RARE Report
The RARE Report updates participating hospitals and Community Partners on news and events related to the RARE Campaign, demonstrates how hospitals and Community Partners can work together across the continuum of care, shares best practices, and provides tools to keep all stakeholders engaged and implementing improvements to achieve RARE goals. Please send your feedback to: MaryBeth.Schwartz@icsi.org.

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Upcoming Events, Web Updates and News

Upcoming Events
Details and registration for all events listed below are available on the calendar page http://www.rarereadmissions.org/resources/calendar.html of the RARE Campaign website.

RARE Action Learning Day, April 24, 2012
Featured Speaker: Stephen Jencks, MD, MPH, along with numerous RARE participants and Community Partners who will share their experiences. Time is running out – sign up today!

Webinar: Challenging the Label of the Non-Compliant Patient
Friday, May 4, 2012, 11 a.m. - Noon (CT)
Speaker: Eric Coleman, MD, MPH (This webinar will not be recorded)

Workshop: Co-creating a Medication Management System for the Triple Aim
Monday, May 7, 2012. Part of ICSI’s 15th Annual Colloquium
Speaker: Brian Isetts, Health Policy Fellow at the Centers for Medicare & Medicaid Innovation Center, and Professor, College of Pharmacy, University of Minnesota. Details and registration information are available here: http://bit.ly/0I1PF8
Save the Date: November Action Learning Day
Tuesday, Nov. 13, 2012
The second of two RARE Action Learning Days for 2012 is set to take place at the Crowne Plaza in Plymouth. Additional information will be provided as it becomes available.

Featured on the RARE Campaign Website
We continue to improve the Campaign’s website http://www.rarereadmissions.org/index.html to make it more user-friendly and easier to find the information you need.

- The Patient-Provider Communication and Health Literacy information has been combined and moved to its own page. http://www.rarereadmissions.org/areas/patientcomm.html It’s easily accessible from the left-hand navigation menu within the ‘5 Key Areas’ pages.
- Our growing list of Community Partners now has its own page, too. http://www.rarereadmissions.org/about/communitypartners.html You can get to it quickly from the left-hand navigation menu and it is linked from related pages.

We continue to look for ways to make this resource more valuable to RARE Campaign participants and other visitors. Be sure to bookmark the website and check back frequently to stay informed and see what’s new.

Other Readmissions News
Nursing Home Specialists Help Lower Rehospitalization Rates
Post-acute experts are making the case that nursing home specialists are the change agents who will improve the care of skilled-nursing facility residents — and lower rehospitalization rates. Published in Modern Healthcare. http://bit.ly/GYdFf8

Pilot Program Reduces Preventable Hospital Visits at Regions
A new program at HealthPartners and Regions Hospital reduced preventable hospital visits by 65 percent among patients who frequently sought care in the emergency department. The program was named the Most Innovative by the Society of Hospital Medicine and was selected from among 750 abstracts to be presented at the SHM annual meeting on April 3 in San Diego. http://bit.ly/Hhx4XM

Community Partners: Reducing Hospital Admissions from Nursing Homes
Susan Peterson, RCCC Project Director and Nellie Johnson, CEO of CareChoice Cooperative

For the past year and a half, CareChoice and 17 of its nonprofit nursing homes have been engaged in a project that is successfully lowering the number of hospital admissions from post-acute care/transitional care and long-term residential nursing care. The project, Resident Centered Care Connections (RCCC), is only halfway through its three-year duration and has already reduced 30-day readmissions by 20 percent. Funded by the Minnesota Department of Human Services Pay-for-Performance Incentive Program, the project uses INTERACT (Interventions to Reduce Acute Care Transfers) as well as other evidence-based concepts adapted to the long-term care setting.
INTERACT began as a Centers for Medicare & Medicaid Services (CMS)-funded project in Georgia and has quickly gained popularity in many areas of the country. It focuses on identifying and managing acute changes in a patient’s/resident’s condition. It includes teaching nurses to use the SBAR (Situation, Background, Assessment, Request) format when communicating with the medical provider, and empowering all staff to report changes they may notice.

