“Involving The Community in Reducing Readmissions”

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Vice President Medicare Operations, MPRO (Michigan’s Quality Improvement Organization)
Co-Lead MI STA*AR, IHI Improvement Advisor
Objectives

• Provide an overview of MI STA*AR Initiative
• Community-or-Coalition
• The Michigan picture
• The faces of Detroit
• Detroit Community Action to Reduce Readmissions (DCARR) initiative
• Addressing barriers-affinity groups
• Next steps
MI STA*AR Overview

- A statewide initiative to:
  - reduce avoidable 30-day rehospitalizations by 30%
  - Increase patient/care giver satisfaction with care coordination and transitions
- May 2009 – May 2013
- MPRO and MHA co-leading statewide initiative
  - Improvement Advisors to assist teams
- Over 64 hospitals with transitions teams
- State and Local Learning and Action Networks
- State Steering Committee
Steering Committee Members

- Tina Abbate Marzolf, CEO, Area Agency on Aging 1-B
- Caroline Blaum, MD, MS, Gerontologist, University of Michigan
- Amy Boutwell, MD, MPP, Institute for Healthcare Improvement
- Peggy Brey, Deputy Director, Office of Services for the Aging, MDCH
- Laura Champagne, Executive Director, Citizens for Better Care
- Ed Gamache, President, Michigan MICAH
- David Herbel, President & CEO, Aging Services of MI
- Jeanette Klemczak, RN, MSN, Chief Nurse Executive, MDCH
- David LaLumia, President & CEO, HCAM
- Cecelia Montoye, RN, MSN, CPHQ, Michigan Chapter, American College of Cardiology
- Susan Moran, Bureau Director, Medicaid Program Operations and QA
- Richard Murdock, Executive Director, MAHP
- Julie Novak, Executive Director, MSMS
- Larry Abramson, DO, Michigan Osteopathic Association
- Lisa Ashley, MSW, NHA, CHPCA, President & CEO, Michigan Hospice & Palliative Care
- Tom Simmer, MD, Senior VP & CMO, BCBSM
- Nancy Vecchioni, RN, MSN, CPHQ, VP Medicare Operations, MPRO
- Sam R. Watson, MSA, MT (ASCP), Senior VP Patient Safety and Quality, MHA
- Robert Yellan, JD, MPH, President and Chief Executive Officer, MPRO
- Barry Cargill, Executive Director, MHHA
Key Pieces of Information

Readmission Rates

Patient's / Caregivers Story
• **Patient One**: He doesn’t feel he has any problems getting to his appointments. However, he does have to walk three blocks to the bus stop and then take 3 different buses to reach Dr. X office. He has learned that if he was able to obtain a letter from his physician that the Metro would help him with transportation, but he hasn’t gotten around to it and just walks to the bus stop.

• **Patient Two**: “Both of my legs/feet were swollen—short of breath—I have heart trouble—the Dr. sent into the hospital” “I don’t know why they keep swelling”

• **Patient Three**: “The hospital sent me home with 2 liters of fluid on my lungs so, no sooner than I got home, I got short of breath again. The hospital should have taken the fluid off me before sending me home”.

• **Patient Four**: “I did not do what I was supposed to do. When I got back from the hospital the first time, I wasn’t eating properly. I wasn’t supposed to drink, but I had a beer or two. When I left [the hospital] they told me I had a bad heart. I came home, I was laying around, I wasn’t exercising or anything like that, and it just got worse, and I had to go back.” “….She’s (HIS WIFE) got me eating a lot of cereal—corn flakes and Cheerios and stuff like that. I may have a potato salad, corned beef, some pickles… it’s a variety of things that I eat.

