**Oregon Transitional Care Collaborative**

**REALITY:** Poor care transitions drive higher financial costs for the health care system and high levels of stress for patients and their families. They can compromise patient safety and quality of care. Preventing them depends on coordinated actions among all care providers, targeting people at high risk for repeated acute care episodes for special attention and linking patients to community services that can support their discharge plan.

**SOLUTION:** Active participation in Oregon's Transitional Care Collaborative. Join 15 statewide health care partners in forging real solution for improving patient transitions between care settings.

***Overview:***

A Collaborative is a time-limited, action-oriented effort lasting between six and twelve months. Improvement teams from multiple organizations or communities come together with planners and guest faculty to work towards improvement in a particular topic area.

Teams learn about and use an improvement model where they test or "try out" changes before implementing them throughout their setting. At the same time, each team collects data routinely for measures to help monitor and demonstrate improvement. Improvement teams collaborate or share their changes, experiences and data through learning sessions, conferences call, emails, etc. When "everyone learns and everyone teaches," improvement is greatly accelerated.

At the end of the Collaborative, lessons learned and tools that were refined or created during the Collaborative are shared with others to assist further improvement efforts.

The three main components of a Collaborative are Preparation Activities, Learning Sessions, and Action Periods.

- ***Preparation Activities***
  Community teams will be involved in preparing for the Collaborative from the time of their recruitment until the first learning session in late September 2010. During this time, the team has several important tasks to accomplish including completing "Safe Table" agreements, considering which patient population to target for improvement and agreeing on the logistics that will help focus the team's project. Some consultation or technical assistance will be available to help teams with this work.

- ***Learning Sessions***
  Learning Sessions are the major events of the Collaborative that bring teams together. Through plenary addresses, small group discussions and team meetings, attendees have the opportunity to:

- Learn about “best practices” from guest faculty and other teams.
- Receive coaching.
- Gather new information on the subject matter and process improvement.
- Share information and work on detailed improvement plans for the “Action Period” to follow.

The Oregon Transitional Care Collaborative will involve four one-day Learning Sessions and one closing event to share Lessons Learned and best change strategies. Representatives from each community team are expected to attend all five meetings that are held in the Portland-Salem vicinity.

- ***Action Periods***
  The two to three months between Learning Sessions is called an action period. During action periods, community teams will work toward improvement by first testing and then implementing or making change a permanent part of the way they work. At the same time, they gather data routinely on a small set of measures that will give timely feedback about their improvement efforts. Although each team focuses on its improvement project, they will have access to other teams through conference calls or Webinars.

- ***Spread***
  Ultimately the goal of the Collaborative is not only to improve cross-setting transitions among the community teams, but also to spread the improvements to new health care providers and communities throughout Oregon. To some degree, spread will happen naturally through word of mouth as community teams share their experiences with colleagues and partnering organizations. Spread will also be fostered by documenting successful improvements and disseminating them through stakeholder organizations.

- ***Costs of Participating in the Collaborative***
  The Learning Sessions will be free of charge to community team members, but their organizations are responsible for funding their time out-of-office and travel to and from Collaborative Learning Sessions.

***Charter: Oregon Transitional Care Collaborative***

A Collaborative Charter provides a constant reference point, directing the efforts of the Collaborative, as well as ensuring that all stakeholders understand the mission, goals and expectations from the beginning.

- ***Problem Statements***
  "We saw Mr. Jones in our Emergency Department several times before this admission because of frequent falls at home."

  "We didn't know Mr. Jones' pain medications had been discontinued until he arrived at our facility."

  "When Dad came home from the skilled nursing facility, he didn't understand that the doctor had stopped one of his old medications so he kept taking it."

  "I didn't know Mr. Jones had been in the hospital until his daughter brought him in for an appointment."

  These statements reflect the problems that can arise when a person with complex health care needs transitions from one care setting to another and back to the community.

- ***Mission***
  While a hospital stay may be the starting point for a series of care transitions, improvement efforts need to be targeted across the care continuum, not just to hospitals. Therefore, the aim of this Collaborative is to promote partnerships among local health care providers and community services that ensure quality transitions and enable patients and families to participate more fully in their healthcare, especially when they are leaving the hospital or a skilled nursing facility.

