



Rehospitalization in Washington

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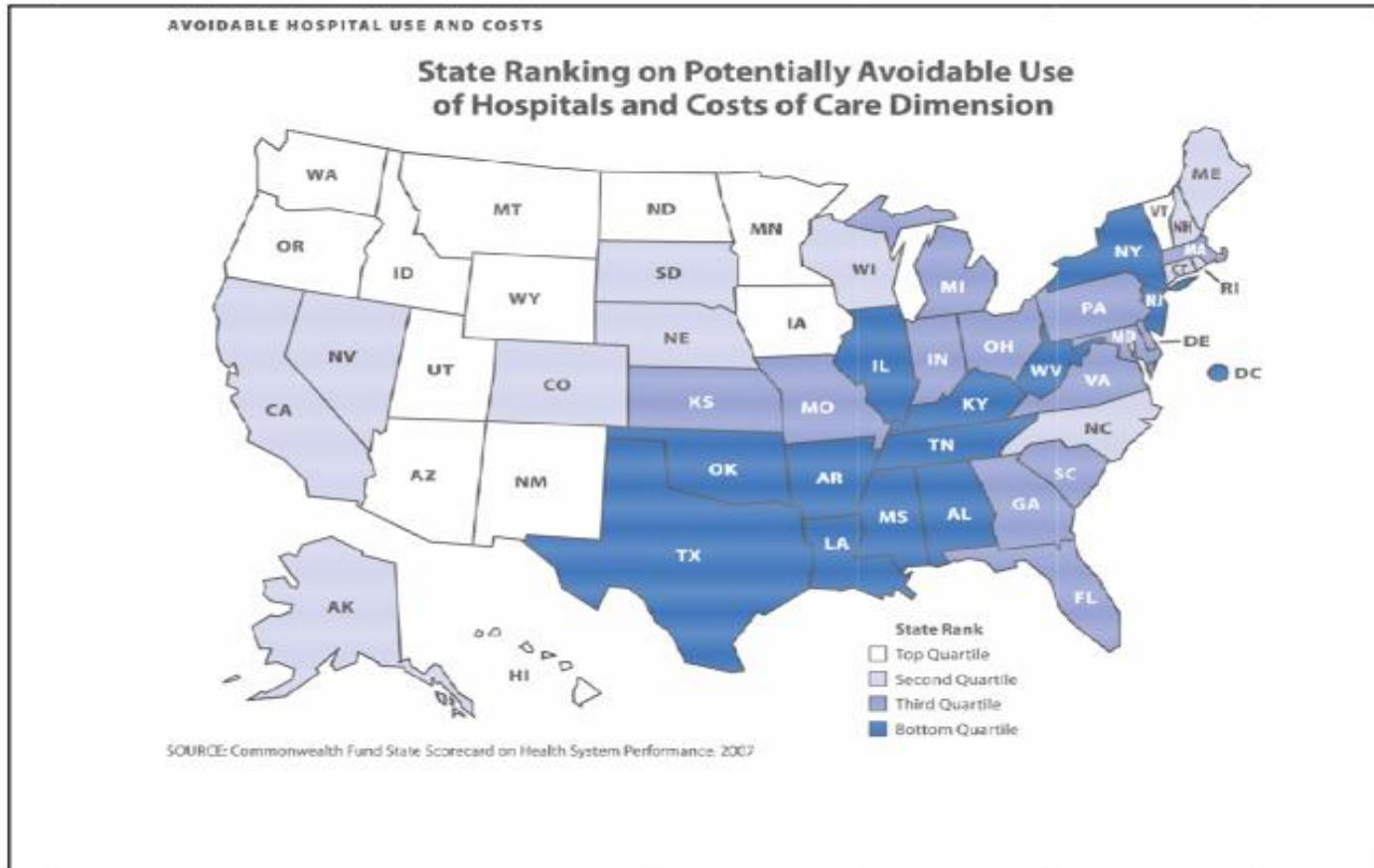
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Washington State Hospital Association

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Commonwealth Fund Ranks Washington in Top Quartile on Rehospitalizations

