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.

In This Issue

1. Upcoming Events, News and Web Updates
2. The Role of Primary Care in Reducing Avoidable Readmissions
3. UCare Teams Up With Providers and Hospitals to Support High-Risk Seniors
4. Executive Q&A: Working with Primary Care Physicians

Upcoming Events, News and Web Updates

Events
Details and registration for all events listed below are available on the calendar page of the RARE Campaign website.

Webinar: The Aging Network — Helping Older Adults Live Well at Home Today
Learn how Minnesota’s seven Area Agencies on Aging (AAAs) and their local service networks help older adults recover from acute illness, manage chronic conditions and prevent injurious falls.

Tuesday, July 24, 2012, Noon – 1 p.m. (CT)
Speakers: Dawn Simonson, MPA, Executive Director, Metropolitan Area Agency on Aging, Inc. and Lori Vrolof, MA, Executive Director, Central Minnesota Council on Aging

Webinar: Meaningful Use and the RARE Campaign
Friday, August 24, 2012, Noon – 1 p.m. (CT)
Speaker: Paul Kleeberg, Chief Medical Informatics Officer at Stratis Health and Clinical Director of the Regional Extension Assistance Center for HIT (REACH) for Minnesota and North Dakota. He provides health information technology (HIT) services to assist clients with their electronic health records (EHR)
planning, implementation and achieving meaningful use of their EHR. Registration information will be available soon.

MAPS Annual Conference
The annual conference of MAPS, the Minnesota Alliance for Patient Safety, will be held October 25 – 26, 2012 at the Minneapolis Marriott Northwest in Brooklyn Center, with a preconference on October 24. The conference will feature a number of sessions relevant to preventing avoidable readmissions, including one focused specifically on the RARE Campaign, along with medication management, patient engagement, and communications. Additional information and registration.

Save the Date: November Action Learning Day
Thursday, November 8, 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.

News

RARE Campaign Featured in Minnesota Physician
The RARE Campaign is featured in the July 2012 edition of Minnesota Physician. The article describes the campaign and the organizational assessment process that all participating hospitals completed, and how two hospitals, one large (Allina Health) and one small (Glencoe Regional Health Services), are acting on their assessments to reduce avoidable readmissions. Read the article.

Home Visits by Health Coaches Reduce Hospital Readmissions (Rochester, NY Democrat and Chronicle)
Patients who were visited by a health coach at least once after being discharged from the hospital were 25% less likely to use hospital services within 30 days than those who didn’t get a visit, as reported by the Finger Lakes Health Systems Agency in this July 9, 2012 article. Officials said when data on the Care Transitions Intervention pilot program is finalized, it is expected to show a reduction in health care costs. Read the article.

Effect of a Pharmacist Intervention on Clinically Important Medication Errors After Hospital Discharge (Annals of Internal Medicine)
Many patients have problems with their medications after hospital discharge. This study published July 3, 2012 looked at adults with acute coronary syndromes or heart failure, and found that half of the patients had a clinically important medication error during the month after discharge, even when pharmacists made special efforts. Read the article.

Web Updates

New resources for you have been added to the RARE Campaign website:

- **Transition Communication Resources:** Targeted Solutions Tool for Hand-Off Communications. Ten leading health care organizations, together with the Joint Commission Center for Transforming Healthcare, examined their hand-off communications problems, identified specific causes of failure and barriers to improvement, and then created solutions that improved their performance.

- **Transition Care Support Resources:** How-To Guides for Improving Care Transitions from the Institute for Healthcare Improvement (IHI). The four IHI guides aim to reduce avoidable
readmissions by improving transitions from hospital to post-acute care settings, clinical office practice, skilled nursing facilities and home health care.

The Role of Primary Care in Reducing Avoidable Readmissions

Rebecca Schierman, MPH is quality improvement manager at the Minnesota Medical Association, a supporting partner of the RARE Campaign.

