The STAAR Initiative:
A quality effort at the heart of system redesign

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Review of Afternoon Session

- Rehospitalizations are frequent, costly, actionable for improvement
- Successful pilots, local programs and research studies demonstrate that rehospitalization rates can be reduced
- Redesign required, even when financial incentives are aligned
- Challenge is how to apply promising, evidence-based ideas to other patient populations and settings of care

General Principles of Successful Efforts

- Measure hospital or community-based rehospitalization rates
  - Examine current performance; set an aim for improvement
- Identify patients at high risk of rehospitalization
  - Population based on overall utilization (medically or socially complex)
  - Population based on disease state (heart failure)
- Provide enhanced support at times of transition
  - Self-management coaching and support
  - Supplemental clinical management services (ANP, remote monitoring)
- Ensure close follow up after discharge
- Improved communication between providers

Transformation is Needed

- Facilitate transitions in care
- Focus on patient learning
- Embrace a comprehensive perspective of needs over time
- Place patients and families as the focus of the care team and recognize they are essential members of the team
- Co-design handoff processes between senders and receivers

What can be done, and how?

There exist a wealth of approaches to reduce unnecessary readmissions that have been locally successful

Which are high leverage?

Which can go to scale?

Success requires engaging clinicians, providers across organizational and service delivery types, patients, payers, and policy makers

How to align incentives?

How to catalyze coordinated effort?

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The Challenge:

- Potentially preventable rehospitalizations are prevalent, costly, burdensome for patients and families and frustrating for providers
- No one provider or patient can “just work harder” to address the complex factors leading to early unplanned rehospitalization
- Exacerbated by a highly fragmented delivery system in which providers largely act in isolation and patients are usually responsible for the own care coordination
- Reinforced by a payment system which rewards maximizing units of care delivered rather than quality care over time

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Purpose

- Improve quality, patient experience, and reduce avoidable utilization through a multi-stakeholder initiative to reduce rehospitalizations.

Methods

- Engage state-level leadership *and* state-wide process improvement .

Aims

- Improve patient/family satisfaction with care transitions.
- Reduce all-cause 30-day rehospitalization rates by 30 percent.

Settings

- Massachusetts, Michigan, Washington.

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The state is the unit of intervention

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Approach of the STAAR Initiative:

- Provide technical assistance to ***front-line teams of providers*** working to improve the transition out of the hospital, the reception into the next setting of care with the specific aim of reducing avoidable rehospitalizations and improving patient satisfaction with care

AND

- Create a state-based, multi-stakeholder initiative to concurrently ***address the systemic barriers*** to improving care transitions, care coordination over time (policies, regulations, accreditation standards, etc)

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- ***Improve the transition out of the hospital***
  - Cross-continuum teams
  - Collaborative learning
  - State-based mentoring and quality improvement infrastructure

- ***Support state-level, multi-stakeholder initiatives to address the systemic barriers***
  - State leadership- coordinating, aligning, convening
  - State-level data and measurement
  - Financial impact of reducing readmissions
  - Engaging payers to reduce barriers
  - Working across the continuum

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STAAR Collaborative:

Optimize the transition for all patients

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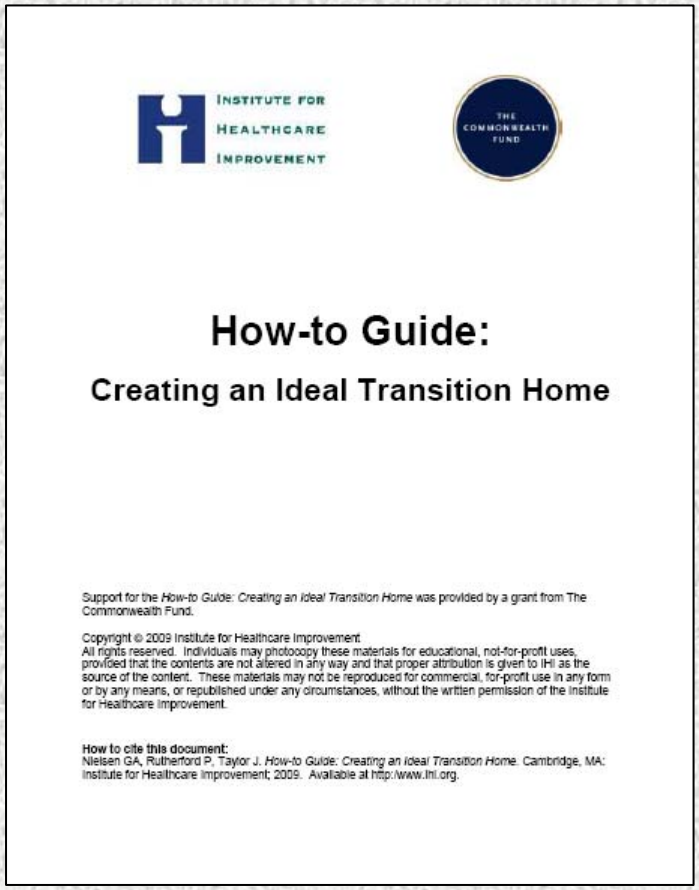
STate Action on Avoidable Rehospitalizations



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THE COMMONWEALTH FUND

How-to Guide:

Creating an Ideal Transition Home

Support for the *How-to Guide: Creating an Ideal Transition Home* was provided by a grant from The Commonwealth Fund.

