Optimizing Care Transitions to Positively Impact Hospital Admission Rates
What practices are...

a) Actively working on reducing readmissions?

b) Studying and planning work on readmissions?

c) Watching and waiting for now, to see what comes out of health reform?
If actively working on readmissions - what is motivating your hospitals?

### Rate of Readmission for Heart Failure Patients

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Rate</th>
<th>Notes</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>MID COAST HOSPITAL</td>
<td>23.9</td>
<td>No Different than U.S. National Rate</td>
<td>Based on 205 patients</td>
</tr>
<tr>
<td>CENTRAL MAINE MEDICAL CENTER</td>
<td>23.0</td>
<td>No Different than U.S. National Rate</td>
<td>Based on 468 patients</td>
</tr>
<tr>
<td>ST MARYS REGIONAL MEDICAL CENTER</td>
<td>22.1</td>
<td>No Different than U.S. National Rate</td>
<td>Based on 268 patients</td>
</tr>
</tbody>
</table>

**Legend**

*Range of uncertainty around estimated death rate ("interval estimate")

\[ x\% \rightarrow \text{Estimated death rate (risk-adjusted)} \]
If studying and planning to work on readmissions: What information would be helpful to accelerate your work?

✓ Patient history and admission pattern
✓ Detailed knowledge of current process for assessing and managing patients at high risk for readmission
✓ Comprehensive cause and effect diagram to understand root causes and patient stated reasons for hospitalizations
✓ Analysis of process failures and patient reported experience of care
✓ Change ideas for reducing process failures
If you are ...

a) Watching and waiting for now, to see what comes out of health reform?

What are your concerns?
What are the consequences of waiting?
Session Aims

• Use (pre-work) case studies to understand readmissions

• Learn from teams who are actively working on reducing readmissions, or studying and planning on reducing readmissions

• Develop your team plan for working on reducing readmissions for a subpopulation (20 min team meeting)
Pre-Work : Thank You

1. Community Health Center
2. Belgrade Family Practice
3. DFD Russell Medical Center
4. Wilson Stream
5. Husson Internal Medicine
6. Newport Family Medicine
7. Winthrop Family Medicine
8. Court Street Family Practice
9. Southern Maine PrimeCare
10. Seaport Family Practice
11. Husson Pediatrics
12. EMMC Center for Family Medicine
13. Penobscot Community Health System
## Good Tips - Pre Work

<table>
<thead>
<tr>
<th>Practice Pre Work</th>
<th>Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>Community Health Center</td>
<td><strong>Cause and Effect Diagram</strong></td>
</tr>
<tr>
<td>Belgrade</td>
<td>Completed History – <strong>whole person</strong></td>
</tr>
<tr>
<td>Wilson Stream</td>
<td>Asked what the <strong>patient wants</strong> – avoid being away from her husband with Alzheimer's, does not want any more procedures</td>
</tr>
<tr>
<td>Winthrop Family Medicine</td>
<td>Assessed Value of PCP and Patient <strong>Trusting Relationship</strong> – communication while patient hospitalized would influence outcome</td>
</tr>
<tr>
<td>DFD Russell</td>
<td>How tracked Hospitalization <strong>Data</strong> – dates, LOS, admitting diagnosis.</td>
</tr>
</tbody>
</table>
One Patient to Many Patients
Redesigning Care Transition Processes and Roles

48 year old female hospital admissions 2011

<table>
<thead>
<tr>
<th>Month</th>
<th>LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>March</td>
<td>4, 10 days</td>
</tr>
<tr>
<td>April</td>
<td>7 days (DVT)</td>
</tr>
<tr>
<td>May</td>
<td>3 days (COPD)</td>
</tr>
</tbody>
</table>
Reducing Hospitalizations for Many Academic Internal Medicine

Transitional Care Interventions and Hand ‘Overs’ Hospital, Primary Care, Home Care

Cross Setting Improvement Meetings

Time to 1st Medical Appointment 30 days to within 7 days
Prepared | Activated Patient
Prepared | Activated Care Team

