Readmissions

Reducing avoidable readmissions by fostering community coalitions, teamwork and patient-centered care to improve how patients transfer between health care settings

Avoidable readmissions and patient satisfaction with discharge care are growing problems nationwide. National research shows that 17.5 percent of Medicare beneficiaries are re-hospitalized within 30 days of a hospital discharge.[1] Of those patients who are re-admitted, the Medicare Payment Advisory Committee estimates that 64 percent received no post-acute care between discharge and readmission and project that 76 percent of readmissions may be preventable. Furthermore, the Centers for Medicare & Medicaid Services' (CMS) research shows beneficiaries report greater dissatisfaction in discharge-related care than any other aspect of care CMS measures.

A Community-Based Approach

Delmarva Foundation has partnered with IPRO in New York and the Carolina Centers for Medical Excellence in South Carolina to form the Atlantic Quality Innovation Network (AQIN) Quality Innovation Network - Quality Improvement Organization (QIN-QIO), under contract with CMS. As part of the AQIN, Delmarva Foundation is convening community coalitions across the District of Columbia that consist of partners, hospitals, skilled nursing facilities, home health agencies, physicians, payers, patients, pharmacies, pharmacists, caregivers and other stakeholders in an effort to address these problems and improve care coordination.

The problems associated with poor transitions of care and 30-day hospital readmissions are not solely the responsibility of the community hospitals; they often result from a breakdown in communication. Weaknesses include the transfer of information between providers and patients at the time of transition, a failure to assure patients and/or caregivers they can self-manage their condition during transition and a lack of standard processes to effectively manage the transition of the patient between settings.

To address these issues, we are focusing on processes of care at a community level to engage providers and stakeholders across the continuum of care, not just in the hospital. This includes pharmacies, pharmacists, home health agencies, dialysis facilities, skilled nursing facilities and physician offices, as well as patients, families, payers and community stakeholders.

We are specifically working with communities that experience a high incidence of adverse drug events and which serve 60 percent of Medicare Fee-for-Service (FFS) beneficiaries and, in particular, those communities that focus on Medicare FFS beneficiaries that fall within at least one of the following sub-populations:

- Eligible for both Medicare and Medicaid
- Multiple chronic conditions
- Behavioral health issues, such as depression

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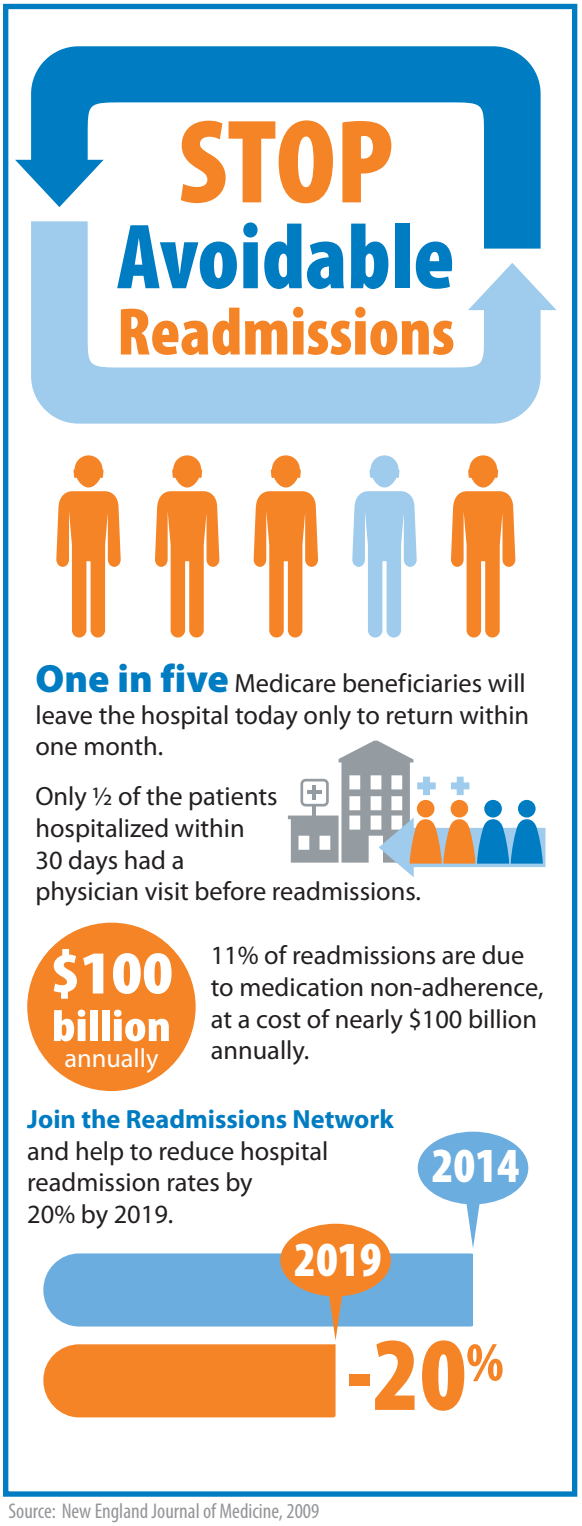

Source: New England Journal of Medicine, 2009
Centers for Medicare & Medicaid, 2012

[1]U.S. Department of Health & Human Services. *New HHS Data Shows Major Strides Made in Patient Safety, Leading to Improved Care and Savings.* May 7, 2014. http://innovation.cms.gov/Files/reports/patient-safety-results.pdf

- Alzheimer's and dementia
- Lower socioeconomic status and other social determinants of health

Our Goals

Providers and partners who participate in our initiative will work with our industry experts to achieve the following goals over a five-year period, ending in 2019:

- Reduce hospital readmission rates in the Medicare program by 20 percent
- Reduce hospital admission rates in the Medicare program by 20 percent
- Increase community tenure by increasing the number of days spent at home by Medicare FFS beneficiaries by 10 percent
- Reduce the prevalence of adverse drug events, emergency department visits and observation stays or readmissions occurring as a result of the care transitions process

Key Strategies & Interventions

Benefits to Participating Providers

In joining the Readmissions Network, participants will:

- Continue to build on the previous QIO readmissions project work, the CMS Partnership for Patients initiative and the Hospital Engagement Networks' current efforts on readmissions
- Partner with multiple community organizations, such as beneficiaries, practitioners and stakeholders, to address problems across the continuum of care in communities
- Develop a project plan, with a timeline, to implement evidence-based interventions, including:
  - Project Re-Engineering Discharge (RED)
  - Care Transition Intervention
  - BOOST (Better Outcomes for Older Adults through Safe Transitions)
  - Transforming care at the bedside
  - Home Health Quality Improvement National Campaign initiatives
  - INTERACT (Interventions to Reduce Acute Care Transfers)
- Establish online data portal accounts for providers to track and monitor readmissions data and download provider and community level 30-day readmission reports
- Participate in live, web-based educational forums to learn and share best practices with other network members

Join the Readmissions Network

All providers are encouraged to join this important endeavor to achieve sustainable, measurable reductions in preventable readmissions and admissions for all patients.

Visit the AQIN website to learn more about how you and members of your community can get involved in this initiative: http://www.atlanticquality.org.

Contact Us

Janet Jones
Task Lead
jonesj3@delmarvafoundation.org
1-800-937-3362

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