

IMPROVING CARE TRANSITIONS:

how quality improvement organizations
and innovative communities can

work together
to reduce
hospitalizations
among at-risk populations

Proceedings of a Joint Meeting:
3rd Innovative Communities Summit
2nd National Learning & Action Event



Integrating Care for
Populations & Communities
National Coordinating
Center

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mission statement

To improve the effectiveness and efficiency of care and the quality of life of people receiving long-term services and supports (LTSS) by fostering person- and family-centered quality measurement and advancing innovative best practices.

LTQA works to promote better care and outcomes while reducing costs, advances best practices at the community level, and strives to raise the visibility of LTSS as part of the Health Care Spectrum.



Integrating Care for Populations and Communities (ICPC) is a strategic Aim where Quality Improvement Organizations (QIOs) are bringing together hospitals, nursing homes, patient advocacy organizations, and other stakeholders in community coalitions. The Centers for Medicare & Medicaid Services (CMS) looks to QIOs to implement community-based projects that effect process improvements to address issues in medication management, post-discharge follow-up, and plans of care for patients who move across health care settings.



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IMPROVING CARE TRANSITIONS: How Quality Improvement Organizations and Innovative Communities Can Work Together to Reduce Hospitalizations among At-Risk Populations

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introduction

REDUCING HOSPITAL READMISSIONS THROUGH LOCAL AND NATIONAL COLLABORATION

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Janna is a spry, 94-year-old yoga aficionado. As a grandmother and great grandmother, she has witnessed the birth of many babies over the years. She has also seen the other end of life, having bid farewell to many friends and family members who have died. Both experiences have given Janna a unique perspective on the nation's health care system.

“When I had my eldest child, I was traumatized by that hospital experience,” she confides. “But nowadays, the birth experience is so different. The environment is changed — no harsh lighting and the room isn't cold and sterile. The room looks like home. There is music. It is welcoming.”

Janna has had the same impression of hospice care. “It used to be that when a friend or relative was dying, you would go to the hospital and stand around not knowing what to do,” she recalls. “Today, it is a very different experience. When you visit someone in an inpatient hospice, the rooms are comfortable. The sheets have flowers on them. The staff lets you know that there is a pot of soup on the stove.”

Janna's conclusion: “We seem to have mastered care at the beginning and at the end of life, but we have much more work to do before we master the care in between.”

Based on a story shared by Karen Love
President, Center for Excellence in Assisted Living

The desire to master health care at what Janna calls the “in between” periods of life is what brought more than 250 professionals in the health and long-term care fields to an historic joint meeting of Innovative Communities and Quality Improvement Organizations (QIOs) on June 4-5, 2012 in Washington, DC.

We had Janna’s wise words to guide us through 2 days of collaborative exploration into how we might work together to ensure that Americans receive high-quality, person-centered care from the time they leave the hospital as an infant until the time they enter hospice care at the very end of life.

This is a challenging aspiration, particularly for those serving older people and people with disabilities who struggle to maintain health and independence in the face of frailty and chronic disease. What we heard during our 2-day meeting confirmed that the ability to move easily and safely between care settings and home often makes the difference between health and illness and between independence and dependence for the Medicare and Medicaid beneficiaries we serve.

That is why care transitions are a high priority for QIOs and Innovative Communities. That is why our important joint meeting emphasized our common goal to improve these transitions. That is why we walked away from our meeting with confidence that collaboration between Innovative Communities and QIOs will eventually lead to positive change.

Care Transitions and Health Reform

Programs and initiatives authorized by the Affordable Care Act (ACA) encourage providers of health and long-term care to pay close attention

to the supports that hospital patients receive while recovering from acute-care episodes. Unfortunately, the process of transitioning patients from the hospital to their homes or other care settings is becoming increasingly unreliable as hospital stays become shorter and the health care systems becomes more fragmented. Indeed, Medicare patients report greater dissatisfaction with the hospital discharge process than with any other aspect of care that the Centers for Medicare & Medicaid Services (CMS) measures.

Within 30 days of discharge, 17.6 percent of Medicare beneficiaries are rehospitalized. The Medicare Payment Advisory Commission estimates that up to 76 percent of these readmissions may be preventable. To find out what is behind these troubling statistics, it is necessary to look at one more number: 64 percent of Medicare beneficiaries who are readmitted to the hospital within 30 days of discharge have received no post-acute care between their discharge and their readmission.

Nursing home transitions are particularly worrisome. Approximately one quarter of long-stay nursing home residents is hospitalized each year and that proportion is increasing. At CMS, we believe that between 25 and 42 percent of these admissions is avoidable.

The estimated cost and the frequency of these unsuccessful transitions are staggering and under-reported. First, avoidable readmissions place a physical and emotional burden on patients and their families. For example, nursing home patients who are transferred repeatedly are more likely to become immobilized and physically restricted. With each hospital admission, their ability to return home or to other settings in the community decreases.

Unnecessary rehospitalizations also cost Medicare an estimated \$12 billion annually. And, as of Oct. 1, 2012, these rehospitalizations are creating financial issues for hospitals that accept Medicare reimbursement. The ACA stipulates that these hospitals will incur financial penalties for every preventable rehospitalization that occurs within 30 days of discharge.

Bringing Together QIOs and Innovative Communities

The challenges associated with care transitions and avoidable rehospitalizations are too complex to be left to one organization or agency. It takes many stakeholders – working closely together at the local level – to ensure that a hospitalized consumer receives the services and supports he or she needs to recover fully from an acute episode.

This need for collaboration is very clear to the two individuals who worked so hard to bring QIOs and Innovative Communities together at this meeting. Jane Brock, MD is chief medical director of the Colorado Foundation for Medical Care (CFMC), which serves as the Integrating Care for Populations & Communities National Coordinating Center (ICPC NCC) for the 10th Scope of Work. Amy Boutwell, MD is co-chair of the Innovative Communities Initiative sponsored by the Long-Term Quality Alliance (LTQA).

At Dr. Boutwell's invitation, Dr. Brock attended an Innovative Communities Summit sponsored by LTQA in June 2011. During that Summit, providers of long-term services and supports and their community partners spent a full day discussing care transitions issues. This, of course, was the

very issue that the QIOs were getting ready to address as part of their contracts with CMS.

Dr. Boutwell and LTQA understood that these two stakeholder groups needed to work proactively to coordinate their care transitions work. It quickly became clear to Dr. Brock that these two groups should collaborate on the community-based care transitions initiatives that both are working to facilitate. Following the LTQA meeting, Drs. Brock and Boutwell worked together to make our joint meeting a reality.

Two Partners with Common Goals

Innovative Communities and QIOs complement one another beautifully in their support of local collaboration and improved care transitions. This became abundantly clear during our joint meeting.

Innovative Communities

Twenty-two self-identified Innovative Communities joined us in Washington, DC. These local collaboratives bring together a variety of stakeholders at the community level to improve care transitions and reduce unnecessary rehospitalizations. They carry out their work with the help of LTQA, which is a neutral convener of broad-based groups concerned about and committed to advancing change within the nation's health care system. Since its founding in 2010, LTQA has worked to:

- Engage consumers and their caregivers in efforts that improve care transitions and coordination.
- Promote earlier access to palliative and end-of-life care and minimize unnecessary overuse of services.

- Introduce into the health care system efficiencies that will trim costs.
- Support and strengthen the workforce that provides critical care and services to older consumers and people with disabilities.

In addition, LTQA serves as a repository for information designed to help local stakeholders create and support Innovative Communities at the local level. The organization also coaches fledgling Innovative Communities and convenes regular meetings to encourage sharing of ideas and best practices.

Quality Improvement Organizations

Forty-one QIOs also attended the joint meeting. These organizations are currently working with CFMC on the ICPC strategic aim, a 3-year effort to reduce hospital readmission rates by 20 percent within 30 days of hospital discharge. QIOs are pursuing this aim by bringing together hospitals, nursing homes, patient advocacy organizations and other stakeholders to form community coalitions called Learning and Action Networks (LANs). QIOs provide data, education and technical assistance to LANs. They also help participating communities build the structure and experience they need to qualify for funding through Section 3026 of the Affordable Care Act, also known as the Community-based Care Transition Program (CCTP).

Collaborating for Change

Innovative communities and QIOs accomplished a number of important outcomes during their joint meeting:

- They convened their respective stakeholders – including representatives of federal agencies, national trade associations, provider organizations, quality measurement organizations, consumer advocates and think tanks — to build a larger and interconnected community.
- They sparked collaboration across traditional fences and identified new partners in the effort to improve quality of care for older people and people with disabilities.
- They shared strategies for increasing patient and family participation in their own health care.
- They focused on their common goal to meet the long-term care and community service needs of our increasingly frail and growing older population.