One Right Medical Plan
Mental Health Assessment Patient And Caregivers
Home Assessment Social and Environment
Long Term and Palliative Care Planning
Medication Reconciliation Symptom Management Goals and Plan of Care
• Population Risk Stratification - Hot Spotting

• Cross Setting Collaboration – communication and improvement discipline, voice of patients

• Focus on the Patient Experience of Care

• Standard Processes, Roles, Tools Across Settings – eliminate service duplication

• Useful, Relevant, Frequent - Measurement and Feedback to all settings, care teams, and patients
## Good Tips - Pre Work

<table>
<thead>
<tr>
<th>Practice Pre Work</th>
<th>Tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>EMMC Center for Family Medicine</td>
<td><strong>Current Process - Detail</strong> Discharge, Pre Visit, Visit, Post Visit, Between Visit Scheduling, Check-In</td>
</tr>
<tr>
<td>Court Street*</td>
<td><strong>Failures Check List</strong> – from assumptions about patient, to system and process failures</td>
</tr>
<tr>
<td>Southern Maine PrimeCare</td>
<td>Assessment Inpatient <strong>Discharge Hand Over's</strong> – patient instructions vague, not legible, meds not reconciled, no PCP appointment</td>
</tr>
<tr>
<td>Newport</td>
<td>Assessment of <strong>Caregivers</strong> – Caregiver Support</td>
</tr>
<tr>
<td>Husson*</td>
<td>Identifying <strong>all the people and services</strong> - part of care continuum – e.g. 2 Care Managers, 5 Specialists</td>
</tr>
</tbody>
</table>
Studying Readmissions – Challenging Assumptions, Attitudes, Beliefs

Physician response to why they have undesirable clinical outcomes.

<table>
<thead>
<tr>
<th>Patients have poor self-discipline</th>
<th>53.2%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients have poor will-power</td>
<td>50.0%</td>
</tr>
<tr>
<td>Patients are not scared enough</td>
<td>36.9%</td>
</tr>
<tr>
<td>Patient are not intelligent enough</td>
<td>16.3%</td>
</tr>
</tbody>
</table>

What beliefs... cause us to draw conclusions we do that result in the actions we take?

In a 1996 survey of physicians (Polonsky, Boswell and Edelman),
Challenges Assumptions and Beliefs
One to Many
Goal Setting, Telephone and Visit Follow Up by RN

Started Goal Setting
Symptom Management Planning
Patient Plotting Data
Email Communication

2-3 admissions Per year

Confidence
Self Management Scale 1-10

Month 1  Month 3  Month 6  Month 12
Your Team’s Number is: ____________________

“My Action Plan”
Call your nurse or physician any time your medical condition changes. A nurse is on call 24 hours a day, including nights, weekends and holidays.

General Problems
- No bowel movement in 3 days
- New skin problems
- Change in balance, coordination, strength
- Change in mental status or behavior
- Pain medication is not effective
- Nausea or vomiting
- Running out of medication
- Fall
- Dizziness
- Diarrhea
- Fever

Urinary Problems
- Foul odor to urine
- Catheter not draining
- Unable to urinate
- Bloody or cloudy urine
- Change in urine color
- Body aches

Signs of wound infection
- Increased redness
- More or different drainage
- Wound or area is more painful
- Temperature of 100 or more
- New odor from a wound
- Temperature is outside my target of ________.

Diabetic Problems
- Sudden weakness
- Uncontrollable thirst
- Sudden dizziness
- Increased urination
- Sweating spells
- Uncontrollable hunger

Heart/Lung Problems
- Productive or frothy cough
- New congestion
- Increased shortness of breath
- Increased swelling in legs or feet
- Increased weakness
- Weight gain of 3 or more pounds in 1 day or 5 or more pounds in one week. My current weight is ________.
- Blood pressure above my target blood pressure of ________.
- Heart rate is outside my target heart range of ________.
- Oxygen saturation level is outside target of ________.

