Care transitions work group helps providers understand capabilities, limitations

Kim Kannely RN, BSN

Almost three years ago Qualis Health launched a care transitions initiative in Washington state aimed at eliminating unnecessary hospital readmissions, according to its Web site.

Qualis Health is the federally designated Medicare Quality Improvement Organization for the state. The project, known as Stepping Stones: Bridging Healthcare Gaps, is one of only 14 such efforts in the nation.

In order to foster communication, participants in 2008 began meeting at St. Joseph Hospital in Bellingham for a monthly receivers' work group that brings together all the organizations that receive patients from the hospital. Participants include representatives not only from the hospital and Qualis Health but also from nursing homes, physician practices, indigent clinics, aging services, assisted living facilities and home health agencies.

Kim Kannely is a member of the work group, which regularly consists of 15 to 20 attendees. The registered nurse is the Director of Clinical Services for Walgreens Infusion and Respiratory Services in Bellingham. The chain drug store also has a home health division with a daily census of about 400 in four counties, she said.

Kannely said the beauty of the care transitions project is the work group itself. She's seen firsthand the challenges the hospital faces in making sure its administrators, hospitalists, private doctors, and discharge planners are all on the same page. Likewise, she's seen the way that other providers must be able to make adjustments. For example, a home health agency may need to expand its use of telehealth before it can accommodate more discharged patients. These change take time, she said, so it's easy to understand why the project is coming to fruition a little more slowly than expected.

The work group also gives participants the chance to learn more about one another, said Kannely. For instance, the group discussed home health agencies' criteria for accepting patients. The group also discussed efforts to keep patients out of the hospital, and the ramifications if they can't. At a recent meeting, the group talked about some new home health regulations and cleared up some misunderstandings. Some physicians thought home health agencies were responsible for the changes, not realizing it was actually a new Medicare policy.

"I can't say enough good things about the project," said Kannely. "It's been a real awakening, and it's raising the consciousness of all the providers."

The project has resulted in other benefits, said Kannely. Walgreens' home care agency expanded its telehealth program and averted rehospitalization of heart failure patients. The hospital added important information to the discharge form, and the process is much improved. In addition, a group doctor who is part of a large family practice network elected to have an office person help to ensure patients are referred appropriately to ease the transition.

In fact, much like the group doctor, some participants have been surprised about the complexity of the discharge process, she said. At the same time, hospital personnel were shocked to discover only 4 percent of their patients are discharged to home health. To lower rehospitalization rates, home health agencies can work with more of these patients if they meet the eligibility requirements, Kannely said. That would benefit everyone involved—both providers and patients, she said.

Kannely said participants value their time together and plan to continue meeting even after the Qualis Health project ends.