

Sustaining Provider Engagement In Care Transitions: Community Collaborative Action

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FMQAI is one of 14 Medicare Quality Improvement Organizations (QIOs) selected by the Centers for Medicare & Medicaid Services (CMS) to participate in the Care Transitions Project. The goal of the project is to reduce unnecessary hospital readmissions that may increase risk or harm to patients and costs to Medicare. The Florida project’s setting is Miami, one of the communities in Florida where the 7-day, 15-day, and 30-day rehospitalization rates are among the worst in the state.

FMQAI partners with consumers, health care providers, and community organizations to implement improvement interventions addressing issues in medication management, post-discharge follow-up, and plans of care for patients who transition across healthcare settings. While the individual quality improvement activities of the partners are invaluable, reducing avoidable readmissions requires collaborative community action. Thus, FMQAI convened the Miami Collaborative to promote improved care transitioning among healthcare providers in Miami.

The Collaborative Connection

FMQAI based the collaborative intervention on the Institute for Healthcare Improvement (IHI) Collaborative Model for Achieving Breakthrough Improvement, where IHI seeks to improve health care by supporting change through collaborative learning.¹ Provider organizations can close the gap between what they *know* and what they *do* by creating a shared environment, where “interested organizations can easily learn from each other and from recognized experts in topic areas” they desire to improve.²

For this project, a collaborative was seen as a recursive process, where two or more people or organizations work together toward an intersection of common goals by sharing knowledge, learning, and building consensus. The Miami Collaborative identified leadership, communication, and trust as key components of successful collaborative partnerships.

When forming the collaborative, FMQAI was guided by the following considerations:³

- One or more agencies must take the lead to organize the joint activities.

- Leadership clarifies expectations and authorities so the collaborative work can be completed efficiently.

- Representative staff members are designated to attend meetings and trust between competing providers will develop over time.

In addition, FMQAI incorporated one other consideration. Collaborative goals must address provider responsibilities based on the decision time points that occur during the patient’s discharge process – discharge to self-care at home or transfer to a post-acute care setting.



A Community Moved To Action

The project community is located in the southeastern portion of Miami-Dade County, in southern Florida. This heavily urbanized area, with many high-rises along the coastline, is the location of the county's central business district. In 2007, the hospitals in this area accounted for 25,456 Medicare (fee-for-service) admissions with 5,371 (21.1%) re-admissions within 30 days. The 30-day readmission rate was 3.6% higher than the state's rate of 17.5%.

The majority of the hospital discharges for this area were directed toward self-care at home (43.1%), with discharges/transfers to skilled nursing facilities (SNFs) at 15.8% and home health agencies (HHAs) at 18.2%. These healthcare providers identified discharge-related communication problems as barriers to the improvement of quality of care. A collaborative process was essential in bridging the communication gap that existed among providers to meet patients' care transition needs.

The Secret Of Getting Started

Facilitating a large, urban community collaborative was at best challenging. Sixteen hospitals, 150 home health agencies, 38 skilled nursing facilities, 3000+ physicians, and numerous other mental health, hospice, palliative care, dialysis, and rehabilitation facilities, and community organizations support the care delivery in this 40 square mile area, 31-ZIP code community.

Mark Twain once said, "The secret of getting ahead is getting started. The secret of getting started is breaking your complex, overwhelming tasks into small manageable tasks, and then starting on the first one." FMQAI incorporated Twain's concept into the project's framework, including the collaborative process.

Medicare claims were analyzed to identify providers associated with the care delivered just prior to the hospital readmission. The Miami community was then organized into several smaller

(mini) hospital-specific collaboratives with 15-25 providers in each group. Ultimately, seven hospitals committed to hosting three, rapid-cycle improvement meetings from June to December 2009 to identify contributing causes of avoidable readmissions. FMQAI invited the provider participants and facilitated the meetings.

The *Model for Improvement* developed by Associates in Process Improvement⁴ provided the foundation for accelerating the needed change. The model included two parts:

- Addressing three fundamental questions – "What are we trying to accomplish? How will we know that a change is an improvement? What changes can we make that will result in an improvement?"
- Adapting the Plan-Do-Study-Act (PDSA) cycle to test and implement changes in the community.

