IMPROVING CARE COORDINATION

READMISSION RATES[1]

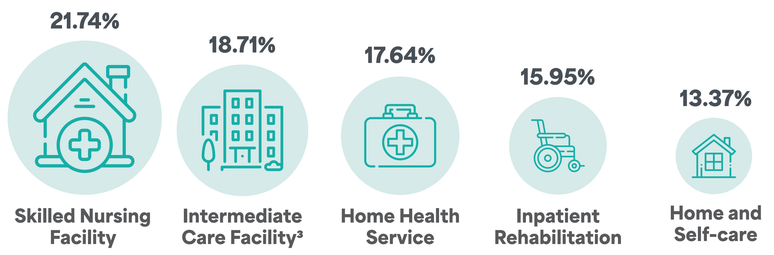
Reducing preventable 30-day hospital readmissions is a priority for the Centers for Medicare & Medicaid Services (CMS). Hospitals are not the only entity to receive financial penalties for readmissions. Skilled nursing facilities (SNFs) have been included in readmission penalties based on performance metrics as of October 1, 2018.[2] Despite these penalties, readmission rates continue to be high.

Share Your Interventions!

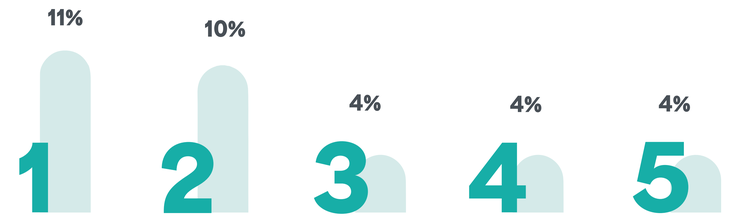
Readmissions at a Glance

In Oklahoma, **3 out of every 20** Medicare beneficiary hospital discharges result in a readmission within 30 days.

Readmission Rates by Setting



Top 5 Readmission Diagnoses



How the Telligen Team is Improving Care Coordination in Oklahoma

We use a multi-pronged approach to address key components to improve care coordination and decrease hospital admissions and readmissions, incorporating evidence-based interventions and best practices, data-driven improvements and stakeholder collaboration.

Learning and Action Networks (LANs)

LANs are regionally-focused improvement tools bringing together healthcare professionals, patients and other stakeholders around an educational, evidence-based agenda to achieve rapid, wide-scale healthcare improvement. Telligen's Learning and Action Network is more than an event; it's **everything** we do through our Telligen QI Connect™ network.

Examples of Interventions

- INTERACT®
- Project RED
- BOOST® Toolkit
- AHRQ ASPIRE/MVP Toolkit
- IHI ED Fast Track
- The Conversation Project
- Care Transitions Intervention® model

Enhanced Technical Assistance (TA)

We use our knowledge and experience to help clients summarize and synthesize evidence-based practices and their own data to generate insights and actionable strategies to inform decision-making and accelerate improvement.

Improvement at any level depends on the collective ability of individuals to apply QI methods and tools to their work. Customized training and supportive coaching are critical to create the conditions for success.

Through in-person, virtual and large group learning opportunities, Telligen offers partners the skills and support they need to continuously learn and improve.

Community Coalitions

A community coalition is a formal, long-term alliance of organizations, groups and agencies that come together to work toward a common goal, such as reducing avoidable hospital readmissions. CMS defines communities as a group of three or more organizations in a geographical contiguous ZIP code area.

Secure Portal

- Medicare data on quarterly readmission rates of their specific community
- Aggregated data from other data sources (i.e., public data, self-reported data)
- Telligen community maps
- Learning management system
- Tools/resources

[1]Based on July 2021 - June 2022 Index Discharges and Subsequent Readmissions Processed through July 2022

[2]CMS. The Skilled Nursing Facility Value-Based Purchasing Program (SNF VBP). 2018. Available at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP.html. Accessed March 11, 2019.

[3]An intermediate care facility (ICF) is a long term care facility that provides nursing and supportive care to residents on a non-continuous skilled nursing care basis, under a physician's direction. An ICF is typically regarded as a lower-level nursing care facility when compared to a skilled nursing facility, but its residents require more care and attention than those in a residential care facility for elderly or an adult residential care facility.

Telligen QI Connect™
Partnering to improve health outcomes through relationships and data

QIN–QIO
Quality Innovation Network - Quality Improvement Organizations
CENTERS FOR MEDICARE & MEDICAID SERVICES iQUALITY IMPROVEMENT & INNOVATION GROUP

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