



The STAAR Initiative

***Pre-Work for the
Transitions Home Collaborative***

Introduction to the Pework

The State Action on Avoidable Rehospitalizations (STAAR) Transitions Home Collaborative brings together patients, cross-continuum care providers, and other stakeholders from Massachusetts, Michigan and Washington states to reduce readmissions and to increase patient and family satisfaction with transitions in and coordination of care. In cooperation with state leaders, the Collaborative will be led by faculty and staff from the Institute for Healthcare Improvement and will include quality improvement assistance from designated in-state Improvement Advisers. This document is designed to assist participating hospitals in preparing for their participation in the Collaborative. Activities outlined below should be completed prior to the Kick-Off Meetings that have been scheduled in each state.

Step 1. The Hospital CEO Selects an Executive Leader to Sponsor the Hospital's Participation in the Transitions Home Collaborative

The role of the Executive Leader is to link the goals of the initiative to the strategic priorities of the organization; he or she will provide oversight and guidance to their teams' work. Depending on the size and organizational structure of the hospital, typical Executive Leaders may include CEO's or COO's, Chief Nursing Officers, Medical Directors or Chief Quality Officers.

The Executive Leader should also select a Day-to-Day Leader for the initiative who will coordinate project activities, provide guidance and support to the medical/surgical unit teams, help to lead the Cross-Continuum Improvement Team, and serve as the hospital's Key Contact to the STAAR Transitions Home Collaborative. This person may be a quality improvement specialist or special projects leader, for example.

Step 2. The Sponsor Convenes a Cross-Continuum Improvement Team

Form a multi-stakeholder team with representatives from across the care continuum along with patients and family members. By understanding mutual interdependencies and identifying internal customers and suppliers for every step of the patient journey across the care continuum, this team will provide oversight to the work and help shape the redesigned process. Together, team members will explore the ideal flow of information as the patient moves from one setting to the next and learn how to improve transition handovers.

We strongly recommend that the Cross Continuum Improvement Team include Patients and Family

Members. In addition, consider choosing team members from the following:

Hospital Staff

Staff Nurses
Nurse Managers
Nurse Educators
Pharmacists
Hospital Physicians or Hospitalists
Case Managers
Quality Improvement Leaders

Staff from Skilled Nursing Facilities

Nursing Leaders
Physician Leaders

Clinicians and Staff from Office Practice Settings

Primary Care Physicians
Specialists
Nurses or Nurse Practitioners
Practice Administrators

Staff from Community or Public Health Services

Case Managers
Home Care Nurses

At the first meeting, describe the goals of the Transitions Home Collaborative and the role of this team in providing oversight to the redesign of the transitions in care processes. Create small workgroups to complete the pre-work (outlined in steps 3 through 5)

Step 3. Identify Opportunities for Improvement

3a. Perform an in-depth review of the last five rehospitalizations to identify opportunities for improvement

- Conduct chart reviews of the last five readmissions, transcribing key information onto the data collection sheets (see **Worksheet A**).
- Conduct interviews with patients recently readmitted and their family members (If possible, interview the same patients whose charts were reviewed). Next, conduct interviews with clinicians in the community who also know the readmitted patient (physicians, nurses in the skilled nursing facility, home care nurse, etc.) to identify problem areas from their perspective. Transcribe information from these interviews onto the data collection sheet (see **Worksheet B**).

n.b., for your reference we have included a list of “typical failures” at the end of the appendices

3b. Review patient experience data regarding communications and discharge preparations to identify opportunities for improvement

Evaluate trends in the scores of the discharge preparation questions on your patient satisfaction or patient experience survey for the last year. Assess survey scores both for the hospital and each medical and surgical unit, when possible. Use the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) or tailored hospital survey questions, if equivalent. Refer to www.hcahpsonline.org for the complete list of HCAHPS questions.

- Display trending data for the hospital on a run chart for at least Questions 19 and 20 from the HCAHPS survey¹.

Relevant HCAHPS Survey Questions:

When you left the hospital . . .

- *During this hospital stay, did doctors, nurses, or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? (Q19)*
- *During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital? (Q20)*

During your hospital stay . . .

