Connected For Health

A Community-Based Care Transitions Project

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Background

The Care Transitions project is a Quality Improvement Organization (QIO) 9th Scope of Work initiative with the primary purpose of improving care transitions for a geographically described population of fee-for-service (FFS) Medicare beneficiaries through interventions that reduce re-hospitalizations. Project success is measured by reduction in readmissions among the population. Providers are recruited into projects based on their potential to impact the readmission experience of the population. This project is funded by the Centers for Medicare & Medicaid Services (CMS) in 14 states, with each community project led by the local QIO. To optimize the learning opportunities inherent in the examination of diverse regional healthcare markets, no specific intervention strategy is mandated by CMS, though several evidence-based methods were suggested.

Colorado's QIO, the Colorado Foundation for Medical Care (CFMC), is funded to facilitate the Care Transitions efforts in Northwest Denver. Our population consists of approximately 78,000 FFS Medicare beneficiaries living in a target region of 44 contiguous ZIP Codes, spanning parts of 10 counties and 5 municipalities, and encompassing several urban, suburban and mountain locales. In this community, we are working with an engaged group of health care providers, consumers and stakeholder groups, collectively named "Connected for Health." Its target population, residing primarily in the Denver metropolitan area, is served by 3 acute care hospitals, 5 long-term care facilities, 2 rehabilitation hospitals, and 26 skilled nursing facilities.

Northwest Denver, as defined in the Care Transitions project, not its own visibly distinct community in terms of geographic or political boundaries. Thus, it was immediately clear that success would depend on developing a sustainable sense of cohesion among providers to drive the common mission of improving care transitions at the community level. Our first step was to convene providers and other local stakeholders to begin building relationships that may not have previously existed.

Convening the Community

Our efforts began by forming a steering committee composed of providers and policy leaders. They were assigned the role of providing guidance to the CFMC team and leadership for the network of participants. The two prominent area hospitals were represented by high-level leadership and front-line management. Also represented were physicians (leadership from a large physician network), employers, state policy leaders, and senior advocates. Once the steering committee membership was established and had outlined a high-level strategy, we began to map out tactics for engaging other key providers. While recruiting the network of providers and stakeholders, we felt it was essential to have an all-inclusive community meeting to raise awareness of the project, and provide opportunities for the people and organizations most impacted to take ownership of the project.

Mastermind Group & Community Action Teams

In preparation for the community Kick-Off meeting and the activities to follow, we invited several influential leaders among the provider network to participate in a one-time meeting of a "Mastermind Group." Most of the participants represented subacute care providers, such as skilled nursing facilities, home health, and other provider organizations. We found that the invitation to participate in a select group sparked enthusiasm and inspired those invited to step into a leadership role to shape the direction of the project.

The mission for the Mastermind Group was to select a strategy, among choices provided by CFMC, for the formation of community-based "Action Teams." The Action Teams would provide an infrastructure for improvement efforts and directly address the major drivers of poor care transitions, delineated in pilot work performed by CFMC:

1. low patient engagement and activation
2. inconsistent workflow processes, and
3. unreliable information transfer across health care settings.

The group ultimately decided on the following 5 teams:

Action Team 1:
Creating Standardized Processes for Notification of Patient Transfer

Action Team 2:
Greater Support for Families of Frail Elderly Patients

Action Team 3:
Patient Engagement and Self-Management

Action Team 4:
Promoting Culture Change Around End-of-Life Issues

Action Team 5:
Community Outreach/ Public Relations

Each Action Team would have both a Community Lead and a CFMC staff member Co-lead. Six of the Mastermind Group

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Table 1: Current Connected For Health Action Teams

