Community Performance Report

Community: Treasure Valley
Includes Data Through: Q2 2018
Report Created: November 8, 2018

Purpose of the Report
This report uses Medicare Part A Fee-for-Service claims data to assess hospital readmission rates and healthcare utilization for Medicare beneficiaries residing in the defined community. It is intended to support efforts within the community to improve care transitions and reduce rehospitalizations.

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About Communities for Safer Transitions of Care
Under our contract with the Centers for Medicare & Medicaid Services, Qualis Health is assisting communities throughout Idaho and Washington to improve care coordination, prevent adverse drug events, and reduce unnecessary rehospitalizations. Our consulting services, which are available at no cost, include helping communities:

• Better understand what drives the local rehospitalization rate
• Maintain a cohesive, energetic coalition that draws from all segments of the healthcare system—including patients
• Successfully implement evidence-based interventions

Learn more about this work at www.Medicare.QualisHealth.org/Transitions.

About the Community
Qualis Health divided the state into 8 communities based on healthcare utilization patterns and Medicare beneficiaries’ home ZIP codes. The boundaries may be slightly different from those used in reports published previously.

The Treasure Valley community includes portions of Ada, Adams, Boise, Camas, Elmore, Gem, Owyhee, Payette, Valley, and Washington Counties. Three prospective payment system hospitals (St. Alphonsus Regional Medical Center, St. Luke’s Regional Medical Center, and Treasure Valley Hospital) and six critical access hospitals (Cascade Medical Center; St. Luke’s Elmore, McCall, and Wood River Medical Centers; Valor Health, and Weiser Memorial Hospital) provide care in the community. The geographic spread of the community presents unique challenges. Beneficiaries in this community live in both large urban areas and small rural towns, so providers need to be equipped to meet the health needs of both of these populations.
Performance Overview

This page is intended to provide an at-a-glance overview of the community’s performance for the current year. Further analyses of each metric are provided in the subsequent sections of the report.

Figure 1: Key Metric Rankings Among the State’s Other Defined Communities

<table>
<thead>
<tr>
<th>Metric</th>
<th>Rate per 1,000 Beneficiaries</th>
<th>Relative Improvement Since 2016</th>
<th>Rank (out of 8)</th>
<th>Rank (out of 8)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All-Cause Hospital Admissions</td>
<td>197.1</td>
<td>-1.2%</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>All-Cause Rehospitalizations</td>
<td>25.6</td>
<td>-9.6%</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Emergency Department Visits</td>
<td>454.1</td>
<td>3.4%</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>Observation Stays</td>
<td>38.4</td>
<td>12.7%</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>All-Cause 30-Day Mortality</td>
<td>36.7</td>
<td>1.3%</td>
<td>2</td>
<td>5</td>
</tr>
</tbody>
</table>

Interpreting the I-shaped markings in Figures 2 and 3 (and similar charts throughout this report):

These markings indicate the 95% confidence intervals for each community’s hospital admissions and rehospitalizations. If the confidence interval does not cross the line shown for the state average, the community’s rate can be considered statistically different from the state’s. (For more about confidence intervals and statistical significance, see Appendix B.)

Figure 2: Hospital Admissions per 1,000 Medicare Beneficiaries by Community, Current Year

Figure 3: 30-Day Rehospitalizations per 1,000 Medicare Beneficiaries by Community, Current Year

1 The lower the ranking, the better the performance.
Community Performance Trends

This section portrays various measures over time. For help in determining whether a trend indicates an actual improvement/worsening of the measure or is simply due to random variation, please see Appendix B.

Admissions and Rehospitalizations

Figures 4 – 6 display the community’s hospital admissions and rehospitalizations. Qualis Health encourages communities to strive for at least 10% improvement from baseline for each of these measures.

