Reaching Rural Residents: Improving Care Transitions in Western New York State

The P² Collaborative of Western New York represents a different spin on the Community-based Care Transitions Program (CCTP) model. It is unique in its focus on a very rural area of Western New York, and is unusual in that it is one of a few community-based organizations in CCTP that is NOT an Area Agency on Aging. P² is a non-profit regional health improvement collaborative, with origins as a Robert Wood Johnson-funded Aligning Forces for Quality community project. Through that work, it has engaged in various activities within eight counties in Western New York.

As Megan Havey, Manager of Care Transitions, explains, “P² doesn’t provide direct services, but acts as a facilitator to members of the collaborative.” The scope of the project really called for coordination by a regionally based group, one that could work with and understand the diversity of partners, and that could offer the sort of infrastructure support that such a collaborative would require.

The collaborative is one of the largest in the CMS CCTP portfolio. It includes eight local community-based organizations (CBOs) and ten hospitals, and works with other community agencies, organizations, and foundations including the Health Foundation for Western & Central New York, IPRO (the QIO), the Alzheimer’s Association, local hospice organizations, and county health departments. The work sprawls across seven counties, with programs that aim to serve more than 2,600 patients annually. The diversity of participating organizations is remarkable, ranging from a 5-bed to a 150-plus-bed hospital.

Over the last six years, many of the participating organizations had participated in pilot programs to improve care transitions. Other groups had little experience, but, Havey says, “…were in a great position to be mentored by groups that had experience.” In building the application, IPRO helped with many tasks, such as creating templates to conduct the required root-cause analysis, analyzing admissions data, and convening partner organizations. Havey says that although IPRO has now “stepped back” from the project, P² continues to solicit IPRO for technical assistance and support.

The application process was instructive, Havey says, in helping the partners to appreciate just how flexible the project would need to be. “Each county had a very different target population and model,” she says. “It was important to be able to engage partners and obtain their buy in, but also to be realistic about what we could achieve in each county. We could not create a cookie cutter model.” All of the local CBOs and hospitals are using the Coleman model, the Care Transitions Intervention™, and are targeting Medicare Fee-For-Service patients.

Havey says that developing a web-based data platform that all partners could use has been an essential step. The platform had to accommodate the range of reporting capacity partners bring to the project. To that end, P² worked with a software company to invest in and develop a platform all hospitals could use to enter data about eligible patients. The system operates within the context of the Care Transitions Intervention, and allows care managers to document data about home and hospital visits, as well as follow-up calls and evaluation information.
Havey notes special challenges in serving a rural population, particularly in terms of accessing care. There are not enough providers, she says, and transportation to get to them can be difficult. “Rural counties have very poor health outcomes, with many medically underserved areas and populations. Our goal is to reduce readmission rates with an intervention that leads to better health outcomes and improves quality of life.”

For more information about the work underway at the P2 Collaborative, contact Havey at MHavey@p2wny.org, or read more about the group’s work at http://www.p2wny.org/

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