Building a Successful Coalition

A Toolkit of Resources

Quality Improvement Organizations
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SUPERIOR HEALTH
Quality Alliance

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Executive Summary

Please use this flowchart as a high-level reference. Superior Health Quality Alliance (Superior Health) has summarized the process for Building a Successful Coalition into the following steps, which are supported by the listed tools.

Step One: Identify Your Opportunity	☐ After deciding to pursue an opportunity for change, identify the stakeholders (actors) who will support/impact your effort by **Mapping Actors, Assets and Power**. ☐ Write your **Organizing Sentence** to clarify your aim.
Step Two: Build Your Foundation	☐ Have **One-to-One Conversations** with your actors to assess motivations, values and resources. ☐ Start your initiative by hosting your Kickoff Meeting using the **Kickoff Meeting Starter Kit**.
Step Three: Develop Your Plan	☐ Using a collaborative approach, create shared leadership through the **Snowflake Structure**. ☐ Uncover potential issues by completing a **Before Action Review**.
Step Four: Implement Your Initiative	☐ Communicate your initiative goals using a **Project Overview Template** which includes roles, timeline, goals and instructions. ☐ Collect your data using **Data Collection Templates**.
Step Five: Sustain Your Progress	☐ Share your progress with intra and extra-coalition stakeholders using a **Project Summary**. ☐ Sustain your progress through collaboratively creating your **Sustainability Plan**.

Introduction

In an increasingly complex health care environment, creative strategies like building community coalitions are recommended to achieve the linked goals of improved health outcomes for patients, and improved communication and coordination for health care and community providers. By approaching complicated issues, like high hospital readmission rates from a broader angle, collaborators can pool resources, develop solutions and implement initiatives together.

The Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization from 2014 to 2019 charged the Lake Superior Quality Innovation Network (Lake Superior QIN) to create and sustain community-based coalitions composed of health care and community-based stakeholders to improve care coordination and health outcomes for their shared patients. Some coalitions had previously worked together, while others convened for the first time.

Lake Superior QIN reformed in 2019 as the Superior Health Quality Alliance (Superior Health). Adapted and updated for CMS' new Community Coalitions for Improving Care initiative, this Toolkit contains the best practices from the coalition work, as well as other health care industry evidence-based sources. This Toolkit is meant to provide your group with the tools and guidance needed to create a grassroots coalition or enhance your current coalition's functioning.

Health care challenges, along with potential focuses for the community-based coalition, are numerous and complex. These concerns range from educating families and caregivers on the importance of end-of-life care to establishing patient transportation systems to and from clinic visits. Highlighted experiences from community-based coalitions are included for context.

What is a Coalition?

A coalition is a group of individuals and/or organizations from a specific community with shared interests, who agree to work together toward a common goal.[1] Goals can be as narrow as obtaining funding for a specific initiative, or as broad as improving the quality of life for their community.[1] Coalition composition, structure, function and longevity vary depending on the scope of the organizations' focus and the complexity of its goal. One size or shape does not fit all, though successful coalitions always include motivated individuals who use proven tools and strategies.

Using the Toolkit

Layout of this Toolkit

This section of the Toolkit provides context and background on the work that inspired and informed the Toolkit.

Steps one through five of the Toolkit are designed to provide guidance to each specific step.

1. **Step Narrative:** Contains instruction, content purpose and timing of when, how and why. When used, this will benefit your coalition endeavor.
2. **Tools Explanation:** An explanation of the tools and key terms used will provide context and enhance understanding.
3. **Coalition Example:** An illustration of how this step was implemented using a successful coalition's experience.
4. **Helpful Hints:** Information is provided that will help your coalition determine if you are on the right track.
5. **Checkpoint Questions:** Checkpoint Questions are included to assist your organization in two ways: first, to confirm the grasp of the concepts/knowledge and second, to encourage reflection before proceeding further. Note, the Checkpoint Questions should be completed after using the tools.

Summary: The Introduction section brings the Toolkit together by providing general, high-level guidance pertinent to successful coalition work, regardless of step or the maturity of the coalition.

Coalition Case Studies and Appendix: To optimize readability and ease of use, we have chosen to reference tools and provide coalition examples within each of the steps. Full coalition case studies from which the examples are drawn are provided starting on page 18.

This Coalition Toolkit is:

- A guide for individuals, community members and stakeholders interested in creating a collaborative, community-based coalition.
- A resource to assist coalitions from inception, through action and into sustainment.
- A collection of experiences, examples and materials from community-based coalition work undertaken in Wisconsin between 2014 and 2019.

Building a Successful Coalition

Superior Health has developed the Building a Successful Coalition toolkit to aid coalition members through the creation of their coalition. Building a Successful Coalition encompasses five steps:

- Step One: Identify Your Opportunity
- Step Two: Build Your Foundation
- Step Three: Develop Your Plan
- Step Four: Implement Your Initiative
- Step Five: Sustain Your Progress

Step One: Identify Your Opportunity

Challenges or opportunities for improvement may present themselves in a variety of forms. Data and inspiration can come from a variety of sources such as the County Health Rankings or collective experience in the field.

As an example, if diabetic patients within your community may benefit from additional resources and education, you may consider hosting Diabetes Self-Management Education and Supports (DSMES) classes throughout your region.

The purpose of this step is two-fold: identify the potential stakeholders who may help address the challenge, and then subsequently, distill from the broader challenge the specific opportunity you see to create change.

Tools

Mapping Actors, Assets and Power (Appendix, page A-1)

An "actor" is anyone who can impact your coalition's mission. A group of actors can collectively achieve more than they would as individuals because of the different assets they bring to an effort, as well as the synergy that emerges from such a public, shared purpose.

This tool allows you (and your leadership team) to visually and thematically map the actors so as to learn about their individual motivation. It is a structured exercise where you are asked to document each actor's home organization, their values, interests and resources.

Organizing Sentence (Appendix, page A-3)

The Organizing Sentence functions as both a Specific, Measurable, Attainable, Realistic, Timely (SMART) goal statement and an aspirational goal statement for your coalition's effort. Completing the Organizing Sentence with your leadership team will help to clarify and establish your priorities and allow you to focus on the opportunity at hand.

Coalition Example

Coalition One has been meeting since 2012. In early 2016, after reviewing community-level data and discussing potential areas of focus, medication safety was identified as a significant driver of community hospital readmissions. After multiple meetings with community experts on medication safety, the coalition implemented a medication bag intervention within the community. The group developed an organizing sentence: "We, the members of the steering committee, are organizing with the other members of the Coalition to deploy 3,000 medication bags to patients

When this tool is completed in a collaborative environment, it provides the basis for building consensus around a targeted goal that all members of the leadership team can support. By reaching a collective agreement on each part of the sentence, you are laying the groundwork for your coalition.

Helpful hints

- When mapping actors, be open-minded and consider an asset-based approach.
- Be as succinct and precise as possible when creating your organizing sentence.
- After achieving consensus on your organizing sentence, treat it as the foundation of your group's work by communicating it to all stakeholders and referring back to it regularly.

in the community in order to reduce adverse drug events and preventable medication-related hospital readmissions by March 2017."

To read more, see page 18 for the full story.

Checkpoint Questions

- ☐ Does your Actors Map feel complete, comprehensive and current?
- ☐ Is your Organizing Sentence clear, succinct and attainable?
- ☐ Do you feel the Organizing Sentence goal can be achieved with the actors mapped?

Step Two: Build Your Foundation

You and your leadership team have a basic understanding of the actors essential to your effort and have created an Organizing Sentence to ground your efforts. Teamwork and collaboration is the underpinning of any successful coalition. Begin by inviting stakeholders to one-to-one meetings to help establish buy-in and to better understand mutual benefits and expectations. During these meetings, map power to develop an understanding of how the relationship may support the opportunity and the Organizing Sentence.

As an example, you may be tasked to assemble a committee to deploy educational opportunities regarding the effects of diet and dysphagia on aspiration pneumonia. Stakeholders might include clinical staff (medical assistants, nurses, speech pathologists), as well as food preparation staff (cooks, dietary aides and dietitians).

The goal of this step is to determine who your key stakeholders are and to establish the roles and expertise each of these stakeholders will contribute.

Tools

One-to-One Conversations (Appendix, page A-4)

One-to-One Conversations is a structured meeting script that facilitates information gathering and relationship building through the following:

1. Attention
2. Interest
3. Exploration
4. Exchange
5. Commitment

These components allow you to understand how individuals support your goal.

Coalition Example

Coalition Two identified aspiration pneumonia as a major contributor to community readmissions in 2014 and focused on improving outcomes for community residents with the diagnosis by creating a Safe Swallowing program. To deploy an effective community intervention that addresses this issue, the coalition determined it needed to include multiple stakeholders throughout the community. Assigning stakeholders defined roles would give the project the best opportunity for success. Staff from the community hospital assumed the lead role for the project, with their dietitians creating educational resources and speech therapists facilitating the training. Community assisted living facility (ALF) staff were invited to the trainings, as

This tool should be used to guide your conversations with specific individuals after you have mapped your actors. Determine which actors (and organizations) are essential to the success of your initiative and invite those actors to your call to action accordingly.

Kickoff Meeting Starter Kit (Appendix, page A-6)

The Kickoff Meeting Starter Kit includes materials which will help guide and document the activities and discussions taking place during your meeting. Included are: Meeting Agenda, Coalition Charter and Sign-in Sheet. It is also imperative to utilize a Data Sharing Agreement to protect the organizations signing it, and ensure that the data is not misused.

A kickoff meeting sets the tone for the initiative and brings your actors and interests together for the official start of the initiative. A kickoff meeting can also be used to reassess or reinvigorate an already established coalition looking to start a new focus.

Helpful hints

- One-to-one conversations can be used at any point in a coalition's journey and are useful to assess actors' initial interests, their status amidst the initiative and in closing.
- It is helpful to create a Welcome Packet for coalition members that join later. It should include copies of the completed documents from the Kickoff Meeting Starter Kit.

ALF staff typically do not have experience in this area and would benefit most from the trainings. The county Aging and Disability Resource Center, the program hub, promoted the program to community organizations. To track the reach of the project, resident and ALF data was collected on the number of staff that received the Safe Swallowing training. Lake Superior QIN assisted with the project management of the initiative and provided data analysis to track the effectiveness the project. The Safe Swallowing program proved very effective in reducing hospital readmissions for community residents with an aspiration pneumonia diagnosis.

To read more, see page 20 for the full case study.

Checkpoint Questions

- ☐ Do you feel your work has laid the foundations for successful working relationships?
- ☐ Have you obtained commitments from your essential actors through your One-to-One Conversations to support your initiative?
- ☐ Has the coalition agreed to roles, norms and goals, documenting them in a charter?