Figure 4: Hospital Admissions per 1,000 Medicare Beneficiaries, Community vs. Statewide

Figure 5: 30-Day Rehospitalizations per 1,000 Medicare Beneficiaries, Community vs. Statewide

Figure 6: 30-Day Rehospitalizations (as a Percent of Medicare Discharges), Community vs. Statewide
Admissions and Rehospitalizations Taking Place Outside of the Community

This report focuses on Medicare beneficiaries residing within the community, regardless of where they receive care. For most communities in the state, the influence exerted by out-of-community hospitals on a community’s rehospitalization rates is small.

Figure 7 illustrates the proportion of in- and out-of-community hospitalizations experienced in the current year. Figure 8 compares the rehospitalization rates of the in- and out-of-community hospitals used by the community’s beneficiaries.

Non-Inpatient Hospital Utilization

Figures 9 and 10 examine hospital utilization other than inpatient admissions. These measures can help communities determine whether reduced rehospitalization rates reflect actual improvements in care or simply a shift in care setting. Additionally, many Accountable Care Organizations track these measures to ensure that patients receive high-value healthcare.

Figure 9: Emergency Department Visits per 1,000 Medicare Beneficiaries, Community vs. Statewide

Figure 10: Observation Stays per 1,000 Medicare Beneficiaries, Community vs. Statewide
Utilization for Select Demographics & Health Conditions

Membership in various demographic groups and the presence of certain diseases are both associated with higher admission and rehospitalization rates. Use this information to identify the community's subpopulations most in need of intervention.

Figure 11: Admissions and Rehospitalizations by Medicare Beneficiary Demographics, Community vs. Statewide, Current Year

<table>
<thead>
<tr>
<th></th>
<th>Community</th>
<th></th>
<th></th>
<th>Community</th>
<th></th>
<th></th>
<th>Statewide</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Percent of Total</td>
<td>Admits per 1,000</td>
<td>Readmits per 1,000</td>
<td>Number</td>
<td>Percent of Total</td>
<td>Admits per 1,000</td>
<td>Readmits per 1,000</td>
<td></td>
</tr>
<tr>
<td>All</td>
<td>62,514</td>
<td>100.0%</td>
<td>199.5</td>
<td>28.1</td>
<td>212,814</td>
<td>100.0%</td>
<td>201.0</td>
<td>26.6</td>
<td></td>
</tr>
<tr>
<td>Dual-Eligibles</td>
<td>10,085</td>
<td>16.1%</td>
<td>311.5</td>
<td>61.7</td>
<td>39,708</td>
<td>18.7%</td>
<td>291.4</td>
<td>50.1</td>
<td></td>
</tr>
<tr>
<td>Individuals Under 65</td>
<td>9,111</td>
<td>16.1%</td>
<td>265.5</td>
<td>52.5</td>
<td>32,652</td>
<td>15.3%</td>
<td>253.0</td>
<td>45.0</td>
<td></td>
</tr>
<tr>
<td>Individuals 65-84</td>
<td>47,298</td>
<td>75.7%</td>
<td>167.1</td>
<td>21.2</td>
<td>159,545</td>
<td>75.0%</td>
<td>173.2</td>
<td>21.2</td>
<td></td>
</tr>
<tr>
<td>Individuals 85+</td>
<td>6,105</td>
<td>9.8%</td>
<td>352.5</td>
<td>44.9</td>
<td>20,617</td>
<td>9.7%</td>
<td>333.2</td>
<td>38.9</td>
<td></td>
</tr>
<tr>
<td>Asian</td>
<td>432</td>
<td>0.7%</td>
<td>175.9</td>
<td>20.8</td>
<td>951</td>
<td>0.4%</td>
<td>160.9</td>
<td>17.9</td>
<td></td>
</tr>
<tr>
<td>Black</td>
<td>319</td>
<td>0.5%</td>
<td>250.8</td>
<td>43.9</td>
<td>682</td>
<td>0.3%</td>
<td>303.5</td>
<td>55.7</td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>802</td>
<td>1.3%</td>
<td>214.5</td>
<td>46.1</td>
<td>3,366</td>
<td>1.6%</td>
<td>203.5</td>
<td>36.8</td>
<td></td>
</tr>
<tr>
<td>Native American</td>
<td>254</td>
<td>0.4%</td>
<td>330.7</td>
<td>74.8</td>
<td>2,199</td>
<td>1.0%</td>
<td>301.0</td>
<td>57.3</td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>58,654</td>
<td>93.8%</td>
<td>201.3</td>
<td>28.0</td>
<td>199,860</td>
<td>93.9%</td>
<td>201.7</td>
<td>26.2</td>
<td></td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>2,053</td>
<td>3.3%</td>
<td>124.7</td>
<td>16.1</td>
<td>5,756</td>
<td>2.7%</td>
<td>130.3</td>
<td>18.6</td>
<td></td>
</tr>
<tr>
<td>Urban Core</td>
<td>39,521</td>
<td>63.2%</td>
<td>181.9</td>
<td>26.4</td>
<td>101,933</td>
<td>47.9%</td>
<td>196.6</td>
<td>27.0</td>
<td></td>
</tr>
<tr>
<td>Suburban</td>
<td>6,798</td>
<td>10.9%</td>
<td>167.4</td>
<td>21.2</td>
<td>21,425</td>
<td>10.1%</td>
<td>176.8</td>
<td>22.2</td>
<td></td>
</tr>
<tr>
<td>Large Rural Town</td>
<td>6,032</td>
<td>9.6%</td>
<td>228.8</td>
<td>31.8</td>
<td>28,349</td>
<td>13.3%</td>
<td>223.6</td>
<td>31.2</td>
<td></td>
</tr>
<tr>
<td>Small Town / Isolated Rural</td>
<td>10,163</td>
<td>16.3%</td>
<td>186.3</td>
<td>24.2</td>
<td>61,107</td>
<td>28.7%</td>
<td>191.8</td>
<td>23.0</td>
<td></td>
</tr>
</tbody>
</table>

