



# MI STA\*AR

## State Action on Avoidable Rehospitalizations

### Frequently Asked Questions

#### Background

On May 1, 2009, the Institute for Healthcare Improvement (IHI) launched the **ST**ate Action on Avoidable **Re**hospitalizations (STA\*AR) initiative. This grant-funded initiative is supported by The Commonwealth Fund and provides technical assistance to state-level coalitions committed to reducing *avoidable* rehospitalizations. MI STA\*AR aims to reduce statewide 30-day rehospitalization rates by 30 percent and to increase patient and family satisfaction with transitions and coordination of care. No grant funding is being provided to the MI STA\*AR initiative to offset costs that may be incurred by the lead organizations, participating Michigan hospitals or providers across the health care continuum.

The Michigan Health & Hospital Association (MHA) Keystone Center for Patient Safety & Quality joined MPRO, Michigan's Quality Improvement Organization, and convened a steering committee of health care providers across the state to coordinate activities. Specifically, this multistakeholder coalition is responsible for developing and shepherding state-specific strategies for reducing avoidable rehospitalizations.

#### Frequently Asked Questions

**Q: What are rehospitalizations, and why are they important to avoid?**

**A:** Rehospitalizations are instances in which an individual who has been a hospital inpatient is released and readmitted within 30 days of their initial release. Rehospitalizations are costly events to both the patient and health care providers, both financially and in resources and time. It is essential that patients being discharged from hospitals receive proper instruction and transitional care plans to avoid rehospitalization and the unnecessary and costly recurrence of illnesses.

**Q: Are all rehospitalizations avoidable?**

**A: No, they are not.** Before pursuing solutions, it is essential to discern *avoidable* rehospitalizations from *unavoidable* rehospitalizations.

The focus of the effort will be to address **unplanned, related rehospitalizations** – as opposed to “planned, related” or “planned, unrelated” or “unplanned, unrelated” rehospitalizations. This classification system is outlined below, and examples of each type of rehospitalization are provided.

An example of a **planned, related** rehospitalization is when a woman is admitted to a hospital with pre-term labor. The hospital prevents the labor and discharges the woman, who is then readmitted the following week to deliver her baby. The rehospitalization was expected/scheduled and clinically related to her initial admission. Other examples include a series of chemotherapy treatments, reconstructive surgery following trauma or removal of a body part, and rehabilitation following orthopedic surgery or stroke, as well as other rehospitalizations that are part of the natural disease/treatment progression.

An example of a *planned, unrelated* rehospitalization is when a man is admitted for treatment of a heart attack, and during his admission, is discovered to have a tumor in his lung. When his heart function is stabilized, he is discharged and then later readmitted when he is strong enough to withstand the surgical procedure to remove the tumor. The rehospitalization was expected/scheduled, but not clinically related to the reason for the initial admission. Other examples include certain palliative care and substance abuse rehospitalizations.

An example of an *unplanned, unrelated* rehospitalization is when a man is admitted for an appendectomy. The hospital performs the procedure and the man is discharged, but then is readmitted the following week with a compound fracture from a car accident. The rehospitalization was not expected/scheduled, and the fracture is not clinically related to the appendectomy the man had during his initial admission.

An example of an *unplanned, related* rehospitalization is when a woman is admitted for an emergency appendectomy, discharged, and then readmitted the following week for a surgical site infection. Another example is when a woman is admitted for treatment of a bleeding ulcer, and it is discovered that the ulcer is related to an eating disorder for which further treatment is recommended. In denial, the woman leaves the hospital against medical advice and is readmitted a week later with further exacerbations of the eating disorder. Another example is an unknown or unanticipated adverse reaction to a medication. **These rehospitalizations were not expected/scheduled, but their reason was clinically related to the initial admission.**

For the majority of planned rehospitalizations, there are no actions hospitals can, or should, take to reduce their occurrence. These rehospitalizations are beneficial for the patient and may be beneficial for the health care system as a whole, as in the example where a premature birth was prevented. Likewise, there are no actions hospitals can take to reduce unplanned, unrelated rehospitalizations because they are not predictable or preventable.

