CommUNITY Collaboration to Reduce Readmissions Guide
This guide was developed by Avoid Readmissions through Collaboration (ARC), a Cynosure Health project. The guide is funded by the Gordon and Betty Moore Foundation.

Background
ARCs began in the fall of 2010 with an engaged group of hospitals who banded together to create an active learning community with the goal to reduce readmissions by 30%. ARC has had three phases which are briefly summarized as follows:

ARC: Fall 2010 – Summer 2012:
- Community learning and action networks
- Planning grants
- Readmission reduction strategies guide with tools to perform an RCA including review of: data, patient interviews, provider interviews, medical record reviews and process gap analysis
- Education on evidence-based models and best practices
- Skill set development e.g. teach back, health assessment, patient activation assessment and motivational interviewing
- Sharing of bright spots and challenges
- Technical Assistance
- Data collection

ARC 2: Summer 2012 – Fall 2014:
What makes this community model effective?

What parts of this community model can be adapted?

What parts of this community model are unique?

- Hospital implementation focus with expanded community and other stakeholder involvement
- Engage physician groups to partner and exchange best practices
- Develop a change package tailored for outpatient practices and medical groups
- Hold meetings with other stakeholder groups
- Develop patient advisory group
- Deep dives into areas needing more support
- Expand and collaborate with others in the state working on readmission reduction
- Sharing of bright spots and challenges
- Technical Assistance
- Data collection

After ARC: Fall 2014 – Fall 2015

- Continue to support ongoing implementation
- Disseminate ARC learnings
- Research community models and develop “how to” guide
- Deep dives into areas needing more support
- Continue collaboration with others in the state working on readmission reduction
- Sharing of bright spots and challenges
- Technical Assistance
- Data collection

Why we developed this guide

The early work to understand why readmissions were occurring and how they could be prevented occasioned most hospitals to initially work within their own organizations to improve discharge, patient education and care transition processes. As those processes began to strengthen the natural evolution was to work beyond the hospital itself and expand into the community. This community work took several forms such as; collaboration with skilled nursing facilities, standardization of information and an improved understanding of community resources and capabilities. As we entered this last phase of ARC we felt that learning more about innovative community approaches would benefit not only ARC participants but all others working to reduce readmissions as well. To this end we reviewed and visited several innovative community models. Throughout our review we asked the following questions:

The learnings from that review as well as our ARC community experiences are summarized in this guide in an effort to support those interested in developing or strengthening the work in their communities.
How to use this guide

This guide can be used in whole or in part. Read it cover to cover or just read about the community or communities, resources or tools that most interest you. The guide is organized in a modular format so that you can easily find the information you are seeking.

When you see this tool icon you will know that the item is located in the tool section and can be downloaded for your adaptation.

Why these community models?

For purposes of this guide we established criteria for selecting the specific communities to review. Selection Criteria:

- Include a variety of community models
- Different geographic locations
- Different funding streams
- Positive trend data

We researched many communities and selected four communities for a more intensive assessment. We gathered information about:

- MedStar – A Mobile Integrated Healthcare and EMS provider in Fort Worth
- The Congregational Health Network - A Faith and Neighborhood Partnership
- Arizona Communities of Care – Using the Collective Impact Model
- Washington County Coalition – A County Partnership with local QIO (Quality Improvement Organization)

We also included a summary of our ARC work with San Mateo County to share their journey organizing county providers toward the AIM of reducing readmissions.

Although there are many effective communities we selected these to reflect a variety of approaches in different types of communities with different assets and challenges.

Key Interviews and Site Visits

**Texas MedStar**- Matt Zavadsky, Director of Public Affairs

**Congregational Health Network**- Bobby Baker, Director of Faith and Community Partnerships

**Arizona Communities of Care**- Marisue Garganta, Director, Community Health Integration, St. Joseph’s Hospital and Medical Center

**Rhode Island: Washington County Coalition**- Lynne Driscoll RN, CCM Director of Case Management, South County Hospital

**Hospital Consortium of San Mateo County** - Francine Serafin-Dickson, MBA, RN, Executive Director
About the Communities

Texas MedStar Program- Fort Worth, Texas

The Spark

Many new ideas come from a dissatisfaction with the status quo and a belief that things need to change. Such was the case with the Fort Worth, TX Emergency Medical Services (EMS). As you can well imagine the summers in Fort Worth, TX are hot. Historically the 911 system was overburdened by non-emergency calls when the temperatures soared. Not wanting to face another summer of excessive calls, the Texas MedStar Mobile Integrated Healthcare program originated in 2009. It started with a hypothesis: Let’s take 20 of our most frequent callers and see if we can do something differently to meet their needs while decreasing utilization of the 911 system. Between July and September 2009 the 20 top utilizers were proactively cared for by specially trained EMS personnel in an effort to anticipate and address issues before they became overwhelming to the patient thus diverting non-essential 911 calls. An amazing 70% reduction in 911 calls by these 20 patients was experienced thus giving the Texas MedStar program proof of concept to further spread their new approach.

