



# STate Action on Avoidable Rehospitalizations



*An initiative of The Commonwealth Fund & the Institute for Healthcare Improvement*

## ***MA STARR Initiative Summit Report 2011 Activities***

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# MA STAAR Learning Session

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- Representation from all existing and new teams
- Sessions Highlighted...
  - *Cohort 1 STAAR Team Presentations*
  - *Engaging Patient and Family Members*
  - *Completing the Transition: Role of Community Care Settings*
  - *New and Emerging Ideas*

## Massachusetts STAAR: STate Action on Avoidable Re-hospitalizations

### Hospitals Enrolled in STAAR in 2009

Baystate Medical Center  
Berkshire Medical Center  
Beth Israel Deaconess Medical Center  
Brigham and Women's Hospital  
Cambridge Health Alliance  
Cooley Dickinson Hospital  
Fairview Hospital  
Faulkner Hospital  
Lahey Clinic  
Massachusetts General Hospital  
MetroWest Medical Center  
Newton Wellesley Hospital  
North Shore Medical Center  
Northeast Health Systems  
Saints Medical Center  
St. Elizabeth's Medical Center  
St. Vincent's Hospital  
South Shore Hospital  
Sturdy Memorial Hospital  
Tufts Medical Center  
Umass Memorial Medical Center  
VA Boston

### Hospitals Enrolled in STAAR in 2010-2111

Baystate Franklin Medical Center  
Baystate Mary Lane Hospital  
Cape Cod Hospital  
Carney Hospital  
Emerson Hospital  
Falmouth Hospital  
Good Samaritan Medical Center  
Hallmark Health Systems  
Harrington Hospital  
Heywood Hospital  
Holy Family Hospital & Medical Center  
Holyoke Medical Center  
Jordan Hospital  
Lawrence General Hospital  
Lowell General Hospital  
Mercy Medical Center  
Merrimack Valley Hospital  
Milford Regional Medical Center  
Milton Hospital  
Morton Hospital & Medical Center  
Mt. Auburn Hospital  
Norwood Hospital  
Southcoast Hospital Group  
Southcoast St. Luke's Hospital  
St. Anne's Hospital  
Winchester Hospital  
Wing Memorial Hospital & Medical Center

### Hospitals Continuing w/Existing Programs

Athol Memorial Hospital  
Boston Medical Center  
Nantucket Cottage Hospital  
New England Sinai Hospital  
North Adams Regional Hospital  
North Shore Medical Center

## Improving Patient Care

- ▶ Pressure Ulcers
- ▶ Patient Falls
- ▶ Preventable Mortality
- ▶ Readmissions
  - [State Action on Avoidable Rehospitalizations Initiative \(STAAR\)](#)
  - [Massachusetts Care Transitions Forum and Care Transitions Seminar](#)
  - [Massachusetts STAAR Learning Session February 2011](#)
- ▶ Healthcare-Acquired Infections (HAIs)
- ▶ Hospitals in Pursuit of Excellence
- ▶ New HRET Guide on Workforce Practices to Drive Quality

## Massachusetts STAAR Learning Session February 2011

One of MHA's Strategic Improvement Performance Agenda priorities made advances in February as more than 400 care providers attended the State Action on Avoidable Readmissions (STAAR) project's second learning session in Framingham, Massachusetts. The STAAR project is focused on improving care transitions to reduce readmissions.

A total of 49 cross-continuum teams attended the session. Twenty-two of the teams have been part of the STAAR project since September 2009, and 27 new teams came to the event to learn from their colleagues and begin their own work. The cross-continuum teams include hospitals, skilled nursing facilities, physician offices, home health agencies, and community service providers from across the state.

The Massachusetts leads for the STAAR Project are MHA, the Department of Public Health, the Massachusetts Coalition for the Prevention of Medical Errors, and the Massachusetts Medical Society.

### Agenda

#### **Presentations:**

- [Day 1.01 0900AM Making The Case](#)
- [Day 1.02A 0945AM Overview STAAR Collaborative](#)
- [Day 1.02B 945AM Reflection and Planning](#)
- [Day 1.03 1045AM Baystate](#)
- [Day 1.03 1045AM Key Change 1](#)
- [Day 1.04 1230PM Key Change 2](#)
- [Day 1.04 1230PM Newton Wellesley](#)
- [Day 1.04 1230PM Northeast](#)
- [Day 1.05 0130PM Key Change 3](#)
- [Day 1.05 0130PM VA Healthcare](#)
- [Day 1.05 0130PM Lahey](#)
- [Day 1.06 0245PM KeyChange 4](#)
- [Day 1.06 0245PM Newton Wellesley](#)
- [Day 1.06 0245PM North Shore](#)
- [Day 1.07 0345PM Model For Improvement](#)
- [Day 2.08 0800AM Debrief](#)
- [Day 2.09 0830AM Metrowest](#)
- [Day 2.09 0830AM Northeast](#)

# MA STAAR Framework 2011

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- **STAAR Steering Committee**
  - Provides oversight and guidance
- **State Leaders**
  - (B.Auerbach, T.Gay, P.Griswold, P.Noga)
  - Monthly calls with IHI
- **Improvement Advisors**
  - (V.Brower, T.Cole-Poklewski, H.Maglioizzi, C.Pacella)
  - Monthly calls with state leaders
- **Mentor hospitals and cross continuum teams**