Step Three: Develop Your Plan

Once the stakeholders (or actors) and powers are mapped, it is time to move from organizing to action. The first step in developing your plan is to conduct a Before Action Review (BAR) to address the opportunity and organizing sentence. Much like a science experiment, the coalition should create a hypothesis of the intended results. Measuring results of coalition and intervention effectiveness can be difficult, but designing metrics and SMART goals early on in the process can prove beneficial for the long term.

An example of this is shown in the following scenario. Through educational offerings for providers and other clinical staff on Medicare reimbursement opportunities, a coalition is interested in spreading awareness for the importance of advance care planning (ACP) and palliative care consultations. In order to measure this, the coalition's goal is to see an increase in Medicare claims for the International Classification of Diseases, 10th Revision (ICD-10) codes attributed to ACP and palliative care consultations.

By conducting a BAR, the coalition should establish SMART goals at the completion of this step.

Tools

Snowflake Structure (Appendix, page A-13)

The Snowflake Structure is a model for an interdependent leadership structure. Redrawing your current leadership structure (which could be hierarchal, random, etc.) that maps to the Snowflake Structure allows for effective organization by team, function, etc. and supports interdependency.

Use this tool to guide your transition from your current leadership structure into one that supports effective collaboration through functional interdependency. As a result, new leadership roles

Coalition Example

Using end-of-life data made available by Lake Superior QIN, the Coalition Three determined that educating community providers and beneficiaries on the importance of advance care planning and palliative care, was of utmost importance. The end-of-life data showed diminished use of advance care planning and palliative care consult ICD-10 codes. The group decided to create a community event where a screening of "Being Mortal" was played, and a panel of end-of-life specialists were on hand to educate beneficiaries about the opportunities and resources available to them within the community when experiencing chronic

and opportunities will emerge, subsequently promoting learning, development and capacity building.

BAR (Appendix, page A-15)

The primary goal of the BAR is to make sure everyone is on the same page with regard to intent; is thinking actively about how to affect outcomes; is taking into account past lessons and ideas; and is aware there will be an after action review to reflect on results. The BAR goes beyond the "plan on paper" and asks "What else will it take? What else can we try?"

SMART Goal (Appendix, page A-17)

A goal should be SMART. In order for the coalition to move together as a team, everyone needs to understand the goal and have the opportunity to have input. It is a priority to make SMART goals as often as necessary. While the group should start with an overall goal, realize that there may be specific actions necessary within a plan to get to a goal that needs additional clarity by making a more granular goal.

conditions and end-of-life needs. Through this event, the coalition expected to increase utilization of advance care planning and palliative care services.

To read more, see page 22 for the full case study.

Helpful hints

- Take an inclusive and expansive view when building your Snowflake Structure. Consider any person or entity that may enhance your group's work, and do not be limited by current organizational roles or positions when building the snowflake.
- Take the time to establish agreed-upon communication channels that connect the different segments (and teams) represented on the snowflake.

Checkpoint Questions

- ☐ Does your Snowflake Structure (with people and roles mapped to it) reflect new leadership opportunities for people who have not acted in that role previously?
- ☐ Does your team understand how interdependent leadership increases efficiency and effectiveness of group efforts through division of duties and communication?
- ☐ Did your team address the issues uncovered through your BAR?

Step Four: Implement Your Initiative

Upon completion of establishing goals and metrics, it is finally time to implement your initiative. Utilize Plan, Do, Study, Act (PDSA) cycles to understand the shortcomings, as well as the successes of the coalition activities, as a structured framework to evaluate activities in a systematic way. Often overlooked are the Study and Act phases of the PDSA cycles. As part of the Study, data collection or analyzing existing data is an essential part of successful interventions. Data collection provides insights about the reach, impact and effectiveness of the program or intervention. The data gathered then informs the coalition on whether to adopt, adapt or abandon the program or intervention.

A data collection example could be as simple as tracking how many patients have received a medication disposal bag after picking up a prescription from their pharmacist. The most important take away from this step is to measure some aspect of the intervention that can help address your organizing sentence.

Upon completion of Step 4, you should be able to react to the findings of your data collection, and determine whether the intervention should be adopted, adapted or abandoned.

Tools

Project Overview (Appendix, page A-20)

The Project Overview is a resource used to familiarize new team members or new stakeholders with a project. The Project Overview also assists in maintaining public awareness and education on the coalition and its efforts.

Use this tool to guide and educate your coalition membership and stakeholders through inception, project development and establishment. The Project Overview is meant to be used in

Coalition Example

Coalition Four identified that their community members struggled with medication adherence for a variety of reasons and thus experienced readmissions that may have been preventable. The Coalition determined that a targeted pharmacy-based intervention to improve patient understanding about their medications would help this issue. The Patient Adherence and Competency of Therapy (PACT) program was implemented at a local pharmacy, and the pharmacy team collected data on patients served by the program. Lake Superior QIN analyzed data on a quarterly basis and provided updates to the Coalition. Informed

conjunction with a PDSA cycle. The PDSA cycle is a model for continuous improvement of processes and projects, and helps provide structure through the ongoing development of coalition projects and needs.

Data Collection Template (Appendix, page A-22)

The Data Collection Template is meant to aid in the collection of data and information generated from a project. The template is a simplistic method in which to easily track necessary information that will be analyzed and help inform the Study and Act steps of the PDSA Cycle.

The template is meant to track your project's hypothesis. The template is meant to inform your project and can be as simple or as robust as you desire.

Helpful hints

- Use the process of creating the Project Overview as a group as an opportunity to gauge any areas of concern for participants and address them before official implementation.
- Make data collection simple, have one central collection point, provide support and share regular updates on progress to maintain energy and commitment.

by this ongoing feedback, the pharmacy team continued to refine PACT and the Coalition members increased referrals to PACT.

To read more, see page 24 for the full case study.

Checkpoint Questions

- ☐ Do all participating actors understand and commit to their roles and responsibilities?
- ☐ What measures will you use to evaluate your initiative? Have you determined whether you are measuring structure, process or outcome measures?
- ☐ Who is responsible for collecting the data for the initiative, to whom will the data be reported and how will the aggregate data be reported to group?

Step Five: Sustain Your Progress

Building coalition sustainability is often the most difficult part in the creation of a coalition. As personnel within the coalition fluctuate and organizations rearrange their focuses, it is imperative to continue to monitor membership engagement to ensure the roles established in Step Two continue to be effective within the coalition structure. Sustainability is not a one-time assessment, rather a continuous process. To better ensure sustainability, some coalitions have sought nonprofit status to further establish themselves as a viable entity, as well as to help address funding issues, particularly for hosting events.

Holding a reboot meeting to re-invite people and organizations who may have missed the initial kickoff meeting, or are new to the coalition efforts, helps to create sustainability. These meetings are a great way to reenergize and refocus the coalition around your organizing sentence.

The purpose of this step is two-fold: to reexamine coalition membership, including planning for the future of coalition membership and to establish the coalition for the long-term.

Tools

Project Summary (Appendix, page A-24)

The Project Summary defines the project and speaks to the goals, outcomes and significance of the project. These would include the history/origin of the project, goal/organizing sentence, members involved, actions taken and results to date. The summary is meant to provide a quick snapshot of the project without going into too much granular detail.

Sustainability Action Plan (Appendix, page A-29)

A step that must not be missed is to create a sustainability plan. Sustainability is the act of balancing all parts of your resources and

Coalition Example

In November 2018, Coalition Five's steering committee evaluated the effectiveness of the coalition's efforts for 2019. It asked members for input and determined that the educational offerings continue to address the needs of its members. It was determined however that membership numbers fluctuated throughout the year, and in order to get more consistent attendance, the committee would begin offering continuing education credits, as well as only have offerings on a quarterly basis.

To read more, see page 26 for the full case study.

energy in a way that your product may live on to reach the goal and to create valuable lasting systems in the community. This should be thought about from the beginning. As you take each step, think about the following: Is the action you are creating sustainable? Working through the sustainability template you must think through various areas of opportunities for improvement. Each area must be addressed and the information collected must be built into the plan of the coalition. Consider sending out a survey to membership to gauge the effectiveness of the coalition or to better understand what members are interested in improving.

Helpful hints

Take the long view of the coalition journey and take time to celebrate small wins to maintain energy and positivity. Small wins could include continued commitment from a core cadre of members, or well-attended community events. Coalition work is challenging but worthwhile, and improved working relationships are as valuable an outcome as an intervention or product.

> "Coming together is a beginning. Keeping together is progress. Working together is success!"
>
> —Henry Ford

Checkpoint Questions

- ☐ Does the Project Summary clearly tell the coalition's story and celebrate its wins?
- ☐ Has the coalition revisited the charter and decided whether to maintain membership?
- ☐ Does the Sustainability Plan clearly (and effectively) establish the actors, systems, resources, and other components needed to support the initiative's gains?

Summary

Thank you for devoting the time to reading Building a Successful Coalition Toolkit. We hope you found its content useful in supporting your coalition-related goals and activities. In closing, our team would like to leave you with the following tips:

- Be sure to take the long view and find positives in every focused effort to maintain member engagement. We view coalition success as having three common forms, and it is important to regularly take time to appreciate and acknowledge success in those forms.
  - Awareness: When a coalition meets on a regular schedule and dedicates a part of the meeting to learning, such as featuring speakers from organizations both within and outside the coalition, all coalition members' benefit from an increased awareness of programs, services, resources and priorities within the community.
  - Relationships: Through regular interactions with the same people, coalition members build and enhance their professional relationships with each other, often resulting in an expanded professional problem-solving pool and improved informal referral networks outside of the coalition. Additionally, stronger relationships between members contribute to a more stable, committed coalition.
  - Actions or Initiatives: Coalitions by nature can take actions or implement initiatives with a broader total impact more so than individual people or organizations can. Actions such as hosting educational events or distributing informational fliers, and initiatives such as community-wide ACP goals are resounding successes and should be celebrated.
- Building and sustaining a successful coalition is a challenging but worthwhile endeavor. It is natural to experience ebbs and flows in interest and enthusiasm from your coalition members, particularly if your coalition has been meeting for a long time,
- Fluctuations in coalition energy should not be viewed as negative as long as the members see value in both the coalition itself and in devoting energy to its current focus, which should be regularly evaluated to assure that all members feel committed.

We wish you the best of luck on your journey of building and sustaining a successful coalition. We believe you have the tools and motivation to accomplish this.

Acknowledgments

Lake Superior QIN—now Superior Health's Community Coalitions for Improving Care—team is grateful for the invaluable assistance of its partners in creating and sustaining coalitions across the region. Coalition leaders and members shared their experiences, tools and techniques for the development and deployment of successful coalition practices and projects. We are very grateful for the opportunity to share coalition stories from their inception, through the development of very successful projects.

The Leadership and Organizing in Action (LOA) teams at ReThink Health and the Quality Improvement Network National Coordinating Center and Marshall Ganz of Harvard University were the original creators of several tools featured in this Toolkit, and our team would not have been able to share their valuable content without these original contributions and their permission to share their work (so long as it was properly attributed).