AIM

The initial aim was to reduce non-emergency 911 calls by the 20 highest utilizers of the EMS system. Historically an EMS call resulted in a trip to the ED. In 2008, 21 individual patients were transported to area emergency rooms more than 2,000 times by MedStar, resulting in $962,429 in ambulance charges (not including the charges from the hospital emergency departments). Majority of these bills are uncollectible. A large number of the population is using EMS as a health care safety net. As the program matured additional goals were added which included:

- Improvement in Patient Self-Assessment of Health Status
- Improvement in Patient Satisfaction
- Reduction in ED and re-hospitalizations for enrolled Heart Failure patients
- Reduction in disenrollment from hospice
- Reduction in overall utilization

That initial pilot led to the development and implementation of several programs all centered on Patient Navigation and Mobile Integrated Healthcare. Since then EMS-Based Mobile Integrated Healthcare and Community Paramedicine (MIH/CP) programs have been implemented in numerous communities across the United States and are demonstrating significant impact with keeping patients out of the hospital.

Organization

MedStar Mobile Healthcare is the exclusive emergency and non-emergency mobile healthcare provider to Fort Worth and 14 other Tarrant County cities. Established in 1986, MedStar provides advanced life support ambulance service to 421 square miles and more than 880,000 residents in Tarrant County, Texas. MedStar responds to about 117,000 calls a year with a fleet of 54 ambulances.
As the EMS provider in the greater Fort Worth area, MedStar sees the use of the 911 system for medical and trauma conditions that, for the patient's benefit, could best be addressed by a response other than an ambulance trip to an emergency department.

MedStar is a governmental authority. Each city it serves appoints a board member all of whom sit on an advisory board of directors.

Funding
Since it is a government program, MedStar cannot make a profit. Its income from taxes was eliminated in 2010 leaving it subsidy free and requiring it to balance its budget on an ongoing basis. Funding now comes from a variety of sources such as health plans who contract with MedStar to manage their high utilizers. Funding includes:

- Patient enrollment fee from referring agencies
- Patient contact fees from referring agencies
- Direct funding from hospitals for 911 Nurse Triage
- Per enrolled patient/per month for Hospice program

Interventions
High Utilizer Group (HUG) – The HUG program uses specially trained paramedics to proactively manage patients through education, connection with patient centered medical homes and 911 redirection, when appropriate. This Mobile Integrated Healthcare Program identifies high system users and gathers information for individual care plans for each patient. The care plan contains mutually agreed upon goals, contacts with other providers, specific actions to be taken such as: referrals to other providers, sign up for insurance, meals on wheels, etc. The patient and family get a copy and it is entered into the Electronic Medical Record (EMR). As part of the service, the enrolled patient receives regularly scheduled home visits by one of their Mobile Healthcare Providers. During those home visits the paramedic provides a medical assessment, ensures the patient is taking their prescribed medications and is following up with their primary care provider. They also provide some often much-needed social interaction for these patients. The ED-5D patient self-assessment of health status tool is used at the start and end of enrollment to assess the degree of change. Patients generally receive support until they become self-sufficient. Paramedics learned that often their patients called 911 because they didn’t know where else to call for help. To that end, patients are now provided a regular 10 digit phone number to call in lieu of 911 for any non-emergency needs.

High utilizer groups can be defined by the payor but generally speaking they consist of patients with a set number of ED visits within a specific time period.

Nurse Triage – The nurse triage program was implemented to allow for selected very low acuity 911 calls to be diverted to a nurse for management vs. sending immediately sending an ambulance which had been done traditionally. The call center nurses use local medical control approved nurse advice algorithms to help the patient access the most appropriate care setting for their medical need. The nurses can call other healthcare and non-healthcare resources.

Heart Failure – When readmission penalties began MedStar was approached by their local cardiologists. In collaboration with these local cardiologists the HF program was developed to
support patients with this chronic condition to manage their condition more effectively and as a result utilize fewer services. The HF program uses specially trained paramedics to proactively managing patients through detail reviews/compliance with discharge instructions, education, medication inventory, and if necessary, in home management of symptoms with referral to Primary Care Providers (PCPs). The EQ-5D patient self-assessment of health status tool is used at the start and end of enrollment to assess the degree of change. Vital signs, ECGs and point-of-care lab tests can be performed as needed. Patients generally receive support until they become self-sufficient. HF patients are identified by the hospital and referred. EMS uses standing orders and a protocol to do point-of-care blood values and adjust diuretics. They can also do IV diuretics 3-5 hours with home reassessment and next day doctor’s appointments. As with the HUGs program patients are provided a regular phone number to use for non-emergency needs.

