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Please stand by for realtime captions.Good afternoon ladies and gentlemen. Welcome to the South Carolina AHRQ Medicaid readmissions webinar. Karen Southard will now begin.

Good afternoon everyone. Thank you for being here. I would like to open by helping [Inaudible - static] Karen Southard for the Atlantic innovation network , QIO. We are your sponsors for the project and we want to recognize the South Carolina Hospital Association and Blue Cross Blue Shield. Together we are happy to bring this collaborative seminar - seminar on readmissions. And we are happy to have trained to, who is an investigator for the AHRQ reducing Medicaid readmissions project, to lead us over the next few months. Amy, I will turn it over to you.

Thank you, Karen. Thank you to everyone that has brought us together today. And to all of you for joining us or this first in a three-part webinar series on Medicaid readmissions. We are thrilled that you decided to take the time to investigate and learn about this topic, and we hope this is worthwhile webinar for you.Today is our first webinar, I will start by read - introducing the project, and where you are meeting us in our journey on this topic, and give you an overview and brief orientation to the guidebook available to you. It is available on our website, the hospital guide to reducing Medicaid readmissions. Why Medicaid readmissions? And we care about readmissions for all patients, and to touch on why are we focusing this particular webinar series on Medicaid patients in particular. Thank you to the QIO and South Carolina Hospital Association, and we are warts that to take a dive into the readmission patterns in South Carolina, and refer you to specific data analysis and analysis tools one, two, three that come to the guidebook we will be walking you through. Our objective today is to hope you feel oriented with regard to the hospital guide to reducing Medicaid readmissions, and the a learning session that we are planning for the end of April. We hope that you come away with being able to identify three specific ways that Medicaid readmission patterns differ in important ways from Medicare readmission patterns that many of us know and are familiar with after the past several years of work. Hopefully, you will walk away from this session with a clear understanding of why conducting your own analysis of readmissions specific to your hospital will position your team better to addressing readmissions and addressing the financial incentives coming your way.The reducing Medicaid readmissions work. The agency for healthcare research and quality made an astute observation several years ago. Readmission reduction efforts have been becoming increasingly adopted in hospitals all across the country for many important reasons.

The best practices have Yardley - largely been based on research in the older adult geriatric population, or Medicare population. Some of those toolkits are relayed here and you will recognize these acronyms. Furthermore, [Indiscernible] has invested heavily in focusing on readmissions whether it is through the penalties or through other payment and incentive programs again that you can see on this slide, we have been quite focused because there's been so much technical assistant and payment read warm, or - reform or in the Medicaid population, it is only natural that we start with a focus on this population.They realized that Medicaid - there are important demographics, social demographic and differences between the Medicaid and Medicare population. They asked us several years go to examine and understand the similarities and differences in the readmission patterns and Medicare versus Medicaid patients. And explore which are the best practices and have come out in informed our work in certain ways, and what are these practices that apply, or whether adaptations might be needed. Where you are meeting us now is that the result of that research and field work today culminated in a guide that we published in August, targeted at hospitals - hospital-based readmission teams in particular, but certainly relevant to community-based coalitions as well to help read - inform readmission teams of advisement and practical ways to extend their work to focus on Medicaid population as well.You can see now, we are in our third phase of work which has to disseminate version 1.0 of the guide and get your feedback and hopefully this is helpful to you. It is version 1.0, and we are eager to disseminate and get broader experience and feedback. We will be creating a version 2.0 to address what is missing. Certainly there must be. Again, we welcome your feedback anytime. Feel free to email myself and my co-principal investigator, and the email addresses will be at the end of the slides. Or you can reach us through Karen, our host for this collaborative.In South Carolina we are excited to meet you. As Karen said meet you in this moment in time. We have market changes underway, and talk around possible Medicaid readmission penalties. We want to bring focus to these issues, and before it was Medicare focused topic. Karen has outlined the two primary sponsors as well, as well as the supporting partners that bring statewide attention to this effort, and we are thrilled about the interest in and willingness of so many different agencies at the state level to collaborate to bring us all together to focus on this topic. As you can see, we will have webinars every other week for three weeks. A few weeks later, we will convene in Columbia for an in person learning session. Let's turn to the actual guide and toolkit. The purpose of the webinar is to summarize and highlight key points and lessons from this guide. We will not walk you through the guide chapter by chapter, but rather take specific topics and angles in the guide. And present that through this webinar format, hoping that you will find this guide as a useful reference. It is much more detail, and has many examples then we can cover in this webinar series itself. Similarly, - one thing I would like to say about the guide is this guide was generated with the spirit, like we said, recognizing that readmission work is happening across the country in