Contact Information

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Find out more at

superiorhealthqa.org

bit.ly/Superior-Health-Community-Coalitions

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Case Study: Coalition One

Coalition One formed in 2012 to convene community health care organizations to improve care outcomes for Medicare beneficiaries who transition among health care settings.

- Coalition membership includes roughly 70 community agencies, with representation from hospitals, skilled nursing facilities, home health agencies, home care agencies, pharmacies, county health agencies and hospices to assure safe transitions between sites for the people in the community.
- Members of the coalition meet on a bi-monthly basis to collaborate with one another, share best practices and to network with their peers and for education sessions on a variety of topics related to care coordination and care transitions.
- Coalition One began working with Lake Superior QIN (now Superior Health Quality Alliance) in 2014 to assist the advancement of coalition priorities and goals. Community Medicare readmission data reports, provided by Lake Superior QIN analysts, help the coalition target patient populations or diagnoses to target for quality improvement initiatives.
- In 2014, the coalition began working to prevent hospital readmissions in the community due to congestive heart failure (CHF). The coalition developed and shared CHF tools and educational resources, and created a data collection form for coalition organizations to track quality improvement activities aimed at their CHF patients. Coalition materials were accessible to members through the creation of a shared Google Drive site. The coalition efforts for the CHF-related work continued through 2015.
- Beginning in late 2015, Coalition One's focus turned to adverse drug events (ADEs) in the community. ADE community data analysis, provided by Lake Superior QIN, showed there was a need to address the issue of medication safety. Given the coalition's strong pharmacy, hospital and skilled nursing representation, reducing ADEs in Dane County was seen as a natural fit for a coalition focus.
- Over the next several coalition meetings, Coalition One began planning a community ADE intervention and formed an ADE workgroup. After leveraging the expertise from multiple coalition members with a pharmacy background, the workgroup decided that an effective intervention to address the issue of medication safety would be to create and distribute medication bags to community patients. These medication bags would be used to safely dispose of excess or expired medications at multiple medication drop sites throughout the county, and thus reducing ADEs. This intervention, "Med Drop," was then introduced to the larger Coalition One group and members were invited to participate.
- Beginning in October of 2016, the Med Drop pilot began and medication bags were distributed to 25

Coalition One (cont'd)

participating coalition members. The number of bags that were distributed by each organization was tracked, as was the amount of medications safely disposed. Local police departments were able to weigh the amount of medications disposed of via the med bags because of the distinct color and label of the bags. The Med Drop pilot concluded in April 2017, with over 50 pounds of medication safely disposed of by the community.

- After the successful Med Drop intervention, the Coalition One began looking for a new focus. To help identify a new target area, in March 2017, Lake Superior QIN helped facilitate a Root Cause Analysis (RCA) and the group held a discussion about the root causes of preventable readmissions and opportunities to improve care for patients in the community. Six areas of opportunities were determined, with the larger coalition group selecting "supportive services" to be pursued as a coalition initiative in September 2017.
- Throughout 2018, the Coalition One steering committee worked to create an effective supportive services resource guide. Through discussions with steering committee members, it was agreed upon that many in the group, even with years of experience in the community, were not fully aware of the local health services available in the community. Such a situation is not unique to the members of the Coalition One steering committee, as health care professionals in general may not be familiar with which services exist within their community. Creating a resource guide, which could act as a one-stop tool health care professionals could use to connect their patients with appropriate services, would alleviate many of these information gaps. The resource guide would provide information and available agencies for community services on five topics: caregiving, home safety, nutrition, medication management and transportation.
- A project overview of the supportive services intervention was created and shared with the larger coalition membership in early 2018. The overview provided information about the intervention as well as defined the roles and responsibilities for organizations that wished to participate. The resource guides would be distributed to clients, patients and customers of participating Coalition One organizations, and the number of guides given out would be tracked. The supportive services intervention was another good example of the Coalition One identifying a community need, and addressing it through thoughtful collaboration by creating a product that benefited nearly every organization in the coalition.
- Coalition One will meet and collaborate on potential community projects going into 2019. The coalition meetings serve as great opportunities to network with community colleagues as well as share and learn best practices. Selecting a new coalition project focus area will be a priority for 2019.

Case Study: Coalition Two

Coalition Two was formed in 2013 after the coalition leadership members attended a workshop sponsored by Lake Superior QIN (now Superior Health Quality Alliance) . The coalition was created to improve the quality of care for more Medicare beneficiaries who transition among health care settings.

- Coalition membership began with one hospital, two home health agencies, three skilled nursing facilities and two managed care organizations.
- Coalition members agreed to collaborate and cooperate to prevent duplication of efforts and resources, to share and exchange data and analytics to drive allocation of resources, to collaborate and encourage efforts and best practices of organizations with shared visions, to promote effective strategies to improve and ensure appropriate transitions of care and to advance policies that further the vision.
- Coalition Two began their partnership with Lake Superior QIN in 2013 to assist the advancement of coalition priorities and goals.
- Coalition Two uses innovative data-driven analysis to identify gaps in community care and services.
- In 2014, aspiration pneumonia was identified as one of the community's key contributors to 30-day hospital readmissions. From November 2013 to March 2014, over half of the patients admitted to the hospital were arriving with an aspiration pneumonia diagnosis. Coalition Two strategized how to address patients with aspiration pneumonia, and began with a pilot of a Safe Swallowing program. The pilot began at a single assisted living facility (ALF) in June 2015. Led by the community hospital's care transition nurses and speech therapist, in-person Safe Swallowing trainings were offered to ALF staff, community members and caregivers with the intent that these newly trained staff could then train their own staff.
- After the success of the Safe Swallowing pilot at a single ALF, the trainings were then expanded to include all ALF staff and community members. Multiple trainings were held from 2015-2016. The quantity of ALF staff receiving the training was tracked, as was the training's effectiveness via survey feedback. Safe Swallowing trainings were offered to the public through September of 2016, but discontinued after that date.
- In 2017, Coalition Two worked to create its own website specific to the topics and work related to the coalition. Previously, information about the coalition was exclusively available on a local aging and disability organization's website. With the creation of the Coalition Two website, the coalition could have a hub of information specific to coalition activities.

Coalition Two (cont'd)

- Also in 2017, Coalition Two began the development of Safe Swallowing training modules. These training modules are intended for use by both health care organizations and community members, and provide valuable information on the following topics: Safe Swallowing training, choking, oral care, recipes and dysphagia diet. All five training modules were completed by various coalition members and placed on the Coalition Two website by the end of 2017.
- Throughout 2018, Coalition Two began looking at another focus for a community project. Ideas such as improving the care transition for patients discharged from a nursing home to home setting and preventable falls were brought to the table. However, the data analysis on these topics showed that there actually was not a community need, as both the results for transitions for patients from the nursing home to home setting and preventable falls showed that Jefferson County was performing well, above the state averages. Identifying gaps in community health services and outcomes can be difficult, especially for a high performing community such as Jefferson County. Going forward into 2019, Coalition Two will continue to strategize and brainstorm to select a new focus area.
- Since its inception in 2013, Coalition Two has maintained strong results in both reducing admissions and readmissions. Per 1,000 Medicare Fee-for-Service beneficiaries, the community has seen consistent positive results in readmissions and steady improvement for admissions. Results for both admissions and readmissions have historically been lower than both state and national averages.
- While Coalition Two has been an effective group that has produced positive outcomes, opportunities to improve still exist. One area for improvement is to attract new community organizations to become consistent members of the coalition. Staff turnover and workload capacity is a constant barrier to this, but this issue will continue to be addressed in the future. Another area for improvement lies within the selection of a coalition project. For high-performing communities, where gaps in care are difficult to identify, this can be all the more difficult. Coalition Two will aim to identify and develop a community focus area going forward into 2019.

Case Study: Coalition Three

Coalition Three began in 2010 with the purpose to improve the continuum of care process as patients transitioned from the acute care setting to a skilled nursing facility (SNF) in a time sensitive manner.

- Coalition membership started with two hospitals, five SNFs and a Family Care Organization and has grown to include three hospitals, hospice and home care agencies, Family Care, medical clinics, Community Based Residential Facilities (CBRFs) and multiple SNFs.
- Coalition members join in a commitment to share best practices, to mentor partners and providers, share data and support analysis and promote implementation of evidence-based interventions.
- In June 2016, Lake Superior QIN (now Superior Health Quality Alliance) met with a skilled nursing facility administrator and influential member of the coalition. The discussion focused on the coalition's history and work around discharge planning and handoffs from hospital to SNF. It was determined that there was a need for more data and a more robust way of tracking data within their community.
- In August 2017, Lake Superior QIN attended the Coalition Three meeting held at one of the community hospitals to present their involvement in the Medicare 11th Scope of Work and provide community-level data. For the latest data through Quarter 4 2016, The community's readmission rate was 16.09 percent. End-Stage Renal Disease (ESRD) readmission rate was 29.91 percent, leading Coalition Three to further examine readmission trends for beneficiaries with ESRD. Lake Superior QIN returned in October to present the ESRD-Specific Report to the group.
- In December 2017, Lake Superior QIN's End of Life Report showed the underutilization of hospice, as well as the cost-savings for conducting palliative care consults, as well as beneficiaries completing advance directives billable by Medicare. At this time the education workgroups determined there was a need to establish educational offerings for both providers and community members on the importance of end of life care planning.
- In 2018, Coalition Three continued to review data provided by Lake Superior QIN to determine opportunities to improve the coordination of care in the area. In April, the Community-Level Report showed the all-cause readmission rate for four rolling quarters from Quarter 3 2017 was 15.16 percent, a reduction of 0.93 percent since the presentation given in August 2017. After the April meeting, members planned to examine the effects behavioral health diagnoses had on readmission rates during the next

Coalition Three (cont'd)

meeting. Lake Superior QIN presented the Behavioral Health Report, showing community beneficiaries with behavioral health diagnoses had a higher rate of readmission as opposed to those beneficiaries without any behavioral health diagnoses.

- Workgroups provided updates at the September 2018 meeting.
  - The Provider Education workgroup postponed the previously planned End of Life Provider event to November 2019.
  - The Community Education workgroup planned to host a screening of "Being Mortal," a documentary about making end-of-life decisions, as part of their event on November 29.
  - The Transportation workgroup decided the need to further the legitimacy of the coalition and establish it as a non-profit. A hospital executive is spearheading the process of obtaining 501c3 status.
  - The Transitions of Care workgroup began piloting SNF Discharge Packets across the region. The discharge packets remain different across the various workgroup organizations, however, the components are the same across the SNFs partaking in this initiative.
- Coalition Three concluded 2018 with the Community Education Group's event "Be Empowered—Health Care Decision Making," on November 29, which included a screening of "Being Mortal."
- In 2019, Coalition Three planned to continue to implement and test the effectiveness of their SNF discharge paperwork pilot. They are also planning to hold a provider education event focused on the importance of advance care planning and palliative care consultations.