I invite you to read this report to gain a better insight into the discussions of our 2-day gathering. I hope it will give you a better understanding of the resources at the federal level, and the ingenuity at the local level, which will help us improve care transitions and, in the process, allow us to meet Janna’s challenge to master the care we provide during the “in between” periods of life.

part 1

seizing opportunities: taking advantage of new federal support for cross-setting collaboration

Opportunities abound at the federal level for community stakeholders affiliated with Innovative Communities and QIOs to forge cross-setting collaborations that improve care transitions and help older people and people with disabilities receive quality care that preserves their health and independence. Participants in the QIO/Innovative Communities joint meeting learned about two of these opportunities within the Department of Health and Human Services (HHS):

- The **Administration for Community Living**, a new federal agency that brings together three aging and disability-related resources under one consolidated administrative entity; and
- The **Center for Medicare and Medicaid Innovation (CMMI)**, a \$10 billion initiative authorized by the Affordable Care Act (ACA), which speeds the process of putting innovative care and payment models into practice.

The Administration for Community Living

Kathy Greenlee

*Administrator, Administration for Community Living
Assistant Secretary for Aging
U.S. Department of Health and Human Services*

The Administration for Community Living (ACL) works with states, tribes, community providers, universities, nonprofit organizations, businesses and families to help seniors and people with disabilities live in their homes and participate fully in their communities. The ACL brings together, under one administrative umbrella, three agencies that have been an integral part of HHS for many years:

- **The Administration on Aging (AoA)**, which has been providing services authorized by the Older Americans Act (OAA) since 1965.
- **The Office on Disability**, which oversees the implementation and coordination of programs and policies that enhance the health and wellbeing of people with disabilities across all ages, races and ethnicities.

- ***The Administration on Developmental and Intellectual Disabilities***, which is dedicated to ensuring that individuals with developmental disabilities and their families can participate fully in and contribute to all aspects of community life.

Our new agency demonstrates the federal government's commitment to create the right atmosphere and the right policy approach for people who are older and people who have disabilities. We chose the name "community living" because it reflects the missions of our three entities.

Community living is the aspiration of all of the people that these entities serve. So it makes sense to bring these entities together to develop robust community supports so older people and people with disabilities can fulfill their desire to stay in their homes and stay engaged in their communities.

Despite the "community living" name, however, the new agency remains strongly committed to fulfilling its responsibility to people living in a variety of settings, including nursing homes and other long-term care facilities. For that reason, AoA continues to administer the Long-term Care Ombudsman Program. It is also important to note that each of the entities in the ACL has an independent relationship with the Substance Abuse and Mental Health Services Administration (SAMHSA) and plans to incorporate mental health services into its strategies to help individuals stay connected with their communities for a lifetime.

Finding the Right Balance

The ACL will work hard to find a good balance as we serve both older people and people with disabilities. How will we recognize and support

the differences in these populations? And how will we work together on our common issues, which include transportation, housing, workforce and support for individuals?

We expect advocates for the aging and for people with disabilities to hold us accountable for making sure that no group "disappears" from the national radar screen. We also want these advocates to help us ensure that we are working on behalf of all individuals.

Preventing Hospital Admissions

AoA will continue to work hard in the area of care transitions, even though we did not receive financial support from the ACA. We remain committed to care transitions because we believe that the nation cannot transform its health care system without the community services that the aging network provides to older adults.

AoA has been doing care transitions work for years. As a result, we now have a collection of evidence-based practices that we can disseminate to our aging network. This evidence base tells us that our best chance of success comes from interventions aimed at diversion rather than hospital discharge. Our work cannot be only about keeping people from coming back to the hospital. It must be about using community intervention, prevention and support to prevent them from going to the hospital in the first place.

To achieve the goal of diversion, we will need to promote integration among a variety of providers operating in a variety of settings. To facilitate this integration, we must invest in health information technology — as well as technology-related training and technical assistance — so that Area Agencies on Aging can be transformed into sophisticated users

of electronic information and data. Our network understands that this transformation is necessary, but it struggles to find the resources that can help facilitate that transformation.

The intersection between the work of QIOs and Innovative Communities is chronic disease. How can we work together in the community to help support the health and longevity of people managing their chronic diseases? The answer is not to make the community system a medical system. Instead, we need to pull the best quality measures from the acute-care system, embed them in the community, and supplement them with quality measures that reflect our values of person centeredness, self-direction and engagement.

The Center for Medicare and Medicaid Innovation

Dennis Wagner and Dr. Paul McGann

*Co-Directors, Partnership for Patients,
U.S. Department of Health and Human Services*

Prior to passage of the ACA, anyone interested in incorporating an innovative idea into payment programs at the Centers for Medicare & Medicaid Services (CMS) had to follow multi-step process that took 6-11 years. That process included:

- Seeking legislative authority and demonstration funding to test out the idea and assess its impact (1-3 years).
- Fielding the demonstration (3 years).
- Evaluating the demonstration and its impact (1 year).
- Seeking legislative authority to put the results of the demonstration into practice (1-3 years).

The Center for Medicare and Medicaid Innovation (CMMI) at CMS represents an attempt to change that timeline dramatically. If innovations are certified by the actuary as generating outcomes in line with the CMS three-part AIM (better care, better health, reduced cost), CMMI can put those changes into the payment pipeline immediately. This process can take as little as 3 years.

CMMI has been in existence for 16 months. During that time, it has created an impressive portfolio of 24 initiatives in a variety of areas, including the transformation of primary care, the development of Accountable Care Organizations, and the bundling of payments for care improvement.

Four of these programs fall in the “sweet spot” of QIOs and Innovative Communities:

- The **Partnership for Patients** brings together a wide variety of public and private partners to achieve a 40-percent reduction in preventable acquired hospital conditions and a 20-percent reduction in 30-day hospital readmissions. Our goal on hospital readmissions means that we must prevent 947,106 readmissions by Dec. 31, 2013. We cannot achieve this goal without our partners in the field of long-term services and supports.
- The **Community-based Care Transitions Program (CCTP)** supports 2-year programs to improve transitions of Medicare beneficiaries from inpatient hospital settings to other care settings while improving quality of care, reducing

readmissions for high-risk beneficiaries and documenting measurable savings to the Medicare program. QIOs around the country are helping their constituents apply for these grants.

- The ***Health Care Innovation Challenges*** provides funding for implementation of compelling new ideas to deliver better health while improving care and lowering costs for Medicare, Medicaid and Children’s Health Insurance Program beneficiaries with the highest health care needs.
- The ***Demonstration to Reduce Avoidable Hospitalizations of Nursing Facility Residents*** supports organizations that partner with nursing facilities to implement evidence-based interventions that improve care and lower costs for long-stay nursing facility residents who are enrolled in the Medicare and Medicaid programs.

With the exception of the last item — the Demonstration to Reduce Avoidable Hospitalizations of Nursing Facility Residents — a perusal of the 24 Innovation Center projects might lead one to conclude that CMS resources and demonstrations still are earmarked exclusively for hospitals and physicians offices and leave very little for long-term care. Keep in mind, however, that there are opportunities for long-term care providers within the CMMI portfolio. However, you will have to pay attention in order to spot your opportunity.

There has been a transformation at CMS. Our agency has a very new and very different accountability due to the agency’s leadership, the ACA and the economic imperative that we generate better care and better health at lower costs. The work that QIOs and Innovative Communities are doing is part of that transformation. All of us are together in this work.

part 2

preparing for change: strategies for improving care transitions through collaboration

Forging Collaborative Partnerships

Lori Peterson

Founder

Collaborative Consulting

“In the long history of humankind ... those who learned to collaborate and improvise most effectively have prevailed.”

Charles Darwin

“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.”

Margaret Mead

“You have got to collaborate.”

“You have got to partner.”

We hear these directives all the time at conferences and workshops. However, we do not often hear much talk about *how* to collaborate. We certainly do not hear much talk about how challenging collaboration can be.

Imagine, for example, that you are bringing a group of people together to work on a common goal.

You have asked your group to tackle huge, system-oriented challenges. Whatever solutions they devise will take months to implement. It will be years before you feel the impact.

Every member of the group knows what they have to do and everyone is interested in doing it. But then group dynamics get in the way. Some people in the group are very shy. They don't like to talk in groups, regardless of the level of expertise that they bring to the table. Others in the group like to talk — maybe too much.

To make matters even more complicated, you intentionally bring the most diverse group of people to the table so you can have a variety of expertise represented. Within this diverse group, you will be likely to find different motivations and different agendas.

However challenging collaborations may be, they are unavoidable. Collaborative models are becoming more common as health care moves toward integrated care delivery models that require significant amounts of multi-layer collaboration. Many providers are realizing that they need to collaborate for survival.

Given the necessity of collaboration, it stands to reason that partners need to learn how to do it right.

These rules may help:

Rule #1 - Know Thyself

Collaboration starts with you. That's why it's important to "know thyself." Be aware of how you think and how you interact with others. Pay attention to what prompts your reactions and responses. When you participate in meetings, people will read your attitudes whether you know it or not. So it's best to ask yourself a few questions in advance, evaluate your answers and decide whether you need to change:

- How open am I? Can I let another person's opinion and perspective affect me?
- How transparent can I be? Am I willing to be seen for who I really am? Am I willing to say how I think and how I feel regardless of who is at the table?
- Can I be intense? Can I challenge myself to ask one more question or make one more statement, knowing that I might ruffle some feathers in the group?

