



Louisiana Health Care Review

The Medicare Quality Improvement Organization
www.lhcr.org

For Immediate Release

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Project to Reduce Unnecessary Hospitalizations Showing Success *Baton Rouge project reports 80% improvement*

Baton Rouge – A new effort to improve a key measure of health care quality is showing remarkable success in Baton Rouge due to a program designed to reduce unnecessary hospitalizations.

Put in place at five local hospitals, the Care Transitions program has succeeded in dropping the rate of unnecessary hospitalizations from almost 19 percent to approximately 4 percent in the pilot group of patients receiving transitions coaching.

Preventable hospitalization is a health statistic recognized by many experts as an indicator of poor quality care and higher costs. It was this measure, among others, that resulted in Louisiana being ranked last for its state of health care in the United Health Foundation's 2008 *America's Health Rankings*.

The project is funded by the federal Centers for Medicare & Medicaid Services (CMS) and is targeted to patients 65 years and older. It involves pairing older patients with a health coach. The coach works with the patients while they are hospitalized, but the real work begins once the patients are discharged.

According to Laurie Robinson, quality improvement director for Louisiana Health Care Review (LHCR), the time of discharge is very stressful for patients and their caregivers. LHCR is leading the project.

“You have a patient who is anxious to go home and who is being given all sorts of confusing instructions,” Robinson said. “The doctor or nurse is explaining how much rest to get, what and when to eat, what medicines to take and when to make the next doctor's appointment.”

She added that the reality is this is a difficult time for the patient to comprehend everything that is being said.

Introduced to the patient upon admission, the health coach establishes a relationship, letting the patient know what to expect while in the hospital and after they are discharged. By the time they are ready to leave the hospital, the patient has been given advice and information about how to manage their own care.

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This includes information about rest and exercise, managing medicines and their potential complications, using a personal health record, when to schedule an appointment with their primary care doctor and what to do if something goes wrong.

Gary Curtis, president of LHCR, said he is very pleased with the results of the program after its first six months.

“We’ve worked with about 93 patients and have only had four readmissions, a four percent rate, and an almost 80 percent improvement,” he said. “These results have been achieved because of the commitment and participation of the local hospitals, nursing homes and home health agencies.”

The push to reduce these unnecessary hospital readmissions is also one of the many ideas found in pending health care reform legislation. Included in draft legislation from the Senate Finance Committee, it is one idea that appears to have bi-partisan support.

Scott Flowers, quality improvement director for LHCR, added the project focuses on patients admitted to the hospital following a heart attack, who have congestive heart failure or pneumonia.

“The project is helping to quickly identify interventions that work,” he said. “These successful strategies can then be put in place in other communities. Then, we should begin to see real and substantial improvements in this key measure of health care quality.”

For more information about The Care Transitions Program, call Laurie Robinson, Quality Improvement Director at LHCR, 225-926-6353 or go to www.lhcr.org

The attached Fact Sheet provides project details.

This material was produced by Louisiana Health Care Review, Inc. (LHCR), the Medicare Quality Improvement Organization for Louisiana, 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. LA9SoW5E109-2054

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THE CARE TRANSITIONS PROJECT IN LOUISIANA DEMONSTRATES COST AND QUALITY SUCCESS – 9/09

Fact Sheet

As of September 2009, The CMS Pilot Project to reduce avoidable readmissions in Louisiana has exceeded expectations.

LHCR reports that only four patients have been readmitted to the hospital within 30 days of discharge within the group of 93 hospital patients who were coached in the Care Transitions Project thru May 31st, 2009. This represents a 4.3 percent readmission rate ⁽¹⁾.

Diagnoses for the coached patients include pneumonia, chronic obstructive pulmonary disease, congestive heart failure and acute myocardial infarction. The readmission rate calculated during baseline measures for these diagnoses in the target area ranged from 18.9% to 22.4%. ⁽²⁾

Louisiana Health Care Review is one of 14 Quality Improvement Organizations in the country to be awarded the three-year Care Transitions Project by CMS.

If this rate of reduced readmissions continues and can be replicated nationwide, the Medicare Payment Advisory Committee (MedPAC) estimates a potential savings to Medicare of over \$12 billion. ⁽³⁾

Project Background: Although potentially avoidable hospital readmissions is a national problem affecting 17.6 percent of all Medicare patients, the Commonwealth Fund reported in 2007 that Louisiana had the highest Medicare 30-day readmission rate in the country. ⁽⁴⁾

Within 30 days of discharge, 18.8 percent of Medicare beneficiaries in the Baton Rouge metro area are re-hospitalized. ⁽⁵⁾

Methodology: Recent studies by Coleman and Naylor suggest that interventions targeting comprehensive transitional care from the hospital to the community can reduce readmission rates by one-third.

- Of the Medicare beneficiaries who are readmitted within 30 days, 64 percent receive no post-acute care between discharge and readmission
- Medicare patients report greater dissatisfaction in discharge-related care than in any other aspect of care measured by CMS.

Care Transitions Pilot interventions include one-on-one patient coaching and various discharge planning re-engineering steps to ensure that patients receive the proper after-care and follow-up.

Community-wide provider commitment:

Louisiana Care Transitions collaborative members:

- Baton Rouge General Medical Center

- Lane Regional Medical Center
- Ochsner Medical Center – Baton Rouge
- Our Lady of the Lake Regional Medical Center
- St. Elizabeth Hospital in Gonzales

More than ten home health agencies operating in the Baton Rouge area are also participating including:

Amedisys Home Health
 Health Care Options
 Feliciana Home Health
 Pinnacle Home Health
 Lane RMC Home Health
 Delta Home Health
 Pointe Coupee Homebound Health Services
 Audubon Home Health

Call Laurie Robinson, 225-926-6353, LHCR Director of Quality, for more information

References, Sources

¹Results are preliminary and it is not intended that the reader should assume that the information is official or final. The results are subject to change as additional patients enter the project. Final results will be published at the completion of the three-year pilot.

²CMS Program Progress Report, baseline measurement period 10/07 – 03/08; unadjusted readmission rate for Acute Myocardial Infarction 20.9%, Congestive Heart Failure 22.4%, and Pneumonia 18.9%

³A path to bundled payment around a rehospitalization: In Report to the congress: reforming the delivery system. Washington, DC: Medicare Payment Advisory Commission, June 2005:83-103 as referenced in New England Journal of Medicine, “Rehospitalizations among Patients in the Medicare Fee-for-Service Program,” by Stephen F. Jencks, M.D., April 2nd, 2009

⁴The Commonwealth Fund, State Scorecard Data Tables, June 2007, Supplement to **Aiming Higher: Results from a State Scorecard on Health System Performance**, Table 4.8

⁵CMS Claims Data 10/07 – 3/08 , calculated as of 09/09, CMS Data Warehouse, 1985 readmissions, 10581 discharges, claims for beneficiaries in the target area (81 zips), all diagnoses .

Additional Resources

Committee on Finance news Release, April 28th, 2009, “Finance Leaders Release health Care Reform Policy Options,” <http://finance.senate.gov>

http://www.whitehouse.gov/omb/fy2010_key_healthcare/

“18 percent of hospitalizations of Medicare beneficiaries resulted in the readmission of patients who had been discharged within the last 30 days...”

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