Case Study: Coalition Four

As a result of attending a conference hosted by the Administration for Community Living in late 2011 focused on the importance of care transitions in the community, the quality coordinator at the local aging and disability organization introduced the idea for a Coalition to her colleagues from a community Health System and other community providers. The Coalition would address community-wide challenges with care transitions and preventable readmissions.

- Coalition Four was formed in November 2011 and established and signed their first charter in January of 2012, which they revisit and update every three years.
- The Coalition Four Vision: The transition of health care consumers between health care settings and practitioners in the community will be well-coordinated between all institutions, practitioners, and community service organizations with the patient, family, and caregiver as the center of care.
- The Coalition Four Purpose: to promote effective systems for transitions of care, to promote inclusion of the patient and family voice, to encourage person-centered and person-directed models of care, to collaborate and encourage efforts and best practices of health and human service organizations which share the vision, and to advocate for public policies that further the vision of the Coalition.
- Using the Social Network analysis in the 10th SOW and again in 2017, the Coalition identified facilities in the community with high patient throughput that would best serve Coalition Four goals.
- The membership of the Coalition currently includes two hospitals, one hospice, one aging and disability organization, four skilled nursing facilities (SNFs), two home health agencies (HHAs), one pharmacy, two personal care agencies, and one citizen member.
- Coalition Four included: Steering Committee (meetings in the even months of the year, Advance Care Planning Workgroup (meetings in the odd months of the year), Heading Home Workgroup (meetings in the odd months of the year), Nursing Home Workgroup (meetings in the even months of the year), Facilitator, and Lake Superior QIN (now Superior Health Quality Alliance) and part of the Data Workgroup (meetings in the odd months of the year).
- Only clinical and quality representatives from organizations and facilities sit on the Steering Committee. Marketing and business development representatives may join the Workgroups.
- Coalition Four committed to maintaining stable, bounded Coalition membership and endeavors to keep all of its organizations represented on the Steering Committee by actively recruited new representatives in times of turnover.
- Coalition Four committed to use data continuously to inform and drive their decision-making and monitor their progress.

Coalition Four (cont'd)

- The group built and maintained organizational and individual relationships through shared commitment to the same regularly revisited and agreed-upon goals.
- When the Coalition Four charter was first developed, it was decided that the coalition would make it a priority to support and share evidence-based interventions to support successful transitions of care throughout the community and reduce preventable hospitalizations.
- To promote spread and impact across the community, Coalition Four also would advance interventions through focused Workgroup efforts and shared progress on current interventions at and between Steering Committee meetings.
- One of the coalition's main actions was to support workgroups that systematically grouped similar providers to allow focus on targeted topics. The Heading Home Workgroup holds educational sessions and problem-solves with providers from across the county involved in the transition to home process; the Nursing Home Workgroup tracks follow-up calls made to discharged patients, and the Advance Care Planning Workgroup provides education sessions to facilities' staff and groups across the community, using a toolkit they developed for completing Advance Care Directives.
- Coalition Four's other primary action was to implement and measure interventions. Three of the interventions with the strongest results are the Patient Adherence and Competency of Therapy intervention from a community pharmacy, Meals on Wheels and the Options Counseling intervention.
- Coalition Four regularly checks its overall progress toward its multiple goals. Its major successes include maintaining a largely stable organizational membership since November 2011 despite turnover at individual facilities; consistently positive relative improvement rates or reductions in admissions and readmissions per 1,000 Medicare Fee-For-Service (FFS) beneficiaries living in the community; and multiple interventions showing statistically significant results related to reducing admission and readmissions for enrolled patients.

Case Study: Coalition Five

Coalition Five started in 2011 to improve care coordination and education for health providers and partners in the community.

- Health care and non-health care organizations including skilled nursing facilities (SNFs), hospitals, home health agencies, community health providers, and local aging resource centers are invited for education sessions every other month. These training opportunities include topics such as health care literacy, models of transitions of care and more. Several organizations participate in monthly steering committee meetings to plan the group's direction and activities.
- In December 2015 the Coalition Five reassessed the group's goals of implementing a measurable intervention to positively impact the residents of their community. Coalition Five selected a theme to guide their work in 2016; Staying Healthy in the Community While Staying Out of the Hospital.
- A root cause analysis was facilitated in February 2016 to better understand factors contributing to readmissions in the community. Multiple areas of focus were explored, including insurance barriers, socioeconomic, environmental factors, etc. Engagement and empowerment for patients with chronic conditions was selected as the focus area.
- The s Coalition Five steering committee reviewed a detailed admissions and readmissions data report for Medicare Fee for Service beneficiaries in their community in March 2016. Through the analysis of the data the team agreed that diabetes and related conditions were the top four of ten diagnoses for readmissions. The group selected diabetes as a chronic condition to create a patient empowerment tool. The Diabetes Instruction & Empowerment Tool (DIET) was created by the steering committee and piloted at a local SNF.
- In 2017, Coalition Five set forth its goal to address advanced care planning. With the help of a consultant from a statewide organization that promotes end of life issues, and data provided by Lake Superior QIN (now Superior HealthQuality Alliance) on the utilization of palliative care consultation and advance care planning, this was deemed an important project. Lake Superior QIN provided end-of-life data report, in addition to a panel discussion during the July 2017 coalition meeting. Panelists included a nurse, social worker, chaplain and an aging and disability organization. The panel shared anecdotal stories of where things went wrong in end of life scenarios and what could have gone differently if palliative care and advance care planning (ACP) occurred. The group decided they would train and organize facilitators to serve the community, create and sustain an ACP referral process, and to coordinate outreach and community education.
- Coalition Five continued their work to improve health care coordination and began 2018 with a mental health panel with presenters from community agencies from throughout the county, as well as updates

Coalition Five (cont'd)

from a SNF's use of the DIET tool. The DIET tool had an effective deployment at the SNF, as patients admitted there that received the tool had fewer admissions and readmissions per patient over a six month period, 1.27 and 0.27 respectively, than those patients admitted to the SNF that did not receive the tool, 1.73 and 0.73 respectively. The coalition also discussed an advanced care planning and palliative care pilot with a community hospital under the direction of a palliative care doctor. The May 2018 meeting showcased what hospital systems in the community were working on to address readmissions.

- By the end of summer 2018, the coalition determined community-based advanced care planning efforts should educate not only the community, but also providers.
- Quarter 3 2018 brought some rearrangement in Coalition Five leadership as the leader and facilitator moved on to a new job at another local public health department. To help the leader with the logistics of the large coalition meetings, a transition nurse from a community hospital had joined as a co-facilitator of Coalition Five.
- Coalition Five prepared for 2019 with reorganizing the frequency of coalition meetings and determined the focus to be on social determinants of health. Large coalition members will see presentations on suicide prevention and mental health, health literacy, housing and trauma.

Appendix Table of Contents

The following resources have been included in this Toolkit in order to make your coalition development successful. Each tool aligns with one of the five steps.

Tool 5: Mapping Actors, Assets And Power

Mapping Actors, Assets, And Power And Developing A Relational Strategy

Mapping actors allows us to see the values, interests, resources, and power that each group brings to the table to achieve the coalition's shared purpose and understand the potential range of directions for change. We use this approach to develop and implement a relational strategy to build collective leadership capacity and enlist stakeholders' commitments to our coalition's shared purpose.

Work individually or with your team to create a visual representation of your actors and their values, interests, resources, and power. Your can start mapping at any time, but it is important to periodically "re-map" as you continue to build relationships and engage new networks.

Set-Up To Map Actors, Values, Interests, Resources, And Power

If you are working individually, use the template on the next page to first map actors, then list the values, interests, and resources that each brings to bear.

If you are mapping actors with your team, consider using a more visually-effective technique. Use a 2'x3' piece of paper (or tape four of them together to create a 4'x6' map). Adhere the paper to a wall or easel. Sketch the template on the following page. As you map actors, use different-colored markers to code the names of people in your leadership team, constituency, supporters, competition, and opposition. When you brainstorm their values, interests, and resources, use different-colored sticky notes for each of these three categories. Place the sticky notes next to the name of the relevant actor.

Map Actors

What are their individual names? What organizations do they work in? What other community groups do they participate in? Where do they live? Some actors may belong in more than one category.

Map Values

Now consider the choices that various stakeholders make. What does that tell you about their values as individuals, groups, and organizations? List these values next to their names.

Map Interests

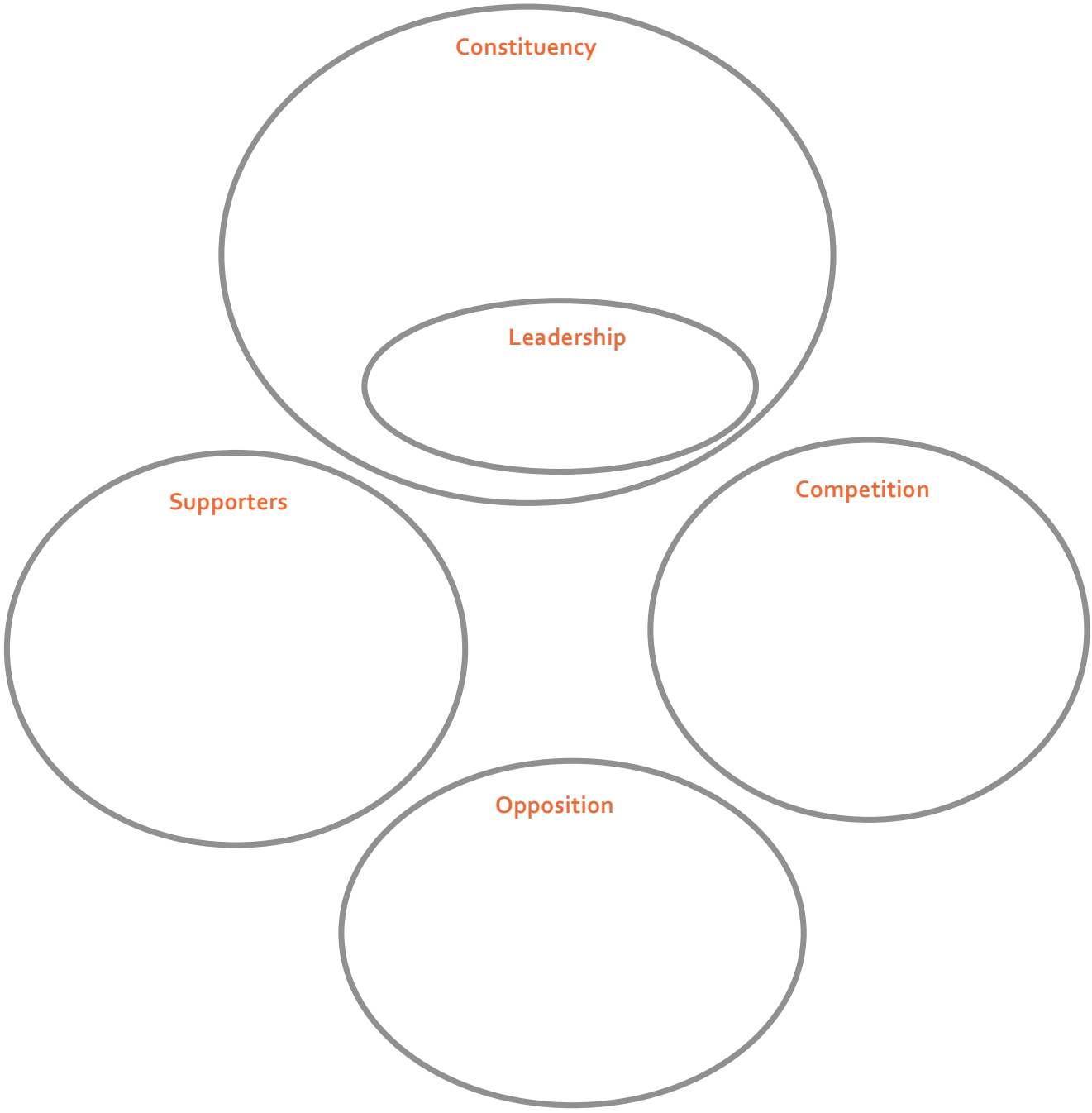
Next, brainstorm stakeholders' interests. Put yourself in their shoes. Remember that the same stakeholder may be operating on the basis of conflicting interests. In particular, consider stakeholders' interests in the work of the coalition.

