

Three-prong approach helps New Jersey Agency reduce ACH



When it comes to reducing acute care hospitalization (ACH), Virtua Home Care in New Jersey takes a three-pronged approach, according to Director of Quality Management Pat Quackenbush.

In addition to its 40-unit telemonitoring program, the agency recently debuted what's called a chronic navigation program to help patients schedule appointments and tests after they've been discharged.

The two complement the care transitions program, which is the agency's centerpiece.

"Reducing ACH is the overarching concept, and each of the programs is a pillar," she said. "Each of the three pillars is an intervention for certain groups of patients."

The care transitions program is geared to patients who are willing and able to learn how to manage their chronic conditions, she said.

"We work with the patients themselves, not the husband or wife or daughter," said Quackenbush. "This program promotes self-management."

Virtua had an ACH program two years ago, when the agency agreed to take part in a care transitions project sponsored by Healthcare Quality Strategies Inc (HQSI), the federally designated Medicare Quality Improvement Organization for New Jersey.

The first step narrowed the project's focus to the Cherry Hill zip code, which had the most cases of readmission, according to Diane Costanzo, the Director of Patient Care for Virtua Home Care West Jersey.

The project targeted Medicare beneficiaries with pneumonia, heart failure, chronic obstructive pulmonary disease and diabetes, four of the prime causes of readmission.

Administrators were frank about their limitations when they met with the New Jersey QIO and transitional care leader Mary Naylor, said Costanzo.

"In working with Dr. Naylor, we had to figure out how to do this in real life and real time," she said. "We needed to remain budget neutral and be practical."

Naylor helped the agency to develop its own version of the Transitional Care Model, which calls for specially trained transitional care nurses to provide comprehensive in-hospital planning and home follow-up.

The agency chose two nurses with backgrounds in cardiac care and home health, said Quackenbush. The Naylor team helped the agency train the two nurses, who serve as case managers for the same group of patients.

The case managers perform medication reconciliation and help patients manage their medications. They schedule follow-up doctor appointments seven to 14 days after patients have been discharged from the hospital. In addition, they teach patients about the warning signs that might send them back to the hospital.

At first, the three programs – telemonitoring, chronic navigation and care transitions -- operated separately. But since the establishment of a care transitions committee, the agency has made an effort to link them, said Quackenbush.

“We’re getting everyone to recognize that they all have one goal: keeping the patient at home.”