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Cross-Continuum Improvement Teams

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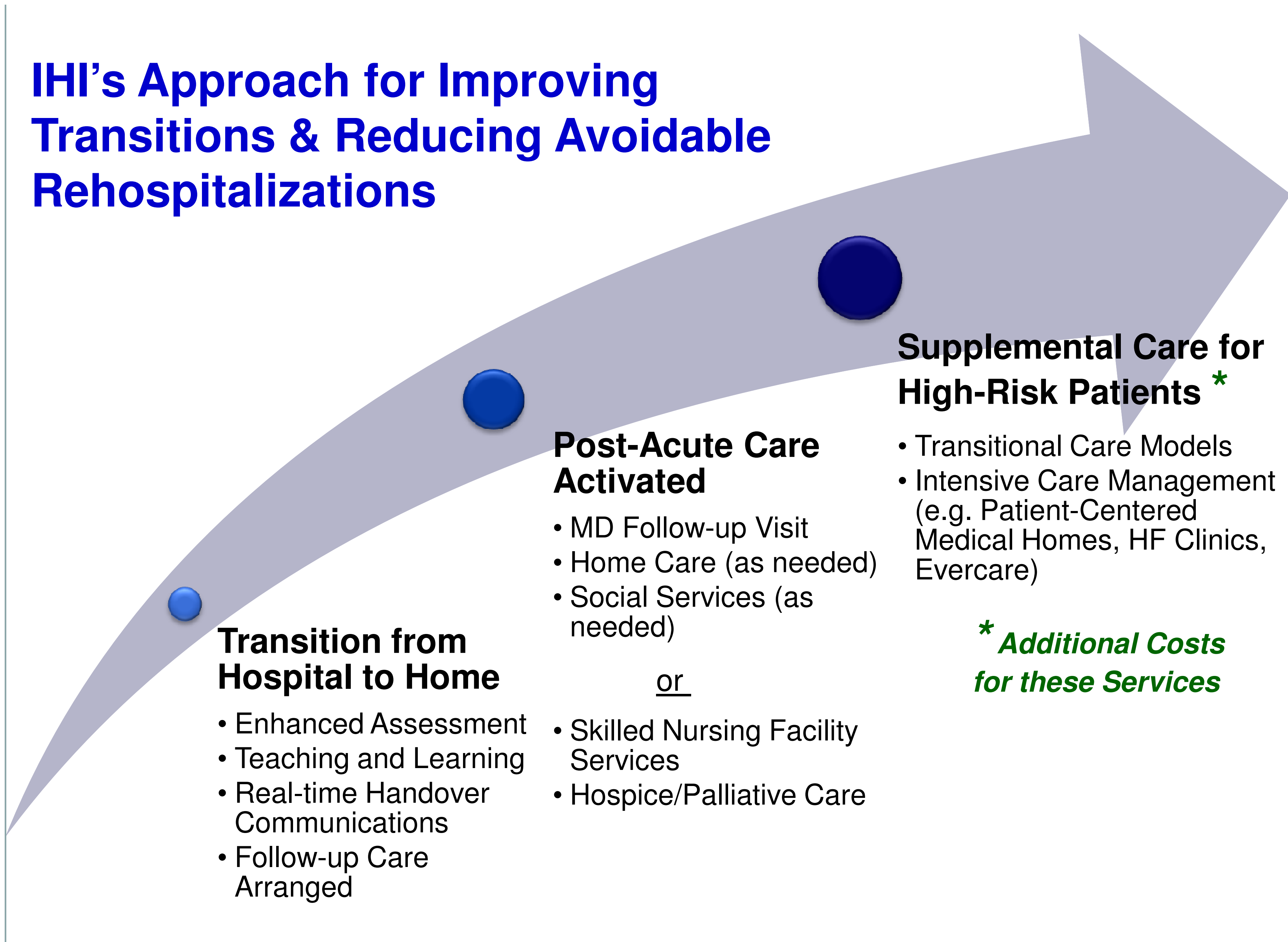
These presenters have nothing to disclose.

Session Objectives

Participants will be able to:

- Describe the role of the Day-to-Day Leaders in structuring and sustaining the work of STAAR.
- Describe the role of the Frontline Improvement Team in structure and sustain the work of STAAR.
- Describe the role of the Cross-Continuum Project Team in structure and sustain the work of STAAR.
- Identify key activities tied to successful redesign.
- List the 3 things to do when you get back to work.



