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Engaging Communities in Improving Care Transitions and Reducing Utilization

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Prescriptions for Excellence in HEALTH CARE

A COLLABORATION BETWEEN JEFFERSON SCHOOL OF POPULATION HEALTH AND LILLY USA, LLC

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Engaging Communities in Improving Care Transitions and Reducing Utilization

Presentation by Alicia D. Goroski, MPH; adapted for publication by Janice L. Clarke, RN

By their very nature, transitions from one health care setting to another are prone to errors. The more complex a patient's condition and medical management requirements, the more likely that errors and "near misses" will occur during transitions of care. The ripple effect from poor care transitions is substantial for patients (ie, undue suffering, disability, death) and for the health care system (ie, unnecessary utilization, unwarranted costs).

The drivers of poor care transitions are well documented. The first driver is a low level of "patient activation" that stems from low health literacy, lack of self-management skills, and motivational issues. The second driver is the lack of standardized and generally known processes, which lead to breakdowns in communication during patient discharges and handoffs. The third driver, inadequate transfer of information across settings, continues to cause delays, inaccuracies, and omissions.

Care Transitions is an innovative, community-based Quality Improvement Organization (QIO) initiative with the primary purpose of improving care transitions for a geographically described population of fee-for-service (FFS) Medicare beneficiaries through interventions that reduce rehospitalizations.

Medicare defines rehospitalization as a return to the hospital within 30 days of discharge.

Care Transitions projects are funded by the Centers for Medicare and Medicaid Services (CMS). Target communities within each of 14 regional QIOs received awards for a 3-year scope of work that began August 1, 2008. The QIOs and their target communities included:

1. Alabama (Tuscaloosa)
2. Colorado (Northwest Denver)
3. Florida (Miami)
4. Georgia (Metropolitan Atlanta East)
5. Indiana (Evansville)
6. Louisiana (Baton Rouge)
7. Michigan (Greater Lansing Area)
8. Nebraska (Omaha)
9. New Jersey (Southwestern NJ)
10. New York (Upper capital)
11. Pennsylvania (Western PA)
12. Rhode Island (Providence)

13. Texas (Harlingen)

14. Washington (Whatcom County)

The 14 QIOs began with the same general strategy. First, the target communities were defined using "zip code overlap" (ie, identifying FFS Medicare beneficiaries living in zip codes of interest and discharged from hospitals of interest).

Next, appropriate providers were engaged (eg, hospitals, skilled nursing facilities, home health agencies, outpatient rehabilitation facilities). Problematic utilization patterns were identified by means of FFS Medicare claims analysis, root cause analysis, and provider observations and insights.

To accommodate regional health care market variations, CMS did not mandate specific interventions but rather suggested several evidence-based methods. Each QIO developed and implemented interventions and tools tailored to its target population.

Why engage a community in care transitions? Every hospital readmission begins with a care transition (ie, from hospital to home setting). Problems tend to arise when the patient - and pertinent information regarding the patient's medical management and health status - is isolated in the home

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setting. In addition to providing the impetus for improvement, information sharing is critical to safe medical management.

How do we build “community-ness”? Most important is to assure that any intervention is visibly a community effort. The 4 suggested models for community engagement are:

- Assembling a multistakeholder steering committee
- Aggregating providers vertically in clusters at first, then merging the clusters
- Aggregating providers by setting at first, then integrating them vertically
- Developing individual improvement projects using an information and data broker

A Closer Look: Colorado Foundation for Medical Care

Colorado Foundation for Medical Care (CFMC), the QIO for Colorado, is under contract with CMS for the Care Transitions project in Northwest Denver. In 2008, CFMC formed a steering committee to outline an overall strategy and to map out tactics for engaging other key providers and stakeholders. All of the community’s key stakeholders – 2 prominent area hospitals, a large physician network, employers, state policy leaders, and senior citizen advocates – were represented on the steering committee.

