TARGETED INTERVENTIONS REDUCE REHOSPITALIZATIONS

COMMUNITY-BASED INTERVENTIONS WITH HOSPITALS are effective in reducing rehospitalizations and hospitalizations, according to a recent study from the *Journal of the American Medical Association (JAMA)*. The study, which was implemented via 14 state-based Quality Improvement Organizations (QIOs), found a 6 percent correlation in such reductions.

According to the American Health Quality Association (AHQA), QIOs "systematically coordinated community-based efforts with hospitals and other providers to improve the quality-of-care transitions and avoid rehospitalizations."

The communities in the study averaged a 5.70 percent reduction in rehospitalizations, the study found. In addition, Medicare beneficiaries in the communities also experienced a 5.74 percent reduction in hospitalizations over the two-year period of the study.

"Communities of comparable size, demographics, and hospital utilization—but where there were no concerted efforts to improve care transitions—averaged considerably more modest reductions, just a 2.05 percent drop in rehospitalizations and a 3.17 percent decline in hospitalizations," AHQA said.

The study reports that among Medicare beneficiaries in intervention communities, all-cause 30-day rehospitalization and all-cause hospitalization declined. However, there was no change in the rates of all-cause 30-day re-shospitalizations as a percentage of hospital discharges.

Among the interventions used in the study were Care Transition Interventions, which coaches patients toward activation and self-care; the Best Practices Intervention Package, which organizes an array of improvements in home health; the Transitional Care Nursing Model, which provides a skilled nurse to counsel patients and families through transitions and at home; and Interventions To Reduce Acute-Care Transfers (INTERACT).

According to AHQA, the QIOs "continually reviewed progress and tailored activities to implement interventions that were effective and met the needs of each community."

Some of the successful strategies the QIOs used include:

- Developing effective community coalitions involving hospitals, nursing facilities, home care, hospice agencies, physicians, and local agencies to help meet social service needs that may prevent patients from getting or staying well;
- Generating and implementing standard transition processes across all local health care settings;
- Transferring patient clinical information between providers in a timely and effective way; and
- Helping patients and their family members become actively engaged in their transitions by keeping a personal record, knowing the "red flags" for trouble, ensuring they receive the right medications, and follow-through on appropriate follow-up care.

"While many communities are working to reduce rehospitalization rates, the communities supported by QIO efforts experienced double the rate of reduction as others," said Jane Brock, MD, lead study author and chief medical officer, Colorado Foundation for Medical Care.

—Meg LaPorte

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