



MI STAAR

State Action on Avoidable Rehospitalizations

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Michigan Hospitals Chosen for National Pilot Project to Reduce Rehospitalizations, Improve Transitions of Care

LANSING and FARMINGTON HILLS, Mich. — Fifteen Michigan hospitals will participate in a three-state initiative aimed at reducing avoidable rehospitalizations by improving patient care transitions through interventions including enhanced patient communication and timely follow-up after hospital discharge. This effort will target **unplanned, related rehospitalizations** — which are rehospitalizations that are not expected/scheduled, but whose reason is clinically related to the initial admission. The project seeks to reduce 30-day rehospitalization rates (patients being hospitalized again within 30 days of discharge) by 30 percent and increase patient and family satisfaction with transitions and coordination of care. Massachusetts and Washington join Michigan as the states selected for the pilot program. Ultimately, the goal is to apply what is learned from the pilot program to statewide and regional efforts.

The initiative, known as the **ST**ate Action on Avoidable **Re**hospitalizations (STAAR), is being coordinated by MPRO, Michigan's Quality Improvement Organization, and the Michigan Health & Hospital Association (MHA) Keystone Center for Patient Safety & Quality, with technical assistance from the Institute for Healthcare Improvement (IHI), whose efforts are supported by a grant from The Commonwealth Fund.

To ensure success across the health care continuum, a voluntary steering committee has been convened including the Aging Services of Michigan, Blue Cross Blue Shield of Michigan, Health Care Association of Michigan, IHI, Medicaid Program Operations and Quality Assurance, Michigan Association of Health Plans, Michigan Critical Access Hospital Quality Network, Michigan Department of Community Health, Michigan Home Health Association, Michigan Hospice and Palliative Care Organization, Michigan Osteopathic Association, the Michigan State Medical Society and the University of Michigan Health System.

“Our hospitals realize that patient care is not completed when patients leave our facilities,” said Spencer Johnson, president, MHA. “How patients transition from hospital care to their home or long-term-care facilities is key to the effectiveness of their treatment. By addressing unplanned, related rehospitalizations, Michigan hospitals will continue to be at the forefront of patient safety and quality improvement.”

“Michigan’s entire health care community is poised to begin work to develop systemwide interventions to effectuate change and improve communications among providers and patients,” said Robert Yellan, president and chief executive officer, MPRO. “The collaboration is unique in its communitywide approach to find solutions to improve patient care and safety across all health settings. Efforts will further be enhanced through innovation, sharing of best practices and supported by health information technology.”

Initially, 15 hospitals will be selected to participate in the Transitions Home Collaborative (which will aim to improve the transition out of the hospital for all patients) and additional hospitals may be added as the project advances. Although the process improvement work is anchored by a clinical hospital-based team, the IHI strongly encourages participating hospitals to reach out to representatives from skilled nursing facilities, home health agencies, and ambulatory practices, as well as patients and family caregivers, to form a cross continuum team. Medical and surgical units will focus on achieving:

- enhanced assessment of post-discharge needs
- enhanced teaching and learning for patients by the acute-care team
- enhanced communication at discharge between the hospital and the provider assuming care for the patient
- timely follow-up after hospital discharge

Initial participating hospitals in Michigan will be selected based on the following criteria:

- regional representation
- representation by rural/urban, teaching/nonteaching, critical access hospitals
- ethnic diversity in hospital service area
- representation by independent and system hospitals
- willingness to recruit post-acute care partners (long-term care, home health, etc.)
- willingness and capacity to collect data

The focus of the effort will be to address unplanned, related rehospitalizations, as opposed to the other three classifications of rehospitalizations: “planned, related,” “planned, unrelated” and “unplanned, unrelated.” Hospitals will commit to reducing avoidable rehospitalizations as a priority and pledge staff time, resources and leadership at all levels of the organization to support the improvement work. The initiative will identify a small number of individuals who will receive in-depth training through the IHI’s Improvement Advisor Professional Development Program to serve as improvement advisors to the hospitals.

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Headquartered in Lansing, Michigan, the MHA Keystone Center for Patient Safety & Quality combines state and national patient safety experts and multiple hospitals and health systems, working together in collaborative programs that identify best practices and evidence-based medicine to improve patient safety and health care quality and to reduce medical errors. For more information about the MHA Keystone Center for Patient Safety & Quality, visit www.MHAKeystoneCenter.org.

MPRO, based in Farmington Hills, Michigan, is a recognized independent leader in health care quality improvement, patient safety initiatives, clinical assessment and medical review. Since 1984, MPRO has been working with providers across all care settings and consumers regarding best practices to assess and improve the quality and safety of health care. MPRO's mission is improving quality, safety and efficiency of health care across the continuum. For more information about MPRO, visit www.mpro.org.

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