Rule #2 - Know Thy Organization

Get a clear picture of your organization's internal culture and aspirations before you offer yourself as a potential partner. Ask yourself:

- Is the organization competitive or is it collaborative?
- What is the definition of collaboration within your organization?
- Does your organization want to own a bigger chunk of the continuum? If so, who do you need as a partner?
- How will you evaluate those partnerships?

Rule #3 - Conduct an External Scan

Identify the organizations with which you share your residents and clients. Get to know these potential collaborators to make sure that you are not duplicating their efforts. Start by asking:

- What is going on in the market?
- How fast is that market moving toward integrated care?
- What are the physicians doing?
- How are they lining up with hospitals?
- Who is collaborating?
- Who is being acquired?

Rule #4 - Understand Your Core Capabilities

Identify what you bring to the table and how it lines up with what is going on in the market. Then ask yourself one very important question: "So what?"

Answer that question by articulating what your organization's core capabilities should mean to your potential partner. Once you have done this, you are more prepared to talk with your partners about what you can accomplish together. This discussion lets you define your shared vision — the reason you want to collaborate — early in the process.

Taking it to the Next Level

Larry Minnix, president and CEO of LeadingAge, suggests that collaborators must first agree on their common philosophy and common goals. Then they can move to a period of building relationships and becoming good friends.

The next big hurdle — arguably the biggest hurdle — involves aligning finances and information systems.

If you can blend money and integrate information, it's hard to turn back, says Minnix. But if that does not happen, it's very hard to get to the next step of developing and sustaining a program that actually works.

Using Collaboration to Build Community Coalitions

Amy Boutwell

Founder

Collaborative Healthcare Strategies

In the absence of new public or grant funding, Innovative Communities need to identify local resources to support their care transitions work. In addition, community stakeholders must learn how to depend on one another. This may involve sharing data. It may involve recognizing that multiple stakeholders care for the same consumers. It may involve making simple process changes that can improve the quality of each partners' interactions with those consumers.

The State Action on Avoidable Rehospitalizations (STAAR) initiative, the first large-scale readmission reduction program, has illustrated the power and feasibility of forming local and state-level coalitions to improve care across settings. In STAAR, we strongly advised hospitals to form "cross-continuum teams" and this recommendation has been rated as the most innovative recommendation we made.

A cross-continuum team is comprised of a hospital or a set of hospitals convening coalitions of community organizations that operate across the post-acute and community settings to reduce hospitalizations. Once this group of stakeholders and providers is convened, each participant plays

a role in educating the others about what it has to offer and what its core competencies are. Armed with this information, hospitals then know who to call when they need help supporting discharged patients.

Collaboration across settings requires that partners make changes in the way they do business. These changes can be as simple as identifying some process that would improve if all stakeholders approached it in the same way. A few examples include:

- Redesigning how hospitals transition patients to post-acute providers by implementing a process of verbal ("warm") handoffs.
- Redesigning heart failure patient teaching materials so that all providers in the coalition deliver the same consistent teaching points across settings.

Recognizing that we are all part of the patient's care experience is a powerful and specific way to leverage community partnerships. This helps all stakeholders recognize that they can and should collaborate more closely to ensure that basic care elements such as communication, coordination and education are consistent.

Keys to Success

A number of Innovative Communities have been working at collaboration for many years and have learned important lessons in the process:

- **Reach out.** Hospitals need community partners like you. But they may not even know you exist. If you want to be one of the hospital's partners, don't wait for them to forget you. Reach out to them

and identify yourself. Tell your hospital that you would love to be part of its readmission task force and the cross-continuum team it convenes.

- **Involve all stakeholders.** Hospitals are important partners. But they are not the only partners. There are layers and layers of other stakeholders in your community. Unfortunately, these stakeholders are not always at the table. When you are forming your collaborative, make sure your steering committee is open and inclusive of new partners. That's the best way to ensure you are leveraging the good will, skills and resources available in your community.
- **Tap into federal programs.** There has been an unprecedented federal investment over the past year in supporting partnerships aimed at delivering effective care outside the hospital setting. These programs will be ramping up and maturing over the next year and will form a foundation for new partnerships and models in communities across the U.S.
- **Enlist your partners in the grant application process.** The relationships forged during a grant application process are often very strong and sustainable. Even if funding does not materialize, those who collaborated on the application may decide to pursue the project anyway. That project may not turn out to be the extensive service described in the grant application. But it may represent a better way to build partnerships and leverage existing community resources.

Forging Effective Collaborations in Winston-Salem, NC

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The 10th Scope of Work (SOW) began on Aug. 1, 2011. On Aug. 3, Pam Duncan of Wake Forest Baptist Medical Center and Lynn Watkins of Forsyth Medical Center arrived on the doorstep of The Carolinas Center for Medical Excellence, the Quality Improvement Organization (QIO) in North Carolina. They had three purposes in mind when they knocked on the door:

- To make their case for participation in the QIO's care transitions initiative.
- To gain assistance in creating the Northwest Triad Community Alliance, which would bring community stakeholders together to improve care transitions and reduce avoidable hospital admissions.
- To apply for funding through the federal Community-based Care Transitions Program (CCTP). CCTP, created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The Alliance would eventually receive that funding.

Building on Existing Initiatives

The Wake Forest Baptist Medical Center and Forsyth Medical Center are located in the Triad Area of North Carolina, which encompasses both urban and rural communities. Winston-Salem is a dynamic city at the heart of an urban area that is home to Wake Forest University and offers older residents a host of resources. Outside the city limits, however, the area quickly becomes very rural. These rural communities have fewer resources and are

depressed economically due to declines in clothing and furniture manufacturing over the past decades. Prior to 2011, the community was home to 46,720 fee-for-serve Medicare beneficiaries. The all-cause readmission rate was 18.5 percent.

When the SOW commenced, members of the Southwest Triad Community Alliance were already engaged in improving care transitions.

For example, **Forsyth Medical Center** recognized in 2008 that a gap existed in community services available from the time a person is discharged from the hospital until community supports kick in. To fill this gap, Forsyth developed the Hospital to Home Program for Older Adults, an initiative that bridges the medical and social models by using social workers to address the psychosocial issues of discharged Medicare and Medicaid patients and help them remain independent in their homes.

Hospital to Home features a navigator who works closely with each older adult enrolled in the program. The first meeting between navigator and patient takes place in the hospital. Home visits follow after the patient is discharged.

During the first home visit, the navigator assesses the patient's home environment and his or her ability to live independently in that environment. During subsequent visits, the navigator coaches, counsels, educates and empowers the patient and family caregivers to help them negotiate the health care system and to connect them with community supports. The program also provides non-reimbursable services, including transportation to medical visits, prescription pickup, grocery shopping, light housekeeping and light meal preparation.

Hospital to Home has been credited with reducing the 30-day, all-cause readmission rate from 14.7 percent in 2009 to 11.9 percent in 2011. Savings to Medicare are estimated at \$3 million over the course of the 3-year program.

In 2009, **Senior Services** received a grant from the Centers for Medicare & Medicaid Services (CMS) to start a conversation in its community about patient-centered discharge planning and transitional care. Research by Senior Services made it clear that this grant made sense for the agency. Senior Services looked at its 2,600 clients over a 15-month period and documented 2,800 emergency department visits and several hundred readmissions. Armed with that data, the chief executive officer (CEO) of Senior Services approached the CEOs of Forsyth Medical Center and Wake Forest Baptist Medical Center and invited them to sit on the Senior Services board. Senior Services also launched a transitional care advisory committee that had broad representation from community partners.

Northwest Community Care Network (NCCN) is the managed care arm of North Carolina's Medicaid program. According to its mission statement, the organization is patient-centered, physician-led, community-based and cost-effective. NCCN, which serves as the designated community-based organization for the CCTP project, has three foundational components: a medical home, which connects Medicaid patients to a primary care practice; care management services for the high-risk Medicaid population; and community partnerships aimed at building local networks and systems of care.

Root Cause Analysis

Applicants for the CCTP program must conduct a root cause analysis of the challenges associated with care transitions in their service areas. As health systems, Wake Forest Baptist Medical Center and Forsyth Medical Center did not have the capacity to conduct such an analysis because they lacked access to the necessary data from other sectors, including home health, nursing homes and the community's social service systems. Instead, the health systems relied on The Carolinas Center for Medical Excellence for help in developing a root cause analysis that would not only inform the CCTP proposal but would also help the Northwest Triad Community Alliance address community issues and develop a model for sustainability.

In carrying out the root cause analysis, the QIO collected a plethora of data tracing 30-day readmissions back into the community in order to understand better where systems and processes did not align. The analysis also facilitated efforts to bring together the care transitions work that participants had been carrying out in their own silos.

