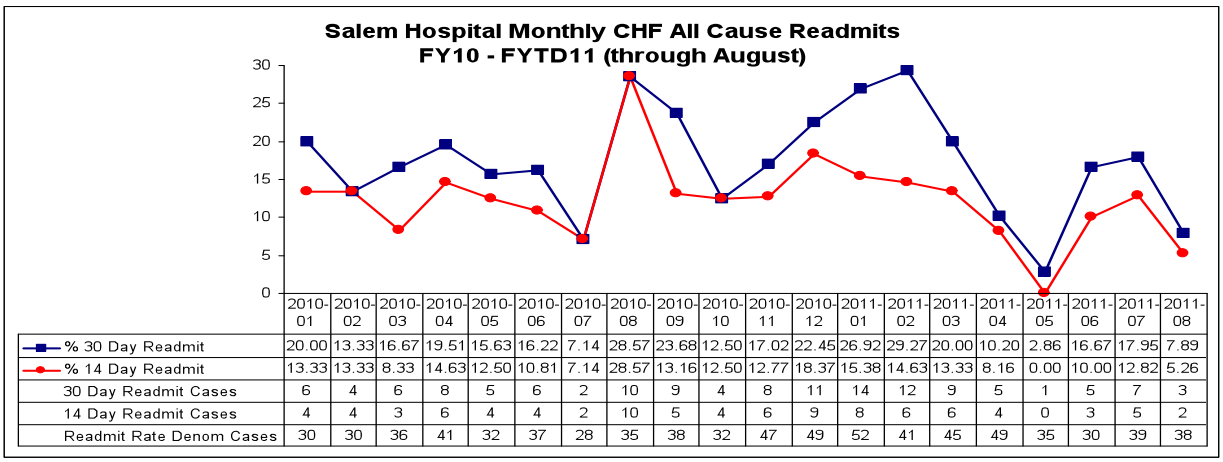
Contact Name:	Phone:	Email:
Lee Ann Baldini Janet Groth	978-825-6583 617-449-8748	lbaldini@partners.org jgroth@partners.org

Aim Statement:

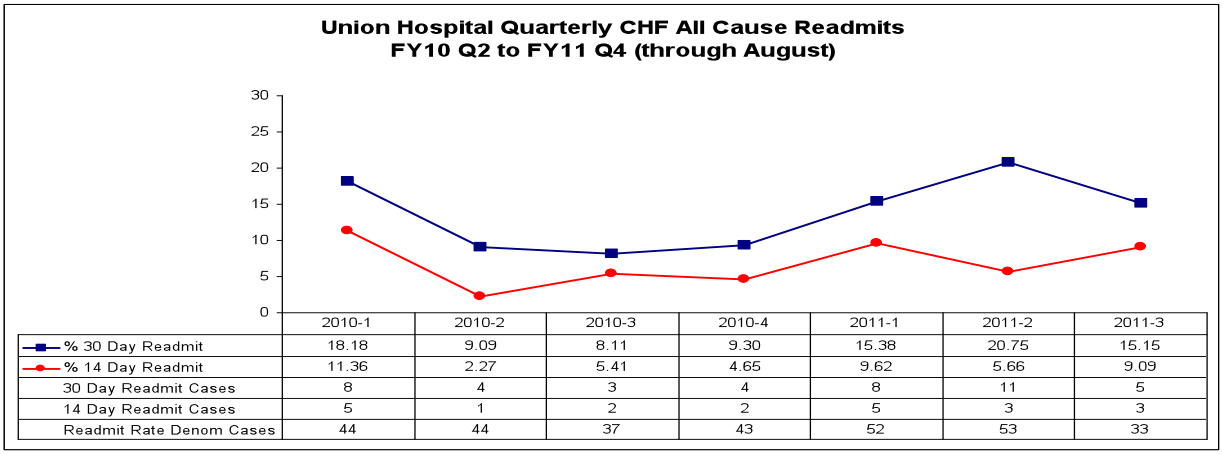
- By December 2011, NSMC will implement process improvements to reduce readmissions for CHF readmissions from 22.5% to 19%
- There will be no negative impact in patient experience scores
- NSMC will develop a community based transition team with focus on improved handoff and connection back to PCP

Results:

STAAR pilot on Salem campus – Union campus pilot started in January 2012



	2010-01	2010-02	2010-03	2010-04	2010-05	2010-06	2010-07	2010-08	2010-09	2010-10	2010-11	2010-12	2011-01	2011-02	2011-03	2011-04	2011-05	2011-06	2011-07	2011-08
% 30 Day Readmit	20.00	13.33	16.67	19.51	15.63	16.22	7.14	28.57	23.68	12.50	17.02	22.45	26.92	29.27	20.00	10.20	2.86	16.67	17.95	7.89
% 14 Day Readmit	13.33	13.33	8.33	14.63	12.50	10.81	7.14	28.57	13.16	12.50	12.77	18.37	15.38	14.63	13.33	8.16	0.00	10.00	12.82	5.26
30 Day Readmit Cases	6	4	6	8	5	6	2	10	9	4	8	11	14	12	9	5	1	5	7	3
14 Day Readmit Cases	4	4	3	6	4	4	2	10	5	4	6	9	8	6	6	4	0	3	5	2
Readmit Rate Denom Cases	30	30	36	41	32	37	28	35	38	32	47	49	52	41	45	49	35	30	39	38



	2010-1	2010-2	2010-3	2010-4	2011-1	2011-2	2011-3
% 30 Day Readmit	18.18	9.09	8.11	9.30	15.38	20.75	15.15
% 14 Day Readmit	11.36	2.27	5.41	4.65	9.62	5.66	9.09
30 Day Readmit Cases	8	4	3	4	8	11	5
14 Day Readmit Cases	5	1	2	2	5	3	3
Readmit Rate Denom Cases	44	44	37	43	52	53	33

List the types of organizations represented on your Cross-Continuum Team

- SNF
- Rehab
- Home Care
- ASAP
- PCP office
- CMS demo Case Managers

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- Transition team focus on education- CHF updates / new trends (ACO) / handoffs
- Pilot of enhanced risk assessment - establishment of CHF discharge checklist- currently being proposed for practice in an innovation unit on Salem campus
- Medication reconciliation on admission and discharge for CHF patients on Salem and Union campuses
- Follow up appointments for CHF patients within 7 days when discharging from hospital- request for SNF to establish the same protocol
- New pilot for SNF follow up with Janet Groth as the contact:The SNF connects to the PCP for a 7-14 day follow up appointment prior to the patient's discharge from SNF; NP then sends a clinical message with update to the PCP office who then pulls the discharge summary for review. After discharge, there is a 48 hour follow up phone call made by the Care Manager in the office. The LMR is updated and medication list is reviewed.

Key lessons learned

- The right staff needs to be involved. The discharge checklist initial trial failed as it did not fit staff workflow
- The Transition team had to be revamped as initial makeup was focused on marketing roles
- Find a forum to keep senior administration aware of projects

Important tools used for these changes

- CHF discharge instructions
- Enhanced Risk Assessment Version 4 (still in progress)

Norwood Hospital

Contact Name:	Phone:	Email:
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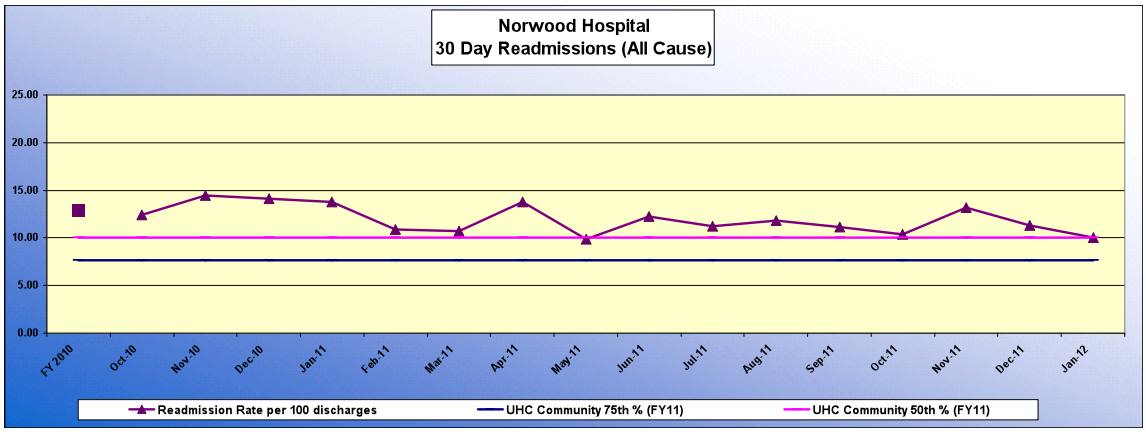
Aim Statement:

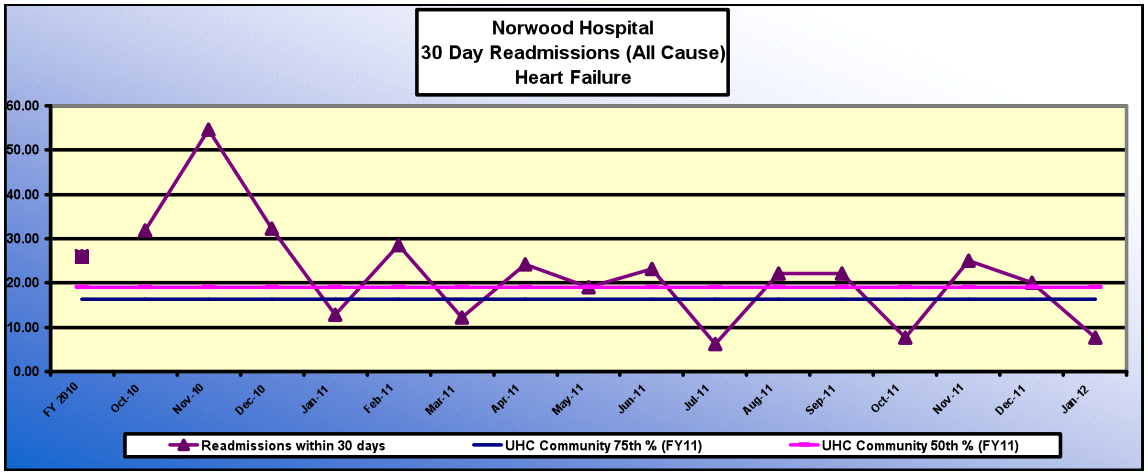
From March 2011

- Over the next 12 months, Norwood Hospital will reduce all cause unplanned 30-day readmissions from 13.4% to 12.2%.

- Over the next 12 months, Norwood Hospital will reduce unplanned 30-day readmissions of patients with heart failure from 26.3% to 21%.

Results:





		Actual Rates by FY		
	FY 2009	FY 2010	FY 2011	FY 2012
All Cause	12.8	13.0	12.2	11.3
HF	26.3	26.0	24.0	17.1

List the types of organizations represented on your Cross-Continuum Team

VNA, Skilled Nursing Facilities, Steward Physician Network Services, HESSCO Elder Services

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- Enhanced readmission assessments for patients returning in 30 days
- Improved teach back education and planned rollout for teach back education throughout the hospital
- Dedicated a team of hospitalists to work with Heart Failure patients
- Warm handoff on transfer out of facility- completed transfer sheet and number to call with questions
- Re-education of staff re: Intake and output information and weights
- Follow-up appointments made prior to discharge
- Zone trigger tools (signs and symptoms triggers) and education to patients
- Addition of "Steward Healthy Transitions" program, which brings a pharmacist to the patient's home following discharge to assist the patient in understanding and managing his/her medications

Key lessons learned

- Patients do not retain much of the information that is taught
- Reinforcement of information is needed to maximize retention
- Not all patients are capable for assuming responsibility for their healthcare therefore we must maximize teaching and include family and significant others

Important tools used for these changes

- Enhanced Assessment Form
- Zone Trigger Tools

Saint Anne's Hospital

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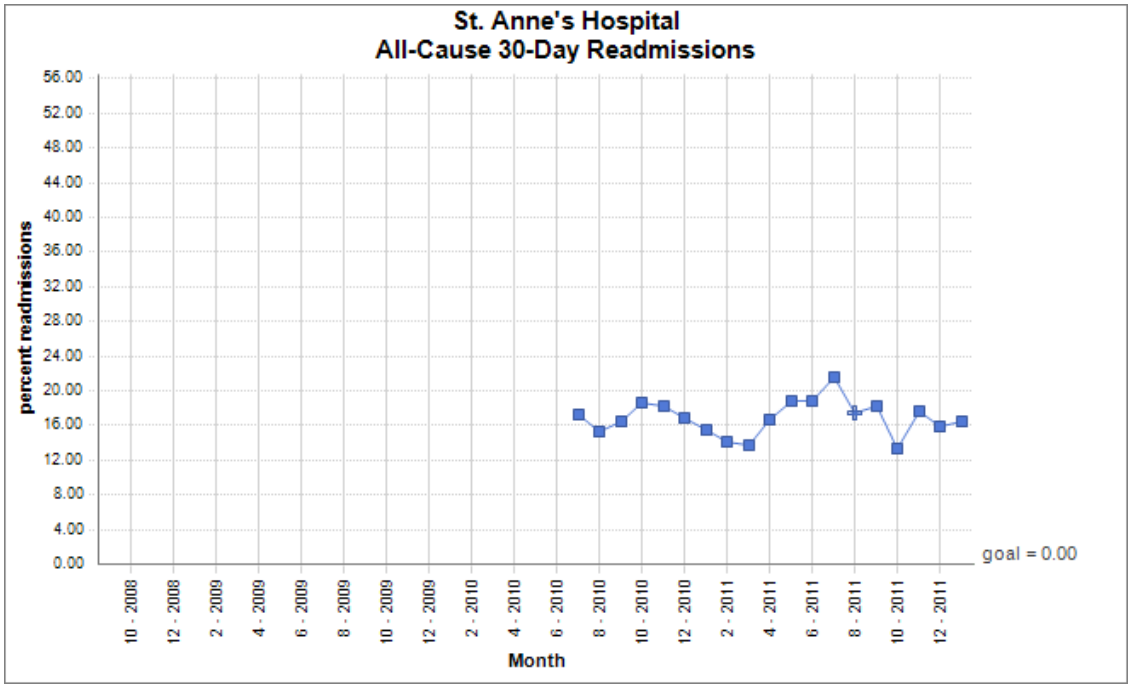
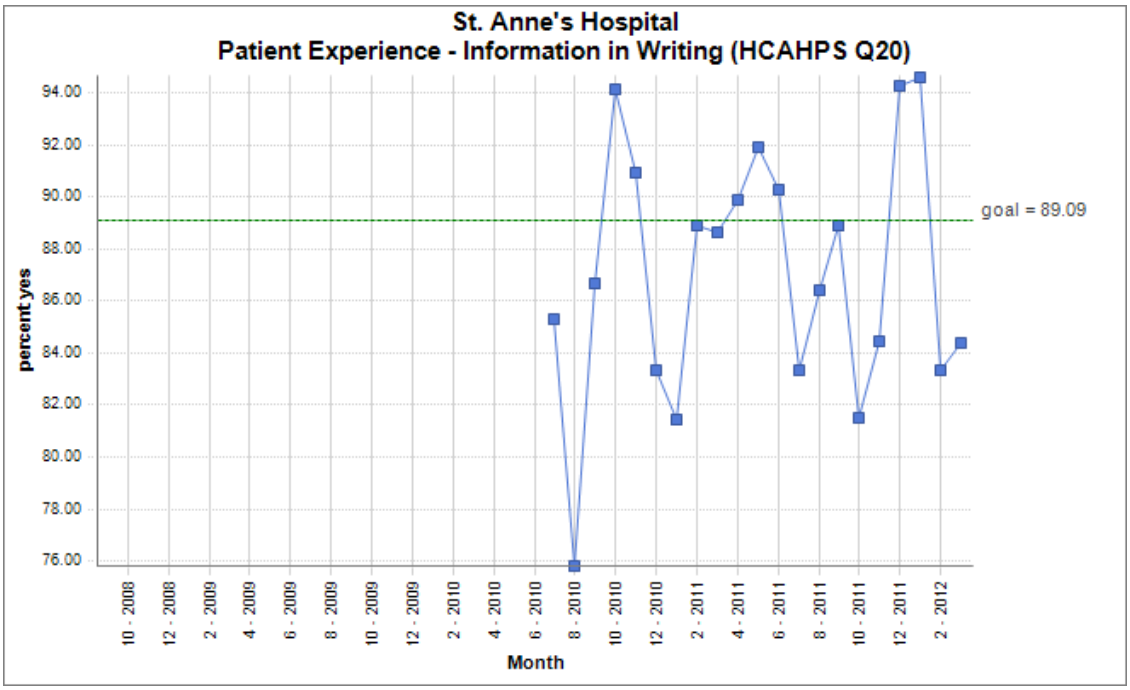
Aim Statement:

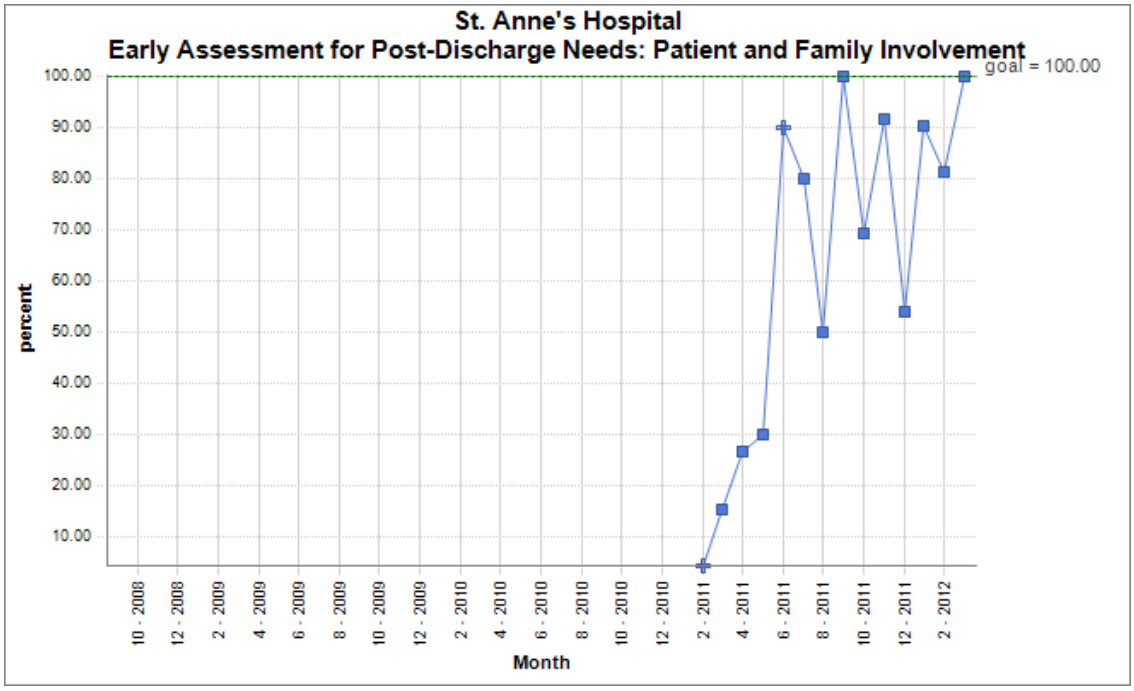
To improve transitions home for all patients by improving assessment of discharge needs, patient/family education, post-acute follow-up, and verbal handovers to community providers. The primary vehicle for achieving our aim will be through education of direct care providers and re-structuring Multidisciplinary Rounds.

TARGET: Decrease 30-day all-cause readmissions from Skilled Nursing Facilities for Heart Failure from 15.69% to 13.69% by December 2012.

Results:




St. Anne's Hospital
Patient Experience - Information in Writing (HCAHPS Q20)
94.00
92.00
90.00
88.00
86.00
84.00
82.00
80.00
78.00
76.00
percent yes
goal = 89.09
10 - 2008
12 - 2008
2 - 2009
4 - 2009
6 - 2009
8 - 2009
10 - 2009
12 - 2009
2 - 2010
4 - 2010
6 - 2010
8 - 2010
10 - 2010
12 - 2010
2 - 2011
4 - 2011
6 - 2011
8 - 2011
10 - 2011
12 - 2011
2 - 2012
Month


St. Anne's Hospital
Early Assessment for Post-Discharge Needs: Patient and Family Involvement
100.00
90.00
80.00
70.00
60.00
50.00
40.00
30.00
20.00
10.00
percent
goal = 100.00
10 - 2008
12 - 2008
2 - 2009
4 - 2009
6 - 2009
8 - 2009
10 - 2009
12 - 2009
2 - 2010
4 - 2010
6 - 2010
8 - 2010
10 - 2010
12 - 2010
2 - 2011
4 - 2011
6 - 2011
8 - 2011
10 - 2011
12 - 2011
2 - 2012
Month

List the types of organizations represented on your Cross-Continuum Team

Community Organizations: Elder Services, Skilled Nursing facilities, Home Care, Community Support (Patient and Family Advisory Committee), Assisted Living facilities, Rehabilitation facility

Other Members: Patient Care Coordinator for physician practice, inpatient and outpatient Directors and Clinical Leaders, Vice President of Community Relations, Patient Representative, Vice President of Medical Affairs, Emergency Department Case Manager, Director of Hospice and Palliative Care, Health Promotion Advocate Emergency Department Chief, Supervisor of Clinical Social Work, Pharmacist

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

The Pilot Team has been very successful in implementing many of the key elements for decreasing readmissions:

Scheduling Appointments:
We changed the process for scheduling follow-up appointments from day of discharge to starting the process on day of admission due to barriers identified with weekend and after hour discharges, e.g.:

- Not timely: Physician offices returned calls after the patient left the hospital
- Not Convenient: As patient was not present, often the scheduled appointment did not meet the patient's/family's needs and availability
- Labor-Intensive: Staff must make multiple phone calls to the physician office and patient/family

Telemonitoring Patients:
Heart Failure patients are identified daily by the Clinical Documentation Specialist and disseminated to the case managers. The case managers then address the need for VNA and telemonitoring services at Multidisciplinary Rounds and schedules as appropriate.

We identified a knowledge deficit with inpatient nurses in regards to services available at discharge, for example: they were not aware telemonitoring services were available. Steward VNA did a presentation on telemonitoring at the Nurse Practice Council in February, which resulted in increased requests for Telemonitoring. Steward Hospice and Palliative Care and VNA have acquired additional units to meet increased demand. There are plans for additional unit-level education.

Medical Record Review:
The Pilot Team selects (1) medical record of a readmitted patient and analyzes all causes for discharge "failure" and reason for readmission. We identified breakdowns in communication of discharge goals and realistic expectations with patient/family/caregiver. A common trend was the patient/family/caregiver not recognizing and agreeing to need for home care services, hospice, or palliative care at time of discharge.

Family Meetings:
The ICU implemented physician led multidisciplinary family meetings that focus on the discharge plan (from ICU and to the next level of care). The meetings are scheduled at identified intervals of ICU stay.

Hand off Communication:
One-way communication from hospital to next level of care is occurring, but the inpatient units are not receiving communication directly from the admission source. The direct communication is occurring only to the ED providers. The ED nursing staff document pre-hospital information, but that is not being shared with inpatient providers.There are plans to include verbal communication from Admission source to nursing unit.

Verbal nurse to nurse reports have spread to include all Visiting Nurse Organizations on discharge.
A database has been created for nurse access to telephone numbers for verbal hand off on discharge.

Post-acute Collaborative Team: (PACT)
In September 2011 we implemented a team comprised of the Vice President of Patient Care Services, Vice President of Medical Affairs, Director of Case Management, Nursing Directors, clinicians and Licensed Independent Practitioners from Skilled Nursing Facilities, acute care, and home care. The team performs monthly clinical reviews on all 30-day readmissions from skilled nursing facilities. Opportunities for improvement are reviewed during index hospital admission, skilled nursing facility admission and discharge, and hospital readmission.

Discharge Checklist:
We created and implemented a comprehensive Discharge Checklist in November 2011.
Completion is confirmed by (2) nurses.

Multidisciplinary Rounds Checklist:
We developed and implemented this checklist in January 2012 that is partially effective. The checklist is specifically focused on readmission and information documented on enhanced nursing assessment.
The team is restructuring and refining the format of Multidisciplinary Rounds.

Observation of Admission/Discharge Process:
The Home Care nurse observed the discharge process for a patient at risk for readmission, and the inpatient nurse observed the Home Care admission process. Both nurses reported findings which resulted in an improved understanding of the complexities of both processes, e.g.: medication reconciliation which can take up to (3) days to complete in the home care setting.

