Chapter Two: Taking Time to Plan

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Chapter Overview

With the growth of funding sources, resources, and tools available to communities for care transitions programs, the path to developing or enhancing a local care transitions program is full of opportunities. Taking the time to weigh your options, while taking your target population, partners, community, and resources into account, will be of great value as opportunities for new care transitions partnerships present themselves.

One size does not fit all when it comes to care transitions initiatives and even in the planning phase there are a variety of options and choices to consider. One thing is sure: Developing and implementing a care transitions program will take some upfront investment on the part of all partners involved in the initiative. This chapter contains resources to help plan for care transitions programs on two levels:

- Methods to examine root causes for failed care transitions through a community-wide process
- Strategies to examine how your own organization is equipped to support care transitions

This chapter focuses on assessing your readiness to begin a formalized care transitions program. Additional resources and best practices for building capacity and effectively using existing programs and organizational resources are addressed in Chapter Five: Building Organizational Capacity and Chapter Six: Implementation and Day-to-Day Operations.

Examining Root Causes

A root cause analysis (RCA) is a process for identifying the "root" of the problem in a course of action or procedure, including how, where, and why a problem, adverse event, or trend exists. There are many approaches to developing a holistic RCA, including but not limited

to medical chart reviews, process mapping, and focus groups. Some general considerations include:

- What are the frequency and extent of transitions across settings?
- Where is there a breakdown?
- What is the local impact on consumers and caregivers?
- What services are currently used to support transitions between settings?
- What are the incentives for improving or continuing with the status quo?

An important resource to consider when beginning your RCA is the local Quality Improvement Organization (QIO). QIOs can be well equipped to facilitate the process of examining root causes. They can:

- Help build trust and reliable interfaces among partners, including providers from various health care and community based settings.
- Share data in aggregate and assist in a root cause analysis to help further understand readmission rates and patterns and opportunities for improvement.

Resources

- Care Transitions QIOSC Toolkit: Root Cause Analysis
- AHRQ Patient Safety Primer: Root Cause Analysis
- AoA Care Transitions Webinar: Making the Programmatic Case
  - Slides
  - Transcript
  - Recording

Assessing Your Organization

Any new program requires some basic planning that assesses your local market, environment, community assets, business and financial readiness, and sustainability. These processes are overlapping and will help identify existing infrastructure as well as integrate care transitions within the larger service system in the organization.

Resource

- Taking Inventory—Multiple Perspectives for Planning Chart (PDF)

Key Areas to Examine in an Organizational Assessment

As you collaborate with health care partners to design and implement a care transitions program, examining existing organizational infrastructure can create opportunities for cost savings and efficiency. An organizational assessment can promote integration across other services within your organization and community and provide an opportunity to explore how your organization can be responsive to a variety of providers across care settings. Throughout your organizational assessment, consider the impact any changes will have on any partnerships currently in place or in development for your care transitions program. As you review the following sections and begin to develop questions for your organization to address, be sure to check out the Toolkit's Care Transitions Readiness Assessment Worksheet.

Resource

- Care Transitions Readiness Assessment Worksheet (PDF)

Program Policies, Procedures, and Day-to-Day Operations

Taking stock of your existing policies and protocols will help you evaluate how a care transitions program will fit within your current operating structure. This could include identifying your target audience for your care transitions program. How does this target population compare to the individuals your organization currently serves? While there may be considerable overlap between the two populations, also consider how the populations differ, and how new consumers will be connected to your organization and to your wider network of community based services. Mapping how individuals flow through the system can help you target those critical daily operations and policies that will need to be adjusted for a new care transitions program. For example, do you have an existing policy related to the standard timeframe for responding to referrals? Is it responsive to the needs of hospitalized patients? What are your hours of operation? Do you have capacity to receive referrals on weekends or afterhours? How will hospital referrals be triaged by your organization?