Figure 1: State Ranking of Avoidable Hospitalizations



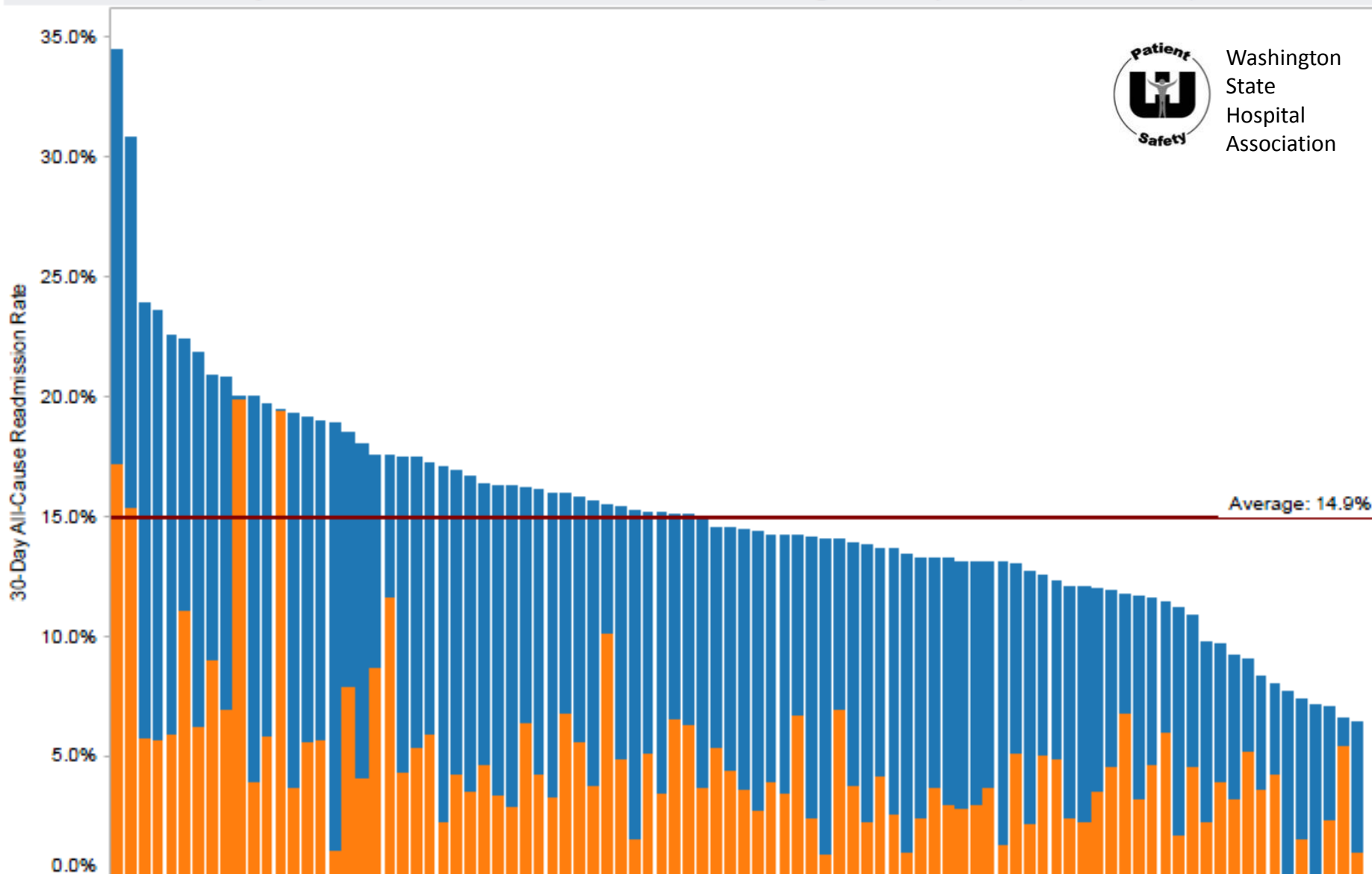
Medicare 30-day rehospitalization rates vary from 13 percent to 24 percent by state.



30-Day All-Cause Readmission Rate for Washington Hospitals (Q1/Q2 2010)



