HRET HIINnovation Roadshow

North Dakota Hospital Association

Fargo, ND

October 2-3, 2017

#WhyImHIIN

Wifi:
Delta_CONFERENCE

American Hospital Association

HRET HEALTH RESEARCH & EDUCATIONAL TRUST

Agenda

October 2, 2017 | Day 1 | 12:30-4:15 p.m. C.T.		
11:30 a.m. – 12:30 p.m.	**Registration**	
Time	**Session Title**	**Speakers**
12:30-1:00 p.m.	Welcome and Overview	
	• North Dakota Hospital Association and HRET will provide an overview of the Partnership for Patients work, including our accomplishments to date and ambitious goals for the HIIN project.	Jean Roland, RN, BSN, CPHQ Quality Improvement Specialist- Quality Health Associates of North Dakota Shereen Shojaat, MS Program Manager-HRET
1:00-1:30 p.m.	Networking: Speed Dating	
	• Evaluate your organization's progress in reducing hospital acquired conditions. • Share topic success factors and those requiring support.	Shereen Shojaat, MS Program Manager-HRET
1:30-1:45 p.m.	**Afternoon Break**	
1:45-4:15 p.m.	Organizing and Leading for High Reliability	
	• Summarize the characteristics of an organization on an HRO journey. • Assess where your organization is on the journey to high reliability. • Select one area where you will begin testing a new idea from this session. • Discuss how achieving the characteristics of HRO support your aims in the HIIN.	Fran Griffin, RRT, MPA Faculty- Institute for Healthcare Improvement

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Agenda (CONTINUED)

October 3, 2017 | Day 2 | 8:00-10:30 a.m. C.T.		
8:00-10:15 a.m.	**Community Collaboration in Readmissions**	
	• Describe the importance of community collaboration. • Recognize an effective community model and identify non-traditional community partners. • Design an approach to accelerate collaboration with community partners. • Inventory resources that influence opioid use in your community.	**Pat Teske, MHA, RN** *Improvement Advisor- Cynosure Health*
10:15-10:30 a.m.	**Reflection and Next Steps**	
	• Review themes from the day, opportunities for collaboration and next steps.	**Shereen Shojaat, MS** *Program Manager-HRET*

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Welcome

Jerry Jurena, President, NDHA

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Getting to Know Our Hospitals

Jean Roland, RN, BSN, CPHQ
Innovate-ND|HRET HIIN
Program Manager

Nikki Medalen, MS, BSN, APHN-BC
Innovate-ND|HRET HIIN
Quality Improvement Specialist

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Shereen Shojaat, MS | Program Manager, HRET

HIIN: THE ROAD TRAVELED AND JOURNEY AHEAD

AHA/HRET Original HEN Results

FINAL AHA/HRET HEN ESTIMATED TOTAL HARMS PREVENTED WITH COST SAVINGS

Topic	Estimated Harms Prevented [1]	Estimated Cost Savings
ADE	8,155	$24,465,000
CAUTI	2,805	$2,805,000
CLABSI	893	$15,181,000
EED	992 (NICU Admissions)	$7,811,000
Falls	1,331	$882,000
OB Harm	766	$705,000
Pressure Ulcers	4,655	$188,528,000
Readmissions	65,022	$572,714,000
SSI	4,860	$102,060,000
VAE/VAP	58	$1,218,000
VTE	3,255	$72,391,200
TOTAL	92,792	$988,760,000

DATA SOURCE:
Comprehensive Data System (CDS) (11/18/14); Data covers January 2012 through November 2014. Cost reference sources listed in PEC April 2014 Formative Feedback report appendices.

1 Harms prevented calculated at hospital level and then aggregated to HEN level (hospital compared to own baseline). Harm calculated only with months that have sufficient *n* (85 percent of hospitals reporting at baseline). Hospitals omitting months of data were determined to be negligible at HEN level.

AHA/HRET HEN 2.0 Results

TOPIC	HARMS PREVENTED	COST/HARM	COST SAVINGS
ADE[1]	15,611	$5,000[1]	$78,054,063
CAUTI	505	$1,000	$505,078
CLABSI	439	$17,000	$7,469,333
EED	1,151	$9,732	$11,240,529
Falls	1,409	$12,965	$18,265,363
OB Harm[2]	4,336	$114 (with instrument) $197 (without instrument)	$753,627
Pressure Ulcers	1,122	$17,000	$19,077,915
Readmissions	8,040	$15,477	$124,440,097
SSI[3]	792	$21,000	$16,630,883
VAE	278	$21,000	$5,832,649
VTE	738	$8,000	$5,901,515
TOTAL	**34,422**	---	**$288,171,052**

** Totals may not match sum of individual topics due to rounding.*

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HIIN: Hospital Improvement Innovation Network

- Ctr for Clinical Standards and Quality
- HIIN funded out of Medicare Trust Fund

- Public-private partnership
- Set 20/12 goal all cause harm

- Tool: HIIN
- 16 contracts awarded

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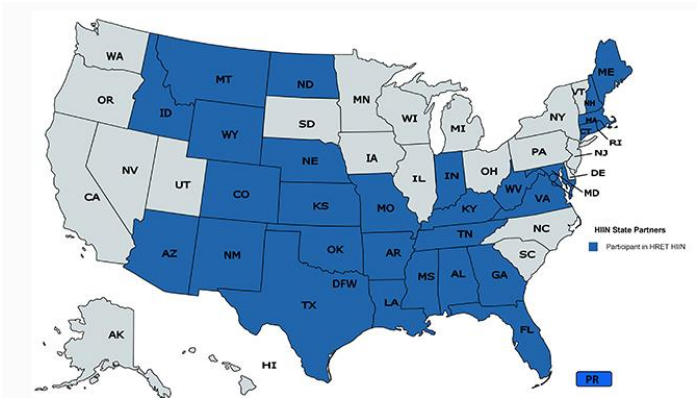
- Contracted with 33 state and regional hospital associations
- 1,634 hospitals



Hospital leadership

Clinicians and front line staff (teams)

THE PATIENT

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HIIN: Where We Are Going

Goals:

- **20%** **Overall reduction in hospital-acquired conditions** (baseline 2014)
- **12%** **Reduction in 30-day readmissions** (baseline 2014)

"America's hospitals embrace the ambitious new goals CMS has proposed," said Rick Pollack, president and CEO of the American Hospital Association (AHA). "The vast majority of the nation's 5,000 hospitals were involved in the successful pursuit of the initial Partnership for Patients aims. **Our goal is to get to zero incidents**. AHA and our members intend to keep an unrelenting focus on providing better, safer care to our patients -- working in close partnership with the federal government and with each other."

partnershipforpatients.cms.gov

2010	145 Harms/1,000 Discharges
2011	142 Harms/1,000 Discharges
2012	132 Harms/1,000 Discharges
2013	121 Harms/1,000 Discharges
2014	121 Harms/1,000 Discharges
***New Goal* 2019**	**97 Harms/1,000 Discharges**

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Bold Aims For HIIN

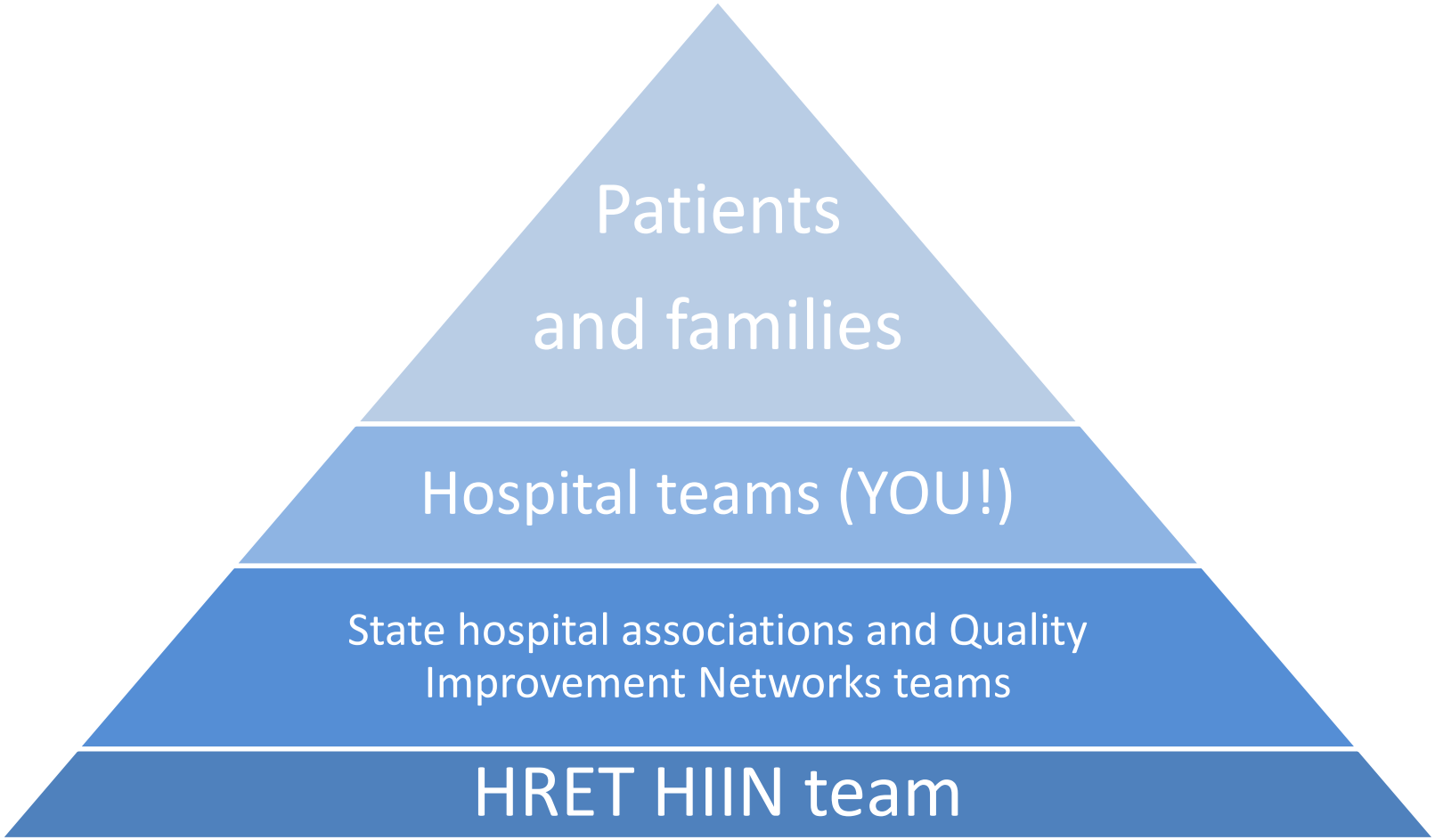
Two base years to reduce all-cause inpatient harm by 20 percent and readmissions by 12 percent.

1. Be in action to support your patients and their families by committing to this project.
2. Work to reduce harm *across the board.*
3. Learn together by sharing your hospital stories – successes and opportunities.
4. Data is the foundation of all improvement at the unit level, hospital level, state and national level.
5. ***Accelerate***, ***align*** and ***amplify*** the work of the previous HEN projects.

HRET HIIN Goals

Alignment with the Goals / Aims of the Partnership for Patients Program		
Recruitment		
Commitment to total # of hospitals the HIIN shall support		1,710
Bold Aim Milestones	**Year 1**	**Year 2**
Commitment to Reducing All-Cause Harm by 20%		
% Reduction of Adverse Drug Events	7%	20%
% Reduction of Central Line-Associated Bloodstream Infections	10%	20%
Bold Aim Milestones	**Year 1**	**Year 2**
% Reduction of Catheter Association Urinary Tract Infections	10%	20%
% Reduction of Clostridium difficile	7%	20%
% Reduction of Falls	7%	20%
% Reduction of Pressure Ulcers	10%	20%
% Reduction of Sepsis & Septic Shock	7%	20%
% Reduction of Surgical Site Infections	10%	20%
% Reduction of Venous Thromboembolism	7%	20%
% Reduction of Ventilator-Associated Events	7%	20%
Commitment to Reducing Harms Most Meaningful to the HRET HIIN		
% Increase in Hospital Culture of Safety	5%	20%
% Reduction in MDRO (i.e., MRSA)	5%	10%
Commitment to Reducing 30-day Readmissions by 12%		
% Reduction of Readmissions as a population-based measure	4%	12%
Total Proposed Impact		
Goal for Estimated Number of Harms Avoided Overall	26,635	73,150
Goal for Estimated Number of Lives Saved Overall	1,326	3,639
Goal for Estimated Cost Savings Overall	$233 million	$641 million

HRET HIIN Structure



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HRET HIIN State Partners

1. Alabama
2. Arizona
3. Arkansas
4. Colorado
5. Connecticut
6. Dallas Fort-Worth
7. Delaware
8. Florida
9. Georgia
10. Idaho
11. Indiana
12. Kansas
13. Kentucky
14. Louisiana
15. Maine
16. Maryland
17. Massachusetts
18. Mississippi
19. Missouri
20. Montana
21. Nebraska
22. New Hampshire
23. New Mexico
24. **North Dakota**
25. Oklahoma
26. Puerto Rico
27. Rhode Island
28. Tennessee
29. Texas
30. Vermont
31. Virginia
32. West Virginia
33. Wyoming

