

## STAAR Initiative

### *STate Action on Avoidable Rehospitalizations*

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THE COMMONWEALTH FUND



## STAAR Initiative

### *STate Action on Avoidable Rehospitalizations*

- Commonwealth Fund-supported initiative to reduce avoidable rehospitalizations, taking states as unit of intervention
  - May 1, 2009 launch
  - Anticipated 4-year initiative
- State-based Initiatives
  - Public, non-governmental, and/or private sector leadership focused specifically on rehospitalizations
  - 3 states selected to receive Commonwealth Fund-IHI supported technical assistance (Massachusetts, Michigan, Washington)



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### Why a state-based strategy?

- Must work across organizations, entities
- Data
- Financial implications
- Engaging payers
- Patterns and utilization of care
  - Requires new patterns and approaches to care
    - E.g. Advanced directives, palliative care



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### State-based initiatives in health system reform

#### Public sector

- Health reform legislation
- All-payer data
- Licensing, regulation
- Convener
- Public payer
- Purchaser

#### Private / non-governmental sector

- Provider networks, history of successful prior initiatives
- Ability to iteratively test innovations
- Ability to pilot payment innovations
- Some hospital associations manage all-payer databases
- Convener
- Mobilize front-line providers, interest, and will



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### “Sense-making” and evaluating interventions

#### Will / Incentives

- Who is motivated to make this change?
- Are there incentives and adequate ways to pay for this intervention?
- Are there winners and losers or a potential for win-wins?

#### Degree of Belief / Impact

- Level of evidence for the change
- Availability or awareness of credible “best practices”
- Impact on reducing rehospitalizations

#### Degree of Difficulty to Implement or Replicate

- Alignment with other local and national quality initiatives
- Relative ease of implementation & measurement
- Are there partners (national and within the region) to assist with implementation and spread?



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### High-leverage opportunities for action

#### **1. Improve Transitions for *All Patients***

- a) Transitions “out” of the hospital
- b) Reception “in” to home (home health, office practice)
- c) Reception “in” to skilled nursing (post-acute rehab, NH)

#### **2. Proactively Address the Needs of “*High Risk*” Patients**

- a) Enhanced services for high risk patients
- b) Local market assessment of plausibility of payment

#### **3. Engage Patients/Caregivers**

- a) Proactive role, navigating/advocacy skills
- b) Shared care plans
- c) Proactive advanced care planning



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#### Goals

- Reduce avoidable rehospitalizations in a state by 30%
- Increase patient /family satisfaction with care

#### Methods

- Support state-based initiatives to improve care transitions and reduce avoidable rehospitalizations
- Provide technical assistance in 2 areas:
  - Front-line process improvements in transitions of care
    - Transitions “out” and Reception “in”
  - Address systemic barriers to improving transitions in care
    - State-wide data/ measurement
    - Payment/policy reforms
    - Financial implications on providers
    - Working / communicating across continuum



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#### May 2009 to Fall 2010

- Front-line process improvement technical assistance
  - May 2009: identify 15-20 hospitals in MA to improve transitions out
  - June-August 2009: hospitals and cross-continuum partners complete prework\*
  - September 2009: Transitions Out collaborative launch in MA
  - October 2009-Dec 2010: process improvements active phase
  - Fall 2010 (proposed): Reception In collaborative launch in MA
  - Fall 2010 (proposed): Second wave of Transitions Out collaborative
- Targeted technical assistance to address systemic barriers
  - May 2009 launch inter-state technical assistance workgroups
  - Workgroups will have 120-day cycles
  - Facilitate inter-state learning, intra-state convening, leverage external expertise on common challenges
  - Provide targeted state-specific technical assistance when needed

\*prework includes reviewing rehospitalization data, plan in MA to coordinate with DHCFP 3M PPR pilot hospitals if desired



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#### States in STAAR Initiative

- Massachusetts
  - Ranks 41<sup>st</sup> in US on Medicare 30-day readmissions
  - Focus of robust public-private-nongovernmental attention and coordination
- Michigan
  - Ranks 40<sup>th</sup> in US 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 US
- Washington
  - Ranks 18<sup>th</sup> in US on Medicare 30-day readmissions
  - Effort led by Washington State Hospital Association
  - Building on unique case for attention/change: state-wide bed capacity challenges



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#### Resources:

1. How-to Guide: Creating an Ideal Transition Home
2. Guide for Field Testing: Creating an Ideal Transition to the Office Practice
3. Guide for Field Testing: Creating an Ideal Transition to a Skilled Nursing Facility
4. Reducing Avoidable Rehospitalizations: Applying Early Evidence and Experience in Front-Line Process Improvements to Develop a State-Based Strategy
5. Effective Interventions to Reduce Rehospitalizations: A Survey of the Published Evidence
6. Effective Interventions to Reduce Rehospitalizations: A Compendium of 15 Promising Interventions
7. Reducing Avoidable Rehospitalizations: A Tool for State Policy Makers
8. Reducing Avoidable Rehospitalizations: Data and Measurement Issues for the Initiative

Available at [www.ihl.org](http://www.ihl.org) or [www.commonwealthfund.org](http://www.commonwealthfund.org) in May 2009



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