However, in the case of some types of unplanned, related rehospitalizations, there may be actions that hospitals can take to reduce the occurrence of rehospitalizations. Even within the category of unplanned, related rehospitalizations, there are many factors that make it inappropriate to hold hospitals accountable for all rehospitalizations, including health care delivery system flaws that are well beyond the control of the hospital, yet lead to hospital rehospitalizations. Thus, policies to reduce rehospitalizations must take into account the reasons particular patients are returning to the hospital. **Therefore, efforts to reduce rehospitalizations should focus exclusively on certain types of unplanned, related rehospitalizations that are avoidable rehospitalizations.**

**Q: What does STA\*AR do to prevent avoidable rehospitalizations?**

A: STA\*AR will provides hospitals with technical and quality guidance from IHI leaders and expert faculty, which includes coaching to enhance improvement capacity of project leaders at the state level; facilitation of a quality improvement initiative to improve transitions of care after patients leave the hospital; and facilitation of work groups to develop strategies to address systemic barriers to reducing avoidable rehospitalizations.

In addition, the roles and expectations for participating states include convening a multistakeholder coalition to develop a written, state-specific, strategic plan for reducing avoidable rehospitalizations and to drive results in the project; and designation of staff resources to lead the project (includes participation in expert training in quality

improvement methods and provision of coaching and evaluating the progress of improvement teams).

**Q: What does “transitional care” mean?**

A: Transitional care refers to the movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness.

**Q: What does “coordination of care” mean?**

A: Coordination of care refers to time spent by a health care provider arranging for follow-up treatment, care, consultations and other services not typically arranged by the provider making these preparations.

**Q: The Centers for Medicare & Medicaid Services (CMS) is involved in a rehospitalization prevention effort called Care Transitions in the Greater Lansing area. Are STA\*AR and Care Transitions the same effort?**

A: No. Though they both focus on reducing preventable rehospitalizations, the STA\*AR and Care Transitions initiatives are separate and unrelated.

**Q: How are STA\*AR and Care Transitions similar, and how are they different?**

A: Both the IHI and the CMS have launched efforts to improve the process of patient care transition and ultimately reduce preventable and costly rehospitalizations.

**STA\*AR** initially launched in the states of Michigan, Massachusetts and Washington state and is currently expanding statewide. Michigan hospitals have been sought to participate in these initiatives as a result of the experience and large-scale success of the MHA *Keystone: ICU* project and the other initiatives conducted by the MHA Keystone Center for Patient Safety & Quality. These efforts will help Michigan hospitals maintain a leadership role in providing high-quality, safe patient care. The STA\*AR effort aims to:

- Reduce statewide 30-day rehospitalization rates by 30 percent and increase patient and family satisfaction with transitions and coordination of care.
- Coordinate and leverage existing state and national activities to reduce avoidable rehospitalizations.
- Provide examples for the nation where providers in settings across the continuum of care have dramatically improved transitions and reduced rehospitalizations.
- Identify and develop approaches to remove systemic barriers to reducing avoidable rehospitalizations.

Under **Care Transitions**, MPRO and other state quality improvement organizations (QIOs) are working with health care providers and other organizations to implement communitywide interventions, including those that target specific diseases or conditions and reasons for admission. Each of the 14 Care Transitions communities (including Lansing) is led by a state QIO. Each QIO in the project is required to work with partners to implement the following:

- Hospital and community system-wide interventions.
- Interventions that target specific diseases or conditions.
- Interventions that target specific reasons for admission.

The CMS will monitor the success of this project by watching the rates at which patients in these communities return to the hospital. The Care Transitions project will continue in all 14 communities through summer 2011.