- *During this hospital stay, how often did nurses listen carefully to you?*
- *During this hospital stay, how often did nurses explain things in a way you could understand?*
- *Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?*
- *Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?*

Measure Name	Description	Numerator	Denominator
HCAHPS Q 19 Need help	Percent of survey Yes responses to question: “did staff talk with you about whether you would have the help you needed when you left the hospital?”	Number of patients surveyed in month who answer yes	Total number of patients surveyed in month

¹ If HCAHPS 19 and 20 (described in the table on the following page) are not available, choose alternate questions at your discretion.

HCAHPS Q 20 Information in writing	Percent of survey Yes responses to question: “did you get information in writing about what symptoms or health problems to look out for after you left the hospital?”	Number of patients surveyed in month who answer yes	Total number of patients surveyed in month
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3c. Review 30-day readmission rates to identify opportunities for improvement

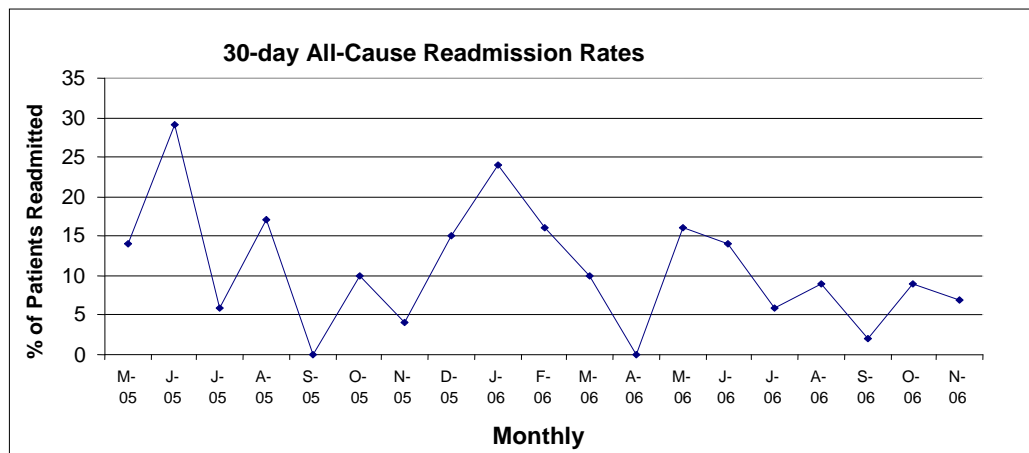
Collect historical data and display monthly readmission rates over time, include at least 12 months of data (i.e., Aug 08 – July 09), preferably more. In addition to the required 30-Day All-Cause Readmission rate defined below, hospitals may choose to look at a segment of their population (e.g., heart failure patients). An optional measure for such a segmented population is also defined below. Display trending data for the required (and optional measure if selected) for the entire hospital on a run chart.

N.B. Data collection clarification: For each month of data you collect, you look forward from that month’s discharges, not backwards from that month’s admissions. For example, for the August 08 data point, we would look 30 days after the last discharge in August (i.e., through September 30) and count how many discharges resulted in readmissions within 30 days; the denominator of our data point is the number of discharges in August and the numerator is the number of those discharges that resulted in a readmission within 30 days.

Measure Name	Description	Numerator	Denominator
30-Day All-Cause Readmissions	Percent of discharges with readmission for any cause within 30 days	Number of discharges in the measurement month with readmission for any cause within 30 days of discharge Exclusion: planned readmissions (e.g., chemotherapy schedule)	The number of discharges in the measurement month Exclusions: transfers to another acute care hospital, patients who die before discharge

<p><u>Optional:</u> 30-Day All-Cause Readmissions for Chronic Conditions such as heart failure and COPD</p>	<p>Percent of discharges with heart failure, COPD, etc., who were readmitted for any cause within 30 days of discharge</p>	<p>Number of discharges with heart failure or other chronic conditions readmitted for any cause within 30 days of discharge Exclusion: planned readmissions (e.g., chemotherapy schedule)</p>	<p>Number of discharges in the measurement period with heart failure or other chronic conditions Exclusions: transfers to another acute care hospital, patients who die before discharge</p>
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Sample Run Chart:



Step 4. Develop an Aim Statement to Create an Ideal Transition Home for Patients

4a. Report findings from Step 3 to the entire team

- Chart reviews for readmitted patients (**Worksheet A**)
- Interviews with readmitted patients and their families; interviews with clinicians in the community (**Worksheet B**)
- Trending data of patient experience with discharge preparations (HCAPHS)
- Trending data for 30-day readmission rates

Share the stories of the patients and families and their struggles to navigate transitions in care between participating facilities. Stories of patients and families will resonate more deeply than the statistics or the business case for doing this work.