Originally adapted from the works of Marshall Ganz, Harvard University; modified by Kate B. Hilton, ReThink Health

Map Resources

To what specific resources does each stakeholder have unique access – directly or indirectly? What decision-making power do they have? What networks can they bring with them? Over whom can they exercise influence?

Template for Mapping Actors, Values, Interests, and Resources



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Organizing Sentence

Directions

Gather your team and define the key areas listed below to create your organizing sentence.

- **We are organizing (state all organization names)** _____
  (Who: constituency)
- **To** _____
  (What: measurable aim)
- **By**_____
  (How: turning resources into tactics)
- **In order to** _____
  (Why: motivating vision)

Organizing Sentence Example

> **We are organizing** key stakeholders—MetaStar, Holy Family Memorial and Wisconsin Institute for Healthy Aging—into a collaborative diabetes self-management education and support committee, **to** provide unified, ongoing support to patients in eastern Wisconsin who have concerns about or have diabetes, **by** building a referral process, sharing updates and information, **in order to** support clinicians as they reduce disparities in diabetes for their patients.

The above organizing sentence is intentionally long so you can include all details allowing for complete transparency and understanding for all teammates. Remember, all teammates may come from different cultures and vocational backgrounds as well as different learning styles.

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Tool 4: One-to-One Meeting

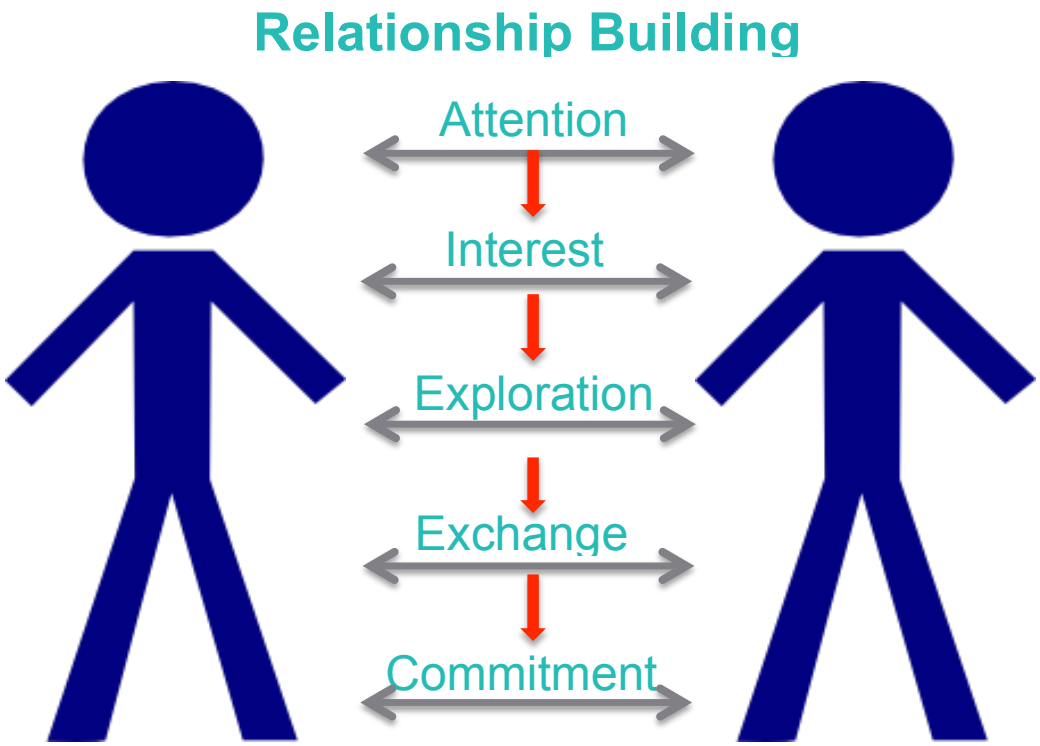
Practice Relationship Building

We build relationships with potential collaborators to explore values, learn about resources, discern common purpose, and find others with whom leadership responsibility can be shared. We need to invest significant time and intentionality into building the relationships that generate commitment to each other and our shared purpose. The more that volunteers or members find purpose in the intentional community we build, the more they will commit resources toward our shared purpose. Commitment is one of our greatest resources in organizing.

The one-to-one meeting is an effective technique for initiating relationships. This five-step method for relationship building has been developed and refined by organizers over many years. Use the guide below to practice the one-to-one meeting with a partner.

Worksheet: The One-To-One Meeting (15 minutes)

Choose a partner who you do not know well. One of you will initiate a 15-minute one-to-one meeting with the other. If you are the instigator, you may want to take a few minutes to think through and write down notes about your interest, purpose, and the specific "ask" before starting the activity. During the one-to one, be sure to move through all five steps shown in the graphic below:



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Step #1 – Get The Person's Attention. In this exercise you have already gotten their attention by asking the other person to be your partner. Check to make sure that the person has 15 minutes for the meeting so you are clear from the start on when you need to end.

Step #2 – Describe Your Interest And Purpose. Be clear and straightforward when stating your reason for the meeting. For example, "I am working on a project to improve the health of our community by involving stakeholders to work together in new ways. I want to learn more about your interests; tell you about our efforts; and see if you want to get involved in some way."

Step #3 – Elicit And Explore. Most of the one-to-one is devoted to exploration to learn about the other person's values, interests, skills, and resources. Ask probing questions and listen deeply to get to choice points and specific experiences that shaped the other person's life. Listen carefully for the motivations and the resources she or he might bring (particular leadership skills, network, etc.). Once you hear your partner's story, briefly share your story of self – where you came from, what drives you, and what motivates you to participate in this work. Be specific – avoid talking about issues in an abstract way. Use the questions below to guide your exploration:

- **Story:** What in your life brought you here today? What made you care about this? How did you learn these values? From whom?
- **Hope:** What is your vision of how things could be different? What motivates you to act?
- **Challenge:** What keeps you from action? What do you fear? What would you want to learn?
- **Leadership resources:** What skills do you bring to this work? How would you describe your leadership style?

Step #4 – Make An Exchange. As you listen, take mental notes about what you are discovering and think strategically about possible exchanges of resources – it may not be the same exchange that you originally imagined. Also, identify the exchanges happening during the meeting such as information, support, appreciation, challenge, and insight.

Step #5 – Seek A Commitment. Make a specific "ask" of your partner. Put a date and time on it as a way to secure the commitment. If the person does not want to get involved directly, will he or she introduce you to others? Look for ways where you might find points of synergy and seek a commitment to those particular follow-up steps.

By the end of your one-to-one meeting, be sure you can answer the following:

1. What does this person **value**? What is her history of acting on her values?
2. What **interests** does this person have? How can the coalition support his interests?
3. What **skills** and **resources** do does she bring to this work?
4. When will we **meet again** and/or **what will we do next** to take action and continue building this relationship?

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Kickoff Meeting Starter Kit

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Coalition Charter

Sample - Mission

The mission of the Transition of Care (TOC) Steering Committee is to improve the quality of care for Medicare beneficiaries who transition among health care settings. This committee will work together to enhance care coordination for successful healthcare transitions across the State of Wisconsin. Committee members will identify the needs of all stakeholder, collaborate on efforts to meet these needs and work to prevent the duplication of efforts**. The Committee is committed to the Centers for Medicare & Medicaid Services (CMS) *Partnership for Patients* goal to reduce 30 day readmission rates by 20 percent over three years.**

Your Community Mission:

_____

_____

_____

_____

_____

Sample - Vision

The TOC Steering Committee envisions the transition of patients/clients/residents between health care settings and practitioners throughout Wisconsin will be well coordinated between all institutions, practitioners, and community service organizations with the patient and caregiver as the center of care.

Your Community Vision:

_____

_____

_____

_____

_____

Sample - Purpose

- To collaborate and cooperate to prevent duplication of effort and resources
- To share and exchange data and analytics to drive the allocation of resources
- To collaborate and encourage efforts and best practices of organizations with shared visions
- To promote effective strategies to improve and ensure appropriate transitions of care
- To advance policies that further the vision

Your Community Purpose:

Sample - Coalition Participant Responsibilities

Collaboration

Participation in the TOC Steering Committee is comprised of organizations and individuals interested in fostering the vision by actively engaging in the planning and work of the Committee. This collaborative effort includes a commitment as partners in the State of Wisconsin to share best practices, knowledge, and findings from ongoing monitoring of readmission drivers and to promote implementation of evidence-based interventions to improve transitions of care and decrease avoidable readmissions.

Your Community Coalition Participant Responsibilities:

Sample - Meeting Attendance

Committee members agree to actively participate and attend in person committee meetings.

Ad Hoc Committees may be formed at the discretion of the committee members.

Your Community Meeting Attendance:

Sample- Meetings

Meetings of the Committee shall be held monthly for 2012 and may be changed as found appropriate by the committee.

Your Community Meetings:

Sample - Conflicts

No one may profit financially from membership in the Committee by sales or solicitation at meetings or workshops. Participants will disclose any actual or potential conflicts of interest to the Committee membership.

Your Community Conflicts:

Sample - Decision Making

In the spirit of the Committee vision, all TOC Steering Committee business shall be conducted based on the philosophy of mutual respect. Simple majority rules will apply. Committee participants are entitled to one vote per member.