hospitals. There is a cross continuum work happening in several communities in South Carolina, and growing all the time. We want to meet you where you grow and work. You recognizing that you have readmission work going on and if started practice changes. The approach is not to have a Medicare versus Medicaid set of recommendations, but rather we formulate this guide to say we recognize that you have learned a lot about Medicare readmissions, now here are ways to expand your thinking and incorporate the high risk Medicaid patients as well as highlight some of their transitional care needs so that you can build out your cross continuum teams and adapt and expand your readmission work to reincorporate the entire high risk population. We're hoping this will help you develop a comprehensive and inclusive strategy, not one pay your type versus another pay or type for example. - payor type.As we run across questions, we tried to develop a tool that would be helpful. These 13 tools, again, they are works in progress. We are eager to find out if you have any strategies that are better or different from what we have in this guide. These are new tools that you may not of seen in the other readmission best practice guide books before, or maybe an enhanced or updated version with more Medicaid specific focus. We encourage you to look at all 13 tools, and we will present the majority of these tools through these next three webinars.There are couple of questions in the chat box, and the presentation will be circulated, and you will most definitely be able to get a copy of the slides. If you look in the chat box, they have posted the Atlantic quality QI in as a website there. - QIN, And I bet slides we posted there as well. Why Medicaid admission? We all have to start somewhere in quality improvement. The field has collectively been focused on Medicare fee-for-service, and usually the Medicare penalty conditions. Because of the Medicare readmission penalties, many hospitals have focused their first phase, if you will of readmission efforts, on heart failure and pneumonia. And now these penalty conditions have increase, COPD and knee and hip replacement. We recognize that we all need to start somewhere and gain experience. In 2015, as we expand and encourage you to expand your thinking around this readmission a reduction work, is racially as you think about expanding to deal with the Medicare to program which is increasing the number of conditions, and now you may have another Medicaid penalty program coming down the pike. Looking at your data and understanding, how do we focus and understand readmission risks? Anti-pneumonia, COPD and hip and knee replacement AMI, DNA, and they are among the top but they are not the only. There are important diagnoses that lead to more readmissions to AMI and pneumonia that are not part of this penalty program. Many hospital readmission teams do not realize this in addition, we have been a little bit blinded by taking the disease specific focus that Medicare has led us to incorporate, and really population health programs that are successful, they may conceptualize risk in slightly different ways such as hide utilizer's, social complexity, behavioral health comorbidities, and they made use these. There are other ways to identify higher readmission groups that are not limited to these categories. This is the Blinder that we