If you take Coumadin
- Bleeding from nose, gums, rectum
- Bruising
- Tarry stools
- Falls

Call 911 if you (have):
- Fall and are bleeding.
- Fall and have a broken bone.
- Severe or prolonged bleeding.
- Severe or prolonged pain.
- Are unable to wake the patient.
- New onset of slurred speech.
- Sudden weakness in arms or legs.
- Chest pain that medication does not help.
- Increased difficulty breathing not relieved by rest or medications.

My Goals

My Treatment Plan

My Symptom Management Plan

My Medication Management
2/3rds admissions - medication management

<table>
<thead>
<tr>
<th>DISCHARGE MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Brand Name</strong> (Generic Name)</td>
</tr>
<tr>
<td>ASA</td>
</tr>
<tr>
<td>Atorvastatin Tablet</td>
</tr>
<tr>
<td>Wellbutrin XL</td>
</tr>
<tr>
<td>Plavix (Clopidogrel Bisulfate)</td>
</tr>
<tr>
<td>Lanoxin (Digoxin)</td>
</tr>
<tr>
<td>PEPcid (Pamidronate)</td>
</tr>
<tr>
<td>Fish Oil (Fish Oil)</td>
</tr>
<tr>
<td>Lasix (Furosemide)</td>
</tr>
<tr>
<td>Toprol XL (Metoprolol Succinate)</td>
</tr>
<tr>
<td>Nitrogast (Nitroglycerin SL)</td>
</tr>
<tr>
<td>KLORCON (Potassium Chloride SR)</td>
</tr>
<tr>
<td>Flomax (Tamsulosin)</td>
</tr>
<tr>
<td>Diovan (Valsartan)</td>
</tr>
<tr>
<td>Warfarin Sodium UD Tablet</td>
</tr>
</tbody>
</table>

**Comment:** TAKE 1 TABLET AT 5PM ON 10/08/2011.

**As of 3-23-2011**

<table>
<thead>
<tr>
<th>BRAND NAME</th>
<th>GENERIC</th>
<th>HOW MUCH</th>
<th>WHY TAKING</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Morning 9am Daily</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin</td>
<td>Aspirin</td>
<td>81 MG</td>
<td>Blood thinner</td>
</tr>
<tr>
<td>Wellbutrin</td>
<td>Bupropion</td>
<td>150 MG</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Finasteride</td>
<td>Proscar</td>
<td>5 MG</td>
<td>Enlarged Prostate</td>
</tr>
<tr>
<td>Fish Oil</td>
<td>1000 MG</td>
<td>Heart prevention</td>
<td></td>
</tr>
<tr>
<td>Lasix</td>
<td>Furosemide</td>
<td>20 MG</td>
<td>Fluid</td>
</tr>
<tr>
<td>Toprol</td>
<td>Metoprolol</td>
<td>50 MG</td>
<td>Blood pressure</td>
</tr>
<tr>
<td>Klor-con</td>
<td>Potassium</td>
<td>20 MG</td>
<td>Heart electrolyte</td>
</tr>
<tr>
<td>Flomax</td>
<td>Tamsulosin</td>
<td>0.4 MG</td>
<td>Urine flow</td>
</tr>
<tr>
<td>Pepsid</td>
<td>Famotidine</td>
<td>20 MG</td>
<td>Indigestion as needed</td>
</tr>
<tr>
<td><strong>Noontime</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fish Oil</td>
<td>1000 MG</td>
<td>Heart prevention</td>
<td></td>
</tr>
<tr>
<td><strong>Dinnertime</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wellbutrin</td>
<td>Bupropion</td>
<td>150 MG</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Fish Oil</td>
<td>20 MG</td>
<td>Fluid</td>
<td></td>
</tr>
<tr>
<td>Lipator</td>
<td>Atorvastatin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peptic</td>
<td>Famotidine</td>
<td>20 MG</td>
<td>Indigestion as needed</td>
</tr>
</tbody>
</table>

**As Needed Chest Pain**

| Nitrostat | |

**As of October 9th, 2009 onwards, please take Coumadin as directed by the Anticoagulation Clinic**

Your INR should be checked on *** Fill in Date *** INR results should be sent to ** Fill in name **
External Mapping

