

Healthcare Quality/ Re-Admissions Issues Brief

Patients in transition – those moving from one care setting to another – are at increased risk for hospital re-admission (also known as re-hospitalization). These patients need several things: to know who is in charge of the transition, to be part of the plan, to understand the plan and any follow-up instructions, and to know whom to call with their questions when they are back at home. Some patients also need a family caregiver (someone designated to manage their care or advocate for them) actively involved in the transition process.

Coordination of care transitions is very difficult because of the “silos within silos” in the current healthcare system, where the tendency is for individual practitioners to have narrowly defined roles.

Massachusetts is currently participating in many projects to address and improve hospital readmission issues. These efforts are largely coordinated state-wide by the Massachusetts Care Transitions Forum, and a summary of these projects follows.

The Care Transitions Forum is a collaborative of more than 110 members representing some 50 organizations throughout the Commonwealth. The forum’s mission is to improve the quality of care transitions when patients are moved from one care setting to another, whether it is to a different unit in the hospital, to a different care facility, or discharging to home. Improving these transitions should result in the elusive “triple-win” in healthcare: care that is of higher quality, lower cost, and patient-centered.

The forum is the merged efforts of the Massachusetts Senior Care Federation Transitions Task Force and the Massachusetts Health Data Consortium Continuum of Care Forum, with additional support from the Massachusetts Hospital Association and Mass. Coalition for the Prevention of Medical Errors. The Care Transitions Forum reports to the Patient Safety Committee of the Healthcare Quality and Cost Council (HCQCC).

Numerous agencies and organizations have provided funding to these research projects aimed at reducing readmissions, including the Commonwealth Fund, CMS and MassHealth, and Commonwealth Medicine.

CURRENT PROJECTS OVERVIEW:

Potentially Preventable Readmissions (PPR) Project with 3-M

The Division of Healthcare Finance and Policy has identified an important opportunity for improvement in preventable readmissions. The Division has initiated a multi-stakeholder, statewide initiative to improve the quality of care through evaluating the 3M PPR (Potentially Preventable Readmission) tool. Different regions in the state have differing rates of re-admissions, as do teaching hospitals, Medicare/Medicaid and disproportionate share hospitals.

DHCFP has convened a Steering Committee for the project that includes a broad range of stakeholders, including MHA. Templates for both hospitals and statewide reports have been developed, and confidential reporting to hospitals has begun. Results of a survey of hospitals' feedback on the tool

were released this summer (2009), and the issues of continued surveillance and reporting are now being evaluated.

- » **Who's involved:** DHCFP, MHA and all MA hospitals.
- » **What's the goal:** Identify, pilot, and implement a tool to measure preventable readmissions.
- » **Current Status:** In pilot.

STAAR Initiative: State Action on Avoidable Re-hospitalizations

The STAAR initiative (State Action on Avoidable Re-hospitalizations) is an initiative supported by the Commonwealth Fund that aims to reduce avoidable re-hospitalizations within a given state. Currently three states are involved in the STAAR initiative: Massachusetts, Michigan and Washington.

The project has three high leverage opportunities for action: improving transitions for all patients, proactively addressing the needs of high risk patients, and engaging patients and their caregivers in assuming a proactive role in their plans. The initiative's goals include working across organizational boundaries, reducing avoidable re-hospitalizations by 30 percent state-wide and simultaneously increasing patient and caregiver satisfaction with the care received.

Project leaders have signed on 20 hospitals to pilot the STAAR Initiative's "Transitions Home Collaborative." Participating facilities are clustered throughout the Commonwealth. Each hospital is developing a cross-continuum Improvement Project

Team, and selecting two medical or surgical units for the front-line improvement work in their facilities. "Pre-work" is now underway and a team kick-off meeting was held September 29-30. Training for each participating hospital's Improvement Advisors began October 2009.

- » **Who's involved:** IHI, MHA, MA Senior Care, MACOPME, MMS, 20 hospitals.
- » **What's the goal:** Reduce statewide 30-day re-hospitalization rates by 30% and to increase patient and family satisfaction with transitions in care and with coordination of care.
- » **Current Status:** Kick-off in Sept. 2009



Interventions to Reduce Acute Care Transfers (INTERACT-II) Initiative

It is not uncommon for nursing home (or other skilled nursing facility) patients to be transferred to a hospital. In addition to being very expensive, these transfers often result in morbid complications, and previous research shows that many of the events triggering these hospitalizations can actually be managed without transfer to a hospital. Reducing such potentially avoidable hospitalizations could improve the quality of care and reduce overall medical expenditures for the nursing home population. The Massachusetts Senior Care Foundation began looking to accomplish these patient benefits through a CMS special study awarded to the Georgia Medical Care Foundation. The study results informed the creation of a toolkit for providers, the Interventions to Reduce Acute Care Transfers (INTERACT II).