Action Team	ACTION TEAM 1: Standard Process Team	ACTION TEAM 2: Patient Activation & Family Support Team	ACTION TEAM 3: Communications Team	ACTION TEAM 4: Culture Change around End-of-Life Issues
Problems to address:	○ Lack of Primary Care Physician knowledge of patient hospitalization ○ Delayed/inadequate information transfer ○ Disorganized/chaotic discharge ○ Unprepared patients/families	○ Low patient activation/ engagement ○ Poor self-management due to low knowledge of health condition, symptoms ○ Medication mismanagement ○ Inappropriate use of Emergency Department ○ Delayed post-discharge physician follow-up ○ Caregiver burnout	○ Lack of a sense of community ○ Organizational silos ○ Poor coordination of services and care ○ Low lay-community involvement	○ Lack of agreed-upon protocol for recognition/ identification of patients in end-of-life trajectory (end-stage chronic illnesses) ○ Under-utilization of palliative care/hospice referrals ○ Low prevalence of advance care planning
Main Objectives:	Standardize transfer/transitions processes and tools to increase appropriate use of post-acute care services, and reduce rework and frustration.	Expand the use and reach of patient- and family-centered tools and techniques that activate self-management and family/caregiver support.	Engage community support for the NW Denver Care Transitions efforts and create a foundation for sustainability.	Provide palliative care education to providers and beneficiaries in the community.
Products:	○ Post-acute care decision support tool for interactive use by both patients/families and discharge planners ○ One or two page matrix with overview of post acute care services, addressing the myths and misconceptions ○ Handover management data-set/fax form	○ Educational presentations and interaction classes for physicians and seniors for Personal Health Records (PHRs) and post-acute services ○ Overview presentations for physician offices to encourage PHR use and coaching ○ Share-the-Care pilot project	○ Standardized, branded PHR ○ Website ○ Newsletter	○ Two part educational series. 1) Palliative Care 101, 2) The Providers' Role in Palliative Care. ○ Educational curriculum and presentation for patients/families ○ Expert panel and discussion group to serve as a resource for program development and implementation ○ Position paper/talking points for legislative activity related to palliative care
Recent Achievements	○ Began creation of a post-acute care awareness and education campaign ○ Piloted Web-based decision support tool	○ Created Speakers Bureau ○ Provided educational materials and coaching assistance on using PHRs and increasing self-management	○ Developed a logo and name: Connected for Health ○ Designed a standardized PHR for community-wide use ○ Began a Connected for Health website	○ Developed curriculum for "Palliative Care 101" for Case Managers/Discharge Planners ○ Completed education sessions with case managers

participants volunteered to serve as Community Leads for the action teams, once formed. Recruitment for the teams started among those attending the community kick-off meeting.

Community Kick-off

The objectives of the Kick-off Meeting were to raise awareness, attract media attention, generate enthusiasm for the effort, and recruit additional key participants. We invited a cross-section of the community: payers, pharmacies, large employers, state and local government, patient advocacy groups, senior resource centers, community service organizations, physician networks, patients, residents, retirement communities, and all other stakeholders we could identify. The meeting was attended by nearly 200 people from over 70 organizations. Our agenda featured nationally-known care transitions experts, including keynote speakers Dr. Joanne Lynn and Dr. Eric Coleman, as well as local leadership. We provided a brief background and overview of the goals for the project and areas targeted by our improvement efforts. The meeting concluded with a call to action, featuring the primary message of the evening from the hospital Chief Medical Officers: "It's up to all of us in this community to design the system we want for our family, friends, and ourselves."

After the call to action, each Action Team Community Lead presented a brief description of their team, the reasons he/she accepted team leadership, and an invitation for others to join. Each presentation was heart-felt and passionate; each presenter held both professional and personal connections to the topic targeted by their team. By the end of the night, each Action Team had recruited between 10 and15 people, and we continue to receive emails and phone calls from interested community members.

(more on next page)

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Action Team Development

On each Action Team, the Community Lead's role is to provide vision, community awareness and cross-setting influence, while the CFMC Lead provides logistical support and facilitation.