The QIO began the data collection process by conducting 12 focus groups with:

- Physicians working in the community and in the hospital emergency departments.
- The beneficiary community.
- Home health agencies that drove readmissions.
- Providers of long-term services and supports.

Some of these stakeholders already worked together. Others were newcomers to the table.

The most valuable data came from the QIO's social networking analysis. This analysis gave the QIO and stakeholders a better understanding of the relationships that hospitals forged with other providers during the discharge process. The analysis also helped shed light on which organizations helped to transition beneficiaries out of a health or long-term care facility and where beneficiaries went after discharge. This knowledge helped the QIO identify which partners should be invited to join the Northwest Triad Community Alliance.

CCTP Application Process

The root cause analysis became the blueprint for the Alliance's care transition initiative because it helped the leadership team understand the patient population and the drivers of readmissions. That initiative would emphasize:

- A patient navigator.
- Medication reconciliation.
- Patient self-management and self-education.
- Health Information Technology (HIT).

In the HIT area, the model makes use of the Case Management Information Systems (CMIS), a web-based software application designed by Community Care of North Carolina. The software provides a single point of entry for care managers interested in creating patient-centric, comprehensive care plans. All caregivers interacting with the patient can use the software to document medication reconciliation, health assessments, referrals, services, claims and discharge instructions.

Keys to Success

The Carolinas Center for Medical Excellence used a logic model to map and develop strategies for mobilizing and operationalizing findings from the root cause analysis. This work will allow the Northwest Triad Community Alliance to develop good process measures and to identify any changes that will be necessary to ensure good outcomes. In addition, the QIO suggests that community coalitions:

- **Develop mission and vision statements.** When disagreements arise, it will be helpful to revisit that mission and vision and encourage team members to reframe their thinking around those statements.
- **Complete a community SWOT analysis.** Identifying strengths, weaknesses, opportunities and threats helps get groups mobilized. It is important to find out what each community player is currently doing in care transitions, what's working, and what barriers remain. By the end of SWOT analysis, group members often begin to think as one.
- **Ask an outside entity to conduct the root cause analysis.** This will help ensure that all partners accept the analysis as a valid study.
- **Instill a collaborative spirit.** Make sure you have all the interested stakeholders at the table early in the process. All the players should feel that they are contributing to the conversation.
- **Remember that this is not a sprint.** The process of improving care transitions and reducing avoidable hospital admissions is a long journey with few quick fixes.

Forging Effective Collaborations in Worcester, MA

Larry Garber, MD

Medical Director for Informatics
Reliant Medical Group

Lou Swan

Executive Director
Elder Services of Worcester Area

Christine Alessandro

Executive Director
BayPath Elder Services

Worcester, a city of 180,000 in the middle of Massachusetts, may have more health-care innovations per capita than any other city in the country. For example, the city has been a pioneer in the development of the following innovative approaches to improve health care:

- **The Medical Orders for Life-Sustaining Treatment (MOLST)** program is a physician order form that patients use to document their advance directives. MOLST was piloted in Worcester.
- **The State Action on Avoidable Rehospitalizations (STAAR)** is a groundbreaking, multi-state initiative that aims to reduce rehospitalizations by encouraging community stakeholders to work across organizational boundaries. The city hosts two STAAR sites.
- **Patient Centered Medical Homes** feature a team of caregivers, all of whom are connected to primary care physician practices and work collaboratively to care for

patients. Worcester has 20 patient-centered medical homes that are certified by the National Committee for Quality Assurance.

- **INTERACT** helps nursing facilities use a prescribed set of tools to prevent emergency room visits and hospitalizations when residents get sick. Many INTERACT sites are located in Worcester.
- **The Community-based Care Transition Program (CCTP)**, created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. To date, there are three CCTP grants in Massachusetts, including one in Worcester.
- **Health Information Exchanges (HIEs)** are networks that connect hospitals and health care organizations electronically. Massachusetts has four HIEs, including one in Worcester.
- **The Improving Massachusetts Post-Acute Care Transfers (IMPACT)** project is piloting a new electronic version of the state's Universal Transfer Form. This form provides key health data to coordinate care for patients making the transition from one clinical setting to another. Fifteen health care organizations in Worcester County are participating in the pilot.
- **Ageing Services Access Points (ASAPs)** are private, nonprofit agencies that provide information and referral, case management and care planning services.

ASAPs and CCTP

Worcester's high level of health-care innovation and its robust activities to prevent hospital readmissions helped two ASAPs submit a successful CCTP application. BayPath Elder Services and Elder Services of the Worcester will be coordinating the project, which will add a new dimension to the city's ongoing care transition initiatives by bringing the medical community into play with the aging network. The project aims to reduce all-cause readmissions by 20 percent through five initiatives:

1. Implementing the Coleman Care Transitions intervention model, which uses a transition coach to teach patients with complex conditions how to self-manage their medications and how to recognize red flags if their conditions worsen.
2. Providing support services for individuals who are not eligible for other kinds of government services and do not have help from family or friends.
3. Launching a nurse transition model through which three hospitals will follow individuals after discharge and conduct teach-back with them to help prevent readmission.
4. Conducting a palliative care initiative to make sure patients understand their medical situation, what kind of medical care they need, and what level of care makes sense for them.
5. Contacting discharged patients by telephone to conduct necessary follow up.

part III

innovative care models supporting care transitions

Person-Centered Care Models

Jackie Pinkowitz

Chair

CCAL—Advancing Person-Centered Living

Howard Gleckman

Journalist & Author

Karen Love

President

Center for Excellence in Assisted Living

The relationship between individuals and providers is the fundamental building block of person-centered care. Providers need to know the holistic “personhood” of an individual: their history, interests, preferences and routines. This holistic orientation reframes the relationship with the person from one focused on their care needs and deficits to one based on supporting their strengths, capabilities and goals.

Person-centered care is considered the gold standard of care. It includes treating residents and clients with dignity, caring and respect. It means honoring

the values that they hold most dear: independence, privacy, choice and self-determination. It means supporting their holistic wellbeing, which includes their social, emotional, spiritual, intellectual and physical wellbeing. By following these practices, providers can enhance the person’s quality of life every bit as much as their quality of care.

Person-centered practices require a culture shift away from task-centered, health care-centered practices. This process involves a total system commitment that includes owners and/or boards of directors.

There is no cookie-cutter method for transitioning to person-centered practices. Each organization has its own culture and will approach this transition in different ways. Choose an approach that best fits your organization and what you want to accomplish. Two of those approaches include the Eden Alternative and the Green House® Model.

THE EDEN ALTERNATIVE

Chris Perna

*Chief Executive Officer
The Eden Alternative*

When you adopt the Eden Alternative model, change happens to the individual, the organization and the physical plant.

Individual Change: Through the “warming of the hearts” process, people at all levels of an Eden Alternative organization come to understand that there is a different way to provide care to elders. They begin to see things in a different way, they learn a new language, and they feel empowered.

Organizational Change: This change starts with the willingness of organizational leaders to give up their power. Typically, health care organizations are extremely hierarchical. But in the Eden Alternative, all of the organization’s staff — as well as the people who are receiving care — have the opportunity to influence what happens in that organization. The goal is to drive decision making as close to the people needing services as humanly possible.

Physical Change: Physical change is the last step in the culture change process. An organization cannot jump into major renovations without setting the vision for what it is trying to accomplish organizationally. You must write the script first and then think about what you need to do physically so that the script plays out exactly as you would like it to.

Culture change is not about adding new items to the menu or giving people the choice of two or three dinner entrees. It’s not about redecorating. It’s not about painting the walls or installing new carpeting.

It is not about bringing plants or animals into the organization. Culture change is about relationships that lead to feelings of wellbeing.

Staff members benefit every bit as much from the delivery of person-centered care as the elder or the resident do. The Eden Alternative has statistics showing that staff satisfaction levels rise, staff turnover levels drop and staff burnout is greatly reduced in organizations that practice person-centered care.

This shouldn’t surprise us. People go into the health field so they can deliver compassionate care. Burnout and frustration occur when we strip them of that ability. When management creates an environment where professionals can practice their craft, it is liberating. They get satisfaction out of coming to work every day in that environment.

THE GREEN HOUSE® MODEL

Robert Jenkins

*Director
THE GREEN HOUSE® Project*

Nursing homes will continue to provide a necessary service, even within a rebalanced long-term care system. While traditional systems have the ability to provide excellent clinical care, they have not always been able to deliver the quality of life people really seek.

In order to deliver that quality of life, everyone involved in a nursing home — including elders, their families and staff members — must be able to exercise real control, live with dignity and receive respect from those around them. Achieving this goal

requires three radical changes that are embodied in The Green House® model:

Philosophy: We believe that all people, no matter what their level of disability, deserve meaningful lives. We know that meaningful lives require real homes, not simply an environment that is “homelike.” Real homes offer their residents true control.

Architecture: Green House® homes look dramatically different from traditional nursing home units. Single-family style Green House® homes, which can be found in rural or low-density areas, look like any other single-family home in the community. In urban areas, Green House® homes resemble the apartment buildings that other community residents inhabit. Ideally, each Green House® home will house 10 residents. Private rooms and baths are a prerequisite.

