Be the Solution: Join a Transitional Care Collaborative

The Transitional Care Collaborative is endorsed by the following organizations:

AARP Oregon State Office

Acumentra Health

CareOregon

Legacy Medical Group, Good Samaritan

Northwest Health Foundation

Oregon Alliance of Senior and Health Services

Oregon Association of Area Agencies on Aging & Disabilities

Oregon Association for Home Care

Oregon Association of Hospitals and Health Systems

Oregon Department of Human Services, Seniors and People with Disabilities

Oregon Health Care Association

Oregon Nurses Association

Oregon Patient Safety Commission

PeaceHealth Gerontology Institute

Portland IPA

The Reality Today

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 people to community services that can support their discharge plan. Below are real testimonials outlining the challenges of today:

- "Mr. Jones was 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 discontinued 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."

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. The goal of this Improvement Collaborative is to promote partnerships among local health care providers and community services that ensure quality transitions and enable patients and their families to participate more fully in their healthcare, especially when they are leaving the hospital or a skilled nursing facility.

Help Find the Solutions

The Transitional Care Collaborative is a time-limited, action-oriented effort throughout 2010-2011. Teams composed of staff from hospitals, skilled nursing facilities, home health agencies, physician practices, community-based long-term care settings, and Area Agencies on Aging will come together with planners and guest faculty in a series of Learning Sessions to learn about emerging best practices for improving care transitions. Teams will also learn about and use an improvement model where they test or "try out" changes before implementing them throughout their settings. At the same time, each team will collect data routinely for measures to help monitor and demonstrate improvement. Community teams will collaborate or share their changes, experiences and data through the Learning Sessions, conference calls, e-letters, etc. When "everyone learns and everyone teaches," improvement is greatly accelerated.

As part of the requirements for participating in the Collaborative, community teams will:

- Select a target population for testing improved cross-setting transitions,
- Draft a work plan for coordinating local improvement activities,
- Share the work of convening community team meetings and staying engaged with the work plan's tasks, and
- Make sure the team is represented at all Collaborative Learning Sessions.

Why You Should Participate: Benefits to You

The Collaborative's Learning Sessions will be ***free of charge*** to participating team members. While we recognize that facilities will incur costs, we believe those costs will be off-set by these benefits:

- ✓ Improved hand-offs between care providers
- ✓ More timely, accurate care plans
- ✓ Reduction in re-admissions and related staff time and administrative costs
- ✓ Improved patient and family satisfaction
- ✓ Better public relations
- ✓ Opportunities to
    - o Expand your facility's expertise with quality improvement methods
    - o Enhance your staffs' professional development
    - o Transfer new knowledge to other conditions or patient populations

Next Steps

The deadline for Team applications is September 13, 2010. For more information and guidance in recruiting a community team, please contact Linda Dreyer, Collaborative Coordinator, at (971) 673-0139 or email at linda.dreyer@state.or.us.