Through the RARE Campaign, Minnesota hospitals are realizing reductions in avoidable readmissions due to better discharge planning and transfer communications, ensuring patients understand their medications, and assigning staff to follow up with patients after discharge.

But primary care providers also play an important role in reducing readmissions. Most avoidable hospital readmissions are not due to the lack of care in the hospital, but rather the lack of coordinated care after a patient leaves the hospital. Improvements in patient engagement and education, post-discharge follow up, and coordination of care across health care settings offer a variety of opportunities to prevent avoidable readmissions.

We know that primary care physicians often don’t know that their patients have been discharged from a hospital and that patients often are unclear about how, when and who to contact if they experience problems after a hospital discharge. So what can primary care providers do to improve the flow of information from hospitals and to ensure patients have the skills they need to reduce avoidable hospital readmissions?

We have several opportunities to improve the management of patients in the primary care practice once they transition from hospital to home.

Develop systems and processes to track and follow up on patients with hospitalizations. Through RARE, hospitals are improving their discharge processes. They’re working to standardize communication and the exchange of information between the hospital and receiving provider in time to allow the receiving provider to effectively care for the patient. On the receiving end, primary care can help by having systems in place to receive and exchange the information and using it to track and reach out to patients.

Provide in-person education and medication management to reinforce messages to patients. RARE is encouraging hospitals to follow up with patients after discharge. At the same time, primary care practices are implementing the health care home or medical home model. One key feature of medical homes is robust care coordination. Hospital discharge coordinators and medical home care coordinators need to work in tandem to ensure effective post-discharge care. These care coordinators should work together and with the patient to address care plans, compliance with medication, diet, and other measures to prevent readmissions.

Proactively identify high-risk patients. Reducing risks for readmission requires identification of patient populations at highest risk. Once primary care providers identify those patients, staff can work to modify patient risk via education or patient-engagement interventions. Additionally, primary care can employ broader-based support in the form of access to home services and longitudinal care, and targeted post-discharge patient education.

Preventing avoidable hospital readmissions is the responsibility of the entire health care community. Each provider, group or organization must improve their processes to ensure that transitions of care meet the
patient’s needs. Additional direction and support can be found in the RARE Campaign’s *Recommended Actions for Improved Care Transitions*.

**Community Partner: UCare Teams Up with Providers and Hospitals to Support High-Risk Seniors**

For some patient populations, the RARE Campaign’s goal of reducing hospital readmissions by 20 percent is more than achievable — higher reductions may be very realistic. A joint project of UCare; Fairview Physicians Associates (FPA), a network of 2,000 primary and specialty care providers; Fairview Southdale Hospital; and Fairview Ridges Hospital has achieved between a 30 and 44 percent reduction, depending on measurement and definition of readmission. The pilot project, which began Feb. 1, 2010, targets patients covered by *UCare for Seniors* Medicare Advantage plan who are hospitalized and who have diabetes, chronic obstructive pulmonary disease, or heart disease, or a combination of the three.

The four organizations have developed a series of touchpoints with *UCare for Seniors* patients discharged from the hospital to ensure their health and recovery is well managed once they are back in the community. [Learn more.]

“We saw an opportunity for swift follow-up with hospitalized patients to avoid preventable hospital readmissions,” said Russel Kuzel, MD, MMM, senior vice president and chief medical officer, UCare. “We seized the opportunity to intervene first with our *UCare for Seniors* members who suffer from chronic conditions that make them even more vulnerable for a relapse. Preventing hospital readmissions is a win/win for everyone in the health care system.”

The initiative involves collaboration between the hospitalist, discharge planner, hospital pharmacist, case manager, and primary care provider. “Care team members work together to ensure the patient is safely discharged back home,” said Kuzel. “They ensure a safe transition by making sure the patient knows what medication to take and when to take it, that they have the equipment and post-acute care they need, and that they have a timely follow-up visit.”