Washington State Hospital Association



Measure Names

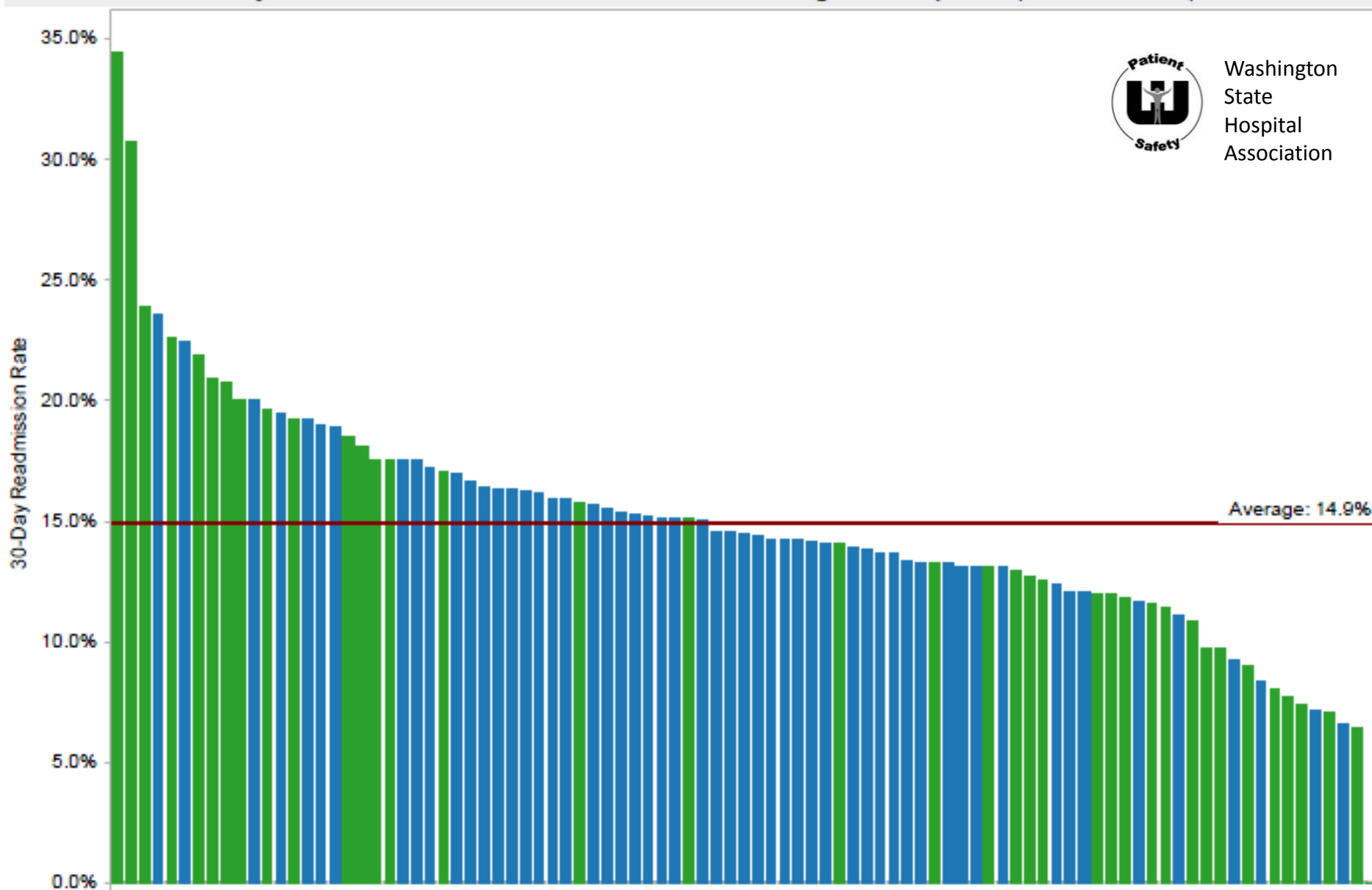
Readmission Rate To Same Hospital Readmission Rate to Different Hospital

Data Source: HIP-Enhanced CHARS Inpatient Discharge File with DOH Readmit Identifiers.

30-Day All-Cause Readmission Rate for Washington Hospitals (Q1/Q2 2010)



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Hospital Type
■ Prospective Payment System Hospital ■ Critical Access Hospital

Data Source: HIP-Enhanced CHARS Inpatient Discharge File with DOH Readmit Identifiers.

Are Transitions a Problem for Patients?

- The availability of a discharge summary at the first post-discharge visit is only 12-34%. (JAMA 2007)
- Nearly 20% of discharged patients experience an adverse event within three weeks of leaving the hospital; two-thirds of these are adverse drug events. (Ann Intern Med 2003)
- Between September 2004 and July 2005, the United States Pharmacopeia received 2,022 reports of medication reconciliation errors; 66% occurred during the patient transitions.
- An estimated 19% of patients discharged from the hospital to a skilled nursing facility are readmitted to the hospital within 30 days.



Are Transitions a Problem for Providers?

- “Handoffs and Transitions” ranks the lowest of 12 domains of patient safety culture in average percent positive response on the Hospital Survey of Patient Safety Culture. (AHRQ 2010 database)
- “Information Exchange with Other Settings” ranks the second lowest on the medical office version of that survey.



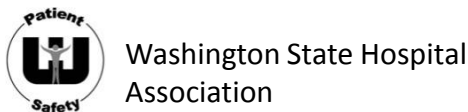
STAAR

**State Action on Avoidable Rehospitalizations –
Institute for Healthcare Improvement
Commonwealth Fund**



Washington State Hospital
Association

Washington State Rehospitalization Steering Committee



Creation of Statewide Initiative

State Action on Avoidable Rehospitalizations

Multi-Stakeholder Statewide Steering Committee

Align Incentives

- CMS Value Based Purchasing
- Medicare Quality Incentive
- Medical Home

Data/Information

- Readmission Report (from any hospital)
- Physician Visit (develop.)

Smooth Transitions

- Cohesive plan of care at arrival
- Integrated plan at discharge (patient, family, and care provider)
- Coordinated follow up call or visit
- Timely visit to primary care provider
- Reconciliation of medications
- Coordinated education
- Support through care management



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State Action on Avoidable Rehospitalizations

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