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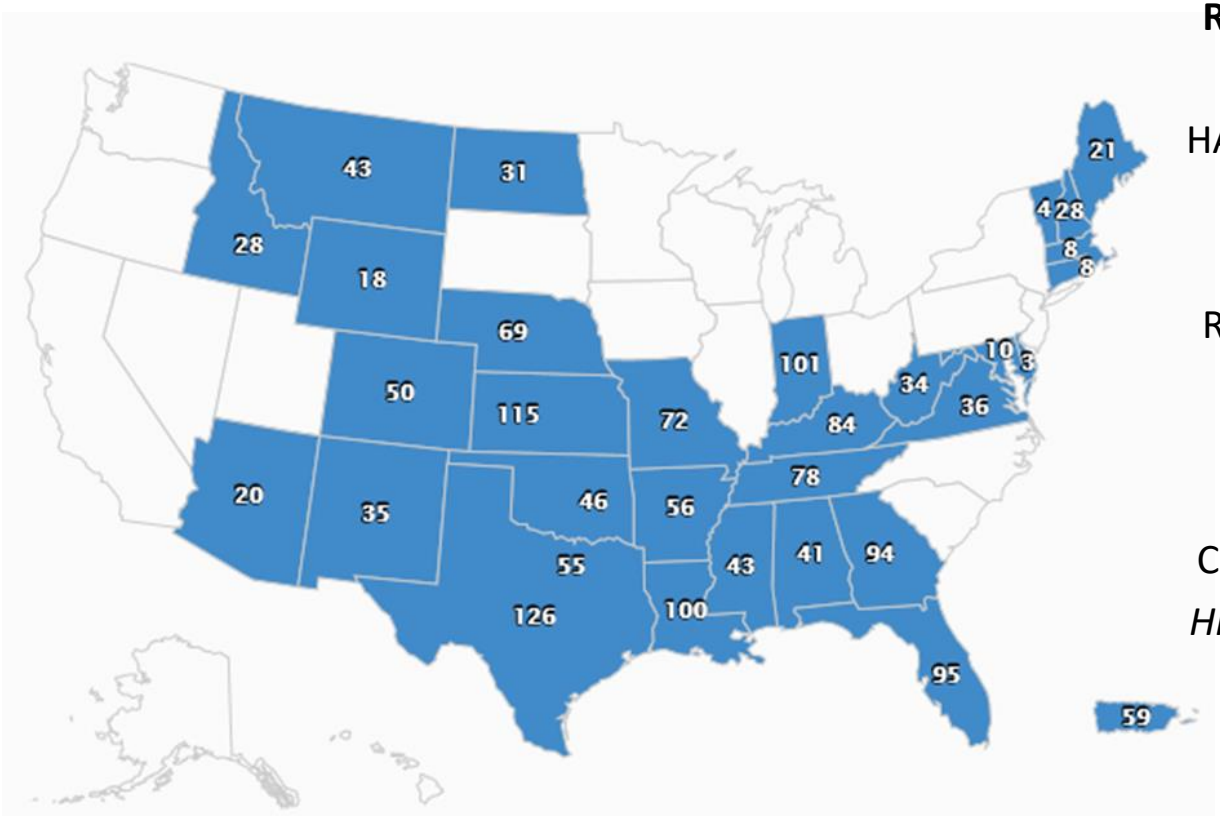
HRET HIIN Hospitals

1634 Hospitals

817 Rural

560 CAHs

816 Urban



Results to Date

29,447

HARMS AVOIDED

10,205

READMISSIONS AVOIDED

$271M

COSTS AVOIDED

HIIN Data (10/16 – 5/17)

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We're here to help!

Resources and Tools

Peer Sharing

Education and Skill Building

Data

NEW AND IMPROVED

HRET's Approach

- Framing all HIIN work as a single, cross-cutting improvement initiative rather than series of discrete efforts
  - Group a few interventions together (leadership, current/accurate data, physician engagement, culture of safety, PFE)
- Emphasize "doing" within the hospital rather than "attending" as the route to substantive progress
  - Look at the improvement occurring within the organization
- Stressing rapid progress vs. chance
  - Focus on rapid change linked to process improvement

Core Topics – Aim Is 20 Percent Reduction

1. Adverse drug events (ADE)
2. Catheter-associated urinary tract infections (CAUTI)
3. *C. difficile* infections (C. *diff*)
4. Central line-associated blood stream infections (CLABSI)
5. Injuries from falls and immobility
6. Pressure ulcers (PrU)
7. Sepsis
8. Surgical site infections (SSI)
9. Venous thromboembolisms (VTE)
10. Ventilator-associated events (VAE)
11. Readmissions (12 percent reduction)

Note: patient and family engagement (PFE) and health care disparities (HCD) woven throughout all topics.

All Other Forms Of Harm

1. Multi-drug resistant organisms (e.g. MRSA)*
2. Hospital patient safety culture*
3. Diagnostic error**
4. Airway safety**
5. Iatrogenic delirium**
6. Undue exposure to radiation**
7. Malnutrition in the inpatient setting**

***HRET will have a strong focus on MRSA and hospital patient safety culture throughout the project.**

Education and Skill Building

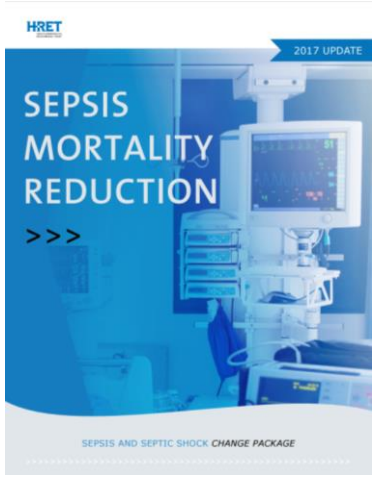
- Virtual Events – new formats!
  - Topic-specific and cross-cutting
  - Interactive and focused on participant feedback
- Safety Networks to Accelerate Performance (SNAP)
  - Small learning collaboratives to test emerging best practices
- UP Campaign
  - A cross-cutting approach to reduce harm
  - More information here: http://www.hret-hiin.org/topics/up_campaign/index.shtml
- Fellowship programs
- HIIN Roadshow (today!)

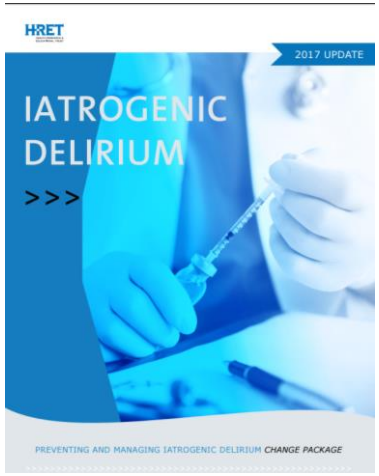
Resources and Tools

- Website and resource library: www.hret-hiin.org
  - Topic-specific information
  - Peer-shared and expert resources and tools
  - Evidence-based practice and guidelines

Change Packages and Top-Ten Checklists

- Jump-start your improvement projects





LISTSERV® Collaboration

- Subscriber-based email group.
- Each email group covers a different topic or group of topics.
- Ideal for:
  - Peer-shared learning
  - Asking questions about barriers
  - Sharing data collection opportunities
  - Clarifications about measures or inclusion/exclusion criteria

Sign up today!

Data Resources and Support

- Comprehensive Data System
  - Reports, tools, comparisons
- Encyclopedia of Measures
- Improvement Calculator
- How-to data videos

HRET Pearls of Wisdom

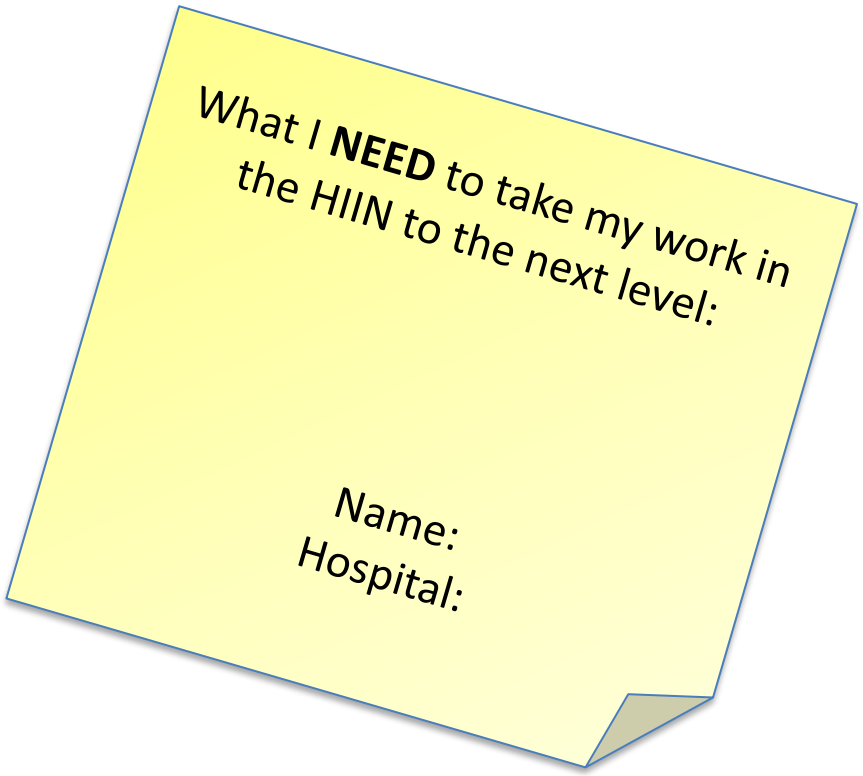
- **Commit to the new bold aims** of the Partnership for Patients. Bold aims challenge us to build systems that get results.
- We've shown we can achieve results. Now, our challenge is to **align, amplify and accelerate** our work.
- Manage competing priorities through **cross-cutting, aligned approaches** to harm reduction. Remain focused on **reducing harm across the board**.
- Use your **peers** – in the state and across the country – to accelerate improvement.
- Authentically and fully **engage your patients** in the improvement work.
- Lead in engaging others in the work. Create an army of supporters in your organization!
- Change is not easy. Stand together in serving as **catalysts for change**.

Networking:
Speed Dating

WELCOME TO SPEED DATING

INSTRUCTIONS

- Fill out 2 post it notes

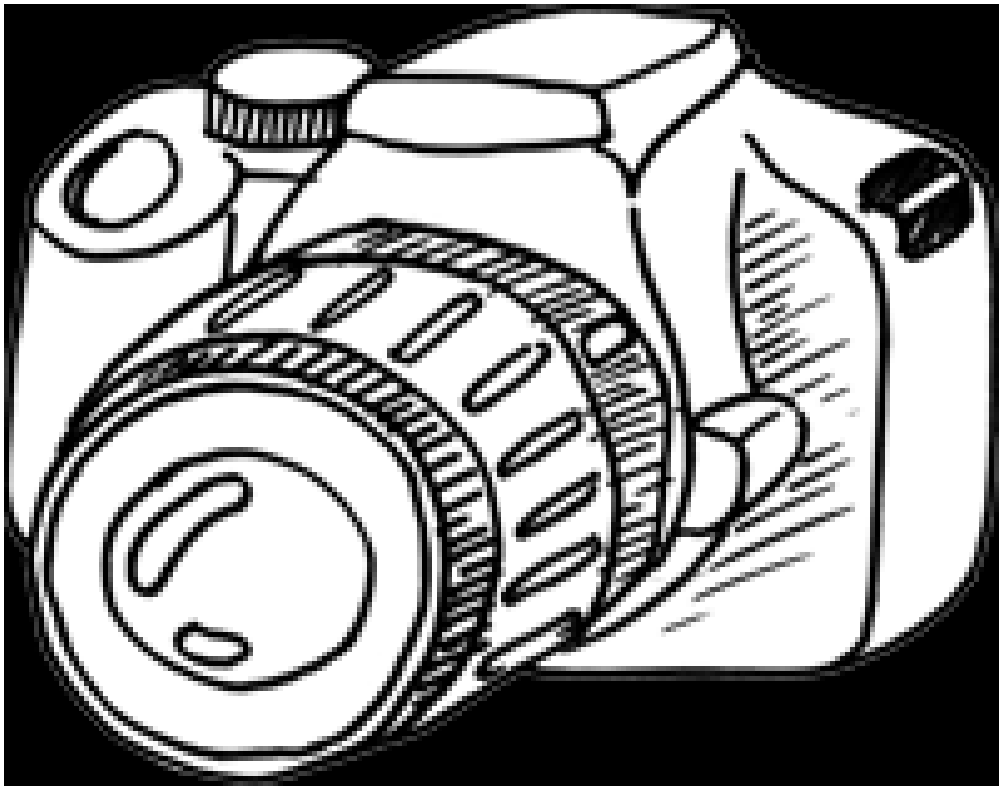


- Place your post it note on the corresponding Poster board

Meet a new friend. Exchange “prouds” and “needs” SWITCH!

What did you learn?

BREAK



Organizing and Leading for High Reliability

Fran Griffin, RRT, MPA
Faculty, The Institute for Healthcare Improvement
October 2, 2017

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Faculty Disclosure

Fran Griffin, RRT, MPA

Fran Griffin & Associates, LLC

This presenter has nothing to disclose.

