

Making Gains...Expressing Gratitude

Three years ago, the concept of improving care transitions was very new. Nearly everyone had experienced a care transition; perhaps it was a personal event or a family member who was being discharged from a hospital. Even though most had experienced a transition of care in some fashion, few recognized that a care transition was a process that could be re-engineered in a positive way.

Things have changed in three years. As the 9th Scope of Work (9SOW) comes to a close, we are witnessing providers improving their processes to make care transitions better. Providers are implementing evidence-based interventions to improve transitional care, including the Care Transitions Intervention (CTI), Project RED and INTERACT tools. Patient safety is being addressed through improved communication methods. For example, the SBAR (Situation, Background, Assessment and Recommendation) tool sets the framework for prompt and appropriate communication; and a nurse-to-nurse call provides an opportunity for additional communication between the sender and receiver during the patient transition. In addition, Omaha providers are considering these evidence-based interventions: Project BOOST (Better Outcomes for Older Adults through Safe Transitions), the Transitional Care Model (TCM) and Transforming Care at the Bedside (TCAB).

The CareTrek™ community is making a difference. Medicare beneficiaries living in Douglas and Sarpy counties are less likely to be readmitted to the hospital in 2011 than they were in 2008.

You should congratulate yourselves for a job well done. The CareTrek team commends you for your efforts. Thank you for reading and contributing to these newsletters. Thank you for sharing your stories with us. Thank you for being leaders and for caring for Medicare beneficiaries in our state.

More importantly, we would like to thank you for your help, participation, input and insight over the past three years. You, the CareTrek community, have been dedicated to the cause of reducing readmissions and we are appreciative. Your commitment is helping us meet our vision of making healthcare in Nebraska the nation's best.



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The Trek...

The purpose of this newsletter is to keep you informed of CareTrek activity and topics relating to improving transitions of care. Visit www.cimronebraska.org/caretrek.aspx for additional information, trainings, newsletters, tools and links.