INTERACT offers care paths for nursing homes with symptom guidelines for major diagnoses that have been identified as leading causes of readmissions: congestive heart failure, pneumonia, dehydration, urinary tract infection, acute mental status change and fever. Nurses receive education and competency testing on managing each of these conditions. Audits and a readmission-tracking tool enable staff to collect and analyze characteristics of each transfer. As part of the RARE Campaign, this tool has been made available for any nursing home to use – read more at: http://www.rarereadmissions.org/resources/ltc.html

Other strategies used in the project include POLST (Provider Orders for Life Sustaining Treatment) and the implementation of a palliative care program in each participating nursing home. Since the beginning of the project, 80 percent of the residents in these homes now have completed POLST forms and the number of residents receiving palliative care has increased by more than 30 percent.

Together, these nursing homes discharge more than 5,000 patients to home each year, and using elements of Project RED, they are just now initiating additional strategies such as medication reconciliation, a personal health record, teaching self-care to residents and identified family members, communicating with and arranging a visit with the health care home/community medical provider and a post-discharge follow-up phone call.

The participating nursing homes are primarily located in the Twin Cities metropolitan area and range in size from 66 to more than 300 beds. In total they have more than 2,500 nursing home beds, of which 476 are designated for post-acute/short-term rehabilitation.

CareChoice is the nation’s first cooperative made up of not-for-profit, mission-driven providers of aging services. It consists of 21 member organizations representing nearly 10,000 units across the full continuum of care, as well as home health and other community-based services. The 17 nursing homes involved in the RCCC previously completed a successful one-year project to reduce the incidence of pain in the nursing home patients/residents. For more information about RCCC, contact Susan Peterson at susanp@sttheresemn.org.

**Hospital Executives Share Insights about Work with Community Partners**

In each issue of the RARE Report, we ask executives from participating hospitals or Community Partners questions about how they are engaged in the campaign. In this issue we asked:

"Have you had leadership level discussions with any Community Partners? What insights can you share?"

**Beth Heinz, MHA, MSW; Vice President, Operations, Chief Quality Officer, Regions Hospital**

More than three years ago, HealthPartners and Regions Hospital started the journey to reduce readmissions. To do this, we knew that any patient-centered solution needed to focus on meeting both the medical and non-medical needs of our patients. We also recognized that successful transitions across the
spectrum of care (e.g. from the hospital to transitional care, to home care, or to clinics) are key in preventing rehospitalizations but are most effective when the patient is psychosocially strong and has a robust support system. We saw the need for the assistance, insight, partnership and expertise of community organizations and groups to solve the challenge of reducing readmissions.

Over the last several years, our leaders and staff have reached beyond the hospital and clinic walls to engage others in our efforts. We have not only had discussions with community partners, but we have engaged them and integrated their organizations into our efforts. One example of this is our EBAN Experience – a successful, team-based collaborative that focuses on reducing health disparities through community dialogue, experiential education and quality improvement projects. From addressing the disparities in how pain is controlled in the emergency department to working with community clinics to help self-pay patients with multiple admissions get care in primary care clinic settings, we learned to look through a different lens to solve these challenges.

Our list of partners is long; some of the most exciting examples come not only from the commonly identified partners (clinics, transitional care facilities and home care agencies) but also from other organizations serving a shared clientele (social service agencies, supportive housing organizations and homeless shelters, etc.). A collaboration we are excited about is our work with the St. Paul Emergency Medical Service. We hope to leverage their knowledge of our community and our shared patients and that they will proactively help by visiting these patients before they need emergency care. Additionally, we have had great success and learned invaluable lessons from community leaders from various ethnic and cultural groups. Insights into our patients’ lives, their non-medical needs, their cultural barriers to care, and the strengths of their communities have helped guide us through our journey to reduce readmissions.