Days Elapsed Prior to Rehospitalization

Figure 12 shows the full 30-day window during which Medicare penalizes rehospitalizations, and indicates the percent of the community’s Medicare rehospitalizations occurring each day after discharge.

The median is the day by which half of the rehospitalizations have occurred. Statewide, the median is Day 11.

Figure 12: Days Elapsed Prior to a 30-Day Rehospitalization of the Community’s Medicare Beneficiaries, Current Year

2 Results are not displayed when there are fewer than 50 applicable individuals in the community.
Figure 13 shows instances in which a select set of conditions\(^3\) are documented during the index hospitalization. Conditions marked with an asterisk (*) are included in at least one of the Medicare penalty programs.

**Figure 13: Number of Discharges and Percent Readmitted by Condition, Community vs. Statewide, Current Year\(^4\)**

<table>
<thead>
<tr>
<th>Chronic conditions documented as the primary or secondary diagnosis</th>
<th>Community Discharges</th>
<th>Community Rehospitalization</th>
<th>Statewide Discharges</th>
<th>Statewide Rehospitalization</th>
</tr>
</thead>
<tbody>
<tr>
<td>4+ Chronic Conditions</td>
<td>6,869</td>
<td>16.2%</td>
<td>15.8%</td>
<td></td>
</tr>
<tr>
<td>Chronic Obstructive Pulmonary Disease (COPD)*</td>
<td>2,666</td>
<td>18.9%</td>
<td>17.5%</td>
<td></td>
</tr>
<tr>
<td>Dementia</td>
<td>1,315</td>
<td>13.2%</td>
<td>12.5%</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>3,565</td>
<td>16.5%</td>
<td>16.4%</td>
<td></td>
</tr>
<tr>
<td>Heart Failure (HF)*</td>
<td>2,690</td>
<td>20.2%</td>
<td>19.1%</td>
<td></td>
</tr>
<tr>
<td>Hypertension</td>
<td>8,545</td>
<td>15.0%</td>
<td>14.1%</td>
<td></td>
</tr>
</tbody>
</table>