**Q: Will STA\*AR and Care Transitions interact?**

A: Yes. There will be some exchange of information as it pertains to best practices to foster peer-to-peer learning. The Care Transitions project has been in existence longer than the STA\*AR initiative and Care Transitions will be best able to share lessons learned.

**Q: What Michigan hospitals are eligible for involvement in the STA\*AR initiative?**

A: The MI STA\*AR initiative is open to all Michigan hospitals that complete the commitment form and agree to the participation requirements.

**Q: Are Michigan, Massachusetts and Washington operating identical programs?**

A: Yes, all three states will be operating programs based on STA\*AR's broad plan for success.

**Q: When will the Michigan hospitals be announced?**

A: Recruitment of Michigan hospitals participating in the MI STA\*AR initiative began in September 2010. A public announcement will be made in November 2010, after the hospitals have been confirmed as participants.

**Q: What resources (people, time, and money) must participating hospitals commit?**

A: While hospitals should not need to hire additional staff for the participation in MI STA\*AR, depending upon the size of the participating hospital, the IHI estimates roughly 1.5 to 2.0 full-time equivalents (FTEs) (portions of FTEs from participating leaders and front-line staff) will be required to support the improvement work. Additionally, a small amount of financial support will be needed for staff to attend the two-day training seminar on Feb. 28 and March 1, 2011, although there is no registration fee associated with the seminar.

Although the process improvement work is anchored by a clinical hospital-based team, participating hospitals will develop a cross continuum transitions team by recruiting post-acute care providers (to which they transition patients) for participation in this initiative. This includes physicians, long-term care providers, home health and hospice providers, patients/caregivers and other relevant individuals.

**Q: Are there any other financial considerations of which participating hospitals should be aware?**

A: Under current reimbursement models, hospitals are generally rewarded for increased volume; as a result, the short-term impact of reducing hospital readmissions may actually be a reduction in revenue. However, emerging models — including the “bundled payment” concept — will increasingly incentivize the effective management of preventable readmissions by hospitals. Through participation in this initiative, Michigan hospitals have an opportunity to be ahead of the curve and better prepared to deal with these new reimbursement models.

**Q: What is the overall timeline for this initiative?**

A: The STA\*AR initiative is slated to run through 2013. During this time, the initiative will focus on a state-specific strategy for reducing avoidable rehospitalizations through a multistakeholder coalition, as well as improve transitions of patient care.

In late 2010, the steering committees evaluated the achievements of the initial hospital participants and will be expanding the initiative statewide.

**Q: How will the progress of the initiative be evaluated?**

A: The steering committee will continually assess the progress of the participating hospitals.

**Q: Who is on the STA\*AR steering committee?**

A: The steering committee includes health care providers from across Michigan who lend significant knowledge and experience to this initiative. Represented on this steering committee are:

- MHA Keystone Center for Patient Safety & Quality (**project lead**)
- MPRO, Michigan's Quality Improvement Organization (**project lead**)
- Aging Services of Michigan
- American College of Cardiology, Michigan Chapter
- Area Agency on Aging 1-B
- Blue Cross Blue Shield of Michigan
- Citizens for Better Care
- Health Care Association of Michigan
- Institute for Healthcare Improvement
- Medicaid Program Operations and Quality Assurance
- Michigan Association of Health Plans
- Michigan Critical Access Hospital Quality Network
- Michigan Department of Community Health
- MDCH Office of Services for the Aging
- Michigan Home Health Association
- Michigan Osteopathic Association
- Michigan Hospice and Palliative Care Organization
- Michigan State Medical Society
- The Office of Gov. Jennifer Granholm
- University of Michigan Health System

For more information regarding the statewide STA\*AR project, contact Sam R. Watson, executive director, at (517) 323-3443 or [swatson@mha.org](mailto:swatson@mha.org) at the MHA Keystone Center or Nancy Vecchioni, RN, vice president, Medicare Operations, at (248) 465-7454 or [nvecchio@mpro.org](mailto:nvecchio@mpro.org) at MPRO.

