Editor's Note: *This article and the one that follows, by Jason Niehaus, are companion pieces intended to show how one Catholic health care system (Catholic Health Partners) is strengthening acute care and long-term care to ease transitions for elderly patients.*

Blueprint for Improving Transitions

Teamwork Closes the Gap

BY CATHERINE FOLLMER, RN, M.B.A., CHCE, CRNI

Today's interstate highways are very similar to the present health care environment: riddled with construction, delays and multiple detours. The driver faces many dilemmas, one being "pass at your own risk," which makes travel complex and complicated. The challenges health care systems face are basically the same; do you stay on the familiar path, or do you take the risk of the unfamiliar detour on uncharted terrain — in other words, pass at your own risk? The unanswered questions are "What's the risk?" and "Will it get you to your desired end state?"

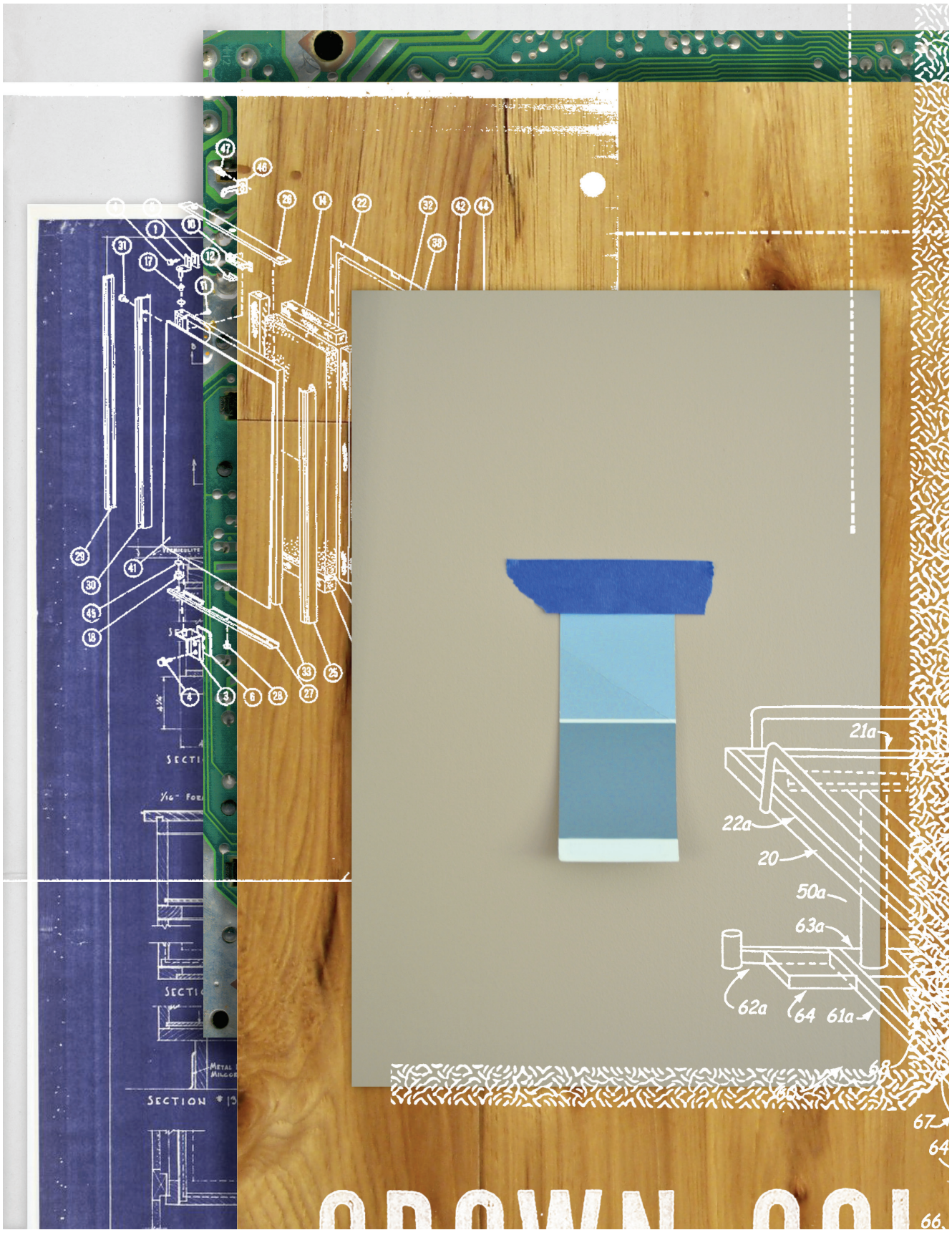
Over the last decade, health care has begun the transition to transparency, public reporting and pay for performance. In the midst of this has come the realization that the hospital is no longer the driver of the bus — it has begun the transition to its rightful place as a necessary rest stop along the continuum-of-care journey.

