

Tightening transitions of care

Hospital Builds Post-Acute Care Partnerships

By Tyler Smith

Like any good health care provider, University of Colorado Hospital does all it can to get people ready for the day they can leave. Now the hospital is more concerned than ever in forging relationships to reduce the chances they will have to come back.

Among the recent efforts are partnerships with a pair of post-acute care providers, [Kindred Healthcare](#) and [Vivage Quality Health Partners](#). The two cover a wide spectrum of services in the Denver area, including long-term acute care, skilled nursing, home care, hospice, and outpatient rehabilitation.

The hospital has no ownership stake in the arrangements, which were announced in mid-January, said Derek Rushing, vice president of clinical and support services for UCH. Patients and families are not required to choose either facility, he added.



The idea, developed after a series of meetings that included both hospital and physician leaders, is to build strong ties with organizations the hospital believes are best suited to delivering high-quality care to patients after discharge and working collaboratively to achieve that goal.

Kindred and Vivage emerged as the choices after the group reviewed some 20 requests for information (RFIs), Rushing said. They winnowed the original group to eight contenders before making the final decision based on “dozens of criteria,” he said.

“We said if we are going to choose organizations to collaborate with, what things would be most important to us?” Rushing said. The key RFI factors included quality measures, such as hospital readmission rates, patient falls, and infections; strong patient satisfaction scores; well-developed information technology systems; a broad payer mix; and a willingness to integrate care with the hospital.

“We wanted to make sure this wasn’t just about wanting to grow the number of admissions,” Rushing said. “We wanted organizations that are interested in working with us to improve transitions of care.”

Piece of the puzzle. The stakes for developing strong relationships with community providers are high for UCH and other hospitals. The Readmissions Reduction Program initiated by the Centers for Medicare and Medicaid Services (CMS) imposes financial penalties on hospitals with excessively high 30-day readmission rates for patients with a growing list of conditions. A readmission for any reason counts against the hospital.

“From an economic standpoint alone, hospitals want to align with institutions they know will provide quality care,” Rushing said.

In addition, improvements that result from the hospital’s work with Kindred and Vivage could be applied more broadly, said Barbara Carveth, chief financial officer for UCH.

Continued

"We need to create better alignment with community providers and options for improving transitions of care," she said. "These two organizations have experience in doing that. They can help us figure out initiatives to work on to benefit patients and help us make changes we can use with other post-acute care providers."

One way to do that is to create evidence-based standards of care for patients who are, say, managing cardiology issues or rehabbing from orthopedic injuries or procedures. Marty Ardron, division vice president for Kindred Healthcare, said his organization aims to work closely with UCH providers and faculty to develop "clinical pathways" that ensure patients get consistent care when they leave the hospital and move on to post-acute care.



The hospital's partnership with two area post-acute care providers aims to reduce 30-day readmission rates.

"We're getting out of the concept that discharge is from point A to point B," Ardron said. "The concept we like to use is you don't discharge your children to college; you transition them, and you still have responsibility for them. We're looking at transitioning patients, realizing that it is in the best interest of both organizations and the health care community that patients' care continues in a way that allows them to stay as well as possible and have good outcomes."

Regular review. The groups meet in monthly joint quality committees to review process and outcomes for patients they jointly manage. Subcommittees tackle specific issues, such as difficult-to-transition patients and barriers to care – "anything that can impact quality care," as Ardron put it.

For example, Ardon said, Kindred and UCH are working to make sure providers follow patients' end-of-life wishes after they transition from the hospital to the next level of care. Work on the interface between information systems containing patients' medical records is sure to be another critical area of discussion, he said.

The collaborative work includes a "joint quality scorecard" that includes metrics such as length of transition, length of stay, and readmissions, Rushing said.

"For example, we will be digging into the data to find the reasons for unplanned readmissions," he noted. Partnership leaders could also conduct case reviews to pinpoint not only barriers to smooth transitions, but also hand-offs that went well and the lessons that might be applied more broadly to improve care, he added.

The work is "small in scope" today, but the partnership idea could translate to other areas of care, Carveth said.

"Process improvement is translatable," she said. "There is no definite end. We're creating alignments that we will continue to expand on in the future."