CREATING REGIONAL PARTNERSHIPS TO IMPROVE CARE TRANSITIONS

Care Transitions Programs: Hiring Care Transition Coaches

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When an elderly patient or a patient with a serious or complex illness is discharged from the hospital, that person is particularly vulnerable. As patients move from one care setting to another, problems such as lack of follow-up care and miscommunication among clinicians often occur and can put patients at risk for serious complications and hospital readmission. Some patients have additional problems such as depression, social isolation, or a lack of housing or transportation that may increase their risk of hospital readmission. Nearly one in five Medicare patients discharged from the hospital is readmitted within 30 days, at a cost of more than $26 billion every year.[1]

Several Aligning Forces for Quality (AF4Q) Alliances have implemented or are partnering in care transitions programs using care transitions coaches to ensure patient care that is coordinated across care settings. Care transitions coalitions hire coaches who can conduct assessments and help patients gain the knowledge, skills, and confidence to become active participants in their own care and achieve their personal health goals. The qualifications coalitions look for when hiring a coach vary depending on the settings in which the coach will work and whether the coach will take on a specialized role such as working mainly with patients with behavioral health problems.

Here's how two Alliances have approached hiring coaches and how they've adjusted their staffing strategies over time as their needs have changed.*

CASE STUDY

Southeast Michigan Community-Based Care Transitions Coalition

Recognizing that many patients have unique circumstances or characteristics that can contribute to avoidable readmissions, the Southeast Michigan Community-Based Care Transitions Coalition developed five care transitions strategies targeted to specific patient populations. These included patients discharged to skilled nursing facilities, patients who are unsuccessful at self-activation and need directive interventions, patients with unmet needs who require additional supportive services, patients with behavioral health problems, and patients who need traditional care transitions coaching.

The Area Agency on Aging 1-B (AAA 1-B), which led the coalition, hired several bachelor's-level social workers, one Licensed Master Social Worker, and one nurse to serve as coaches when the care transitions program began in 2012. All were trained initially in Dr. Eric Coleman's Care Transition Intervention® and in one specialized area so they could focus on a particular patient population—for example, one coach worked mainly with the patients discharged to skilled nursing facilities (SNFs), and one worked with the patients with behavioral health problems. AAA 1-B is a partner in the Greater Detroit Area Health Council, which leads the AF4Q initiative in Detroit.

Tina Abbate Marzolf, chief executive officer of the AAA 1-B, says one lesson she learned is that it would have been easier to focus only on traditional care transitions coaching for the first nine months of the program and then introduce the strategies targeted to particular patient populations later in the project. She feels that if all of the coaches had been cross-trained to work with any kind of patient, she could have utilized them more efficiently and reduced her overhead costs.

"What we discovered was that identifying patients that fit the original Community-Based Care Transitions Program (CCTP) criteria was not easy and mining for referrals took more time than we expected," she said. "Adding in more complexity with these different care transitions strategies should have come later—after the referral process was better established."

Soon after the CCTP funding for the Southeast Michigan Community-Based Care Transitions Coalition ended in 2014, AAA 1-B secured several contracts with private payers. Now AAA 1-B is providing care transitions coaching and other services to a hospital, an ACO, and two continuing care retirement communities (CCRCs). AAA 1-B is also working to secure contracts with five health insurance companies to provide services as part of the state of Michigan's integrated care demonstration project. While all of the coaches AAA 1-B employed while receiving CCTP funding were on staff, the majority of coaches they've hired for the private-payer contracts are temporary employees. This helps AAA 1-B control their overhead costs when patient volume varies.

For the private-payer contracts, AAA 1-B hires nurses and social workers and trains them based on what the client is asking them to do. This can include not only care transitions coaching but also things like fall risk screening, depression screening, assessing stress in caregivers, and medication reconciliation. Abbate Marzolf has found that some clients request nurses even though she personally thinks social workers could provide most of these services, and hiring them would be more cost-effective. She added

QUALIFICATIONS TO LOOK FOR WHEN HIRING CARE TRANSITIONS COACHES

- Coaches need to be flexible, detail oriented, and have good organizational and time management skills.
- Bachelor's or master's level social workers and community health workers can be effective coaches.
- Consider hiring nurses to work as coaches in settings or roles in which a higher level of clinical knowledge is important—for example, working with higher-acuity patients or on medication reconciliation.
- If a coach needs to drive frequently among hospitals, SNFs, and patients' homes, it's important that they understand this about the job up front and are comfortable with it.
- You can train coaches on many of the skills they will need, but it's important to choose candidates who are motivated and able to help patients advocate and find solutions for themselves.

that it works best, however, to have nurses do medication reconciliation in clinical settings because clients want the coach to be able to fix any problem they identify with a patient's medications.