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1. Measure all-cause readmission rate
2. Form a cross-continuum team
3. Cross-continuum team reviews longitudinal, cross-setting story of 5 recently readmitted patients

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STAAR Initiative Key Changes

1. **Enhanced Assessment of Patients:** why does the patient/caregiver/SNF/outpatient provider think caused readmit?

2. **Enhanced Teaching and Learning:** change focus from what providers tell patients to what patients/caregivers *learn*

3. **Real-time Communication and Handoffs:** timely, clinically meaning information exchange with opportunity for clarification

4. **Timely Post Acute Care Follow-Up:** clinical contact (call, home health visit, office visit) within 48h or 5 days depending on risk

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STAAR Collaborative

State	# of Hospitals
MA	22/81 (27% of hospitals)
MI	30/143 (21%of hospitals)
WA	15/95 (16% of hospitals)

Month	Milestone
May 2009	STAAR Initiative launched
Summer 2009	First cohort formed cross continuum teams, performed diagnostic reviews
Fall 2009	STAAR Collaborative (first cohort) launched
Spring 2010	Harvest best practices, tools
December 2010	STAAR Collaborative (first cohort) finishes
Winter 2011	STAAR Summits; second cohort launches

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Recommended Changes	% Testing	Description
Cross-Continuum Team	70%	Understanding mutual interdependencies, the hospital-based teams co-design care processes with their cross-continuum partners to improve the transition out of the hospital
Diagnostic Review	40-50%	Teams perform a diagnostic review of five recently readmitted patients to understand transitions from the perspective of the longitudinal patient experience and to identify opportunities for improvement
Enhanced Teaching	33/64 (52%)	Utilizing health literacy principles, effectively teach patients about their conditions, medications, and self-care
Enhanced Assessment	25/64 (39%)	On admission, perform a comprehensive assessment of patients' post-discharge needs and initiate a customized discharge plan
Communication	22/64 (34%)	Provide customized, real-time critical information to the next care provider(s); Provide the patient and his or her family caregiver with written self-care instructions
Timely Follow-up	28/64 (44%)	Based on assessed risk of readmission, schedule post-hospital care follow-up prior to discharge

Support State Level Multi-Stakeholder Coalitions to Address Systemic Barriers

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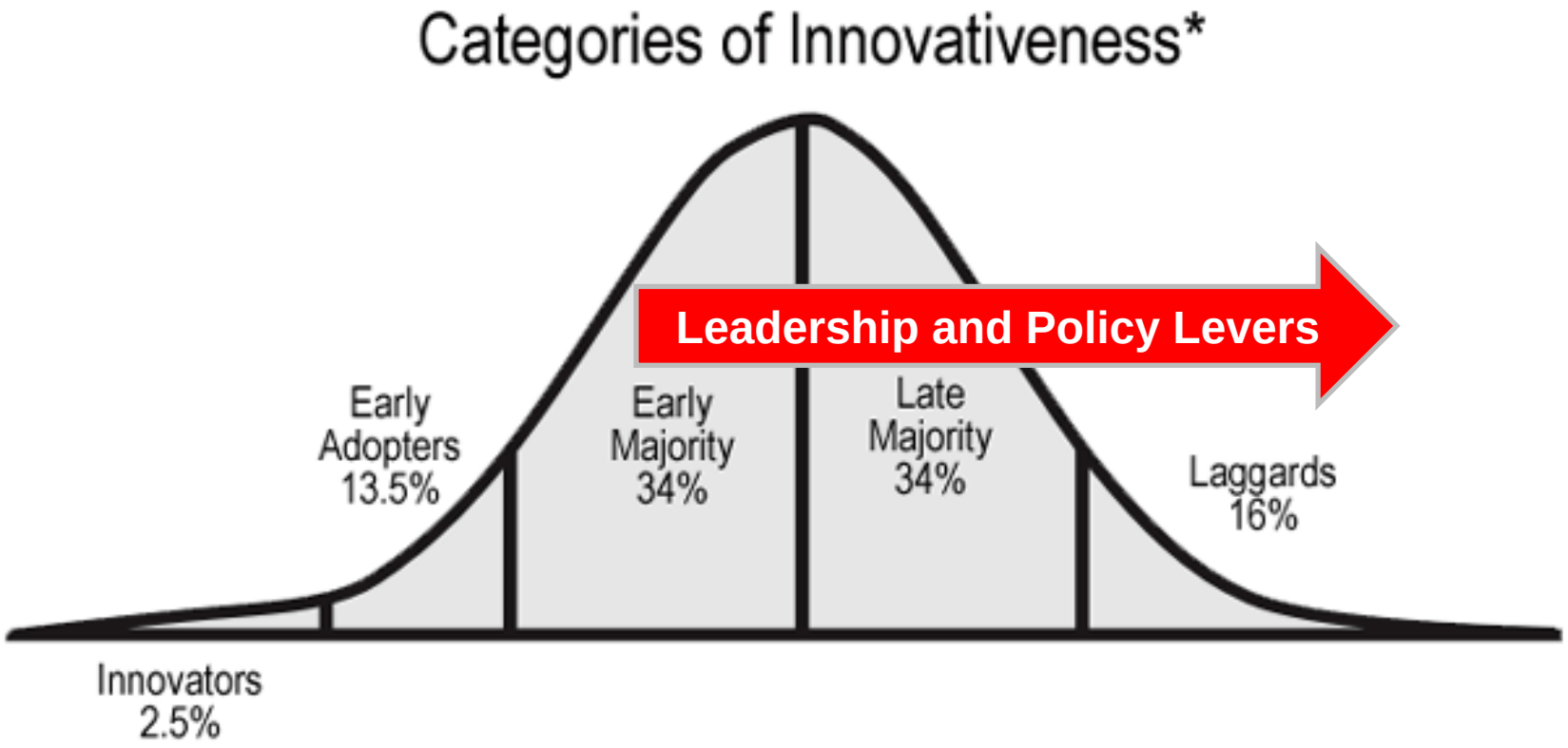

