Putting the Pieces Together in a Community-Wide Care Transitions Initiative: Our Role

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We’re not a hospital—how does Care Transitions involve us?
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Hospitals tried this model. It doesn’t work very well.
“A community-based approach to improving care transitions and reducing hospital readmissions cannot be considered truly comprehensive until there are sustainable partnerships in place to actively work toward quality improvement.…. (Today, we will) learn more about potential partnerships that can be leveraged on a local level to improve care transitions in your area. Hear from the experts about national initiatives, resources, and partnership opportunities.”

Source: cfmc.org/integratingcare
Care transitions definition

Refers to the patients moving between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness (Care Transitions Program, University of Colorado).

http://www.caretransitions.org
Care Transitions: Why does it matter? Not a small issue. . .

17.6% of admissions result in re-admissions within 30 days (6% in 7 days). This translates to $15 billion in unnecessary costs to Medicare.

Approximately 13% of patients who are recurrently hospitalized use 60% of resources!

One-fourth of discharged patients require outpatient workup, but more than one third are not done (35.9%)

Increased time from discharge to scheduled follow-up appointment resulted in decreased work up rate

Moore, Tying up loose ends, discharging patients with unresolved medical issues, arch int med, 2007;167:1305-1311
What are common reasons patients are being readmitted?

- Poor communication between sending and receiving providers
- Poor or lack of patient/caregiver education and instructions
- Lack of access to follow-up care—appointments with primary care providers or no primary care provider available
- Lack of community support systems for patients and caregivers (e.g., nutrition home delivery, medical transportation)
- Socioeconomic factors—patients who cannot afford medications, specialty physician co-pays, nutritional food)
Transitional care coordination goes both ways

Sending
Hospital
Physician’s Office
SNF
HHA
Home
LTAC

Receiving
Hospice
Hospital
Home
Home Health
ADRC
Physician’s Office

Community coordination and support
Specific questions we will explore today:

• Why are patients being readmitted to the hospital setting?
• Why is this a community problem?
• Who is my community?
• How do we build a care transitions community to resolve this problem?
• Are there specific examples of how cooperation in communities has worked?

Ultimate goal: Provide a seamless transition for patients
PART: Preventing Avoidable Readmissions Together

Tommie’s Story
Community Building
Tanishah Nellom, MSPH
What is a Community?

- A social, religious, occupational, or other group sharing common characteristics or interests and perceived or perceiving itself as distinct in some respect from the larger society within which it exists.
  - Healthcare community, Care transitions community, Hospital, SNF, HHA, Hospice

- When you decide to build a community you must first DEFINE your community.
Things to Consider

- What is the challenge your community faces?
- What is the change you want to see?
- What is your approach to change?
- What is your measureable outcome or goal?
- Who are the participants in your campaign?
- What are your participants’ resources and interests?
- Develop action items from resources.
- Create timeline from action items.
Organizing a Community

‘Organizing is equipping people (constituency) with the power (resources) to make change (real outcomes)’ - Organizing for Health
Leadership for Change

- Develop leadership to build a team
- Build a community based on shared values
- Build power to take collective action for change
Motivation and Engagement

- Leadership practice motivates others to join in action.

- Uniting people with a common goal to work on together, committing to take specific actions and building energy to achieve change.

- Inspire local communities to take action and make commitments that will drive our work to reduce hospital readmissions.
Building Relationships

• Develop intentional relationships

• By developing relationships, communities can:
  o Inspire creativity
  o Engage diverse social networks
  o Connect to the broader community

• People are your greatest RESOURCE
Good Community Leaders

- Are passionate and committed to positive change
- Will put in the time and resources necessary to meet goals
- Are able to connect with others and engage community members
- May not be the person “In-charge” but able to bring in others
Identifying Leaders

• Who brings others to meetings?

• Who encourages participation?

• Who are the “doer’s” (from community service groups, churches, other “informal schools of leadership”)?

• Who has the ability to see the system from multiple view points?
Leadership Teams

- Critical to creating change
- Shares insight into the elements of developing a “dream team”
- Establishes a clear purpose
- Engaging the right people
- Enabling team structure
- SUSTAINABLE
Leadership Teams

PART: Preventing Avoidable Readmissions Together
Common Goals

- **Goal of Care Transitions**: to organize a campaign to reduce avoidable hospital readmissions within communities.

- Develop a motivating vision and mission. Measureable goal(s) work best.

  - **Specific**
  - **Measurable**
  - **Attainable**
  - **Relevant/Realistic**
  - **Timely**
Developing a Timeline and Action Plan

How will your community achieve goals?
  • Develop a set of tactics or action items
  • Meet goals by using the resources available
  • Develop the capacity of the team
  • Staying on track (timely)
  • Keeping focused on the goal
  • Keeping records of measures (measurable)
Engaging Partners

- After the community leadership has agreed on goals, mission, vision, and leadership style, community partners should be invited.

- Important to partner with other providers:
  - Community, regional, and statewide
  - Smaller community groups within the large community that focus on the larger goal
    - Example: SNF meetings or pharmacy association meetings
Final Thoughts on Community Building

- Delegate--build leadership into all you do
- Set goals--encourage excellence!
- Offer responsibility--not task
- Don’t make it too easy
- Encourage action--develop capacity
- Keep yourself and others motivated
- Evaluate goals as learning opportunities
- Coach….a lot!
Questions?

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