Objectives

- Summarize the characteristics of an organization on an HRO journey
- Assess where your organization is on the journey to high reliability
- Select one area where you will begin testing new idea(s) from this session
- Discuss how achieving the characteristics of HRO support your aims in the HIIN

A COMPREHENSIVE FRAMEWORK FOR PATIENT SAFETY, RELIABILITY AND CLINICAL EXCELLENCE

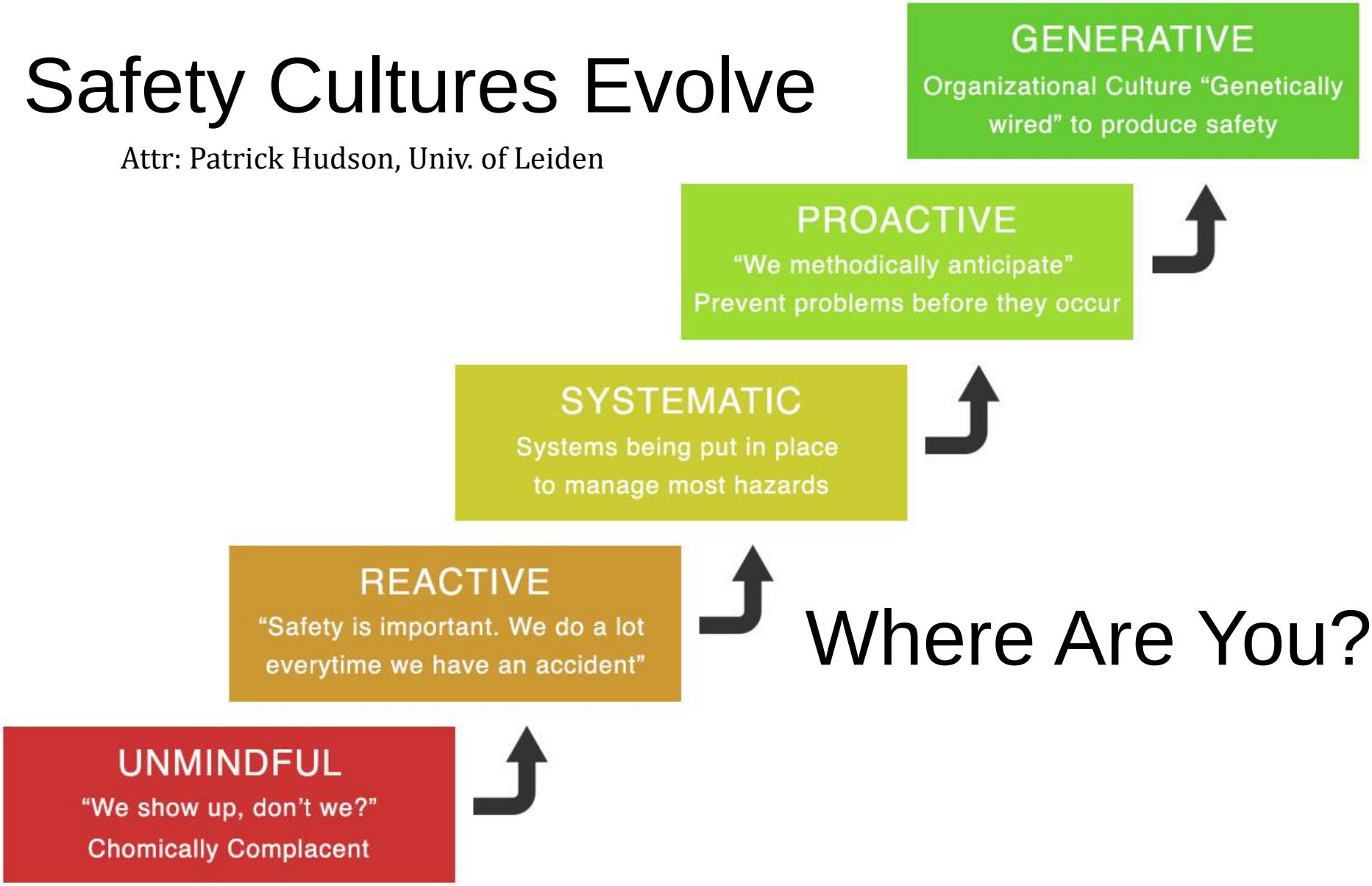
Manage the expected to managing the unexpected

What does being a high reliability organization (HRO) mean to you?

How will you attain the characteristics of an HRO?

Safety Cultures Evolve

Attr: Patrick Hudson, Univ. of Leiden

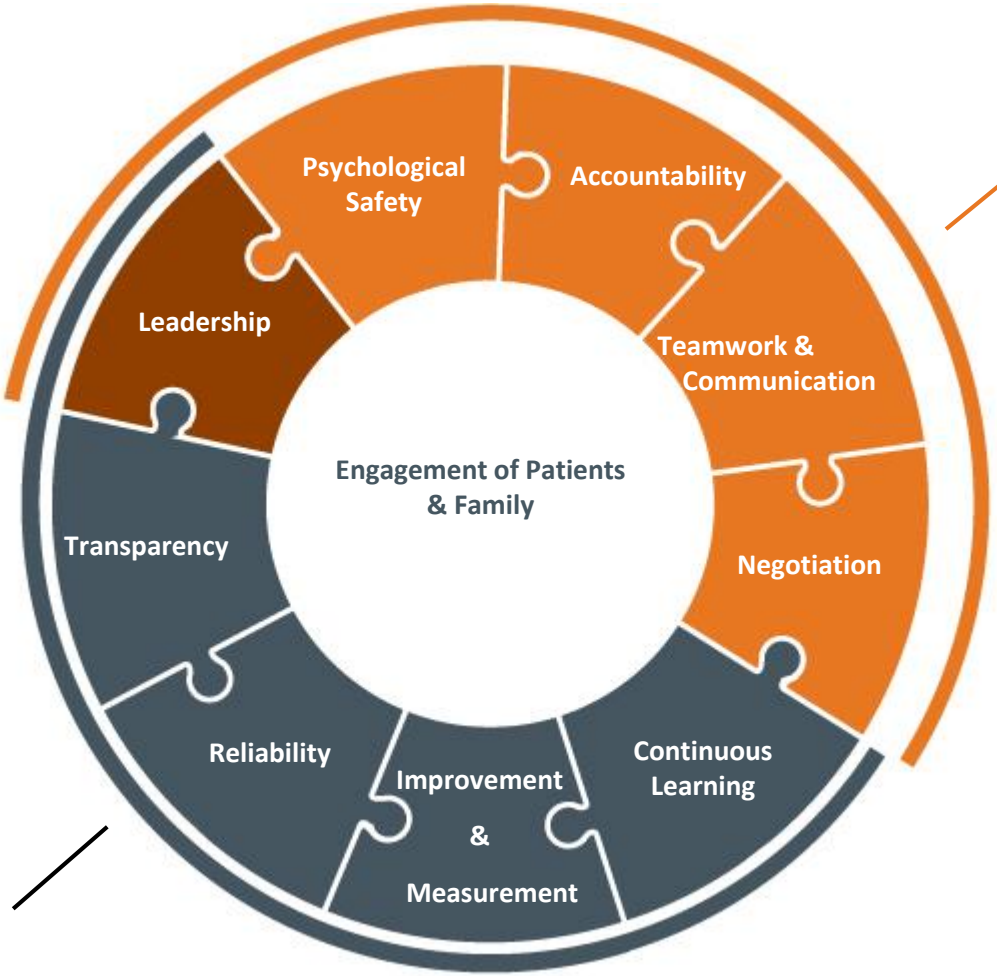


Where Are You?

A Reliability Framework

1. Link safety and reliability to organizational strategy and resources
2. Define safety culture
3. Incorporate human factors and reliability science into improvement methods
4. Differentiate types of continuous learning systems (at organization and unit levels)

Framework for Clinical Excellence



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Framework for Clinical Excellence

Creating an environment where people feel comfortable and have opportunities to raise concerns or ask questions.

Being held to act in a safe and respectful manner given the training and support to do so.

Facilitating and mentoring teamwork, improvement, respect and psychological safety.

Developing a shared understanding, anticipation of needs and problems, agreed methods to manage these as well as conflict situations

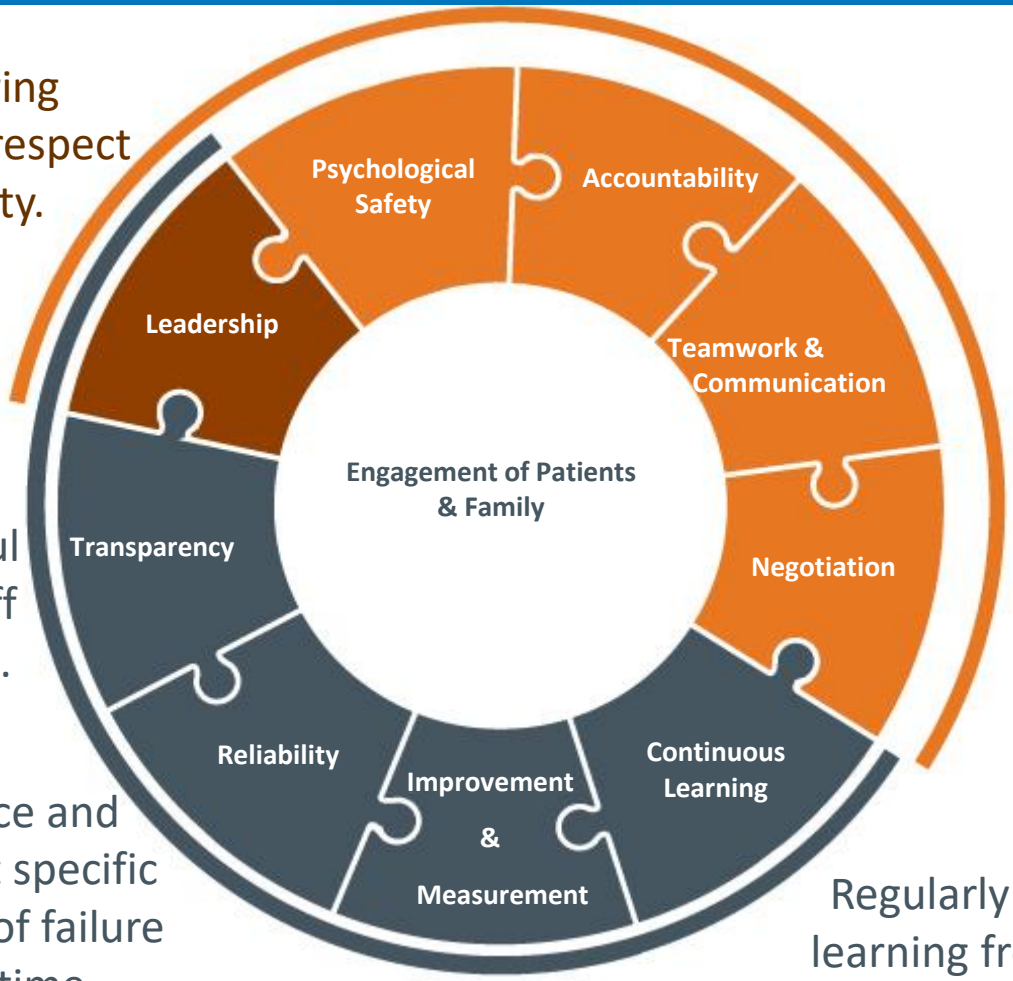
Gaining genuine agreement on matters of importance to team members, patients and families.

Framework for Clinical Excellence

Facilitating and mentoring teamwork, improvement, respect and psychological safety.

Openly sharing data and other information concerning safe, respectful and reliable care with staff and partners and families.

Applying best evidence and minimizing non-patient specific variation with the goal of failure free operation over time.



Improving work processes and patient outcomes using standard improvement tools including measurements over time.

Regularly collecting and learning from defects and successes.

IHI Safe and Reliable Care Framework	National Patient Safety Foundation Framework
Leadership	**Define the problem and set national goals**
Continuous learning Improvement methods Negotiations	**Coordinate activities across multiple sectors to ensure widespread adoption and evaluation**
Patient and family engagement	**Inform, educate and empower the community**
Improvement methods Measurement Transparency	**Measure and monitor progress at all levels effectively**
Continuous learning Transparency Psychological safety	**Identify causes and interventions that work**
Continuous learning Transparency	**Educate and train**

APPLYING THE FRAMEWORK

Characteristics of HROs

- Pre-occupation with failure
- Reluctance to simplify interpretations
- Sensitivity to operations
- Commitment to resilience
- Deference to expertise

From “Managing the Unexpected” by Weick & Sutcliffe

HRO Characteristics[1]	Reliability Under Routine Conditions[2]	IHI Framework for Safe, Reliable and Effective Care Elements
Preoccupation with Failure	Leaders and teams are preoccupied with the reliability of their processes. Default - there are no good processes in place, or organizations have processes in place but they are not reliable, therefore they must be continually improved	Leadership Reliability Improvement & Measurement Continuous Learning Transparency
Reluctance to Simplify Interpretation	Leaders and Teams are reluctant to interpret variation as normal. Processes have become complex resulting in wide variation and results.	Leadership Reliability Continuous Learning Transparency
Sensitivity to Operations	Leaders and Teams know the common failure modes in their routine processes.	Leadership Psychological Safety Accountability Improvement & Measurement Continuous Learning Transparency

1 - Managing the Unexpected: Assuring High Performance in an Age of Complexity. Sutcliffe KE, Weick KM. San Francisco, CA, USA: Jossey-Bass; 2001.

