

Transcript for A Health Care Community's Efforts to Reduce Hospital Readmissions

One of the goals of the readmissions project team is to work with providers to identify the gaps in communication. Are we communicating the information across the continuum of care to ensure that the patients and the next provider has the information needed to care for them?

An unnecessary hospital readmission is an indicator of the fragmented health care system. It means that the patient was unprepared at the time of discharge. It could also mean that the patient was readmitted due to lack of communication between the providers across the continuum of care. For example, one of our hospitals in the lower Rio Grande valley, when we started the project with them, they had an astounding 23% readmission rate for their Medicare patients. To date, that hospital is currently reporting a 15% readmission rate for their patients.

A program such as the QIN-QIO Readmissions Initiative focuses on engaging communities to address the fragmentation that occurs around readmissions. We engage providers across the continuum of care, and facilitate discussions around the barriers to care transitions. Everyone in the community, from hospitals, nursing homes, home health agencies, hospice, inpatient psych facilities, [INAUDIBLE], and all stakeholders that are impacted by transitions are invited to participate in the community meetings and coalitions.

We encourage an all-learn and all-share atmosphere that promotes best practices and open communication. In addition, the program team identifies community leaders early in the project to ensure the sustainability of the project. Engaged providers receive technical assistance from the program team in the form of educational webinars, access to tools, resources, 30-day readmissions data reports, and access to our data portal to help them further their quality initiatives.

To date, the TMF QIN has engaged 31 communities that represent 1,704,558 Medicare fee-for-service beneficiaries. The QIN region continues to see a reduction in the readmissions rate, and providers continue to work towards improving communication across the continuum of care.

Hi, I am Matt Boettcher. I am the Vice President of Comprehensive Care Management for the Central Texas Division of Baylor Scott & White Health. I got involved in the coalition with TMF primarily because I think the game has changed for most hospitals, in that length of stay used to be, if you will, the holy grail for most hospitals. And the holy grail has now changed. Its readmissions, both because of penalties, but also because it's just good care to take care of patients and make sure they have the services they need to stay well when they go home.

But so far, when we have patients who participate in the program, our numbers are showing a single-digit readmission rate, which is certainly quite a bit better than the national average, and

what most hospitals are trying to achieve. Our hope is that within the five regions of the Central Texas Division of Baylor Scott and White, we want this replicated in all five regions.

My name is Donna Parker, and I work for the Central Texas Aging and Veterans Disability Resource Center. And I am the Program Manager for External Programs, and run a care transition program. And we also have evidence-based programs that we run from the Aging Disability and Veterans Resource Center. The veteran population is a huge part of our community here in Central Texas.

One of the things that we're really focusing on right now, we would like to, within the next year, reach a 30% decrease in readmission rates with our partner hospitals. And one of the things with the coalition, the community data has been very, very helpful for us to really target which areas that we need to look at in our community to try to help improve readmission rates. One of the things that we are focused on in TMF, has really brought this to the forefront for us, is the medication reconciliation is such an important piece to these readmissions. We're finding that a lot of people who discharge from the hospital have difficulty figuring out which medications they need to be taking, and that's one of the things that we've included in our technology, which has a medication reconciliation.

So without TMF's involvement with this, I think we would not be where we are today in terms of being able to evaluate our community and what direction we need to take. So creating that infrastructure has been a huge piece for us.

My name is Ryan Holler. I'm the Administrator at Cornerstone Gardens Skilled Nursing Facility in Temple, Texas. One of the areas that we're working on with TMF relates to quality measures. The new composite score tool that is on the website has been a big help. We've worked in several different areas. Falls with injuries were something where we had an opportunity. Urinary tract infections was another area we had some opportunity in.

I'm happy to say that we've been able to use the tools, not just the composite score, but also a lot of the references that are on the website to put practices into place, do some education, and reduce the rates on both of those. We're now under the state and national rankings.

OK, my name is Gary Luft. I am the Director of Health and Human Services for the Heart of Texas Council of Governments. We actually have appreciated the work that has been offered by TMF because it's helped us crystallize the efforts and the attention that we need to pay toward hospital readmissions.

The obvious benefit to them is that it helps them identify the support services that they can receive to remain hospital-free and remain in their home, and also helps them identify services that can assist them. Many, many times, the support services may not be easily recognized or easily accessed through the community. And our services and the TMF services help those individuals not have to return back to the hospital, and in many, many, many cases, it makes the difference, and helps them stay home and stay out of the medical facility.

I'm Norma Mathis, Director of Case Management at Hill Regional Hospital. Our hospital's part of a big corporation that focuses, also, on readmission. So this was an avenue for us to be able to help us improve our readmission rate. We feel like this coalition has really helped us. Our readmission rate went from 25% down to 10% from 2011 to the end of 2014. The health care system nowadays is more of a community process, and to get the patient's healthy, we all have to work together as community. And it's all of us working together that helps it and helps the patient stay healthy.