Catholic Health Partners (CHP) began a journey in 2006 with a focus on preventing avoidable harm and mortality and improving end-of-life care in the acute-care settings. In 2007 CHP expanded the focus to increasing efficiencies, decreasing waste and redundancy in efforts to decrease length of stay. In 2008, this effort evolved to improving the coordination of care across the continuum.

In the process, it became apparent that to succeed we needed to move away from silos of care, identify industry experts as partners and engage leadership, along with middle managers and point-of-service staff, throughout the continuum.

Achieving high reliability results requires a systems approach to improvement versus disconnected, isolated projects. To support the improvement of the care delivery process across the system, CHP partnered with the Institute of Healthcare Improvement (IHI) of Cambridge, Mass., and adopted that organization's improvement methodologies, measures and approaches to improve the quality, safety and operational efficiency of care.

CHP used "collaborative model" as a term for its strengthened initiatives. A collaborative is a learning system that brings interdisciplinary teams together from various health care settings to seek improvement in a focused area that includes global aims, formal measurement and reporting, execution and spread of proven practices.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CHP's action plan, with a time frame of 12 to 24 months, included the following:

- Face-to-face meetings attended by interdisciplinary service lines crossing the continuum of services every six months
- Scheduled conference calls and webinars
- Designated team members for each hospital or entity, to include an executive sponsor who is an administrative or clinical leader and part of the senior leadership team; a collaborative team leader who will be accountable for coordinating process improvement teams and hospital- or entitywide improvement activities; and a physician champion committed to quality and patient safety.
- Formal action plan for each facility
- Successful practices identified and spread to other facilities
- Local and regional meetings as appropriate

A successful collaborative requires senior leadership engagement and an energized multidisciplinary team at the collaborative learning sessions and at the facility or entity to implement changes.

The collaboratives host:

- Industry experts presenting on proven strategies, trends and evidence-based practices implemented throughout the country
- Workshop sessions that will assist the facilities and service lines in developing action plans, identifying cross-continuum teams and developing shared key results indicators to gauge progress
- Poster presentations showcasing facilities and service line achievements
- Panel discussions highlighting internal and external service lines' successes and challenges.

With the Centers for Medicare and Medicaid Services (CMS) penalties for rehospitalizations targeted to begin in 2012, under which CMS will penalize hospitals with readmission rates above the risk-adjusted national average, CHP identified the need to begin a care coordination collaborative that would focus on preventing unnecessary rehospitalizations through identifying and improving transitions of care. As a system, CHP performed close to the national average; however, variation among hospitals had been significant and, without improvement, some of the CHP hospitals would experience payment reductions. The collaborative kickoff took place in January 2011, after a considerable amount of preparation.

As the saying goes, to know where you're going, you need to know where you are. To prepare for this collaborative, the facilities and service lines participated in the CHP rehospitalization audit. CHP developed a retrospective readmissions audit tool and named it the 3x3 to assist CHP acute-care facilities, home-care agencies and long-term care facilities in identifying areas of potential improvement related to unnecessary rehospitalizations.

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The 3x3 is based on the Institute of Healthcare Improvement (IHI) mortality 2x2 tool that helps identify areas of opportunity for improvement in end-of-life care and preventable death. It is a directional tool that can be used across the continuum of care to identify opportunities to improve processes and quality of care and to decrease unnecessary rehospitalizations. The 3x3 name refers to designated time ranges in which readmissions fell: 0-7 days, 8-14 days and 15-30 days.

The study looked at the last 25 readmissions. For acute-care facilities, cases were narrowed to the three diagnoses that will be targeted for future reimbursement penalties: acute myocardial infarction, heart failure and pneumonia.

The following information was collected: reason for rehospitalizations, planned or unplanned readmission, discharge disposition, physician follow up code status and point of re-entry into the system. Examining this information assisted the cross-continuum teams in developing action plans. This retrospective review is a snapshot used as a guide to identify opportunities. Additional real time patient and caregiver interviews regarding rehospitalizations also were recommended.