| Acute conditions documented as the primary diagnosis               |                      |                             |                      |                             |
| Acute Myocardial Infarction (AMI)*                                 | 355                  | 14.1%                       | 14.3%                |                             |
| Coronary Artery Bypass Grafting (CABG)*                            | 84                   | 14.3%                       | 14.2%                |                             |
| Pneumonia*                                                        | 1,035                | 15.1%                       | 15.2%                |                             |
| Septicemia                                                        | 1,195                | 16.0%                       | 16.3%                |                             |
| Stroke                                                            | 464                  | 11.4%                       | 10.1%                |                             |
| Total Hip Arthroplasty (THA)*                                     | 419                  | 4.3%                        | 5.2%                 |                             |
| Total Knee Arthroplasty (TKA)*                                    | 723                  | 4.3%                        | 3.9%                 |                             |

**Potentially Unwanted Care**

Two populations tend to receive a disproportionate share of hospital care that may be better provided elsewhere: individuals who are approaching the end of their lives, and individuals who use the hospital as their primary source of care.

**Figure 14: Overview of Medicare Beneficiaries’ End-of-Life Care, Community vs. Statewide, Current Year**

<table>
<thead>
<tr>
<th>Deceased beneficiaries, total</th>
<th>Community</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiaries who died while a hospital inpatient</td>
<td>2,270</td>
<td>8,185</td>
</tr>
<tr>
<td>Deceased beneficiaries who had at least one rehospitalization in the last 6 months of life</td>
<td>410 18.1%</td>
<td>1,418 17.3%</td>
</tr>
<tr>
<td>Deceased beneficiaries who had at least one rehospitalization in the last 6 months of life</td>
<td>287 12.6%</td>
<td>1,022 12.5%</td>
</tr>
</tbody>
</table>

As a proxy for the population who uses the hospital as a primary source of care, Figure 15 highlights the impact that individuals with three or more hospitalizations within a year have on the overall admission rate.

**Figure 15: Utilization Among Medicare Beneficiaries with at Least Three Hospitalizations, Community vs. Statewide, Current Year**

<table>
<thead>
<tr>
<th>Beneficiary hospitalizations, total</th>
<th>Community</th>
<th>Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiaries with at least 3 hospitalizations</td>
<td>12,855</td>
<td>42,771</td>
</tr>
<tr>
<td>Total hospitalizations used by beneficiaries with at least 3 hospitalizations</td>
<td>2,941 22.9%</td>
<td>9,621 22.5%</td>
</tr>
</tbody>
</table>

---

\(^3\) This list is not exhaustive; there may be additional conditions that a community finds valuable to track in relation to rehospitalizations.

\(^4\) Results are not displayed for conditions in which there are fewer than 20 applicable hospitalizations.
Post-Acute Services Utilization

Many patients continue to receive healthcare services following an inpatient hospitalization. Medicare claims data can identify those cases in which beneficiaries used nursing home, home health agency, hospice services, or other discharge locations (such as inpatient rehabilitation facilities, long-term acute care facilities, and inpatient psychiatric facilities).

In this section of the report, the data are stratified according to those four post-acute categories and a “home” group. (Individuals classified as being at “home” may in fact be discharged to assisted living situations or other environments that do not generate a Medicare claim.) Please note that it is not possible to accurately infer whether a patient received care in the “right” setting. Likewise, there is no ideal distribution of patients across the various post-acute settings.

Initial Discharge Destinations

Figure 16: Percent of Medicare Beneficiaries’ Hospital Discharges to Select Post-Acute Destinations, Community vs. Statewide, Current Year

Rehospitalizations by Discharge Destination

In some cases, a patient might receive care in more than one post-acute care setting before being readmitted to a hospital.

- **Total rehospitalizations** encompass all individuals who are readmitted to a hospital within 30 days. (For example, an individual who is discharged to a nursing home, recuperates there, is discharged to home, then returns to the hospital within 30 days of the index admission would be counted in the total rehospitalization category.)

- The total rehospitalizations include a subset of “direct rehospitalizations.” **Direct rehospitalizations** are limited to those individuals who are readmitted directly from their initial discharge destination.