Organizational structure: Person-directed care is delivered through work teams of “Shahbazim” who take on a blended role to provide housekeeping, laundry, direct care and cooking. These teams make decisions through a self-managed structure that provides the empowerment and flexibility to meet an individual elder’s need or desires.

Regulations and Research

The Green House® model meets all current federal and state rules and regulations for nursing homes and skilled nursing facilities. The model is based on research funded by the Robert Wood Johnson Foundation. Principal research findings by the Green House® Project and others suggest that:

- Residents, staff and families are much more satisfied with Green House® homes than with traditional nursing homes.

- The stress of direct care staff is much lower in Green House® homes.
- Clinical outcomes are as good or better in Green House® homes than in traditional nursing homes. Studies show that Green House® residents have fewer pressure ulcers and a much lower rate of hospitalization.
- The national median operating costs for Green House® homes are three-quarters of a percent more than the median cost of operating a nursing home. Capital costs for building Green House® homes are at the low end of the culture change spectrum because Green House® homes require fewer square feet.
- The Green House® model potentially saves Medicare and Medicaid between \$1,400 to \$2,300 per person annually due to a reduction in hospitalizations and daily care costs.

Technology-Enabled Care Models

Majd Alwan

Executive Director

LeadingAge Center for Aging Services Technologies

Over the past 18 months, the LeadingAge Center for Aging Services Technologies (CAST) has been working on a project to identify innovative, technology-enabled business models that promise to improve the quality and efficiency of long-term services and supports while helping providers survive and thrive in the future. CAST has also identified examples of pioneering and forward-

thinking aging service providers that are using these technologies to change the way they operate. A collection of these case studies is available at www.leadingage.org/CAST.

CAST's work has been motivated by three important changes in our field: declining reimbursement rates, the advent of payment reforms, and a new emphasis on reducing the rate of avoidable hospital readmissions. As an organization of aging services providers, technology companies and university researchers, CAST believes that the pace and complexity of these changes could bring exciting opportunities for technology to enable new models of care. The models we identified fall into three categories:

1. Integrated or coordinated health care models, like the Program of All-Inclusive Care for the Elderly (PACE), which helps older adults avoid an acute episode through shared planning across care teams.
2. Community-based service and support models, which provide a host of services to older people living in the place they call home, and range from home health to technology-enabled senior centers.
3. Real estate-based models like Continuing Care at Home programs, through which long-term care campuses serve as hubs for delivering services in the community.

Technology can play an important role in all of these models by enhancing their efficiency and cost effectiveness while facilitating communication and coordination among members of an older person's care team. Some of these technologies include:

- **Interoperable electronic health records (EHRs).** EHRs that are interoperable facilitate the continuity and completeness of an older person's personal health information. They also allow for the sharing of that information by the person's primary care physician, hospital, provider of long-term services and supports, and other caregivers. This sharing is particularly important for smooth care transitions.
- **Telehealth for chronic disease management.** This technology can help stabilize a patient after hospital discharge. It can also be used to help older adults manage their chronic conditions and avoid an acute episode and hospital admission in the first place. Telehealth devices usually use a set of ancillary devices to measure biometric signals like blood pressure and glucose weight and share these measurements with clinicians. Today's telehealth technologies also give clinicians the ability to create questionnaires that capture contextual information from the patient. If the user has a high blood pressure reading, for example, the telehealth device can ask questions that help get to the root cause of the elevated reading. It can then offer tips for better self-management.
- **Care coordination tools.** These tools allow for shared care planning between care teams consisting of the primary care physician and hospital discharge planner as well as long-term and post-acute care providers.

- **Medication adherence technology.** These technologies include devices that remind patients to take their medications and provide educational information to ensure that the person takes the right pill at the right time. For those who need more help, pill dispensers are available that organize medications, alert the patient to take a pill, and dispense the proper dose. Some of these dispensers also have the ability to create and send a medication adherence record to the clinician for review. When a medication is not taken as directed, some devices send an alert to the clinician or designated caregiver, who can then follow up with the individual.
- **Wellness monitoring.** A number of devices can monitor wellness in older adults. We are starting to see wearable devices that measure heart rate and activity levels, devices that use motion sensors to monitor activities of daily living, and sensor-laden mattress pads that collect sleep quality measures by tracking heart rate, breathing rate and movement in bed.

Barriers to Technology Adoption

Return on Investment (ROI) is often difficult to calculate for aging services technologies and for infrastructure technologies like information and communication systems that are intertwined with other organizational processes. However, technology deployment brings with it several important secondary ROIs, including the ability to help older adults avoid higher levels of care, improve seniors' quality of life, and enhance job quality for staff.

Reimbursement is also a barrier to technology deployment. Pennsylvania is the only state that reimburses for personal emergency response systems (PERS), telehealth, wellness monitoring and medication dispensers. The vast majority of the other states only reimburse for PERS, which is a relatively old technology. Long-term and post-acute care (LTPAC) providers need to convince states to pursue Medicaid waiver programs that cover other types of technologies. But first, state regulators and surveyors must be educated about how these technologies can transform the care process.

Interoperability has also been a barrier to technology adoption, particularly with respect to EHRs. But, thankfully, we are starting to see this issue disappear due to the development of common standards for EHRs and the creation of a certification program that focus on EHRs that are especially designed for LTPAC settings.

Behavioral Health Models

Steve Hornberger
President/CEO
Hornberger & Associates

In 2010, more than 23 million Americans over age 12 met the criteria for alcohol and drug dependence. Yet, according to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health, only 2.6 million received any treatment that year.

Who are the people who meet the survey criteria for alcohol and drug dependence but don't receive any treatment? They are your friends, family, neighbors and the people you serve. Of the people who

met the criteria (20.5 million) but did not receive any treatment, only 5 percent (1 million) reported believing they have a problem. The unfortunate history of shame, secrecy and silence associated with the disease of alcohol and drug dependence causes this profound “denial gap.”

There is also a “treatment gap.” Of the 5 percent who thought they had a problem, only a third (341,000) made an effort to get help but said they could not access treatment services. Finally, there is a “motivation gap.” Of the 5 percent who thought they had a problem, two-thirds (683,000) reported making no effort to get any help.

As health and human service professionals and community members, we need to raise awareness of the scope of problem; the consequences of unmet behavioral health needs; and the racial, ethnic, gender, geographic and socioeconomic disparities that currently exist. While there is a growing evidence base of effective health promotion, treatment and recovery approaches, far too many communities lack an accessible, available and appropriate continuum of care.

Policy Implications

In 2005, the National Center on Addiction and Substance Abuse at Columbia University analyzed Medicaid data from all 50 states and found that \$467 billion — or 10 percent of the combined budgets of all of the states and the federal government — was spent on substance abuse issues. Most of those dollars — 96 cents of every dollar spent — went toward cleaning up the wreckage from substance abuse. This includes the cost of medical treatment, the costs of law enforcement and correctional institutions, child welfare-related costs and lost productivity. Only two cents went toward

prevention and treatment. Less than half a cent went toward research.

As a country, we are not focusing on substance abuse and addiction issues. Our 2012 policies are lagging behind the knowledge we have gained to better understand the etiology, prevention, progression, treatment and recovery of this disease over the past 20 years.

During that time, we have learned an incredible amount about how this disease is initiated, its genetic predispositions, risk and protective factors, the impact of trauma and the social conditions that contribute to it. We have recognized that recovery from substance abuse and addiction is possible. Relapse is not inevitable. We now have a National Registry of Effective Programs and Practices. Follow-up studies have demonstrated that outcomes are sustainable 5 years after treatment. Further, there is a National Center for Integrative Health Solutions that highlights innovative primary care and behavioral health efforts.

In addition, there is now a rich history of evolving peer-to-peer recovery supports as well as long-standing, informal 12-Step programs. We know how to provide recovery services and supports before, during and after treatment. We know how to help people make a successful transition from treatment, and to increase the hope and opportunities for a productive life in the community. Informed with this knowledge, we need to scale up what we are learning so we can address the individual, family and community impacts of unmet behavioral health needs.

We also have a new working definition of recovery. Twenty years ago, we referred to recovering “one day at a time.” Today we have come to appreciate

that there are many pathways to recovery and that different people recover in different ways. We now talk about recovery as a process of change by which individuals improve their health and wellness, live a self-directed life and strive to reach their full potential.

For many years, the substance abuse field tried to do everything by itself. But now, we are discovering that no one system has the mandate, resources or reach to address all the person-specific issues and social conditions that exacerbate adverse consequences. This understanding has led to a new approach that is much more aligned with a public health model.

