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 Mary Beth Schwartz.

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The Joint Commission Journal on Quality and Patient Safety Features RARE Campaign, Other Eisenberg Award Winners
The May issue of The Joint Commission Journal on Quality and Patient Safety features articles about all recipients of the 2013 Eisenberg Award, including Minnesota’s RARE Campaign, which was recognized at the national level for quality and patient safety. The publication notes that the peer-to-peer networking and collaboration between hospitals facing similar issues, coupled with statewide resources, collaborating Operating Partners, and support for system improvements, have led to improved discharge planning, better management of care transitions and medications, engaged patients and families, and lower readmission rates. Read the abstract.

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

Come Together at the Final Action Learning Day and Celebration
Tuesday, June 17, 2014, Crowne Plaza, Plymouth, MN
Round up your RARE team – and your pillows – and make plans to join us at the Crowne Plaza Hotel in Plymouth for our last Action Learning Day. Be sure to bring your pillow for a special photo opportunity!

Our keynote speaker is Eric Coleman, MD, MPH, professor of medicine and director of the Care Transitions Program at the University of Colorado, and a strong supporter of our RARE Campaign. The agenda will include patient engagement, end of life care, and learning more about how motivational interviewing, shared decision-making and health coaching can work together in a synergy and symphony of care.
Following the learning day program, we'll celebrate your accomplishments with a reception, including a brief program, special photo opportunities and more. We hope you can participate in both events, but you are welcome to attend just the learning day or reception. Register by June 12, 2014. Cost for the learning day is just $45; there's no charge for the reception. For questions about the learning day, contact MHA's Kattie Bear-Pfaffendorf at 651-659-1404. Contact ICSI's Patty Staack at 952-814-7063 with registration questions.

RARE Webinar: Winona Health Community Care Network Program
Wednesday, April 30, 2014, Noon – 1 p.m. CDT
In this challenging time of health care reform, we need innovative and collaborative strategies to meet the health care needs of our communities. Winona Health has developed the Community Care Network, a community-based program that targets individuals with chronic health conditions who are at high risk for frequent emergency room visits and hospital readmissions. The program also provides a health coach in the home through a collaboration with Winona State University. Register for this webinar by April 25, 2014. More information.

RARE Webinar: A Perfect Partnership: Ensuring a Safe Patient Transition With a Post-discharge Firefighter Visit
Tuesday, May 20, 2014, 1 – 2 p.m. CDT
Transition support occurs in that critical time after hospital discharge. How do you follow up quickly with patients to make sure they are doing well and will continue to do so? In this program we will learn about a joint effort between the St. Louis Park Fire Department and Park Nicollet Health Services, who are collaborating to help people make this transition from hospital to home safely and prevent further problems and avoidable readmissions. The March 30, 2014 edition of the Minneapolis Star Tribune included an article about this program. Register for this webinar by May 15, 2014. More information.

Campaign News
Another Hospital Joins the Campaign
Welcome to Mille Lacs Health System in Onamia, which recently joined the RARE Campaign, bringing the total number of participating hospitals to 86. A complete listing and map are available on the campaign website.

Six Readmission Reduction Success Stories Article Includes RARE Campaign
The RARE Campaign is included in this article’s six readmission reduction success stories, highlighting what works and what doesn't when launching a readmission reduction initiative. (Fierce Healthcare, March 24, 2014). Read the article.

Other News
Predictors of Rehospitalization After Admission for Pneumonia in the Veterans Affairs Healthcare System
Although some factors associated with rehospitalization after community-acquired pneumonia have been identified, other factors such as medical care utilization and medication use have not been previously studied. The authors investigated novel predictors of rehospitalization in patients admitted with pneumonia, and concluded that factors associated with readmission were largely unrelated to the underlying pneumonia, but were related to demographics, comorbidities, healthcare utilization, and length of stay on index admission. (Journal of Hospital Medicine, March 19, 2014)
Variation in the Risk of Readmission Among Hospitals: The Relative Contribution of Patient, Hospital and Inpatient Provider Characteristics

This research looked at admissions for certain Medicare beneficiaries in Texas in 2008 and 2009 to describe the variation in risk of readmission among hospitals and partition it by patient characteristics, hospital characteristics and provider type. The authors conclude that patient characteristics are the largest contributor to variation in risk of readmission among hospitals, and that measurable hospital characteristics and the type of inpatient provider contribute little to variation in risk of readmission among hospitals.

In an editorial about the study in the same issue, The Ninety-Nine Percent: Focusing on the Patient to Reduce Readmissions, author Karen Joynt says, “This study actually has important lessons for both clinical leaders and policymakers not on why we should give up, but on where we should shift our focus in future efforts to improve patient care. Few would disagree that we can do better—we can do better in discharge planning, we can do better in care coordination, and we can certainly do better in improving access to high-quality outpatient care. But what this study suggests is that it’s really all about the patients.” (Journal of General Internal Medicine, April 2014)

Pharmacy Pilot at Regions Hospital Aims to Improve Patient Care, Reduce Readmissions

Regions Hospital is one of 12 participating hospitals in the RARE Mental Health Collaborative.