Your Community Decision Making:

Sample - Voting

Voting on the business of the Committee may be conducted by those in attendance at the meeting. Proxy voting via email is permissible.

Your Community Voting

Sample - COMMUNITY Partnership Agreement Authorization

By my signature, I agree to be an active member of the TOC Steering Committee and agree to the responsibilities outlined in this Agreement.

Your Community Partnership Agreement Authorization:

SIGNATURE	ORGANIZATION

AGENDA

INSERT MEETING NAME

Location

Insert Date – Insert Time

I. SUBJECT HEADING

II. SUBJECT HEADING

A. **Subject Sub-Heading**

B. **Subject Sub-Heading**
1. **Subject Sub-Heading**
2. **Subject Sub-Heading**
3. **Subject Sub-Heading**

C. **Subject Sub-Heading**
1. **Subject Sub-Heading**
2. **Subject Sub-Heading**
   a. **Subject Sub-Heading**
   b. **Subject Sub-Heading**

III. SUBJECT HEADING

IV. NEXT MEETING DATE

V. ADJOURN

Coalition Name – Sign-in Sheet

Location
Date

Name	Company	Role	Email	Phone Number

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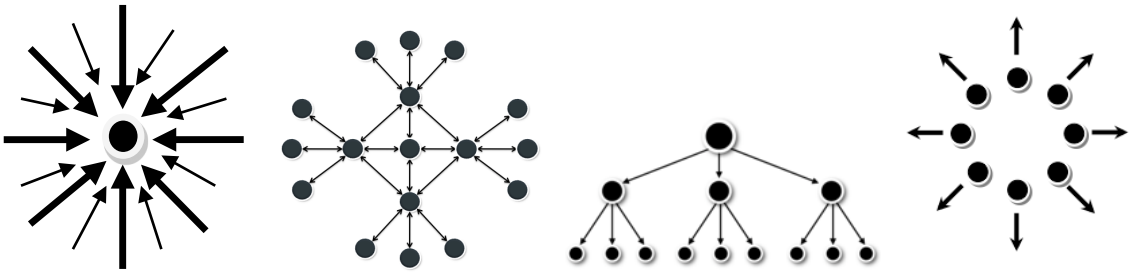
Tool 9: Snowflake Structure

The purpose of this exercise is to develop a more interdependent leadership structure on your team or coalition.

Step 1: Draw your team or coalition's existing leadership structure in the space below. You may draw on or combine multiple structures.



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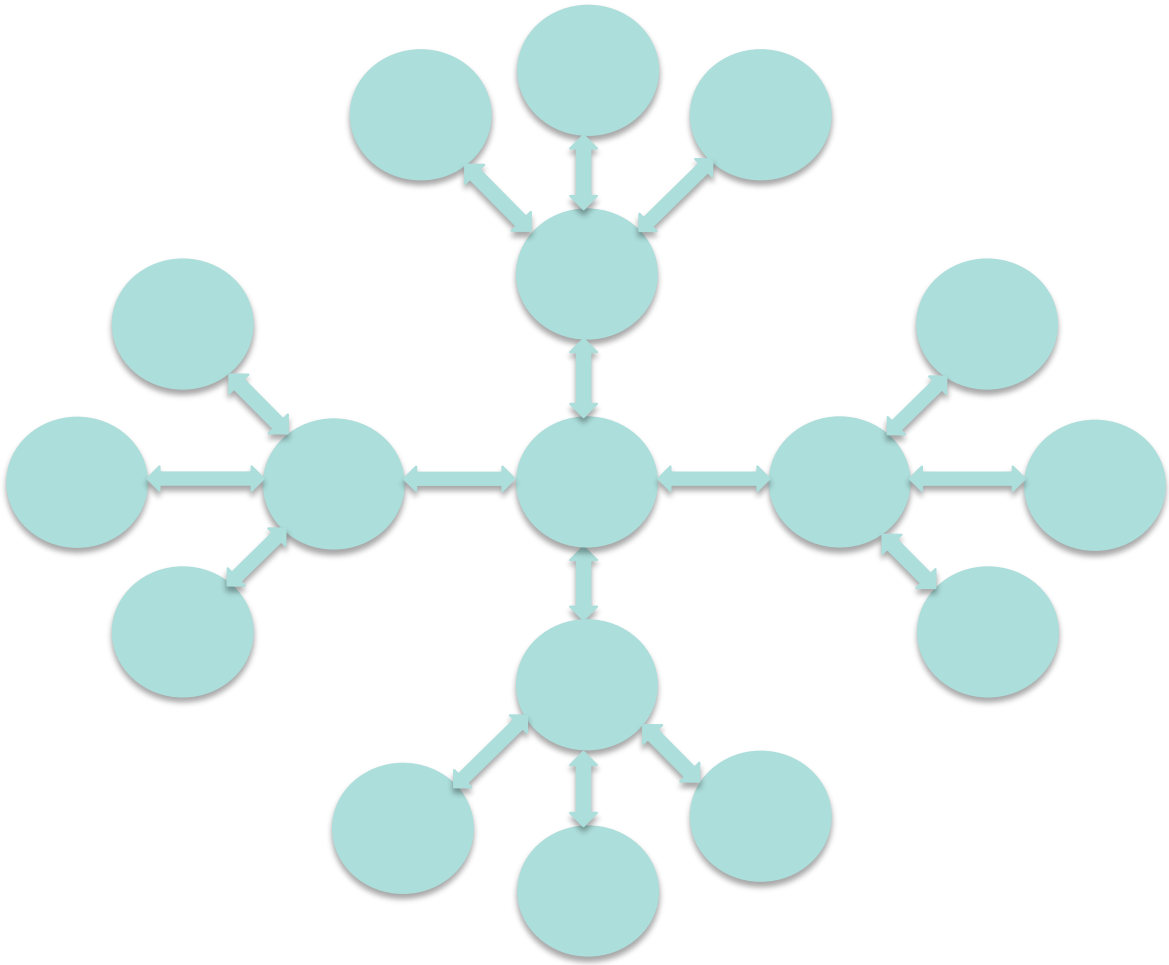
Step 2: Redraw your team or coalition leadership structure as a snowflake. Consider organizing teams by function, geography, and/or group identity. Weigh the consequences of these choices. To the best of your ability, name each team and its members by name.



Step 3: Take a moment to reflect on what it will take to transition from your existing leadership structure to a more interdependent structure.

Step 4: Building a snowflake requires creating opportunities for leadership development. For instance, are you and other leaders co-facilitating interdependent meetings? Do you delegate and hold others accountable to commitments? Are you coaching along the way?

What could you do to provide more support for leadership development? Why is that important to building the snowflake?

Before Action Review

While a Before Action Review (BAR) may take 10 minutes or two hours, the same basic steps apply. Use the instructions below and the template on the following page to complete your BAR.

Step 1: What is our intended result?

- This may be as simple as reviewing the goals for an initiative launch, or a stakeholder meeting. Without clear, shared resolve, it will be difficult to compare intent with actual results.

Step 2: What are our success measures?

- In your BAR, you will use your success measures to compare intended versus actual results – a very important part of the learning conversation. Your measures may be quantitative (meeting deadlines, budgets, quality standards; receiving funding; performing to standard) or qualitative (having every voice heard; having a clear idea of who will do what by when; gaining stakeholder commitment). But the more concrete the metric, the easier it will be to compare intent and results in your after action review.

Step 3: What challenges will we face?

Step 4: What did we learn from last time?

If any lessons exist from past activities conducted by this group, or from similar activities conducted by other organizations, this is the time to bring them into the conversation. The goal is not to exhaustively replicate every idea proposed by someone in the past but to realistically plan for stumbling blocks you might face and to identify one good idea that you can try.

- Consider this step to be a requirement. In every organization we have worked with, the weak link in the learning process is between reflection and planning. Being rigorous about looking back helps to strengthen the link and ensure that you don't keep learning the same lessons over and over.

Step 5: What do we think will make us successful this time

Taking Steps 1–4 into account, what is the one thing the group can do that you predict will make the biggest difference in its results? Create an experiment. Think through any additional plans it will take to try this out. Because you will be conducting an after action review afterward, you will have a perfect opportunity to ask yourselves, "Did it work?"

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BAR / AAR Planning Tool

Organization or Team:

Framing Question:

Event or Activity:

Before Action Review (BAR)
Date:
What is our intended result?
What are our success measures?
What challenges will we face? (Predictions)
What did we learn from last time? (REQUIRED FIELD: Lessons/plans from last AAR, if available)
What do we think will make us successful this time? (Hypotheses and Experiments)

SMART

S — SPECIFIC

Specifically define what you expect the employee to do/deliver. Avoid generalities and use action verbs as much as possible.

M — MEASURABLE

You should be able to measure whether the Outpatient AS is meeting the goals or not.

A — ACHIEVABLE

Make sure that accomplishing the goal is within the team's realm of authority and capabilities.

R — RELEVANT

Where appropriate, link the goal to a higher-level departmental or organizational goal, and ensure all team members understand how their goal and actions contributes to the attainment of the higher level goal.

T — TIME-BOUND

Specify when the goal needs to be completed (e.g. by the end of Quarter 2, monthly).

SMART Goals Template

SMART	Comments
INITIAL GOAL— Write the goal you have in mind.	
SPECIFIC— What do you want to accomplish? Who needs to be included? When do you want to do this? Why is this a goal?	
MEASURABLE— How can you measure progress and know if you've successfully met your goal?	
ACHIEVABLE— Do you have the skills required to achieve the goal? If not, can you obtain them? What is the motivation for this goal? Is the amount of effort required on par with what the goal will achieve?	
RELEVANT— Why am I setting this goal now? Is it aligned with overall objectives?	
TIME-BOUND— What's the deadline and is it realistic?	
SMART Goal— Review what you have written, and craft a new goal statement based on the answers above.	

SMART Goals Template Example

SMART	Comments
INITIAL GOAL— Write the goal you have in mind.	Educate patients about antibiotics.
SPECIFIC— What do you want to accomplish? Who needs to be included? When do you want to do this? Why is this a goal?	Provide and teach clinic and pharmacy staff communication strategies through scripting on how to educate patients about when antibiotics are and are not needed, and document in the EHR that the topic was discussed.
MEASURABLE— How can you measure progress and know if you've successfully met your goal?	Monitor the staff education plans and attendance to ensure all clinic, MDs, PACs, NPs and housing staff have attended and completed the education. Monitor patient education through documentation in the EHR.
ACHIEVABLE— Do you have the skills required to achieve the goal? If not, can you obtain them? What is the motivation for this goal? Is the amount of effort required on par with what the goal will achieve?	We have the resources available to provide education and materials to staff: • Print and laminate scripts • Include reasons in patient summary of visit • Printed brochures on display in the exam room
RELEVANT— Why am I setting this goal now? Is it aligned with overall objectives?	I am setting this goal now because cold and flu season will be upon us in the fall and it is necessary for my team to have the proper tools to educate patients.
TIME-BOUND— What's the deadline and is it realistic?	• Education completed by August 31 • Support material in exam rooms by September 3 • Documentation report from EHR by September 15 • Entire process active by October 15
SMART Goal— Review what you have written, and craft a new goal statement based on the answers above.	Use effective communication strategies to educate patients about when antibiotics are and are not needed (e.g. provide information on methods to reduce symptoms if antibiotic are not appropriate, recommend contacting primary provider if antibiotics may be appropriate.) Patient education on antibiotics will be provided 100% for all respiratory illness regardless if antibiotix are ordered.

