The Stepping Stones Project:
Final Report to the Community

2008–2011

July 2011

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The Stepping Stones project was featured in the January 23rd issue of the Journal of the American Medical Association (JAMA) as part of an article focusing on Medicare QIO-led care transitions initiatives nationwide.
Introduction

“Stepping Stones: Bridging Healthcare Gaps” (The Care Transitions Project of Whatcom County) aimed to engage the community and activate patients and healthcare providers to eliminate unnecessary readmissions to PeaceHealth St. Joseph Medical Center. Studies across the country have demonstrated that there are potential gaps in communication and coordination when patients move from one setting or aspect of care to another—resulting in patient risk and increased costs. The aim of this project was to bridge those gaps and enable safer and more effective transitions.

The Centers for Medicare & Medicaid Services (CMS) contracted with Qualis Health (Washington’s Medicare quality improvement organization) to engage community partners including healthcare providers, patients, and families, in the August 2008 through July 2011 project. The Stepping Stones project was one of only 14 such Medicare demonstration studies across the US.

Working together, Qualis Health and the Whatcom County community made substantial progress across the project’s three goals:

- Connect providers throughout the healthcare system in Whatcom County to enable safe and effective transition of patients.
- Eliminate unnecessary hospital readmissions to PeaceHealth St. Joseph Medical Center.
- Enable Whatcom County patients and their families to participate fully in their health and healthcare, particularly when leaving the hospital.

A key result was a reduction in hospital readmissions among all Medicare beneficiaries in this community over a two-year period. This reduction reflects an 8% relative improvement rate.

**Project Results in 8% Improvement in Readmissions**

*Figure 1: 30-Day Readmissions in Whatcom County*

Data Source: Medicare Fee-For-Service claims

This report tells the story of the project, its activities, and its accomplishments.
To guide the work, Qualis Health engaged with the Whatcom County community to form a steering committee comprising the target hospital, community providers, stakeholders, and patient representatives. The steering committee endorsed a framework to achieve sustainable progress across five strategic areas centered on the needs of the patient, as shown in the diagram below.

The following sections of this report address each of these areas of activity.

*Figure 2: Strategic Areas*

**Sustainable Outcomes**

Connect providers throughout the healthcare system in Whatcom County to enable safe and effective transition of patients.

Eliminate unnecessary hospital readmissions to PeaceHealth St. Joseph Medical Center.

Enable Whatcom County patients and their families to participate fully in their health and healthcare, particularly when leaving the hospital.
Strategic Area 1: Family/Patient Self-Management

Evidence suggests that patients and families who take an active role in managing their healthcare have fewer readmissions to the hospital.

The Stepping Stones project developed and implemented multiple strategies to increase family and patient activation on behalf of their own or loved one’s healthcare, and to support safe and effective care transitions.

Care Transitions Coaching
Transition coaching is based on the Care Transitions Intervention® developed by Eric Coleman, MD, an evidence-based model that is linked to reduced readmission rates. The transitions coach supports patients over a four-week period that includes a visit to the patient in the hospital or skilled nursing facility, one home visit, and three follow-up phone calls. Patients with complex care receive specific tools and—with the help of the Transitions Coach—learn self-management skills to ensure their needs are met during the transition from hospital or facility to home.

The Care Transitions Intervention focuses on four conceptual areas, referred to as pillars:

• Medication self-management
• Use of a dynamic patient-centered health record
• Follow-up care
• Red flags (signs of a worsening condition, and what to do about them)

The project sponsors turned to the community and the local university to develop a volunteer coaching program. The program would not have been possible without the significant support of the hospital, including office space and IT access for the program coordinator. Volunteer coaches were integrated into the hospital volunteer department to address patient access, privacy, and supervisory affiliation issues. A Qualis Health care transitions specialist served as coach coordinator, designing structures and processes for implementation. Since CTI® is not oriented toward volunteers, this involved a significant commitment of resources, including initial and ongoing coach recruitment, as well as careful screening and selection of volunteers. Once recruited, the volunteers received intensive training in the model and then ongoing support and mentoring as they began coaching in the community. The level of supervision decreased as the coaches’ skill and confidence increased. A coaching “community of practice” was formed to address the challenges relating to all aspects of volunteer coordination.