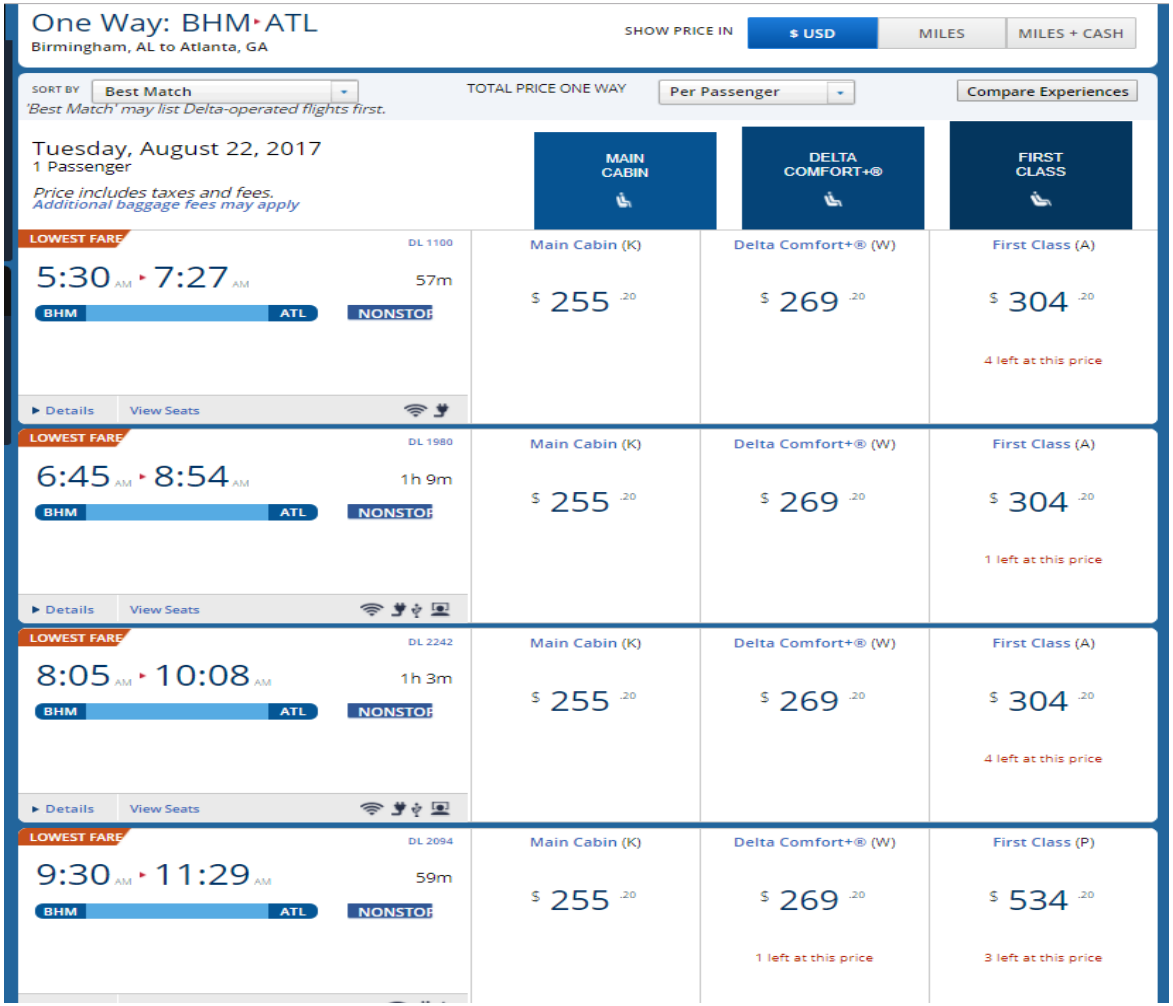
2- Institute for Healthcare Improvement

HRO Characteristics[1]	Reliability Under Routine Conditions[2]	IHI Framework for Safe, Reliable and Effective Care Elements
Commitment and Resilience	Leaders and Teams are committed to timely feedback with data and action to front line about processes and outcomes and commitment at all levels about timely action when sub-optimal performance.	Leadership Psychological Safety Accountability Teamwork and Communication Improvement & Measurement Transparency Continuous Learning
Deference to Expertise	Processes need to be designed by the experts, those with the most relevant training in that area. There expertise if most essential in design not necessarily execution of the process.	Leadership Psychological Safety Teamwork and Communication Continuous Learning Improvement & Measurement

1 - Managing the Unexpected: Assuring High Performance in an Age of Complexity. Sutcliffe KE, Weick KM. San Francisco, California, USA: Jossey-Bass; 2001.

2- Institute for Healthcare Improvement

Expected Conditions



- What are the expected conditions for this schedule?
- What assumptions are made?

The Unexpected

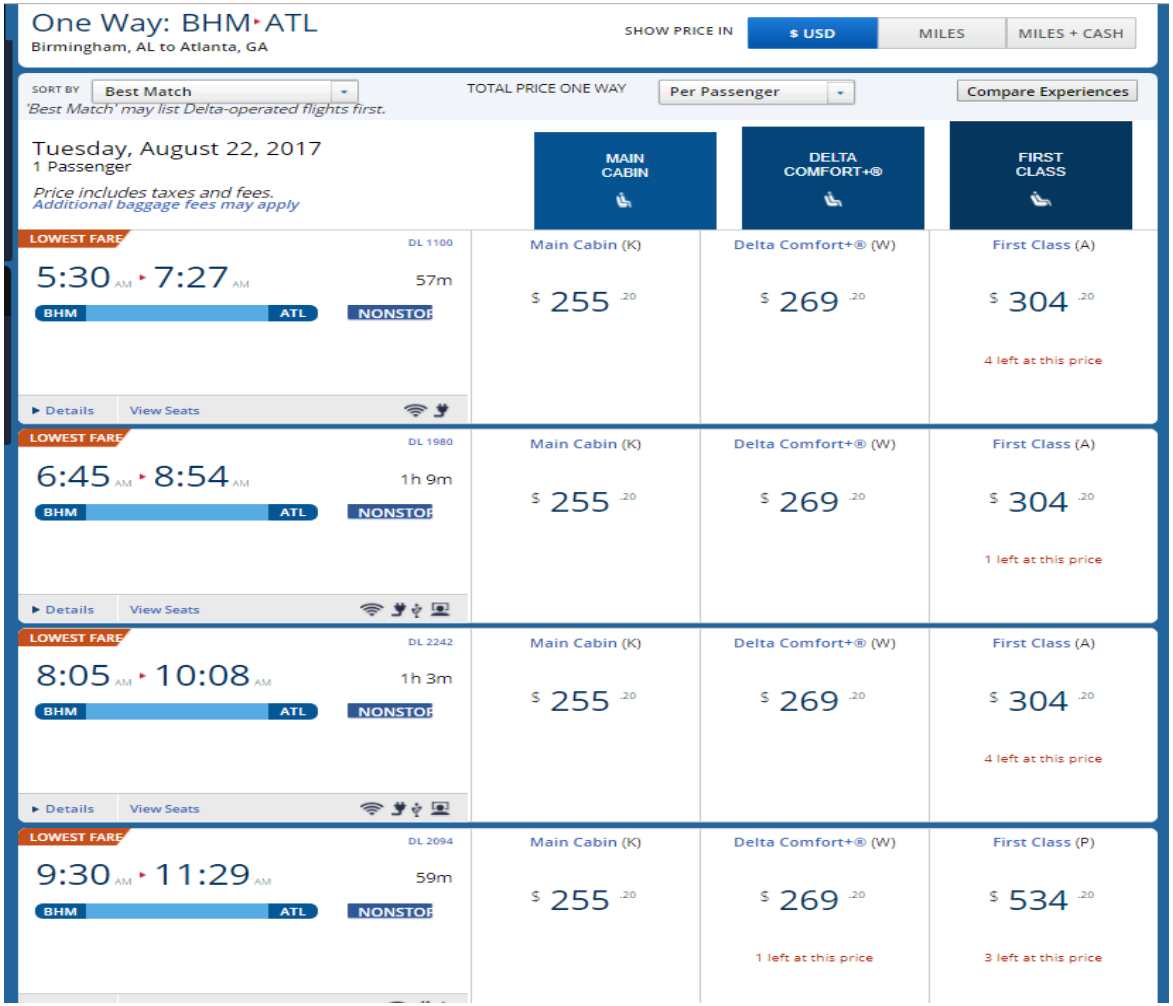
- A person or unit has an intention, takes action, misunderstands the world.
- Actual events fail to coincide with the intended sequence.

From “Managing the Unexpected” by Weick & Sutcliffe

High Reliability Organizations

- …rarely fail even though they encounter numerous unexpected events
- …face an "excess" of unexpected events because
  - technologies are complex
  - constituencies vary in demand
  - people who run the systems have incomplete understanding

What is unexpected?



- What conditions or events are unexpected in the design of this schedule?
- How does an airline identify and respond to these unexpected situations?

Group Exercise

- What steps in the process should be standard?
- What are the expected conditions?
  - What assumptions are there about staff, supplies, patients, environment, etc.?
- What unexpected events or conditions often occur?
- How is the unexpected recognized?
- What is the response to the unexpected?

Moving to High Reliability

- Define the expected conditions
- Set standard(s) for consistency within expected conditions
- Learn from variation to identify recurring unexpected conditions
- Design standard response to common unexpected conditions
- Support mindfulness
  - Identification of unexpected conditions
  - Real time solutions
- Continuous learning and adjustment

Assessing where your organization is on the journey

Key Categories

- Design
  - Standardization, Input, Human Factors
- Analysis
  - Failures and Successes
  - Data, Feedback
- Redesign
  - Continuous, based on learning from operational adjustments
- Response
  - Proactive vs. Reactive
  - Standard for recurring unexpected conditions

Process Reliability

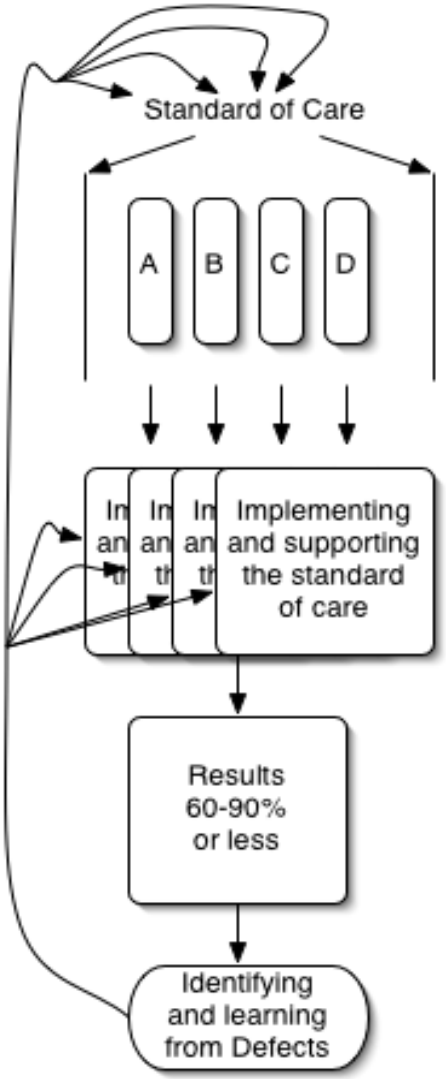
- If you ask each person how they do it, there would be differences?

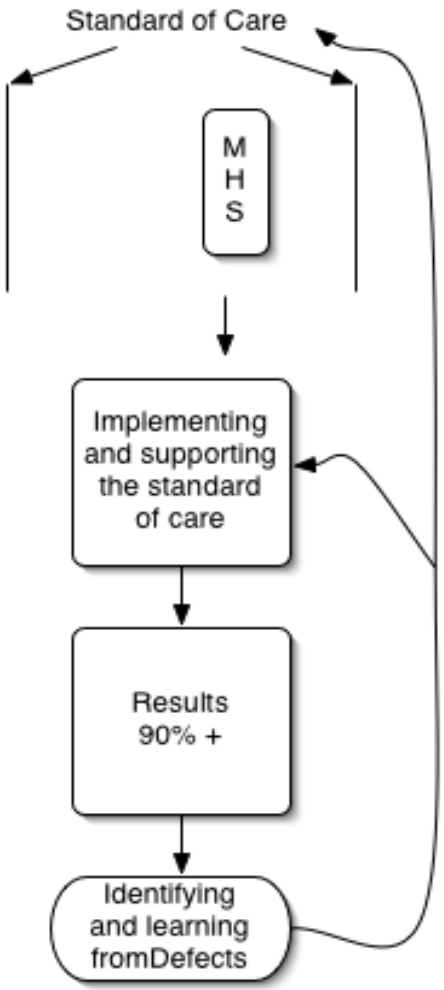
- If the step fails, how people respond is different?