**Mission:** The Dartmouth-Hitchcock Clinic exists to serve the health care needs of our patients.

**Very High Risk**

**Chronic**

**Healthy**

**Assign to PCP**

**Orient to Team**

**Assess & Plan Care**

**Functional & Risks**

**Biological Costs**

**Expectations**

**Palliative**

**Very High Risk +**

**Chronic ++**

**Prevention**

**Educate**

**Acute**

**Educate**

**P A C E**

**P**

**A**

**C**

**E**

**People with healthcare needs**

**People with healthcare needs met**

**Phone, Nurse First**

**Physical Space**

**Info Systems & Data**

**Billing**

**Referrals**

**Pharmacy**

**Radiology**

**Laboratory**

**Medical Records**

**Scheduling**

**Department**

**Division and Community Southern Region**

**Measuring Team Performance & Patient Outcomes and Costs**

**Measure Current Target Measure Current Target PMPM Adj.**

**Direct Pt. Care Hours:**

**MD/Assoc.**

**% Panel Seeing Own PCP:**

**Total PMPM Adj.**

**PMPM-Team**

**External Referral Adj.**

**PMPM-Team**

**Patient Satisfaction**

**Access Satisfaction**

**Staff Satisfaction**

**TEAM MEMBERS:**

**Skill Mix:**

**MDs**

**2.8**

**RNs**

**6.8**

**NP/PAs**

**2**

**MA**

**4.8**

**LPN**

**SECs**

**4**

**Micro-System Approach 6/17/98**

**Revised: 1/27/00**

**Eugene C. Nelson, DSc, MPH**

**Paul B. Batalden, MD**

**Dartmouth-Hitchcock Clinic, June 1998**

**40 Year Old Male**

**CHF, EF15%**

**Cardiomyopathy**

**Crohns**

**Cardiology CHF Care Manager**

**Laboratories**

**EMMC Care Manager**

**EMMC – Hospital care team**

**Health Plans**

**Pharmacies**

**Medical Equipment Suppliers**

**Community Health Teams**

**Outpatient Observation Unit IV Infusion**

**4 SPECIALIST**

**5 SPECIALIST**

**2 SPECIALIST**

**3 SPECIALIST**

**Nashua Internal Medicine**

**Amy, Secretary**

**Buffy, Secretary**

**Mary Ellen, Secretary**

**Kristy, Secretary**

**Charlene, Secretary**

**40 Y ear Old Male**

**CHF, EF15%**

**Cardiomyopathy**

**Crohns**

**Community Health Teams**

**Outpatient Observation Unit IV Infusion**

**EMMC – Hospital care team**

**Health Plans**

**Pharmacies**

**Medical Equipment Suppliers**

**Cardiology CHF Care Manager**

**Laboratories**

**EMMC Care Manager**

**4 SPECIALIST**

**5 SPECIALIST**

**2 SPECIALIST**

**3 SPECIALIST**

**Nashua Internal Medicine**

**Amy, Secretary**

**Buffy, Secretary**

**Mary Ellen, Secretary**

**Kristy, Secretary**

**Charlene, Secretary**

**40 Y ear Old Male**

**CHF, EF15%**

**Cardiomyopathy**

**Crohns**

**Community Health Teams**

**Outpatient Observation Unit IV Infusion**

**EMMC – Hospital care team**

**Health Plans**

**Pharmacies**

**Medical Equipment Suppliers**

**Cardiology CHF Care Manager**

**Laboratories**

**EMMC Care Manager**

**4 SPECIALIST**

**5 SPECIALIST**

**2 SPECIALIST**

**3 SPECIALIST**

**Nashua Internal Medicine**

**Amy, Secretary**

**Buffy, Secretary**

**Mary Ellen, Secretary**

**Kristy, Secretary**

**Charlene, Secretary**

**40 Y ear Old Male**

**CHF, EF15%**

**Cardiomyopathy**

**Crohns**
Transitional Care Definition

“A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.”