Abbate Marzolf says another key lesson she has learned is that clients don't want to contract with an Area Agency on Aging to do care transitions coaching alone. "We have to be able to provide multiple services to be valuable to third-party payers," she said.

CASE STUDY

Kansas City Bi-State Community-Based Transitions of Care Program

During 2013, the first year they received CCTP funding, the Kansas City Quality Improvement Consortium (KCQIC) subcontracted with four different agencies to provide care transitions coaches for the Kansas City Bi-State Community-Based Transitions of Care Program: the Visiting Nurse Association of Kansas City, Blessed Trinity Home Health Care, Wyandotte County Agency on Aging, and McDonnell and Associates. KCQIC oversees and meets regularly with the people who manage the coaches within those agencies. KCQIC, which leads the Greater Kansas City area's AF4Q initiative, realized in 2014 that they needed to bring on more coaches quickly because their care transitions program was expanding. They opted to directly hire and manage eight additional full-time coaches and one coach who is an independent contractor.

Some of the Kansas City hospitals that are partners in the consortium initially thought all the coaches should be nurses because they wanted them to be able to provide clinical information to patients. The KCQIC team convinced them that social workers and community health workers could also make good coaches, particularly since the main role of the coach is to empower the patient to better manage their own care. The hospitals haven't questioned this hiring strategy since the program began because they have seen that the coaches with a background in social work or community health are effective and have built strong relationships with the case management directors and discharge teams.

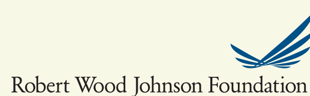
Most of the current coaches are master's level social workers, three have backgrounds as community health workers (two of those are certified nursing assistants), and one is a nurse. Trent DeVreugd, MHA, who works for KCQIC as the director of the Kansas City Bi-State Community-Based Transitions of Care Program, believes that it's essential to hire coaches who are good at managing their own schedule, can relate well to people, and are detail oriented. If their background is in social work, they need to be comfortable working in a hospital setting. "Social workers are trained to listen, and that supports being a successful care transitions coach," said DeVreugd.

Cathy Lauridsen, RN, who works for KCQIC as the clinical director for the Kansas City Bi-State Community-Based Transitions of Care Program, thinks that ideally care transitions coaches who work with SNF patients should have an LPN, RN, or other clinical background. That's because SNF patients tend to be higher acuity, and the coaches need to have credibility when interacting with the providers who work at the SNFs. Lauridsen said that currently the Kansas City Bi-State Community-Based Transitions of Care Program has a coach with a community health background and experience working in a physician's office that is particularly good at working with SNF patients, but in the future she would also like to have coaches with a nursing background visiting the patients in the SNFs.

*This "peer-to-peer" meeting about care transitions was held on August 21, 2014, in Detroit. Aligning Forces for Quality organized and funded the meeting, with a goal of sharing strategies and tools for sustainability planning, staffing, physician engagement, and serving patient subsets. Attendees and subsequent interviewees were involved in the Center for Medicare & Medicaid Services (CMS) Community-Based Care Transitions Program. Attendees included Lisa Mason from the Greater Detroit Area Health Council; Caitlin Gerlach from MPRO; Tina Abbate Marzolf and Barbara Lavery from Area Agency on Aging 1-B; Sandy Kiesel from Go Lean, Inc.; Micheline Sommers from Oakland Family Services; Carrie Hays McElroy and Cathy Ponder from St. Mary Mercy Livonia Hospital; Dave Wilson and Jason Maciejewski from The Senior Alliance/Area Agency on Aging 1-C; Barbara Bremer and Denise Robertson from St. John Providence Health System; Susan Miller and Sara Gleicher from Adult Well-Being Services; Cathy Davis, Trent DeVreugd, and Cathy Lauridsen from the Kansas City Quality Improvement Consortium; Lori O'Connor from Elder Services of the Merrimack Valley; Melissa Pessefall from Akron Canton Area Agency on Aging; Dee Moore from Brewster Place Topeka Kansas; Megan MacDavey from the P2 Collaborative of Western New York; Sharon Mathe from Healthy Community Alliance; Jerry Bartone from Community Concern of WNY; Deanna Ruff from the York County Area Agency on Aging; Amy Shuttlesworth, Winnie Reineberg, and Mandi Waltemyer from WellSpan Health.

REFERENCES

[1] *The Revolving Door: A Report on U.S. Hospital Readmissions*. 2013. Princeton, NJ: The Robert Wood Johnson Foundation.



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