INTERACT II has three major foci: improvement of clinical assessment skills by nurses, improving communication tools, and increased advance care planning. Conservative estimates on the Medicare savings achieved nationally by using this toolkit could reach over \$1 billion annually. Further studies in

30 nursing homes across Florida, New York and Massachusetts will continue to refine the INTERACT toolkit and implementation strategies of the project. This effort is supported by a grant from the Commonwealth Fund.

Revised versions of the toolkit will soon be available on www.geriu.org.

- » **Who's involved:** MA Senior Care, 10 nursing homes in MA, 10 in FL, 10 in NY for total of 30 nursing homes.
- » **What's the goal:** Reduce patient transfers from nursing homes to hospitals.
- » **Current Status:** In study at total of 30 nursing homes. Implementation period is May 2009 - January 2010.

MOLST Demonstration Project: Medical Orders for Life-Sustaining Treatment

MOLST – Medical Orders for Life-Sustaining Treatment - is a portable medical form that translates the patient's wishes for end of life care into immediate, actionable medical orders that can be transferred across healthcare settings. MOLST is actually a process that begins with frank discussions between patients and their care providers (MD, RN or PA) and culminates in the completion of this actionable form. Communication between the patient and the provider is the core of the approach. The form is much more than just a Do Not Resuscitate – it includes wishes around transfer to a hospital (yes, no, not to ICU, etc.), and can include other preferences such as dialysis, artificial nutrition and more.

The goal of the MOLST program is to implement a process in Massachusetts for communicating patients' wishes for care at the end of life similar to the Physician Order for Life Sustaining Treatment (POLST) program started in Oregon in 1995, and now in other states including Washington, North Carolina, Wisconsin, New York, West Virginia and California. The MOLST program is expected to make it much easier for consumers/patients and providers to collaborate, by creating a common language to talk about end of life issues.

Members of the Massachusetts Care Transitions Forum are currently finalizing and vetting the MOLST form in several communities, and continuing education and outreach efforts. These results will serve as the basis for refining and then spreading the MOLST program state-wide.

- » **Who's involved:** Local participants from the Worcester, MA community including hospitals, long-term acute care facilities, sub-acute care, home care, EMS.
- » **What's the goal:** Establish a standardized process for communicating patients' end of life care wishes across the continuum of care in Massachusetts.
- » **Current Status:** Project ongoing, with Program Development, Education and Outreach, and Evaluation Workgroups in process. Timeline: January 2009 - December 2010.



Home Care Projects: Masspro Collaborative Project

Masspro is a nationally recognized healthcare performance improvement organization founded by the Massachusetts Medical Society. The group's goal is to transform healthcare by developing and disseminating innovative improvement concepts across all sectors of the healthcare delivery system. Masspro engages in collaborative efforts with healthcare providers, the Centers for Medicare and Medicaid Services (CMS), the Massachusetts Office of Medicaid, employer groups, physician practices, health plans, specialty societies, advocacy groups, and beneficiaries.

The Masspro Collaborative Project looks at the role of home care in improving care transitions. It has several key initiatives:

- » Identification of patients at high risk to be re-admitted, and “front-loading” their care in the first several weeks after discharge
- » The “call me first campaign,” which encourages patients and families to call the home care agency before calling 911
- » Encouragement of patient self management
- » Working with care transitions to decrease unneeded re-admissions and strive for seamless transitions from inpatient settings to home care.

The project frames the Collaborative's benefits as “What's In It for Me” from the perspective of hospitals, patients and home care. Hospitals can save money, patients will have higher overall satisfaction and quality of life, and home care will be freed

from the burden of much of the bureaucracy caused by stopping and resuming care of these patients. Pilot projects have shown a decrease in the re-hospitalization rates of patients in the program. The program has overcome initial barriers in using and maintaining coaches, solutions are being developed and the process continues to advance.

» **Who's involved:** Five home care agencies.

» **What's the goal:**

1. Enhance the clarity of discharge information so as to improve care processes and empower the patient to take an active role in health management.
2. Decrease the acute care hospitalization with participants in the project.