can move forward from, I think at this point. This is through the Medicare focused at the exclusion of other high-risk patient groups, and you will see in these next slides that Medicaid helps, including in South Carolina, they actually have a higher readmission rate than Medicare. They are both high, and they are both important, but many of these didn't - many of us to not realize that looking at adults not in for labor and delivery, they have a very high readmission rate. Furthermore, even walking away from tier specific, there are important low-frequency but high political risk diagnoses that were not being taken into consideration. Again, because we're looking at these from how Medicare has encouraged us to start out. And one other thing is the encouraging case Finder approach. We're trying to find her versus her, and him versus Tim, instead of focusing on what we're trying to do is build a better system of inpatient and outpatient coordination and care transition for everybody. The patient who has no pride of utilization and family at the bedside, but has a devastating diagnosis of cancer, that patient has transitional care needs. That is just as important to pick up on and attend to.Readmissions are frequent or Medicaid adults. You know these patients, you have them every day in your hospital, or if you are outpatient provider, you are struggling to serve these people in the community every day. Ask yourself if your current hospital readmission reduction strategy would've helped these particular patients. The 61-year-old man that has been hospitalized eight times and is in yet again for shortness of breath. The ¬45 woman who had HIV and hospitalized for pneumonia and bounced back a week later again for pneumonia. The 32-year-old man with a tragic lifetime of chaos and consequences of uncontrolled diabetes with everything you can see here on this slide. About how challenging his life is and he comes in to one hospital with Planck pain - flank pain, and are we addressing his needs. We need to target these, and target the non-Medicare patient, and how we should target them, and if not, why not.Facts and figures on Medicaid readmission. We are fortunate these agencies have put out some very helpful just in the past year to, and so this is not very widely known information. I want to make sure we bring this to your direct attention as you get up to speed on learning about the differences between Medicaid and Medicare readmissions. This came out last year, and they look to the top 10 diagnoses that led to the highest number of readmissions. And compared Medicare versus Medicaid.They included obstetrics, so it was inclusive of the OB population. Of the top 10 Medicaid diagnoses, for our behavioral health, two relating to pregnancy, and the others are the well-known diabetes, CHF, and COPD. Number eight is interesting and very important condition we will touch briefly on this today, sepsis. It always shows up in everyone's top 10 lists, and to me as a position it makes a lot of sense is - sense to me. I don't know why we have not focused on sepsis before. Data tells us we need to focus it and as we move into South Carolina, you recognize your patients with sepsis are at high risk for readmission. The top 10 medical care diagnoses, you can see the penalty conditions and CHF is at the top. Pneumonia and COPD, and you notice that hip and knee replacement is not on the top 10. It has a low

rate of readmissions, and ask yourself if you know what the rate of hip replacement in Medicare for hip and new replacement is versus heart failure.For hot failure, it is 20%. But for hip and knee replacement is actually in the single digits. The national average is 3% to 4%. Very low. It is a high-volume condition though. Again, I am encouraging you to use this conversation, this opportunity from this data, and look at the real data. And ask yourself why you are focusing where you're focusing, and does it make sense, and do you want to modify moving forward. And another brief that came out before the holidays is very interesting with regard to readmissions. This is a specific look at utilizing Medicaid patients. This is semi-national data published by our program officer Doctor Jiang and her team found that among people hospitalized three more times, Medicaid patients, the vast majority of all Medicaid, including OB and adults, the vast majority were adults. The average was that they were having six hospitalizations per year. You can see the length of's - length of stay is significantly higher than the overall. The cost per hospitalization for a Medicaid high utilizer is higher as well. Readmission rate only shows, understandably so, it is very high because of the definition. These were frequently admitted patients, and frequently readmitted. These readmissions happen in quick succession of each other. They are three days if you can believe it, it was 52%. If you are Medicaid patient that was not a high utilizer, the readmission rate was 8%. The split is very high and very profound and it lets us know that if we focus on high utilizer's in the Medicaid population, we are targeting well and in a data-driven manner.I find this statistic very interesting and it Ormandy of, 75% of the high utilizer's are discharged to home. We are discharging them time and time again back into the care environment from which they came. That tells us that as we think about cross continuum on teams, and how to specifically address utilization patterns for Medicaid, we need to think about the home and community, it not so much around skilled nursing or post acute partners. That is a high leverage opportunity for the Medicare population.This is another data slide before we get into the South Carolina stats. Coming from the national data, and what I love about this slide taught me a lot about pair in a. Notice at the - care and age. We all know that readmission patients are needy and a good important place to focus on are read admission reduction effort. Many of us, for good reason, we have focused on the Medicare beneficiary with heart failure. If you look at all patients with hot failure against all pay yours - payors it is counterintuitive, and the 65+ Medicare and/or Medicare beneficiaries, they have very high readmissions, but comparatively speaking, they have lower readmission rates than the younger adults with heart failure, or the Medicaid adults with heart failure. To me the teaching point from this slide was to cast aside assumptions around age, and also to point out that even we're talking about a classic chronic condition of the older adults, we need to remember that readmission across a variety of tran16, but tickly Medicare and Medicaid is high, particularly Medicare and Medicaid, and did not cut off our screening for Medicaid or Medicare just because of age.Moving to the South Carolina data, let me catch up with

myself here on this slide.Sorry, I am having a little bit of trouble getting my slides to advance. Karen, can you see my slides advancing?