4b. Select two pilot units for participation in the Transitions Home Collaborative

Based on the review of hospital-wide data on 30-Day all-cause readmissions, the Cross Continuum Improvement Team selects two medical surgical units where readmissions are most likely to occur. These two units together make up the Front Line Improvement Team. If there is a particular patient population within one or both of these units that accounts for a large percent of the readmissions (e.g., heart failure patients) then the teams may want to focus their testing initially on this patient segment within the unit. Process improvements can then be further tested and implemented for all patients on the selected pilot units.

The size of the Front Line Improvement Team will vary from hospital to hospital but would probably involve 6 – 8 people. Each team should consist of the Day-to-Day leader identified in Step 1 as well as members of the following groups:

Patients and Family Members

Hospital Staff

Team Leader for each pilot unit who will drive the work on their respective pilot units
(e.g., Nurse Manager, QI Leader, etc)

Physician Champion

Staff Nurses

Clinical Nurse Specialists or Educators

Social worker, discharge planner, or case manager

Other team members as needed

Clinicians and Staff from the Community (office practices, skilled nursing facilities and home care agencies)

4c. Write an aim statement

Aim statements communicate to all stakeholders the magnitude of change and the time by which the change will happen. Aim statements help teams commit to the improvement work.

The Cross Continuum Improvement Team and the Front Line Improvement Team work together to develop a clear aim statement for reducing readmissions in the selected pilot units. Effective aim statements include five pieces of information:

- What to improve
- Where (specific unit(s) or entire hospital)
- For which patients
- By when (specific deadline)
- Measurable goal

Sample aim statements:

- 1) *By October 2010, St. Elsewhere hospital will decrease all 30-day readmissions on 4W and 5S by 50% and improve our patients' experience at discharge as measured by HCAHPS scores of 95% or more on questions 19 and 20.*
- 2) *Reduce all unplanned 30-day readmissions of patients with heart failure from 15 percent to 5 percent or less by October 31, 2010 and improve our heart failure patients' experience at discharge as measured by HCAHPS scores of 95% or more on questions 19 and 20.*

For more on setting aims, see:

<http://www.ihl.org/IHI/Topics/ChronicConditions/AllConditions/HowToImprove/ChronicSettingAims.htm>

**Step 5. Plan for Participation at the Kick-off Meeting:
September 14, 8:00 a.m. – 5:30 p.m.**

- Attend Prewrite Calls [Call schedule will be announced separately]
- Identify who will attend the Kick-Off Meeting
- Participants in the state Kick-Off Meeting may include:
 - Executive Leader
 - Day-to-Day Leader
 - Members of the Front Line Improvement Team from the selected medical-surgical units (e.g., staff nurse, unit manager, etc.)
 - Patient and Family members of the Cross Continuum Improvement Team and/or Front Line Improvement Team
 - Other stakeholders from the Cross Continuum Improvement Team (e.g., representative from nursing homes, home health, and or physician office practices)
- Register and obtain more information for the Kick-Off Meeting by sending an e-mail to:
safetables@wsha.org
- Complete the prework
- Prepare a Storyboard for the Meeting

Each hospital team attending the meeting should bring copies of their diagnostic prework and baseline data and their team aim statements to the meeting. Large poster boards [22 x 26 inch tri-folds) will be available for each team to post their prework.

Storyboards should include:

- Your hospital name and location
- Cross Continuum Improvement Team Members, and Front Line Improvement Team Members

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- A brief description or list of current activities in the area of reducing readmissions and improving transitions
- At least 12 months of baseline data on readmissions and patient experience, displayed in run charts
- Summary reflections on Worksheets A and B

Worksheet A: Chart Reviews of Patients Who Were Readmitted

Conduct chart reviews of the last five readmitted patients. Reviewers should be physicians or nurses experienced in the clinical setting and in chart review for quality and safety. Reviewers should not look to assign blame, but rather to discover opportunities to improve the care of patients. Worksheet A3 is a reference list of typical failures. The intent is to learn how we might prevent these failures that we once thought impossible to prevent.