Like Innovative Communities, the behavioral health field is moving to recovery-oriented “systems of care.” Like Innovative Communities, we have shifted focus from simply “treating” people to supporting their quality of life through self-management and community resources and supports. Truly, there is “No Wrong Door to Recovery.”

part IV

QIOs: organizing, measuring and engaging

Accepting the Challenge: Effective Learning & Action Networks

Quality Improvement Organizations (QIOs) in Nebraska, Minnesota and Arizona have undertaken different strategies for building effective Learning and Action Networks. These strategies include Community Organizing for Health Care Change, Reducing Avoidable Readmissions Effectively (RARE) and No Place Like Home.

NEBRASKA: COMMUNITY ORGANIZING FOR HEALTH CARE CHANGE

Audrey Paulman, MD, MMM

Principal Clinical Coordinator

CIMRO of Nebraska

QIOs usually focus their efforts on education and advocacy. Community Organizing for Health Care Change represents a different theory of change than what we have used in the past.

Community Organizing for Health Care Change is not technical assistance. It does not entail information/training programs, awareness raising,

technological innovation, marketing or service to others. Instead, community organizing involves bringing together community leaders, providers, beneficiaries and community-based organizations so that they will, in turn, recruit and develop regional and statewide leaders. These leaders work to make health care better for Medicare beneficiaries by implementing interventions to reduce hospital readmissions by 20 percent.

CIMRO of Nebraska practices this organizing strategy because it brings us back to the root of what we are supposed to be doing. That's why we brought together a number of stakeholders in the state of Nebraska — including community-based organizations who are interested in care transitions — to organize for change through the development of a Learning and Action Network (LAN).

The Community Organizing for Health Care Change webinars are publically available on the website of the Integrating Care for Populations & Communities National Coordinating Center — <http://www.cfmc.org/integratingcare/>. These webinars provide a guide to the actors who must be involved in structuring Community Organizing for Health Care Change. This includes a leadership team of people within the QIO, and a constituency that includes anyone in the

state who has an interest in reducing readmissions for Medicare beneficiaries. This constituency can include individuals and organizations that support this cause, those who compete with this cause, and those who are directly in opposition with this cause.

CIMRO of Nebraska's 3-month campaign to recruit participants for the LAN involved a number of components, including a kick-off event, the public launch of our LAN website, a face-to-face LAN meeting to identify gaps in care transitions, and ongoing education about care transitions.

During our face-to-face LAN meeting, participants were given standard scenarios to identify gaps in care. Once those gaps were identified, a software program called "Wordle" helped us identify the issues that we should work on together during our next campaign.

MINNESOTA: REDUCING AVOIDABLE READMISSIONS EFFECTIVELY (RARE)

Janelle Shearer, RN, BSN, MA

Program Manager

Stratis Health

RARE (Reducing Avoidable Readmissions Effectively) began in Minnesota on July 1, 2011. The statewide campaign is designed to reduce avoidable hospital readmissions across the continuum of care in Minnesota and surrounding areas. As the QIO in Minnesota, Stratis Health chose hospitals as the drivers of the campaign because they are affected first by readmissions. However, we realized that readmissions are the result of a fragmented health care system and are not a hospital issue alone. Therefore, the campaign takes a regional approach

and is supported by hospitals, providers, health plans and other key stakeholders.

Three types of partners play a part in RARE:

- **Operating partners** include Stratis Health, the Minnesota Hospital Association, and the Institute for Clinical Systems Improvement, which is a member-based quality improvement organization supported by health plans and working with hospitals and clinics. These organizations had been working separately on readmission work for several years and came together in Spring 2011 as a way to avoid confusing hospitals with three separate initiatives.
- **Supporting Partners** include the Minnesota Medical Association, Minnesota Community Measurement and VHA Upper Midwest, a group of health systems that work together on quality issues. Supporting partners are at the table with the operating partners almost weekly, but do not provide financial support.
- **Community partners** endorse and actively support the campaign. They include providers, trade organizations, the health department, health plans, state health agencies, home health agencies, nursing homes, patient advocacy groups and other community organizations. A list of Community Partners can be found at www.RAREadmissions.org.

The RARE campaign focuses on reaching three goals within 18 months. Meeting these goals could save an estimated \$30 million for commercially insured patients and more for the Medicare population. The goals include:

- Reducing avoidable readmissions by 20 percent. This will translate into 4,000 avoidable 30-day readmissions.
- Making it possible for Minnesotans to sleep 16,000 more nights in their own home.
- Improving Hospital Consumer Assessment of Health Plans Survey (HCAHPS) scores by five percent.

More than 80 of Minnesota's 130 hospitals – which represent 87 percent of our readmissions – are participating in the campaign. The campaign roadmap begins when a hospital CEO signs on for the campaign. Then, several steps take place.

First, the hospital completes some “Getting Started Steps,” including the development of a Guidance/Leadership team that includes top hospital leadership and other organizations such as nursing homes and home health agencies. Next, the hospital develops an interdisciplinary, multi-setting Working Team. Finally, the hospital chooses to focus on one of five key areas:

1. Comprehensive discharge planning.
2. Medication management.
3. Patient and family engagement.
4. Transition care support.
5. Transition communications.

Hospitals receive various forms of support during the RARE campaign:

- Access to a RARE resource consultant who provides one-on-one assistance.
- A standard discussion guide that sets the stage for talking about the hospital's organizational assessment, successes, challenges, barriers and needs.
- Quarterly readmissions data from the Minnesota Hospital Association.
- Toolkits, face-to-face LAN meetings, monthly webinars and conference calls.
- The opportunity to participate in learning collaboratives and workgroups with other providers.

Since the RARE campaign began in July 2011, participants have reduced avoidable hospital readmissions to fewer than 10 percent, which translates into 2,000 readmissions prevented. We have also made it possible for the state's patients to experience 8,000 more nights of sleep in their own homes.

ARIZONA: NO PLACE LIKE HOME

Barb Averyt, BSHA

*Program Director, Care Transitions
Health Services Advisory Group, Inc.*

Two weeks after I joined the Health Services Advisory Group, Inc. (HSAG) — Arizona’s QIO — I had coffee with two colleagues:

- Tanie Sherman from the Arizona Hospital and Healthcare Association (AzHHA), where I had worked previously.
- Kathy McKenna from the Arizona Department of Health Services, where I had worked as a chief quality officer.

The three of us met to discuss our common interests. Before long, we found that hospital readmission was our common ground.

Kathy was rolling out a new tool from the Centers for Medicare & Medicaid Services (CMS) that would be looking at readmissions. Tanie was leading the state’s readmission initiative. As luck would have it, I was also working on readmissions through the 10th Scope of Work (SOW).

After sharing our common interest in readmissions, we began discussing how we could align our efforts so that our separate initiatives wouldn’t drive the hospitals crazy. We immediately decided to put all of our initiatives under one tent and call it “No Place Like Home.” We also added one organization to our group: the Arizona Partnership in Implementing Patient Safety (APIPS), a broad-based stakeholder group consisting of organizations related to health care.

Idea to Launch in 102 Days

Over the next three-to-four months, our small group of partners moved from an idea to a full-scale campaign. This involved a number of steps, including designing a logo and website — <http://www.noplacelikehomeaz.com/>; adopting RARE, which gave us the means to organize a campaign in a short amount of time; recruiting partners by making 30 site visits with hospital executives; and planning a kick-off event that attracted 171 participants.

After the Hospital Joins

After joining the No Place Like Home campaign, a hospital agrees to:

- Reduce its overall readmissions by 20 percent, using 2010 baseline data, before June 30, 2013.
- Allocate resources and identify a team leader and physician champion.
- Conduct a root cause analysis and develop an action plan.
- Submit monthly process measures and quarterly admit/readmit data.
- Participate in collaboratives and share promising practices and lessons learned.
- Publicly disclose its participation in the campaign.

As part of the campaign, the QIO hosts numerous community engagement activities:

- Twice-yearly statewide LAN events.
- Quarterly regional in-person LAN

- meetings.
- Monthly webinars.
- Monthly “Phone Home” calls during which two presenters share an innovative practice.
- Weekly e-mails to keep all participants connected and informed.

In addition, thank-you notes are sent continually. This is our way of seed planting. They are sent to anyone that shares on a call or at a regional LAN event, or to anyone who provides a form to post on the website. It’s important to let participants know their time and effort is appreciated.

Replication

No Place Like Home has been adopted by California www.noplacelikehomeca.com, Florida www.noplacelikehomefl.com, and Nevada www.noplacelikehomenv.com.

Conversations are currently being held with New Mexico and Utah. It took California 45 days and Nevada 60 days to import this campaign into their states.

Lessons Learned

We learned a number of important lessons during our campaign planning:

- Get executive support. It is critical.
- Have a physician champion.
- Don’t reinvent the wheel.
- Make sure your recruiting team makes site visits and personal connections.

- Communicate clearly when assigning tasks.
- Have a plan B and a plan C. When glitches occur, use your team to solve problems. A campaign belongs to partners, so the solutions (and the setbacks) belong to everyone.
- Conduct a practice session and a walk-through before your kick-off event so everything goes off without a hitch.