• **Patient Five**: “Nothing but the cost of the medication. I have obtained some of the medications but not all of them. I have Medicare Part B. I have an issue with the co-payments. I am enrolled in the spend down program with FIA but I don’t know the number.”
## Strategies to Reduce Rehospitalization

<table>
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<tr>
<th>Strategy</th>
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<th>LTAC</th>
<th>EC</th>
<th>HH</th>
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<td>Perform an Enhanced Assessment of Post-transition Needs</td>
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<td>Provide Effective Teaching and Facilitate Learning</td>
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<td>Provide Real-time Patient Centered Handover Communications</td>
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<td>Ensure timely Post-Transition Care Follow-Up</td>
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<td>Ensure staff ready and capable to care for the patient</td>
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<td>Engage the patient and family members in a partnership to create an overall plan of care</td>
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<td>Obtain a timely consultation when the patient’s condition changes</td>
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<td>Coordinate care across acute care and outpatient providers and settings</td>
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Definitions

Community
“A group of interacting people, possibly living in close proximity, and often refers to a group that shares some common values, and is attributed with social cohesion within a shared geographical location, generally in social units larger than a household”.

Coalition
“Union of organizations and individuals working to influence outcomes on a specific problem to accomplish a broad range of goals that reach beyond the capacity of any individual member organization.”
Michigan Medicare Patient 30-Day All Cause Readmission Rates (%) by County, 2010

Statewide Medicare Patient Readmission Rate = 19.9%

Readmission Rates are Greatest in Southeast Michigan

Readmission Rates Highest in Detroit = 26%
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<th>Population Segment</th>
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<th>Detroit Region</th>
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<td>Total Discharges Eligible for Readmission</td>
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Detroit Population

- Population: 715,000
- Median income: $28.097
- Poverty rate: 26.1%
- Over 28% have a disability
- As compared to national average
  - Rate of heart disease is twice as high
  - Rate of HIV/AIDS is nearly three times as high
  - Cancer rate is 20% higher
  - Diabetes rate is 35% higher
  - Rate of asthma in preschool children is over three times as high
    - Half of states deaths
Detroit Population (continued)

- One-fifth of population has no transportation
- Diet is the major risk factor for chronic disease
- 56% are on Medicaid
- 13% on Medicare
- Over 19,000 homeless
- 17.5% are uninsured
- Unemployment rate is over 13.8%, for the period 2006-2008 is 21.8%
- Rate of substance abuse 9.5% and ranked third highest city in U.S.
- Mental health issues
**Percentage of Residents who are Uninsured or Covered by Medicaid/SCHIP, 2000**

<table>
<thead>
<tr>
<th>Location</th>
<th>Uninsured</th>
<th>Medicaid/SCHIP</th>
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<tbody>
<tr>
<td>Bexar County, TX</td>
<td>25.4%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Bronx, NY</td>
<td>23.8%</td>
<td>27.0%</td>
</tr>
<tr>
<td>Broward County, FL</td>
<td>17.5%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Cook County, IL</td>
<td>19.9%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Detroit, MI</td>
<td>21.0%</td>
<td>31.5%</td>
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<tr>
<td>Durham County, NC</td>
<td>18.7%</td>
<td>13.6%</td>
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<tr>
<td>El Paso County, TX</td>
<td>16.7%</td>
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<td>Hinds County, MS</td>
<td>17.3%</td>
<td>21.6%</td>
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<td>Washington, DC</td>
<td>14.5%</td>
<td>17.3%</td>
</tr>
<tr>
<td>Washington County, MS</td>
<td>19.0%</td>
<td>21.0%</td>
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Percentage of Population Living Below Poverty

**Sources:** U.S. Census Bureau, 2004 American Community Survey, and 2000 Census, Profile of Demographic Characteristics. Durham, Jackson, and Washington County data are for 2000.
Detroit and Statewide All-Cause Re-Hospitalization Within 30 Days of Index Discharge from State of Michigan Acute Care Facility by Quarter, State of Michigan Medicare (FFS) Patients, [January 1, 2008 - December 31, 2010]
AIM

Healthcare and community collaborative to identify barriers that impact safe transitions, for the adult population in Detroit, and implement interventions that will reduce all-cause 30 day rehospitalizations by 30% by May 2014
DCAAR Participating Organizations