  The Collaborative is funded through a grant from the Administration on Aging (AoA). Participants will be recruited from counties where AoA funds are also being used to develop "Aging and Disability Resource Centers" (ADRC) that have the capacity to deliver a wide range of information and assistance to people living with chronic conditions and/or physical disabilities. Those counties include: Benton, Clatsop, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Yamhill, and Washington.

  Participants in this Collaborative will:
  - Partner with other health care providers in their community to improve coordination, communication and information exchange;
  - Apply best practices within their own facility that can improve transitions; and

- Enable patients and families in their community to participate more fully in their healthcare, especially when they are leaving the hospital or a skilled nursing facility.

By choosing to participate in this Collaborative, community teams can learn about emerging best practices for improving transitions from experts in the field and then determine how to apply them within their community. Their efforts will benefit from shared learning among teams. Some specific change ideas that participants could test include making post-discharge follow-up phone calls to patients; making the SBAR format the preferred communication tool between care providers; making sure patients and providers understand each other through a process called "Teach Back;" or referring patients or their care givers to an ADRC for home-based interventions such as medication reviews.

- ***Collaborative Goals***
  The primary emphasis in this Collaborative is to test changes in cross-setting transitions with a targeted population of patients. Community teams will be asked to select a clinical condition that meet at least three of these four criteria:

  - There are accepted clinical guidelines for managing the condition;
  - There is evidence that good self-management has a positive impact on the condition;
  - There is evidence that early re-integration of patients with their primary care providers can impact medical outcomes; and
  - There are high financial costs associated with frequent or unplanned acute care episodes.

  Some examples of clinical conditions that meet these criteria are congestive heart failure, diabetes with one or more complications, COPD, and palliative or end-of-life care.

  Each team will draft an Aim statement with measurable goals for their target population. Measures will depend on where the partners think they have opportunities for improvement, what changes they wish to put in place, and their ability to collect data for measures. Then they will "test" and implement changes that they believe will help them reach their goals. To measure progress toward their goal, teams will routinely collect and monitor a small set of data monthly for their measures.

- ***Community Team Composition***
  Each community team will consist of staff from hospitals, skilled nursing facilities, home health agencies, primary care practices, community-based long term care settings such as Assisted Living Facilities, and ADRC program sites. Staff who have responsibilities for QA/QI activities, coordinating patient care, patient and staff education, or providing direct patient care are good candidates for team members. Each team also needs to

recruit a patient/family care-giver who can serve as a "patient advisor" to the team. Most important, all team members should be invested in the Collaborative's goals.

Each team is expected to develop a plan for sharing the work of convening partners, developing a work plan, and keeping partners engaged with the required tasks.

- ***Collaborative Expectations***
  The Oregon Transitional Care Collaborative is endorsed by organizations that have a vested interest in the overall quality of healthcare for Oregonians. The Collaborative is guided by a Steering Committee that is expected to:

  - Plan and help implement Collaborative Learning Sessions.
  - Help recruit community teams.
  - Identify and refine indicators that can be used to measure transitions.
  - Offer coaching and technical assistance to community teams as appropriate and feasible.
  - Promote the Collaborative and its work among their organization's constituency.
  - Assist with compiling successful improvements into a "Change Package" for dissemination to a statewide audience.

  Community Teams are expected to:

  - Designate a local convener who can organize and facilitate team meetings.
  - Complete preparation activities before the first learning session.
  - Draft a work plan for their transition improvement project.
  - Ensure that the team is represented at all of the Learning Sessions.
  - Share information with others in the Collaborative including details of changes made and measurement data.
  - Submit a brief written report at the close of the Collaborative that describes their successes, challenges, and lessons learned.

These expectations are summarized in a separate document called a ***Participation Agreement***, which needs to be signed by all facilities participating on a Community Team. The deadline for submitting an Agreement is September 13, 2010.

The first Learning Session is scheduled for the week of September 27. The other four events are tentatively scheduled for early January, late March, late May, and September 2011.

For more guidance on recruiting a Community Team and completing the preparation activities, contact Linda Dreyer, Collaborative Coordinator, at 971-673-0139 or email at Linda.dreyer@state.or.us.