

Transforming Transitions From Patient Interventions To Systems Change

Quality Partners Of Rhode Island's Safe Transitions Project

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Home health agencies have long focused on reducing hospital re-admission rates, first by publicly reporting agency-level rates and later through the implementation of nationwide campaigns. Nationally, the Centers for Medicare & Medicaid Services (CMS) estimates that one in five hospitalized Medicare patients return to the hospital within 30 days of discharge, translating to approximately one million hospital readmissions and over \$15 billion annually. As a result, there is increasing emphasis on supporting cross-setting partnerships among home health agencies and hospitals, nursing homes, and physician offices to synchronize efforts and improve cross-setting care coordination and communication.

In 2008, Medicare provided funding to Quality Improvement Organizations in 14 states, including Rhode Island, to pilot such cross-setting interventions to reduce hospital readmissions. Quality Partners of Rhode Island's three-year project aims to improve care transitions – when patients move from one care setting or provider to another – by demonstrating the local efficacy of patient- and systems-level interventions while simultaneously building the business case to sustain and spread evidence-based processes. The project includes bolstering patient discharge education through face-to-face coaching (primary intervention) and computerized education, as well as working with providers to improve cross-setting discharge communication. To sustain and further integrate change, the business case is designed to link hospital and phy-

sician best practices (from interventions and published literature) to commercial health insurance payment, so that evidence-based care practices are financially incentivized.

This dual focus allowed the team to implement patient and systems changes quickly, while simultaneously generating the consensus and data necessary to obtain stakeholder buy-in to implement systems change after the Medicare funding period.

Patient-Level Intervention: Coaching

Quality Partners implemented the evidence-based Care Transitions Intervention (CTI or “coaching”) starting in January 2009, beginning in a single hospital and expanding to six hospitals over the course of a year. A randomized, controlled CTI trial in Colorado demonstrated that health coaches working with hospitalized patients for the 30 days following discharge can reduce hospital readmission rates 30% or more; methods and results are detailed elsewhere.¹ In Rhode Island, coaches were interdisciplinary, including nurses, certified nursing assistants (CNAs), and social workers. Working in collaboration with hospital staff, the coaches identified Medicare fee-for-service (FFS) patients, initially targeting those with specific high-risk conditions (e.g., heart failure) and gradually expanding to include all non-surgical diagnoses. Coaches approached patients for consent prior to discharge, and followed-up with home visits and phone calls. Their work

with patients focused on “four pillars” of patient activation or empowerment: 1) helping with the use of a personal health record; 2) assisting with medication reconciliation; 3) ensuring that patients made and kept outpatient follow-up appointments; and 4) teaching patients about the signs and symptoms of worsening conditions, so they could seek help before their condition became emergent and required hospital readmission. Despite initial concerns by some stakeholders that coaching might be duplicative of existing home care services, the coaching activities were intended to complement home health services rather than replace them. Additionally, the coaches worked with home health agency staff to ensure that scheduling priority was given to home health visits.

Reduction In Readmission Rate

From January 2009 to March 2010, 191 patients participated in the intervention, receiving at least the hospital visit and home visit.

The 30-day readmission rate in the intervention group is 16%. After controlling for differences between those receiving coaching and those not receiving it, this reflects a 34% reduction in readmission for patients receiving coaching as compared to those not approached. Methods are described elsewhere.² There are several limitations to these results, including the fact that sicker patients may be less likely to consent to coaching (e.g., if they are feeling overwhelmed

with health care) and that patients with higher baseline self-activation or health literacy (and therefore lower readmission risk) may be more likely to consent. Nevertheless, these results demonstrate a significant and meaningful association between coaching and reduction in readmissions – indicating that the CTI can be effectively translated from a research setting in a closed healthcare system to real-world implementation in an open healthcare system.

Cost Avoidance

The coaching data form the basis of Quality Partners’ business case for improved care transitions. By examining the costs incurred (regardless of patient consent or participation in coaching), the team calculates a cost differential of \$1,111 per patient from January 2009 to March 2010. After taking into account the coaching program costs, the cost-benefit analyses illustrate that, over just 15 months, the coaching program yielded a Medicare cost avoidance of approximately \$250 per Rhode Island Medicare FFS patient approached. Basing calculations on all screened and approached patients most conservatively estimates the cost-

benefit balance; because not everyone is eligible for the program or consents and completes the intervention, the staff time and other resources required to screen eligible patients and recruit a sufficient population are substantial. Evaluating only the cost of patients who received the intervention would overestimate cost avoidance.

Systems-Level Intervention: Cross-Setting Communication

For over 25 years, the Rhode Island Department of Health has mandated that some licensed healthcare facilities (i.e., home health agencies, nursing homes, hospitals) complete a five-page CoC Form for every discharged patient and transmit the completed form to the downstream provider. The goal of the CoC Form is to prompt healthcare staff to log pertinent patient information – thus ensuring that providers share the right information at the right time. The paper-based form incorporates requirements from all relevant Rhode Island regulations, and also supports local initiatives on topics such as cross-setting pressure ulcer prevention. Importantly, the information contained in the form serves as the “orders” for the

patient’s next level of care.

Quality Partners’ cross-setting communication intervention includes two concurrent tactics to improve communication using the CoC Form. First, the project educated providers about the Department of Health’s expectations for the completion and transmission of the existing form. Second, the project convened a stakeholder workgroup to improve the form’s content and flow, while ensuring that it meets Joint Commission discharge summary requirements and maps to federal interoperability standards for data elements of electronic medical records (EMRs). Provider feedback on current CoC Form usage, including a Fall 2009 survey, informed the revisions: suggestions included Department of Health efforts to address variation in CoC Form completeness and legibility, reduce errors, and enhance medication reconciliation and patient safety. Once the form’s content and design changes are complete in Spring 2011, the Department of Health and Quality Partners will educate end users to ensure accurate, timely use.