Setting Aims

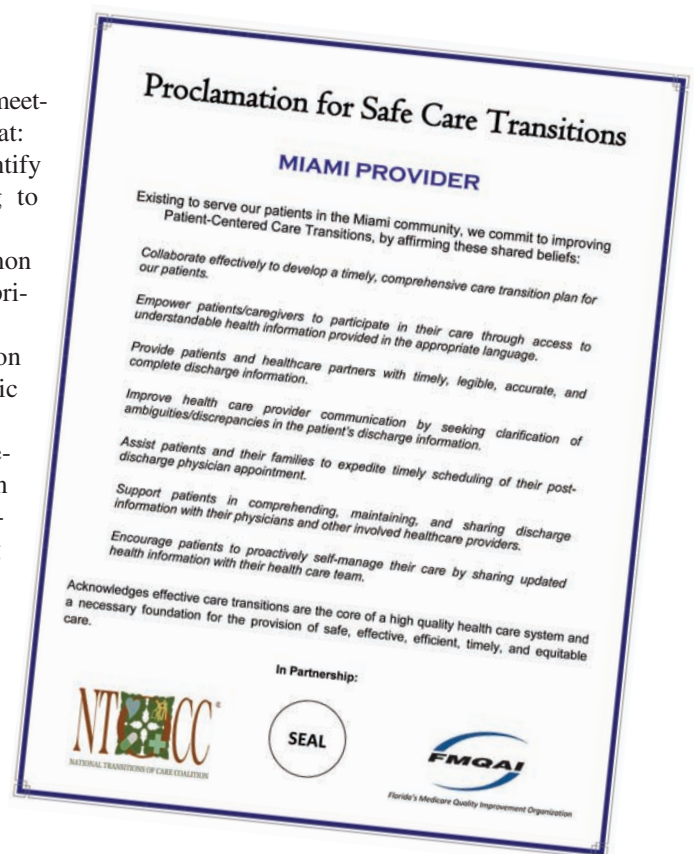
All of the mini-collaborative meetings followed a similar format:

1. Brainstorming to identify contributing factors leading to avoidable readmissions;
2. Agreeing on a common cause through consensus (prioritizing matrix); and
3. Developing an action plan for improvement specific to the group's needs.

Inconsistent, patient-specific hand-off communication among providers was unanimously seen as the leading contributing driver of unnecessary readmissions. The collective group determined that poorly coordinated care transitions also leads to greater potential for inappropriate post-acute care placement, inconsistent identification of the physician responsible for managing a patient's care after discharge, lack of standardized verbal/written discharge infor-

mation, and an increase in medication discrepancy events.

Collaborative members were eager to communicate the *shared* findings of the combined action plans to the entire community in an effort to gain support for a community-wide action plan focused on improving care transitions. In March 2010, The National Transitions of Care Coalition (NTOCC) hosted a Miami community-wide collaborative meeting. The findings identified during the mini-collaborative sessions in 2009 were summarized and presented to the community as a *Proclamation for Safe Care Transitions*. Over 75 Miami providers and community associations unanimously adopted the proclamation to show their commitment to improve care transitions:



(more on next page)

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Establishing A Measure

The general structure of a collaborative will influence its effectiveness and opportunity for measurement. Collaboratives can be portrayed as “black boxes,” where evaluating the collaborative activities is especially difficult because what is inside the *box* varies considerably.⁵ Yet, measurement is a critical element in testing and implementing change. Measures evaluate the effectiveness of the interventions and facilitate the direction for further planning.

Since the collaborative “black box” could potentially be difficult to evaluate, the collaborative wanted to establish a measure that would immediately quantify change. The collaborative developed the *Community Activation Measure* (CAM), (pages 21-22) which incorporates the Proclamation’s shared beliefs/value statements into a community assessment tool measured with a 5-point Likert scale. The tool allows any provider to assess its perceived frequency of the collaborative’s (community’s) commitment to acknowledging effective care transitions are the core of a high quality healthcare system and a necessary foundation for the provision of safe, effective, efficient, timely, and equitable care. The CAM also provides a section where the shared beliefs/value statements are further defined to include a set of action items that were identified during the collaborative meetings for implementation among the providers. The assessment tool was distributed to Miami providers during on-site, technical support visits by FMQAI staff and results were analyzed monthly.

Findings

Collaborative findings clearly identified Miami health care providers are striving to supply patients with optimal, safe care transitions. At baseline (April 2010) Mi-

ami providers scored their community at 56.5% – below the level the collaborative felt was needed to improve patient-centered care transitions. Although May 2010 (63.8%) and June 2010 (71.6%) rates showed an improvement, gaps continue between knowledge (desired or expected) and actual practice when it comes to consistently providing optimal hand-off communication. The third shared belief, “provide patients and healthcare providers with timely, legible, accurate, and complete discharge information,” continues to perform poorly when measured against the other shared beliefs.

