Collaborating to Make Communities Healthier: A Case Study in Community Coalitions

Institute for Healthcare Improvement
National Forum 2017

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LifePoint Health
“Making Communities Healthier”

- Founded in 1999
- More than $6.5 billion in revenues
- Fortune 500 (#374)
- 71 hospitals in 22 states
- More than 43,000 employees
- More than 5,300 physician relationships
- Leading healthcare provider in our communities
- Focused patient engagement and physician engagement models
- Committed to keeping healthcare local
- Proven partnership strategies
- Only investor-owned company awarded HEN 1.0 and 2.0 contracts from CMS; top performer in enhancing patient safety
**Culture that Supports Safety & Learning**
- Environment that fosters speaking up & patient advocacy
- Engaging patients & their families

**Process Improvement Methods**
- Foundational tools
- Multidisciplinary team collaboration
- Evidence based clinical processes

**Leadership**
- Every level of the organization
- Accountability that is fair & expected
- Engagement of all stakeholders

**Patient & Family Engagement**
- At Moment of Care: Bedside Shift Report
- In Process Improvement: Initiatives Around Patient Safety and Patient Experience
- In Governance: Patient on Hospital Board or Patient Advisory Council

**LP HEN Reliable Framework**
Inpatient Harms at Baseline Performance (HEN Harm Roll Up)

Lifepoint Harm Rate for Preventable Harms

- 2010 Baseline
- HEN Goal (40% Reduction)
- Preventable Harms 2011

Rate of Preventable Harms per 1000 Inpatient Days

LifePoint HEALTH
Inpatient Harms Reduced and Sustained Across Enterprise (HEN Harm Roll Up)

Lifepoint Harm Rate for Preventable Harms

Preventable Harms  2010 Baseline  HEN Goal (40% Reduction)

57% reduction September 2017 compared to 2010
Continuous, Measurable Improvement in Culture:
Teamwork/Safety Climate Index

30% Statistically-significant improvement 2012 – 2016 (p<0.01)
LifePoint is Taking a National Lead in Establishing Coalitions With Community Resources

• LifePoint is in a privileged position to be the “convener” of resources across the care continuum and throughout the community, in order to address difficult problems:
  ▪ Readmissions and Complex Care Transitions
  ▪ Chronic Disease Management
  ▪ Wellness and Prevention
  ▪ Primary Care Access and Affordability
  ▪ Patient and Family Social Determinants of Health

• To address these challenges, LifePoint has taken a leadership position in creating Community Coalitions – collaborative efforts between LifePoint and a wide range of disparate community agencies and resources.
The Selma, Alabama Story
Community Coalition START UP – Alabama Black Belt Region
Alabama Black Belt Region

- Refers to the region's rich black topsoil good for farming and agricultural
- Nine out of the 10 poorest counties in Alabama
- Characteristics include low property taxes, high rates of poverty (36.8%) and unemployment (12.9%)
- Challenges include: food insecurity, teenage pregnancy, single parent households, and poor access to healthcare services
- Amazing opportunity for community engagement to improve safety and quality of living

Business Case to Charter a Community Coalition

• Need to decrease the rate of 30-day readmission for improved patient safety, outcomes, and experience
• CMS Readmission Penalty 2013 (1%) – 2017 (0.78%)

Based on the latest CMS data for the Selma community patients:

• 47.8% of the patients were returning within 30 days
• 76% of the readmissions may have been preventable
• 64% received no post-acute care between discharge and readmission
• The process by which patients were moved from hospitals to other care settings was becoming increasingly problematic and fragmented

• Readmission Rate is a visible Quality Work Plan with High Priority
Method and Procedures for Coalition Start-Up

1. Partnered with subject matter experts in the community

2. Identified multiple causes for readmissions
   • Conducted a root cause analysis

3. Identified barriers that existed in the community
   • Access to care-transportation
   • Disease specific education
   • Provider/post acute follow up
   • Medication knowledge deficit or finance
   • Patient/provider knowledge about available resources

