Engaging Your Community-based Organizations and Resources: *Aligning Forces for Improved Care Coordination Across the Healthcare Continuum*

January 23, 2020

Presented by:
Sara Butterfield RN, BSN, CPHQ
AIM Lead, Care Coordination

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Jennifer Hodge

TECHNICAL ADVISOR, COMMUNITY COALITION

With a background in hospital nursing leadership, Jennifer has spent years working to help make healthcare improvement easier for providers. In recent years, Jennifer has served as a subject matter expert in reducing readmissions and Improving Care Transitions.

"Safe, quality healthcare should be a minimum expectation for everyone who accesses health services in this country. This is my commitment through the work I do at Alliant Quality in partnership with healthcare providers at all levels of care as well as stakeholders - especially patients and their families."

"The opposite of love is not hate, it's indifference. The opposite of art is not ugliness, it's indifference. The opposite of faith is not heresy, it's indifference. And the opposite of life is not death, it's indifference."

— Elie Wiesel"

Contact:
Jennifer.Hodge@AlliantQuality.org

Sara Butterfield RN, BSN, CPHQ

AIM LEAD, CARE COORDINATION

By way of discipline, I have been a Registered Nurse for 40 years with 20 years of experience working within hospital setting in the areas of management, direct care, performance improvement, case management and utilization review. I have been with IPRO, Alliant Quality's collaborator in the 12th Scope of Work, for 21 years, serving as lead for many different CMS priority projects, including the Coordination of Care task, Community Based Sepsis SIP and Transforming End of Life Care SIP. During my time outside of work, I enjoy traveling, time with family and friends, and spending time with my very spoiled chocolate Lab.

"It is what it is...we will get through it together!"

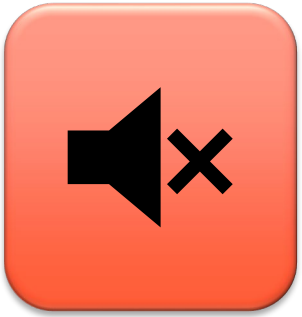
Contact:
sbutterfield@ipro.org

Objectives

- By the end of this session, you will be able to:
  - Discuss strategies and opportunities to collaborate as a community to improve communication, care coordination and patient/care partner activation
  - Review process to identify potential community partners
  - Identify next steps for your organization and community…*what will you do by next Tuesday?*

Ground Rules

- All lines are muted, so please ask your questions in chat



- Be present and actively participate

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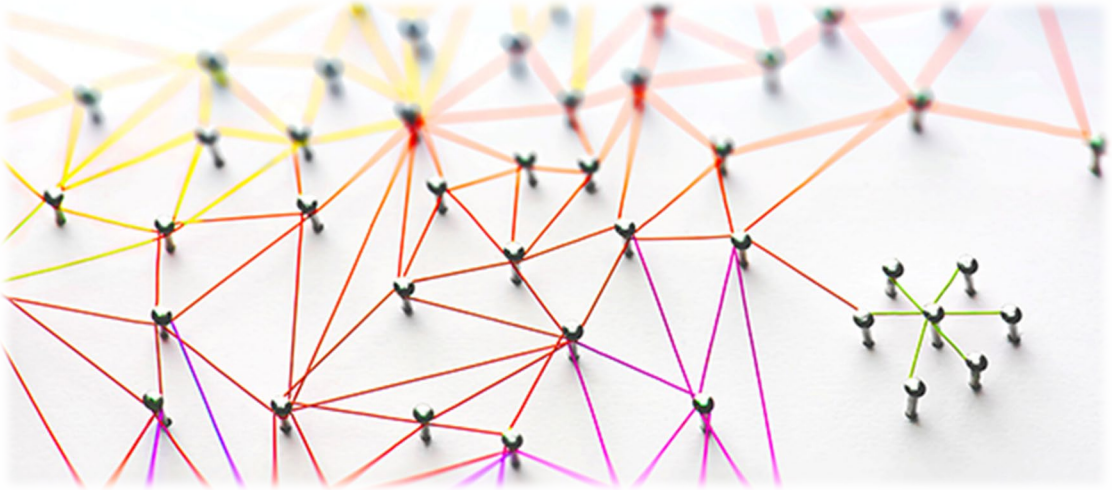
Personal Connections



- What state are you from?
- What is your setting?
- Are you already working in a community coalition?