This approach improves patient care and long-range health, and helps contain costs. Each prevented readmission could save $10,000 on average. Part of those savings provides additional support to patients to improve their care. UCare provides a $50 incentive to the primary care physicians to see patients within five days after discharge, as well as funds to the hospital for a pharmacist to evaluate patients in the program.

Health plans and other payers play a critical role in supporting reduced readmissions. They see all of the care that their member receives, no matter where it is provided, and can reward improvements in care delivery, meeting the intent of accountable care.

The dedicated physician leaders at Fairview were essential to implementing the system to improve this process. The initial success with Fairview Southdale led to the program’s expansion to Fairview Ridges Hospital in November 2011. Kuzel notes, “We have a shared vision and commitment.” UCare is exploring ways to expand the success of this work.
Executive Q&A: Working with Primary Care Physicians

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:

“How are you working with primary care physicians to help reduce avoidable readmissions?

David Klocke MD, Chair, Division of Hospital Internal Medicine, Mayo Clinic

At Mayo Clinic, we have worked steadily since early 2011 to design, pilot and implement a set of best practices to reduce avoidable readmissions. The basic elements of that plan include early risk stratification, enhanced patient education, improved discharge processes and risk-based follow-up after a hospitalization. In my view, no plan to reduce readmissions will be as effective without the key component of follow-up to engage the outpatient practice. Following are some of the ways Mayo is working with our primary care physicians to reduce avoidable readmissions.

Stratification of patients across outpatient and inpatient settings is an important part of how we identify their risk for hospitalization or rehospitalization. We partnered with staff across Mayo Clinic to develop a risk stratification process, and Dr. Rajeev Chaudhry and his IT team helped us create an electronic tool using Microsoft’s AMALGA to help us better identify patients at high risk for readmission and to target resources to those most likely to benefit from interventions tailored to their needs.

Our primary care providers and their medical home teams are notified when their patients are hospitalized. This allows the inpatient and outpatient teams to effectively coordinate the transition to outpatient care, often facilitating earlier hospital discharge. Using our risk tool, targeted patients are scheduled for early follow-up phone calls, visits or both. This care takes place in our primary care medical home in Rochester or with the patient’s primary care provider within our health system. In addition, our EMR automatically notifies the medical home team when one of their patients is admitted.

For Mayo, two keys to success as we reduce readmissions across our organization are to make patient risk factors transparent and accessible to all providers across the continuum of care and to consistently apply high-value interventions to help our patients remain well and in their homes.

Ron Ommen, Interim CEO, Paynesville Area Health Care System

I believe that our primary care providers (both physicians and mid-level personnel) must become “self starters” in our work to reduce avoidable readmissions. As Paynesville Area Health Care System incorporates the RARE Campaign work into its processes, we keep the interests of these providers in mind as we consider how patients move through our system.

I also believe it is the administration’s primary responsibility to clearly set the goals and priorities for the organization. As such, it is important that communication with providers clearly establishes the goals of the RARE Campaign as an organizational priority and a key quality indicator for the system. I am personally involved in the teams that oversee the work of the hospital, giving me the opportunity to reiterate the organization’s commitment of time and resources to successfully discharge patients while minimizing the need for a repeat admission.
At the same time, we must ensure that our hospital staff that work with patients and providers also know the priorities of the organization and are aware that the hospital has dedicated appropriate resources to accomplishing those priorities. For example, we have dedicated discharge advocate and clinical pharmacy resources to consult with patients to verify current medications and educate them about any newly prescribed medications.

That said, if the providers and hospital staff agree on the importance of this priority, as I believe they do at Paynesville, management should step back and let the professionals work the program. In this manner, I’m confident we will successfully reduce avoidable hospital readmissions and help our patients spend more nights in their own beds.

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.

If you have any questions related to the content of the RARE Report, contact:
  Mary Beth Schwartz, ICSI, marybeth.schwartz@icsi.org, (952) 814-8292
  Deb McKinley, Stratis Health, dmckinley@stratishealth.org, (952) 853-8576
  Wendy Burt, MHA, wburt@mnhospitals.org, (651) 603-3549