There was a strong relationship between the number of coaching encounters a patient had and the 30-day readmission date. The more encounters, the lower the readmission rate. Additionally, the mean days to rehospitalization increased with number of coaching encounters.

Coaching Reduces 30-Day Readmissions

Data Source: Medicare FFS claims, PeaceHealth St. Joseph Medical Center
Along with coaching, the Patient Activation Measure (PAM) was used. The PAM is a survey that assesses the knowledge, skills, and confidence integral to managing one’s own health and healthcare. This was one of the first times the PAM was used in conjunction with transitions coaching. Combining these two tools revealed significant correlation between coaching and patient activation.

From January 2009 through May 2011, over 400 people were coached (using an average of 150 volunteer hours per month). Self-management skills increased for those who were coached; there was a 4.8% readmit rate for patients who completed all five coaching encounters. This contrasts with the 10.7% readmission rate for similar discharged patients who were not coached.

Care Transitions Coaching Helped Reduce Readmissions for Dual-Eligible Patient

A Qualis Health care transitions coach worked with a dual-eligible (Medicare/Medicaid) beneficiary with multiple chronic illnesses on how to better manage her own care. For seven months, she remained in her own home and successfully managed to avoid a return trip to the hospital—quite an improvement compared to the previous 13 months, when she was hospitalized nine times. Nine typical readmissions cost approximately $86,400 based on Medicare’s estimates of $9,600 for each admission or readmission.

At the first coaching meeting, the beneficiary and her family caregiver were overwhelmed and unable to mobilize self-management skills. Over the course of a month, the coach helped the beneficiary and her caregiver on the four pillars (medication reconciliation, physician follow-up, red flags, and personal health record). The coach also referred them to existing community services, where the caregiver was able to receive further training.

Over time, the pair became much more activated in her care. The beneficiary understood that she could have a voice in her own healthcare decisions, and was empowered to make her needs known. Consequently, the coach was able to complete the intervention knowing that the Stepping Stones project had made a lasting improvement in this beneficiary’s healthcare.

Coaching not only results in avoided rehospitalizations and improved quality of life, but also represents a significant savings in Medicare and Medicaid dollars.
Community Outreach and Education

Educating people on self-management skills BEFORE they go to the hospital increases the likelihood of a smoother care transition.

The Stepping Stones project developed an approach to community education which particularly reached out to Whatcom County seniors and the people who support them.

The Northwest Regional Council (Whatcom County’s Area Agency on Aging) and Qualis Health collaborated on an educational curriculum aimed at preparing people for a successful hospitalization. NWRC’s “Hospital 101” and Qualis Health’s “Know Before You Go” presentations were conducted in senior centers and at community meetings, covering the stepping stones of effective care transitions along with other tips and resources.

Between the NWRC and Qualis Health, dozens of workshops and presentations have been given in Whatcom County—reaching more than 800 community members. The audiences for the presentations included retired professional groups, social workers, state employees, neighborhood associations, elected officials, senior centers, senior living centers, faith communities, and community groups.

Responses from participants were very positive:

“Even though it’s hard, my family needs to talk more about my goals and my advanced care orders.”

“This is a good idea to help us be smart before we get sick.”

“I gave some of the medication and medical history forms to a friend who is a home care nurse. He thought they were great and is helping his patients fill them out.”

"This is a good idea to help us be smart before we get sick.”
Strategic Area 2: Physician & Community Continuity

Communication and coordination among providers is key to ensuring patients receive consistent care in, and as they transition between, care settings.

The project steering committee chartered a “Receivers Workgroup” chaired by a local physician and comprised of downstream providers who “receive” patients post-discharge from the hospital. Members included primary care physicians, community safety net clinics, community-based pharmacies, skilled nursing facilities, home health agencies, hospice and palliative care teams, and assisted living facilities. Their aim was to increase communication and improve coordination among providers to facilitate safer and more effective care transitions. At the end of the project period, participants determined that the workgroup provided great value, committed to continuing the dialogue, and individuals volunteered to coordinate and chair future meetings.

The workgroup collaborated on multiple strategies, including these potentially sustainable efforts.