- Corporation for Supportive Housing
- MPRO
- Carelink
- Ciena Nursing Homes
- Citizens for Better Care
- City of Detroit
- Community Living Services
- Henry Ford Health System
- Detroit Area Agency on Aging
- Detroit Wayne County Health Authority
- Department of Housing and Urban Development
- Detroit Medical Center
- EMS
- Extended care facilities
- Federally Qualified Health Centers
- Neighborhood Service Organization
- Gateway
- Greater Detroit Area Health Council
- Great Lakes Health Plan
- Homeless Action Network of Detroit
- Hospice of Michigan
- Michigan Department of Human Services
- Neighborhood Services Organization
- Nexcare
- Parish Nurses
- SSI/SSDI Outreach, Access and Recovery, MDCH
- St John Providence Health System
- Veterans Administration Hospital Detroit
- Visiting Nurses Association South East Michigan
- Voices of Detroit Initiative
- Wayne County Human Services
- Wayne County Mental Health Authority
- Wayne State University
Root Cause Analysis

- Lack of awareness of community resources
- Health Illiteracy
- Homeless, uninsured
- Substance abuse and mental health
- Lack of transportation
- Misalignment between healthcare discharge planning process and community resource processes
- Lack of boundarilessness and interagency coordination of resources
- Insufficient teamwork within and between acute care, post acute care and community based organizations
- Lack of information sharing between hospitals
- End of life issues not addressed
Interventions

Extended Care
- Implementation of INTERACT
  - SBAR communication
  - Early identification of changes of condition
- Consistent assignment
- Standardized process for determining transfers to hospital
- Nurse to nurse verbal communication prior to transition
- Implementation of Cardiac Rehab Unit
  - Coordination with acute care providers
- Individual case reviews of rehospitalizations with acute care

Home Health Care
- Front load visits
- Sliding scale medications
- SBAR communication
- Coaching patients regarding personal health plan
- After hours care-24-7
- Telehealth
- Medication reconciliation
- Assuming responsibility to determine if patient qualifies
- Care paths
Interventions

Acute Care
• Providing from three to 30-day supply of medications
• Health plans overriding their formulary
• Brand to generic medications e.g., 8 medications 40 dollars a month
• Follow-up appointments made prior to discharge
• Review readmissions with post acute care providers
• Nurse calls patients 48 hours post transition
• Home visits to patient within 1 to 2 days of transition
• Patients/care givers assist in design of educational materials
• Implementation of palliative care program
• Teach back and show back utilized by all staff and physicians
• Case managers in emergency department
• Multidisciplinary rounds in patient rooms
• Identification of readmitted patients in ED and on nursing units

Clinical Office Practice
• Utilize rapid cycle PDSA for process improvement
• Provide timely access to care following a hospitalization
• Medication Reconciliation
• Taking responsibility for patients with no PCP
• Bridging care with skilled nursing facility’s cardiac rehab program
MI STAAR
STate Action on Avoidable Rehospitalizations

Affinity Groups

HeLPeR
Healthcare Link to Prevent Rehospitalizations

TICKET TO RIDE

FUSE
Frequent Users Systems Engagement

POLST
physician orders for life-sustaining treatment paradigm

ReWaRd
Rehospitalization Workgroup for Reporting Rates
A collaborative to align healthcare providers and community resources to assist in reducing readmissions
Standardization of communication and information between sending and receiving organizations

- Acute and Post Acute Care providers identified critical information
- Implementing into EMRs and electronic communication between providers

Does not replace verbal handover communication
Transition Form

Demographic Information (Please attach the patient's face sheet)

Date

Transition coordinator

Pt name

Address of care

Contact person

Guardian - Name

Advance directive (attach) Yes No

Palliative care Yes No

Primary Care Physician - Name

Follow-up appt made Yes No If yes, appointment date/time

Primary diagnosis

Surgical/Special procedures during admission

Procedure

Date

Date

Complete this section if patient will require home healthcare

Ordering MD signature

Reason for home care referral

Homenew due to

Services requested

□ Skilled Nursing

□ Physical Therapy

□ Occupational Therapy

□ Speech Therapy

□ Wound

□ Pressure Ulcer

□ Medical Social Work

□ Home Health Ad

□ Telehealth

□ Dietician

□ Hospice

□ Staples

□ Glue

□ Sutures

□ Steri Strips

□ Do not remove

□ Remove

LABS to be drawn

Report lab results to

□ Attach significant lab results and the medication reconciliation form including last dose and time administered

