Coordination of Care Initiative
Home Health Gap Collaborative

Planning Meeting
January 17, 2018

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The Voice of Home Care

Coordination of Care Initiative Update

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Coordination of Care Initiative Goals

- Improve quality of care for Medicare beneficiaries who transition among care settings
- Reduce 30-day hospital readmission rates and admission by 20% by 2019
- Increase the number of days at home
- Establish sustainable, transferrable transition practices across the spectrum of care

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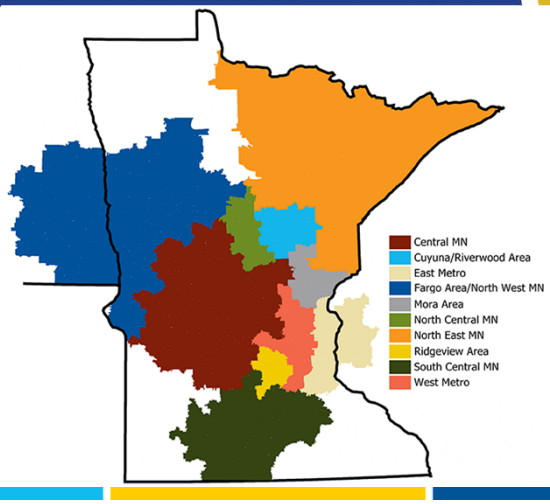
Coordination of Care Communities



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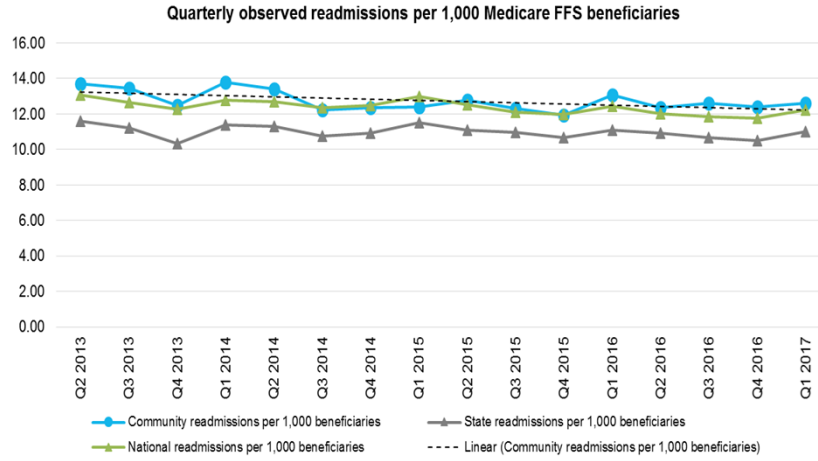
Readmissions



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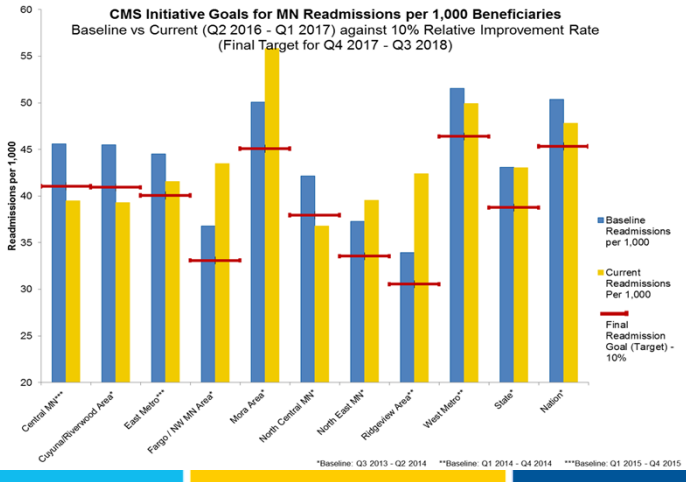
Community Progress Toward CMS Initiative Readmissions Goals



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Situation (The problem)

- There's a huge gap between the number of patients referred to home health services by the discharging hospital and the number who actually receive services.
- Those patients that are referred but do not receive home health services have a significant higher readmission rate.