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Project Overview Template

Name of Coalition _____

Mission of Coalition _____

Steering Committee Members: <organization names> _____

<website address>

Beginning

- How did the Coalition begin?
- What brought these organizations together?
- Include baseline data

Focus

- How many organizations were initially included?
- What types of invidivuals were included (ie. nurses, social workers, physicians, etc.)?
- What were the goals and areas of focus for the Coalition? County.

Root Cause Analysis

- What were the outcomes of the Coalition's first Root Cause Analysis?
- How did this help guide the Coalition efforts?

Intervention

- What was the project or intervention that helped address the Root Cause Analysis?
- Provide high-level information of the intervention
- What is the patient population?
- What was the aim of the intervention?
- Why was this intervention chosen?

Call to Action

- How did Coalition members contribute?
- How was the intervention promoted and disseminated in community?

Collective Impact

- Include initial analysis and outcomes of intervention
- How has the intervention made an impact?

[Coalition Name] Pilot Intervention Narrative

The mission of the Coalition is to improve the quality of care and experience for every patient in our community who requires care among multiple health care settings. Through a comprehensive community effort including improved communication, care coordination, and patient/caregiver education, the coalition is dedicated to reducing readmission and improving the health and satisfaction of our community.

Steering Committee Members: [List]

Beginning

- The Coalition's county had an overall rate of hospital readmission of 19.4%, making it the highest in the state.
- The Coalition started in 2011 to address the county's readmission rate. It began as a group effort to improve care coordination and education for health providers and partners in the coalition 's community. Improving the community's overall readmission rate will lessen the likelihood of penalties due to high readmission rates, as well as save the healthcare system $26B in Medicare losses annually.
- Health care organizations from the county are invited to educational sessions every other month on topics attributed to higher readmission rates. Examples include; health care literacy, models of transitions of care, and more.

Focus

- As of August 2016, there are currently 275 active members in the Coalition, from 71 different facilities.
- Several organizations participate in monthly Steering Committee meetings to plan the Coalition's direction and activities.
- In December 2015, the Coalition reassessed the Coalition's goals of implementing a measurable intervention to positively impact the residents of the community. The Coalition selected a theme to guide their work in 2016; Staying Healthy in the Community while Staying out of the Hospital.
- Rising out of the Coalition, the Managed Care Task force, spearheaded by a Coalition physician, was created and is developing a pilot program with 3 of the 4 health systems within the community.

Root Cause Analysis

- A root cause analysis (a process for identifying underlying problems, or "root causes") was facilitated in February 2016 to better understand factors contributing to the readmission rate in the community.
- Multiple areas of focus were explored, including insurance barriers, socioeconomic and environmental factors, and health literacy, etc. —Engagement and empowerment for patients with chronic conditions was selected as the focus area.

Intervention

- In March 2016, the Steering Committee examined data that showed that diabetes was the fourth most attributable diagnosis to readmissions, occuring at a rate of 34.1%; the top three diagnoses were encounters for antineoplastic chemotherapy, hepatic encephalopathy, and sickle cell. The Coalition agreed that diabets and related conditions greatly affect readmissions and thus selected diabetes as its focus for the creation of a diabetic patient empowerment tool.
- The Coalition has tailored an existing patient-facing empowerment tool to meet the needs of patients with diabetes. The goal of the "Diabetic Instruction and Empowerment Tool" (DIET) is to reduce readmission rates and improve health outcomes by empowering diabetic patients.
- This intervention was chosen due to combined membership's ability to make a positive impact.

Call to Action

- Coalition members will be piloting the use of DIET at various member sites. The goal of this pilot is to test the effectiveness of DIET on readmissions on a small scale, with the ultimate goal of expanding the use of DIET with a much larger population. Testing DIET on a smaller scale will help members learn best practices and address barriers to implementation . The results of the pilot will be shared on the Coalition website, as well as at the Spring 2017 ACMA Conference.
- Buy-in has been stated by all acute and post-acute care members of the Steering Committee. Leadership support is crucial for this intervention to succeed and reach the goals determined by the Coalition.

Collective Impact

- Pilot Criteria includes: reaching 5 patients per facility/site team per month—40 patients reached over 6 months is the overall goal.
- MetaStar (Wisconsin's Quality Improvement Organization) will monitor Medicare FFS claims to determine if patients receiving the intervention were readmitted in 30 and/or 60 days.
- Analysis will demonstrate the quantitative impact of this pilot, including readmissions avoided compared to a control population.
- The pilot will begin in late 2016 and will continue until 40 patients are enrolled to allow for analysis., with enrollment continuing past the initial 40 patients.

Superior Health Quality Alliance serves Michigan, Minnesota, and Wisconsin, under the Centers for Medicare & Medicaid Services Quality Improvement Organization Program.

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Data Collection Template

Participating Organization Information

Organization Name _____

Contact Name: _____

Patient Number	Criteria	Site	Setting	Discharge/ Intervention Date	Method of reaching patient

Example on following page.

Example: Data Collection Template

Participating Organization Information

Organization Name _____

Contact Name: _____

Patient Number	Criteria	Site	Setting	Discharge/ Intervention Date	Method of reaching patient
Title 19 #	Db – primary dx	Site 1	Inpatient	08/10/2016	In hospital
Medicare FFS #	Db – pt. dx list	Site 2	Emergency Dept.	08/12/2016	Via phone post d/c
Medicare FFS #	Db – secondary dx	Site 3	Outpatient	08/10/2016	In hospital
Medicare FFS #	Db – primary dx	Site 4	SNF	08/11/2016	In facility

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Sample Project Summary

Situation

What is trying to be addressed?

Background

What has already been done to address the situation?

Assessment

What is the issue?

Why should we be concerned?

- Provide 3-5 bullets to outline questions above

Recommendation

How should we respond to the situation?

What can be done to address the situation?

- Provide 3-5 bullets to outline questions above

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Transportation Project Brief for Patients, Families and Caregivers

Situation:

The county care coordination coalition ("the Coalition") would like to share information on health care related transportation with patients, families, and caregivers.

Background:

The Coalition determined that health care related transportation within the community was at times a barrier for patients, their families and their caregivers. The Coalition adopted transportation as one of its focus areas for 2017 so it could clarify and address the issue.

Assessment:

The Coalition completed the following activities during their 18 month (April 2017 – September 2018) focus on transportation:

- Discussed the variety of medical transportation issues faced by patients and providers in various health care and community settings and selected "after hours transport" and "sub-optimal transport" as defined focus areas for Coalition work;
- Collected data across multiple organizations using a common "Transportation Issues Log" to determine the extent of after-hours transports and sub-optimal transport use (e.g. ambulance use for non-emergent transport);
- Conducted a survey of transport providers in the community to learn about their hours, capacity, special services, service area and other characteristics of interest;
- Explored the possibility of a joint venture to provide e.g. transport vehicles, driver time, insurance, etc. to address the gaps in transport that impacted patients and were experienced across the community by multiple organizations; and
- Invited local transportation providers and Aging and Disability Resource Center (ADRC) leadership from neighboring counties to share their knowledge and experiences with the Coalition to inform their activities.

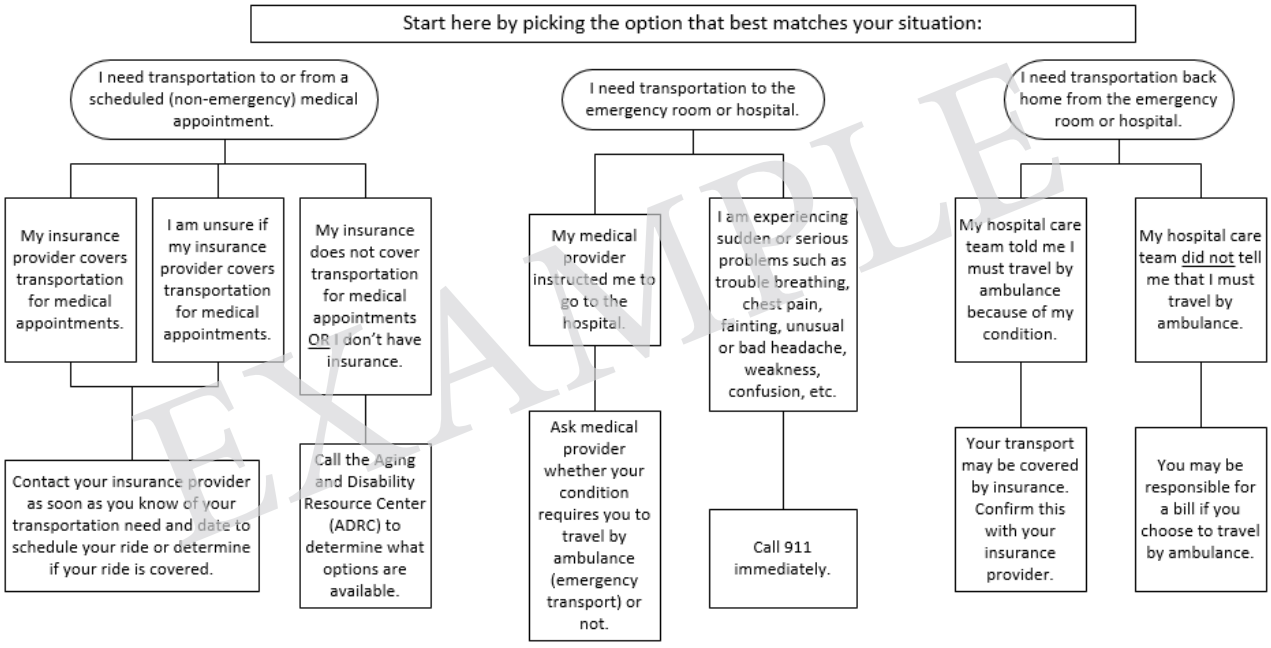
Recommendation:

Upon review of information gathered, the Coalition has concluded the following:

- The need for after-hours transport was not significant or frequent enough to warrant resources needed to support a joint venture that would staff an on-call driver and vehicle.
- There is potential for County/City-level funds to become available at a later date to facilitate the provision of some services to patients, families and caregivers in the community. The Coalition will stay tuned for developments.
- Patients, families and caregivers may benefit from increased knowledge about:
    - The types of transportation services available in the community
    - When to use emergent (ambulance) vs. non-emergent medical transport
    - Insurance coverage, billing, and payment for different transport services
- The Coalition is in a position to provide helpful information regarding health care related transportation to empower patients, families and caregivers in their care interactions.

