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: Tracking Performance Metrics

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 transition coaches to ensure patient care that is coordinated across care settings. This brief highlights metrics and data alliances are tracking to achieve the shared goal of reducing hospital readmissions through participation 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/.

By collecting and analyzing data, care transitions programs can gauge whether they are achieving their program goal of reducing hospital readmissions for Medicare fee-for-service patients. Alliances have identified it is important not just to measure the programs outcome goal of lowered readmissions, but also to measure and monitor key program processes to drive quality improvement.

Data review leads to productive brainstorming sessions about whether quality improvement efforts are working. Data are shared with care transitions coaches and hospital management and staffs at least monthly so any needed changes can be identified and made quickly. Teams also look closely at patients who complete the 30-day care transitions program and are subsequently readmitted to the hospital.

Here's how two care transitions coalitions are tracking performance metrics and sharing their data.*

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

Trent DeVreugd, director of Transitions of Care for KCQIC, meets with the director of case management and the director of quality improvement at each of the partner hospitals in the transitions of care program about once a month to share data and discuss trends that are starting to develop. They review monthly data, for example, on the percentage of Medicare fee-for-service patients who were eligible for the program based on diagnosis, how many accepted and declined enrollment, which coaches have the most success enrolling patients, how many received a home visit within 72 hours, how many received specific services like a medication reconciliation, how many completed the full 30-day care transitions intervention, and the reasons patients gave for not enrolling in the program. They also look at data on patients in the program who were readmitted and talk about what they could have done differently in those cases—for instance, whether the patients could have benefited from other services such as home health care. Some of the data are collected by the care transitions coaches, and the rest are from the hospitals—in particular, from the patients' charts and from monthly hospital admissions reports.

KCQIC also publishes a program brief on a regular basis that includes a few statistics on patient enrollment for each of the partner hospitals that have started offering care transitions services. This brief is shared with the logistics committee, physicians groups, and many other stakeholders.

DeVreugd noted that one example of the kinds of analysis they're starting to do is looking at whether there is any correlation when the data show an increase in a hospital's readmission rate and an increase in the number of patients refusing transitions of care services.

What performance metrics are collected?

Programs developed process metrics that help them evaluate and improve performance toward meeting the outcome of reduced hospital readmissions.

- The number and percentage of Medicare fee-for-service patients who were eligible for the care transitions program based on diagnoses
- The number of patients who accepted/declined enrollment
- The number of patients who accepted/declined enrollment stratified by care transition coach
- The reasons patients have given for not enrolling in the program
- The number of patients who completed the full 30-day care transitions intervention
- The number of home visits conducted
- The number of patients who received a home visit within 72 hours of hospital discharge
- The number of patients who received medication reconciliation

How are the data collected?

- By the care transitions coaches
- By the hospitals, from patient charts and monthly admission reports

Who are data shared with?

Shared monthly with:

- Partner (participating) hospitals
- Physician groups
- Logistic/steering committee
- Hospital leaders involved on a daily basis with patients (e.g., directors of case management, directors of QI, discharge planners)
- Leads at community-based organizations that provide care transition coordinators
- Partners and stakeholders

Case Study: Care Transitions of Western New York

The P2 Collaborative of Western New York collects data that the care transitions coaches enter into a customized online database. They track on an ongoing basis, for example, the number of patients who are eligible for the program, the number who enrolled, and how many home visits were completed. They also collect readmissions data for patients in the program and those who are not in the program but who were eligible to participate. Megan MacDavey, manager of care transitions for the P2 Collaborative, and her team share this data during monthly phone calls with hospital leaders who are involved on a daily basis with the program, including directors of case management, directors of quality improvement, discharge planners, and the lead contacts at the community-based organizations that provide the

transitions coaches. They also share data every month with a steering committee made up of hospital leaders and the directors of the community-based organizations.

In addition, P2 Collaborative sends quarterly reports to their partners that include a more in-depth analysis of the data, including statistics like the number and type of medication discrepancies identified by the coaches, the number of completed 30-day interventions, and scores by county for the CTM-3 (a patient survey about coordination of hospital discharge care).

MacDavey says that when her team reviews data with their partners over the phone, it leads to productive brainstorming sessions about whether quality improvement efforts are working. Now they're starting to look at data on patients who completed the care transitions program and were later readmitted to the hospital. By conducting case reviews with the partner hospitals, they hope to learn what they could do differently in the future to prevent readmissions in similar cases.

**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.*

References

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