Initially, each team selected multiple interventions, usually suggested by a passionate champion. Fluctuating membership and competing priorities pulled members away from the Action Team work, slowed progress, and began to impact the teams' momentum. CFMC's role was to facilitate the creative thinking and planning, and to enable competitors to work collaboratively with the shared philosophy that by working on community improvements together, they would also benefit individually.

Within the first three months, membership stabilized and with help from CFMC, the teams began to narrow their focus, outlining specific goals and products. Once the teams began outlining specific, tangible products, the momentum picked up considerably. Two teams, with very closely related goals, the Patient Activation Team and the Family Support Team, combined into one team. Table 1 shows the current make-up and goals of the Connected for Health Community Action Teams. The emerging value of the Action Teams is that they create an accountable neighborhood of providers and stakeholders who are discussing solutions to the drivers of poor care transitions (Table 1).

Action Team Achievements

Our goal for the formation of the community Action Teams was to create an infrastructure for improvement efforts that would directly focus on the three major drivers of poor care transitions previously listed in this article. The Action Teams also serve as instruments for sustaining and expanding those efforts. We feel that the achievements of the Action Teams have succeeded in reaching those goals.

The Standard Process Team is addressing two of the drivers, inconsistent processes and unreliable information transfer, by creating a post-acute care (PAC) decision support tool to be used by the two major hospitals in the community and initiating a regional health information exchange. The PAC tool is now generating interest from physicians, skilled nursing facilities, and home health agencies. The team's ultimate hope is for a standard tool that will be used in all settings by providers and patients.

The Patient Activation and Family Support Team concentrates on low patient activation and engagement by initiating community-wide use of personal health records (PHRs). They created presentations and educational materials for physicians, seniors, and families to increase the use and understanding of PHRs and coaching in the community. This team has also researched and been trained in evidence-based family support models, such as Share-the-Care (http://www.sharethecare.org/), and Next Step in Care (http://www.nextstepincare.org/).

The Culture Change Around End-of-Life Issues Team is addressing all three drivers through its efforts to expand and support culture change in how we prepare for and care for patients at the end of life. This team is focusing on both processes and

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patient activation with educational and awareness campaigns for providers and patients, and is participating in policy discussions to increase the timely use of palliative and hospice care.

The Communications Team focuses on low patient engagement and activation through its concentrated efforts to design a standardized PHR for community-wide use. This Team has been instrumental in fostering community cohesion and setting the stage for the continuation of the action teams.

Next Steps: Social Network Analysis

In larger or spread-out communities it is often difficult to know who your partners are or to foster collaboration among competitors, yet we have seen that this collaboration is critical for the improvement of care transitions for both patients and the health care professionals who work hard to provide the best care they can. Each organization's success depends on its upstream and downstream partners and competitors. We have begun a social networking analysis to help identify previously existing networks based on utilization patterns and to understand the impact that our effort to create a "sense of community" has had on the quality and coordination of care here in Northwest Denver.

Conclusion: The Care Transitions project goals are broad and community-based, thus requiring wide-reaching inter-community and community-QIO engagement. Many of the changes needed to improve care transitions and to meet the goals of the project require culture change, which takes time and tenacity.

The Mastermind Group concept was a significant lesson learned; it allowed us not only to successfully engage participants, but to inspire a higher level of commitment and creativity than we had envisioned. The Mastermind participants have led the Action Teams with a strong sense of shared ownership and belief in their ability to direct and carry out significant change.

With the formation of the Action Teams, we have learned that people and organizations will participate if given a structured, goal-oriented way to do so – "If you invite them, they will come." The Action Teams allowed for broader and effective community engagement, not only with providers, but with organizations we hadn't previously targeted. Also, the action teams served as a forum for providers and other organizations to showcase and test existing or developmental programs not initiated through the project. The personal connections formed within the teams have allowed us to identify organizations working on similar goals, and attract attention from those who want to learn from us.

CFMC believes the community-building efforts and work of the Action Teams have been a big factor in reaching the short-term goals and will certainly dictate the future and sustainability of the "Connected for Health" community. **RR**

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