*From E.M. Rogers, *Diffusion of Innovations*, 4th edition (New York: The Free Press, 1995)

State Level Leadership and Strategy

Michigan STAAR Steering Committee

• Tina Abbate Marzolf	CEO, Area Agency on Aging 1-B
• Caroline Blaum, MD, MS	Gerontologist, University of Michigan
• Amy Boutwell, MD, MPP	Institute for Healthcare Improvement
• Peggy Brey	Director, Office of Services for the Aging, MDCH
• Laura Champagne	Executive Director, Citizens for Better Care
• Ed Gamache	President, Michigan MICAH
• David Herbel	President & CEO, Aging Services of MI
• Jeanette Klemczak, RN, MSN	Chief Nurse Executive, MDCH
• David LaLumia	President & CEO, HCAM
• Cecelia Montoye, RN, MSN, CPHQ	Michigan Chapter , American College of Cardiology
• Susan Moran	Bureau Director, Medicaid Program Operations and QA
• Richard Murdock	Executive Director, MAHP
• Julie Novak	Executive Director, MSMS
• Larry Abramson, DO	Michigan Osteopathic Association
• Jeff Towns	Michigan Hospice & Palliative Care
• Tom Simmer, MD	Senior VP & CMO, BCBSM
• Nancy Vecchioni, RN, MSN, CPHQ	VP Strategic Initiatives, MPRO
• Sam R. Watson, MSA, MT (ASCP)	Senior VP Patient Safety and Quality, MHA
• Pam Yager	Policy Advisor, Office of Governor Jennifer Granholm
• Robert Yellan, JD, MPH	President and Chief Executive Officer, MPRO
• Harvey Zuckerberg	Executive Director, MHHA

Michigan STAAR Portfolio of Projects

STAAR State Level Strategy

- **Hospital-level**
  - Improve the transition out of the hospital for *all* patients*
  - Measure and track 30-day readmission rates*
  - Understand the financial implications of reducing rehospitalizations*
- **Community-level**
  - Engage organizations across continuum to collaborate on improving care, partner with non-clinical community based services, address lack of IT connectivity, clarify who "owns" coordination, engage patient advocates*
  - Ensure post-acute providers are able to detect and manage clinical changes, develop common communication and education tools
- **State-level**
  - Develop state-level population based rehospitalization data*
  - Convene all payer discussions to explore coordinated action*
  - Link with efforts to expand coverage, engage patients, improve HIT infrastructure, establish medical homes, contain costs, etc.*

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** Elements of the STAAR Initiative*

Address Systemic Barriers

Action	Description
State Data	MA - Division of Health Care Finance and Policy Steering Committee MI - Multi-payer collaboration to run standard reports WA - quarterly rehospitalization reports to all WA hospitals
Financial impact	STAAR partnered with 16 CFOs to understand financial impact of readmissions in current payment climate. Created roadmap, issue brief, manuscript, webinar.
Engaging Payers	Understand which specific challenges in delivering optimal care at transitions are amenable to action by payers in short term.
Working Across Continuum	Highlight opportunities to make new partners in STAAR work; encourage evolution of hospital-based cross continuum teams leading to community-based level of coordination between local cross continuum teams as well as community-based non-clinical services. Networking, mapping and identifying specific ways to coordinate care and services is promising and concrete. The “STAAR Effect”, Care Transitions Map in MA , Detroit CARR.