Follow-Up Phone Call Pilot Program
One clinic tested follow-up phone calls to patients recently discharged from the hospital (inpatient stays and observation visits) who were considered high-risk for readmission. Nurse case managers from the clinic called patients and followed a conversation guide based on the stepping stones of a safe care transition (i.e., medication self-management, follow-up care, and red flags). More than 67% of the post-hospital patients called had some adverse finding such as a medication discrepancy or a missed follow-up appointment. The nurse, while on the phone, was able to address the issues, answer questions, and direct the patient to resources for additional help.

Standardizing Information Transfer between Skilled Nursing Facilities and the Hospital Emergency Department
Beginning in 2010, members of the Receivers Workgroup and staff from the hospital emergency department agreed to pilot test a universal transfer form and simplified medication list to standardize a reliable, efficient, and effective exchange of information.

Prior to this, patients from extended care facilities or skilled nursing facilities would often arrive in the ED with paperwork that did not meet the needs of the receiving provider; also, patients often returned to nursing homes from the ED with insufficient information to allow for effective follow-up care.

The group committed to pilot testing a one-page, simple form to include critical information (such as the patient’s baseline health status and current medications) when the patient is sent to the ED, and conversely, a standard process for the ED to provide critical information (including medication changes) when the patient returns. The group considered the pilot highly successful, continued to use it beyond the pilot period, and agreed to make future refinements if needed.
Home Health Utilization

One of the most significant findings that emerged from various data sources was Whatcom County’s relatively low utilization of home health and hospice. The steering committee review of local home health utilization compared to the Washington state average triggered discussion of hospital-based activities to increase appropriate utilization.

This work was carried forward with in-depth discussions at the Receivers Workgroup, which included representatives from Whatcom’s two home health agencies. A process-mapping session quickly demonstrated the lack of a standardized process. Educational sessions trained nurses on multiple hospital units regarding the criteria, value, and need for home health after discharge.

Also, the Qualis Health team developed a poster with input from both hospital and outpatient settings of care to provide a simple, clear description of home health and other services options with eligibility criteria for care after hospital discharge.

Finally, the team worked to create a hospital documentation form to address the new face-to-face regulation for ordering home health services, thus reducing another potential barrier to providing service to eligible patients.

The larger of the two home health agencies in the community indicated that following these efforts, they are experiencing improved communication and coordination with the hospital regarding discharge information and timing of initial contact.

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**Figure 4: Discharge Risk Assessment Form**
Strategic Area 3: Hospital Discharge Process

A newly discharged patient from the hospital faces many issues—possibly new medications or a change in medications, new red flags to watch out for, and new safety challenges at home. Therefore it is important for the hospital to have a standardized discharge process in place that meets the needs of the patient.

Project RED (Re-Engineered Discharge) is an intervention to improve the hospital discharge process, promote patient safety, and reduce rehospitalization rates. It has been proven to reduce rehospitalizations and yields high rates of patient satisfaction. The Stepping Stones team focused on standardizing the discharge process to ensure each patient received the best information to allow them a successful transition.

Standardizing the Hospital Discharge Process

The cardiovascular unit of PeaceHealth St. Joseph Medical Center implemented a “bundle” of Stepping Stones’ tactics focusing on the unit’s discharge process:

- Using new standardized discharge orders and patient instructions based in part on Project RED’s 11-component checklist
- Making appointments for follow-up visits to the outpatient physician provider prior to leaving the hospital
- Making follow-up phone calls to discharged patients
- Using “teach back” techniques for interactions with patients
- Providing structured information about the patient’s/family’s care transition responsibilities

As a result, the readmission rate for patients receiving the discharge bundle was 6.8% compared to 15.2% for those patients not receiving the bundle, a reduction of more than 50%.

This remarkable achievement now serves as a springboard for implementing similar changes to the discharge process across the hospital.