Observation Stay Avoidance – This program was designed to reduce preventable observation admissions using specially trained paramedics to do follow-up home visits to assure patient safety and compliance with follow-up physician appointment the next business day. Patients are referred right from the ED and are managed at home with next day PCP follow up.

Hospice Voluntary Disenrollment Avoidance – In this program the paramedic helps make patient and family comfortable until hospice RN arrives to avoid voluntary disenrollment/revocation.

Training
Since these were all new programs extensive training was required. A 16 day curriculum was built to ensure that paramedics promoted from within had the new skills necessary to administer these new programs. The community health portion emphasized how to assess patients for long-term, chronic conditions, in contrast to the paramedic’s traditional approach of identifying and addressing immediately life-threatening issues. Future training will utilize the community health worker curriculum since this is now a Medicaid covered service. Nurses used for the nurse triage program are also trained to understand the decision algorithms and resources. The EMS paramedics and nurses are trained on the procedures for documentation in the shared electronic medical record (EMR) and coordination with other providers. Quality improvement skills were acquired using the Institute for Healthcare Improvement (IHI) online training programs.

Outcomes
For all of its programs MedStar has a robust data collection process which tracks enrolment and outcomes. As of May 2015 the following outcomes were achieved:

Nurse Triage Patient Satisfaction – With five being the highest score all elements of the program scored 4.5 or higher. 93.4% of patients enjoyed speaking with the nurse and 94.7% said they saved time and money and 84.5% of the patients reported that they got better.

Hospice Program – 196 enrolled with 20 patients having voluntarily disenrolled or had their hospice status revoked.

HF – Enrolled patients experienced a 9.4% rate of ED visits within 90 days and a 13.4% readmission rate. Additionally, their self-assessed health status improved by 43.3%. 100% of enrollees would recommend this service to others.
HUG – One year after enrollment ended these high utilizers experienced a 72.2% reduction in ED visits and a 36.4% reduction in admissions. These patients also showed a 34.7% improvement in their self-assessed health status. 98.7% of enrollees would recommend this service to others.

Lessons Learned

• Start small and build trust.
• Find the problem that needs to be fixed. e.g. For you it might be excessive 911 calls but for the hospital administrator it might be patient experience.
• Plan for discharge as soon as the patient is enrolled and continuously reinforce self-management.
• Perform rigorous data collection and analysis
• Share skin in the game. e.g. For some of these programs to work next day appointments were needed. Schedules must be cleared to make this a reality.

Tools and Resources

- [MedStar Observation Admission Avoidance Program Overview](http://www.medstar911.org/Websites/medstar911/files/Content/1089414/Observation_Admission_Avoidance_Program_Overview_-_2015.pdf)
- [MedStar Hospice program Overview](http://www.medstar911.org/Websites/medstar911/files/Content/1089414/Medstar_Formalized_Hospice_Program_-_Generic_-_2015.pdf)
- Link to Texas community health worker curriculum [https://www.dshs.state.tx.us/mch/chw.shtm](https://www.dshs.state.tx.us/mch/chw.shtm)

Congregational Health Network: Memphis, Tennessee

The Spark

In 2006 when the CEO of Methodist Le Bonheur Healthcare South realized that one of the fastest growing businesses in the community was renal dialysis he knew that more needed to be done to
address the underlying healthcare needs of the population. The patients in his community experienced poorer status and health outcomes. Survey results that showed approximately 70% of the people who entered the Emergency Room had attended worship within the past month. It was determined that quite possibly over 45,500 of the people admitted as in-patients into the hospital annually have attended worship within the past month. Many served are of African-American descent, with premature aging secondary to multiple chronic co-morbidities (e.g., cardiovascular disease, diabetes, hypertension, end-stage renal disease and obesity). To deal proactively with coming penalties in avoidable readmissions among this chronically ill and venerable population, MLH created the Congregational Health Network (CHN). As a deacon in his church, in an area often described as the “buckle of the bible belt”, the CEO reached out to a group of local pastors and asked for their guidance. Over the next 18 months, this covenant committee, planned what is now known as the CHN.