CMS Aims

Behavioral Health Outcomes and Opioid Misuse

- Promote opioid best practices
- Decrease high dose opioid prescribing and opioid adverse events in all settings
- Increase access to behavioral health services

Patient Safety

- Reduce risky medication combinations
- Reduce adverse drug events
- Reduce C. difficile in all settings

Chronic Disease Self-Management

- Increase performance on ABCS clinical quality measures (i.e. aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- Smoking cessation
- Identify patients at high-risk for developing kidney disease and improve outcomes
- Identify patients at high risk for diabetes –related complications and improve outcomes

Quality of Care Transitions

- Convene community coalitions
- Identify and promote optimal care for superutilizers
- Reduce community-based adverse drug events

Nursing Home Quality

- Improve the mean total quality score
- Develop national baselines for healthcare related infections in nursing homes
- Reduce emergency department visits and readmissions of short stay residents

The Reality

- *"CARE TRANSITIONS IS A TEAM SPORT and yet all too often we don't know who our teammates are, or how they can help."*
  ~ Eric A. Coleman, MD, MPH

- *There was an important job to be done and Everybody was sure that Somebody would do it. Anybody could have done it, but Nobody did…Everybody blamed Somebody when Nobody did what Anybody could have done.*
  ~Anonymous

The Paradigm Shift in Health Care

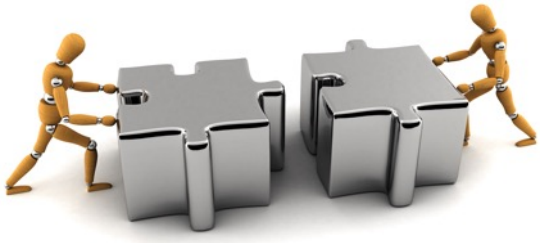
Community-based Partnerships

"Our Patient" → "Patient Within Our Community"

The Journey….

Building Community Based Teams

Establishing Community Based Partnerships



Building Capacity

- Collaboration is the key to success!
- Identify referral sources & community partners who have a stake in improving care transitions:
  - Hospitals
  - Home health
  - Skilled Nursing Facilities (SNF)
  - Hospice
  - Dialysis Centers
  - High Volume Physician Offices
  - Community Based Organizations
  - Federal Qualified Health Centers
  - Area Aging and Huma Service Providers
  - Homeless Shelters
  - Community Stakeholders/Partners
  - Medical Homes
  - Community Service Providers

Building Capacity

Build a Strong Team

- Promote integration across all services & disciplines
- Identify current initiatives that support your efforts
- Senior leadership buy-in is essential
- Involve point of care/service representatives
- Identify a champion
- Refine roles based on individual skills and expertise
- Use existing relationships and resources

Building Capacity

- Build on existing relationships
  - Social Work
  - Case Management
  - Patient Representative
  - Statewide Advocacy Organizations
- Establish the business case when approaching new partners:
  - Why is investment of time & resources valuable to them, their customers & their community?
- Utilize your Alliant Quality Innovation Network-Quality Improvement Organization (QIN-QIO) partners for introduction into the community effort