Additionally, current care transitions programs operating within the Aging Network have found it helpful to develop program policies and procedures, including operating manuals for various audiences. These could include:

- Detailed operational procedures for internal use
- Policies and procedures shared with partners and payers
- Information for program participants

Service Management

If you are planning to develop or enhance a formal care transitions program, consider which of your existing programs may help you build the foundation for care transitions. Programs such as the ADRC Options Counseling Standards and Evidence Based Care Transition Programs, CLP, Money Follows the Person, VD-HCBS, Medicaid Waiver and Hospital Discharge Planning Grants, as well as existing OAA services will help with your planning processes. How do current programs and policies within your organization support your plans for care transitions work? What resources can be shared or staff expertise utilized that will contribute to a more seamless process across programs? For example, do you provide a standard service package for individuals transferring to a community based setting under your Money Follows the Person program? How can staffing and departments among current programs be coordinated to accommodate a care transitions program?

The Aging Network has a distinct advantage in developing and implementing care transitions programs that are aligned with existing programs and services. Community planning and convening partnerships have been foundational components for AAAs and ADRCs. Your organization may also have experience developing and monitoring care plans, and arranging transportation, meals, and in-home services and supports. You may offer a variety of options and services that are self directed and make participant involvement the center of service planning. All of these elements will be valuable assets for a care transitions initiative. As you and your partners plan the day-to-day operations of the care transitions

program, you may also assess existing referral processes, client intake, service planning and tools, and address areas for streamlining and maximizing efficiency.

Resource

- South Carolina Hospital Discharge Planning Program Process Enhancements

Assessing Existing Contracting and Procurement Processes

Direct service provision and contracting procedures vary greatly among Aging Network service providers. Some services or programs are provided directly by AAAs or ADRCs, such as information and assistance, options and benefits counseling, and health promotion and education programs. Some services are provided through existing contracts with other aging service providers such as home delivered meals and transportation. As you develop and enhance a care transitions program, it may be important to assess your current contracts and operations to identify any potential barriers to supporting smooth transitions across settings.

Consumer Data and Health Information Technology Systems

If your organization already uses a client data system that provides the ability to track by client and program, it may be helpful to explore using the existing system to follow clients across various care settings. Use of existing information technology data systems will reduce costs associated with development and training and create internal linkages between programs.

Your existing system may already have mechanisms to communicate with outside entities. If these linkages don't exist, consider collaborating with partners to develop mutually beneficial communication protocols and safeguards. Do you have access to a health information exchange or electronic patient health record? The Aging Network has explored a variety of different information technology (IT) strategies to increase opportunities for collaboration with health care partners.

Resource

- Tech4Impact Grantee Profiles

Program Costs and Billing Systems

Aging Network funding sources vary at the state and local levels. The vast majority of AAAs and ADRCs receive the majority of funding in the form of grants or cooperative agreements. A care transitions program has the ability to generate funding from various sources (Medicare, private insurance plans, Medicare Advantage, hospitals, private payers, etc.), but will require standard billing rates and bundled service packages. Do you know what your organization's actual costs are relative to providing certain services? Examining your organization's total costs for providing services, as well as existing billing procedures, will help identify any financial service gaps your organization may need to address. These two figures (total organization costs for providing services and billing rates) may not necessarily be the same and will require some reconciliation to make sure your care transitions program is sustainable.

A common theme across current care transitions programs is the recognition that there are upfront costs associated with preparing an organization for this new program. Additionally, the financial resources required for start up through sustainability will likely depend on the number of individuals accessing services and the scope of services to be provided. As you identify the services and administrative components of your care transitions program, it will be important to track the overall cost of implementation. For example, what are the services and unit rates that you provide under a private pay or the Veterans Direct Home and Community Based Services program? How might these rates be similar or different for assessing your costs under a care transitions program?

Resources

- AoA Care Transitions Webinar: Making the Programmatic Case
  Slides
  Transcript
  Recording
- AoA Care Transitions Webinar: Making the Business Case
  Slides
  Transcript
  Recording

Staffing

During the organizational assessment process, it will be useful to identify and define key staff position(s) and roles and responsibilities within the care transitions program, including individuals responsible for supporting transitions, billing operations, and performance measurement and reporting. Within your internal organization structure, where will the care transitions program reside and who will be responsible at various levels? Have you assessed what skills current staff members have that will be helpful in a new care transitions program?