4. Plan
   • Made a commitment to work together as a community
Method and Procedures for Coalition Start-Up

5. Collaborated with AQAF for leadership training as a part of the 11th Scope of Work

6. Bridging Care Transitions Coalition President completed the Leadership and Organizing in Action training offered by CMS

7. All Coalition Leaders were invited to participate in a day-long leadership training to enhance their leadership skills, especially as they related to community activation and engagement
<table>
<thead>
<tr>
<th>Community Coalition Contributors/Members</th>
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<tbody>
<tr>
<td>Alabama Quality Assurance Foundation</td>
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<tr>
<td>Vaughan Regional Medical Center</td>
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<td>UAB Family Medicine</td>
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<td>Warren Manor Health and Rehab</td>
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<td>Alabama Tombigbee Area Agency</td>
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<td>Apogee Physicians</td>
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<td>Regency Long Term Acute Care</td>
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<td>Lighthouse Rehab Center</td>
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<td>Selma Dallas County Leadership</td>
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<td>Care Ambulance</td>
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<td>Park Place Nursing and Rehab Comfort</td>
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<td>Care Hospice</td>
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<td>HealthSouth Rehab Hospital</td>
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<td>Kindred Home Health and Hospice</td>
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<td>Alabama Home Care</td>
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<td>Colonial Haven Care and Rehab</td>
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<td>Cahaba for Mental Health</td>
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<td>Amedisys Home Health</td>
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<td>Rural Healthcare</td>
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Method and Procedures for Coalition Start-Up

8. Recruited our hospital staff along with local skilled nursing facilities, physician practices, home health/hospice agencies, assisted living, pharmacies, mental health facilities and churches to establish a charter, governance and membership.


10. Members commit to attending meetings, educational events, share data, use evidence based interventions, and maintain confidentiality.

11. Identified location for the meeting, date and time.

12. Used a standard agenda format and created a code of conduct for meetings.

13. Divided a mixture of liaisons into 3 focus groups.
Aims and Structure of our Coalition

• **Charter the Bridging Care Transitions (BCT)**
  - **GOAL:** Reduce readmission rate 20% by JULY 2019
  - Improve communication & coordination of care
  - Strengthen community-clinical partnerships
  - Engage patient, family, and local healthcare agencies around a central goal of building a healthier community

• **Infrastructure that Supports the Coalition**
  - Vaughan Regional Medical Center took the lead to charter the BCT to focus on the problems surrounding readmissions
  - Workgroup Leads encouraged each facility to standardize methods to track readmission rates & perform analysis on each 30 day readmission
  - Workgroup Leads made an agenda to form rules and regulations for its governance and formed focus groups to tackle the barriers and challenges of readmissions with liaisons from each facility
Community Coalition –
Bridging Care Transition Coalition

Mission Statement

To improve the safety and quality of care for older adults living in Selma and the surrounding region in Alabama by developing and sustaining patient-centered and seamless transitions of care reducing 30-day readmission to the hospital.
Bridging Care Transition Coalition Goals

- Reduce 30 day readmission rate 20% by July 2019
- Reduce adverse drug reactions among our participants July 2019
- Increase the number of nights the patient stays at home after discharge 10% by July 2019
- Improve patient and family engagement in self-care by July 2019
- Implement community level process improvement efforts through root cause analysis and transparency of readmissions by May 2016
- Facilitate the use of evidence based processes among care providers, through dissemination and education of information, best practices and research by March 2016
Bridging Care Transition Coalition
Focus Groups

Board of Directors
Provide oversight and direction to subcommittees

Safe Coordinated Care Group
To implement community level process through root cause analysis and transparency of readmission data

Community Health and Wellness Group
To improve patient and family engagement for self-care

Medication Safety Adherence Group
Reduce adverse drug events among participants
Challenges with Coalition Start-Up