Key Lessons Learned

- Creating and coordinating a successful discharge plan requires excellent communication at all levels – patient/family/caregiver, physician, nurse, case manager, home care, and Skilled Nursing Facilities.
- The direct care providers require user-friendly tools and processes to develop a comprehensive, successful discharge plan.
- All changes must be meaningful to direct care providers (demonstrate added value) or compliance will not be consistent.

- Changes must be monitored and direct care providers must receive timely feedback (positive and negative).
- Teach Back is difficult and cannot be viewed as a task that can be checked off. Feedback from peers is much more effective than from direct supervisor.

Important tools used for these changes

- Discharge Checklist
- Multidisciplinary Rounds Checklist

Work Plan for Next 3 Months

- Re-energize and re-focus team:
- Provide basic Total Quality Management education for team members: roles and responsibilities
- Total Quality Management tools, principles, data collection, etc.
- Focused PDSA cycles
- Refine work plan to include specific goals, action steps, responsibility, and timelines.
- Re-structure Multidisciplinary Rounds
    + Include Licensed Independent Practitioners and patient/family/caregiver when possible
    + Integrate IHI Categories for Patients at Risk for Hospitalization
    + Integrate IHI guidelines for Post-Acute Care Follow-up
    + Integrate some of BOOST 8Ps, e.g., problem medications, polypharmacy, health literacy, prior hospitalization
    + Educate Hospitalists, nurses, case managers to above

Saints Medical Center

Contact Name:	Phone:	Email:
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Deborah McCrady	978-458-1411 x4080	dmccrady@saintsmed.org

Aim Statement:

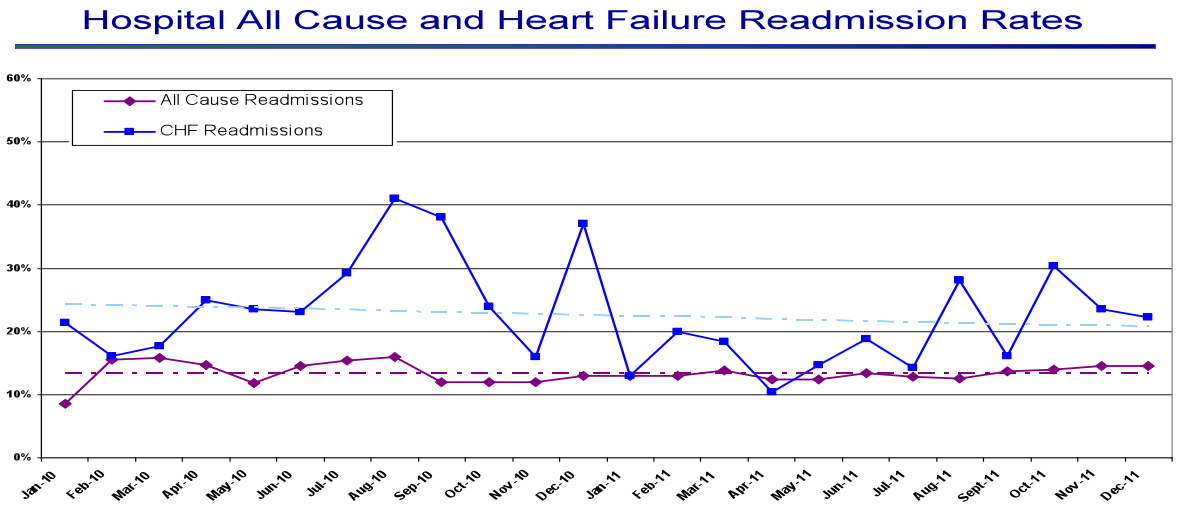
Reduce preventable all cause 30-day hospital readmissions by 20% by 2013.

We will focus on:

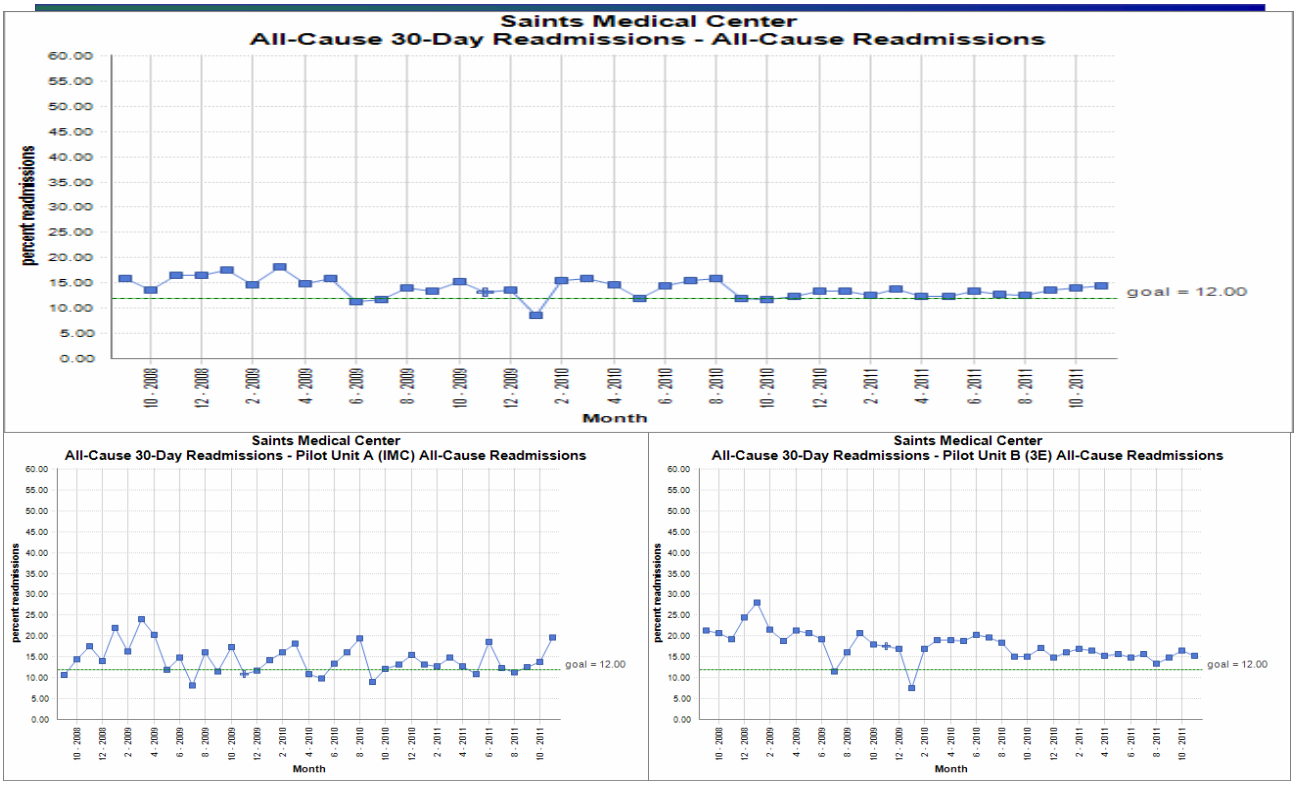
- Improving communication and care coordination at discharge
- Improving medication reconciliation to ensure patient safety
- Enhancing patients' ability to manage their chronic conditions
- Ensuring timely follow-up care
- Integrating Transition Coaching for high risk for readmission Medicare patients

Results:

Outcome Measures

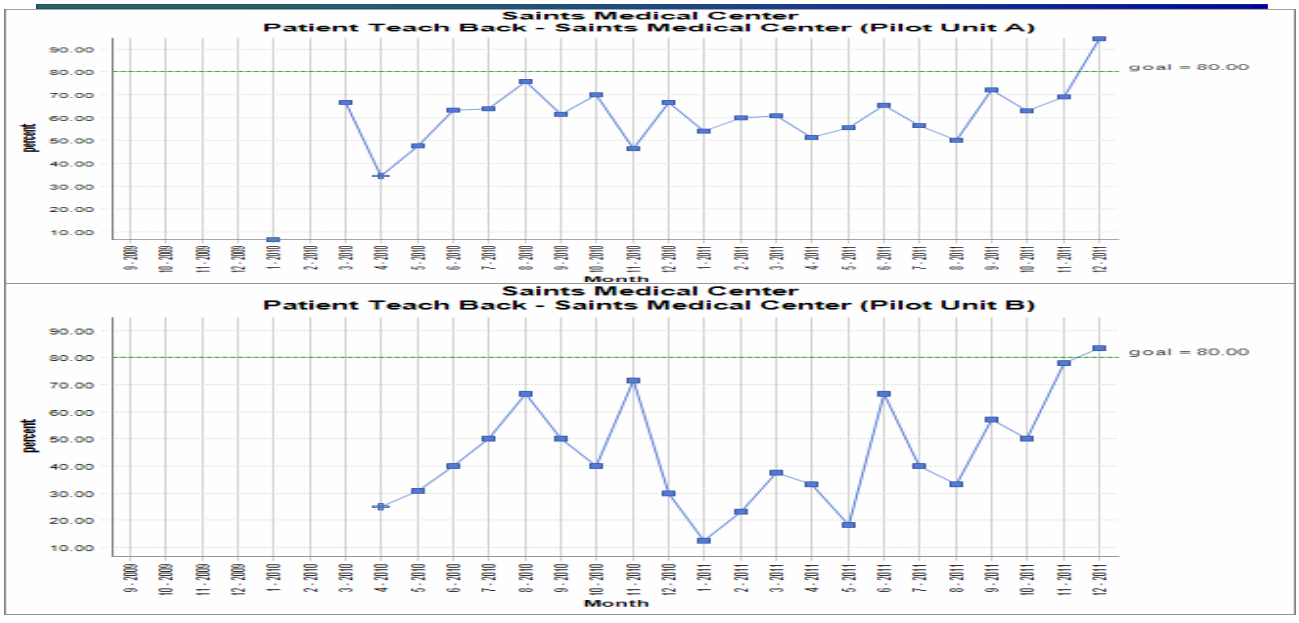


30-Day All Cause Readmissions

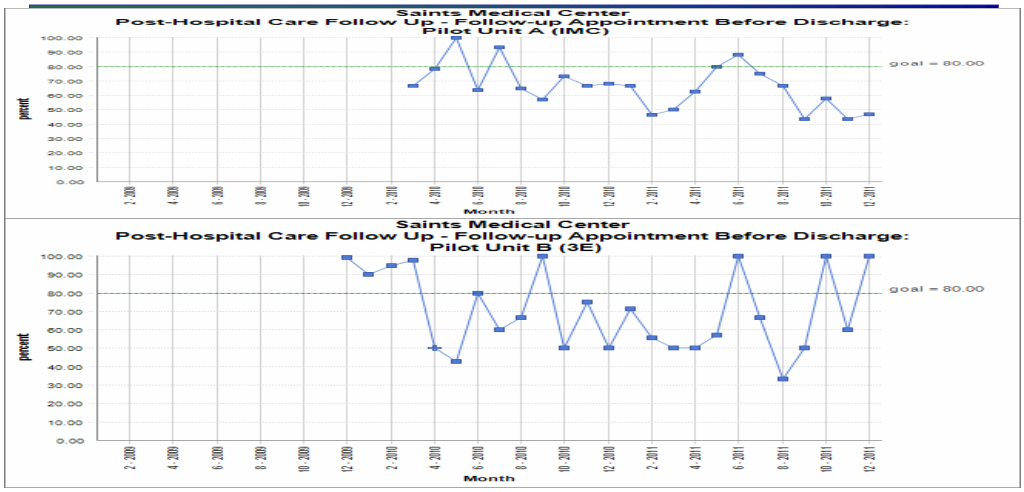


Process Measures

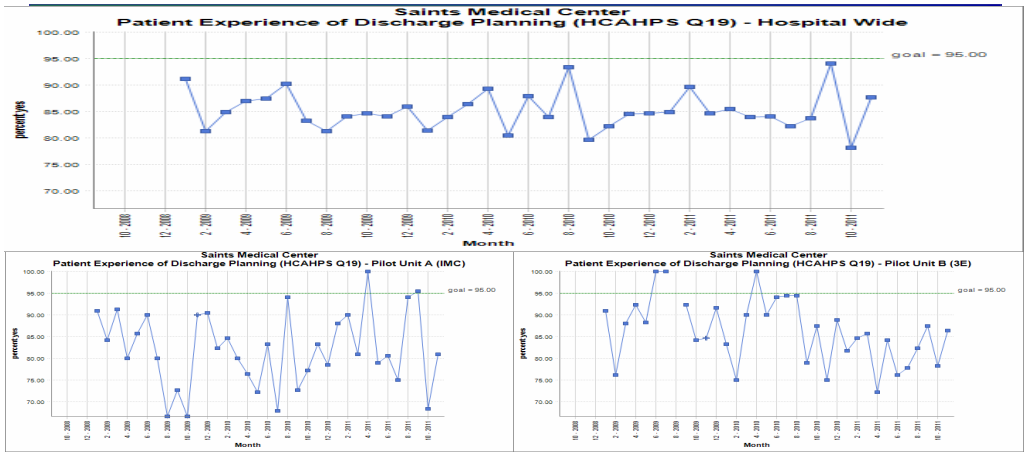
Pilot Units Key Change #2: Enhanced Learning
Heart Failure Teach Back



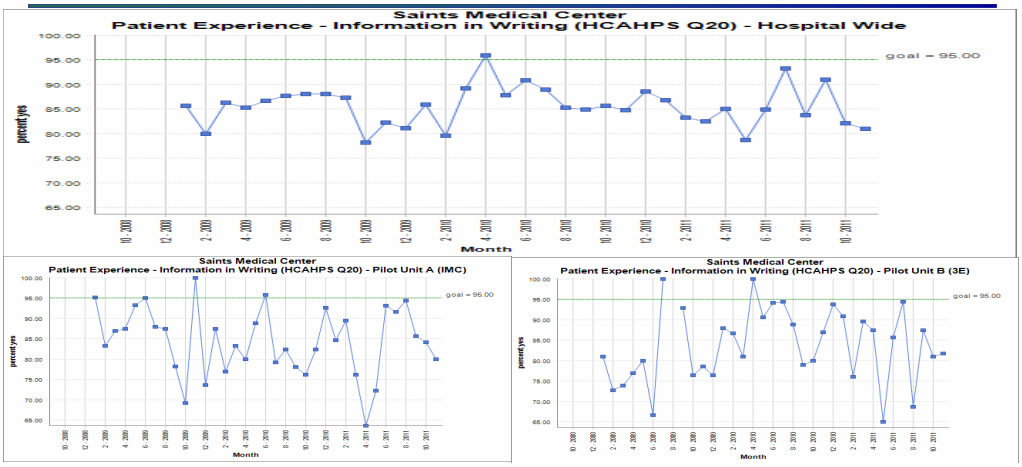
Pilot Units Key Change #4: Timely Follow-up Care
PCP Follow-up Appointment Scheduled before Discharge



HCAHPS #19



HCAHPS #20



Types of organizations represented on our Cross-Continuum Team:

- Area on Aging
- Hospital
- Home Health Agencies
- Skilled Nursing Facilities
- Rehabilitation Facilities
- Tufts NEQCA

Changes we have made that we believe are helping us achieve results in decreasing readmissions and improving the patient experience:

- Identifying patients by (exacerbated) chronic condition on admission
- Teaching patients skills of chronic disease management during inpatient hospitalization
- Developed and standardized home health agency care delivery in a Heart Failure Discharge to Home Care Pathway
- Provided INTERACT Learning Session for Skilled Nursing Facilities
- Provide Transition Coaching to enable "soft landing" from hospital to home
- Scheduling 3 – 5 day follow-up Primary Care Physician appointment prior to discharge
- Partner with Elder Services of Merrimack Valley to offer Chronic Disease Self Management Program
- All staff who have patient education responsibilities are trained in teach back on orientation, at annual skills day, and through annual on-line education through Caring Well Institute
- Cardiac Rehabilitation Nurses are identified as experts in Heart Failure teaching and serve as lead educators, role models, and resource for unit staff

Key lessons learned

Providing nurses with teach back tools, education, and an effective process to identify patient teaching needs has enhanced our patients and families abilities to manage their chronic conditions more successfully at home and to seek medical help promptly to avoid necessity of hospitalization.

Standardizing teach back content and training across the continuum of care has allowed Home Health Agencies, Skilled Nursing Facilities and Transition Coaches the ability to deliver a consistent message on chronic disease self management for our patients and families.