AIM
The CHN was created to improve access to care and overall health status of the population. Ten Memphis zip codes served by MLH accounted for 56% of total system charity care costs. Of these, the largest zip code, as defined by a percentage of total charity costs, contributed 18% of the inpatient utilization and 17% of the cost. The CHN strives to:

1. To lower acuity Level (come in not as sick)
2. Decrease Length of Stay in hospital
3. Decrease non-emergency visits to the Emergency Room

Organization
The CHN is a partnership with the hospital, the congregations and the community aimed at developing person-centered care pathways. The CHN is ultimately accountable to the hospital’s governing board.

Each congregation has identified liaisons who directly interface with individuals within the community both proactively to reduce potential healthcare needs as well as in response to health events such as ED visits or hospitalizations.

In an effort to better understand the assets of the community, a formal community mapping project was undertaken wherein providers and community members identified. Out of this our Population Health Model was birthed “Wellness without Walls”. In an effort to improve the health of its community, MLH used geocoding technology to identify hot-spots of healthcare utilization. The goal was to identify geographic areas of focus on which to direct hospital resources in a targeted effort to improve the health of the neediest communities. The result was the identification of zip code 38109 in South Memphis. Patients originating from 38109 had the highest utilization of MLH emergency departments (EDs) as well as the highest consumption of hospital charitable care. Moreover, 38109 is one of the poorest zip codes in the MLH service area – the average household income is about half the national average. One in four residents have not graduated high school. Ninety-six percent of residents are of African American descent. (Truven Market Estimator, 2013)

As a first step in addressing the health needs of 38109, MLH launched an on-going innovative community health navigator pilot program – Familiar Faces – in January 2014. The pilot is
designed to support the most frequent users of MLH EDs and test the effectiveness of the CHN on improving health behaviors and appropriate healthcare utilization. The most common diagnoses for Familiar Faces – a group of about 100 patients – are heart failure, COPD, diabetes, hypertension and chronic kidney disease. Patients with chronic kidney disease and hypertension have the highest hospital encounter rates in this cohort. Additionally, this group has a shockingly high all-cause readmission rate approaching 60% at MLH hospitals.

As of March, 2015 the CHN had one director, one manager, and 11 navigators who are paid staff. They work in collaboration with 565 congregations who have identified 688 volunteer liaisons.

**Funding**
The MLH System is the primary funder the CHN. Additional funding was obtained through Cigna when they awarded MLH a community-based grant to continue their “hot spotting” work. MLH employees the Director of Faith and Community Partnerships as well as the program manager and the Navigators. Liaisons are program volunteers.

**Interventions**
The CHN provides health education to parishioners and assigns liaisons should any congregant need hospital care. Individuals who choose to be enrolled in the CHN are flagged by the health care system’s electronic health record upon hospital admission. A hospital-employed navigator meets with the flagged patient to establish his or her needs once discharged and then works with the affiliated congregation’s volunteer health liaison to arrange post-discharge services and facilitate the transition back into the home.

The CHN has five key programs that support community members to attain the highest level of health possible throughout the continuum of care.

**Education** – This program seeks to educate congregations and individuals on disease processes, community resource, access and navigation.

**Prevention** – Through proactive health and spiritual assessments and information sharing this program aims at preventing health care crises.

**Treatment** – Through this program the CNH aims to ensure the infrastructure to support optimal health is in place by linking patients with primary care providers, clinics or other community resources.

**Intervention** – This program provides services when a CHN member is hospitalized such as: clergy notification, assistance with visitation, translation assistance, ethical assistance or assistance in developing an after hospital care plan.

**Aftercare** – This program supports the newly discharged CHN member during their care transition by providing items such as: care giver support, assistance in follow up care such as doctor’s visits, transportation, housekeeping, etc.

**How it works**

- The congregation pastor signs a covenant agreement which is a written document detailing the partnership agreement.
• Congregation liaisons are selected
• The hospital assigns a navigator
• Individuals within the congregation are registered
• They receive a membership card and are entered into the shared electronic health record
• A congressional care plan is developed

The role of the Liaison:

• Recruit congregational members into the CHN
• Notify navigator of any developments/changes
• Follows CHN members into and out of inpatient settings
• Coordinates transitions from hospital
• Marshals community resources
• Provides information and referral services
• Facilitates wellness activity participation

The role of the Navigator:

• Develops a network of community resources
• Coordinates outpatient care
• Helps clients navigate the service system
• Provides avenues for prevention and education
• Maintains program documentation and participates in ongoing program evaluation and reporting

Additionally, the CHN provides the following services:

• Development and maintenance of a social system (including congregations, volunteers, MLH and partners)
• Implementation of covenant relationships (including value-added incentives)
• In-hospital support and accompaniment
• Community health promotion
• Micro-grants to congregations and community partners to support health-promoting work and networking
• Mapping and leveraging of religious health assets in Memphis
• Building practical interfaith collaboration
• Training and education of congregations and liaisons (e.g. in community care, hospital visitation, aftercare training, end of life care, mental health first aid)