Placing a pharmacist full time on the mental health floor of a hospital may not be revolutionary, but a pilot study showed it could make a big difference in patient care and costs at Regions Hospital in St. Paul, Minnesota.

Change was necessary because the current model just wasn’t working. In a department with the highest patient-to-pharmacist ratio, the clinical pharmacist was spending five hours every day consulting and reviewing 100 profiles of mental health patients but had little or no time for direct interaction with the patient or medical team. Even at discharge, the pharmacist was not involved in the process. Studies have shown that proper discharge education, along with medication reconciliation, can reduce readmissions by up to 37 percent.

In a pilot study in November and December of 2013, Pharmacy set out to determine if placing a dedicated pharmacist on the mental health floor as part of the mental health clinical team could help improve patient care and reduce readmissions. Led by Meg Moen, pharmacy resident, the collaborative team consisted of representatives from clinical pharmacy, nursing, psychiatry, medication therapy management, social work, medicine, administration and the discharge pharmacy.

During the 24-day pilot, there were 360 interventions, the most common being discontinuation of inappropriate therapy, a change in drug formulation recommendations and medication reconciliation upon discharge. Health plan data indicated that 30 percent of all discharge prescriptions are never filled, increasing the likelihood of early readmission, according to Craig Harvey, director of pharmacy services.

“We saw a lot of opportunity to control costs, provide patient and staff education and, at the same time, improve patient care,” said Harvey. More than 50 percent of mental health staff surveyed agreed that the discharge medication process improved during the pilot, and 81 percent said they would support having a
A pharmacist on the unit full time. The pilot demonstrated savings of $99,301, with potential annual savings (hard and soft) estimated to be $1.5 million due to lower medication costs and the elimination of preventable medication errors.

As a result of the pilot, Regions Hospital will hire a full-time Board Certified Psychiatric Pharmacist (BCPP) who also is an expert on dosing for patients with compromised medical conditions. The hospital also is hiring an Emergency Department clinical pharmacist to evaluate mental health patients presenting in the emergency department and anticipate coordination of care with the BCPP. Patient medications will be reconciled with discharge orders, and all mental health patients will leave with a 30-day supply of medications to improve compliance and reduce readmissions. High-risk patients will be referred for medication therapy management (MTM), making it more likely they will follow their regimen as directed.

“The entire clinical pharmacy team believes hiring a mental health expert pharmacist is 100 percent the right decision,” said Harvey. “Medications used to treat mental health conditions are very complex, and the assessment for an appropriate patient response is critical. Patient care should benefit from adding a full-time BCPP to the care team.”

For more information, contact Craig Harvey at 651-254-9560.

**RARE’s Collaborative Improvements Benefit Good Samaritan Home Care Patients**

Good Samaritan Society is a RARE Community Partner

Efforts to reduce readmissions for home care patients of Good Samaritan Society in the Nisswa area began when leaders at Essentia Health-St. Joseph’s Medical Center in Brainerd approached the home care agency.

“St. Joseph’s is our major patient referral source,” said Kayla Farr, Good Samaritan director and a nurse who has been with the agency for 24 years. “Being asked to collaborate on improving transitions and reducing readmissions for patients being discharged from St. Joseph’s gave us the opportunity to learn more about the hospital and about the facility’s inner workings.”

Also invited were Good Samaritan “sister” facilities: Good Samaritan Pine River, Good Samaritan Woodland, Good Samaritan Bethany and Good Samaritan Assisted Living.

Farr said the first step in the initiative was to audit charts of patients from St. Joseph’s who were referred to Good Samaritan’s home care program. The audit showed home care patients sometimes going to the emergency department and urgent care clinic when issues may have been resolved by calling the home care agency.

“When a patient was at home and called us with a concern or an issue, we learned that it’s best to go to the patient’s home and not to triage the concern by phone,” said Farr. “We educated our patients – even provided refrigerator magnets as a reminder – that they call us first.”

Because the service area is large with clients who can be 47 miles from the main office, all of Good Samaritan home care patients receive a telehealth machine in their homes within the first 24 hours following a hospitalization. Home care nurses remotely review the information gathered by the machines each day, including blood pressure, oxygen levels, weight and pulse.
“The telehealth machine vitals are then sent as a report to the physician who will see the patient for a post-discharge follow-up appointment – so that caregiver knows what those readings were during the five or so days at home,” said Farr. “Because disease-specific questions are part of the telehealth information collected by the machines, physicians also know how many days patients reported problems with, for example, swollen legs or shortness of breath.”

Sharing information among care providers and collaborating to improve transitions has been a rewarding experience – and one that improves services to patients, according to Farr.

“This project has opened the door for establishing an honest and effective working relationship together,” she said. “The nursing homes had requests and suggestions for improving transitions and we talked through our own recommendations to improve the home care experience. In fact, because of the RARE project and a specific request, we can access information on our home care patients from the hospital’s electronic medical record. Epic Care Link, a web-based and secure portal we can all use for obtaining important patient information, is just one of the many collaborative improvements to benefit our patients.”

For more information, contact Janelle Shearer, Stratis Health program manager, at 952-853-8553 or jshearer@stratishealth.org.