Important tools used for these changes

- Daily STAAR List
- Teach Back (Heart Failure, Pneumonia)
- Risk Assessment Tool
- Heart Failure Discharge to Home Care Pathway
- Discharge Instructions with scheduled follow-up appointment

South Shore Hospital

Contact Name:	Phone:	Email:
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Charlene Long	781-624-8411	charlene_long@sshosp.org
Catherine Nelson	781-624-8136	catherine_nelson@sshosp.org

Aim Statement:

- Decrease all cause readmissions, excluding OB, by 10% from 13.2% (CY2011 average) to 11.88% by December 2012

- Increase patients responding "yes" to the following HCAHPS questions to 95% by December 2012
  - + Did staff talk about help at home?
  - + Information about what symptoms to look for when you leave the hospital

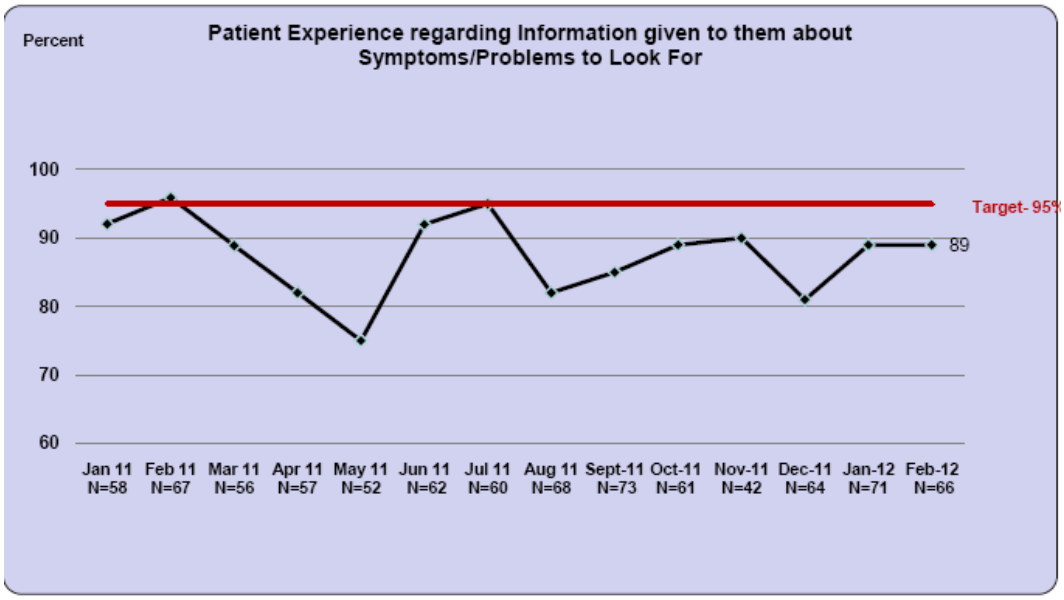
- Increase patients responding "always" to the following HCAHPS question to 95% by December 2012

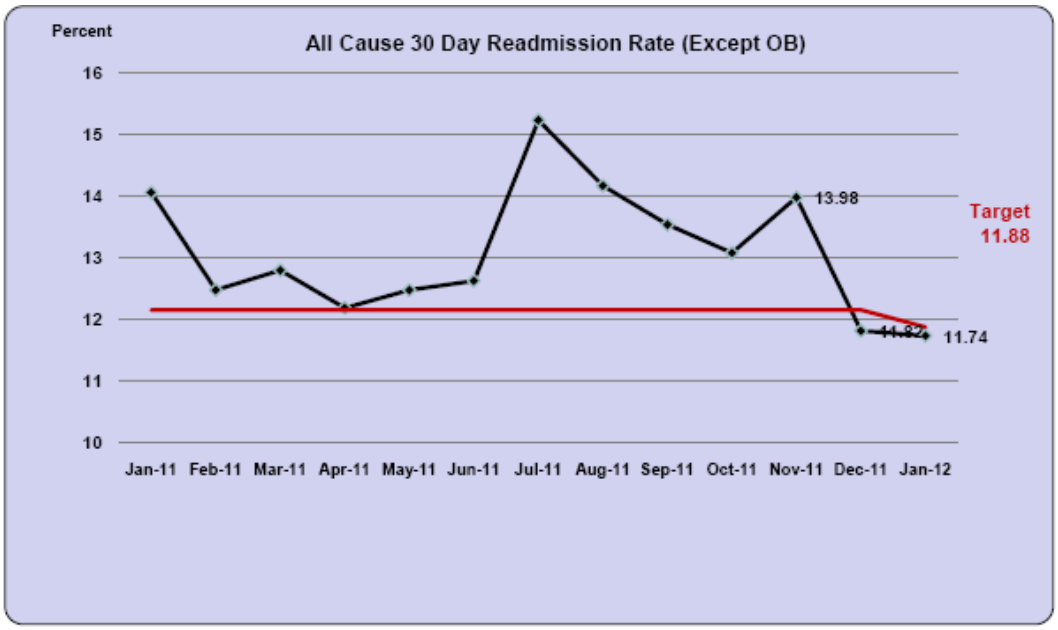
How often did the nurses explain things in a way you could understand?

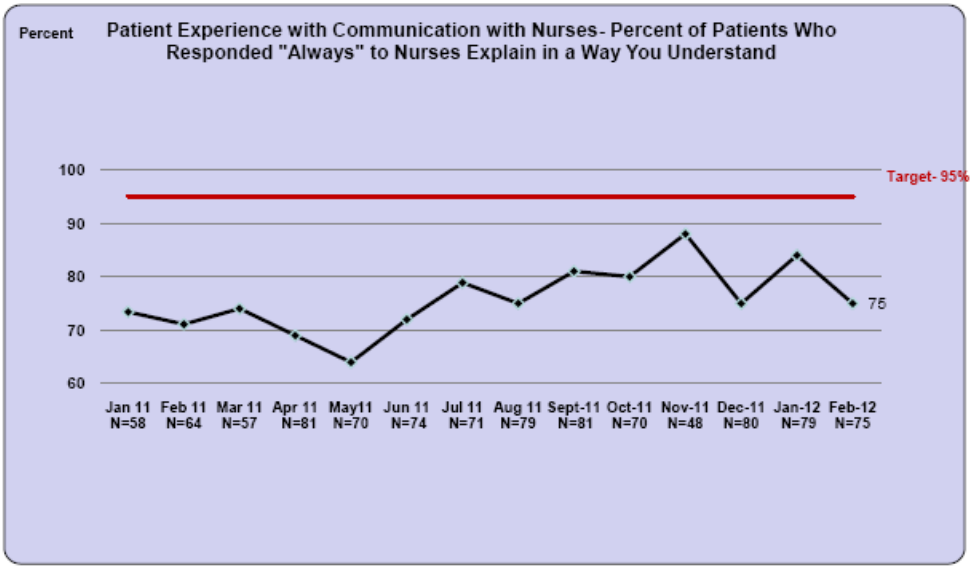
- By March, 2012, research an alternative solution to scheduling follow-up appointments for patients prior to discharge from hospital utilizing lean principles

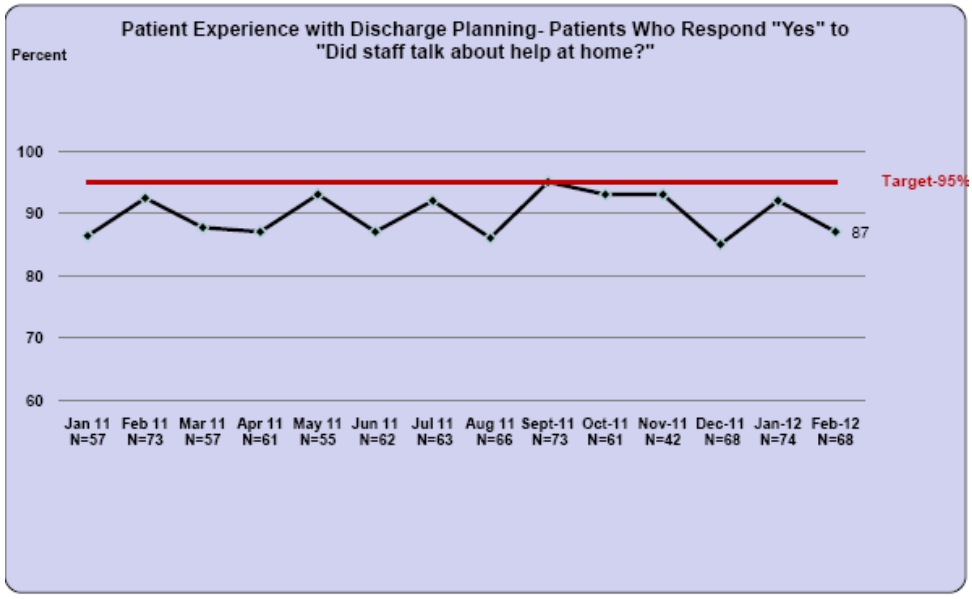
- Cross-Continuum
  - + By March 2012 develop and pilot teach back technique with COPD education in 6 facilities across the continuum
  - + Redesign and implementation of a new education tool for the two highest readmission diagnoses (COPD and pneumonia) will be piloted and implemented by February 2012
  - + By January 2012, use personal health records with patients identified as high risk for readmission and with those patients readmitted to SSH or the rehab facilities