Look for high rehospitalization rates, large differences between the community and the state, and gaps within the community between the direct and total rehospitalization rates. Statewide, there is a difference between direct and total rehospitalizations for beneficiaries discharged to skilled nursing facilities—which points to opportunities to improve transitions from skilled nursing facilities to the next destination (which is typically home).

Figure 17: Discharges and Direct & Total Rehospitalizations by Initial Discharge Destination, Community vs. Statewide, Current Year

<table>
<thead>
<tr>
<th>Initial Discharge Location</th>
<th>Medicare Discharges Community</th>
<th>Medicare Discharges Statewide</th>
<th>Direct Rehospitalizations Community</th>
<th>Direct Rehospitalizations Statewide</th>
<th>Total Rehospitalizations Community</th>
<th>Total Rehospitalizations Statewide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>7,172</td>
<td>23,137</td>
<td>901</td>
<td>27,581</td>
<td>955</td>
<td>2,903</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>2,000</td>
<td>7,923</td>
<td>212</td>
<td>811</td>
<td>337</td>
<td>1,223</td>
</tr>
<tr>
<td>Home Health Agency</td>
<td>1,786</td>
<td>6,544</td>
<td>272</td>
<td>877</td>
<td>316</td>
<td>1,030</td>
</tr>
<tr>
<td>Hospice</td>
<td>391</td>
<td>1,312</td>
<td>7</td>
<td>15</td>
<td>9</td>
<td>22</td>
</tr>
<tr>
<td>Other</td>
<td>233</td>
<td>1,160</td>
<td>31</td>
<td>164</td>
<td>43</td>
<td>226</td>
</tr>
<tr>
<td>Total</td>
<td>11,582</td>
<td>40,076</td>
<td>1,423</td>
<td>4,625</td>
<td>1,660</td>
<td>5,404</td>
</tr>
</tbody>
</table>

Please note that these groupings are based on actual claims—not referrals, which may be substantially different. For more detail about how each post-acute category was classified, please see Appendix C.
Figure 18: Percent of Discharges to Home that are Readmitted Within 30 Days, Community vs. Statewide

Figure 19: Percent of Discharges to Nursing Homes that are Readmitted Within 30 Days, Community vs. Statewide

Figure 20: Percent of Discharges to Home Health Agencies that are Readmitted Within 30 Days, Community vs. Statewide
Community Tenure

Figure 21: Comparison of Baseline vs. Current Year’s Average Days per Year that Beneficiaries Spent in Non-Institutional Settings, Community vs. Statewide

6 “Community tenure” measures how much time individuals are able to reside at home, rather than in hospitals or nursing homes.
Appendix A  Frequent Causes of Rehospitalizations

Multiple Medications

Patients on multiple medications frequently have multiple chronic conditions and are treated by multiple prescribers. As a result, few of these individuals have a provider responsible for overseeing all of their care. The medications may put these individuals at risk for harmful side effects and interactions between drugs. Additionally, individuals on multiple medications may not understand the reasons for taking each of the drugs, which may lead them to skip doses.

Low Income or Social Support

Individuals with low income or social support may not be able to obtain medications or post-acute care due to financial or other resource issues. These individuals also frequently have multiple chronic conditions or advanced disease states due to the lack of primary care or prevention services earlier in life. Additionally, these individuals may be returning to unhealthy living conditions that may exacerbate their underlying conditions, or to living situations where they do not have sufficient assistance to meet their daily needs.

End-of-Life Care

Many individuals who are approaching the end of their lives do not have discussions with their families and providers about their wishes for end-of-life care; as a result, these individuals are likely to be admitted and readmitted for hospital care that extends their life for days or weeks but also prolongs pain and suffering. Frequently, this care continues because family members are unsure of alternative options to care for their loved one other than the hospital or because they do not fully understand the implications of intensive care.