Shaping Your Intervention Measurement Strategies

Tom Ventura, MS, MSPH

*Integrating Care for Populations and Communities
National Coordinating Center (ICPC NCC)
Colorado Foundation for Medical Care*

The best part of my job is talking to Quality Improvement Organizations (QIOs), helping to sort out measurement problems and getting back measurement solutions. I’m not a measurement guru. I’m more of a measurement aficionado. I’m not an expert. But I’m trying to catalog all the strategies that are out there.

A good measurement strategy begins with good working relationships, good questions and a well-defined roadmap.

Good Working Relationships

You can’t get a project off the ground without having relationships with your partners. These relationships enable you to collaborate and make things happen. You may have already had to form relationships in your previous QIO work. Those who are new are

building these relationships through your work in community organizing. Building relationships is important because it makes you confident about having a data discussion with your partners.

Some communities have built data-sharing agreements or commitments into their charters. That is extremely smart. Put community-organizing principles to work by determining what you have to offer your partners. If you are asking partners to contribute a resource to the project, you should be able to offer a resource of your own in return.

It also helps to develop a business case for measurement. Having data about outcomes facilitates rapid cycle improvement. You cannot have a Plan/Do/Act Study without studying indicators of the immediate, ground-level effect of interventions. With that information, you will be able to make efficient, informed program decisions.

Keep in mind that your business case does not need to include onerous data collection. You don't have to design elaborate surveys or elaborate data collection schemes. You may be able to leverage data that is already being collected in the community. If that's not possible, you may be able to incorporate new data elements into existing data collection processes. Try to find a way to use what's already being done to collect your data if possible.

You can also sell measurement to your partners by demonstrating program effectiveness. Measuring outcomes data enables you to tell the real story of how people actually benefited from intervention and how a goal was set and reached.

Guiding Measurement Discussions

The right questions can guide a discussion in which you can convince your partners to provide data.

- ***What is the goal of the intervention and what it is intended to do?*** Your root cause analysis may dictate that you implement a certain intervention. You need to know what that intervention is going to look like so you can design measures to gauge its effectiveness. If the intervention has multiple goals, there may be multiple things to measure.
- ***How will you know that the goal is achieved?*** Make sure you can put some meat around what the outcome should be. Break the goal down into several observable components to be achieved.
- ***What kind of data will you need? Who will be responsible for collecting that data?*** Let your partners know what specific data you want and how you propose to collect that data from them. Are they already collecting the data? Could you insert new data elements into an existing work process? How burdensome would it be to design a completely new data collection process? Your partners will not want to be overburdened.
- ***What would improvement look like?*** Is it a score or a rate that changes over time? Or are you measuring the same outcomes before or after an implementation? Alternatively, you may be giving an intervention to some people and comparing them to a group of people who did not get the intervention.

- **How large of a change do you expect to see?** Is it a clinically meaningful change? Is it something that you can detect? Is it actually observable? Is it a convincing change?
- **What is the timeframe?** If your intended outcome has a long latency, you may want to explore other options. Remember, the idea is to carry out rapid cycle improvement.

Developing Your Roadmap

The Care Transitions roadmap (found on the Toolkit page of the ICPC NCC website — <http://www.cfmc.org/integratingcare/toolkit.htm>) can be defined in terms of:

- **Root cause analysis**, which shows us how to target an intervention and provides a guide on what to measure.
- **Interventions**, which involve getting the right program or service to the right target and being able to track who gets it and how much of it they get.
- **Measurement**, which allows you to envision what happens once the intervention reaches its target.

You can also look at the components of a roadmap through a logic model that identifies internal and external resources and factors; assumptions about the community; outputs that include interventions; short-term and long-term outcomes that you observe when the intervention reaches its intended target; and any changes.

Terminology

It's important for all QIOs to use the same terminology, especially when it comes to measurement strategies. For example:

- **Process** is the action that gets the intervention to its intended target. There are some problems with this word and this definition could be revised. However, this is how it stands right now.
- **Outcome** is what occurs as a result of the intervention reaching its target. Sometimes the outcome you want to see occur is the improvement or expansion of the process. This can muddy the water.
- **Reach** refers to the number of beneficiaries affected by the intervention. This somewhat of a new term that we want to introduce.
- **Improvement** is the measureable change that tells us that the end state is better than the beginning state.

Engaging Rural Areas and Targeting High-Risk Beneficiaries

Paul Moore, DPh

U.S. Department of Health and Human Services

Rural areas have their share of chronic disease. Consider these statistics:

- Diabetes is more common among beneficiaries who live in rural counties (16.7%) than among those who live in urban areas (13.5%).

- Among beneficiaries with diabetes, rural residents are slightly more likely to have at least one hospitalization (13%) than are urban beneficiaries (12%).
- Rural beneficiaries with diabetes are less likely to have physician follow-up within 30 days of a hospital stay (85.5%) than are urban beneficiaries with diabetes (88.3%).

These numbers can be attributed to the independent nature of the rural population, as well as the inconvenience associated with follow-up visits in remote areas. The proportion of beneficiaries with no follow-up visit even after 90 days increased as their place of residence became more rural, from 2.3 percent in micropolitan rural counties to 3.5 percent in remote rural counties.

Role of Critical Access Hospitals

Critical Access Hospitals (CAHs) hold the key to helping us improve these numbers. These hospitals are usually the hub of health care in their rural communities. They often are the sole source of hospital-based care, emergency medical services, home health care and clinic-based services.

Unfortunately, it will be more difficult than expected to get CAHs involved in the Community-based Care Transitions Program (CCTP). CAHs have been excluded from serving as the hospital partner in these projects, even though they represent 25 percent of all the nation's hospitals. The role of the CCTP hospital partner has been reserved for Subsection D hospitals.

This doesn't mean that CAHs cannot participate in CCTP as the designated community-based

organization. In fact, CAHs seem well suited to this role because they are the health care authority in their rural communities. They know who all the players are and they are skilled at coordinating care among a variety of partners.

It behooves QIOs to communicate this opportunity to their CAHs. QIOs must market CCTP as an opportunity for CAHs to do well while doing good. But they can also market CAH involvement in CCTP as a valuable service to other, larger hospitals.

CAHs serve as the skilled nursing facility (SNF) in many communities because they often use their swing beds for skilled nursing. When post-acute patients go to a freestanding long-term care-based SNF unit, they often bounce back to the hospital in the event of a health crisis. But when that same patient occupies a swing bed in a CAH, the CAH is usually able to continue taking care of that patient even when a health crisis occurs. In this way, CAHs can offer bigger hospitals the help they need to avoid preventable readmissions.

This potential relationship between QIOs, Section D hospitals and CAHs can be a win-win-win. But CAHs, which are already taxed with the challenges of their day-to-day operations, will need the help of their QIOs to conduct a root cause analysis and design appropriate interventions.

INDIANA: FOCUSING ON COMMUNITY HEALTH FACTORS TO REDUCE READMISSIONS

Nancy Meadows, RN, BS

Health Care Excel

Underlying risk factors that contribute to health disparities are the result of where people live, learn, work and play. Assessing the needs of a community goes beyond looking at claims analysis, frequency analysis, point of origin and discharge, disposition flowing and tracking. As Health Care Excel, Indiana's QIO, started working with its Kentucky and Indiana communities, we realized a rural component also needed to be taken into consideration.

In May 2011, the American Heart Association Meeting Report included an article entitled "Hospital readmission rates linked to availability of care, socioeconomics." The article claimed that the differences in regional readmission rates for heart failure patients are more closely connected with the availability of care and socioeconomics than with hospital performance or a patient's degree of illness. Additionally, the article found that communities with higher readmission rates were likely to have more physicians and higher utilization of hospital beds. Their populations were also likely to be poor, black and relatively sicker. People 65 and older were also readmitted more frequently.

A review of an evolving Model of Population Health provided by County Health Rankings helped Health Care Excel conduct its root cause analysis. Among the findings:

- **Health outcomes** (patient mortality and morbidity) were affected by health factors and pre-existing policies and programs.

- **Health factors** included health behaviors, clinical care, social and economic factors, and physical environment.
- **Health behaviors** and social and economic factors made up 70 percent of the health factors affecting health outcomes.

The QIO used this data to develop a Community Data Profile that looks at the social determinants of health. These social determinants are health factors that interact to impact health and contribute to health disparities. Eliminating health disparities will necessitate behavioral, environmental and social-level approaches to address issues and create change.

In developing the Community Data Profile, we looked at the utilization data and readmission rates by zip code and then started pulling in social and economic factors. For example, 14 communities in Appalachia had readmission rates that were two-to-three times higher than state and national rates. Most of these communities were below the national poverty line and were medically underserved areas. Additionally we found that the communities had an illiteracy rate that was 12 percent higher than state and national averages. With information like this, communities can consider social factors when implementing interventions.

Focusing on community-level health factors helped to set the stage for community collaboration and may provide a beneficial approach to reducing readmissions as QIOs and local stakeholders look at health care disparities. In addition, the Community Data Profile serves as a valuable tool that standardizes how QIOs assist local leaders in performing effective root cause analyses that help identify what is going on in their community.