Healthcare processes

Unreliable

- Lots of autonomy
- Not owned
- Little or no feedback for improvement
- Constantly altered by individual changes
- Performance stable at low levels
- Variable





Towards Reliability

- No individual autonomy to change process
- Process owned from start to finish
- Learn from defects before harm occurs
- Constantly improved by collective wisdom
- Variation based on clinical criteria

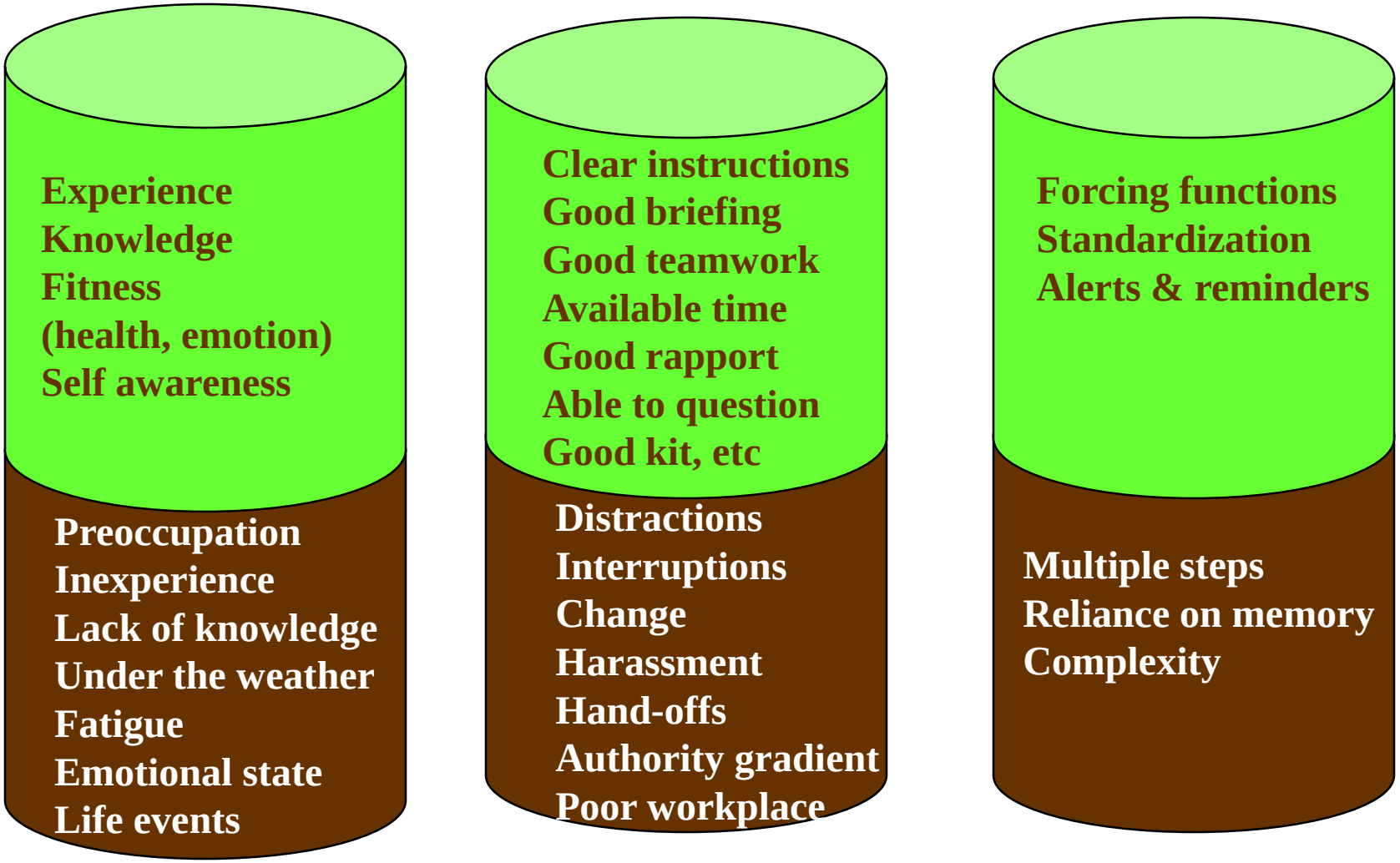
From Terry Borman, MD, Mayo Health System

Examples of Standardized Approaches

- Checklists (remove reliance on memory)
- Standard kits/carts/supplies
- Daily or every shift review of invasive devices

  Adjust sensibly– e.g., urinary catheters in ED
- Protocols
  - Dosing by pharmacists
  - Removal of devices by nurses
  - Ventilator weaning by respiratory therapists

The Three Buckets –*James Reason*



SELF CONTEXT TASK

Workarounds: Good or Bad?

- Good: Signal of unexpected condition
  - Use for learning
  - Design response or redesign as expected
  - Reward staff who identify
- Bad: deliberate variance from standard without unexpected condition

Readiness

- Expected failures
  - Process steps
  - Adverse events, clinical situations
  - Outside events: weather, other organizations
- Do you know what expected failures occur in your organization?
  - If yes, how do you prepare and respond?
- Unexpected failures
  - What have you never prepared for?

What is the role of an expediter?

Managers in an HRO

…take pride in the fact that they spend their time *putting out fires*…as evidence that they are resilient and able to contain the unexpected

Safety 1 to Safety 2

Safety 1

manifestations of safety

are the adverse outcomes

Safety 2

ability of a system to sustain required operations under both expected and unexpected conditions

Hollnagel E., Wears R.L. and Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net: Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.

Moving from Safety 1 to Safety 2

	Safety 1	Safety 2
Definition	Few things as possible go wrong	As many as possible goes right
Management principle	Reactive respond to risk	Proactive and anticipate
Human factors	Humans add risk	Humans are a resource
Accident investigation	Identify cause	Understand what goes right to learn what can go wrong
Risk assessment	Failure effect mode	Understand conditions where variability cannot be controlled

Hollnagel E., Wears R.L. and Braithwaite J. From Safety-I to Safety-II: A White Paper. The Resilient Health Care Net: Published simultaneously by the University of Southern Denmark, University of Florida, USA, and Macquarie University, Australia.

Am I in a learning organization?

- Are my employees and managers learning from our work every day?
- Are staff encouraged to identify the need to modify a process and share for learning?
- How often do staff adjust a process based on changing conditions?
- How often do I ask “why”, or encourage others to do so?
- How do we find external ideas in my organization?
- When is the last time a front line person suggested an idea that we tried?

Getting Started

- Take advantage of existing groundwork
  - Standard tools, response systems, etc.
- Plan for success: pick a topic and location with receptiveness to change and a champion
  1. Design process: standardize, include front line
  2. Identify the expected conditions for the standard
  3. Identify the recurring unexpected conditions (including human factors) and design response(s)

Starting the journey towards high reliability

- Recognize that you cannot change the culture BUT you *can* change things that will change the culture
- Become a learning organization
  - This has no end point!
- Move to reliable processes and responses first
  - Understand what is expected
  - Prepare to more pro-active, less reactive
- Recognize it is a journey

Thank You!

Questions?

Contact Information

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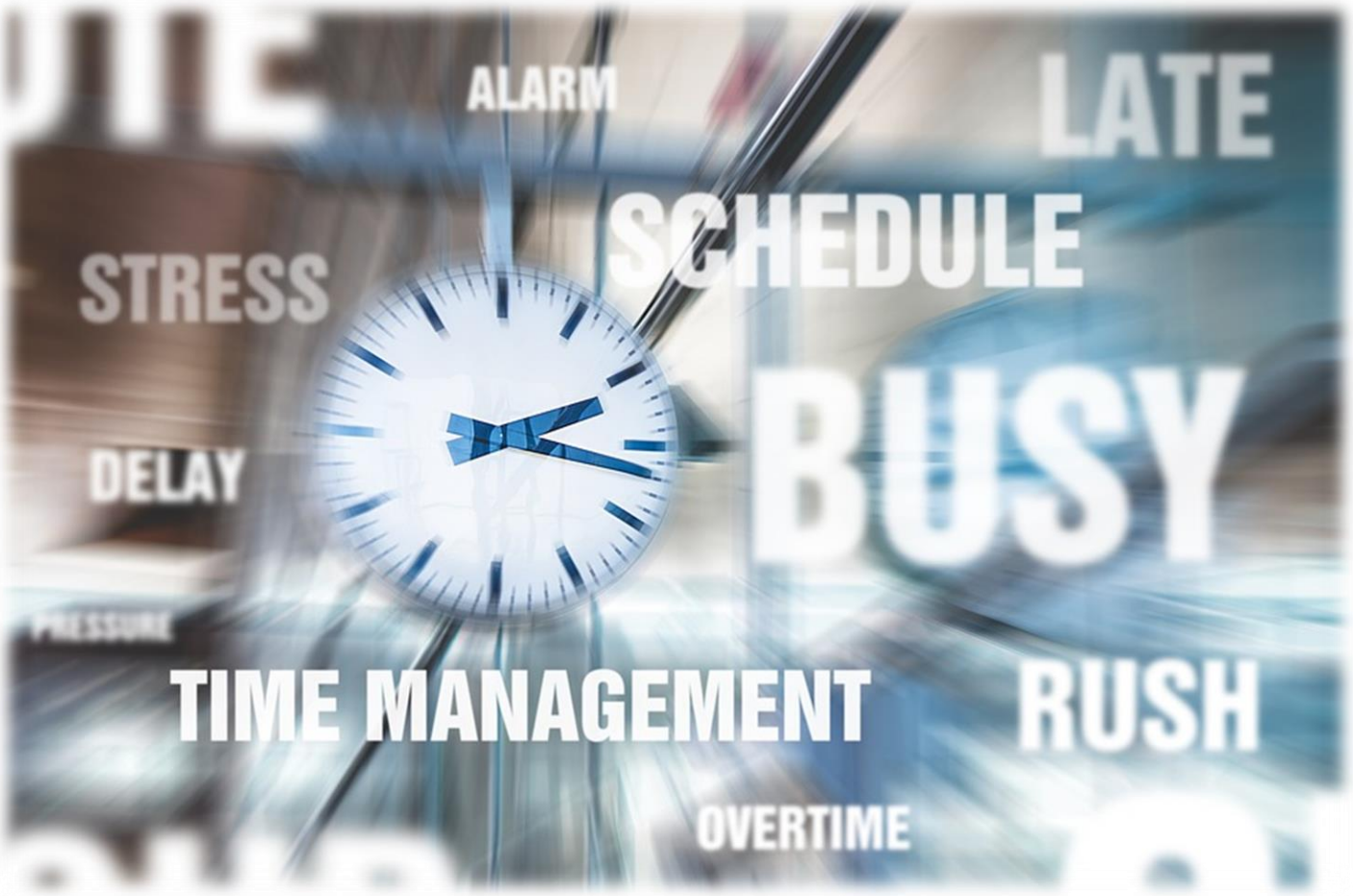
Community Collaboration to Reduce Readmissions

Pat Teske, RN, MHA, Cynosure Health

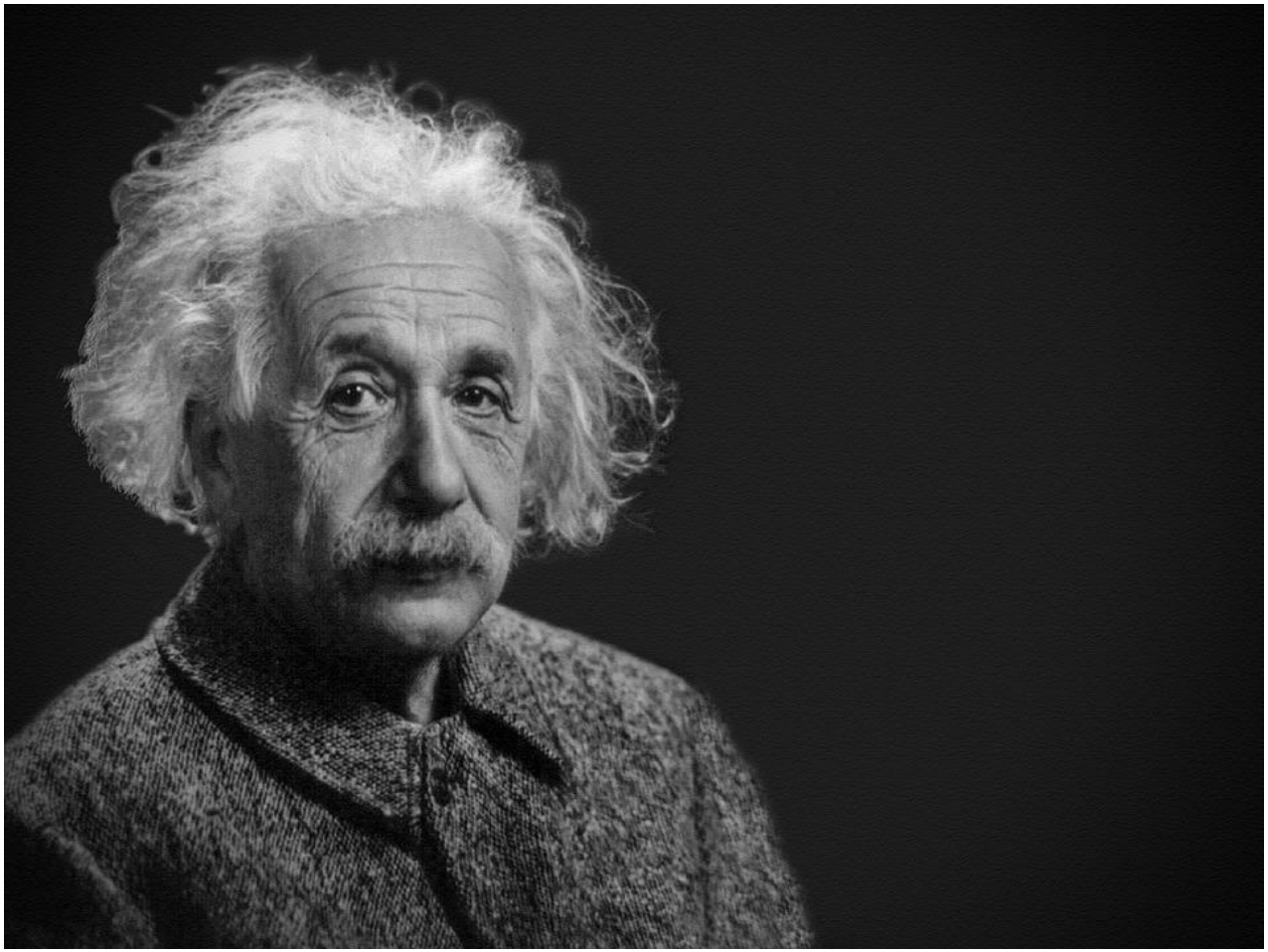
HIIN AIM

Reduce all cause 30-day readmissions by 12 percent by September 27, 2018.

