INNOVATION IN HEALTH CARE AWARD

COMMUNITY MEMORIAL HEALTH SYSTEMS: VENTURA COUNTY HOSPITAL TO HOME ALLIANCE

The Ventura County Hospital to Home Alliance (Alliance) – comprised of three health systems, seven skilled nursing facilities (SNFs), 10 home health agencies (HHAs), a community-based organization (CBO), a large managed care organization (MCO), and a Centers for Medicare & Medicaid Services (CMS) Quality Improvement Organization (QIO) – formed to change how care is delivered in Ventura County. The members of the Alliance have effectively implemented changes that improve communication, coordination, and accountability. In addition to developing solutions to improve the delivery of care and access to supports and services, the Alliance has also placed emphasis on policy and advocacy, looking to inspire legislative changes that better integrate care across the continuum.

RESULTS

- Reductions in home health readmissions (8%), and in readmissions for SNFs for one hospital partner (5%).
- Process for care transitions connects health and social services providers, allowing for seamless referral and delivery of services.
- Commitment from members to be held accountable for quality and outcomes performance.

INSPIRATION

Analyses of the 18 percent readmission rates of Medicare beneficiaries in California revealed a lack of coordination between care settings, especially during transition from the hospital to the community, or a post-acute care facility.

In response, the Alliance formed to find solutions for a seamless transition process for older adults, seeking not only to improve health outcomes but also to improve satisfaction and experience.

COMMUNITY MEMORIAL HEALTH SYSTEMS:

"The Alliance is very much a partnership – truly moving from competitors to collaborators – for the greater good of the community."

ORGANIZATIONS INVOLVED

Three health systems: Community Memorial Health Systems, Dignity Health Ventura County and St. John's Pleasant Valley Hospital, and Ventura County Medical Center. **A QIO:** Health Services Advisory Group. **A MCO:** SeaView IPA. **Seven SNFs:** Camarillo Healthcare Center, Coastal View Healthcare Center, Glenwood Care Center, Ojai Valley Care Center, Shoreline Care Center, Ventura Post-Acute, and Victoria Care Center. **Ten HHA partners:** Access Tender Loving Care, Allied Healthcare Professionals, Assisted Home Health and Hospice, Buena Vista Palliative and Hospice Care, Healthwise Home Care Solutions, Las Posas Home Health, Livingston Memorial Visiting Nurse Association, Los Robles Homecare Services, Mission Healthcare, and Summit Home Health. **A CBO:** Camarillo Health Care District.

PARTNERSHIP STRUCTURE

The Alliance uses a collaborative governance structure with equal representation from members. It has developed a charter, mission, vision, and goals and while no contractual relationship exists, members must pledge to uphold the defined expectations, such as service delivery commitments.

The Alliance meets on a quarterly basis to discuss issues and make decisions through a mutual decision-making process. In addition, several subcommittees meet more often to work through issues, such as data collection or skilled nursing transition. Once ready, subcommittees present findings to the larger group during quarterly meetings.

MODEL DESIGN

Through their collaborative platform, there is a commitment to work together to create new approaches within the Alliance organizations to improve integration of care within the system. By sharing their unique perspectives, Alliance members provide more effective solutions that address the medical and social needs of an individual throughout the full continuum of care. Each member organization is responsible for implementing solutions within its own workflows but there is often related accountability to the Alliance. Most commonly, the approaches address needs related to care transitions and case management.

One example of the Alliance's work has been the incorporation of post-acute partners (SNFs and HHAs) in the pre-discharge planning process at the hospital partners' locations to improve communication and better prepare the patient for the transition process. This includes having clinical liaisons that assist patients in the transition process. The Alliance created the standards and training manual for these liaisons, and they wear the Alliance logo to highlight the effort of the collaboration.

The Alliance has also focused on making numerous improvements to care delivery, including redesigning workflows, building connections between medical and community-based providers, and educating on clinical training as well as policy programs and legislation. The group actively engages in advocacy for policy changes, such as payment redesign to better integrate services along the continuum. Lastly, members share their expertise with one another to provide clinical competency training and development for acute and post-acute members within the Alliance.

FUNDING MECHANISM

The Alliance is financed through in-kind support of its member organizations, which includes time and resource commitments. There are no changes to the way organizations are reimbursed for the services they provide.

LESSONS LEARNED

- There is value in having numerous provider types involved. This was discovered after gaps were identified following conversations between hospitals and post-acute care providers. By bringing together perspectives, the Alliance has broader health system representation and knowledge to develop lasting solutions to address the full range of patient needs.
- Partners have found that learning each other's perspectives and roles in the health system has eliminated barriers and misunderstandings that previously existed. This has led to mutual accountability and trust within the Alliance, which members acknowledge as a critical component to success.

FUTURE

The Alliance aspires to continue and expand efforts in implementing new models and best practices for continual improvement of the care delivery system in their community. They were recently awarded participation in a three-year pilot to test person-centered care models.