Community Partnership Smashes Silos

Western New York

In the current health care delivery system, care often seems fragmented, as though various providers and patients are all working in separate silos, with limited communication. The care any one provider delivers may be excellent, but without coordination among everyone involved in the process—and putting the patient and caregiver front and center—important details might be missed.

The results? More than 17 percent of Medicare beneficiaries are re-hospitalized within 30 days of discharge, and the Medicare Payment Advisory Commission estimates that up to 76 percent of these readmissions might be preventable. Not surprisingly, 64 percent receive no post-acute care between discharge and readmission.

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Lessons Learned

- Be willing to reach out to other providers who share patients with your organization to partner in creating an equal playing field for the work of improving transitional care.

- Take the time to conduct a root cause analysis of readmissions within your organization and include patients, care givers, community service providers, and physicians in the process.

- Involve direct care staff in the root cause analysis for readmissions, as they are directly involved in the system and know the challenges involved.

- Place the patient at the center of focus and stress the importance of redesigning the system, rather than laying blame on a particular setting.

To address this issue, the Centers for Medicare & Medicaid Services (CMS) approved a two-year community-based care transitions program that has been awarded to only 30 communities throughout the United States. One of the chosen was in Western New York, where the P2 Collaborative of Western New York partnered with seven of the region's eight counties, as well as IPRO, the state's Medicare Quality Improvement Organization; hospitals; skilled nursing facilities, community service providers, and other stakeholders.

The goals of the P2 Collaborative were to improve care for patients and enhance self-management skills, reduce hospital readmissions, and improve access to existing programs.IPRO's experience in transitional care comes from the past four years of facilitating the CMS initiative, which covered a community serving more than 68,000 Medicare beneficiaries.

During the course of the program, IPRO worked with 50 cross-setting providers in a five-county region who were able to demonstrate a 10.8 percent relative improvement in the 30-day all-cause readmission rate, an increase in the seven-day follow-up physician appointment rate, and improved patient experience as reflected in HCAHPS survey questions about discharge information.

The biggest challenge in reaching these goals centered around communication, according to Sara Butterfield, senior director of health care quality improvement at IPRO.

"Health care has become a very fragmented delivery system that has many handoffs and opportunities for gaps in communication in care management," Butterfield said. "The willingness for health care providers to partner on equal, cross-cutting levels has been essential to the success and sustainability of care transition efforts."

Another success of the program, apart from impressive readmission statistics, is that it has created an opportunity for all levels of care providers to gather around one table for the first time to discuss what is working well within their communities, identify areas to improve, provide training opportunities across settings, and implement evidence-based interventions and gold standards of care.

Contact

Sara Butterfield
Senior Director
Health Care Quality Improvement
IPRO
sbutterfield@nyqio.sdps.org