Training

Education is a cornerstone of CHNs programming. In addition to training its staff, CHN has a robust education program for its congregations and participants. This strategy endeavors to educate clergy and congregants to: care for self, educate and support congregation members and to support the needs of community members. Education is also provided to: establish support groups, train liaisons and promote ministry development. The CHN Academy offers a seven week series, four time/year which includes topics such as: congregational care and visitation, avoiding
burnout in ministry, mental health issues and resources and health system navigation. Additionally, as a result of the community needs assessment, healthcare disparities in the following were identified: cancer (specifically breast CA), diabetes, hypertension and end-of-life. In response the Academy developed specific courses for CHN members including: Cancer – Medicine & Miracles, Living with Stroke, and, Diabetes self-care and management.

Training programs use internal and external experts, are evidence based and community vetted, and contain specialty curriculum and or linkage to colleges and universities when applicable. Pre and post assessments along with course evaluations for content and instructors are also performed. Upon completion students receive certificates, credits, and or professional certificates such as: community health worker. All training is entered into the CHN student transcripts database.

Lessons Learned
- Map the assets of your community to better understand what is currently in place
- Purposefully trace the relationships among these assets
- Work to continuously build trusting relationships
- Deploy the community navigators (focused specifically on highest utilizers) at the same time the congregational navigators to show the greatest impact more quickly

Outcomes
The health system compared the experiences and costs of 473 patients in the program with those of similar non-participating patients who received standard care from 2007 to 2009: In 25 months the mortality rate for those in the network was 50 percent lower than for non-participating patients; their hospital readmission rates were 20 percent lower. A total of four million dollars in healthcare expenses were avoided.

Tools and Resources
- CHN - 1 Partnership Covenant Agreement
- CHN - 2 Education Registration Form
- CHN - 3 Network Liaison Guide
- Link to community asset mapping
  http://mrhap.fatcow.com/mrhap/?page_id=28

Arizona Communities of Care Network- Phoenix, Arizona

The Spark
As a not-for-profit organization Dignity Health - St. Joseph’s Health and Medical Center conducts a community needs assessment with Maricopa County Department of Public Health, State and National resources every three-years. In doing so, the hospital realized the opportunity to create a backbone organization to provide a structure for coordination and prioritization of the many community needs and activities. The Arizona Communities of Care Network (ACCN) was formed to serve as the community backbone. It helps to create “large-scale” change through engaged collaborative efforts to develop ongoing, system change to challenging problems.
AIM
The overarching AIM of the ACCN is to improve the community’s well-being. Specifically, the ACCN is looking to:

- Increasing the number of insured individuals
- Improving Homeless individuals lives through supportive housing
- Health and job placement
- Access to healthcare
- Behavioral and mental health services
- Disease management
- Preventative health services for those living “hot spot” zip codes
- Connecting premature infants and their families to health resources, education and support services

Individual Communities of Care establish specific goals which will be addressed in the interventions section.

Organization
Dignity Health - St. Joseph’s Hospital and Medical Center created the ACCN as the backbone organization for the community healthcare improvement efforts. The ACCN brings together organizations and individual patients to work collectively on solving complex health and community issues. The coalition consists of individuals from many organizations within the community and serves an oversight function to monitor efforts across the community and across numerous health issues to promote efficiency and effectiveness.

The ACCN uses the Collective Impact model to put plans into action. The five elements of Collective Impact are: common agendas, shared measurement systems, the mutually reinforced activities, the continuous communication and identified backbone organizations. The ACCN fosters shared responsibility among participants to transform health in the community.

Under the umbrella of the ACCN individual programs or collaboratives called Communities of Care are sponsored. The ACCN is staffed by the hospital using the support of the Director, Community Health Integration. It meets six times a year for two to two and half hours. Funded Communities of Care are also required to submit outcome measurements to St. Joseph’s Hospital’s Community Health Integration Department and share their findings with others at the ACCN.

The ACCN reports to Community Health Integration Network (CHIN), a sub-committee of the hospital’s governing board.

Funding
The ACCN backbone organization is funded by Dignity Health’s Community Grants program. Individual Communities of Care receive funding through a variety of mechanisms. These funding sources include: the Dignity Health Community Grants Program, outside funding, and or in-kind services and technical assistance from the hospital. Communities of Care are encouraged to seek
funding through a variety of revenue sources and to create revenue streams to sustain the work for the future.

Interventions (For the purposes of this guide the only Communities of Care associated with care transitions will be described)

ACTIVATE (Advance Clients’ Transition to Independence Via Actions that Empower) – Supports patients with multiple chronic conditions and are in long term care.