Hospital Pilot Reduces 30-Day Readmissions by Over 50%

Figure 5: CVU Pilot

Data Source: Medicare FFS claims, PeaceHealth St. Joseph Medical Center
Discharge Education Video

Education at discharge is key to a safe and effective care transition. Initially, cardiovascular unit patients and family caregivers were offered a 30-minute class that outlined their basic responsibilities revolving around the stepping stones for a safe care transition. However, the pilot effort revealed some weaknesses in getting people to attend, and assuring reliability in how the education was provided. To ensure consistency of the message and presentation, the workgroup developed a discharge education video that could be shown at the bedside, along with a companion brochure. After the patient viewed the video, the nurse gave them a patient brochure and prompted activating conversations about medications, red flags, follow-up appointments, and more.

The video was pilot tested at the PeaceHealth Joint Replacement Center in early 2011. Based on follow-up calls to patients, the video successfully reinforced the topics of medications and red flags—which are critical to effective care transitions. It is available for use in the community.

“Teach Back” Communication Technique is Quickly Embraced by Providers and Patients

As part of the Stepping Stones project, Qualis Health taught the Teach Back communications technique to PeaceHealth St. Joseph Medical Center staff members. Teach Back is a simple protocol that allows healthcare providers to assess and correct patient’s understanding of important instructions, such as those provided during a hospital discharge.

Over the course of three months, more than 70 staff members were trained, including a nurse educator who has since started providing the training herself. This success was evident in their annual skills competency fair.

The following e-mail excerpt, from a staff nurse to her manager, illustrates the positive impact made by the use of the Teach Back method:

“I have to begin by saying that I was not really seeing the value of the Teach Back program. I have changed my mind completely and I want to share the reason why with you.

Last week I was doing patient discharge teaching with an 85 year-old woman and her daughter. Part of her discharge teaching was reviewing the MI packet. We went over all the materials and the patient was restating important points back to me.

As I had just been to the Teach Back part of our competency fair the day before, it was fresh in my memory to ask the patient to “share her understanding” of the exercise portion of the packet. She stated “Well my life is going to change drastically and I won’t be able to do much of anything anymore or go places I liked to go to before.” The patient’s understanding was nothing like the painstaking teaching we had just reviewed.

I was later in tears thinking about how this dear little lady could have gone home and given up on living her life as fully as possible. Had I not asked the question I would have thought she was ready for home. The questions are life-changing.”
Strategic Area 4: IT Development

Whatcom County has been ahead of the curve when it comes to effectively using health information technology (HIT) to support people’s health and healthcare—well before the implementation of the Stepping Stones project. The HIT infrastructure available in the community has been a critical foundation, upholding the project’s interventions and the steady flow of information across care transitions. The Whatcom Health Information Exchange Network (HInet) is a secure, electronic communication channel in Whatcom County connecting the hospital, payers, physician offices, ancillary providers, skilled nursing facilities, and community health services. Since its inception, HInet’s network functionality has steadily grown into a de facto health information exchange.

HInet also supports the Shared Care Plan, a free online personal health record for patients. A personal health record is a powerful tool that allows patients to organize, store, and keep track of health information. Sharing this information with providers is especially helpful during care transitions (for instance, when being discharged from a hospital and transferred to a nursing home or back to your own home). Shared Care Plan’s connection to HealthVault facilitates receipt of data from other clinical tools and systems, as well as from home monitoring devices (like glucometers and scales), making critical information available at the point of care. A personal health record is a key component of the Care Transitions Intervention.

The Stepping Stones project supported enhancements to the Shared Care Plan that allow patients greater self-management of their medications, follow-up care, and red flags.

The Shared Care Plan enrollment has nearly doubled from 1,300 to 2,500 users since the start of the Health Record Bank pilot in 2009. More than 6,000 healthcare professionals in Whatcom County are registered users.

Strategic Area 5: Analytics and Communications

Analytics

The project partners monitored progress using ongoing measurement of key indicators and evaluation of interventions such as those mentioned in this report. Root cause analyses were instrumental in redirecting or developing new interventions. Additionally, Qualis Health developed standardized reports for different settings of providers.

Also of particular importance to the project was a social network analysis. The social network analysis presented a picture of connections within the community—where providers “sent” and “received” patients during care transitions. Understanding how these transitions occurred not only helped with implementing the work of the project but also suggested tactics for how the community might work together in the future.