» **Current Status:** Project “coach” position was eliminated, instead will participate with recipient of Schwartz Center grant. Formed a relationship with local medical center to continue the project.

Community-based Care Transitions Projects

RED & BOOST

Project RED (Re-Engineered Discharge) is an AHRQ funded-research project in which patients being discharged from a general medical inpatient service were sent either to an intervention or a “control” group in which they received standard care but no intervention. Those in the intervention group received attention from a nurse discharge advocate, were given an after hospital care plan, and had a clinical pharmacist call them two- to- four days after discharge. Those in the intervention group displayed improved readiness for discharge, improved the primary care physician follow up rate, and a 30 percent decrease in overall hospital use.

- » **Who's involved:** Adult medical patients admitted to Boston Medical Center (urban academic safety-net hospital), no other providers involved.
- » **What's the goal:** Reduce rehospitalization using the three components of Project Red: Implementation of in hospital Nurse Discharge Advocate (DA), preparation of After Hospital Care Plan (AHCP), and implementation of after discharge Clinical Pharmacist Call.
- » **Current Status:** Conclusions of the randomized clinical trial (RCT) demonstrated that “Re-Engineered Discharge” was successfully delivered using RED (Re-Engineered Discharge) protocols and the After Hospital Care Plan. Results demonstrated decreased re-hospitalization rate and improved primary care physician appointment follow up rate.

Project BOOST (Better Outcomes for Older adults through Safe Transitions) is a Hartford Foundation funded quality/process improvement project run by the Society of Hospital Medicine to improve discharge transitions. The principal BOOST intervention is a tripartite tool called the TARGET (Tool for Adjusting Risk: A Geriatric Evaluation for Transitions). Its three components include:

- » The 7P scale, which analyzes key risk factors for repeat hospitalization with associated risk-specific interventions;
- » The Universal Patient Discharge Checklist to ensure a general improvement for all discharges without risk stratification; and
- » The GAP (General Assessment of Preparedness), a patient-centered checklist of patient concerns that need to be addressed.

Finally, Project BOOST includes a very simple, low-literacy, patient-centered discharge plan called the Patient PASS (Patient Preparation to Address Situations after discharge Successfully). This form brings the key issues and information that patients need to leave the hospital into one place for easy reference and self help.

- » **Who's involved:** 24 hospital sites.
- » **What's the goal:** Reduce re-hospitalizations via improved discharge procedures that identify specific readmission risks and use checklists for both patient and provider.
- » **Current Status:** Now in phase 2: full roll out to 24 sites across the country.

Business-led Projects: Dovetail Health's Pharmacist-Led Transition Services to Avoid Costly Readmissions

Dovetail Health is a health service that connects physicians, family and caregivers to make sure that patients receive the care they need, while preventing unnecessary re-hospitalizations. The company has taken elements from a variety of quality improvement efforts and combined them with the use of a PharmD to not only prevent re-admissions, but possibly initial admissions as well.

By using predictive modeling, Dovetail identifies patients who will need care transition coaches. Selecting only those patients who are most likely to benefit from this service leads to good return on investment, and the use of a PharmD brings in experience and knowledge of drugs and their potential interactions not found in other transitions programs. The group's 30 day re-admission rates are on average nearly one-half of the Massachusetts average, and nearly one-quarter of the home health agency rates.

- » **Who's involved:** Providers, payers and other organizations involved in the delivery of turnkey health and medication management programs to provide in-home chronic care; Dovetail Health.
- » **What's the goal:** Head off potential readmissions by identifying patients who are most at risk and providing them with transition team of a pharmacist "transition coach", Nurse Care Manager, and Transition Care Coordinator to avoid potentially adverse drug interactions.
- » **Current Status:** Five year old company; 10.8% 30-Day Readmission rates (almost half the MA and National Averages).

CONCLUSION:

These projects will not supply a quick fix to the hospital readmissions issue. However, Massachusetts healthcare leaders are making steady, incremental progress in a coordinated fashion. Providers across the continuum are motivated to reduce preventable readmissions, even though the specifics of healthcare reform and alternative payment models such as Accountable Care Organizations are still being debated and incentives are not yet aligned. Through the Care Transitions Forum and HCQCC Patient Safety Committee, these projects will continue to collect data and make decisions based on what has been learned, while remaining connected and communicating with each other to better measure and evaluate their collective results. This ongoing collaboration will help all Massachusetts stakeholders identify true best practices more quickly and efficiently than any sub-set could accomplish on its own.



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