It currently says recommendation one. Now it is changing.

I am having a tough time, and I am probably going to have to turn the ball over to you and go off of my paper slides. My slides are not advancing for some reason on my screen. I can tell I am advancing for you, but I do not see them advancing. Picking up off of the-

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This is Sarah, if you pass me the ball, I will advance those slides.

Thank you.

Sarah, you have the slides. Can you tell me which one - go to the slide that says recommendation one.

Okay.

Recommendation one, know your own data. The net dashed the tool market we share in the guide is a 10 point data analysis where you can compare Medicaid/Medicare and you could add commercial to that line. You can compare tran16 and the listed readmission data elements by payors. We want you to have the all payors view , but we have learned that doing this several times, this is very informative to have the payors specific view as well as the all payors view. You can see important similarities and differences. Next slide. We took that readmission tool and we were fortunate to collaborate with the South Carolina Hospital Association and other partners who have access to the South Carolina hospital discharge database, and we were able to do that 10 point data analysis on the state wide South Carolina data. Next slide.This is entitled South Carolina readmissions, and it has the total number of discharges for Medicare Medicaid commercial, uninsured, and the total population. Our colleagues at the hospital Association were working together, and this was an analysis we did and presented to some of you a year ago. We are updating that for the most recent year available, and I am happy and excited that the hospital Association will make this 10 point data analysis available to each hospital as a member of the service. As you look at this data, I believe that in the next week or two, you may see your hospital specific output of this analysis yourself. Again, staying on this slide, we can see here just again looking at this first data slide, we can see that out of 386 total - 386,000 total discharges in South Carolina, 33,000 work Medicaid, and 280,000 word Medicare. So clearly the prawn - the preponderance is Medicare. Following down, we can see overall, there were 69,000, for an overall rate of 18%. And when we look at the

Medicare and Medicaid readmission columns it gets interesting and relevant. There is basically a 21% Medicare readmission rate and a 22% Medicaid readmission rate. Showing how important those two payors groups are, and even though there are more from Medicare, the rate is just aside, if not a little bit higher for Medicaid. And the commercial, uninsured and insured are lower than the average, and you can see in this example, as well as so many others to come, the all payors column is important, but is really in the payors breakout that you can gain insight as to how to target, and what the unique issues are in terms of driving your work forward. Overall, 65% or 75% occur at the same hospital. We can see if they are readmitted to a different hospital, and that information is valuable. About 25% to 35% of your patients are being readmitted to a different hospital. It is important to remember that as you're treating and tracking your own hospital specific data. You need to accommodate for about 25% or 30's - 30% that are readmissions occurring elsewhere. Next slide, South Carolina readmissions to shows us readmissions, and it shows us the straight discharge disposition of all patients discharged in South Carolina. You can see here, the Medicare beneficiaries are discharged postacute care more frequently than any other type of patient. When you think about, if you have across continuum team or community collaboration, this is nicely designed to meet the transitional care needs of that one third or so of Medicare beneficiaries that are discharged to postacute care facility or provider. But will be moving to looking at Medicaid in the other payors, there are a vast preponderance being discharged to home, which make us think about the community-based providers and agencies that will meet the transitional care needs of those patients.On the second slide, we have presented the number of days, the average number of days between discharging readmission, actually the median number of days. You can see - mean days, you can see that 15% happen within 9 to 11 days of discharge. When you think about getting your patients follow-up in one to two weeks, if two week is 14 days, you can see that you've already missed 50% of all of your readmissions. This is great aided to remind us that the time for early contact post discharge is very important.Moving to South Carolina readmissions slide 3 this is the diagnosis specific slide. You can see for the payors types as well as the overall column on the right, you can see the discharge diagnoses that led to the highest number of readmissions within 30 days. These are the highest numbers of read missions. Again, from Medicare, just highlighting, acute renal failure leads the list and then set this - sepsis, which I call to your attention. And then we see that more familiar penalty conditions. Mixed in with some others that you may not have expected, or maybe you knew clinically, the you've never seen it published before. Such as urinary tract infection, which is always on everyone's top 10 list. The Medicaid column though, is again similar in some ways, and different in some important ways. Most notably in South Carolina, Medicaid patients with sickle cell lead the list as the number one discharge diagnosis that leads to readmissions, but look at the numbers in the parentheses. Sickle cell resulted in more readmissions then by