Do you feel like this?



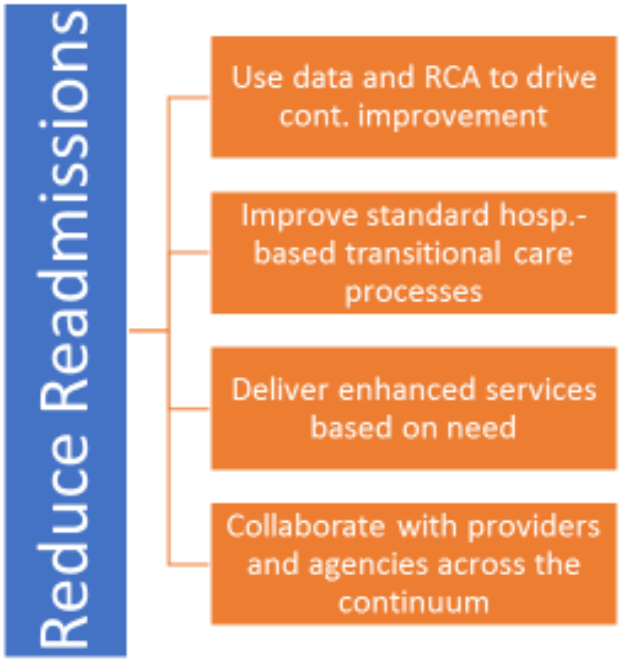
Should you continue?



This is NOT the answer?

What would be better?

Readmission reduction drivers



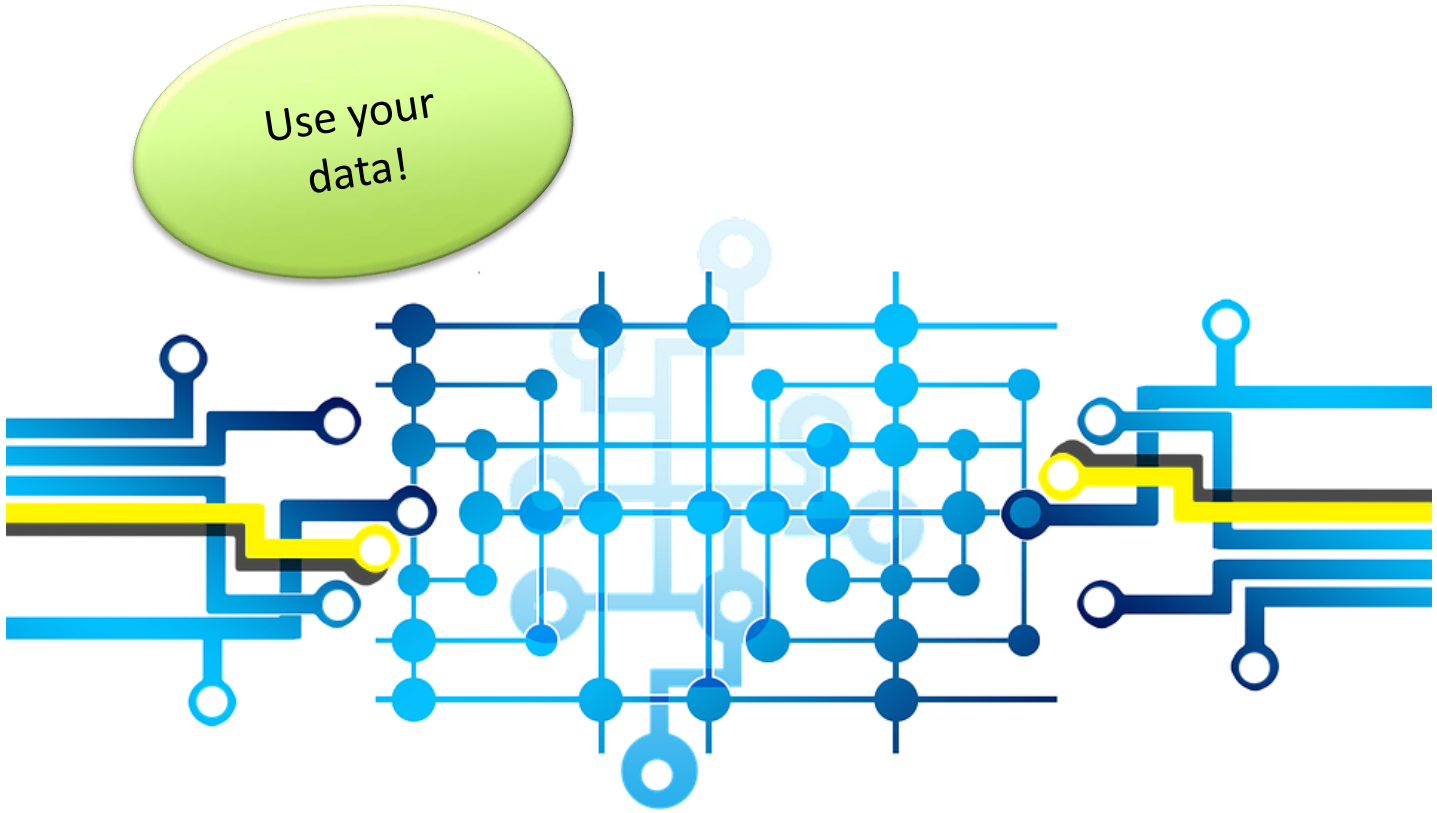
HRET HIIN Readmissions Change Package Driver Diagram

CP

First Primary Driver

USE DATA AND ROOT CAUSE ANALYSIS TO DRIVE CONTINUOUS IMPROVEMENT	ANALYZE DATA TO INFORM YOUR TARGETING APPROACH	Change Idea
	UNDERSTAND ROOT CAUSES OF READMISSIONS; ELICIT THE PATIENT, CAREGIVER AND PROVIDER PERSPECTIVES	Change Idea
	PERIODICALLY UPDATE APPROACH BASED ON FINDINGS; ARTICULATE YOUR READMISSION REDUCTION STRATEGIES	Change Idea
	DEVELOP A PERFORMANCE MEASUREMENT DASHBOARD TO USE DATA TO DRIVE CONTINUOUS IMPROVEMENT	Change Idea

Use data to work strategically



Big DATA + Little DATA = A better approach

BIG Data

- The entire readmissions population
- Dice and slice by payer, REaL, etc.
- Learn which groups are readmitted at a higher rate
- These are the groups you will TARGET with special effort

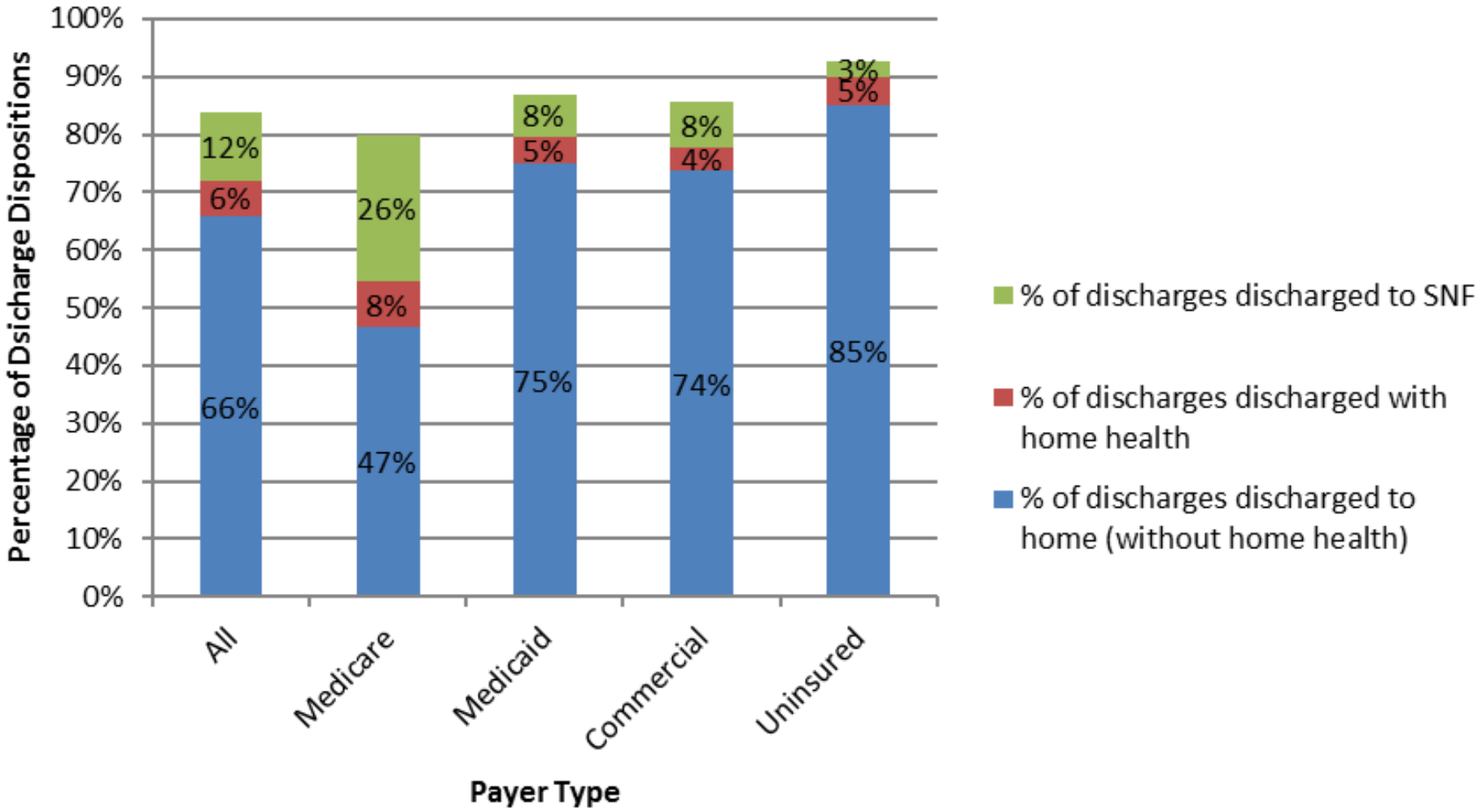
Little Data

- What you are learning on a day-to-day basis
- From patients, providers, case review
- Help you understand where the gaps are in your current processes and program
- Helps you decide WHAT to prioritize from a PI perspective

Data drill down tool

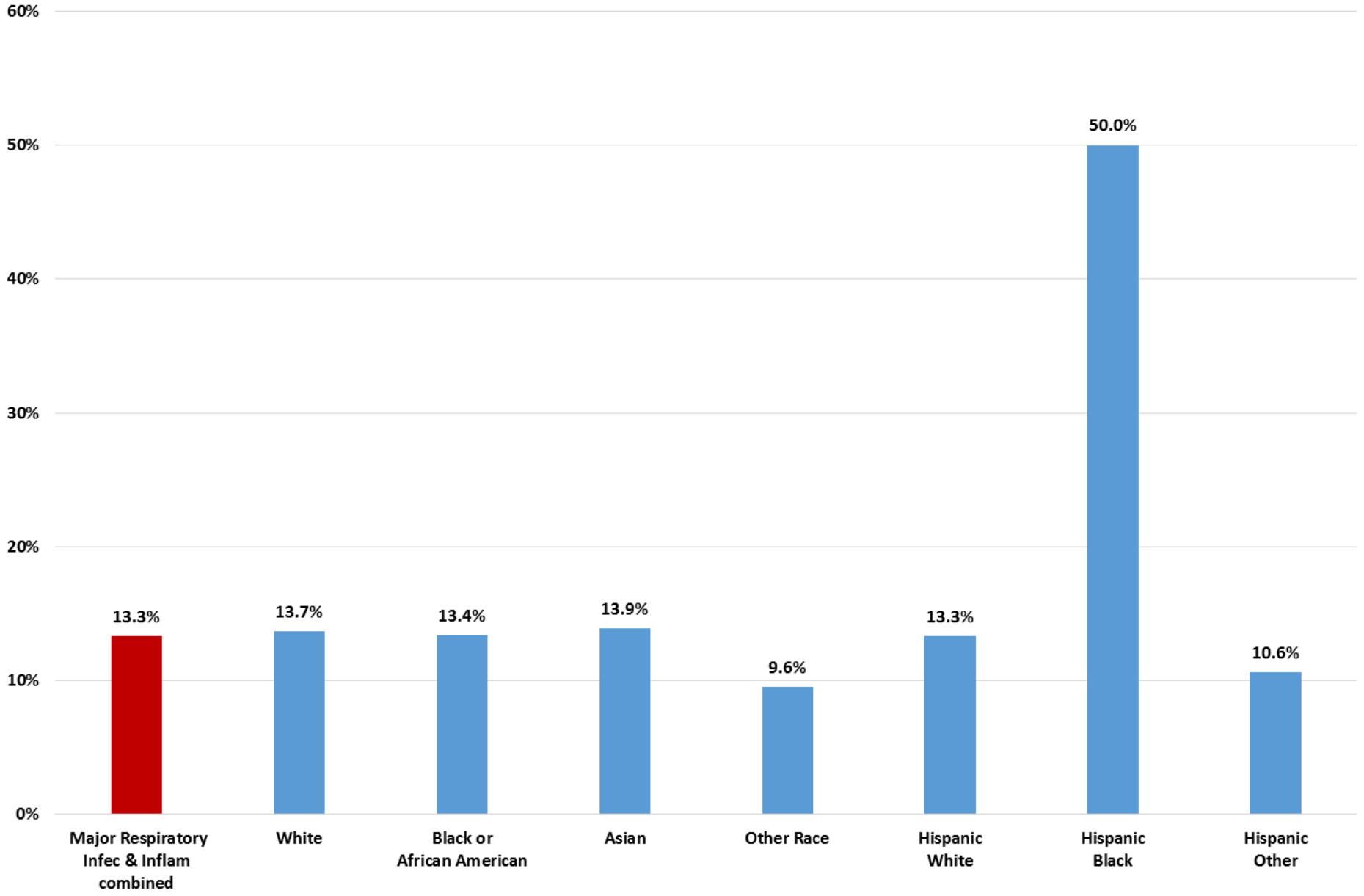
- Tool
- A data analyst friend
- Several hours
- Process
  - Run the data
  - Populate the tool
  - Answer the questions with your team
    - What assumptions did your data confirm?
    - What surprised you?
- Tabs
  - Instructions
    - ICD 10: F0-F9 often used to capture behavioral health
  - Data entry
  - Data dashboard
  - Data entry example
  - Data dashboard example

Figure 4. Discharge Disposition by Payer (adult, non-OB)



30-Day Potentially Preventable Readmission (PPR) Rates by Race and Ethnicity

Major Respiratory Infections & Inflammations for New Jersey Hospitals, 2012



So what? Review and discuss.