Moving forward, we see relationships with Community Partners growing in number and in strength, thus benefiting all of our patients.

The key takeaways I would share are:

- Reach beyond your traditional partners in care
- Look at all the needs of patients, not just the medically related needs
- Understand all of your patients, not just those who might be identified “high risk” or are being readmitted frequently
- Build on the strengths of the community and your Community Partners

This is important work, and it is the right thing to do for our patients and for our community.

**Roy Yawn, MD, President, and Claude Bridges, MD, Hospital Internal Medicine, Olmsted Medical Center**

While Olmsted Medical Center's results for readmissions have been very positive over the past few years, we continue to look for ways to improve our patients’ outcomes. Therefore, we are excited to participate in the RARE Campaign and look forward to learning from others on how we can continue to improve our results.

Our RARE Committee consists of representatives from area nursing homes, home health agencies and adult foster care, as well as OMC’s own medical-surgical and emergency department nursing, pharmacy, inpatient social services, discharge planning, patient education, quality improvement, outpatient internal medicine and hospital internal medicine.

Insights gained from this partnership include:
1. The outpatient care provider community has shown a high degree of interest in maximizing the likelihood of a successful discharge by promoting patient wellness. We all want to see our patients continue to get well, and stay well.

2. There is a need for tailored, patient-specific discharge instructions. The hospitalists strive to identify likely potential actionable situations (call/come in if …) explicitly for the patient and care providers. For example, a weight gain of four pounds in a heart failure patient acted upon promptly may decrease the risk of decompensation. Educating patients to watch for worsening signs/symptoms can improve the likelihood of successful outpatient intervention.

3. Patients experience challenges following discharge instructions and recognizing signs/symptoms. Part of the difficulty is due to the different instructions provided by the various types of health care providers, which includes the patient, family and adult foster care homes, all the way up to skilled nursing facilities. Knowing who your audience is allows for more successful communication.

4. The process of teaching healthy behaviors begins at the patient’s admission to the hospital. It’s difficult for patients to learn everything about their illness during their hospital stay. If teaching can continue following discharge; e.g. providing congestive heart failure education during home health visits, we will be enhancing the medical knowledge of our patients as well as preventing readmission to the hospital.

Campaign Updates

Measurement Work Group Summary and Recommendations

In support of the RARE Campaign, a group of health care stakeholders with measurement interest and expertise convened in February of 2011 with responsibilities for reviewing and advising on publically reported measures related to reducing avoidable readmissions, aligning with national measures impacting readmissions, providing measurement information to campaign participant hospitals, and exploring attribution methodology and advising on data sources. This effort was a collaboration of the RARE Operating Partners and MN Community Measurement (MNCM) to try to identify the measurement needs for public reporting and to support the RARE Campaign.

The work began by knowing that it was not possible to capture all readmissions due to the lack of a common patient identifier across facilities using currently available data (Minnesota Hospital Association (MHA) inpatient file). The work group thus proceeded with measure development believing there was potential value in pursuing a hospital level 30-day all-cause readmission measure for potential public reporting along with additional condition-specific measures that were selected (i.e. heart failure, acute myocardial infarction, pneumonia, chronic obstructive pulmonary disease and mental health). In conjunction with this initial measurement development work, the Minnesota Department of Health requested exploration of avoidable admissions and readmissions attributed to physician clinic. It was envisioned that measure construction would occur using the data already submitted to MHA, thus avoiding duplicate processes, and that the results would be displayed on the Minnesota HealthScores consumer-facing public website. Measurement specifications (following alignment with CMS) were drafted and distributed for public comment in the fall of 2011.
Strong public comment opposing public reporting was received given the inability to capture all readmissions due to the lack of a common patient identifier across facilities using currently available data. Additionally, following extensive exploration, it was determined that until all payer claims (inpatient and outpatient) are available, successful attribution at the physician clinic level is not possible.

