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: Identifying and Recruiting Patients for Participation

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 between 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 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 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 successes of Alliances in identifying patients with a high risk of hospital readmission and recruiting them for participation in a 30-day program to reduce the risk of readmission.

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/.

Each care transitions program has a target population of patients who are about to be discharged from the hospital. Partners identified community-specific root causes of readmissions and specific conditions and diseases with higher rates of readmission to target for the care transitions program. Care transition coaches seek to enroll as many of this target population, with the goal of reducing hospital readmission.

The following shows how two care transitions programs developed effective methods of identifying eligible patients, approaching them, and encouraging them to enroll.*

Case Study: The Merrimack Valley Collaborative

Elder Services of the Merrimack Valley (not a member of an AF4Q Alliance) is targeting Medicare fee-for-service patients with conditions such as congestive heart failure, chronic obstructive pulmonary disease (COPD), myocardial infarction, pneumonia, and diabetes who have been screened and identified as being at medium- or high-risk for readmission.

Staff at all six of the partnering hospitals screen patients using the Louisiana QIO Discharge Risk Assessment tool during the admission process. Most of the questions focus on clinical factors that put patients at risk for readmission, but some focus on issues like requiring assistance with medication management or community support. Every morning, a "lead" care transitions coach, who is an employee of Elder Services of the Merrimack Valley and is embedded in the case management department of a partner hospital, identifies patients who are eligible for the care transitions program.

Addressing Patient Refusals

The Merrimack Valley Collaborative developed the following scripts to address common reasons patients give for turning down the opportunity to enroll in a care transitions program:

I already have VNA.

- This will not interfere with any other services you are receiving.
- We work closely with the VNA to help you manage your condition.
- We have tools to help you organize your health care on an ongoing basis.

My family takes care of that.

- We will work with your family/caregiver.
- We may be able to offer resources to assist your family.
- We have tools to help your family organize your health care management.
- Sometimes a new set of eyes can offer new solutions.

I live in assisted living.

- We can help you identify red flag symptoms for your caregivers.
- We can assist with transportation to appointments.
- We can help you get the most out of your appointments.

This was only a one-time occurrence.

- Our goal is to prevent readmissions and help you stay at home.
- We can help you identify red flags and manage your condition.
- We have tools to help you organize your health care on an ongoing basis.

I've had this condition for a long time, and I know how to manage it.

- We can offer resources to assist with your care.
- We may be able to provide new information/new perspectives about your condition.
- We would like to talk about your successes.

I have a good relationship with my PCP.

- Excellent! This program will help you get the most out of your appointments.
- We can help you identify questions for your doctor.
- We can help you prepare for appointments with specialists.
- We can identify factors at home that may influence your condition between appointments.

I'm leaving the state in two weeks.

- This is a one-time visit.
- We can provide tools to take with you on your vacation to ensure continuity of care.
- This program will help you manage your condition on an ongoing basis.

The nurse went over all of that at discharge.

- We can help to check your understanding of the hospital information.
- We can help identify questions for your

I don't feel well enough for a visit.

- Our goal is to keep you out of the hospital.
- We can help you identify and react to red flags for your condition.
- We can help you organize your health care.

If all else fails: "This is a one-time visit that usually takes only an hour!"

The coach reviews the daily census— an official tally of all the patients admitted to the hospital since 12:01 and includes room number, age, and insurance information—to see which Medicare fee-for-service patients will be discharged soon. Members of the hospital's case management or social work staff have flagged the patients on the daily census that scored as medium- or high- risk on the Louisiana QIO Discharge Risk Assessment tool.

The lead coach then meets with eligible patients in the hospital and performs an additional mental/behavioral health risk assessment screening. This tool includes questions about mental and behavioral health factors that put patients at risk for readmission—for example, suicidal ideation or attempts, a history of alcohol or substance abuse, or a psychiatric admission within the past two years. (For more about this assessment, see "Addressing Psychosocial Factors," below). The coach also asks whether the patient has transportation to get to appointments with their primary care provider or if they need any medical equipment or money for medication or copayments.

Patients who participate in the program receive a coach's help coordinating and managing their care for 30 days. The Merrimack Valley Care Transitions program also can provide and cover the cost of additional support services and interventions, such as transportation to medical appointments, medical interpreting, money for medication or medical equipment, chronic disease self-management programs, or a home care aide who can assist with shopping, cooking, and errands. Occasionally, a patient is reluctant to accept a home visit from a coach because they're embarrassed by the state of their home. The coaches can make them more comfortable by offering to meet them on their front porch or at a local coffee shop.

Some patients turn down the opportunity to participate in the care transitions program at first because they've had bad experiences with home health services in the past. Often, the coach can change the patient's mind. The coach might wind up

visiting the patient in the hospital three or four days in a row and building trust before the patient agrees to enroll.

Lori O'Connor, RN, CCTP director at Elder Services of the Merrimack Valley, a collaborator outside the *Aligning Forces for Quality* initiative, says the coaching team found it's useful to ask patients questions about themselves and about what brought them to the hospital. For instance, the coach asks them about why they don't want to get readmitted to the hospital. In many cases, the patient will say they have a pet they want to take care of or some other reason to be home. This establishes a better rapport than just talking with the patient about the care transitions program. "When you can engage the patients on a personal level without pushing the program on them, they see the benefit of it," O'Connor said.

