

## A Statewide Program to Improve Care Transitions and Reduce Avoidable Rehospitalizations from Skilled Nursing Facilities

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The purpose of this Project is to coordinate and synthesize initiatives around avoidable hospital readmissions and care transitions of older adults in the state of Massachusetts. This work will result in a cogent, unified state health policy to improve quality around care transitions, and specifically improve care transitions between hospitals and skilled nursing facilities (SNFs). The changes that result from this work will reduce overall health care costs in the Commonwealth.

Massachusetts has one of the highest rates of rehospitalizations for ambulatory care sensitive diagnoses in the country. In a national sample, approximately 40% of SNFs did not have a specific form or process for information transfer when a resident was sent to an acute care setting; when forms were available, SNFs often did not complete them (Terrell, 2007). In addition, literature suggests that many nursing home residents could be treated for certain acute changes in condition or diagnoses safely, cost-effectively and with better clinical outcomes if they were managed in the long term care setting (Saliba, 2000; Intrator, 2004).

- Massachusetts Secretary of Health and Human Services, Dr. JudyAnn Bigby, has approved that Alice Bonner, PCF, will co-chair a State Quality Improvement Institute (SQII) workgroup. The workgroup will develop a statewide strategic plan to improve care transitions by December 1<sup>st</sup>, 2009. This plan will outline potential new payment models, align incentives around pay for performance, and outline work with regulatory agencies to enact changes that will improve information transfer across settings, including the use of HIT and EMR.
- INTERACT II<sup>1</sup> is an evidence-based approach to staff and provider communication around change in condition of SNF residents. After two years, through dissemination of the INTERACT II program, at least 50% of Massachusetts communities will have a performance improvement system for tracking acute care transfers and rehospitalizations of SNF residents. These communities will also have an ongoing collaborative process to reduce avoidable acute care transfers from SNFs.
- After two years, through dissemination of the INTERACT II program, at least 50% of Massachusetts communities will be using a standardized, measurable process for communication and data exchange during transfers from the SNF to acute care.
- The target population for this project includes all individuals (approximately 43,000) residing in MA nursing homes, including SNF and long term care residents. There are roughly 98,000 hospital discharges to SNFs annually in Massachusetts, and about 50% of those patients return home to the community.

### References

Terrell, KM, Miller, D.K. Critical Review of Transitional Care Between Nursing Homes and Emergency Departments. *Annals of Long-Term Care*. Feb 2007; 15(2): 33-38.

Saliba D, Kington R, Buchanan J, et al. Appropriateness of the decision to transfer nursing facility residents to the hospital. *J Am Geriatr Soc*. Feb 2000; 48(2):154-163.

Intrator O, Zinn J, Mor V. Nursing home characteristics and potentially preventable hospitalizations of long-stay residents. *J Am Geriatr Soc*. Oct 2004; 52(10):1730-1736.

Please [email Alice](#) with any questions or comments regarding this project.

<sup>1</sup> INTERACT II (Interventions to Reduce Acute Care Transfers) project Executive Summary available upon request.