- If this were your data what would it tell you?
- What groups would you prioritize based on these data?
- If you haven't performed an analysis of your big data, what are your plans to do so?

Little data provide a different perspective

- Why ask the patients and providers?
  - Gain their perspectives
  - Understand reasons
  - Identify gaps
  - Develop a better plan for the specific patient
  - Design a more effective program
- Why do case reviews (focus on quick returns)?
  - Determine care gaps
  - Look at plans overtime
  - Prioritize repeated issues

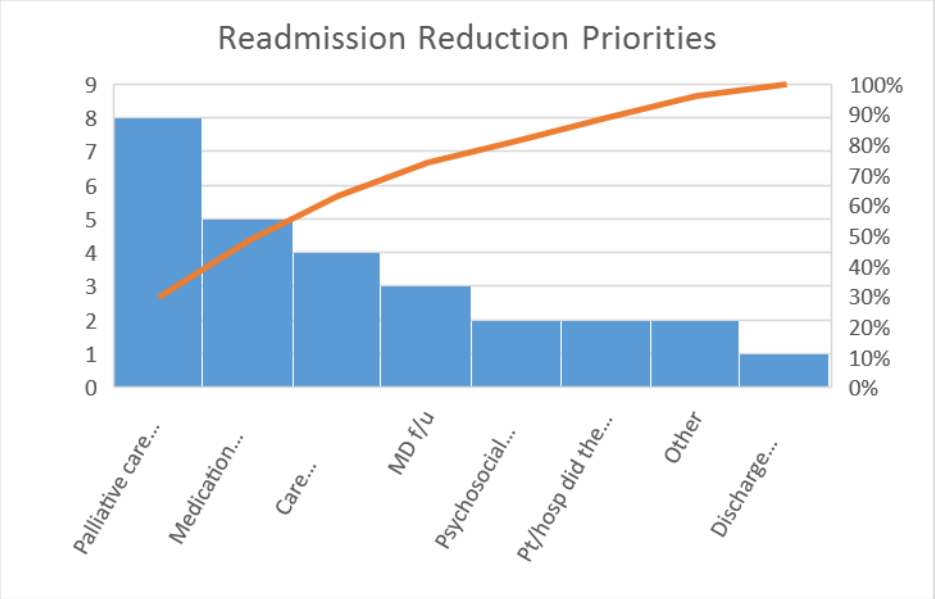
51 year old male with 3 acute care admissions and 2 ED visits in the past 180 days.

When asked why he thought he was readmitted said…

“I RAN OUT OF LASIX”

Aggregate and prioritize

Reason	Pt. A	Pt. B	Pt. C	Pt. D	Pt. E	Pt. F	Pt. G	Pt. H	Pt. I	Pt. J	Pt. K	Pt. L	Pt. M	Pt. N	Pt. O	Pt. P	Pt. Q	Pt. R	Pt. S	Pt. T	Total
Medication Management	Y		Y				Y				Y		Y								5
Discharge Instructions	Y																				1
Palliative care/hospice			Y			Y			Y		Y			Y		Y		Y	Y		8
Care coordination					Y							Y				Y				Y	4
MD f/u			Y					Y							Y						3
Psychosocial/family dynamics					Y					Y											2
Pt/hosp did their best		Y															Y				2
Other	Y													Y							2



The CMS challenge

- Identify patients in the hospital who have been readmitted.
- Ask the patients/caregivers if they are willing to have a 5- to 10-minute discussion about their recent hospitalizations.
- Capture patient/caregiver responses.
- Analyze responses for new insight regarding “why” patients returned to the hospital soon after being discharged.

It's about learning not doing

- Why, why, why….
  - An interview might reveal that a patient did not take her medication, which then contributed to her rehospitalization.
    - Why did she not take her medication?
      - She did not take it because she did not have it. Why?
      - She did not go to pick it up from the pharmacy. Why…?

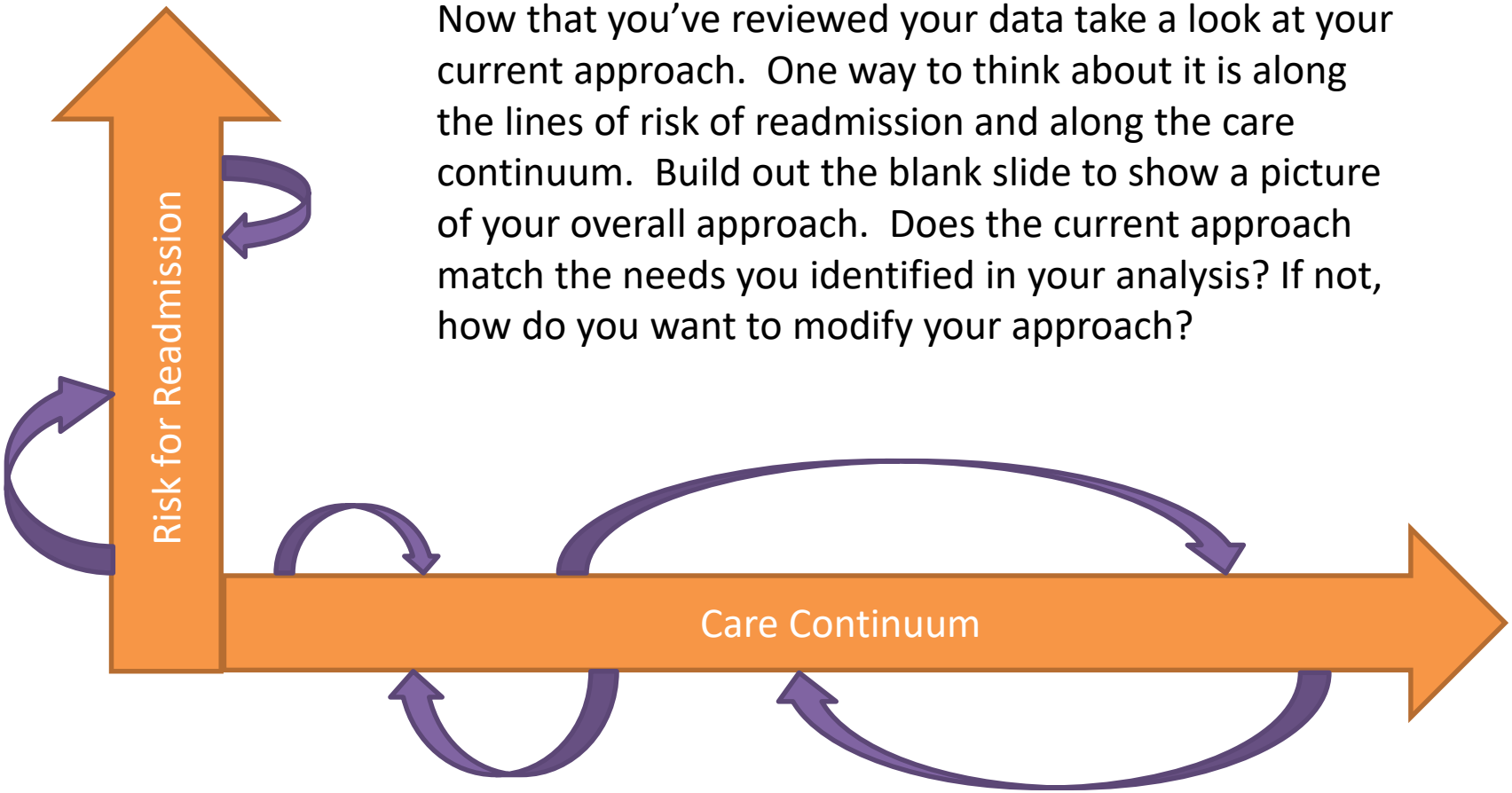
Skill building

- Break up into groups of three
  - Interviewer
  - Interviewee
  - Observer/feedback provider
- Use ASPIRE tool 2
- Practice and share
- If you aren't currently interviewing your readmitted patients, what's your plan to start?

Other data to consider

- Inventory your efforts
  - Across departments
  - Coordination of activities
  - Check for duplication
  - Look for gaps
- Inventory community resources
  - Clinical
  - Non-clinical

Framing or Reframing Your Approach



Now that you've reviewed your data take a look at your current approach. One way to think about it is along the lines of risk of readmission and along the care continuum. Build out the blank slide to show a picture of your overall approach. Does the current approach match the needs you identified in your analysis? If not, how do you want to modify your approach?

Second Primary Driver

IMPROVE STANDARD HOSPITAL-BASED TRANSITIONAL CARE PROCESSES	ENGAGE PATIENTS AND THEIR CAREGIVERS TO IDENTIFY THE "LEARNER," UNDERSTAND CARE PREFERENCES AND ASSESS READMISSION RISK FACTORS	Change Idea
	FACILITATE INTERDISCIPLINARY COLLABORATION ON READMISSION RISKS AND MITIGATION STRATEGIES	Change Idea
	DEVELOP A CUSTOMIZED CARE TRANSITIONS PLAN, TAKING INTO ACCOUNT PATIENT PREFERENCES AND ADDRESSING READMISSION RISK FACTORS AND POST-HOSPITAL CONTACT NAMES AND NUMBERS	Change Idea
	USE TEACH BACK TO VALIDATE PATIENT UNDERSTANDING; USE LOW HEALTH LITERACY TECHNIQUES AND/OR PROFESSIONAL TRANSLATION SERVICES TO OPTIMIZE UNDERSTANDING AND TEACH BACK	Change Idea
	MAKE TIMELY POST-DISCHARGE FOLLOW UP PHONE CALLS TO FOLLOW UP ON SYMPTOMS AND REVIEW THE CARE TRANSITIONS PLAN	Change Idea

CMS Discharge Planning Checklist

- Patients and caregivers

Name: _____

Reason for admission: _____

During your stay, your doctor and the staff will work with you to plan for your discharge. You and your caregiver (a family member or friend who may be helping you) are important members of the planning team. You and your caregiver can use this checklist to prepare for your discharge.

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Instructions

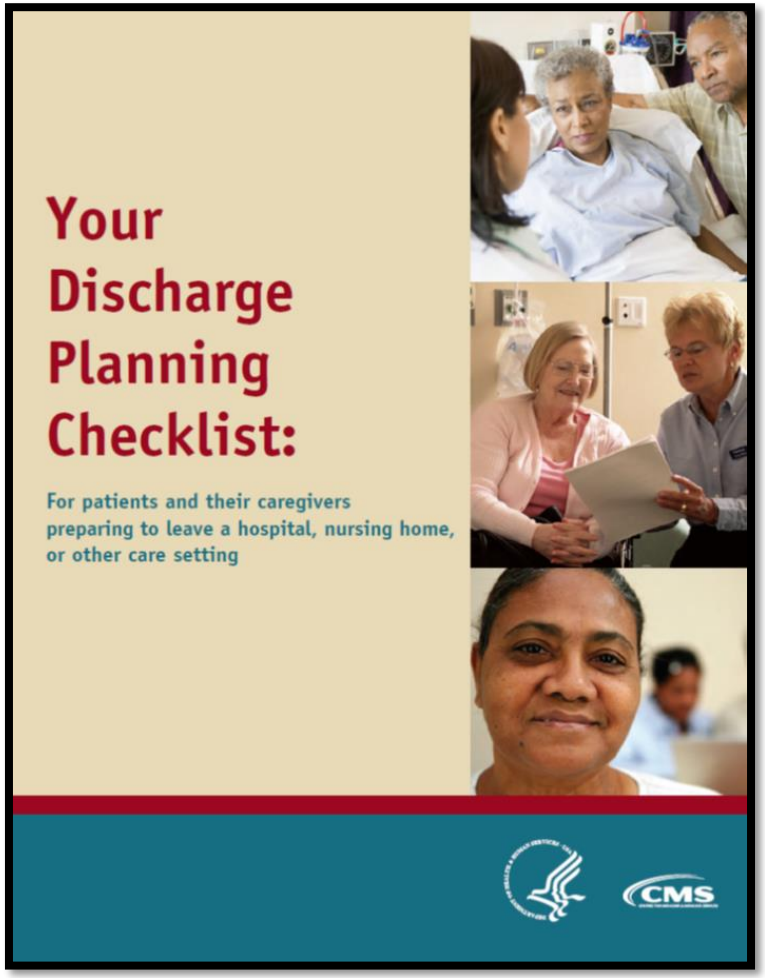
Instructions:

- Use this checklist early and often during your stay.
- Talk to your doctor and the staff (like a discharge planner, social worker, or nurse) about the items on this checklist.
- Check the box next to each item when you and your caregiver complete it. 
- Use the notes column to write down important information (like names and phone numbers).
- Skip any items that don't apply to you.