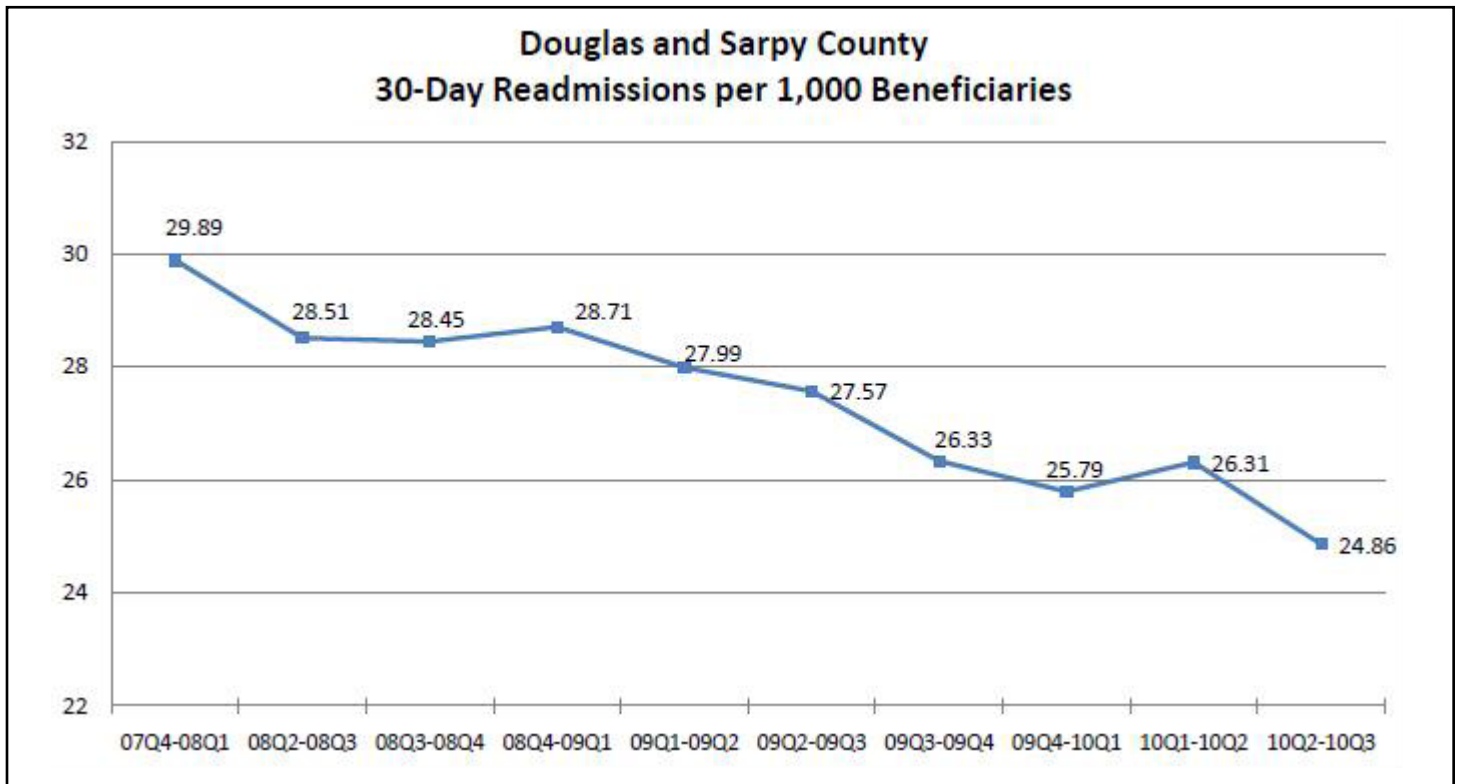
If you wish to be added to the distribution list, visit www.cimronebraska.org and click on "Join our Email List". Select "CareTrek Mailing List" on the CIMRO of Nebraska Mailing List Sign-up Form. For questions, contact Keri McDermott, CIMRO of Nebraska Communications Director, at (402) 476-1399 or via email at kmcdermott@neqio.sdps.org.



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Showing Improvement Through Data



Through CareTrek, implementation of evidence-based interventions have resulted in reducing community readmission rates for Douglas and Sarpy county Medicare beneficiaries. The 30-day readmission per 1,000 beneficiaries has been reduced from 29.89 to 24.86 percent.

- Hospitals in Douglas and Sarpy counties were successful in reducing the 30-day readmission rate for heart attack, heart failure and pneumonia patients
- 30-day readmission rates for beneficiaries with these diagnoses decreased by 30 percent in 2009
- All seven participating hospitals have reduced pneumonia readmissions significantly
- One hospital successfully reduced heart failure readmissions by 50 percent
- All Douglas and Sarpy county hospitals have been consistent in maintaining the acute myocardial infarction readmissions at relatively low numbers

A Special Thanks...

CIMRO of Nebraska would like to thank several CareTrek partners for spreading quality improvement knowledge in the area of care transitions at the 2011 Nebraska Healthcare Quality Forum. The following individuals shared their experiences and lessons learned with conference participants:

- Mary Hamilton, RN, BSN, MS - Nebraska Methodist Hospital
Collaboration: An Essential Component in Decreasing Hospital Readmissions
- Vickie Worden, RN - Hillcrest Health & Rehab
Implementation of INTERACT Tools to Prevent Rehospitalizations from Nursing Facilities
- Nicole Wellensiek, MSW - Immanuel Communities, Trinity Courtyard
Successful Transitioning: Healthcare to Home
- Dianne Hayko, RN, MS & Cathy Jesus, MSW CSW - Creighton University Medical Center
Reducing HF Readmissions: Strategies from Pre-Admission to Post Hospital Follow-up

To access all Quality Forum presentations, visit www.cimronebraska.org/qualityforum.aspx

The Butterfly Effect



According to Wikipedia, "In chaos theory, the **butterfly effect** is the *sensitive dependence on initial conditions*; where a small change at one place in a nonlinear system can result in large differences to a later state. For example, the presence or absence of a butterfly flapping its wings could lead to creation or absence of a hurricane.