Staffing a care transitions program may require consideration of factors that may not be part of the existing staffing process within your organization. For example, care transitions support is often time sensitive and the case load frequently changes. Care transitions specialists typically work very closely with consumers and families during the 30 to 90 days of the intervention. Consumers who need additional long-term support beyond the care transitions program are often introduced to a case manager within the organization for additional follow up. If you plan on implementing one or more specific care transitions models, what are the new skills required by the program and what training will be needed by new or existing staff members? Will dedicated staff be assigned exclusively as care transitions specialists? Will the program be built into the existing infrastructure of your case management unit?

Training Policies and Materials

It may be useful to explore using existing training modules to not only orient new care transitions staff to long-term services and supports but also as an educational tool for new partners regarding the resources offered through your organization. Cross-training key staff from partner organizations in your proposed care transitions model increases understanding of the program and enhances opportunities to collaborate. Some care transitions models also suggest providing model training to program supervisors and managers to ensure appropriate support for the care transitions specialists in the field.

AAAs and ADRCs have also applied components of care transitions programs to other internal services offered by the organization. Patient activation and medication reconciliation strategies have been integrated into training modules for information and assistance, options counseling, and case management functions with great success. Who will be the key staff, both within your organization and at key partner organizations, that will be targeted for training?

Resources

- Missouri Hospital Discharge Planning Grant Training Materials: Show Me Options!
- Missouri Course For Hospital Discharge Planners Tool

Continuous Quality Improvement and Performance Measurement

Given the nature of multiple funding sources and performance measures, your care transitions program will require special consideration in the area of quality assurance and performance measurement. Performance measurement refers to a system of tracking progress of the chosen activities in accomplishing specific goals, objectives, and outcomes.[8] Starting with defining your performance outcomes, what is your current capacity to track these items? What information will be needed from partners and hospitals and how will they be communicated? Considering the tools or assessments your organization currently uses, there may be some areas that can easily be streamlined to create efficiencies across programs. For example, if you are engaged in a Community Living Program or other nursing home diversion program, how do you demonstrate participant success for aging in place or diverting spend down to Medicaid? How can these data elements help you demonstrate success in diverting hospitalizations or readmissions? Similar tactics may work with your consumer outreach and education programs such as Senior Medicare Patrol (SMP) or health promotion/disease prevention programs that can demonstrate increased consumer activation for monitoring health and possible red flags that can lead to a preventable hospitalization. By following up and gathering information from participants after the intervention phase you will help demonstrate the impact of the care transitions program on consumer outcomes. Who will do this work, how much time will it take, or how much will it cost?

Formal Partnerships

Formal partnerships with various health care and other key stakeholders will be necessary to plan and implement a care transitions program. Whether you have existing partnerships in place or are starting to develop new partnerships, a formal agreement will be helpful. Formal agreements such as an MOU, business affiliate agreements, and other legal agreements may be appropriate depending on the context of the partnership and are a few of the possible options to explore. Many community based organizations, hospitals, and health care systems are adept at developing such arrangements. As you develop your care transitions program, you will be able to identify various elements to include in formal agreements.

Branding and Community Perception

As you undergo a root cause analysis with community partners, you will begin to identify key drivers within your community that may lead to preventable hospitalizations. An important consideration for this analysis should include the community perception of your organization and your partners. Having a clear understanding of the public awareness of your organization and the public perception of recurring hospital admissions will help you to identify key education messages that will prepare the public for the availability of care transitions support. Engaging consumers in a discussion of the pros and cons of a rehospitalization will inform your efforts to raise public awareness.