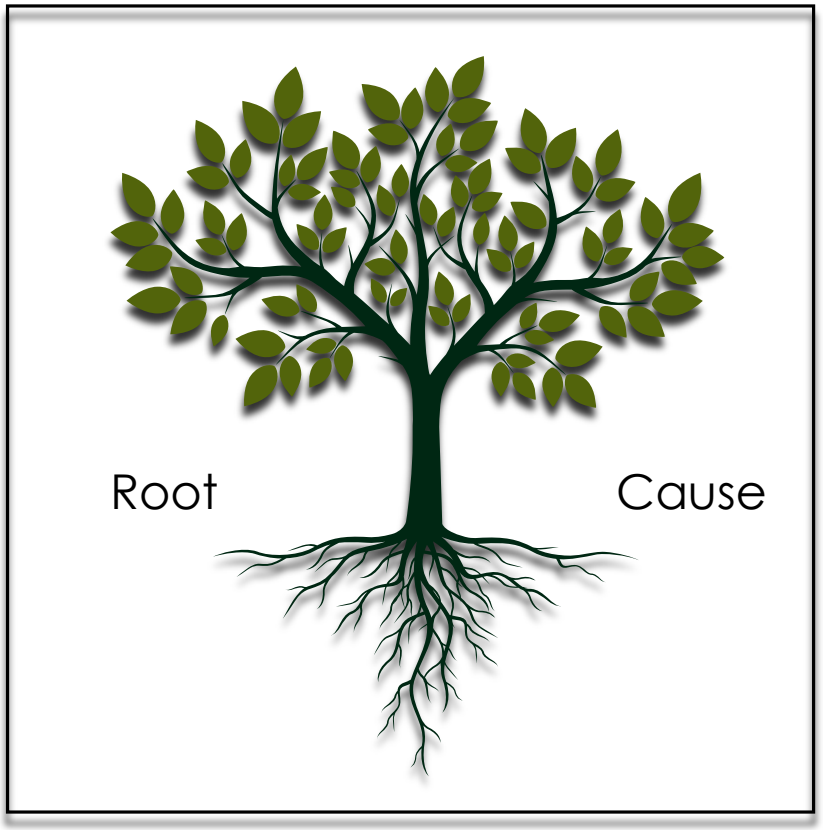
Building Capacity

- Convene a cross-setting partner meeting to discuss:
  - Current efforts taken to improve care transitions to date
  - What is working well?
  - What is not working so well?
  - What opportunities to improve exist?
  - What are **our** priorities to address as a team?

Building Capacity

- Maintain focus
  - Focus on the process not the setting
  - *Blame Game* not allowed

- Identify common goals & shared missions across settings
- Identify cultural & procedural differences across settings
- Each partner has a unique perspective to identify & address issues associated with failed transitions
- Deal with one or two problems at a time, beginning with the easier issues



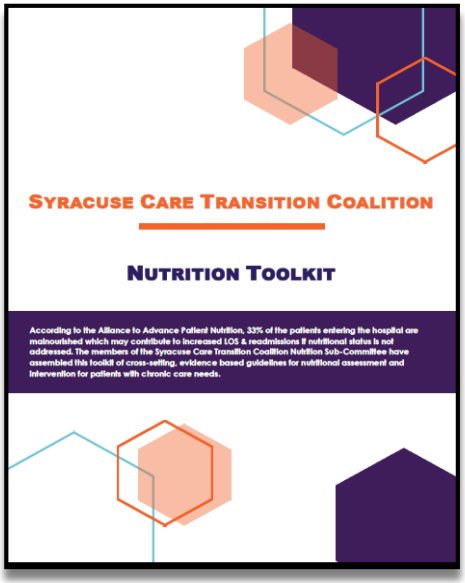
"Every system is perfectly designed to achieve the results it gets.

So improving system performance is a matter of improving system design."

~Edward Deming

Case in Point

- Care Transition Coalition Partnership
- Impact of Malnutrition on Readmissions
- Community work group
- Assessments abound
- Proactive identification of food insecurity in the community
- Community-based organization food insecurity assessment



Bringing it Home

Contact Information

If you wish to join us, please email:
carecoordination@alliantquality.org

Upcoming Events

Nursing Homes Tuesdays, 2pm ET/1pm CT	Community Coalitions Thursdays, 12:30 pm ET/11:30am CT
February 18, 2020: Understanding the Quality Measures and Drill Down to the Resident Level	February 20, 2020: Introduction to the Million Hearts Initiative
March 17, 2020: Identify High Risk Medication Use and Quality Practice(s) to Support ADE Prevention and Reduction	March 26, 2020: Opioid Titration/ Tapering
April 21, 2020: Use of the Infection and Antibiotic Prescribing Data Tracking Tool in Quality Improvement	April 23, 2020: Medication Storage/Disposal
May 19, 2020: Reducing and Preventing ED Visits and Readmissions in the Short-stay Nursing Home Population	May 28, 2020: Anticoagulant Choices for Special Populations (Interim/Draft Entry)
June 16, 2020: Assessing and Reducing Opioid Prescribing in Long-term Care	June 25, 2020: Blood glucose targets and adapting treatment goals for special populations

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