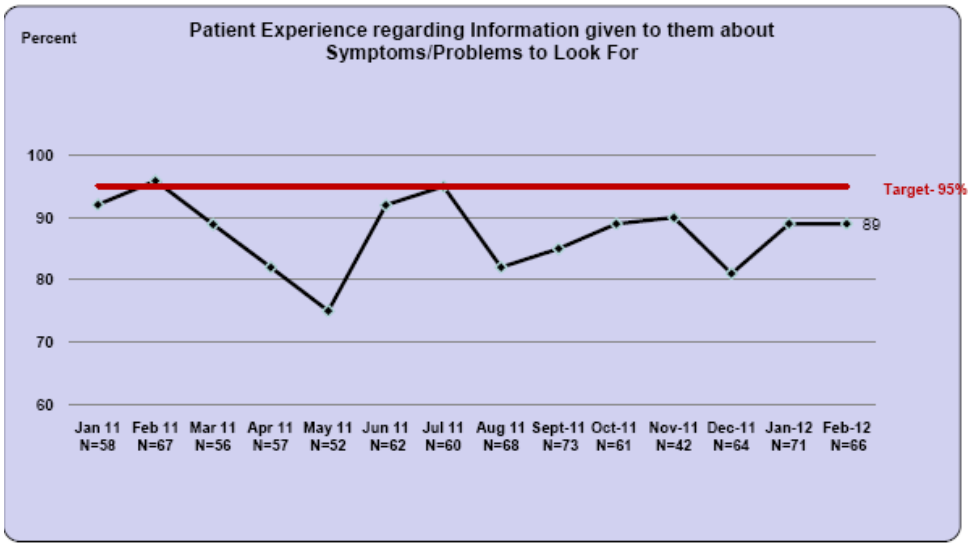
Results:


Percent
Patient Experience regarding Information given to them about Symptoms/Problems to Look For
100
90
80
70
60
Target- 95%
89
Jan 11 N=58
Feb 11 N=67
Mar 11 N=56
Apr 11 N=57
May 11 N=52
Jun 11 N=62
Jul 11 N=60
Aug 11 N=68
Sept-11 N=73
Oct-11 N=61
Nov-11 N=42
Dec-11 N=64
Jan-12 N=71
Feb-12 N=66


Percent
All Cause 30 Day Readmission Rate (Except OB)
16
15
14
13
12
11
10
13.98
Target 11.88
11.74
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12


Percent
Patient Experience with Communication with Nurses- Percent of Patients Who Responded "Always" to Nurses Explain in a Way You Understand
100
90
80
70
60
Target- 95%
75
Jan 11 N=58
Feb 11 N=64
Mar 11 N=57
Apr 11 N=81
May11 N=70
Jun 11 N=74
Jul 11 N=71
Aug 11 N=79
Sept-11 N=81
Oct-11 N=70
Nov-11 N=48
Dec-11 N=80
Jan-12 N=79
Feb-12 N=75


Percent
Patient Experience with Discharge Planning- Patients Who Respond "Yes" to "Did staff talk about help at home?"
100
90
80
70
60
Target-95%
87
Jan 11 N=57
Feb 11 N=73
Mar 11 N=57
Apr 11 N=61
May 11 N=55
Jun 11 N=62
Jul 11 N=63
Aug 11 N=66
Sept-11 N=73
Oct-11 N=61
Nov-11 N=42
Dec-11 N=68
Jan-12 N=74
Feb-12 N=68


Percent
Patient Experience regarding Information given to them about Symptoms/Problems to Look For
100
90
80
70
60
Target- 95%
89
Jan 11 N=58
Feb 11 N=67
Mar 11 N=56
Apr 11 N=57
May 11 N=52
Jun 11 N=62
Jul 11 N=60
Aug 11 N=68
Sept-11 N=73
Oct-11 N=61
Nov-11 N=42
Dec-11 N=64
Jan-12 N=71
Feb-12 N=66

List the types of organizations represented on your Cross-Continuum Team

- Acute Care Hospital
- Visiting Nurse Associations
- Skilled Nursing Facilities
- Long term care facilities
- Assisted Living/ Independent Living communities
- Infusion companies
- Private Duty Care companies
- Aging Service Access Points (ASAP)
- Patient Family Centered Care Representative

Important tools used for these changes

- COPD Action Plans

Sturdy Memorial Hospital

Contact Name:	Phone:	Email:
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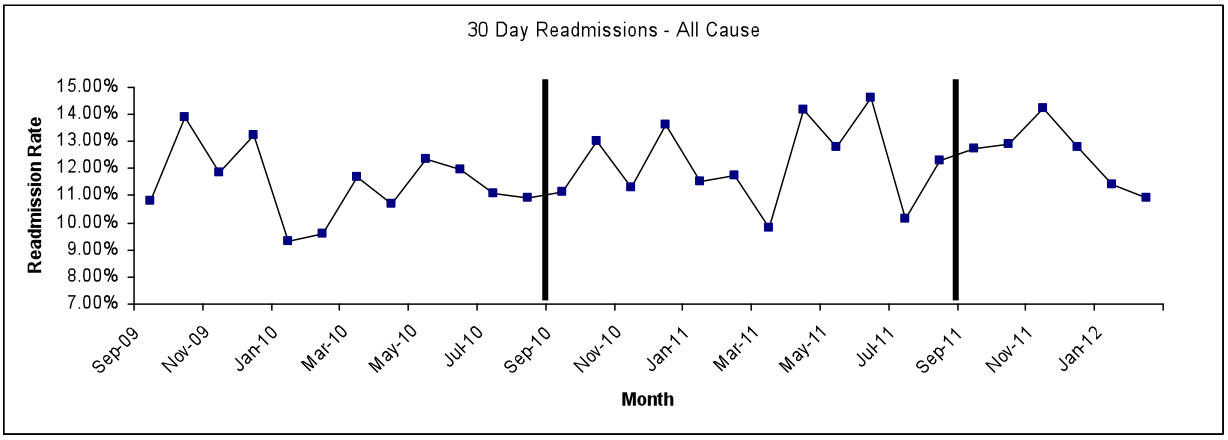
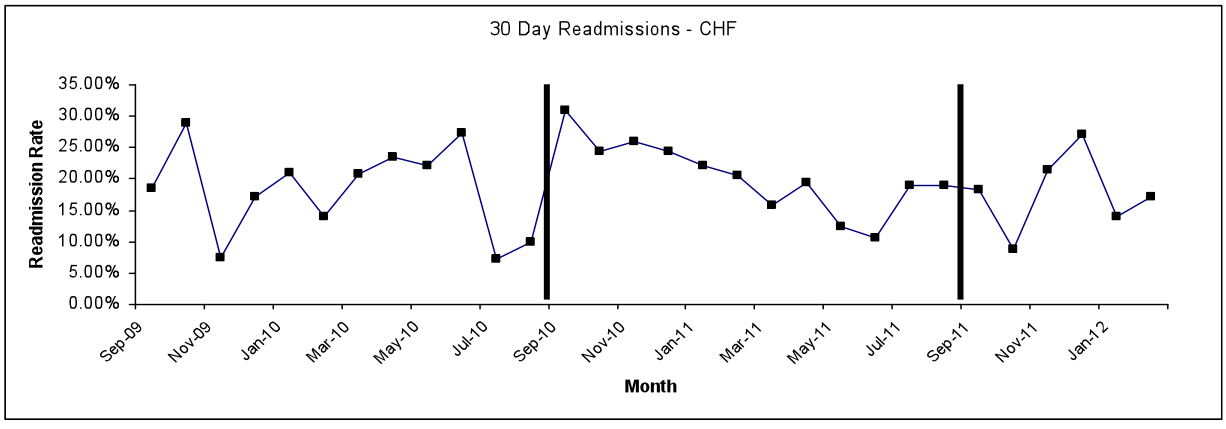
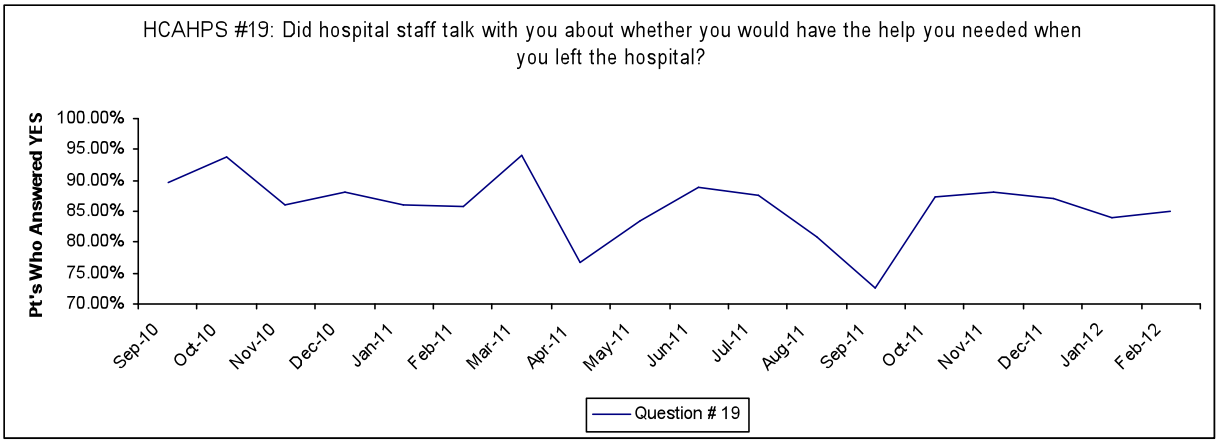
Aim Statement:

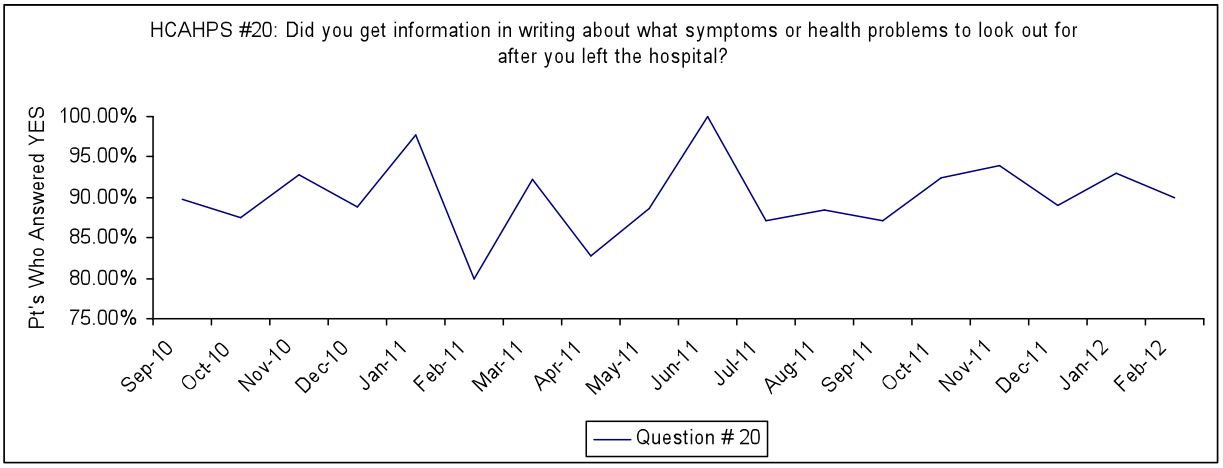
Sturdy Memorial Hospital will reduce the 30-day readmission rate for Congestive Heart Failure (CHF) patients by 6.5% within a 12 month period by focusing on improved care transitions as follows: individualized self care teaching plans, patient centered handovers to community providers, and post-acute follow up via direct communication with patients.

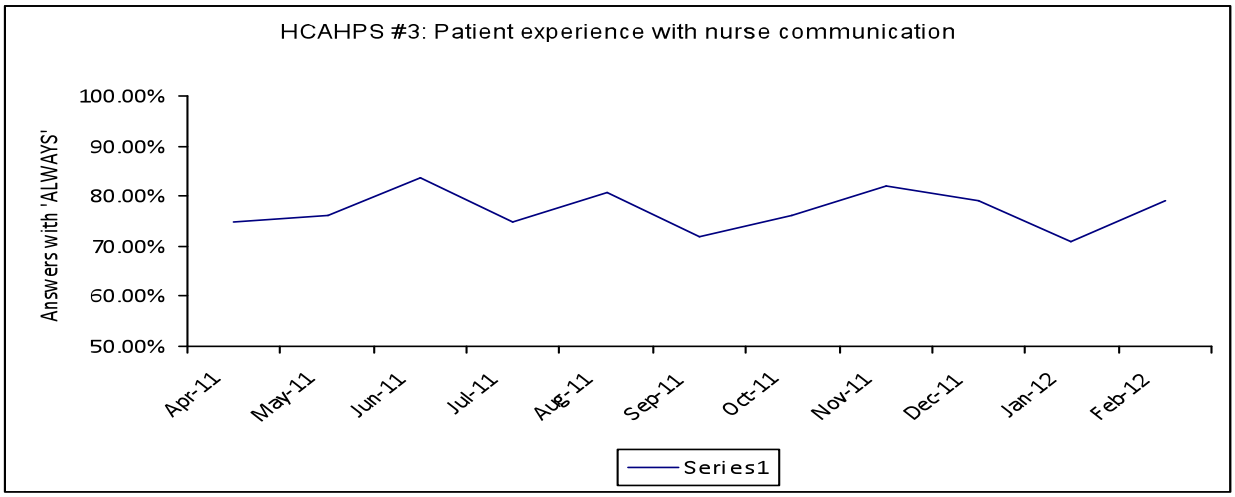
Results:






HCAHPS #19: Did hospital staff talk with you about whether you would have the help you needed when you left the hospital?
Pt's Who Answered YES
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
70.00%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Question # 19


HCAHPS #20: Did you get information in writing about what symptoms or health problems to look out for after you left the hospital?
Pt's Who Answered YES
100.00%
95.00%
90.00%
85.00%
80.00%
75.00%
Sep-10
Oct-10
Nov-10
Dec-10
Jan-11
Feb-11
Mar-11
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Question # 20


HCAHPS #3: Patient experience with nurse communication
Answers with 'ALWAYS'
100.00%
90.00%
80.00%
70.00%
60.00%
50.00%
Apr-11
May-11
Jun-11
Jul-11
Aug-11
Sep-11
Oct-11
Nov-11
Dec-11
Jan-12
Feb-12
Series1

List the types of organizations represented on your Cross-Continuum Team

- SNF
- ASAP
- Home care
- Hospice
- Council On Aging
- Rehab

What changes have you made that you believe are helping you achieve results in decreasing readmissions and improving the patient experience?

- We believe that going back to the basic premise that the patient should be the focus of developing a transition plan improves the ability of all team members to work with the patient/family and MD and share appropriate information related to the plan of care.

- We have established a core Care Team consisting of a Nursing Educator, lead RN on the pilot telemetry unit, Day to Day Leader, Social Worker, RN Case Manager, and Dietician to address each patient's unique issues and challenges. The lead RN and Nursing Educator are screening the most frequent CHF readmissions of the past year to identify opportunities for patient specific approaches to disease management. The Day to Day Leader is reviewing each case and connecting with the PCP to strategize approaches to prevent readmissions; this information is shared at our Front Line and Cross-Continuum Team meetings with individual tailored plans developed for each patient.

- A STAAR Care Team data base is being developed which will be comprised of care plan progress for each individual patient identified.

- A recent meeting with a key physician of one of our Family Practice Groups has paved the way for partnering with physicians in this endeavor.

- Success story: Utilizing the patient centered approach we identified one of our patients with a high readmission rate; we seized the opportunity, while they were an inpatient, to work with the family and the patient to direct them to a home hospice program which they were resistant to in the past. We have followed the patient's progress and have been informed by the Hospice RN that over the past month 3 likely readmissions have been avoided.

Key lessons learned

- Going back to basics and re-focusing our efforts on the patient and their unique challenges has reenergized the team and provided greater focus in approach.
- Feedback from caregivers is essential and provides insight into all aspects of a patient's progress.

Important tools used for these changes

- Patient Care Team Data Base