Health Care Impact: Nevada, New Mexico, Utah

HealthInsight
a partnership for the future of health care

Improving Transitions of Care across Communities

HealthInsight is working with health care communities in Nevada, New Mexico and Utah to streamline transitions of care, or the movement of patients from one practitioner or setting to another as their condition and needs change. Working with providers across all settings, patients, families and community stakeholders, our ultimate goal is to reduce readmissions to the hospital that can and should be prevented.

In Nevada, we have formed health care community coalitions and are working directly with hospital leaders to improve the transition from hospitals to home. Through these coalitions, we are providing data analytic support and technical assistance to learn about the population of focus and target appropriate interventions; spreading best practices of what's working and why via *HealthInsight* Nevada's No Place Like Home Campaign website and related materials; and sharing local successes and educating the provider community of lessons learned in the field.

In New Mexico we are working through county health councils in four communities that bring together representatives from hospitals, nursing homes, home health care agencies, federally qualified health centers, learning institutions, behavioral and substance abuse programs, and social service agencies such as Area Agencies on Aging.

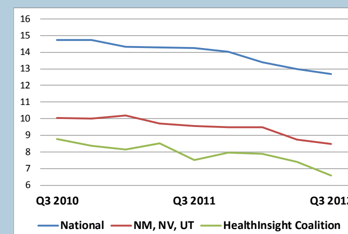
These coalitions have welcomed our expertise and support in conducting hospital and community interventions to improve processes of care at a system level—including redesigning discharge protocols, adopting information technology solutions, or creating a new protocol for transferring hospital patients to or from skilled nursing facilities. We are helping them explore system changes including disease management programs and providing patients with a "transition coach" and education in self-management skills. We're also addressing community-specific reasons for hospital readmission—including enhancing service options that provide patients an alternative to hospitalization.

In Utah, no clear pattern of hospital readmissions emerged despite aggressive data analysis, compelling us to take a broad-based approach. We are conducting a number of interventions, including root cause analysis; partnering with a county senior services program; hosting meetings with hospitals and referring or receiving facilities to discuss care transitions; using verbal reports between providers; teach-back instruction that helps providers assess patient understanding of their health care needs; training on the INTERACT III program in skilled nursing facilities and home health agencies; providing transitions of care reimbursement information to clinics and providers; seminars to Medicare beneficiaries at senior centers to help them understand how to reduce hospital readmission; hosting Learning and Action Networks; and providing hospital-specific readmission reports to CEOs and discharge managers.

Impacting Hospital Readmissions

Since the third quarter of 2010, the hospital readmission rate per 1,000 Medicare fee-for-service beneficiaries has decreased across the nation by 14 percent and in Nevada, New Mexico and Utah by 15 percent. The decrease has been even more dramatic in the communities we are working with, showing a marked decrease of 25 percent.

Readmissions per 1,000 Medicare FFS Beneficiaries



Corporate Offices:
HealthInsight
756 E. Winchester Street, Suite 200
Salt Lake City, Utah 84107
Phone: 801-892-0155
Fax: 801-892-0160

This material was prepared by HealthInsight, the Medicare Quality Improvement Organization for Nevada, New Mexico and Utah, 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.
10SOW-NM-CORP-13-08 6/2013