This intervention is supported by quarterly audits conducted by Quality Partners staff, evaluating the accuracy, com-

(more on next page)

Hospital Visit Timeline	Best Practices	
	Community Physician	Hospital
At Intake	Provide clinical information when referring patients for Emergency Department (ED) evaluation	Notify community physician about hospital utilization
During Visit	Provide ED/hospital with access to outpatient clinical information and staff who can answer clinical questions	Invite primary care physicians (PCPs) to participate in end-of-life discussions Provide patient with effective education (as defined in the best practice), written discharge instructions, and follow-up phone number Perform medication reconciliation Schedule outpatient follow-up appointment
At Discharge	Confirm receipt of hospital discharge information	Provide PCP the hospital contact information and summary clinical information
After Discharge	Follow-up with high-risk patients via phone Conduct outpatient follow-up and perform medication reconciliation	

pleteness, and legibility of forms sent between home health agencies, hospitals, and nursing homes. Providers receive feedback and information from these audits to inform CoC process improvements. Since the CoC Form training and audit and feedback began, data show that overall form completeness (a composite measure of several data fields and legibility) increased from 51.7 to 70.3 on a 100-point scale. Data fields of interest include contact information for the attending and outpatient physicians, identification of the person completing the form, and documentation of worsening symptoms and an advance directive.

Best Practices

To develop stakeholder consensus and buy-in for systems changes to improve care transitions in Rhode Island, Quality Partners convened an Advisory Board comprising opinion leaders representing all healthcare settings and the commercial health plans. The Board's role was to define a shared vision for care transitions and then collaborate on strategies to implement systems change, ultimately ensuring the systematic incorporation of key care processes (sustainability) and expanding the project's impact from Medicare FFS patients to all patients, regardless of age or payer (spread). The final shared vision is:

“A healthcare system where discharged patients understand their conditions and medications, know who to contact with questions, and are supported by healthcare professionals who have access to the right information, at the right time.”

To date, the sustainability/spread initiative has taken form in two complementary sets of best practices: one defined for hospital implementation and the other for community physician practices' implementation (see page 13). The best practices focus on a key component of the vision: communication. Both pull from the pilot program's results, local preferences, and the published evidence base – and both attempt to align incentives with implementation, to mitigate any potential lost revenue (primarily for hospitals seeking to maintain their daily census) and to appropriately incentivize new care processes and workflow, while

also ensuring provider accountability. They are intended to promote enhanced communication surrounding discharges and providing care in the least restrictive setting. In the future, additional best practices will target home health agencies and other settings.

Hospital Best Practices

The hospital best practices were developed in partnership with the commercial health plan Chief Medical Officers (CMOs) and endorsed by the 11 acute-care hospitals' Quality Directors. The Quality Directors then provided input on the associated metrics, helping the team identify metrics that were feasible within existing data sources and consistently defined between facilities. Once the care processes and metrics were finalized, the team undertook parallel processes to obtain hospital executive buy-in (and opt-in) while working with health plans to incorporate the best practices into hospital contracts. All three health plan CMOs have provided verbal commitments to attaching incentive payments to hospitals' voluntary adoption of the best practices. To date, two have begun to incorporate contractual language into their hospital contract negotiations. Although hospital contracts are staggered, meaning that not all hospitals are up for contract renewal this year and their contracts with the various health plans likely renew at different times, the team believes that incorporation of the best practices into any one hospital contract will generate system-wide change within that facility – affecting care delivery for all of its patients.

Outpatient Physician Best Practices

The outpatient physician best practices were developed in partnership with the Advisory Board and select physician groups in the local community, including the PCP Advisory Council regularly convened by the state's Department of Health. Because the outpatient physician community is more diffuse than the hospital community, the team sought opportunities to gather feedback from any existing physician groups and other strate-

gic partners, such as the Department of Health. The next steps will involve partnering with the health plan CMOs to identify strategies to implement incentive payments (e.g., under the state's Affordability Act's Primary Care Spend). Additionally, a long-standing multi-payer medical home pilot program, the Chronic Care Sustainability Initiative (CSI), has expressed interest in incorporating both the hospital and physician best practices into its contracting at a single site, which would facilitate the implementation of the best practices between inpatient and outpatient practitioners working on the same initiative.

Conclusion

Quality Partners' strategy to transform transitions from patient interventions to systems change is a deliberate one that first demonstrates potential gains (patient outcomes and cost avoidance) and then asks local stakeholders to change care systems and align reimbursement accordingly. Providers may choose to implement some of the best practices using patient coaching, or they may choose alternate strategies based on their unique situations. Regardless of the tactics they choose to employ, the common metrics will enable health plans to evaluate the relative efficacy of providers' specific approaches. Over time, Quality Partners plans to expand the best practices to other healthcare settings and providers, to further sustain and spread the lessons learned from the pilot program. These tactics and lessons learned are increasingly important given the national focus on care transitions. Next year, care transitions work will further expand as the Administration on Aging launches a nationwide community-based care transitions program. **RR**

References

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2. Voss R, Gardner R, Baier R, Butterfield K, Lehrman S, Gravenstein S. The Care Transitions Intervention: translating efficacy to effectiveness. *Arch Intern Med*. In submission.