Aligning Forces for Quality | Improving Health & Health Care in Communities Across America

Robert Wood Johnson Foundation

PRIMER/BRIEF

Creating Regional Partnerships to Improve Care Transitions

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Care Transitions Programs: Building Relationships With Providers

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.[i]

Several *Aligning Forces for Quality* (AF4Q) Alliances have implemented or are partnering in care transitions programs using care transition coaches to ensure patient care that is coordinated across care settings. This brief highlights the successes of [alliances] that have developed relationships with organizations and providers in the community so they can collaborate to achieve the shared goal of reducing hospital readmissions through participating in a 30-day care transitions program.

About *Aligning Forces for Quality*

Aligning Forces for Quality (AF4Q) is the Robert Wood Johnson Foundation's signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide real models for national reform. The Foundation's commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at www.forces4quality.org. Learn more about RWJF's efforts to improve quality and equality of care at www.rwjf.org/qualityequality/af4q/.

Effective care transitions programs call for building and sustaining strong partnerships with health care providers in the community so they can collaborate to achieve shared goals. Accomplishing this is difficult in single-setting work and becomes even more challenging and complex when bringing providers from different care settings together who do not typically work with one another and approach their work differently.

Following are the strategies one care transitions coalition* is using to strengthen communication and build trust with a diverse group of partners that includes hospitals, primary care practices, and home health care agencies.

Case Study: Kansas City Bi-State Community-Based Transitions of Care Program

The Kansas City Quality Improvement Consortium (KCQIC) launched the Kansas City Bi-State Community-Based Care Transitions Program (CCTP) in early 2013. Partners in the program include 15 local hospitals, two home health agencies, and the Wyandotte County Agency on Aging. Their goal is to reduce hospital readmission rates by providing care transitions coaching services to Medicare fee-for-service beneficiaries who are admitted to a partner hospital with diagnoses such as such as pneumonia, heart failure, acute myocardial infarction, diabetes, respiratory failure, or stroke.

In 2012, KCQIC, which leads the greater Kansas City area's AF4Q initiative, formed a "logistics committee" made up of representatives from the 15 partner hospitals and the three agencies that provide coaches for the transitions of care program. The hospital staffers who attend the meetings are the directors of social work, directors of case management, or nurse managers. The committee first began meeting when KCQIC was preparing to apply to participate in the CCTP and continues to meet on a quarterly basis.

Initially, the group worked together on designing workflows and creating and approving informational flyers and consent forms. Now they are collaborating with a local accountable care organization called the Kansas City Metropolitan Physician Association to determine the best ways to let local primary care practices know when one of their patients has been enrolled in the transitions of care program and to coordinate care.

"KCQIC was able to get competing hospitals to come together with a common goal because the logistics committee provides a neutral common ground," said Trent DeVreugd, director of Transitions of Care for KCQIC. "We want to keep this group engaged and see what else we can do—even beyond the Transitions of Care program—to reduce readmissions and improve quality of life for patients."

The Basics of Partnerships

Building relationships allows health care providers from different care settings who do not typically work with each other to approach their work differently to collaborate to achieve shared goals.

What do partners do?

- Establish a cross-setting oversight team with the common goal of reducing readmissions and improving quality of life for patients
- Provide care transition coaching services to partner with hospitals with certain conditions/diagnosis
- Share data and results to assess progress towards goals
- Establish a subgroup to discuss operational issues, coordinate scheduling of services, and improve communication concerns

Who to consider for partners:

- Local hospitals
- Home health agencies
- Area Agency on Aging
- Physicians

KCQIC also organized a Downstream Providers group that includes representatives from the large and small home health agencies in the community. Because two of the organizations KCQIC subcontracts with to provide care transitions coaches happen to be home health agencies, some of the other home health agencies in Kansas City have expressed concern that the coaches will refer patients in need of home health care only to their own agencies. At the Downstream Providers group meetings, KCQIC was able to explain that the care transitions coaches are not allowed to make referrals to their own agencies and that they always contact the primary care doctor to discuss whether home health care is needed and which agency they should choose. "We are making sure we can differentiate what the coaches do from what the home health agencies do and that we aren't duplicating services or threatening them," said DeVreugd.

He noted that a home health agency based at North Kansas City Hospital recently worked out a system with the care transitions team to share information about patients who are receiving home visits from both programs and better coordinate the scheduling of those visits. Their collaboration is proving so successful that DeVreugd said he plans to present this model eventually to the other hospitals in the transitions of care program

**This "peer-to-peer" meeting about care transitions was held on May 7, 2013, in Chicago.* Aligning Forces for Quality *organized and funded the meeting, with a goal of sharing strategies, tools, and process designs to increase footprint, increase enrollment, decrease refusals, and report data. Attendees and subsequent interviewees were involved in the Center for Medicare & Medicaid Services (CMS) Community-Based Care Transitions Program unless otherwise indicated. Attendees included Sheri Vogel (moderator), Nancy Strassel, and Rhonda Prince from the Greater Cincinnati Health Council; Kim Clark and Ken Wilson from the Council on Aging of Southwestern Ohio; Shelley Hirshberg, Megan Havey, Mistine Keis, and Kate Ebersole from the P2 Collaborative of Western New York; Cathy Davis, Poornima Kumar, Rosemary Graves, Trent DeVreugd, and Mark Gunther from the Kansas City Quality Improvement Consortium; and Lori O'Connor from Elder Services of the Merrimack Valley.*

References

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