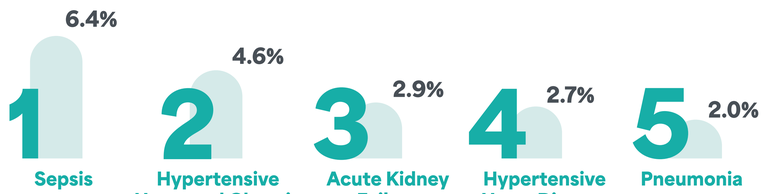
IMPROVING CARE COORDINATION

READMISSION RATES[1]

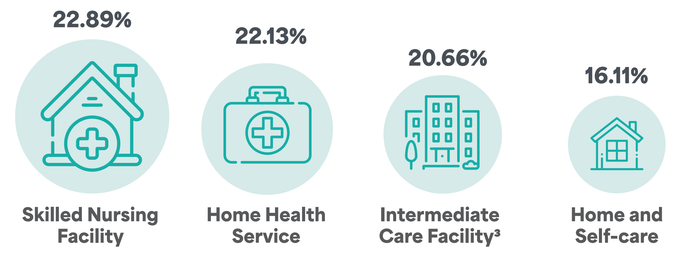
Reducing preventable 30-day hospital readmissions is a priority for the Centers for Medicare & Medicaid Services (CMS). Hospitals are not the only entity to receive financial penalties for readmissions. Skilled nursing facilities (SNFs) have been included in readmission penalties based on performance metrics as of October 1, 2018.[2] Reducing preventable readmissions benefits patient outcomes and hospitals by encouraging them to improve communication and care coordination efforts.

Share Your Interventions!

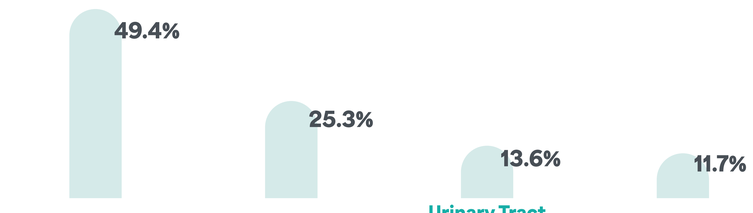
Top 5 Readmissions Diagnoses Codes for Fee-for-Service Medicare Beneficiaries



Readmission Rates by Setting



Rates of Hospitalization for Common Healthcare-Associated Infections (HAIs) in Nursing Homes



In Illinois, **9 out of every 50** Medicare beneficiary hospital discharges result in a readmission within 30 days.

How the Telligen Team is Improving Care Coordination and Reducing Preventable Readmissions in Illinois

We offer 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.

Enhanced Technical Assistance (TA)

We provide 1:1 support to your organization to increase your capacity for quality improvement and to improve processes based on your goals.

Examples of Interventions

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

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 preventable hospital readmissions.

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

[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

This material was prepared by Telligen, the Quality Innovation Network-Quality Improvement Organization, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services (HHS). Views expressed in this material do not necessarily reflect the official views or policy of CMS or HHS, and any reference to a specific product or entity herein does not constitute endorsement of that product or entity by CMS or HHS. This material is for informational purposes only and does not constitute medical advice; it is not intended to be a substitute for professional medical advice, diagnosis or treatment. 12SOW-QIN-05/23/23-4859