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**The MI STAAR Initiative**  
10th Annual Michigan Critical Access Hospital  
Conference

Mark Hutchinson  
Director of Clinical Excellence  
Spectrum Health Kelsey Hospital  
October 29, 2009

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**Reducing re-hospitalizations:  
background**

- Re-hospitalizations are:
  - Frequent
    - 18% of all Medicare hospitalizations are 30 day re-hospitalizations
    - Average >20% for certain patient populations
  - Costly
    - 30-day re-hospitalizations account for \$15B in Medicare annual spending
    - Plus the costs for Medicaid, private insurers, etc.

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**Reducing re-hospitalizations:  
background**

- Re-hospitalizations are:
  - Potentially avoidable
    - 76% of Medicare re-hospitalizations were “potentially preventable” based on 3M definition
    - 14-46% were assessed as “potentially avoidable” in retrospective clinician reviews
  - Actionable for improvement
    - Research and quality improvement initiatives have demonstrated reduction of 30-day readmission rates for various patient populations

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**Reducing re-hospitalizations:  
background**

- If re-hospitalizations are prevalent, costly, and able to be reduced, why haven't they been?
  - Hospital-level barriers
    - Financial disincentives (volume-revenue), no financial incentives not part of P4P contracts, not high on priority list limited disease specific efforts

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**Reducing re-hospitalizations:  
background**

- Community-level barriers
  - Not common to engage organizations across continuum to collaborate on improving care, frustration between inpatient and post-acute providers, lack of IT connectivity, no reimbursement for coordination
- State-level barriers
  - Lack of population-based data, lack of understanding costs of poor quality on systems, effect of fragmented payer market and lack of CMS participation

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**Why reduce re-hospitalizations now?**

- New attention to this issue
  - Commonwealth Fund State Scorecard
  - MedPAC Reports to Congress 2007, 2008
  - CMS Care Transitions contracts in 9<sup>th</sup> SOW
  - Obama administration’s Health Reform
- State-level activity
  - Leaders in several states embrace quality and value shaping health policies
  - Commonwealth Fund State Quality Institute
  - Medicaid Medical Home

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**Why reduce re-hospitalizations now?**

- Provider-initiated activity
  - Voluntary integrated delivery systems desire to thrive in future market based on value
  - RWJF/IHI Transforming Care at the Bedside
  - Boston University Project RED
  - Society for Hospital Medicine Project BOOST
- Payer-initiated activity
  - Utilization tracking and disease management activities
  - Accountable-care organization demos

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**STAAR initiative**

- The Commonwealth Fund-supported initiative to reduce avoidable 30-day re-hospitalizations, taking states as unit of intervention
  - May 1, 2009 launch
  - Anticipated 4-year initiative
  - Institute for Healthcare Improvement providing technical assistance and facilitating a learning system
  - Multi-stakeholder coalitions in three states selected as partners in this initiative (Massachusetts, Michigan, Washington)

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**STAAR initiative**

- Michigan
  - Ranks 40<sup>th</sup> in U.S. on Medicare 30-day readmissions
  - Effort led by MI Hospital Association Keystone Center and MI QIO
  - Building on history of state-wide process improvement successes
  - Stated goal is to be best state in U.S.

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**STAAR initiative**

- Goals
  - Reduce state-wide 30-day re-hospitalization rates by 30 percent
  - Increase patient and family satisfaction with transitions in care and with coordination of care

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**STAAR initiative**

- High-leverage opportunities for action:
  - Improve transitions for all patients
    - Transitions “out” of the hospital
    - Reception “in” to home (office, practice, home health care)
    - Reception “in” to skilled nursing facilities
  - Proactively address the needs of high risk patients
    - Supplement services for high risk patients (market assessment of plausibility of payment)
    - Enhancements to current care in primary care, SNFs, home care and disease management programs)

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**STAAR initiative**

- High-leverage opportunities for action continued:
  - Engage patients/caregivers
    - Patient-owned care plans
    - Proactive advanced directives
    - Health literacy

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**Spectrum Health Kelsey and United hospitals**

