Welcome!
Track II: Care Transitions
Learning and Action Network
March 6, 2012

Objectives of the Day

- **Learn** practical strategies to reduce readmissions in your community.
- **Build** cross-setting partnerships between hospitals, nursing homes, home health and other community partners.
- **Gain** access to evidence-based models, including tools that nursing homes can easily adopt to prevent unnecessary rehospitalizations.

Peer Resources-
30 Day Readmissions

- 19 hospitals have active PI Teams, 6 are in maintenance mode
- 14 have done Medical Staff Education
- 12 have done Nursing Staff Education
- 7 have made P&P Revisions
- 12 are working with Post Acute Providers
**Peer Resources-Care Transitions**
- 17 hospitals have active PI Teams, 3 are in maintenance mode
- 10 have done Medical Staff Education
- 10 have done Nursing Staff Education
- 7 have made P&P Revisions
- 10 are working with Post Acute Providers

**Peer Resources-Pressure Ulcers**
- 15 hospitals have active PI Teams, 7 are in maintenance mode
- 16 have done Medical Staff Education
- 20 have done Nursing Staff Education
- 19 have made P&P Revisions
- 6 are working with Post Acute Providers

**Peer Resources-Other HAC Prevention**
- 10 hospitals have active PI Teams, 5 are in maintenance mode
- 13 have done Medical Staff Education
- 15 have done Nursing Staff Education
- 12 have made P&P Revisions
- 11 are working on VAP Prevention
- Several “other” projects are: prevention of falls, HAI, SSI, DVT
Peer Resources-
More to Share With Each Other!

- In this Collaborative Forum in 2012 we are:
  - Expanding our participant audience
  - Reaching across the Continuum

- Collaborative Sharing includes:
  - Offering peer strengths: what we have to “give”
  - Identifying our needs- what we need to “take”

Who is Here Today?

- Hospitals
- Physicians
- Nursing Homes
- Home Health Agencies
- Dialysis Facilities
- Area Agencies on Aging
- Community-based Organizations
- Other?

Today’s Agenda in the Main Room

- Practical Strategies to Reduce Readmissions
  - Amy E. Boutwell, MD, MPP, President, Collaborative Healthcare Strategies
- Community Building: Establishing Commitment
  - Mary Fermazin, MD, MPA & Jennifer Wieckowski, MSG, HSAG of CA
- Reducing Avoidable Acute Care Transfers with INTERACT
  - Markus Mettler, NHA, PT, Vice President, Operations Healthcare Management Services
- Commitment to Action
**Breakout Session: Navigating the Community Based Care Transitions Program (CCTP) Application**

- Section 3026 of the Affordable Care Act
- $500 million available
- Test models for improving care transitions for high-risk Medicare beneficiaries from the inpatient hospital setting to other care settings
- Multiple hospitals must partner with a community-based organization (CBO) that has care transitions experience

**Breakout Session: Navigating the CCTP Application Process**

- Network with other prospective CCTP applicants.
- Learn from local and nationally recognized CCTP experts, including the first CA grant recipient.
  - Nicholas Trunzo, LCSW, Marin Area Agency on Aging
  - Amy E. Boutwell, MD, MPP, Collaborative Healthcare Strategies
  - Lori Peterson, MA, Collaborative Consulting
  - Eleanor Delaney, FCCA, AMCT, Owl, LLC, Collaborator with Collaborative Consulting

**Give and Take:**

**Moving Forward Together by Sharing Knowledge**
Exchanging Ideas

Give and Take: Moving Forward Together

- In what areas do you have some experience or successes that you might “give” or share with other participants?
- What would you like to “take” or learn from other participants?

Give / Share: HOT Topics

- Medication Management
- Palliative Care
- Patient, Family and Caregiver Education
- INTERACT Program
- Project RED (Re-Engineered Discharge)
- Community Services:
  - Meals on Wheels
  - Transportation
Take / Learn: HOT Topics

- INTERACT Program: 53%
- Medication Management: 48%
- Project RED Re-Engineered Discharge: 37%
- Care Transitions Intervention (CTI): 31%

Give and Take: Moving Forward Together

“If you have knowledge, let others light their candles with it.”
— Winston Churchill

National Partnership for Patients

Reduce avoidable readmissions by 20 percent
By June 2013
**California’s Readmissions Goal**

- **Q4 2010 to Q1 2011 Readmissions Data**
  - 3,429,614 total Medicare FFS beneficiaries
  - 403,880 (12%) were discharged
  - 78,397 (19.4%) were readmitted within 30 days

- **California's Goal:**
  - Reduce overall readmission rate by 20 percent
  - Prevent 15,000 avoidable readmissions

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**Financial Impact in California**

Average readmission costs $8,000-$13,000

+ California prevents 15,000 readmissions

= $120 - $195 million saved

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**Medicare FFS Readmission Data 2010Q4-2011Q1**

<table>
<thead>
<tr>
<th>Setting Discharged To</th>
<th># of Discharges</th>
<th># of discharges readmitted within 30 days</th>
<th>30-day Readmit Rate</th>
<th>30-day readmit rate (to same hospital)</th>
<th>30-day readmit rate (to another hospital)</th>
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</thead>
<tbody>
<tr>
<td>Home</td>
<td>210,568</td>
<td>36,973</td>
<td>17.6%</td>
<td>72.0%</td>
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<td>Home Health</td>
<td>64,575</td>
<td>13,453</td>
<td>20.8%</td>
<td>77.4%</td>
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<tr>
<td>Nursing Home</td>
<td>92,286</td>
<td>21,497</td>
<td>23.3%</td>
<td>73.7%</td>
<td>26.3%</td>
</tr>
<tr>
<td>Hospice</td>
<td>7,973</td>
<td>289</td>
<td>3.6%</td>
<td>64.7%</td>
<td>35.3%</td>
</tr>
<tr>
<td>Other</td>
<td>28,478</td>
<td>6,185</td>
<td>21.7%</td>
<td>58.4%</td>
<td>41.6%</td>
</tr>
<tr>
<td>All</td>
<td>403,880</td>
<td>78,397</td>
<td>19.4%</td>
<td>72.6%</td>
<td>27.4%</td>
</tr>
</tbody>
</table>
Introducing
Amy Boutwell, M.D., M.P.P.,
President, Collaborative Healthcare Strategies
Co-Principal Investigator, STAAR Initiative