Focused on Super-Utilizers:

- Patients that over utilize the ER (usually known to staff) or the hospital (identified by Case Management)
- Multi-morbidities
- Uninsured, Medicare FFS, Medicaid, and Arizona Long-Term Care Patients

The goal of the program is to reduce unnecessary hospitalizations using the Care Transition Intervention model. The period of coverage was expanded from 30 to 90 days during which trained coaches provide:

- In-home Visits (initial, then as needed, and closure visit)
- Psycho-social assessment; patient-Coach relationship deepened
- Home vs. Discharge medication reconciliation
- Primary Care Physician (PCP) follow-up visits tracked; patient status shared
- Caregivers engagement
- Personal Health Record created
- Transitional Care Nurse sees patients in hospital and follows up with home visit
- Telephonic and home visit Follow-up (Transitional Care Coach)
- “Red flags” reviewed
- Medication Protocol Compliance Assessed
- Community Resource Referrals Enabled

Community of Care Title: C.A.T.C.H (Clients Aligned through Community and Hospital) - The CATCH project supports chronic care patients chosen from SJHMC’s Internal Medicine Clinic (IMC). Patients are extensively case managed for three months by a social worker to determine community need. Care is coordinated across community agencies for another nine months. CATCH reports on the effecteness of the package of selected community services has on improving treatment compliance, stabilizing disease indicators and reducing Emergency Department (ED) visits and hospital readmissions. Characteristics of the selected population include:

- High use of ED and medical home
- High hospital readmission rates
- Multiple comorbidities, with high incidence of Congestive Heart Failure (CHF), Acute Myocardial Infarction (AMI), Pneumonia (PNEU)
- 70% have behavioral health issues
- Social isolation: single, living alone, often no regular caregiver
- Need support to access benefits
- Lack of transportation to appointments
The CATCH program will not enroll homeless or seriously ill patients or those residing more than 10 miles from the clinic.

Goals:

1. 20% Reduction in Emergency Department (ED) Visits and Admissions
2. 70% Reduced missed/cancelled appointments at the Internal Medicine Clinic
3. 100% Patient Homes visited jointly by IMC Residents/Faculty/Medical Students and Social Work
4. Improved scores of bio psychosocial indicators

Welcome Home: Prioritizing Medically Vulnerable Individuals for Housing (Outgrowth of the FUSE Pilot – Frequent User Service Enhancement (FUSE)) – The program will develop/implement a process to identify, assess, treat and prioritize medically vulnerable homeless persons for finite subsidized housing (SH) resources so that limited Housing and Urban Development funding can be prioritized for the most medically vulnerable individuals. Welcome Home will also develop a process to administer the tool/process in order to maximize engagement of the target population and to develop a process to prioritize and expedite access to SH.

Goals: The partner goals are focused on improving access to SH, including appropriate medical care for homeless medically vulnerable individuals:

1. Develop a method/process to effectively identify medically vulnerable homeless individuals.
2. Medically vulnerable homeless individuals will have improved access to and more appropriate utilization of health care, resulting in improved health outcomes.
3. Medically vulnerable homeless individuals will demonstrate greater self-sufficiency in both social emotional and economic domains.

Training

Individual programs have specific training requirements. Just in time training is provided to the members of the ACCN by the Director of Community Health Integration. All hospital embedded Communities of Care receive training and hospital integration through the hospital’s volunteer service department.

Lessons Learned

• Hospitals don’t have to do it all
• Expertise rests in the community
• Understand the needs of the community through the community needs assessment
• Partner and create networks that work together with shared accountability
• Having an overarching backbone allows for prioritization and better awareness among all individuals and organizations working to improve care within the community

Outcomes

CATCH: 55% readmission reduction; 68% reduction in ER visits
ACTIVATE: 85% drop in 30-day readmissions from 28% to 4% in 2.5 years

Tools and Resources
- ACCN - 1 2015 summary
- ACCN -2 agenda sample
- ACCN -3 Going Home Guide
- ACCN - 4 Tools for Backbone Agency (www.FSG.org)

Washington County Coalition, Washington County, RI

The Spark
It all started back in 2010 when one of the primary care provider’s (PCP) in the community who was also involved with three local skilled nursing facilities (SNFs) became frustrated at the frequency SNF patients were sent to the local hospital’s emergency department (ED). He believed there was a better way and began to initiate a dialogue between the ED liaison and the SNFs. This early work was recognized for its success and when the state’s quality improvement organization (QIO) was tasked with supporting community collaboration they reached out to both learn from the good work that had already occurred and to lend support for ongoing activities. The single hospital effort expanded to include the other acute care hospitals in the county and their post-acute partners and became the Washington County Coalition (WCC).