sepsis, by factor of three to one. It is not even close. With regard to readmission work when it comes to Medicaid population, it shows that coming up with creative and effective solutions with patients with sickle cell disease is a top priority. You can also see some other diagnoses, and again pointing out the DKA, diabetic key lapse of doses, and this is not show up anywhere else. DKA, PNA, showing up for the Medicaid column and those are rather unique across this grid of diagnoses that you see. This gives us a signal on the unique issues as well as the common high priority areas. New slide next line South Carolina readmissions 4 and this is the high utilizer's. These are those defined is individually hospitalized three or more times in the last 12 months. We can see in the right-hand column at the total, there are only 29,000 high utilizer's in the entire state of South Carolina, which is not that many people when you think about it. And collectively, those 29,000 used 117,000 hospitalizations. That interestingly enough, again looking at the total all payors column, was 30% of all hospitalizations in the state. 12% of the people use 30% of the hospitalization. The readmission rate overall, 40%. We're talking about high readmission rates being 18%, 20%, heart failure, Medicare etc. You can see these numbers are profound, when you focus on a personal history of repeated hospitalization, it is a high leverage strategy. Interesting enough, before move off this slide, I want to point out that there are only 3765 Medicaid high utilizer's in this state. I would invite us to reflect on whether or not weird testing some assumptions, where we might think a Medicaid patient or uninsured patients are the patients that frequent the hospital many many times during the year. Maybe disproportionately show, to the Medicare population. In his interesting to see these numbers, when we are really talking about re-thousand 700 high utilizer's in Medicaid, and 20,000 high utilizer's in Medicare, both important populations to be sure. Moving on to the next slide, South Carolina readmissions 5 and of these 29,000 high utilizer's, what diagnoses where they come in in in our hospital with? This is interesting, and something that our research has borne out time and again, the conditions are basically the same. Mathematically, that makes sense, that they are driving the utilize Asians and driving the results of the other graphs, - utilize Asians, utilizations, and driving the results of the other graphs. We're talking - talking about focusing on the overall. One caveat, before we get excited about diving into focusing on renal failure, and ammonia, COPD, sickle cell etc., it is interesting to note that when we add up the number of readmissions that occur in the top 10 discharge diagnoses, dividing it overall the readmissions in the state, at the hospital as well as the state level. Unfortunately, the top 10 conditions usually only account for about 20% of all the readmissions. While there is insight and leverage in teaching point for sure, on understanding what the top diagnoses that lead to the highest numbers of readmissions, unfortunately, we're not getting to that 80/20 rule. We have not found the 80% of the discharge diagnoses are counting - 20% are accounted for at the readmissions. It is not working out that way unfortunately. Even if you case them for the top 10 diagnoses that led readmissions at your hospital, you would only have a