Additional diagnoses or information

Complete this section if patient will be transitioned to an extended care facility or long term acute care setting

Aids sent with the patient N/A

□ Glasses

□ Dentures

□ Hearing aids

□ Artificial limbs

□ Other

Infection Control Precautions

□ N/A

□ Contact

□ Droplet

□ Airborne

□ MRSA

□ VRE

□ C. Diff

Describe reason

Culture date

Result

If behavioral issue identified

□ Trigger

□ Duration

Please attach the following documents

□ Recent chest x-ray

□ Advance Directive

□ DPOA

□ Guardianship papers

□ Medication reconciliation form including last dose and time administered

□ 3877 & 3878 OBRA Pre-screen

Other significant findings

Complete this section if patient will be transitioned to an acute care facility

□ Attach medication reconciliation form including last dose and time administered

□ Attach significant lab results

□ Reason for Transfer

General Information

Vital Signs - Temp Pulse Resp BP Pulse Ox (if applicable) lb Wt

Pain Intensity (please circle the number that corresponds to the patient’s pain)

□ NA

□ 0 □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 Location

□ Mild

□ Moderate

□ Severe

Immunizations

□ Influenza

□ Pneumococcal

□ Other

□ Date

□ Risk of DVT

□ DVT Prophylaxis

□ No

□ Yes

□ Risk of Low Risk

□ Medium Risk

□ High Risk

Communication/Challenges

□ Blind

□ Hard of hearing

□ Speech problems

□ Unable to understand

□ Unable to understand

□ Unable to read

□ Foreign language

Cognitive Status

□ ADL's

□ 1

□ 2

□ 3

□ Recent change in mental status

□ Confused

□ Able to participate in decision making

□ Delirious

□ Dementia/Alzheimer’s

□ Comatose

□ OBRA Status

□ Exempt

□ Attended

Behavior

□ Inappropriate behaviors

□由于 Mental illness

□ Neuro deficits

□ Physically combative

□ Verbally abusive

□ Resists care (explain)

□ Behavioral intervention

□ Restraints

□ Sitter

□ Elopement Risk

Physical Functioning

□ Independent

□ Ambulates feet

□ Assistive device

□ Walks/transfers with assist (1 or 2)

□ Wheelchair

□ Bed rest

□ Non-ambulatory

□ Total assist

□ Fall risk

□ Restrictions

Nutrition

□ N/A

□ Special

□ Feeds self

□ Needs assistance

□ Dysphagia

□ PP/NTPN

□ Feeding tube

□ Type

□ PEG/G-Tube

□ JP/J-Tube

□ Method of Administration

□ Bolus/Syringe

□ Gravity

Pump

□ On formula name

□ Therapeutic equivalent formula may be used

□ Frequency

□ Rate of pump

□ Flush rate

□ Order

Skin

□ N/A

□ Red areas (location)

□ Incision (location)

□ Open areas

□ Rash

□ Pressure ulcer (stage/location/size)

□ Diabetic foot care

□ Stasis ulcer

□ JUG

□ N/A

□ Incontinent - Urine Bowel

□ Date of last BM

□ Date last voided

□ Urinary catheter

□ Type

□ Foley

□ Suprapubic Size

□ Date inserted/changed

□ Ostomy appliance size

□ Ileostomy appliance size

□ PME/Special Care

□ Oxygen

□ Nasal

□ Mask

□ BiPAP

□ CPAP

□ Tracheostomy

□ Size

□ Suctioning

□ Vent

□ IV date inserted

□ PICC Line date inserted

□ External length

□ Central line date inserted

□ Other equipment

□ HME company

□ Phone

□ Peritoneal Dialysis - last date of

Patient Education

Identified transfer name

□ Relationship to patient

□ Phone

Continued education needed regarding

Pain Date 03/23/22
• Purpose
  – To develop and implement targeted interventions and cross-system strategies to reduce ED use and hospital readmissions in the homeless

• Interventions
  – Case reviews
  – Pilot to identify up to 30 homeless
    • Intensive outreach and services to provide stability
  – Develop and test protocols
  – Share data
**Frequent Users Systems Engagement Initiative**

- Convene a regular working group consisting of key stakeholders that will develop:
  - A program design and intervention,
  - Agree on shared goals, and
  - Develop a MOU among the partners that outlines the roles and responsibilities of each agency.