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Background of the home health gap problem

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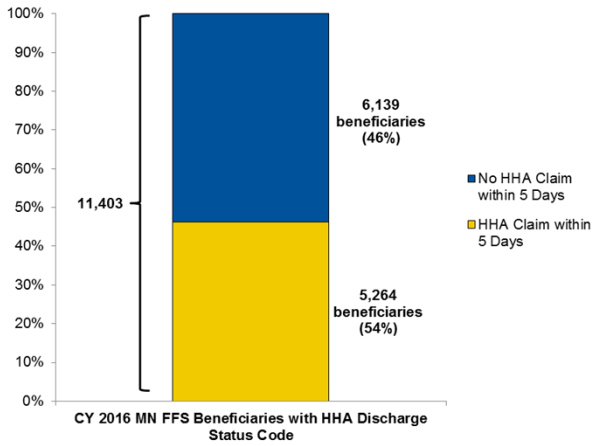
Background (The data)



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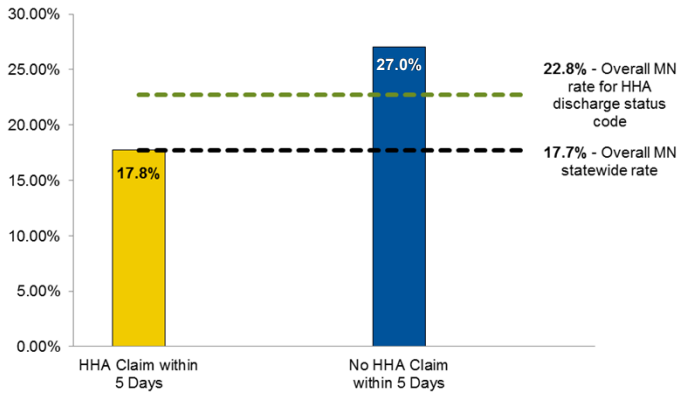
Background (The data)

30-day readmission rates among MN Medicare FFS beneficiaries with HHA discharge status code (CY 2016)



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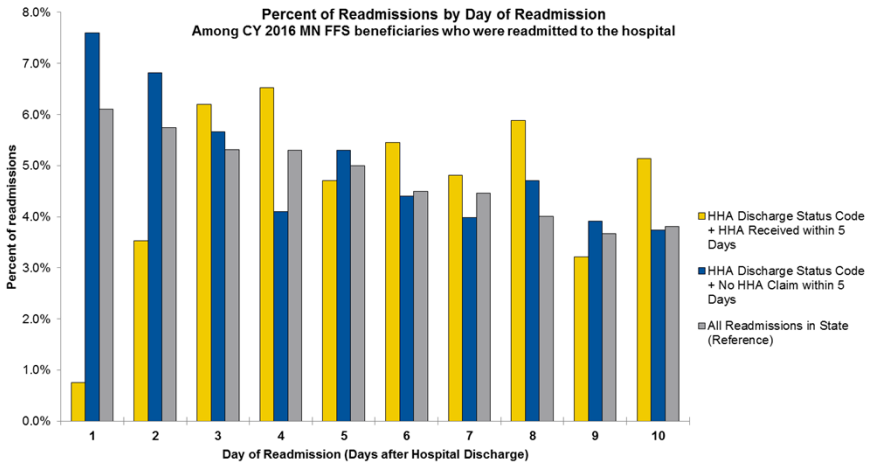
Background (The data)



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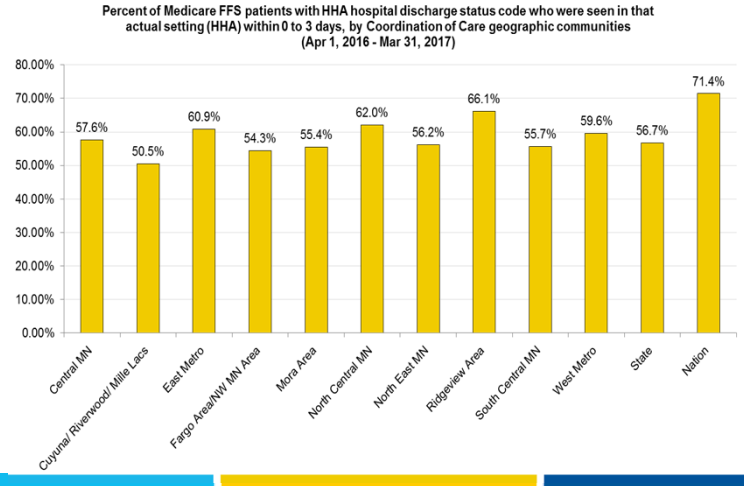
Background (The data)



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Recommendation

- Would you be interested in being part of a collaborative between home health agencies and hospitals to increase the acceptance of home health services? YES!

Discussion

- What could this look like?
- Who would be involved?
- Statewide initiative?

Identify collaborative goals

Plan collaborative structure

Next Steps

- Informational webinar – Feb. 14, 2-3 CT

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