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Reducing readmissions

Minnesota's RARE Campaign

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Across the United States, hospitals and other health care organizations are working to reduce avoidable hospital readmissions, following national priorities set by the Centers for Medicare & Medicaid Services (CMS) and the Affordable Care Act. Minnesota health care leaders recognized the need to improve, since nearly one in five Medicare patients discharged from Minnesota hospitals is readmitted within 30 days. Eighteen states have lower readmission rates.

Minnesota hospitals, health plans and other health care organizations intensified their efforts to reduce avoidable readmissions starting in 2009. To combine and build upon this work and accelerate improvement statewide, three health care organizations collaborated to create the RARE (Reducing Avoidable Readmissions Effectively) Campaign.

The campaign was launched in July 2011 under the leadership of three operating partners: the Institute for Clinical Systems Improvement (ICSI), a quality improvement organization that brings diverse stakeholders together to tackle complex health care issues; the Minnesota Hospital Association (MHA), which represents the state's hospitals; and Stratis Health, an independent nonprofit that leads collaboration and innovation in health care quality and safety, and serves as the Medicare quality improvement organization for Minnesota. Supporting partners are the Minnesota Medical Association, MN Community Measurement, and VHA Upper Midwest.

The operating partners set aggressive goals for the RARE Campaign, based on the "Triple Aim" of optimizing health, care, and costs:

- *Population health:* Prevent 4,000 avoidable readmissions within 30 days of discharge and reduce by 20 percent the overall readmissions rate from the 2009 base by Dec. 31, 2012.
- *Care experience:* Recapture 16,000 nights of patients' sleep in their own beds (based on an average four-day hospital stay X 4,000 avoided readmissions); improve 5 percent on the Hospital Consumer Assessment of Healthcare Providers and Systems survey questions on discharge.
- *Affordability of care:* Save an estimated $30 million for commercially insured patients, with additional savings for Medicare patients (based on per-readmission costs of $8,000 to $13,000).

To date, 80 hospitals, accounting for more than 80 percent of the state's readmissions, are participating in the campaign along with 70 community partners that are committed to helping prevent avoidable readmissions across the continuum of care. To join the campaign, hospitals agreed to reduce their avoidable readmissions by 20 percent based on their Potentially Preventable Readmissions (PPR) 2009 benchmark figures provided by the MHA.

Contributors to avoidable readmissions

Each participating hospital conducted an organizational assessment to identify drivers of its readmissions and to help the hospital select the interventions that would accelerate improvement. Based on all the organizational assessments submitted, the main gaps can be grouped into the following areas:

Discharge planning: This area has the most opportunity for improvement, with hospitals indicating that tools, templates, and technical assistance would help them improve all aspects of the discharge process. Some of the most pressing needs are for standardized discharge summaries, interagency referrals, and improved communication with primary clinics.

Assessment and measurement: Ranking second as a barrier is assessment and measurement, especially how data is measured, tracked, and analyzed so it can be used effectively to identify improvement opportunities. Help also is needed to develop effective tools and scorecards, particularly in the medication reconciliation process.

Patient education: Patient education is an area ripe for improvement, including development of standardized materials written in plain language to facilitate patient teaching early in their hospitalization. Other focus areas are engaging patients at their literacy level, using teach-back techniques, better end-of-life conversations, and a simpler teaching system for medication management.

Staff education: Many participating hospitals advocate training staff to use teach-back and train-the-trainer techniques for maximum effectiveness and efficiency. Additional needs include education for long-term care and skilled nursing facility staff.

IT/Electronic health records: Hospitals are dealing with challenges related to electronic health records (EHRs), including multiple systems that don't "talk" to each other and output that is not easily understood and patient-friendly.

Collaboration and best-practice sharing: The assessments identified a pressing need for better collaboration across care settings and disciplines, more opportunities for best practice sharing, and finding ways to involve family

members and caregivers in support of the patient.

The RARE operating partners provide resource consultants, learning opportunities and tools in the following five areas to help hospitals address their gaps:

- Comprehensive discharge planning
- Medication management
- Patient and family engagement
- Transition care support
- Transition communications

Hospitals also can participate in three learning collaboratives to help address the five key areas:

- ***Care Transition Intervention***, provided by Eric Coleman, MD, MPH, of the University of Colorado, and his team
- ***Project RED*** (Re-Engineered Discharge), developed by Boston University Medical Center.
- ***Safe Transitions***, piloted in 2011 by 13 Minnesota hospitals under the direction and support of the MHA; 27 hospitals are now participating.

These collaboratives offer a structured improvement process and an array of activities with recognized experts to help staff from different hospitals interact and learn from each other.