strategy accounting for 20% of your readmissions. That is what we're trying to say here. Next slide.Insights from the data analysis are the following, and either - eager for your thoughts and feedback. It appears that we're on the right webinar, because Medicaid readmission rates are the highest of any payors group in South Carolina, with Medicaid slightly edging out Medicare, and both of which are higher than any other payors . Including the uninsured. The single highest group of risking readmissions of those with a history of 3+ hospitalizations, the rate is 40%. We found that in statewide data, readmissions occur soon after discharge, about one quarter of those occur within the first four days, and 9 to 10 days of discharge as well focusing on the needs for early contact. About 30% occur to other hospitals, and that is specific as you trend your own data specific. Sickle cell, acute renal failure and sexes are new to be aware of, is always been the data, we just have not looked at it. Those are a couple of key takeaways I think from this analysis. Thank you to the hospital Association for breaking this all down for you, and giving you your hospital specific report individually.Recommendation 2 we need to add to this data-driven approach the experience and input, and feedback from the patients, their family caregivers, and there providers. To do that, we present this tool, the readmission review. This is the strategy that [Indiscernible] and QI in - QIN has used for years, and we try to update this and streamlined for your use today. We really encourage you whether you are payor or community-based provider to go find five Medicaid patient - patients readmitted. If you are in the hospital, your luck because they are already upstairs on your floors. Find a staff member to conduct this brief semistructured interview, and it is really just a series of prop so that you know what to look for. You want the story behind the story. This is where we find out that the food shopping is done by the daughter loll - daughter-in-law, but she went out of state on the fishing trip, and the wheels fell off the bus. Or somebody has been compensating in a certain way, and when that support structure, or the primary caregiver is not around, the well oiled machine grinds to a halt. It is important to elicit the stories, and sometimes as clinicians, we tend to over medicalized admissions. We talk of doubt diagnoses and medication, clinical management strategies, and oftentimes you will hear a shoe interview patients, this is very familiar all, social and statistic in nature. We would be better off to focus on the reason the patient says they came back, rather than the clinical reasons we think underpin a poorly managed chronic condition, for example.Moving onto the next few slides, remember the 61 year old man I mentioned that was hospitalized eight times already for shortness of breath. These are the readmissions insights from his interview. When I first met him, I met him on readmission number eight. I was attending that month on the floor, and I had never met him before. I had no institutional memory. He was presented to me as if it were the first time he had ever graced the halls of that hospital. We had no contact her's is - perspective that he was frequently hospitalized. He had six different reasons for being short of breath on any given day. When I went to talk to him, and I asked him I came

back, I discovered without reading you the book, he was quite comfortable in the hospital. He was marginally house, he lived in a one-room boarding house 81 Melody from McDonald's. - Eight - ate one Melody, and he had resources and the hospital that his day-to-day life did not offer him. His transitional care plan is not about optimizing is care path, it is really about leading straight into - any day on his life, it is nicer to be on the eighth floor of my hospital than to be alone in a row one-room apartment - alone in a one-room apartment. That is a good story that focuses on the entire picture. The ¬41 woman with HIV, she had long-standing HIV. Over the years, even though she had been presenting for regular Bud work - bloodwork, she fell out of the chair. She got pneumonia, and ended up in the hospital. She was admitted, started on antibiotics, and she was discharged because she's 45 looks confident - and looks confident. She was discharged to follow up with a primary care, that she did not have a primary care or an HIV Doctor period she went home with two new diagnoses. And the AIDS defining illness, and on new medication. She had no follow-up. In 2014, I think we can all agree that that is nobodies idea of appropriate.What happened was that even though she was a highly functioning individual, like any of us, she lives with her mother, her stepchildren, and we did not know about her status. She is not about - to get on Google or make phone calls in the midst of her family not knowing about her status. That is understandable. She showed up in the emergency room and I had a team attend to her, and when the team asked her what could we do differently to help you not come back to the emergency room, she said quote, it would've helped if they had made those appointments for me. Remember the patient's story, this is not about complexity of HIV or AIDS, it is about getting them the follow-up help that they need. We need to focus on what matters. There are a lot of things that matter in medicine. The patient's voice is what matters here we're trying to avoid readmissions. I'm good is skipped the slide about the 32-year-old man and the next slide entitled the root cause of his chest painted admission was homeless that. - Homelessness. I encourage you to read this message of his repeated hospitalization. He is a medically, behaviorally, and socially complex individual with a tragic complicated life story. I'm betting the first day that he showed up at the hospital, even though he had been living in the emergency room or patient setting for 149 out of 180 days after being released from jail. He showed us dashing showed up at our hospital, and he got a million-dollar workup even knowing it be in several different hospitals. As a reminder, get the full history of these hide utilizer's, where they were hospitalized and what was done for them. As my mentor says, they the bad on their best day. So we do a million-dollar workup in the mix, without fully understanding the patient and the trajectory and the big picture. That is the take home message about this patient.There is never one reason for readmission. This interview really helps us to understand the multifaceted approach that needs to be developed to effectively address readmissions. This team took the readmission interview tool, and they did me one better. Instead of looking for the reason, they were clever enough to capture all the reek - root causes of remission.