Case Study: Southwest Ohio Care Transitions Collaborative

The Southwest Ohio Care Transitions Collaborative's target population includes all Medicare fee-for-service patients admitted to one of the five partner hospitals who are at high risk for readmission because they have multiple chronic conditions such as COPD, heart disease, or diabetes. Every day, the transitions coaches are onsite at the partner hospitals. They use the hospitals' electronic health record system to sort through the daily census. Then they print out a list of all the eligible Medicare fee-for-service patients who will soon be discharged and decide which patients to visit that day. The list includes details like each patient's admitting diagnosis and last admission to the hospital. Hospital staff, including discharge planners, social workers, and case managers, also refer eligible patients to the coaches. Currently, the five participating hospitals are all trying out different risk assessment tools, and they are not yet ready to begin using the same one.

According to Sheri Vogel, project manager at the Greater Cincinnati Health Council, it can be tricky for the coaches to decide on the best time to meet with a patient. Sometimes the coaches have to see patients two or three times during their hospital stay before they agree to enroll in the program. When patients say they really don't need a care transitions coach, it often helps if the coach can ask a social worker, case manager, or physician to explain the value of the program and encourage them to enroll.

Every patient in the Care Transitions program gets one visit at home from a coach after he or she is discharged. The coaches found that when they call patients to confirm the time for the home visit, they shouldn't give them enough room to back out, but should make sure they'll be home for the appointment. Vogel says the coaching team is also working on fine-tuning the wording they use to introduce the program at the patient's bedside. Instead of asking: "Is it ok if we visit you at home?" they say: "The next step in your care is for me (the coach) to come to your home."

"We shouldn't be tentative in our approach," Vogel explains. "We should present what we're offering as part of the continuum of care."

Case Study: The Care Transitions Program at St. Joseph Health System

Some of the patients who enroll in the Care Transitions Program at St. Joseph Health System in Humboldt County, CA, also qualify for an Intensive Transitional Services program.**These patients typically have complex health conditions and may be homeless and lacking transportation and an established primary care provider. Most of them also suffer from mental health and substance abuse issues. To help support these patients so they can better follow their treatment plans after they're discharged, St. Joseph Hospital provides them with respite housing in a local motel or clean and sober house for a period of two weeks to a month. Members of the Care Transitions team visit the patients more than once after they leave the hospital and work to ensure their basic needs are met, connecting them with resources in the community if they need clothing, food, or transportation.

Sharon Hunter, RN, PHN, Care Transitions Program manager at St. Joseph Health System, said the patients who stay in the respite housing tend to have a much better recovery since they receive support while they transition and heal. For the patients who enrolled in the Care Transitions program between July and December of 2011 and received Intensive Transitional Services, ED utilization dropped an average of 41 percent, and hospital utilization dropped an average of 62 percent one year later.

Case Study: Care Transitions of Western New York

When the coaches for Care Transitions of Western New York visit patients at home, they learn a lot more about them than is apparent in the hospital. In the home, coaches can observe whether or not a patient has a caregiver or receives support from family members or neighbors. They can proactively connect patients with resources in the community like Meals on Wheels and a hotline for services for older adults called New York Connects. If they notice signs of abuse or hoarding problems, they can intervene to get patients the support they need.

In one case, a coach noticed a patient was repeatedly getting readmitted to the hospital around the holidays, and he realized this was due in part to her loneliness. He resolved to help keep her out of the hospital for more than 60 days. Since he works at Medina Memorial Hospital's home health care agency and wears multiple hats, he was able to continue checking in on the patient beyond the 30-day care transitions intervention period. On the weekend of Valentine's Day, he stopped by to ask her how she was doing. He also called her occasionally when he knew she would be having a tough weekend.

Another coach learned during a home visit that a patient in the program loves southern cooking and used to be a chef. Many of the patient's health conditions—including high blood pressure, high cholesterol, and diabetes—were related to his unhealthy diet. The coach helped the patient brainstorm ways to eat healthier so he could achieve his personal goal of returning to cooking in the kitchen.

Case Study: The Merrimack Valley Collaborative

The coaches screen every patient enrolled in the Merrimack Valley Collaborative's care transitions program using a mental/behavioral health risk assessment tool. This tool, as described above, was developed by Elder Services of the Merrimack Valley and includes questions about mental and behavioral health factors that put patients at risk for re-hospitalization, such as a history of alcohol or substance abuse, suicide attempts, and admission to a psychiatric hospital within the past two years. If patients are scored as "high" risk, they are assigned to a transitions coach who specializes in mental health. If they are "medium" risk, they receive an additional assessment to determine whether they should be assigned to this coach.

How you can identify and recruit hospitalized patients for a care transitions program

1. Select a screening tool
2. Review the daily census
3. Meet with patients
4. Use a mental and behavioral health risk assessment screening
5. Help arrange transportation
6. Locate needed medical equipment
7. Help find money for medications and co-pays
8. Use medical interpreters
9. Link to home aid services
10. Review list of soon-to-be-discharged patients
11. Provide staff referrals

The mental health coach connects patients with mental health services in the community. But since it can be hard to access these services in a timely manner, the coach may stay in contact with the patient for longer than the typical intervention period to make sure they get the help they need. If a patient is struggling with depression and social isolation, the coach often focuses on getting them more involved in activities—at the local senior center, for instance—and can arrange for a volunteer to provide their transportation.

One patient in the care transitions program kept getting readmitted to the hospital, and the mental health coach realized she liked being there because she was lonely. The coach was able to help her find an outlet by putting her in touch with the local Council on Aging, where she began teaching knitting classes a couple of days a week. Since then, she has not been readmitted.

**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 (CCTP) 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.

*** The Humboldt County, CA, alliance did not participate in CCTP.*

References

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

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