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**Our locations**

• Kelsey Hospital	• United Hospital
• 418 Washington Avenue	• 615 South Bower Street
• Lakeview, MI 48850	• Greenville, MI 48838
• 989-352-7211	• 616-754-4691
• <a href="http://www.um.spectrum-health.org">www.um.spectrum-health.org</a>	• <a href="http://www.um.spectrum-health.org">www.um.spectrum-health.org</a>

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**Our team**

- Brian Brasser, Chief Nursing Officer
- Mark Hutchinson, Director of Clinical Excellence
- Shelly Parker, Nursing Home Administrator
- Amy Mac Nicol, Director of Inpatient Services
- Denise Brock, Director of Nursing
- Heather Christensen, Manager of Pharmacy
- Dan Ellison, Director of Social Services
- Britt Lenfield, VNA

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**Our team**

- Dr. John Windeler, Hospitalist
- Tammie Beach, Clinical Educator
- Mary Bradford, Care Manager
- Dr. Dom Ausiello, Family Practice and LTCU Medical Director
- Kathy Lobert, Clinical Quality Manager
- Cindy Rollenhagen, Director of Service Excellence and Compliance
- Bill Health, PA, Family Practice

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**Targeted departments**

- Kelsey Hospital
  - Acute
- United Hospital
  - Acute
  - ICU

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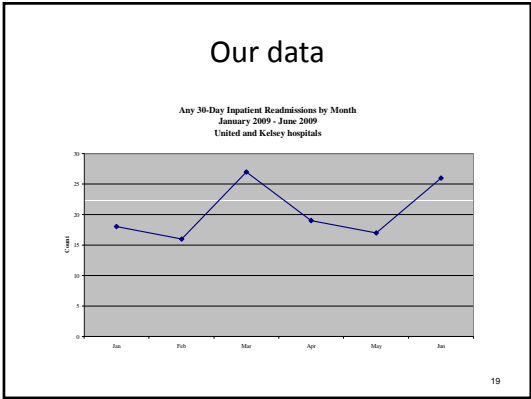
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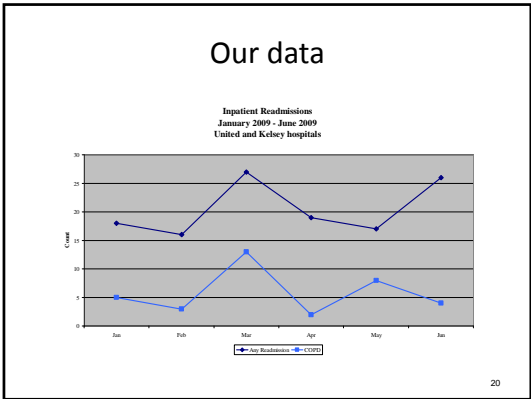
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- ### Additional findings
- The team reviewed five recent readmissions and discovered
    - Need to look at ways to schedule physician follow up visits
    - Need to work closer with area primary care physicians
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### Aim statements

- Kelsey Hospital
  - To reduce all unplanned 30-day readmissions of all patients by 30% by July 1, 2010, at Spectrum Health Kelsey Hospital's Acute Care Department
- United Hospital
  - To reduce all unplanned 30-day readmissions of all patients by 30% by July 1, 2010, at Spectrum Health United Hospital's Acute and ICU Departments

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### Progress to date

- The following has been accomplished
  - Have identified work teams with champions
  - Have completed a couple rapid PDCA projects
  - Have increased collaboration with providers outside of the hospital
  - Have looked at common themes within the Spectrum Health System
  - Have raised awareness of the issue of readmissions
  - Have achieved engagement of key stakeholders from across the continuum of care

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### Challenges

- The following challenges have been identified
  - Getting the complete picture of the readmission data
  - Realizing hospitals are part of the solution not the entire solution
  - Finding time for everyone to meet due to conflicting priorities especially those who are not hospital employees

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**Sources**

Rutherford, P. *The STAAR initiative and the transitions home collaborative (PowerPoint)*.  
*Email September 30, 2009.*

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**Questions?**

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**Thank you**

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