Influential leaders were invited to participate in one of 4 community-based action teams that were co-led by a community leader and a CFMC staff member.¹ These teams were formed to provide infrastructure for improvement efforts directed at the major drivers of poor care transitions:

Action Team 1: Standard Processes – Tasked with creating standardized processes for notification of patient transfer

Action Team 2: Patient Activation and Family Support – Tasked with increasing support for patient self-management and family involvement

Action Team 3: Communications – Tasked with community outreach and public relations

*Action Team 4: Culture Change Regarding End-of-Life Issues*¹

A cross section of the community (ie, payers, pharmacies, large employers, state and local government, patient advocacy groups, senior resource centers, community service organizations, physician networks, patients, area residents, retirement communities) was invited to a community kickoff meeting. Designed to raise awareness, attract media attention, generate enthusiasm for the initiative, and recruit additional participants, the kickoff meeting featured nationally known care transitions experts and was attended by nearly 200 people from more than 70 organizations. By the end of the meeting, each Action Team had recruited between 10 and 15 additional participants.¹

The Action Teams are already making progress toward their goals.

- Team 1 is addressing inconsistent processes and unreliable information transfer by creating a post-acute care decision-support tool to be used by the 2 major hospitals and by initiating a regional health information exchange.
 - By means of presentations and educational materials directed at physicians, patients, and families, Team 2 concentrates on activating patients by initiating community-wide use of personal health records (PHR).
 - Team 3 is focused on designing and refining the standardized PHR for community-wide use and on fostering community cohesion.
- Team 4 combats the drivers of poor transitions via educational and awareness campaigns for providers and patients. The Team also participates in policy discussions aimed at increasing the timely use of palliative and hospice care.¹

The next step for CFMC will be a social interconnections analysis to help identify existing networks based on utilization patterns and to understand the intervention’s effect on the quality and coordination of care in northwest Denver.

Among the valuable lessons CFMC has learned from its Care Transitions project are the key steps toward motivating a community:

1. Identify your community. Who are the people you serve most often? Where do you serve them?
2. Identify your provider community. What providers participate and “share patients” in the community’s health care services? Be sure to include home-based service providers.
3. Create a collaborative forum for routine information exchange and discussion. Be sure to include nonmedical health service providers as well as patients and their families.
4. Exchange quality data routinely.
5. Create a standard communication process within the community.
6. Encourage – and expect – visits among providers and stakeholders.
7. Identify the sickest people in the community. Review their care patterns.
8. Consider integrating patient coaching into the programs provided in your community.
9. Implement a standardized PHR for the community. Measure aggregate data and work toward

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creating population-based measures of utilization.

10. Develop tools to make the community more visible to consumers.
11. Contribute to the formation of local collective action platforms.
12. Promote provider accountability for building an infrastructure that crosses care settings.

Update on the 14-City Care Transitions Demonstration Project

About halfway into the nationwide Care Transitions project, Medicare spending on hospital care for approximately 1.25 million beneficiaries had been reduced by an estimated \$100 million.²

Results at the 2-year interval showed that relative improvement for readmissions per 1000 Medicare

beneficiaries ranged from 0.3% to 14%, with a median of 4.5%.³ At this point, the CFMC program achieved a 9.3% reduction in readmissions among the 80,000 Medicare beneficiaries in its patient target population covering 44 zip codes.²

Recently, CMS Administrator Donald M. Berwick, MD, MPP, joined a meeting celebrating the success of the CFMC project in reducing hospital readmissions and was quoted as saying, “...I just urge you to keep raising the bar. You’re helping not just your area but leading the whole country by your example.”⁴

Note: This article is based on “Engaging Communities in Improving Care Transitions and Reducing Utilization,” a presentation by Alicia D. Goroski, MPH, at the Transitions of Care Advisory Board Meeting in Cambridge, MA, on August 15-16, 2010.

Alicia D. Goroski, MPH is the Care Transitions Project Director for the Colorado Foundation for Medical Care. More information on the project is available at: www.cfmc.org/caretransitions.

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