The WCC is a provider driven initiative including traditional and non-traditional providers that share patients within small networks and is focused on improving transitions between their facilities. The QIO supports this community approach throughout the state, with the following coalitions: Newport; Providence; Warwick; and Washington County.

AIM
The group has adopted the vision that the QIO Leadership Advisory Board: “A healthcare system where discharged patients and their caregivers understand their conditions and medications, know who to contact with questions (and when), and are supported by healthcare professionals who have access to the right information, at the right time.”

In working toward this vision, the WCC outlined their Aim to improve transitions of care and reduce 30 day readmissions by 20%. To achieve this Aim, WCC members are implementing evidence-based interventions and best practices within their facilities and as part of this community collaboration. The QIO is supporting this effort with Medicare FFS claims data, root cause analysis support, intervention identification and measurement strategy consultation.

Organization
The WCC does not exist because of a mandate. It is self-governing. Individuals participate because of the perceived value gained from this collaboration. The group has a charter. Technical and administrative support is provided by the QIO, Healthcentric Advisors. The WCC has co-leaders who volunteer and represent various parts of the continuum. The co-leaders are supported by physician champions.
Funding
The QIO staffs the WCC performing duties such as: preparing agendas and writing minutes, sending meeting notifications, analysis and display of data. Participant’s time is volunteered through their organizations. Individual organizations are funding positions to support improved transitions, including a nurse liaison is employed by South County Health and Nurse Care Managers, employed by the hospital that support primary and behavioral health providers that are funded by the all payor Patient Centered Medical Home.

Interventions
Interventions that address the top drivers of poor transitions of care have been implemented, including examples as noted below:

Information Transfer (Communication)
• Participating hospitals are working to electronically generate the state-mandated Continuity of Care form. The hospitals are surveying receiving providers to ensure that the format and content meets the needs of the receiving providers
• To further enhance communication, participating hospitals and Nursing Homes implemented a structured nurse-to-nurse report. The nursing report uses SBAR format. In addition, the group implemented a physician to physician report for patients with more complex needs.

Provider Education/Awareness – To ensure that providers have a base understanding of other care settings, the group implemented the following:
• A Shadowing Program – “Walk a Day in My Shoes” allows participants and opportunity to understand and have a much greater appreciation for one another’s daily work processes and challenges so they can work more collaboratively.
• Nursing Home Capabilities Guide – This state-wide guide developed by the QIO and Department of Health - includes key information so hospitals have a better understand what facilities are capable of managing and key contact information so they can connect directly. (The guide includes a capabilities listing that was adapted from the one in the INTERACT program.) During coalition meetings, the group discusses how they are incorporating this tool into the ED and Case Management Programs to support appropriate referrals as well as opportunities for improvement with the tool and/or process.

Medication Management:
• Narcotic Orders – A process was developed to facilitate getting narcotic prescriptions to the Nursing Homes prior to transfer so that medications would be available when the patient arrived – previously there could be a few hour delay and unnecessary interruption in the patient’s medication therapy.
• FREE Med Management Clinic – Established to provide medication optimization and education for recently discharged patients who live in this community. This pharmacist-run program includes a full medication review, reconciliation with pre-admission meds
and teaching. A reconciled medication list is provided to the patients and PCP at the end of the visit. This program is provided at two sites for patient convenience.

• Nursing Home Brown Bag Program – One WCC member requests that family/caregivers bring in patient home meds in a brown bag. They schedule a follow up visit with the PCP and provide a supply of all new meds to get patient to the post-discharge primary care visit. The home meds are sealed in a brown bag, set aside for the primary care medication reconciliation.

Training
There was no specific training for this collaborative, although many of the providers actively participate in the QIO hosted learning and action network.

Outcomes
Washington County has one of the top relative improvement rates for Medicare and Medicaid readmissions (down 12.7% in admissions and 31.1% in readmissions from 10/1/11-3/31/11 compared to 10/1/11-3/31/12). The group also had a 96% accurate medication management rate when transitioning a patient from a hospital or skilled nursing facility to home health care.