Moving Forward

According to the IHI, “while all changes do not lead to improvement, all improvement requires change.”⁶ The Community Activation Measure has proved useful in the development of specific ideas for changes that may lead to further improvement in patient care coordination and communication. Currently, one-third of this community’s 30-day readmissions result from patients readmitted to a different hospital, with most of these readmissions occurring within seven days of the index discharge. Hospitals have already organized a sub-collaborative task force to pilot an intervention that improves communication between them in an effort to prevent a potentially avoidable readmission.

The capacity of a community’s infrastructure drives the quality of local health care delivery. Limitation to capacity can be overcome when communities join together to more effectively finance and deliver quality healthcare. Opportunities, such as the Miami Collaborative, foster greater dialogue between health care organizations and could provide the necessary momentum to drive the care transition initiatives forward and sustain im-

provement over time. Great potential exists for this community collaborative to expand work in partnership with others – seeking new approaches to test other safe and reliable care transition processes. **RR**

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COMMUNITY ACTIVATION MEASURE: PAGE 1

Provider (optional) _____

Date _____

Proclamation for Safe Care Transitions: Miami Providers acknowledged effective care transitions are the core of a high quality health care system and a necessary foundation for the provision of safe, effective, efficient, timely, and equitable care.

As an active provider member in the Miami healthcare community, **please ASSESS YOUR COMMUNITY** on meeting the following Care Transition Measures. Examples for each value statement are listed on the back on this page. Rate the following statements:

The providers in our Miami community:	Always	Usually	About Half of the Time	Seldom	Never
1. Collaborate effectively to develop a timely, comprehensive care transition plan for our patients.					
2. Empower patients/caregivers to participate in their care through access to understandable health information provided in the appropriate language.					
3. Provide patients and healthcare partners with timely, legible, accurate, and complete discharge information.					
4. Improve health care provider communication by seeking clarification of ambiguities/discrepancies in the patient's discharge information.					
5. Assist patients and their families to expedite timely scheduling of their post-discharge physician appointment.					
6. Support patients in comprehending, maintaining, and sharing discharge information with their physicians and other involved healthcare providers.					
7. Encourage patients to "proactively" self-manage their care by sharing updated health information with their health care team.					

COMMUNITY ACTIVATION MEASURE: PAGE 2

Shared Beliefs / Value Statement Examples:

- 1. Collaborate effectively to develop a timely, comprehensive care transition plan for our patients.**
 - Adequate time to prepare to meet patients care plan needs.
 - Clinician-to-clinician communication when appropriate.
 - Providers are provided with patient information at discharge (reason for hospitalization, primary diagnoses and co-morbidities, response to treatment, baseline mental and physical functioning anticipated discharge date, physician contact name and phone number).
- 2. Empower patients/caregivers to participate in their care through access to understandable health information provided in the appropriate language.**
 - Use of a *Patient Discharge Checklist* to assist patients with understanding what they need to know before discharge.
 - Patient discharge instructions are complete, legible, and written in patient's primary language. The medication list has no medical abbreviations.
 - Patients understand the need to keep track of their health information – i.e., Personal Health Record.
 - Patients understand the specifics of caring for their health and received hard copy instructions about their disease specifics and when to seek help.
- 3. Provide patients and healthcare partners with timely, legible, accurate, and complete discharge information.**
 - Patient discharge information is contained in a standardized "Envelope/ Folder" to focus on the importance of maintaining all healthcare documentation for review when discharged home, as well as to share with the next provider.
 - Provided with patient information at admission/readmission (family and caregiver contact information/notification including the reason for transfer, current medication list and allergies, DNR, recent labs, current status, consult notes, discharge summary, baseline mental and physical functioning, physician contact name and phone number).
- 4. Improve health care provider communication by seeking clarification of ambiguities/ discrepancies in the patient's discharge information.**
 - Medication Reconciliation Process.
 - Hospital Discharge Instructions.
 - Physician information (name and telephone #) for follow-up appointment.
- 5. Assist patients and their families to expedite timely scheduling of their post-discharge physician appointment.**
 - Facilitate the scheduling of a timely physician follow-up appointment.
- 6. Support patients in comprehending, maintaining, and sharing discharge information with their physicians and other involved healthcare providers.**
 - Patient/caregiver is informed and empowered through inclusion in the discharge planning process.
 - Discharge instructions are reinforced. Encouraged to take information to physician follow-up appointment.
- 7. Encourage patients to proactively self-manage their care by sharing updated health information with their health care team.**
 - Patients keep their health information current and share with all health care providers.