Eric Coleman, MD

Source: Coleman EA, Boult CE. Improving the Quality of Transitional Care for Persons with Complex Care Needs. Journal of the American Geriatrics Society. 2003;51(4):556-557
- Population Risk Stratification - Hot Spotting

- Cross Setting Collaboration – improvement discipline, voice of patients

- Focus on the Patient Experience of Care

- Standard Processes, Roles, Tools Across Settings

- Useful, Relevant, Frequent - Measurement and Feedback
Regional Practice Support Session Reducing Readmission Certainties

• You will not solve your readmission problem without understanding factors leading to admissions
  • one patient at a time

• Reducing readmissions cannot be done within the walls of the hospital, within the walls of primary care
  • cross continuum case reviews and improvement meetings

• Must understand the big picture factors, while focusing on specific challenges and their solutions
  • workflows integrating best practices across settings
Pre Work : Knowledge of 11 High Risk and High Cost Patients

<table>
<thead>
<tr>
<th>Patients</th>
<th>Diagnoses</th>
<th>Hospitalization Patterns</th>
<th>Reason for Readmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>19 yo male</td>
<td>Severe Crohns</td>
<td>4 in 3 months Jan-Mar ‘11</td>
<td>Pain control</td>
</tr>
<tr>
<td>67 yo Female</td>
<td>COPD, CHF, Depression, DM, HTN, HypoThyroid</td>
<td>5 Last 4 years</td>
<td></td>
</tr>
<tr>
<td>73 yo Female</td>
<td>DM, HTN, Afib, RF, CAD, hyperlipidemia,</td>
<td>9 in 12 months 2010 2 hosp &gt; 2 wk LOS</td>
<td>Does not know who to call and when , early symptoms to watch for</td>
</tr>
<tr>
<td>56 yo Male</td>
<td>Multiple chronic illness – admitted with acute infection</td>
<td>Readmission within 7 days post hospital d/c</td>
<td>Stopped taking med due to financial issues</td>
</tr>
<tr>
<td>Patients</td>
<td>Diagnoses</td>
<td>Hospitalization Patterns</td>
<td>Reason for Readmission</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------</td>
<td>--------------------------</td>
<td>--------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>79 yo Female</td>
<td>Multiple Chronic Illness</td>
<td>4 in 4 months (Jan-April 2011)</td>
<td>Patient not able to follow med instructions. In addition to discharge discrepancies.</td>
</tr>
<tr>
<td>84 yo Female</td>
<td>DM, Hyperlipid, Dementia, CVA</td>
<td>2</td>
<td>No caregiver support for adherence to meds, diet, ADLs</td>
</tr>
<tr>
<td>40 yo Male</td>
<td>CHF, EF 15% Cardiomyopathy, Crohns,Bowel Res</td>
<td>5 In 3 months since end March</td>
<td>Cannot stay within fluid restriction – feels needs it. Poor absorption oral Lasix.</td>
</tr>
<tr>
<td>40’s yo Male</td>
<td>Pancreatitis, ETOH, chronic pain, Whipple, DM, anxiety, depression, suicidal ideation, gastritis, AFib</td>
<td>17 in 12 months May 2010-May 11 Plus 5 ED evals</td>
<td>Barriers care management by phone calls, PCP appts. CM - 23 phone calls attempt – 5 successful contacts. 8 of 23 appts kept. Substance abuse and mental health care management gaps.</td>
</tr>
<tr>
<td>Patient</td>
<td>Diagnoses</td>
<td>Hospitalization Patterns</td>
<td>Reason for Readmission</td>
</tr>
<tr>
<td>---------</td>
<td>---------------------------------------------------------------------------</td>
<td>--------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>48 yo Female</td>
<td>Factor V Leiden deficiency, DVT, DM, COPD, CHF, Depression</td>
<td>4 in 3 months March – May 2011 DVT, COPD</td>
<td>Cannot stay within fluid restriction – feels needs it. Poor absorption oral Lasix.</td>
</tr>
<tr>
<td>59 yo Male</td>
<td>CAD, CHF, CVA, HTN, Venous Ulcer, GERD, OSA, Peripheral Neuropathy, Obesity, Afib, Diverticulosis, Hyperlipid, DM, COPD, Valve Replacement</td>
<td>2 in 4 months Feb – May 2011 2 hospitals</td>
<td></td>
</tr>
<tr>
<td>61 yo Male</td>
<td>DM, CAD, CHF, AV replacement, COPD, HTN, Osteoarthritis, Pain, Depression, Cirrhosis</td>
<td>9 in 15 months March 2010 – May 2011</td>
<td></td>
</tr>
</tbody>
</table>
Reducing Hospitalizations and Cost of Care