Transportation Decision Guide

This Decision Guide on the next page helps patients, families and caregivers determine the optimal transportation option for their situation. Contact information for local transportation options and general information on insurance coverage of transportation is provided after this. If you have questions about any of the steps, please discuss your questions with your care team.



County Transportation Resources

Transport Service	Contact Information	Hours of Operation	Medical	General	Wheelchair Accessible	Fees/ Insurance Coverage	Notes
Transport Service Company #1		7:00 a.m. -5:00 p.m. Monday thru Friday	Yes	Yes	Yes	Community Care, Private Pay, Medicaid	Appointments must be made by 2:00 p.m. Monday thru Friday. Special arrangements can be made for Saturdays and holidays.
Transport Service Company #2		8:00 a.m. – 5:00 p.m. Monday thru Friday	Yes	Yes	Yes	Community Care, Private Pay	Special arrangements can be made for weekends.
Transport Service Company #3		7:30 a.m. - 3:30 p.m. Monday thru Friday for persons 60 years and older	No	Yes	Yes	Private Pay	Persons < 60 years old transport services are available 5:45 a.m. - 8:45 p.m. Monday thru Friday and 7:45 a.m. - 5:45 p.m. Saturday.
Transport Service Company #4		24 hours a day, 7 days a week	Yes	No	Yes	Medicaid recipients only	Medicaid member ID required. It is preferred transport be scheduled two days in advance; same day transportation is available for certain exceptions.

Transport Service	Contact Information	Hours Of Operation	Medical	General	Wheelchair Accessible	Fees/ Insurance Coverage	Notes
Transport Service Company #5		8:00 a.m. - 5:00 p.m. Monday thru Friday	Yes	Yes	Yes	Family Care Services	Special transport arrangements can be made outside of usual business hours, if made in advance.
Uber and/or Lyft	N/A	Varies based on driver availability	No	Yes	No	Private Pay	Ask your care team if hospital or insurance provider is partnering with Uber or Lyft.
Transport Service Company #6		24 hours a day, 7 days a week	No	Yes	No	Private Pay	
Transport Service Company #7		24 hours a day, 7 days a week	No	Yes	No	Private Pay	

Insurance Information and other Resources for Transportation

If you are having a life or limb-threatening emergency, call 911. If you need non-emergency medical transportation, refer to your insurance plan coverage for transportation. If you do not have insurance, refer to the bottom of page 6.

Insurance	Description	Contact Information
Medicare Traditional / Medicare Fee For Service	Medicare Part B (Medical Insurance) covers medically necessary ambulance services to or from a hospital, critical access hospital (CAH), or skilled nursing facility (SNF). Medicare covers and helps pay for ambulance services only when other transportation could endanger your health, like if you have a health condition that requires this type of transportation. You can get emergency ambulance transportation when you've had a sudden medical emergency, and your health is in serious danger because you can't be safely transported by other means, like by car or taxi. You may be able to get non-emergency ambulance transportation if you have a written order from your doctor saying that ambulance transportation is medically necessary.	Discuss with your care team what kind of transportation is needed to transport you safely. Note: Medicare determines the final decision on payment. You may be responsible for a bill if Medicare determines that your ambulance ride was not medically necessary.
Medicare Advantage / Commercial Insurance	Transportation services covered vary by Medicare Advantage and Commercial Insurance Plan.	Contact your insurance representative to determine what transportation resources are available to you.

Medicaid (State Medicaid)	MTM, Inc. provides Non-Emergency Medical Transport (NEMT) for most members enrolled in the following programs who do not have other ways of getting to their covered appointments: • State Medicaid (including IRIS) • Tuberculosis-Related Services-Only Benefit • Family Planning Only Services	Routine ride requests are accepted Monday through Friday, 7:00 a.m. to 6:00 p.m. by calling (866) 907-1493 at least two business days in advance.
Family Care	Family Care is a long-term care program that helps frail elders and adults with disabilities get the services they need to remain in their homes. This comprehensive and flexible program offers services to foster independence and quality of life for members while recognizing the need for interdependence and support. Contact a member of your Family Care care team to learn more about the transportation resources that may be available to you.	

Organization	**Description**	**Contact Information**
Aging and Disability Resource Center	Aging and Disability Resource Centers are welcoming and accessible places where older people and people with disabilities and their family and friends, can obtain information, advice and help in locating services or applying for benefits.	**Address:** **Phone**:
Veterans Service Office	The county Veterans Service Department will provide timely and quality service for veterans seeking assistance with local, state and federal benefit programs.	**Address:** **Phone:**

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XXXX

Program Sustainability Plan
Template

2011

Prepared by the Center for Training and Research Translation

UNC Center for Health Promotion and Disease Prevention (SIP 4-09 Cooperative Agreement Number U48-DP001944)

Acknowledgements

{Thank everyone involved in developing the plan.}

Sustainability Plan Template and Instructions

I. Program Summary

INSTRUCTIONS: Describe the program and the efforts you intend to sustain. ***Limit to three pages***. The Program Summary should include:

- A brief overview of your program
- Overall program goals
- Groups responsible for implementing program components
- Resources devoted to program implementation (e.g., partners, sources of funding)
- Efforts you plan to continue revise and continue or ask another organization to take on.

II. Overview of the Sustainability Planning Process

INSTRUCTIONS: Include a brief description of the process you followed to create the program sustainability plan. Consider the results of your sustainability assessment profile. What actions did you take, who was involved in the process, what informed your decisions, etc…

III. Key Elements for Sustainability

INSTRUCTIONS: Describe the current status of each of the eight sustainability domains.

- Refer to the sustainability framework, your sustainability assessment results, and discussions with your planning group.
- Highlight areas of strength and areas in need of improvement.

Political Support	• Text • Text • Text • Text
Funding Stability	• Text • Text • Text • Text
Partnerships	• Text • Text • Text • Text
Organizational Capacity	• Text • Text • Text • Text

Program Evaluation	• Text • Text • Text • Text
Program Adaptation	• Text • Text • Text • Text
Communications	• Text • Text • Text • Text
Strategic Planning	• Text • Text • Text • Text

IV. Acton Plans for Priority Domains

INSTRUCTIONS: Choose 2-3 priority domains to work on. Complete sections A-D for the priority domains you have decided to focus on.

Priority Domain #1: [Insert domain name]

A. Rationale

INSTRUCTIONS: In a brief narrative, describe why this is a priority domain. List the areas you are focusing on for this domain, including the specific indicators from the framework and the major goal you want to achieve. (**Note:** *if your needs for this domain do not correspond to the indicators listed in the framework for this domain, that is ok.*)

B. Action Steps

INSTRUCTIONS: Complete the chart below including action steps, the person/group responsible and the timeframe for completing the step. Be specific and realistic.
SAMPLE: See Appendix B

Action Steps *(How will you get to where you want to be?)*	Responsibility *(Who will make it happen?)*	Timeframe *(When will it happen?)*

C. Resources

INSTRUCTIONS: Describe the resources needed to carry out the action steps described above.

- What information do you need to successfully execute the action steps?
- What, if any, costs will be involved?
- What resources or assistance do you need?

D. Progress Monitoring

INSTRUCTIONS: Use the chart below to document your accomplishments and what helped you accomplish the action steps for Priority Domain 1.

Action Steps Accomplished	Date	What helped you accomplish this action?
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*

INSTRUCTIONS: Denote the challenges you faced working in Priority Domain 1 in the space below. Include the action steps you have yet to accomplish and what hindered your progress. Consider which actions steps you will revise or delete and indicate how you plan to move forward in this domain.

SAMPLE: See Appendix B

Challenges:
Plans to move forward:

Priority Domain #2: [Insert domain name]

A. Rationale

INSTRUCTIONS: In a brief narrative, describe why this is a priority domain. List the areas you are focusing on for this domain, including the specific indicators from the framework and the major goal you want to achieve. (**Note:** *if your needs for this domain do not correspond to the indicators listed in the framework for this domain, that is ok.*)

B. Action Steps

INSTRUCTIONS: Complete the chart below including action steps, the person/group responsible and the timeframe for completing the step. Be specific and realistic.

Action Steps *(How will you get to where you want to be?)*	**Responsibility** *(Who will make it happen?)*	**Timeframe** *(When will it happen?)*

C. Resources

INSTRUCTIONS: Describe the resources needed to carry out the action steps described above.

- What information do you need to successfully execute the action steps?
- What, if any, costs will be involved?
- What resources or assistance do you need?

D. Progress Monitoring

INSTRUCTIONS: Use the chart below to document your accomplishments and what helped you accomplish the action steps for Priority Domain 2.

Action Steps Accomplished	Date	What helped you accomplish this action?
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*

INSTRUCTIONS: Denote the challenges you faced working in Priority Domain 2 in the space below. Include the action steps you have yet to accomplish and what hindered your progress. Consider which actions steps you will revise or delete and indicate how you plan to move forward in this domain.

Challenges:
Plans to move forward:

Priority Domain #3: [Insert domain name]

A. Rationale

INSTRUCTIONS: In a brief narrative, describe why this is a priority domain. List the areas you are focusing on for this domain, including the specific indicators from the framework and the major goal you want to achieve. (**Note:** *if your needs for this domain do not correspond to the indicators listed in the framework for this domain, that is ok.*)

B. Action Steps

INSTRUCTIONS: Complete the chart below including action steps, the person/group responsible and the timeframe for completing the step. Be specific and realistic.

Action Steps *(How will you get to where you want to be?)*	**Responsibility** *(Who will make it happen?)*	**Timeframe** *(When will it happen?)*

C. Resources

INSTRUCTIONS: Describe the resources needed to carry out the action steps described above.

- What information do you need to successfully execute the action steps?
- What, if any, costs will be involved?
- What resources or assistance do you need?

D. Progress Monitoring

INSTRUCTIONS: Use the chart below to document your accomplishments and what helped you accomplish the action steps for Priority Domain 3.

Action Steps Accomplished	Date	What helped you accomplish this action?
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*
{Specific action completed}	*Month/Year*	*{List 2-4 contributors}*

INSTRUCTIONS: Denote the challenges you faced working in Priority Domain 3 in the space below. Include the action steps you have yet to accomplish and what hindered your progress. Consider which actions steps you will revise or delete and indicate how you plan to move forward in this domain.

Challenges:
Plans to move forward:

IV. Sustainability Plan Follow-up

INSTRUCTIONS: In a brief narrative, describe the process you will use to review the action plans and make modifications.

- How do you plan to monitor your progress on sustainability moving forward?
- Who is responsible for evaluating and documenting progress?
- When will you assess your progress?
- When will you set new goals?