

STAAR - States Taking Action on Avoidable Rehospitalizations

Washington is one of only three states that received funding to participate in the Commonwealth-Funded STAAR (States Taking Action on Avoidable Rehospitalization) initiative, run by the Institute for Healthcare Improvement (IHI). This initiative has focused largely on helping hospitals reduce readmissions.

Now the IHI has developing materials for use by long-term care. The IHI has recruited long term care providers from Massachusetts and Michigan to field test and provide feedback on those materials over a 9-month period, and is interested in doing the same in Washington State.

This is a great opportunity for long term care facilities in Washington State to work directly with the IHI, testing the materials and giving input, while receiving personalized assistance from the IHI and the virtual networking of similar organizations. The work includes attendance at webinars and subsequent testing and evaluation of the materials in the Getting Started Guide over a 9-month period.

IHI is recruiting 10-20 motivated, early-adopter facilities (skilled nursing and assisted living) to participate in the workgroup and represent Washington on this highly visible effort. Time is of the essence as we work to identify providers who can participate in the next webinar, which occurs on December 21.

Washington providers who sign on now will receive additional instruction in order to be fully informed about the program. Please contact Susan Hausmann at susanh@qualishealth.org or 206.288.2475 for additional information about this exciting effort.

The How-to Guide: Improving Transitions from the Hospital to Long-Term Care Facilities to Reduce Avoidable Rehospitalizations outlines four recommendations

1. Ensure That Staff Are Ready and Capable to Care for the Resident
A. Develop mutually agreed-upon standardized transfer criteria. B. Receive and confirm understanding of resident's care needs from hospital staff. C. Resolve questions regarding resident's status to ensure fit between resident needs and facility resources and capabilities. D. Identify an emergency clinician contact for the resident.
2. Reconcile the Treatment Plan and Medication List
A. Re-evaluate resident's clinical status since transfer. B. Reconcile the treatment plan and medication list based on an assessment of the resident's clinical status, information from the hospital, and past knowledge of the resident.
3. Engage the Resident and Their Family or Caregiver in a Partnership to Create an Overall Plan of Care
A. Assess resident's and family members' desires and understanding of the current plan of care as well as any possible next care settings. B. Develop the care plan collaboratively with the resident and family.
4. Obtain a Timely Consultation when the Resident's Condition Changes
A. Use protocols to guide immediate interventions for conditions and complications that commonly occur.

<http://www.ihl.org/knowledge/Pages/Tools/HowtoGuideImprovingTransitionHospitalSNFstoReduceRehospitalizations.aspx>