In the Hospital

In the Community

Improved Transitions after an Acute-care Hospitalization for all Patients

Hospitals

Ambulatory Care Clinics

Home

Skilled Nursing Facilities

Home Care & Community Services

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Improved Transitions from SNFs to Home

Hospitals

Ambulatory Care Clinics

Home

Skilled Nursing Facilities

Home Care &
Community Services

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Key Changes to Achieve an Ideal Transition from Hospital (or SNF) to Home

1. Perform an Enhanced Assessment of Post-Hospital Needs
2. Provide Effective Teaching and Facilitate Learning
3. Provide Real-Time Handover Communications
4. Ensure Post-Hospital Care Follow-Up

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Completing the Transition into Care Settings within the Community

Office Practices	Home Care	Skilled Nursing Facilities
• Provide timely access • Reconcile meds and plan of care • Coordinate care with other community clinicians	• Reconcile meds • Reinforce self-care plan • Communicate as indicated with primary care provider and specialists	• Assure staff are capable to care for patient's needs • Reconcile meds and plan of care • Provide timely consultation when patient's condition changes

Vision for Cross-Continuum Teams

Understanding mutual interdependencies, the hospital-based teams co-design care processes with their cross-continuum care partners and collaborate to solve problems to improve the transition out of the hospital and reception into community settings of care.

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Cross-Continuum Improvement Teams

Multi-stakeholder team (e.g., staff in the hospital, skilled nursing, home health care and office practices, and patients and family members):

- Provides oversight and guidance and help connect hospital improvement efforts with those of partnering organizations within the community
  - Identify improvement opportunities
  - Facilitate learning across care settings
  - Facilitate collaboration to test and implement changes
- Provides oversight for the initial pilot unit work and to establish a dissemination strategy

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Cross-Continuum Improvement Teams

- One of the most transformational changes in the STAAR Collaborative – some have called the formation of CCTs the "STAAR Effect"
- Reinforces that readmissions are not solely a hospital problem
- Need for involvement at two levels:
  1) at the executive level to remove barriers and develop overall strategies for ensuring care coordination
  2) at the front-lines -- power of "senders" and "receivers" co-redesigning processes to improve transitions of care
- New competencies in partnering across care settings will be a great foundation integrated care delivery models (e.g. bundled payment models, ACOs)

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Quotes from STAAR Collaborative Teams

"It is a lot of work to establish this team, but it is worth it."

"The conversations change when everyone is at the table. It feels good to have us all in the room with the patient at the center of our work."

"Even if we haven't moved the numbers, we have moved the mindset."

"Staff at different sites of care pick up the phone, where they didn't before."

"We make more referrals to home care as a result of the improved communications."

"The cross-continuum team will last beyond STAAR. All future initiatives will benefit from the open communications and less silo-ed care."

"We are making great strides in opening the communication of patient care between our diversified organizations. It is truly encouraging after 40+ years in health care to see this transformation."

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General Recommendations for CCTs

- Meet regularly to facilitate bi-directional communications and collaboration, assess progress, remove barriers to progress and support the improvement of the front-line teams in all clinical settings
- Have members from the cross-continuum team visit each other's sites (including accompanying a nurse on a home visit) to observe patient care processes during transitions
- Complete periodic diagnostic reviews of patients that have been readmitted
- Add patients and family members to the cross-continuum team to enhance the focus on the patient's experience and to harvest their suggestions for improving care processes.

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CCT's Role in Performing an Enhanced Assessment of Post-Hospital Needs

- On admission, how can hospital clinicians and staff get timely and relevant information from community providers (e.g. medication lists, comprehensive care plans, insights about the patient's ability to provide self-care, advanced directives)
- Other emerging best practices?

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CCT's Role in Providing Effective Teaching and Facilitating Learning

- Develop and utilize universal patient-friendly education materials for common clinical conditions in all health care settings in a community
- Ensure that all health care providers in the community are competent in effectively teaching and facilitating learning for patients and family caregivers utilizing health literacy principles
- Other emerging best practices?

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CCT's Role in Providing Real-Time Handover Communications

- Hospital team members and community providers co-design real-time handover communications (including preferred format, mode of communication and specific information about the patient's status)
- Consider adopting a universal format for patient care plans (with information about medications, diet, treatments, signs and symptoms that require medical attention and plans for follow-up)
- Other emerging best practices?

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CCT's Role in Ensuring Post-Hospital Care Follow-Up

- Decide upon who is the best clinical provider (from the patient's perspective) to complete follow-up phone calls
- Collaborate with payers and post-acute care providers to determine eligibility for intensive care management and best clinical provider for various patient populations (Care Transitions Intervention, APN Transitional Care, HF Clinic, Patient-Centered Medical Home, Evercare, etc.)
- Other emerging best practices?

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