Overall findings show that the reason for rehospitalization related to the original diagnosis in more than half of the cases reviewed. CHP determined that for the acute-care and long-

term care facilities, the largest opportunities for improvement were within the first seven days of discharge, and for home care, the 15-30 day readmissions.

Opportunity also exists with identification of the appropriate level of care upon discharge. The audit shows 54 percent of rehospitalized patients had initially been discharged home with no home care services, 13 percent were rehospitalized from a home-care agency and 26 percent from a long-term care facility.

In both acute care and home care, the study found a need to ensure patients made follow-up visits to physicians. Most often, information about whether a patient had seen a physician for a follow up was not documented by the hospital.

The majority of the patients had a "full code" status, which suggested there were opportunities to work with patients and families on advance care planning and for earlier palliative care interventions.

Ninety-one percent of rehospitalized patients return through the emergency department. At the time of the audit, CHP facilities did not have an adequate model for accessing case managers in emergency departments, so pilots were put in place.

The findings noted above are not surprising. They are in line with findings across the health care industry and were instrumental in setting the road map for improvement.

The January 2011 collaborative marked the initiation of multidisciplinary cross-continuum teams charged with reducing unnecessary readmissions and improving transitions of care. Aligning with the IHI model for improvement and the "small test of change" process for quality improvement, CHP assisted regions with a simple format for "What can you do by next Tuesday?" that managed expectations, kept it simple and generated will.

Throughout the CHP system, the different cross-continuum teams are working on small tests of change and Plan-Do-Study-Act cycles — another improvement process — on the following:

- Physician follow-up visits
- Simple discharge instructions
- Patient caregiver education
- Readmission risk assessment
- Post-acute transition process
- Models of care
- Medication reconciliation
- EMR implementation
- Patient activation

Each team shares its focus area and progress during monthly care-coordination collaborative calls. Successful practices are then tested and spread by the other teams.

Other supporting work includes:

- Several CHP facilities are participating in national readmission initiatives — State Action on Avoidable Rehospitalizations (STARR), Re-Engineering Hospital Discharge project (Project RED), Better Outcomes for Older Adults through Safe Transitions (BOOST), as well as local initiatives with the Council on Aging
- The Palliative Care Medical Consultation model has been successfully implemented in one CHP region, with recommendations to spread systemwide
- "Palliative Care across the Lifespan with a Uniquely Catholic Perspective," a three-week course that covers life's continuum, has been developed by CHP. The course focuses on improving end-of-life care. CHP worked with Mercy College in Toledo and developed an online platform to increase access for CHP associates

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- "Safety Across the System," CHP's safety improvement partnership with IHI, has helped build engagement, support and buy-in among front-line managers and staff for safety improvement efforts
- CMS Partnership for Patients initiative furthers process-improvement competencies and achieve better outcomes. Ultimately, better quality results not only in better outcomes and experiences for patients, but a better work experience for caregivers
- Quality Operating System, a CHP initiative, engages top hospital leaders with weekly walk rounds focusing on quality and safety, throughput (flow) and patient experience. It is done at the department level and engages leadership at the point of care delivery or service
- Quality Flow Rounds, a CHP initiative, is being rolled out in several CHP facilities. It is a

daily nurse-to-leader review of a patient with a "plan for the day, plan for the stay" focus. This will eventually be spread to each shift to increase timeliness and efficiency of the seamless progression of patients for the next level of care

As a result of the action plan, CHP is closing the gap. The system has seen a decrease in variation for rehospitalizations among its hospitals. Decreased variation seems to indicate two things: (1) The readmission population in areas with higher readmission rates does appear to be sicker; and (2) teams have had success in tackling some readily available opportunities for improvement, such as discharge planning for those readmitted patients who are less acutely ill, more reliable assessment and discharge processes and more cross-continuum collaboration and alignment.

As are many across the industry, CHP is still struggling with rehospitalizations. As a system, it continues to identify evidence-based practices to implement and spread. CHP has learned that this challenge does not lie with just one service line, but requires deliberate strategies that include the patient, families, physicians, emergency departments, acute-care facilities, post-acute and community services. Communication, technology and information system all play integral roles. Success does not have one owner but a collaboration of owners: acute-care facilities, physicians, post-acute service, community services and — most importantly — alignment with patient and families.

We have learned to use the detours and road bumps on our journey as a time for reflections, and in collaboration with our cross-continuum teams and improvement partners, we make the necessary adjustments. In this ever-changing and challenging health care and economic environment, we will not be overwhelmed or overcome in this most important work.

CATHERINE FOLLMER is vice president, care continuum, for Catholic Health Partners in Cincinnati.

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