What's ahead

Action items	Notes
What's ahead?	
☐ Ask where you'll get care after you leave (after you're discharged). Do you have options (like home health care)? Be sure you tell the staff what you prefer.	
☐ If a caregiver will be helping you after discharge, write down their name and phone number.	
Your health	
☐ Ask the staff about your health condition and what you can do to help yourself get better.	
☐ Ask about problems to watch for and what to do about them. Write down a name and phone number of a person to call if you have problems.	

How are you using it?



- https://www.medicare.gov/Pubs/pdf/11376.pdf
- If you're not already using it, make a plan to start

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After Hospital Care Plan

Sample After Hospital Care Plan (AHCP)

*****Bring This Plan to ALL Appointments*****

After Hospital Care Plan for:

Oscar Sanchez

Discharge Date: August 1, 2012

TRY TO QUIT SMOKING: Call Jon Doe at (555) 555-3344 at ABC Medical Center.

Question or Problem with this Packet? Call your Discharge Educator: (555) 555-2222

Serious health problem? Call Dr. Mark Avery: (555) 555-5555

EACH DAY follow this schedule:

1

BOOST PASS

project BOOST
Better Outcomes for Older adults through Safe Transitions

Patient PASS: A Transition Record

Patient Preparation to Address Situations (after discharge) Successfully

I was in the hospital because _____

If I have the following problems ...	I should ...
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

My appointments:

1. _____
   On: __/__/___ at __:__ am/pm
   For: _____
2. _____
   On: __/__/___ at __:__ am/pm For:
   _____
3. _____
   On: __/__/___ at __:__ am/pm
   For: _____
4. _____
   On: __/__/___ at __:__ am/pm
   For: _____

Tests and issues I need to talk with my doctor(s) about at my clinic visit:

1. _____
2. _____
3. _____
4. _____
5. _____

Important contact information:

1. My primary doctor:
   _____
   (____) _____
2. My hospital doctor:
   _____
   (____) _____
3. My visiting nurse:
   _____
   (____) _____
4. My pharmacy: _____
   (____) _____
5. Other: _____
   _____

I understand my treatment plan. I feel able and willing to participate actively in my care:

_____
Patient/Caregiver Signature

_____
Provider Signature

____/____/_____
Date

Other instructions: 1. _____
2. _____
3. _____

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Validate understanding

"I'm going to talk to you about what you need to do every day at home to control your heart failure.

Every day:

- Weigh yourself in the morning before breakfast and write it down
- Take your medication the way you should
- Check for swelling in your feet, ankles, legs and stomach
- Eat low-salt food
- Balance activity and rest periods"

Teach-back

Not teach-back

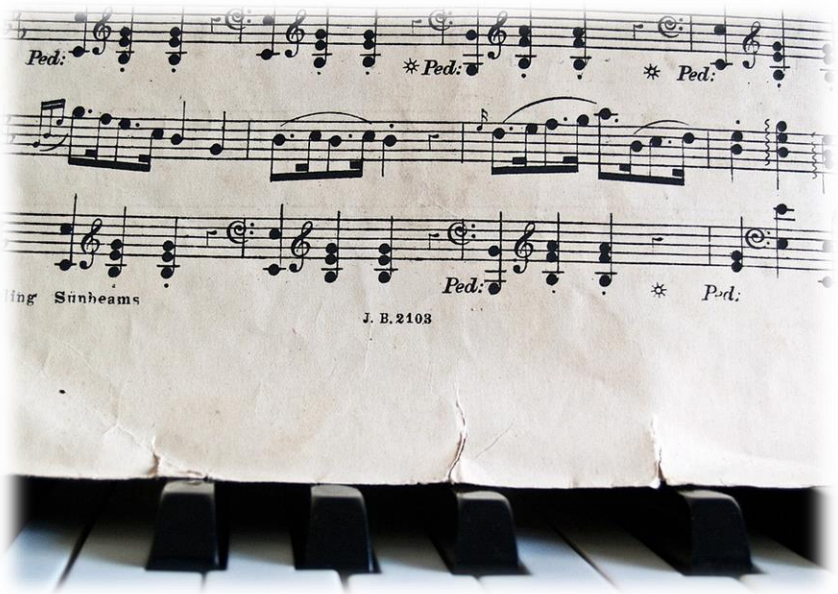
- List four things for me that you are going to do everyday?

Teach-back

- I teach people about this every day, and sometimes I go over it quickly or may not make myself clear. I want to make sure you know what you need to do. So, can you tell me some things you will do each day?
- We just discussed a lot of things for you to do every day. You might be doing some of these already. Have you already been doing any of these things? What do you think will be the hardest one for you to do at home?"

Give it a try

- Break up into groups of three
  - Nurse
  - Patient
  - Observer/feedback provider
- Provide mock discharge instructions followed by teach-back - Practice and share
- If you don't use teach-back what are your plans to start?



2017 Driver Diagram

DELIVER ENHANCED SERVICES BASED ON NEED	PALLIATIVE CARE	Change Idea
	CONDITION SPECIFIC PROGRAMS	Change Idea
	PHARMACY INTERVENTION	Change Idea
	COMPLEX CARE MANAGEMENT	Change Idea
	ED PAUSE	Change Idea

Enhanced services

- Enhanced services generally mean $
- Choose enhanced services based on need
- Prioritize
  - What will benefit my readmission reduction efforts the most?

Palliative Care & Advance Care Planning

- https://www.nhpco.org/palliative-care-resources
- https://www.capc.org/topics/palliative-care-guidelines-quality-standards/
- https://guideline.gov/summaries/summary/47629/palliative-care-for-adults
- http://theconversationproject.org/starter-kits/
- http://polst.org/

ED Pause

- Disrupt the ordinary process of automatic readmissions
- Know who was recently discharged
  - E.g. Flag
- Identify person & process for ED to get support to determine patient's disposition

2017 Driver Diagram

COLLABORATE WITH PROVIDERS AND AGENCIES ACROSS THE CONTINUUM	IDENTIFY THE CLINICAL, BEHAVIORAL, SOCIAL AND COMMUNITY BASED SUPPORTS THAT SHARE THE CARE OF YOUR HIGH RISK PATIENTS	Change Idea
	CONVENE A CROSS-CONTINUUM TEAM OF PROVIDERS AND AGENCIES THAT SHARE THE CARE OF YOUR HIGH RISK PATIENT POPULATIONS	Change Idea
	IMPROVE REFERRAL PROCESSES TO MAKE LINKING TO BEHAVIORAL, SOCIAL AND COMMUNITY BASED SERVICES MORE EFFECTIVE AND EFFICIENT	Change Idea

Readmission Reduction Beyond the Four Walls

I. Developing a Map of Actors - April 20, 2017

II. Developing a Motivating Vision and Calling Stakeholders to Action - August 14-17, 2017

III. Building the Dream Team: Establishing the Conditions for Effective Multi-Stakeholder Coalitions - November 13-16, 2017

IV. Building Interdependent Leadership Structures/Distributive Community Leadership - January 22-25, 2018

The U.S. has 5% of the world's population

and consumes nearly 80% of the world's opioids.

Source: CNBC, 2016

Opioid Resources

- North Dakota awarded federal grant to fight opioid abuse
- ND Prevention resource and media center
- Stop Overdose: Preventing Prescription Drug and Opioid Abuse in the Community
- Physician training in ND

Encourage your partners to use

- http://www.pathway-interact.com/
  - Free tools for:
    - Nursing homes
    - Home health
    - Assisted living
    - LTAC

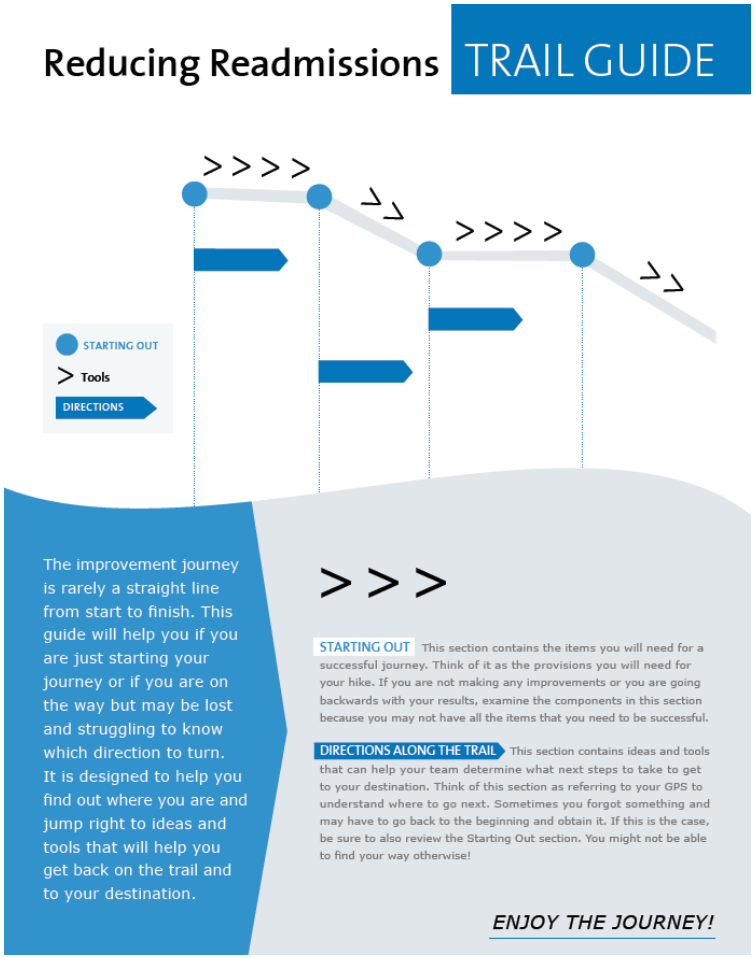
Walk a mile in my shoes

- Shadow program
- ED & SNF
- Experience a day in the life
- Stronger understanding and empathy

How is it going?

- What connections have you made?
- Which stakeholders have you met with?
- What new referral pathways are you testing?

NEW! Readmissions Trail Guide



- Get your GUIDE
- Action oriented resource to:
  - Help get you started, or
  - Help you along the way
- Imbedded links to key tools and resources
- Go directly to where you need help

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Preventable Readmissions Top Ten Checklist

- Develop a data-informed targeting strategy to identify target populations with higher than average rates of readmissions. Deliver enhanced readmission reduction strategies to these "target population" patients.
- Identify root causes of readmissions based on interviewing patients, caregivers and providers. Prioritize your improvement strategies based on those that will address the root causes of readmissions among your patients.
- Improve care transition processes for all patients, regardless of readmission risk. Refer to the proposed practices articulated in the proposed CMS Conditions of Participation for Discharge Planning.
- Provide a customized transitional care plan for all patients.
- Effectively communicate with patients and caregivers. Use translation services, teach-back, motivational interviewing and materials written in plain language.
- Deliver enhanced readmission reduction services for your target populations based on their root causes of readmissions.
- Design a high utilizer approach for patients with four or more admissions per year. Identify their "driver of utilization," and use care plans to improve care across settings.
- Engage the emergency department as a new site of readmission reduction activities.
- Collaborate with clinical, behavioral, and social service providers to improve cross-setting care processes for shared patient populations. Ensure you are aware of the services and supports that are available from other providers and agencies in your community.
- Measure what you implement, striving to reliable delivery of improved processes.

Readmissions Resources - LISTSERV

- Join the LISTSERV®
  - Ask questions
  - Share best practices, tools and resources
  - Learn from subject matter experts
  - Receive follow-up from this event and notice of future events
- Huddle for Care Discussion Forum https://www.huddleforcare.org/

Next Steps!

- Download the 2017 readmissions reductions CP and other resources
- Ask - What changes are needed?
  - Your approach
  - Team(s)
- Test your new ideas

Commitments

- What ideas did you like?
- What idea will you test in your organization?
  - Who?
  - By when?

Any questions?

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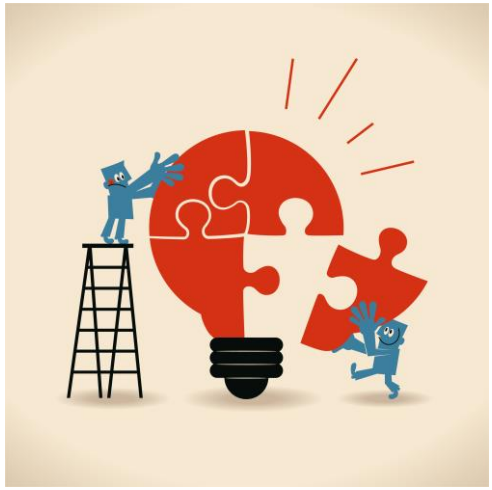
Shereen Shojaat, MS| HRET

REFLECTION AND NEXT STEPS

Our Top Takeaways

- Think of what you can bring back to your hospital by next week
- Write your top one or two takeaways on a post-it
- Put your post-it on the front easel



Thank You

- For committing to the bold aims of the HIIN project
- For joining us today and engaging with your peers
- For your enthusiasm, generosity, curiosity and persistence
- For the care you provide for patients and families every day

Any questions?

Thank You!

- We look forward to further engagement and collaboration with you during HIIN on our quality and patient safety journey.
- Find more information on our website: www.hret-hiin.org
- Questions or Comments: HIIN@aha.org