In November 2011, the work group learned that the Agency for Health Care Research and Quality (AHRQ) was releasing a Beta SAS software package to calculate Readmission Quality Indicator (RQI) measures. This could significantly change the need for programming on the part of MNCM to calculate hospital readmissions rates as initially planned, but it would not solve the lack of a common patient identifier across facilities. Additionally, though not a show-stopper, in February 2012, CMS/Yale proposed a new Hospital Wide Unplanned Readmission for National Quality Council endorsement that has a completely different calculation methodology (compared to the current measures reported on Hospital Compare), and numerous algorithms would need to be applied to determine an unplanned readmission. Current measurement specifications would need to be significantly adjusted in order to maintain alignment.

With the above considerations in mind, the RARE Measurement Work Group met and formulated the following recommendation:

The work group recommends suspending further efforts to create Minnesota publically reportable hospital readmissions measures through MNCM until a more satisfactory data source is available. The work group further recommends that efforts continue to support and enhance the utilization of Potentially Preventable Readmissions (PPR) data by organizations for the purposes of quality improvement.

Hospitals are receiving quarterly, detailed PPR data from MHA. PPR is a software algorithm module produced by 3M that was obtained by MHA in 2009. RARE Campaign goals of a 20 percent reduction (4,000 readmissions or 16,000 more nights of sleep in one’s own bed) in the statewide number of readmission from the baseline of 2009 were determined using PPR data. Hospitals are receiving:

1. Their readmission rates as compared to all other Minnesota hospitals in a transparent fashion (though not publicly reported),
2. Observed-to-expected ratio for their readmission rate in addition to comparison to individual target, and
3. Access to patient-level detailed information that allows analysis of individual patients or ability to roll-up by APR-DRG or Major Diagnostic Category.

The technical workgroup concluded that this data was sufficient to be used by hospitals for internal quality improvement purposes and that it was not necessary to build this data capability into the MNCM data portal as was suggested in December of 2011.

On April 11, 2012, MNCM’s Measure and Reporting Committee (MARC) reviewed the progress of the work group to date. MARC was appreciative of the exploratory work completed by the measurement work group for these important measures and voted unanimously to accept the work group’s recommendation as stated above.

**MN Epic Users Group Selects Medication Management as Improvement Focus**

During the past few months, participating RARE hospitals have identified a variety of opportunities to better use electronic medical records (EMRs) in support of their work to reduce readmissions. To build on these ideas, Stratis Health convened representatives from the Minnesota hospitals and health systems that
are using the Epic EMR to identify, define, and prioritize strategies to improve its ability to serve as a tool to reduce avoidable readmissions.

RARE Operating Partners staff came together with health informatics representatives and members of the MN Epic Users Group to recommend one priority area for action in the coming year. Areas of need identified included discharge planning, care coordination, medication management, risk assessment, user-friendly documentation, patient education and patient record standardization. At a meeting on April 9, the group agreed to focus its initial proposal on medication management. A proposal will be presented to the entire MN Epic Users Group that will include recommendations to improve areas such as providers’ access to complete and accurate medication information, documentation of medication use and patient education, and user-friendly materials for patients and their families.

The MN Epic Users Group will consider the proposal in the context of its work for the next year and will also work with Epic to assess feasibility and next steps. The RARE Operating Partners will continue to work with hospitals and the MN Epic Users Group to support implementation of the medication management proposal and to develop an approach for addressing the other opportunities for improvement.

The RARE Report is brought to you by the RARE Campaign’s Operating Partners: Institute for Clinical Systems Improvement, Minnesota Hospital Association and Stratis Health, with contributions by the campaign’s Supporting Partners, Minnesota Medical Association and MN Community Measurement.

Launched in September 2011, the RARE Campaign seeks to achieve Triple Aim goals by preventing 4,000 avoidable readmissions in Minnesota by Dec. 31, 2012. We thank all stakeholders in this regional initiative for their ongoing support.

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