Lessons Learned
• Dare to be a leader!
• Transparency is painful but necessary
• Talk less and act more
• It’s all about the relationships
• Identify one area to improve and start
• Identify strong champions
• Celebrate all successes both small and large
• Build trust

Tools and Resources

- WCC -1 Liaison tool
- WCC -2 Shadowing Program
- WCC -3 Collaborative Shadow Agenda
- WCC – 4 Nursing Home Collaborative Shadow Program
- WCC -5 RI Nursing Home Guide
- WCC - 6 Medication Management Clinic Brochure
- WCC – 7 Charter

Improving Care Transitions in San Mateo County, San Mateo, CA

The Spark
San Mateo County is located in northern California and is considered to be part of the San Francisco Bay Area. The population of San Mateo County is 758,581 with 21.7% being 18 or below. San Mateo currently has six acute care hospitals. All of these hospitals have a history of
collaboration. The County has a hospital consortium which serves as a convener for healthcare related issues.

In 2012 the hospital consortium’s board of directors engaged the hospitals within the County to reduce acute care hospital readmissions by improving care transitions. The Executive Director of the Hospital Consortium was tasked with this responsibility. At the same time a grant funded collaborative, Avoid Readmissions through Collaboration (ARC) was looking to support communities interested in reducing their readmissions. ARC lent support to the Hospital Consortium to plan and run its care transitions improvement effort.

AIM

Setting an AIM. We all know the importance of setting an aim and addressing the questions – how much by when? But it was a challenge at the County level to set an AIM because the different local hospitals were all working towards the AIM established by their organizations. Rather than establishing unique county AIM a blended AIM was determined. This was done by weighting the number of discharges from each facility by their stated AIM then summing these for the overall county AIM. 30 Day readmission data were gathered from all six hospitals and tracked over time to determine progress towards the blended AIM of 8.7%.

Organization

The hospital consortium provides the backbone for this work. A steering committee with members from the hospitals, health plan, the ombudsman and the area on aging meeting approximately six times a year to prioritize the work. The committee has three task force sub-committees: SNF, Home Health and in-home assistants/board and cares. These sub-committees are staffed by the executive director or her designee and report into the steering committee. The executive director reports to the hospital consortium board of directors. The steering committee is supported by the Improvement Advisor from the ARC program.

Finding

All participants on the task force and sub-committees volunteer their time through in-kind support from their employers. The large county meetings are paid for by the hospital consortium.

Interventions

The County rapidly moved to:

- Establish relationships among hospitals and agencies receiving discharged patients to optimize care transitions
- Utilize the Collective Impact Process to ensure smooth patient transition to discharge disposition location
- Identify mechanisms to improve care transitions/discharges from hospitals to community agencies
- Hold a community convening with representatives from: Board & Care Facilities, Skilled Nursing Facilities, In-Home Assistance Agencies and Home Health Care Agencies
The convening was held in October 2013 to map the day of transition from the local hospitals to these agencies to identify the current state and the desired state for care transitions within the community.

As a result of the work performed during the initial convening the following County priorities were established:

- Need for two way communication; exchange of critical pt. care needs; verbal report; PCP involvement
- Need for involvement of patient and family/caregiver(s)
- Need trainings from hospitals
- Need for relationships
- Need for communication End-Of-Life documentation: Advance Healthcare Directives and Physician Order for Life Sustaining Treatment
- Need for identifying community assets to pt. needs
- Medication reconciliation

In order to proceed with improvement activities three task forces were established: SNF, HH and RCFE/In-home assistance. Throughout 2014 these task forces meet to work on these priorities. First and foremost these groups worked collaboratively to develop a share core information set that all hospitals agreed to send when patient transitions occur. Additionally, they developed a capabilities grid so that all interested members would be able to determine at-a-glance the services offered at the various agencies.

In March 2015 a 2nd County convening was held to assess progress and establish next steps.

As a result of that convening additional work in palliative care and medication reconciliation were prioritized.

**Training**

Just-in-time facilitation and training was provide to the steering and sub-committees on facilitation and quality improvement by the executive director and the improvement advisor.

**Outcomes**

While there remains much to accomplish the County of San Mateo continues to work towards their goal by leveraging their relationships and common expectations. So far the County has reduced its 30 day readmission rate by more than 20%.

**Lessons Learned**

- Leverage the work already being done by the organizations within the community
- Prioritize needs and proceed based on resources
- Invite all of the stakeholders to the conversation

**Tools and Resources**

- SM -1 San Mateo Initial Convening Agenda October 2013
- SM -2 Day of Transitions Mapping Facilitators Instructions 2013
- SM -3 DoT Sample Worksheet – Hospital to SNF
Guide Summary

As we traveled and talked to communities across the country we learned several important lessons. Although these communities all differed in location, size, needs and approaches they shared some commonalities. All communities addressed the need to improve communication, relationships and trust. All emphasized the value of mapping the community’s assets.

We hope that this glimpse into several diverse communities prompts you to think about ways that you begin to or further collaborate with others in your community to sever your most vulnerable patients.

If you want to go fast, go alone.
If you want to go far, go together.

- African Proverb