OASIS Alert

News You Can Use : PILOT PROJECT ADDRESSES CARE TRANSITIONS

CARE tool connects with OASIS C.

Home health agencies in 14 states,including Michigan, Louisiana, New York,Rhode Island, Colorado, and Florida are participating in the **Centers for Medicare & Medicaid Services'** two-year Patient Pathways/Care Transitions project. The national healthcare initiative seeks to improve patient care transitions across health settings and reduce hospital readmissions,according to **MPRO**, Michigan's Quality Improvement Organization. Local providers from the hospital, nursing home,home health, and hospice settings work with Medicare beneficiaries to improve coordination of care, MPRO explains.

Within 30 days of discharge, 17.6 percent of Medicare beneficiaries are re-hospitalized,and the **Medicare Payment Advisory Commission** estimates that up to 76 percent of these readmissions may be preventable, MPRO reports. Of beneficiaries who are readmitted within 30 days of discharge, 64 percent received no post-acute care between discharge and readmission, MedPAC said in its June 2007 report to Congress.

Another way: These projects include discharge instructions for hospital patients; follow up "coaching" phone calls after discharge;and convening of community-based workgroups of hospital, physician, and post-acute care provider staff who have informal referral relationships that result in them often treating the same patients, the **American Health Quality Association** reports. As part of the program,coaches will work with patients to help them develop skills to ensure their needs are met during transitions.

"Results from the initial pilot suggest dramatic reductions in rehospitalizations are being achieved," AHQA says and recommends expanding the initiative nationwide.

• **Nearly 150 providers, including 40 home health agencies, are currently testing** the Continuity Assessment Record and Evaluation (CARE) tool.

The CARE tool collects data with the same assessment tool across multiple post acute settings -- HHAs, long-term care hospitals,inpatient rehab facilities, and skilled nursing facilities. CMS is using the tool in its Post Acute Care (PAC) Payment Reform Demonstration,which is proceeding in 11 markets this year.

Items on the new OASIS C tool were crafted with the CARE tool in mind, CMS confirms.More information on the CARE tool and the PAC demo is at www.pacdemo.rti.org.

• **Falls prevention programs that**

include balance training, occurred at least twice a week for 25 weeks, and did not include walking were most effective in preventing falls in older people, according to a meta-analysis published in the January issue of the Journal of the American Geriatric Society. Falls account for more than half of the injury-related hospitalizations for those over 65, the study says. The study is at www.interscience.wiley.com/journal/121598297/issue.

• **A selection of assessment tools for older adults is available** from the **Hartford Institute for Geriatric Nursing's** "Try This: Best Practices in Nursing Care to Older Adults"collection. Among the many tools are assessments of mental status, depression, sleep quality, pressure ulcer risk, falls risk, nutrition, incontinence,and dysphagia. Articles and videos about these resources are at www.hartfordign.org/Resources/Try_This_Series.

• **Occupational and physical therapy sessions at home to instruct** elderly participants in compensatory strategies, home modifications,home safety, fall recovery techniques,and balance and muscle strength exercises extended survivorship up to 3.5 years and maintained statistically significant differences for 2 years, according to a

study published in the March issue of the Journal of the American Geriatric Society, available at www.americangeriatrics.org. Subjects at moderate mortality risk derived the most intervention benefit.Findings suggest that the intervention could be a low-cost clinical tool to delay functional decline and mortality, according to the report.