This team has up 14% readmission rate, and we think they are pretty good as it stands. They were able to look at their readmissions and see prevent ability they are. - Prevent ability, and they found that there was an average of nine issues that contribute to the readmission events. This is a great context to approach these readmission interviews. Think of it as you are trying to discover everything that contributed to the readmission. If we just keep looking for THE root cause we will continue the same leverage point. Next slide.The next best article that has been published is this one from my colleague from Doctor in Philadelphia, Kristin Rising and she move this into the emergency room. These are 60 of her readmission interviews. She now - and found that ED had bounced back patients, and some of these regum, and had no problem getting medications and the majority had a PCP. These are issues to be sure. But when she dug into the primary reason why the patient said that returned, they returned because of some element of fear or uncertainty about their condition. There is no better way to connect to the human side of this work then to realize that people come back because they are trying to do the best for themselves that they can. Maybe they are the marginally housed individual trying to find safety and security and contact. When they come back to us, as Doctor rising said, it is fear and uncertainty about their condition, and it is meaningful to take a moment and contemplate. Her conclusions were that in order to reduce the current utilization, patients appear to need more reassert - reinsurance - reassurance and they need a way to ask assess - access advice between visits. We do not have the typical delivery system to provide that longitudinal high touch of assurance between the office visits or between their episodes of care. This is insightful, and this article is really worth your attention. Moving on for the last few minutes, recommendation 3 this is tool number three, and take this data and the interviews and your interpretation and summarize it in this tool number three. This is the data analysis synthesis tool. We have found that it doesn't live somewhere where the information has been put together, it can be circulated up to the hospital leadership, out to front-line staff, circulated across the settings, the continuum care partners. This is very valuable information that you will generate. Don't let it live and die with your readmissions task forces. Give life to it, summarize it in a way that creates a narrative that is meaningful to front-line staff, hospital readmissions, and partners that are eager to support your transitional care efforts. Next slide. Summary and action steps, I hope from this webinar come away understanding that readmission rates for Medicaid adults are high. And they are are probably high at your hospital. There are important differences among medicated Mary Kay - Medicaid and Medicare readmission patterns. It is essential that you are educated and aware of how these patterns are similar and different, and it will allow you to update in strengthening your readmission efforts moving forward. It is essential that you have your own readmission analysis at your own hospital. I think you are about to get a fantastic gift, and I know you have been receiving reports from Laura and the hospital Association over time, and the QIO provides very the able analysis. And to leverage

this data that you have to get a handle on how many utilizer's you have and how many visits they have etc. And as we think about dealing with the changing market, and incentives that you have, whether it's penalties in Medicaid or Medicare, or other market dynamics, I would like to suggest that an updated hospitals specific understanding of your readmissions and understanding what your patience come back, this will better position you to develop a strategy that will address your readmission rates overall, and to optimize your efforts. The hospital said of me great progress nationally and staying out of that penalty zone, and making readmission reductions at the hospital wide level, they have not left the tail wag the dolled. - Dog. They have looked at readmissions and studied it in a way that we have described here today, and they have developed a program that meets the needs of their patients in a targeted data, informed way. And that is how they became successful in the market, as opposed to letting the rules in a particular program drive their work. Next slide. Thank you so much for your inclusion in our webinar, and thank you Sarah for dancing my slides. We have two more webinars as you can see, every other week for the next month. And then April 29 in Columbia or a in person learning session. Next slide. Thank you very much for your participation in this webinar and in this effort. Please send myself or my called league - colleague Doctor Maxwell, and we want to continually improve our advice to the field. With that, I will turn it over to you, Karen, to adjourn the webinar. Thank you for your attention.

Thank you Dr. Amy Boutwell . We appreciate this fabulous information and this is just a teaser of more to come. Thank you everyone for attending, and thank you to the hospital Association for preparing this data. It has been most helpful. As you begin this process over the next few weeks, we would like you to go back and use chapters 1 through four that the doctor review, and we would like you to focus on these patient interviews, and we would like to communicate with the details, and spend a day or two and sign up for the next webinar which is on March 26. Again, we will communicate this to our website, and this is posted in the chat box. We will also send slides and information to you. We will also be distributing this information to the hospitals. Thank you everyone in this concludes our webinar. Thank you. [Event concluded]