Although the butterfly effect may appear to be an esoteric and unusual behavior, it is exhibited by very simple systems. For example, a ball placed at the crest of a hill might roll into any of several valleys depending on slight differences in initial position."

Why is this interesting and how might it apply to care transitions?

A patient, at the hospital, may transition into several places depending on slight differences in the initial process:

- A correct medication list, including allergies and a concise list of diagnoses can be the butterfly effect that makes the transition safer
- A referral to the appropriate level of care can make the transition safer
- Good discharge instructions affect not only the patient, but the family and professional caregivers

Each of these tasks is not large. Each is just like a butterfly.

But for the butterfly effect to be significant, we must all participate. No one of us has the wingspan to go across the entire state and care for all of Nebraska. We must all work together, in our own way, to make a difference in making care transitions safer.

We are asking you to help. Together, if we work in coalitions, each of us can participate and make a difference. It is not the individual effort, but the efforts of each individual in the community, working together, that will make care transitions safer for all Nebraskans.

Thank you for your efforts to improve care coordination; we look forward to continuing this work on a broader scale in the coming months.

Care Transitions Toolkit Available



The Colorado Foundation for Medical Care serves as the Quality Improvement Organization Service Center (QIOSC) for the care transitions work in the 9SOW. The QIOSC developed a toolkit to assist with care transition coordination and implementation. The toolkit is available to download at: www.cfmco.org/caretransitions/toolkit.htm. The toolkit contains the following sections:

1. Getting Started: Steps to begin the process
2. Participants: Involving traditional and non-traditional partners
3. Interventions: Evidence-based intervention models
4. Measure: Ways to measure the effect(s) of a care transition
5. Root Cause Analysis: Identify basic factors for variations in outcomes
6. Engagement: Recruitment and tactics for sustainability

Your Rights During Transitions of Care: A Guide for Consumers and Family Care Givers

Patient and family caregivers are often unsure how to communicate with providers or what to expect.

The National Transitions of Care Coalition (NTOCC) just released **Your Rights During Transitions of Care: A Guide for Health Care Consumers and Family Care Givers**.

This guide will assist patients and family care givers in getting the information and services they need. Included are topics such as, "You have the right to be treated fairly and with respect during care transitions."

Providers can print the guide directly from the NTOCC website for patients and their family caregivers. Consumers may also access the guide and download the information.

The Guide is provided in two forms: A short summary format and a longer version providing expanded explanation of each statement.

Download the NTOCC Guide at:

www.ntocc.org/Home/HealthCareProfessionals/WWS_HCP_Tools.aspx

Looking Ahead...

Effective interventions to reduce hospital readmissions depend on changes in the processes of care at the community level. Hospitals, home health agencies, dialysis facilities, nursing homes and physician offices must be active participants. Patients, families and community organizations and stakeholder groups have a vital role as well.

As CIMRO of Nebraska begins the 10SOW on August 1, 2011, efforts to improve care transitions for Nebraska Medicare beneficiaries will continue. The work of the 14 care transition pilot projects is being expanded to communities within each state. The goal nationally is to reduce readmissions following hospitalization by 20 percent over the next three years. Through the process, CMS also hopes to identify and implement sustainable and replicable strategies to achieve high-value healthcare.

CIMRO of Nebraska will work with communities selected for participation in this 10SOW care transitions project to identify and implement interventions best suited for their individual community. Technical assistance and resources will be offered through a Learning and Action Network. The goal will be a reduction in hospital readmissions through community-wide understanding, buy-in and adoption of improved practices.

We will share details as they become available. We look forward to expanding the knowledge and successes experienced in the Omaha area, through CareTrek, with other communities in Nebraska.



Resources for better healthcare

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