NORTH DAKOTA: CARE TRANSITIONS ON THE PRAIRIE

Sally May, RN, BSN

North Dakota Health Care Review, Inc.

Four out of the 50-plus counties in North Dakota represent about 50 percent of the state's population. The density of those four counties makes them the QIO's candidate communities for recruitment. We could not limit our work to those counties, however. That would have meant that about 50 percent of our state's population would not have access to the evidence-based practices that we know improve care transitions. That would make patients in the majority of our counties part of an underserved population.

Instead, we knew that we needed to take a broader perspective.

Identifying North Dakota's Resources

Rather than looking at spread as being a challenge, we used it to identify resources in the state that could help us fulfill our mission.

First, we have four large communities, six tertiary care hospitals and a host of hospital referral centers. The relationship between these entities is something the QIO can build on, whether those relationships are positive or negative. We may need to start a negative relationship over, but at least there is already a connection there on which to build.

Second, North Dakota has been fairly successful in keeping readmission rates low. This is also an asset. We have the 10th lowest readmission rates in the country, according to the ranking tables provided by the National Coordinating Committee. And

we are in the second quartile as far as Medicare expenditures go, according to the Commonwealth Fund. These figures indicate that we have people in the state who are doing something right. It is the job of the QIO to find out exactly what these people are doing right so we can share that information with those in our state that are having less success.

Third, we have identified partners throughout the state who are playing a critical role in helping us meet our goals. They include:

- ***The North Dakota Long Term Care Association (NDLTCA)***. North Dakota has the third highest percentage of patients discharged to skilled nursing facilities (27%) and the eighth highest percentage of patients readmitted within 30 days from skilled nursing facilities (28%). Nursing facilities play an important role in our state's health care system because they often provide the only health care service available in rural communities. The QIO is working with NDLTCA to capitalize on that resource. In that effort, we are providing technical assistance to the NDLTCA Resident Issues Committee and piloting measurement strategies, interventions and tools.
- ***The North Dakota Medical Directors Association (NDMDA)***. We have been providing NDMDA with information about our care transitions work over the last couple of years. The QIO will be expanding that information sharing by providing training at an upcoming NDMDA meeting that will include participants from the North Dakota Chapter of the American College of

Physicians. This will represent a good opportunity to get physicians engaged.

■ ***The Aging Services Division of the North Dakota Department of Human Services.***

The QIO is concerned about the 56 percent of older adults who live in the community without access to services and supports. These patients have access to social services, but those services are not connected to the medical community. The QIO has recruited the Regional Area Aging Services Program Administrators in our effort to make that connection.

As the state's QIO, North Dakota Health Care Review Inc. uses two important tools when working with communities. First, we have incorporated a team assessment scale into each one of our evaluations and every contact with our providers.

In addition, we use the personal story of Mrs. B, a patient whose story I tell every chance I get. I ask communities to identify readmission drivers as if Mrs. B were living in their community. Everyone who hears Mrs. B's story is touched in one way or the other. This has helped us identify transition strategies in a number of communities.

NEW MEXICO: ON THE ROAD TO SUCCESSFUL CARE TRANSITIONS

Sheila Conneen

HealthInsight

This is a big year for New Mexico: the 100th anniversary of statehood. Yet, despite this centennial, New Mexico has a culture that goes back hundreds, even thousands of years. Over that time, our state

has developed many characteristics that make it a unique gem among its fellow states.

First, New Mexico is surprisingly big. The state actually represents 96 percent of the land mass of New England and New York.

Rural issues really matter here. More than a third (35%) of the state's population lives in rural or frontier areas and we average only 18 residents per square mile, compared to 87 people per square mile in the United States. Thirty-two of the state's 33 counties are medically underserved areas. Sixty percent of the state's population lives in rural counties where only 40 percent of the health workforce practices.

Our state is also culturally diverse, with almost half (46%) of the state's population sharing a Hispanic heritage. More than a third (36%) of state residents speaks a language other than English at home.

Poverty is a challenge for us. Nearly 30 percent of the population is uninsured, the highest uninsured rate in the country. Twenty percent of the population lives below the poverty line. Our literacy rates are below the national average and we have the highest death rate from substance abuse.

With all these challenges, you would think New Mexico would have enormous admission or readmission rates. On the contrary, New Mexico is at the national rate for 30-day readmissions for acute myocardial infarction, heart failure and pneumonia. Isolation and the fact that our residents are sturdy ranching and farming folks may be the reasons our hospital rates are so low. It's not unusual to hear patients say they were "too sick" to go the emergency department, so they "just stayed home."

The Strengths of Rural Communities

The QIO has identified many strengths in the state's rural communities. For one thing, New Mexico has a community infrastructure for achieving common goals. This infrastructure resides in Health Councils that are active and engaged despite funding constraints. There are 33 county-based councils and 5 councils in Native American communities. Their membership is broad and includes consumers, health providers, schools, social service agencies, volunteer organizations and law enforcement agencies.

Health Councils plan and coordinate community-level responses to pressing health issues. They have experience in gathering and reviewing data, performing community health assessments, and developing plans for health and social services. Working under the auspices of the Department of Health, they carry out a community assessment and a community profile every 2 years.

The QIO began working with the health council in Hernandez, NM at the suggestion of Dr. Paul McGann, co-director of the Partnership for Patients at the Centers for Medicare & Medicaid Services. This health council has a record of success. The Agency for Healthcare Research and Quality has recognized its Pathways Project, which works to improve care for pregnant women with substance-abuse problems.

We have helped the health council gather data and look at measures across all settings. We gathered representatives of every health care setting in the same room and presented the data to everyone. Stakeholders at the meeting decided they were unhappy with their patient satisfaction numbers and that they were very interested

in good care transitions and patient satisfaction in the hospital.

This community has already implemented interventions to address care transitions:

- An interagency care navigation team supports seniors and others at risk for hospitalization. This team includes hospitals, primary care providers and senior services.
- A patient navigator works in the Emergency Department (ED) to increase the effectiveness of emergency services. This navigator identifies frequent users of the ED and those who are at risk for admission.
- Workforce development programs facilitate the recruitment and retention of local residents for Bachelor of Science programs in nursing, as well as training programs for licensed practical nurses and community health workers.
- Partnerships are an important part of all interventions. Community health workers pick up at-risk patients, get them to their follow-up appointments at the federally qualified health center and make sure they connect with university pharmacy residents who perform medication reconciliation. In addition, the county health department tracks discharged patients through an adult day health center. Students from the community college's accredited 4-year nursing program are working in this care transitions program.

part V

next steps

Amy Boutwell

Founder

Collaborative Healthcare Strategies

How do we expand the concept of an effective care team and how do we make sure that providers of long-term services and supports are part of that team?

In a small-group discussion held during the joint QIO/Innovative Communities joint meeting, representatives of QIOs and Innovative Communities explored this question. Their conclusions could serve as logical next steps in the effort to strengthen collaboration between these two groups:

- **Enlarge the collaborative.** When launching a new collaborative, make sure everyone is included. That means inviting hospitals and Medicare-reimbursed providers. But it also means including Area Agencies on Aging and other community-based organizations that serve older adults. In addition, the long-term services and supports sector must help convince continuing care retirement communities, affordable senior housing communities and other providers to participate.
- **Find your care transitions point of contact at the QIO.** Aging services providers need to reach out and educate QIOs about the important role that providers of long-term services and supports can play in improving care transitions and reducing hospital readmissions. Many Innovative Communities haven't connected with their QIOs. Doing so will take some effort and will require that Innovative Communities be proactive.
- **Honor progress already made.** In some cases, the QIO may be the driver of change in a community. But in some locations, the long-term services and supports community has already been building coalitions and networks. QIOs must be aware of these efforts and must be willing to become involved in ongoing initiatives rather than trying to start their own, separate efforts. Innovative Communities must value and appreciate the new tools and methods that come from the QIO program. By the same token, QIOs must acknowledge and respect the fact that communities around the nation have made their own progress in improving care transitions.

- ***Outline the benefits of collaboration.***

A national group like the Long-Term Quality Alliance (LTQA) should outline in writing the benefits that Innovative Communities can reap by working with QIOs. Similarly, QIOs could write a similar treatise about the benefits that QIOs can gain by working with Innovative Communities. QIOs and Innovative Communities are not always knowledgeable about what each sector does and how they can work together.

- ***Emphasize the importance of serving the needs of high-risk individuals, no matter who pays their health care bills.***

Innovative Communities may feel limited working with QIOs who have a mandate to work with Medicare fee-for-service

beneficiaries. QIOs should be aware that Innovation Communities promote person-centered care that mobilizes the entire continuum of care and is not limited to one payer. Innovative Communities should consider developing strategies to insert a social model of services and supports into the medical model implemented by health maintenance organizations, health plans and medical centers administered by the Department of Veterans Affairs.

- ***Don't assume that we understand each other's languages.*** QIOs and Innovative Communities must take the time to be articulate and descriptive as they share their vision of where they want to go and why, as well as how they will get there.



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