Geisinger PCMH patients - 14 percent reduction in hospital admissions vs control group.

“A trend towards a 9% reduction in medical costs" after two years.

6-7% Medicare Primary Care Demo

Cost of Care

11 Patients
63 Admissions, most in past 12 mo
Avg Hosp Cost/Pt ME - $7,775*
$489,825

14 % Reduction hosp admissions
Avoid 9 Admissions
Admission Cost Saving - $69,975

Generic Medications

(*MHA 2005 report)
Themes and Solutions - Avoidable Readmission

- Poor transfer of information to patient:
  - Poor patient understanding of how to use medications after hospital discharge
  - Patient doesn’t understand warning signs that warrant an emergency call to their physician or self care plan implementation
  - Patients do not have a coordinated medical plan of care

- Poor handovers and communication within and between settings
  - Among and between hospitals and EDs, primary care, specialists, care managers, nursing homes, patient/caregivers

- Lack of clarity on end of life care preferences – palliative and long term care planning gaps

- Gaps Mental Health Assessment |Management- Patient & Caregivers
Regional Practice Support Session
Reducing Readmission Certainties

• You will not solve your readmission problem without understanding factors leading to admissions

• Reducing readmissions cannot be done within the walls of the hospital, within the walls of primary care

• Must understand the big picture factors, while focusing on specific challenges and their solutions
Small Tests of Change

Specific Aim: Increase % of patients with SMGs for 0 - 80% in 6 months.

Patients setting self-management goals will improve care.

0% SMG

80% SMG

Cycle 1: MD tries self-management goal form with 3 patients – Diabetes not in control

Cycle 2: MD use form with all patients for one week.

Cycle 3: RN introduces goal-setting during rooming, MD follows up.

Cycle 4: All patients work with RN Goal Setting. Motivational Interviewing.

Cycle 5: All staff oriented in use of SM goal sheet.

Standardizing and Spreading

Adapted Catahoula Parish Clinic, Louisiana [www.improvingcare.org](http://www.improvingcare.org)
From One to Many

- Profile of Patient to Population Profile
- Admission Pattern Tracking – on the wall
- Assessing Risk Status
- Process for Managing High Risk – 48 hr post d/c
- Root Cause Analysis – System and Process Failures, Reasons for Readmission – not chief complaint or diagnosis
- Redesigned Process
- Testing Steps or Complete Redesigned Process
Your Next Steps Agenda

20 minute meeting

Agenda

1 min  Identify Meeting Lead, Facilitator, Timekeeper, Recorder

15 min  Plan Your Next Steps Reducing Admission
        - starts with understanding your patterns and root causes
        - study (pre work tips) – at least 5 patients, include all settings

4 min  Recorder - Feedback Your Plan to Group
ACTION PLANNING: Reducing Potentially Avoidable Hospital Readmissions

Site Name___________________Key Contact____________________

What are the next steps for working on reducing potentially avoidable hospital readmissions?

______________________________________________

What is the intended goal or outcome?

___________________________________________________________________________

<table>
<thead>
<tr>
<th>WHAT</th>
<th>WHO</th>
<th>WHEN</th>
<th>HOW</th>
<th>HOW WILL YOU MEASURE?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Identify potential barriers and strategies and plans to avoid them:

<table>
<thead>
<tr>
<th>BARRIERS</th>
<th>PLANS FOR ADDRESSING THE BARRIERS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>