Governance Boards

Formal governance structures play an important role in care transitions programs. In order to be eligible for some funding sources, your organization must have sufficient representation of consumer and health care stakeholders (e.g., more than one individual, such as consumers, doctors, hospital staff, pharmacists, home health agencies). Based on your organizational structure, you may or may not have a degree of flexibility that will allow you to structure your own board. If this is the case, examine other options that can serve as the

8 Office of Juvenile Justice and Delinquency Prevention, Understanding Performance Measures. http://www.ojjdp.gov/grantees/pm/understanding.html

formal governance structure for your care transitions program. Does your organization have ties to a nonprofit or associated foundation for fundraising purposes? Have you ever operated with another community based organization in partnership as a fiscal "pass-through" in order to secure funding quickly? Since building a care transitions program will take some time, beginning to address creative solutions to governance structures early on should help you avoid complications later in the implementation process.

Resources

- n4a Board and Advisory Training Manual
- Resources to Develop a Foundation (Presentation from the 2010 n4a Business Academy)

Planning in Action—A Case Study

One thing is certain with developing a new program: It takes time to plan. This is particularly true for care transitions work. The following case study from Carol Woods Retirement Community in Chapel Hill, NC, highlights the planning process through a community-wide approach and features the benefit of seeking initial foundation support for getting started.

We conducted a one-year planning grant where we spent the year asking questions and listening… to statewide and local leaders, advocates, providers, and seniors themselves. The Duke Endowment, which has been a key partner over the years, first provided funding for the planning grant and the support and resources to help us identify the strengths and needs. They understand the urgency to develop innovative, collaborative, community based initiatives to address the critical issues we are discussing today.

In November 2008 we hosted a two-day Community Engagement Planning Meeting. The focus was strengthening the services and supports for older adults and adults with disabilities during times of transitions. There were 87 participants; one-third were consumers (older adults or adults with disabilities) and caregivers.

Participants worked in small groups to map out the current realities related to transitions, identifying what worked, what did not work, and where there was a sense of urgency in the community. The discussions focused on seven objectives related to successful transitions, including:

- Having a Choice of Life Setting/Aging in Place
- Being Engaged with Family and Family Support
- Being Knowledgeable and Educated Consumers About Services
- Being Engaged Mentally, Physically, and Spiritually
- Living Safely in the Community
- Having Accessible and Responsive Care
- Having Appropriate Emergency Room and Hospital Use
- From these seven objectives, the participants identified key action steps that needed to be addressed in each focus area. From that list of 25 actions, participants voted on the top priorities. The top two priorities were:
  1. Patient Advocacy in the Hospital (including at discharge and follow up)
  2. Education/Outreach About Services Available (for consumers and providers)

Community Connections Project
Carol Woods Retirement Community

Questions to Consider and Practical Advice from the Field

Q: How did you begin to gather information?

We looked at Medicare's Hospital Compare website data to see local hospitals' performance ratings and build an argument that the care transitions program can help them come into greater compliance. A selling point or area to start a conversation also includes hospital ratings under the patient satisfaction surveys (HCAHPS). Oregon never had to convince our hospital partner to participate in the Person-Centered Hospital Discharge project. I advised other states who were having difficulty knowing where to start building a case to look at the data on the Hospital Compare website and to be familiar with the HCAHPS questions related to discharge planning. You may want to delete this entirely since I think people are a lot more sophisticated about working with the health care system than they were in 2009. *Oregon Seniors & People with Disabilities, Hospital Discharge Planning Program*

We created two surveys through Survey Monkey early in the planning process: one for discharge planners and the other for community providers. This gave us current discharge planning process information and also gave us a pool of people for our focus groups. *Kansas Department on Aging, Hospital Discharge Planning Program*

Q: What is your general advice for starting the planning process?