- Develop protocols and agreement to share data across systems to identify the target population.

- Provide intensive outreach and engagement efforts to the target population, complemented by an initial concentration of intensive services to help people stabilize in housing and the community and address the risk factors for re-hospitalization and homelessness.

- Supportive housing – affordable, safe, decent housing that is closely linked the necessary medical, behavioral health, and other services people need to be stabilized
To improve the quality of care people receive at the end of life through effective communication of patient wishes, documentation of medical orders and a promise by health care professionals to honor these wishes.

http://www.ohsu.edu/polst/
Coordinate multi-payer data sharing to construct readmission profiles for Michigan hospitals.

Provide data reports to hospitals that include their readmission and rehospitalization rates.

Led by MPRO’s Statistical Analysis Resource Group Director.

Blue Cross Blue Shield of MI., Blue Care Network of MI., Health Alliance Plan, HealthPlus, Priority Health, Medicaid, Medicare, Aetna, etc.
### Report of 30-Day All-Cause Readmission Rates for:

**Time Period:** 2009Q3 - 2010Q2

**Payers:** Medicare FFS, Medicaid FFS, BCNM, BCBSM, HAP, Priority Health, Health Plus (Managed Care Data are reported by these payers)

### See Data Definitions for Column Descriptions

<table>
<thead>
<tr>
<th>PRODUCT Line</th>
<th>Type of Index Admission</th>
<th>Discharges at Risk</th>
<th>RA to the Same Hospital</th>
<th>RA to a Different Hospital</th>
<th>RA to Any Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AGE GROUP</strong></td>
<td></td>
<td>N</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Adult</td>
<td>M</td>
<td>78,982</td>
<td>9,150</td>
<td>11.6%</td>
<td>2,807</td>
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<tr>
<td></td>
<td>S</td>
<td>83,019</td>
<td>4,445</td>
<td>5.4%</td>
<td>1,084</td>
</tr>
<tr>
<td></td>
<td>O</td>
<td>38,447</td>
<td>952</td>
<td>2.5%</td>
<td>121</td>
</tr>
<tr>
<td>Pediatric</td>
<td>M</td>
<td>9,326</td>
<td>793</td>
<td>8.6%</td>
<td>121</td>
</tr>
<tr>
<td></td>
<td>O</td>
<td>3,693</td>
<td>188</td>
<td>5.1%</td>
<td>38</td>
</tr>
<tr>
<td>Post-neonatal</td>
<td>M</td>
<td>1,819</td>
<td>121</td>
<td>6.7%</td>
<td>37</td>
</tr>
<tr>
<td></td>
<td>S</td>
<td>418</td>
<td>31</td>
<td>7.4%</td>
<td>3</td>
</tr>
<tr>
<td>Neonatal</td>
<td>M</td>
<td>34,976</td>
<td>309</td>
<td>0.9%</td>
<td>218</td>
</tr>
<tr>
<td></td>
<td>S</td>
<td>63</td>
<td>8</td>
<td>7.9%</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>251,200</td>
<td>16,020</td>
<td>6.4%</td>
<td>4,438</td>
</tr>
</tbody>
</table>

**Medicaid FFS**

| Adult        | M                       | 90,074             | 12,206                  | 13.6%                     | 3,551            | 3.9%     | 15,751   | 17.5%   |
|              | S                       | 30,950             | 4,081                   | 13.2%                     | 1,048            | 3.4%     | 5,127    | 16.6%   |
| Pediatric    | M                       | 58,473             | 2,108                   | 3.6%                      | 462              | 0.8%     | 2,570    | 4.4%     |
|              | O                       | 14,483             | 1,487                   | 10.3%                     | 127              | 0.9%     | 1,614    | 11.1%    |
| Post-neonatal| M                       | 4,425              | 429                     | 9.7%                      | 24               | 0.5%     | 453      | 10.2%    |
|              | O                       | 2,939              | 103                     | 3.5%                      | 18               | 0.5%     | 115      | 4.0%     |
| Neonatal     | M                       | 5,538              | 492                     | 8.9%                      | 108              | 2.0%     | 600      | 10.8%    |
|              | S                       | 1,460              | 171                     | 11.7%                     | 36               | 2.5%     | 273      | 14.2%    |
| Total        |                          | 257,931            | 21,756                  | 8.4%                      | 5,858            | 2.3%     | 27,614   | 10.7%    |