State-Level Data and Measurement Barriers

- Lack of uniform measurement strategy for rehospitalizations
  - Time interval (7, 14, 30 days)
  - Conditions of interest (selected conditions, service lines, all patients)
  - Conditions of interest causing readmission (clinically related or all-cause)
  - Exclusions (trauma, ob/newborn, discharge against medical advice)
- All provider discharge database limitations
  - Many lack unique patient identifiers
  - Lack of reliable fields to capture where patients are coming from (eg home, NH)
  - Do not capture outpatient services rendered (i.e. follow up visits)
- All payer claims database benefits
  - Can track utilization across continuum

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Financial Impact of Reducing Readmissions

- Few hospitals have examined the financial implications of reducing readmissions- either in the current payment climate or in any number of future states.

- Understanding current reality will allow more informed examination of the impact of proposed payment reforms regarding readmissions and proactive engagement in shaping the transition to creating value across the continuum.

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STAAR Financial Impact Analysis Roadmap

1. Calculate the all-cause 30 day readmission rate for the hospital and the percentage of the average daily census due to readmitted patients.

2. Partner Financial Lead with Clinical Lead and review the personal, clinical, and financial story of one (or more) recently readmitted patient(s).
   - Calculate revenue, expenses, and margin.
   - Analyze clinical/operational insights from this story.

3. Conduct a financial analysis on a sample set of readmissions for a select time period (1 month, 12 months, etc).
   - Analyze characteristics of this sample set (payer mix, LOS, conditions, outliers, etc)
   - What is the average direct and total margin per readmitted patient in this sample?

4. What financial variables does your hospital consider when examining the impact of readmissions?
   - Revenue, expenses, direct costs, indirect costs, variable costs, fixed costs, etc.
   - How does your organization define direct, indirect, fixed and variable costs?
   - How does your organization allocate indirect costs?

5. How do readmissions to your hospital, *today,* influence your hospital's bottom line?

6. If you were to successfully reduce readmissions by 10%, 30%, 50%, which costs would be influenced and which costs would remain fixed?

7. What is your hospital's ability to influence (reduce) fixed costs? In the near and long term?

8. Is there latent demand in your hospital service area? Would you expect to keep volume stable if readmissions decreased? What would happen to ED visits? Observation stays?

9. What there anything that surprised you about this analysis?

10. Is there anything that your hospital will do differently as a result of this analysis?

Working as a Team Across Boundaries

- New competencies in partnering across boundaries
  - Power of “senders”, “receivers” and patients meeting together
  - Moving past blame and finger-pointing
  - Establishing standard communication processes
  - Addressing shared health information
- Testing new organizational delivery models (e.g. ACOs)

Cross-continuum team the single most meaningful change in the STAAR Collaborative

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Engaging Payers

- Payers are highly motivated to reduce avoidable rehospitalization
- Individual payer efforts have some limitations
  - Pre-discharge preparation
  - History of strife between payers and providers
  - Difficulty recruiting providers to these efforts
- Myriad payer-based discharge planning and care coordination services create chaos at provider level
- How can interests be aligned and coordinated?

Summary

- Rehospitalizations are frequent, costly, and actionable for improvement
- Working to reduce rehospitalizations focuses on improved communication and coordination over time and across settings
  - With patients families/caregivers and
  - Between clinical providers and
  - Between the medical and social services (e.g. aging services, etc)
- Working to reduce rehospitalizations is one part of a comprehensive strategy to promote appropriate utilization of health care
- Act on multiple levels – the hospital, the community, and the state level to design a robust strategy to accelerate state wide change

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Resources:

1. STAAR How-to Guide: Creating an Ideal Transition Home
2. STAAR Guide for Field Testing: Creating an Ideal Transition to the Office Practice
3. STAAR Guide for Field Testing: Creating an Ideal Transition to a Skilled Nursing Facility
4. Applying Early Evidence and Experience in Front-Line Process Improvements to Develop a State-Based Strategy: *The STAAR Initiative*
5. The STAAR Initiative: A Survey of the Published Evidence
6. The STAAR Initiative: A Compendium of 15 Promising Interventions
7. The STAAR Initiative: A Tool for State Policy Makers
8. The STAAR Initiative: Data and Measurement Issues for the STAAR Initiative
9. The STAAR Initiative: The Financial Impact of Readmissions, A Roadmap

Available at www.ihi.org/STAAR

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Thank you

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