Acting on assessments

Steve Bergeson, MD, medical director of quality for Allina Health, found that participating in the RARE Campaign has expanded Allina's readmissions focus beyond patients with the three conditions identified by CMS as top causes of readmissions: heart failure, acute myocardial infarction, and pneumonia.

"The PPR methodology helped us learn about additional populations experiencing avoidable readmissions including patients younger than the Medicare population, and patients with specific medical and surgical diagnoses," Bergeson noted. "We were surprised at how quickly some of these patients return to our hospitals. The RARE PPR data has helped individual Allina hospitals to focus on the reasons patients are returning."

Completing the organizational assessment helped Allina Health identify a new infrastructure to support the full range of performance improvement (PI) required to analyze and interpret data and facilitate improvement teams. The interdisciplinary PI teams are designing new care processes to ensure that transitions are repeatable and reliable for all Allina patients, including:

Discharge disposition: Create standardized clinical assessment tools, documented in the EHR, to plan the transition of care after hospitalization.

The discharge package: Redesign the package of written instructions given to the patient at discharge with concise and relevant information to promote patient self-management following hospitalization.

Provider transitions: Create consistent and reliable communication between Allina's inpatient and all outpatient providers at the time of discharge to ensure the care plan started in the hospital is continued in the post-hospitalization setting.

Readmission predictive model: Create a predictive model to help clinicians identify patients who could benefit from a transition conference about resources available for the next level of care.

Allina realized it needed to empower its patients to manage their own health care. It chose to participate in the Care Transitions Intervention (CTI) collaborative because CTI focuses on skills transfer and helping patients achieve their personal goals by taking charge of their own health care. They implemented CTI as a pilot program on a targeted population based on past readmissions in one rural and one metro Allina hospital.

Allina has discovered the following challenges as it pilots CTI:

- Patients may agree while in the hospital to participate in the program, but by the time they get home they've changed their mind. CTI's consultants continue to work with the Allina coaches on ways to better engage patients while they are still in the hospital.
- It is important to contact the patient as soon as possible after discharge to schedule the in-home visit. Allina is using its EHR systems to ensure the coach is notified when an eligible patient is discharged.
- It is common for care transition coaches to have other responsibilities, as they do at Allina. As the pilot moves forward, Allina plans to have its coaches spend more of their time in the CTI intervention.

Bergeson noted that they're seeing great collaboration and have a coaching team that is very engaged and believes strongly in the CTI program. "The plan is to show a steady gain in number of patients coached, and the decision has been made to extend the pilot," he added.

At the other end of the spectrum is Glencoe Medical Clinic. Continuity of care is simplified somewhat because the small critical access hospital has a clinic and long-term care facility all located at one site. Glencoe doesn't admit many critically ill patients, which reduces the possibility of potential readmissions, and its readmission rate was low even before joining the RARE campaign. But that doesn't mean there isn't room for improvement, according to internist Bryan Fritsch, DO, Glencoe's physician champion for the campaign.

"The most surprising discovery to come out of our assessment was how fractured, nonstandardized, and varying our discharge process is from patient to patient," Fritsch said. "Each physician seemed to have their own way of doing things, and that led to confusion among the nurses about what is expected."

Glencoe chose Project RED to streamline and improve its medication reconciliation process, improve patient education throughout the hospital stay, and ensure better follow-up at discharge. This collaborative supports hospital teams as they implement strategies to improve patient safety and reduce hospital readmissions by focusing on processes related to discharge planning. "We found things that we can improve to help us cut down on follow-up phone calls from patients, medication confusion, and gaps in lab follow-up," Fritsch commented.

Fritsch noted that it was initially challenging to implement Project RED. "There has been a lot of work by the nurses and also by the pharmacists, and it wasn't easy to get everyone together for rounds, but it has been worth it. Now all the key players know the plan for the patient, and that can only be a good thing for everyone involved."

Early results and going forward

Work begun before the launch of RARE and six months since has prevented 1,915 avoidable readmissions through 2011. Hospitals receive their individual PPR data quarterly so they can monitor progress, and the operating partners can determine how best to help individual hospitals progress toward their goals.

As the campaign continues, enthusiasm, and commitment remain very high. For example, nearly 200 representatives from participating hospitals and community partners recently gathered for a day of learning and sharing best practices.

Many participating hospitals and community partners note the value of the operating partners combining efforts, helping them focus on five key areas known to prevent avoidable readmissions, and providing resource consultants and programs that accelerated progress. All the groups participating in this statewide, collaborative effort are looking forward to achieving the goal of ensuring Minnesotans spend 16,000 more nights in their own beds.

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