# What Happens After the Learning Session?

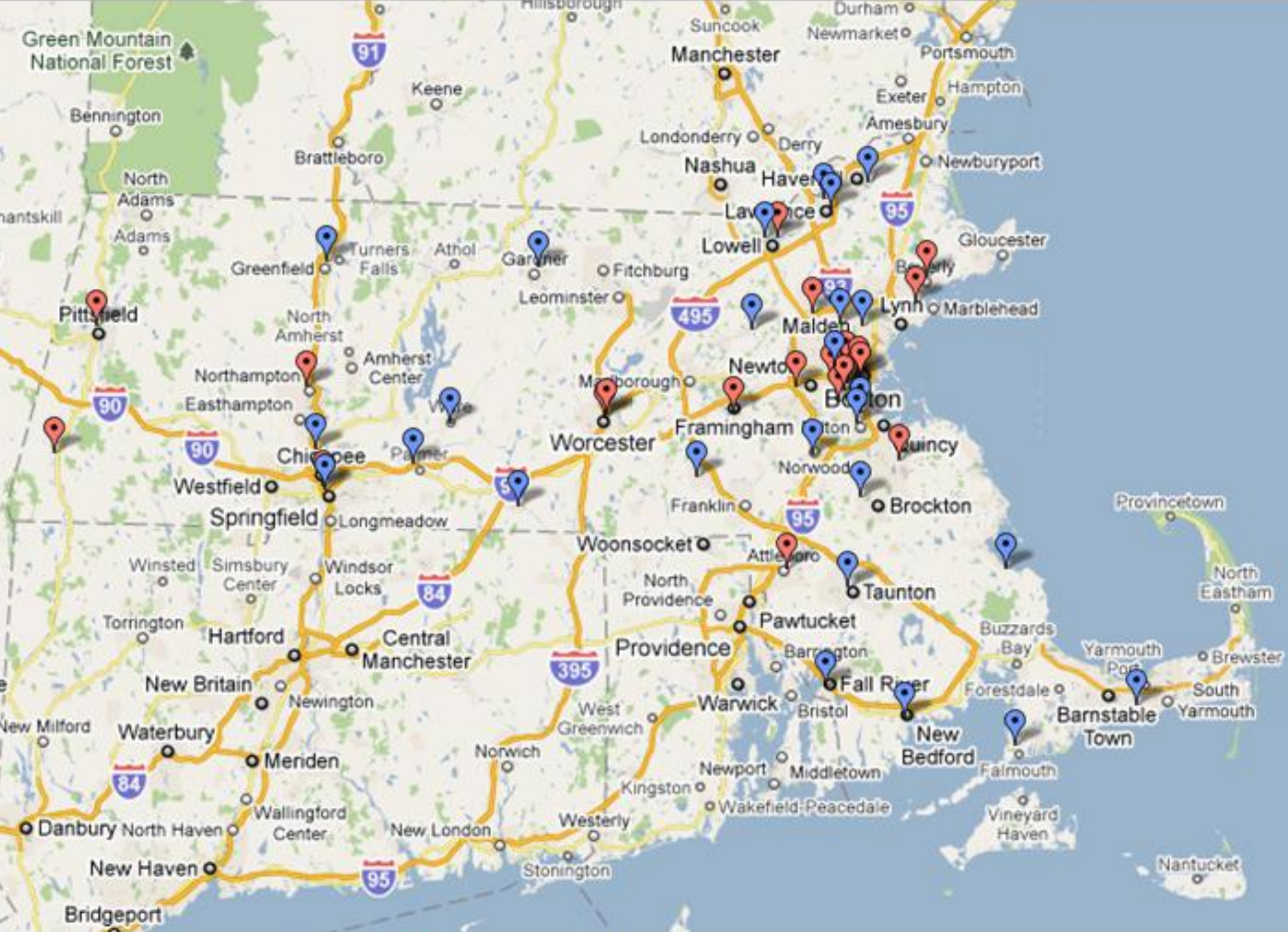
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- Monthly Calls with IHI Faculty and MA teams
- State-based activities and meetings
- Reporting:
  - Monthly data on outcomes measures
  - Periodic reporting on process measures



📍 STAAR Cohort 1

📍 STAAR Cohort 2



📍 STAAR Cohort 1

📍 STAAR Cohort 2

# Calls and Virtual Learning

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- **Monthly: Content call for teams with IHI Faculty**
- **Quarterly (in lieu of content call): Extended virtual learning session** where teams share their approaches and receive feedback from Faculty (aka Ring of Knowledge)
  - First Tuesday of each month
  - April 5, 1:00-2:00 pm: Teaching and Learning
  - May 3, 1:00-3:00 pm: Extended Ring of Knowledge Session

# State-Based Activities

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- **Additional monthly coaching calls with MA teams**
  - Schedule TBD, led by MA State Leaders and IAs
  - Focus on issues important to teams and use collective wisdom of teams participating to provide suggestions
  - Utilize cross continuum team suggestions and IA advisement for topics
- **Regional meetings**
  - First in a series during month of July
  - Possibly 5 meetings in different areas of state
- **MA STAAR Listserv**
  - Continue to encourage and grow use of tool to ask questions, share information among teams

# Reporting: Outcomes Measures

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- **Monthly submission of data on MA STAAR Extranet**
  - 30-day all-cause readmissions rates and counts
    - Hospital level for all participants
    - Pilot units and/or clinical conditions as desired
  - Measures of patient experience
    - HCAHPS communications and discharge questions (3, 7, 19, and 20)
    - Care Transitions Measure (CTM-3)

# Reporting: Process Measures

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- **Periodic narrative reports on process measures via surveys**
  - Enhanced Admission Assessment for Post-Hospital Needs
  - Effective Teaching and Enhanced Learning
  - Real-time Patient- and Family- Centered Handoff Communication
  - Post-Hospital Care Follow Up
- **Storyboard presentations in conjunction with in-state meetings**