Reducing Medicare Readmissions in a Community: The New Jersey Care Transitions Project

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HEALTHCARE QUALITY STRATEGIES

This material was prepared by Healthcare Quality Strategies, Inc., (HQSI), the Medicare Quality Improvement Organization for New Jersey, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 9th SOW-NJ-7.2-10-12

Rates of Rehospitalization within 30 Days after Hospital Discharge

16.4%
16.5%
19.0%
18.2%
15.7%
13.3%
19.5%
17.0%
18.2%
17.6%
18.1%
20.2%
20.7%
19.8%
18.4%
16.6%
19.4%
19.6%
17.4%
17.3%
19.7%
21.9%
18.0%
22.0%
14.2%
21.7%
17.7%
19.9%
16.2%
19.5%
19.2%
21.3%
18.8%
21.2%
20.8%
18.5%
19.8%
20.1%
17.6%
20.3%
16.3%
18.1%
21.1%
19.5%
19.1%
21.9%
19.4%
19.0%

US Virgin Islands
20.3%

Puerto Rico
19.2%

16.2%
17.1%

Legend
20.2% to 23.2%
19.2% to 20.1%
17.6% to 19.1%
13.3% to 17.4%

Jencks S et al. N Engl J Med 2009;360:1418-1428

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Problems Leading to Avoidable Readmissions

- Lack of effective medication reconciliation (on readmission, on discharge, at the doctor's office)
- Teach back not used
- No follow-up appointment made
- Insufficient follow-up from hospital about questions/problems (filling Rx, making follow-up appointment, managing conditions/ red flags)

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Problems Leading to Avoidable Readmissions (cont'd)

- Patient not understanding that being in the hospital has risks
- Lack of patient engagement in self-management of their chronic conditions
- Need for patient education about diet

Problems Leading to Avoidable Readmissions (cont'd)

- Insufficient communication
  - Between the inpatient attending physician (could be a hospitalist) and a patient's other doctors
  - Within and between physician offices
  - Between the ED and physicians; unavailability of information about previous admissions

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Potential Interventions

- Patient education (about their disease process and what they need to do)
- Patient activation (getting patients to feel that they have a role in controlling their chronic conditions)
- Improved communication and patient handovers/handoffs

Potential Interventions (cont'd)

- Tools to promote education, activation, and communication, for example:
  - Recognizing patients at high risk of readmission
  - Reminding providers about the need for effective education
  - Documenting interventions undertaken

Transitional Care Model (TCM): Hospital Discharge Screening Criteria for High Risk Older Adults

Are the following statements true for the patient? Check if yes.

Age 80 or older
Moderate to severe functional deficits (e.g., HARP score >2, KATZ < 4, Lawton <5)
An active behavioral and/or psychiatric health issue (e.g., GDS >5)
Four or more active co-existing health conditions
Six or more prescribed medications
Two or more hospitalizations within the past 6 months
A hospitalization within the past 30 days
Inadequate support system
Low health literacy
Documented history of non-adherence to the therapeutic regimen

If 2 or more findings are present further investigation is warranted and formal collaborative assessment of discharge planning – transitional care needs should be initiated.

Cognitive impairment (e.g., Mini-Cog positive)
Any suspected or diagnosed cognitive impairment with or without the above screening criteria would independently trigger post-discharge intervention to assure appropriate information transfer and follow-up after discharge to home or other care setting.

Bixby and Naylor, http://consultgerirn.org/uploads/File/trythis/issue26.pdf

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New Jersey Care Transitions Project

- Improve quality of care for Medicare beneficiaries who transition between different healthcare settings through a comprehensive community effort
- Reduce readmissions following hospitalization

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New Jersey Care Transitions Project

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Reducing readmissions requires much more than inpatient interventions!

New Jersey Care Transitions Project: Participating Provider Types

- Hospitals
- Nursing facilities (LTC and SNF)
- Home health agencies
- Hospices
- Dialysis facilities
- Physician practices (primary care and specialty)
- Community agencies

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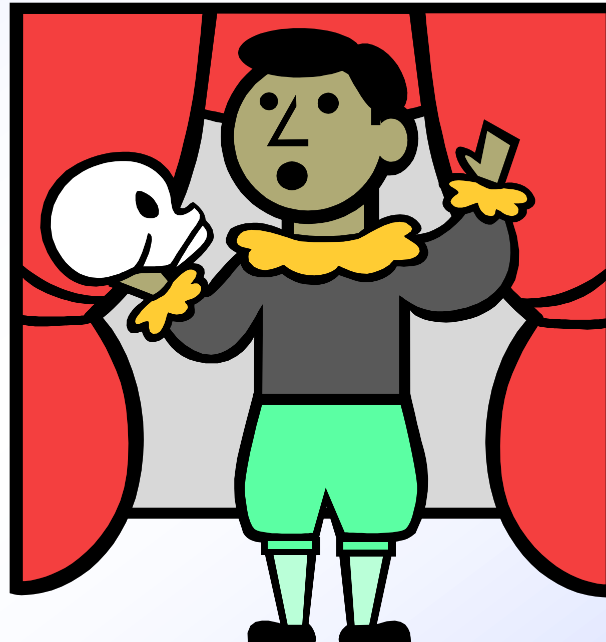
What's my motivation?



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INTERACT II

- **Inter**ventions to **R**educe **A**cute **C**are **T**ransfers (of nursing home residents)
- Developed by the Georgia Medical Care Foundation, the Georgia QIO
- http://interact.geriu.org

Signs of Heart Failure

If you have one or more of these symptoms:

- Weight gain of 3 pounds in 1 day *or*
- Weight gain of 5 pounds or more in 1 week
- More shortness of breath
- More swelling of your feet, ankles, legs, or stomach
- Feeling more tired – no energy
- Dry, hacking cough
- Harder to breathe when lying down
- Chest pain

Call doctor ______________________________

at ______________________________________

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Signs of Chronic Obstructive Pulmonary Disease (COPD)

If you have one or more of these symptoms:

- Shortness of breath when you are resting that won't go away
- Needing to sleep in a chair because of shortness of breath
- More mucus or a change in sputum color to yellow or green
- More cough or wheezing
- Sudden tightness in your chest
- Weight gain or loss of more than five pounds
- More forgetfulness, confusion, slurring of speech, and tiredness

Call doctor ____________________________

at ______________________________

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New Jersey Care Transitions Project Key Messages

- Schedule patients for follow-up visits shortly after discharge (within 1 or 2 weeks in most cases)
- Perform medication reconciliation
- Educate patients (or caregivers, when appropriate) about warning signs
- Communicate with other facilities and providers when patients are being transitioned
- Refer patients for palliative care and hospice as appropriate

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New Jersey Care Transitions Project Website

- http://www.hqsi.org/index/community-projects/Community-Projects-Care-Transitions.html

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