Figure 7: Example of a Care Transitions Social Network Diagram
Communications
The Stepping Stones Framework

Early in the project the steering committee endorsed the CTI® “four pillars” messaging. As the project evolved, the steering committee endorsed additional messages associated with assuring safe and effective care transitions. These messages fell into three sub-areas: messages critical to acute episodes; messages needed before, during, or after acute episodes; and messages that could be appropriate at any time. Together, these seven “stepping stones” serve as a common platform to standardizing information shared among patients, caregivers, and providers in all settings.

Figure 8: Seven Stepping Stones of an Effective Care Transition

- Acute episode
  - Medication self-management
  - Red flags
  - Physician follow-up

- Before/during/after acute episode
  - Use of a patient-centered record
  - Home safety and support

- Any time
  - Rights and resources
  - Advanced illness planning
Other communications support for the project included:

**Website**

A Stepping Stones project website supported and brought visibility to the project. The website launched in March of 2009. The intended audience was all community members including healthcare providers, patients, family, caregivers, and stakeholders. The website included tools, and resources for all entities to help ensure effective care transitions.

Monthly visits to the website increased consistently throughout the three-year project. There was an eight-fold increase in web visitors. Most significantly, spikes in visitors correlate to specific postings on the website such as the Stepping Stones educational videos, the Stepping Stones newsletter and coverage in other publications.

**Figure 9: Website Metrics**

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</tr>
<tr>
<td>March 2011</td>
<td>900</td>
</tr>
</tbody>
</table>

**Media and Visibility**

The project generated national interest and received visibility over multiple platforms. During the past three years, the Stepping Stones team members have:

- Presented at the National Medicare Readmissions Summit; National Society for Social Work Leadership in Healthcare; QualityNet Annual Conference, Washington State Hospital Association “Safe Table” Conference; Northwest AIRS conference; Washington State AAA Advisory Group; National Quality Improvement Leaders within Quality Improvement Organizations; and the bi-annual Elder Service Providers Conference

- Been featured in publications including *The Hospitalist*, *QIO News*, Commonwealth Foundation’s “WhyNotTheBest.org” and the IHI STAAR initiative, HHQI Best Practice Intervention Package, and *The Remington Report*
Community collateral resources were developed throughout the three years of the project. These included a consumer brochure that focused on the four pillars of a safe transition, project fact sheets, coaching flyers and postcards, a community education PowerPoint presentation, a handout to accompany the discharge video, and more. To view the project videos, please go to www.QualisHealthMedicare.org/SteppingStones

**Figure 10: Community Collateral**

**Steps to Better Care**

1. Manage your medicines
2. Understand your warning signs
3. Make a follow-up appointment
4. Start a personal health record

www.SteppingStonesWhatcom.org

**Four Steps to a Safe Care Transition**

1. **Manage your medicines**
   - Bring a list of your discharge and prior medications
   - Recruit for two lists
   - For new medications and side effects with your doctors

2. **Monitor your condition at home and watch out for red flags**
   - Write your red flags before discharge
   - Write them down
   - Call your doctor's office with any questions or concerns

3. **Set up your follow-up**

4. **Practice home safety**

**Get Started**

**Stay Updated**

**Step Forward**

**Resources**

The success of the project is based on gathering key players in Whatcom County committed to safe and effective care transitions, particularly through multi-layered interventions that mutually support activating patients toward self-management. The steering committee was instrumental in activating community involvement in the project. Key to success of the project was gathering the right people and building the will to do new work. This process took several years, adding community members along the way. Through multiple tactics across multiple venues, the community was able to make progress on all goals. Importantly, the community developed infrastructure for sustaining outcomes and continued improvement in bridging healthcare gaps.
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Family Care Network
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Health Ministries Network/Faith Community Nursing
Highland Care Center
Hlnet (the Whatcom Health Information Network)
Interfaith Community Health Center
Hoagland Pharmacy
Lummi Tribal Health Center
Mt. Baker Care Center
Nooksack Tribal Clinic
North Cascade Cardiology
North Cascades Health and Rehabilitation Center
Northwest Regional Council
Orchard Park Assisted Living
PeaceHealth Medical Group/Whatcom Region
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PeaceHealth St. Joseph Cancer Center
The Shared Care Plan
Shuksan Healthcare Center
Signature Home Health
St. Francis of Bellingham
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