



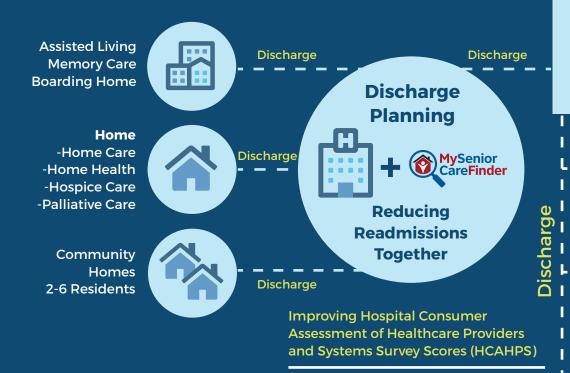


Successful Partnership



REDUCED READMISSIONS

Improving Patient Outcomes



Discharge Planning
SNF Rehabilitation Center



Reducing Readmissions Together



Assisted Living Memory Care Boarding Home



Home

- -Home Care -Home Health
- -Hospice Care
- -Palliative Care



Community
Homes
2-6 Residents

FACTS:



1 in 5 patients are readmitted within 30 days costing over \$41 Billion a year



Lowering Medicare Spend Per

Beneficiary (MSPB)

Hospitals are now **financially penalized up to** 3% of Total Medicare Billing



71% of WA hospitals evaluated for readmissions were financially pentilized





Hospital Readmission Reduction Program HRRP

Patient Condition



Identifying Best Post Acute Care with Live Real Time Community Facility Data.



48/72 Hour Call to Patient

- -Does the patient Understand Discharge Plan/Orders?
- -Medication Compliant?
- -Following Wound Care Orders?
- -Does the patient have an appointment scheduled to see the doctor?

7-10 Day Call To Patient



- -Did the patient Make it to his/her doctor appointment?
- -Medication Compliant?
- -Wound Care?
- -Questions about Discharge Plan/Order?

30 Day Call To Patient.



- -Patient Care Satisfaction Survey.
- -Was patient readmitted to the hospital in the last 30 days.
- ·if So: When, Where, and for What?

COPD

Chronic Obstructive Pulmonary Disease

HE -

Heart Failure

AMI -

Acute Myocardial Infarction

CABG -

Coronary Artery Bypass Graft

DN -

Pneumonia

TKA

Total Knee Arthroplasty

THA -

Total Hip Arthroplasty

Stroke -

LIM/D

Hospital Wide All Caused Readmission

A partnership with - - -



Reducing Readmissions and Improving Patient Outcomes



National Bundled Payment Collaborative
Own the Continuum.