**Medicaid Managed Care**

| Adult        | M                       | 4,872              | 600                     | 12.3%                     | 156              | 3.2%     | 754      | 15.5%    |
|              | S                       | 1,442              | 136                     | 9.4%                      | 30               | 2.1%     | 166      | 11.5%    |
| Pediatric    | M                       | 5,341              | 168                     | 3.1%                      | 31               | 0.6%     | 200      | 3.7%     |
|              | O                       | 1,146              | 41                      | 3.6%                      | 13               | 1.3%     | 56       | 4.9%     |
| Post-neonatal| M                       | 307                | 9                      | 2.9%                      | 3               | 1.0%     | 11       | 3.9%     |
|              | O                       | 251                | 14                     | 5.6%                      | 3               | 0.4%     | 15       | 6.0%     |
| Neonatal     | M                       | 440                | 11                     | 2.5%                      | 6               | 1.4%     | 17       | 3.9%     |
|              | S                       | 32                 | 1                      | 3.1%                      | 3               | 3.1%     | 2        | 6.3%     |
| Total        |                          | 17,159             | 1,027                   | 6.0%                      | 260              | 1.5%     | 1,287    | 7.5%     |

**Medicare Managed Care (reported by payers)**

| Adult        | M                       | 16,246             | 2,672                   | 16.4%                     | 760              | 4.7%     | 3,432    | 21.1%    |
|              | S                       | 5                  | 0                      | 0.0%                      | 0                | 0.0%     | 0        | 0.0%     |
| Total        |                          | 25,027             | 3,424                   | 13.7%                     | 984              | 3.9%     | 4,408    | 17.6%    |

**Medicare (FFS)**

| Adult        | M                       | 320,396            | 54,002                  | 16.9%                     | 14,123           | 4.4%     | 68,123   | 21.3%    |
|              | S                       | 127,390            | 10,893                  | 8.6%                      | 2,993            | 2.4%     | 13,688   | 10.9%    |
| U            | M                       | 351                | 725                     | 21.1%                     | 1,082            | 12.1%    | 4,183    | 36.6%    |
|              | O                       | 450,761            | 65,624                  | 14.56%                    | 17,473           | 3.9%     | 83,103   | 18.4%    |

**Total by Age Group**

| Adult        | M                       | 867,388            | 102,894                 | 11.9%                     | 27,754           | 3.2%     | 130,648  | 15.1%    |
| Pediatric    | M                       | 37,001             | 3,088                   | 8.3%                      | 343              | 0.9%     | 3,437    | 9.3%     |
| Post-neonatal| M                       | 9,707              | 827                     | 8.5%                      | 193              | 2.0%     | 1,020    | 10.5%    |
| Neonatal     | M                       | 87,982             | 1,042                   | 1.2%                      | 723              | 0.8%     | 1,763    | 2.0%     |
| Total        |                          | 1,002,078          | 107,851                 | 10.8%                     | 30,859           | 3.0%     | 118,378  | 14.4%    |

**Grand Total**

<table>
<thead>
<tr>
<th>M</th>
<th>S</th>
<th>O</th>
<th>M</th>
<th>S</th>
<th>O</th>
<th>M</th>
<th>S</th>
<th>O</th>
</tr>
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<tr>
<td>1,002,078</td>
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<td>14.4%</td>
<td>Grand Total</td>
<td>1,002,078</td>
</tr>
</tbody>
</table>
Next Steps

- Formalize Coalition
- Implement a Consumer Advisory Panel
- Standardization of community wide education
- Continue with process redesign (LEAN) to reduce rehospitalizations
- Data mining—provide data regarding post acute care, ED and Observation bed usage, physician office follow-up
- Standardize on communication regarding rehospitalizations
Individually, we are one drop. Together, we are an ocean." – Ryunosuke Satoro