- Personal interests and agendas
- Time and commitment constraints
- Commuting to meeting location
- Other work responsibilities
- Change in leadership and facilities
- Inconsistency in attending meetings
- Lack of follow-through on assignments
- Communication breakdown
- Different sources of data results
Resources that Led to our Success

• Provided 30-day supply of medications through funding award provided by “Blessings in a Box”
• Increased availability of “Doc in the Bus” clinic for patients that do not have primary care
• Improved access to cab rides through expansion of service area and hours of service
• Implemented a screening process in the Vaughan Regional Emergency Department to determine patient eligibility for home health or skilled nursing home placement
• Created a Community Resource Guide for Dallas County
• Increased referrals to the community Rural Health clinic
Vaughan Regional Medical Center 30-Day Readmission Percentage for Hospital-Wide

- LPNT Baseline (2014)
- LPNT Goal

Jan 2016 Coalition First Meeting
Outcomes of our Community Coalition

• **Decline in 30 day readmission rate from 11% - 7.3%**

• Enhanced communication among the community healthcare providers

• Assisted patient with co-pays, self care education, and medication management

• NH/HH conducts an RCAs on patients readmitted to the hospital within 30 days of discharge

• Increase in community agency charity for indigent patients

• Continuous recruiting of other organizations to coalition

• Improved resources for the community to address barriers and challenges of readmissions
Outcomes of our Community Coalition

Doc in the Bus

**List your medications including vitamins and herbs**

Medicines I am ALLERGIC to: ____________________________________________

<table>
<thead>
<tr>
<th>Medicine Name &amp; Dose</th>
<th>When do you take this medicine</th>
<th>Doctor</th>
<th>Why do you take this medicine?</th>
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Blessing in a Box
Outcomes of our Community Coalition

• Resource Sharing - AQAF Campaign
  – Know Your Meds Alabama
  – Standard Medication List

• Nursing homes conducting RCAs for hospital readmission

• “Love Your Loved Ones Enough To Let Them Know Your Wishes”

• SNF/NH and hospital working together

• Community wellness fair

• Living with Heart Failure

• Teaching home care CHF

• Booklet Living with Heart Failure

• Reviewing readmission reasons and prevention

• Medication Administration Pilot

• Readmission armbands
A gentleman who is employed, but uninsured, was frequently re-admitted due to exacerbation of his underlying chronic respiratory condition. He was unable to afford the CPAP breathing machine prescribed to him. The “Blessings in a Box” award bought the CPAP machine for him in June 2016. Since that date, this patient has not been readmitted to the facility for his respiratory condition. As a result of appropriate healthcare and weight loss, he was able to pursue his dream job of assistant coach at one of the local high schools.
Community Coalition Success Stories

• 60 year old AA male was admitted from home with a diagnosis of CVA. Two months prior, the patient was discharged from rehab center from a previous stroke, and still owed the center an outstanding balance. During the current admission, the patient initially believed he had someone at home to care for him; however, upon discharge, the family stated there were no caregivers at home. Returning to the rehab center was problematic given the balance still due to the facility. The hospital asked the family to raise half the funds, hospice provided a free wheelchair, and “Blessing in a Box” paid the remaining balance.

• Blessing in a Box - Patient needing assistance with medication during a complex transition from the hospital. We were able to purchase existing medications through Blessing in a Box for $69.00. The patient also had a new prescription for a medication, the cost of which was $399.00 with a discount price $352.62. We were able to identify and use a trial offer from a pharma company at $0.00 cost. The trial period could be used for a 12-month supply that would be established directly by the patient.
Next Steps & Sustainability

• Include more physicians with local ties to the community
• Add former patients to the committee
• Take the coalition out to the community  
  – Facebook, radio, local news
• Partnering with other resources/support services
• Increase church and local government involvement
• Include local colleges and business
CEO Perspective – Leadership Lessons

There is no final destination on your improvement journey.
Thank you!

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Reflections

If you want something in your life that you've never had, you'll have to do something you've never done.

JD Hudson