You must understand the community's needs collectively and the drivers of readmission for each of the providers individually. Root cause analysis identifies drivers, which may be different for each provider. As a result, interventions may differ across providers. Regardless of the model chosen, the patient should always be in the center of the approach. *Quality Insights (PA QIO) regarding work with Southwestern PA AAA and Westmoreland County AAA from the QIO 9th Scope of Work Care Transitions Theme*

Budget cuts have presented a challenge to this project as they have impacted the resources our coalition partners have been able to bring to the table. To deal with this issue, we have been dedicated to planning our initiative with available resources, and have expressly avoided creating a need for new, expensive resources at this time. This has been particularly true for staffing and IT planning. We have striven to make the most of existing staff by retraining personnel to incorporate options counseling at all levels. As we continue to achieve milestones in implementing the program, we will continue to tweak our workplan and make investments in staff and online databases and other expensive resources. *Missouri Department of Health and Senior Services, Division of Senior and Disability Services, Hospital Discharge Planning Program*

During our strategic planning process a couple of years ago, we saw the need to be more aggressive with nursing home diversion in order to increase our effectiveness of moving the needle and rebalancing long-term care. Since 60 percent of all longer term nursing home stays start with an acute episode from a hospital, it makes sense to start with the source: the people that are leaving a hospital. We determined that it made sense to have a staff presence in hospitals and to help seniors who are in the midst of a major transition of care. We started care transitions by reprioritizing and using existing sources of funding that we already had. We formed a new department that is dedicated to nursing home diversion and transition strategies. And we did this through a reorganization that resulted in eliminating departments and positions and creating new ones. We've removed a layer of management essentially, and we've created self directed teams. We've also reorganized some of our administrative functions that were no longer needed and shifted roles around the organization. All of this resulted in us being able to free up some resources to make an investment in care transitions. We've had to do a lot of education with our care managers about care transitions and about what the roles are, and developing documentation procedures and procedures for

communication, because there is a handoff between the care transitions specialist and a care manager that needs to occur. It was not an easy project by any means. But it was a necessary one for us to be able to do new things with the same or less resources. It was a very disruptive process at first, but we've come through it, and we're starting to see the results of that effort. *Council on Aging of Southwestern Ohio, Cincinnati, OH*

Q : What has been the role of the QIO, hospitals, and others in your planning process?

Our partnership with the QIO has been invaluable. We started a project in northeast Georgia where the AAA provides coaching. QIOs support the quality improvement process and help to put the intervention into place. They support the process of trial and error in project development. They also serve as liaisons to pull the right people together. The QIO played an important role in making introductions and bridging the gap between organizations. The hospital was a little hesitant at first, but the QIO helped us open the door and build the relationships. Another wonderful thing about the partnership is the level of data that can be provided by the QIO. We can measure the percentage of people returning to the community. *Georgia Division for Aging Services, QIO 9th Scope of Work Care Transitions Theme*

Key to the care transitions work in Atlanta has been the care transitions workgroup that was formed about a year ago under the leadership of Piedmont Hospital. This partnership includes major hospitals, the Georgia Hospital Association, home health agencies, home care providers, our QIO, our Quality Improvement Organization—the Georgia Medical Care Foundation, the Area Agency on Aging, and other key aging service providers. We have been getting together for the purpose of bringing together everybody who really has a stake in care transitions for the purpose of sharing best practices, educating ourselves, professionals, and consumers and to promote a common understanding of care transitions for the purpose of establishing a regional approach.

This workgroup has become the driving force sponsoring work sessions, training programs. We've had, in the Atlanta region, some key experts visit, and we sponsor quarterly network meetings that really have provided for a lot of discussion and motivation for many of us to move forward. It certainly has been one of the key factors that made the Atlanta Area Agency on Aging and the Aging Network move forward under the shared goal of safe transitions and preventing the trauma of readmission and making sure that as an Aging Network we are supporting care transitions with the right services at the right time. *Atlanta Regional Commission AAA, Atlanta, GA*

Additional Resources

- NASUAD TASC Planning Zone http://www.nasuad.org/tasc/tasc_index.html
- Understanding a Logic Model http://www.ojjdp.gov/grantees/pm/logic_models_understanding.html

Tools

- Taking Inventory—Multiple Perspectives for Planning (PDF)
- Care Transitions Readiness Assessment Worksheet (PDF)