Question	Patient #1	Patient #2	Patient #3	Patient #4	Patient #5
Number of days between the last discharge and this readmission date?	_____ days	_____ days	_____ days	_____ days	_____ days
Was the follow-up physician visit scheduled prior to discharge?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, was the patient able to attend the office visit?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Were there any urgent clinic/ED visits before readmission?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Functional status of the patient on discharge?	Comments:	Comments:	Comments:	Comments:	Comments:
Was a clear discharge plan documented?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Was evidence of "Teach Back" documented?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
List any documented reason/s for readmission	Comments:	Comments:	Comments:	Comments:	Comments:
Did any social conditions (transportation, lack of money for medication, lack of housing) contribute to the readmission?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Worksheet A: Reflective Summary of Chart Review Findings

What did you learn?

What trends or themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you curious about?

What do you think you should do next?

What assumptions about readmissions that you held previously are now challenged?

Worksheet B: Interviews with Patients, Family Members, and Care Team Members

If possible, conduct the interviews on the same patients from the chart review. Use a separate worksheet for each interview.

Ask Patients and Families:

How do you think you became sick enough to come back to the hospital?

Did you see your doctor or the doctor's nurse in the office before you came back to the hospital?

Yes

If yes, which doctor (PCP or specialist) did you see?

No

If no, why not?

Describe any difficulties you had to get an appointment or getting to that office visit.

Has anything gotten in the way of your taking your medicines?

How do you take your medicines and set up your pills each day?

Describe your typical meals since you got home.

Ask Care Team Members:

What do you think caused this patient to be readmitted?

After talking to the provider and the care team about why they think the patient was readmitted, write a brief story about the patient's circumstances that contributed to the readmission:

Worksheet B: Summary of Interview Findings

What did you learn?

What were the most common failures discovered?

What trends or themes emerged?

What, if anything, surprised you?

What new questions do you have?

What are you now curious about?

What do you think you should do next?

What assumptions about readmissions that you held previously are now challenged?

List of Typical Failures:

Typical failures associated with patient assessment:

- Failure to actively include the patient and family caregivers in identifying needs, resources, and planning for the discharge;
- Unrealistic optimism of patient and family to manage at home;
- Failure to recognize worsening clinical status in the hospital;
- Lack of understanding of the patient's physical and cognitive functional health status may result in a transfer to a care venue that does not meet the patient's needs;
- Not addressing whole patient (underlying depression, etc.);
- No advance directive or planning beyond DNR status;
- Medication errors and adverse drug events; and
- Multiple drugs exceed patient's ability to manage.

Typical failures found in patient and family caregiver education:

- Assuming the patient is the key learner;
- Written discharge instructions that are confusing, contradictory to other instructions, or not tailored to a patient's level of health literacy or current health status;
- Failure to ask clarifying questions on instructions and plan of care; and
- Non-adherent patients (resulting in unplanned readmissions):
 - a. About self-care, diet, medications, therapies, daily weights, follow-up and testing; and
 - b. Caused by patient and family-caregiver confusion.

Typical failures in handover communication:

- Poor hospital care (evidence-based care missing/incomplete);
- Medication discrepancies;
- Discharge plan not communicated in a timely fashion or adequately conveying important anticipated next steps;
- Poor communication of the care plan to the nursing home team, home health care team, primary care physician, or family caregiver;
- Current and baseline functional status of patient rarely described, making it difficult to assess progress and prognosis;
- Discharge instructions missing, inadequate, incomplete, or illegible;
- Patient returning home without essential equipment (e.g., scale, supplemental oxygen, or equipment used to suction respiratory secretions);
- Having the care provided by the facility unravel as the patient leaves the hospital (e.g., poorly understood cognition issues emerge); and
- Poor understanding that social support is lacking.

Typical failures following discharge from the hospital:

- Medication errors;
- Discharge instructions that are confusing, contradictory to other instructions, or are not tailored to a patient's level of health literacy;
- No follow-up appointment or follow-up needed with additional physician expertise;
- Follow-up too long after hospitalization;
- Follow-up is the responsibility of the patient;
- Inability to keep follow-up appointments because of illness or transportation issues;
- Lack of an emergency plan with number the patient should call first;
- Multiple care providers; patient believes someone is in charge;
- Lack of social support; and
- Patient lack of adherence to self-care, e.g., medications, therapies, daily weights, or wound care because of poor understanding or confusion about needed care, transportation, how to get appointments, or how to access or pay for medications.