Unclear Discharge Communication

Patients sometimes do not understand discharge instructions from providers, often because providers are too rushed to communicate clearly or use medical jargon that a layperson does not understand. This is a problem for patients discharged from both hospitals and post-acute providers. Patients who do not understand follow-up care conversations are less likely to comply with instructions and thus more likely to return to the hospital when their condition deteriorates.

Underlying Behavioral Health Conditions

Individuals with an underlying behavioral health condition such as depression, dementia, or substance abuse are more likely to be readmitted, regardless of the primary reason they were initially admitted to the hospital. These individuals are less likely to be able to care for themselves and are less likely to have robust social supports to help meet their daily needs. Additionally, their behavioral illness may exacerbate the symptoms of their physical illness.

Multiple Chronic Conditions

Individuals with multiple chronic conditions are frequently admitted and readmitted to the hospital. The conditions may interact with each other to worsen overall health more rapidly than any single condition would alone. Additionally, these individuals are more likely to be readmitted to the hospital with a different diagnosis than the initial admission.
Appendix B  Understanding this Report’s Graphs—A Brief Tutorial

What is a confidence interval?
Confidence intervals indicate how sure one can be, when accounting for possible random variation, that the interval includes the true population value. For example, with a 95% confidence interval of 5 – 12, one can be 95% confident that the actual number is somewhere between five and 12. By noting the range of likely values, better decisions can be made when determining whether a difference between two data sets indicates an actual change or simply random variation.

What does it mean if something is statistically significant?
When the difference between two numbers is shown to be statistically significant, it means that there is only a small chance that the difference could have happened due to chance alone. In this report’s calculations, that amount of chance is limited to less than 5% probability (p<0.05). So, if the confidence intervals of the two rates being compared do not overlap, there is less than a 5% likelihood that this difference is due to chance alone.

Why is the median shown on run charts?
The median is the point where half the data fall above and half the data fall below. (This is different from the mean, which is the average of all of the points.) It is a measure of where the data are centered and helps highlight trends. Look for:

1. Six or more consecutive points either all above or all below the median. (If a point falls on the median, skip it and keep counting).

2. Five or more consecutive points all going up or all going down. (If two consecutive points are the same, count the first one and ignore the repeating points).

3. A clear outlier value that is substantially larger or smaller than the neighboring points.

These three methods will help identify “special cause” variation (meaning trends that are likely caused by something other than random variation). Please note that there are many other ways to identify trends in run charts. Other methods can be found online or discussed with individuals at Qualis Health.
Appendix C  Data Sources & Definitions

Data Source
The source of this report’s data is Medicare Part A Fee-For-Service claims for beneficiaries residing in the state.

Community’s Medicare Population
The report’s population includes individuals under age 65 who qualify for Medicare due to chronic disability (approximately 20% of the Medicare population), regardless of whether they receive care inside or outside the community. It does not include data on individuals living outside the state who may seek care in the defined community.

30-Day Rehospitalizations
Rehospitalizations are for any cause to any hospital within 30 days of the index hospital discharge. All ages of Medicare Part A patients are included unless otherwise noted. The data in this report are not risk-adjusted and therefore may be different from what appears on publicly reported websites. Individuals who are excluded from analysis include:

- Patients who die during the index hospitalizations
- Patients who leave against medical advice
- Patients with a length of stay longer than one year
- Patients transferred to another facility (except acute patients discharged to swing beds)

Post-Acute Discharge Destinations
Designations of post-acute discharge destinations are based on claims. As such, they may differ substantially from hospitals’ records since the claims reflect services actually used, not just referrals.

An individual is considered to be discharged to a skilled nursing facility or hospice if there is a claim within two days of hospital discharge. An individual is considered discharged to a home health agency if there is a claim within five days of hospital discharge. Otherwise the individual is considered to be discharged to “home,” even though it is possible that they are receiving care that is not paid for by Medicare (for instance, in an adult family home or assisted living facility).
More Information


To discuss ideas for developing interventions specific to your community, contact one of our Communities for Safer Transitions of Care consultants; see [www.Medicare.QualisHealth.org/CTcontacts](http://www.Medicare.QualisHealth.org/CTcontacts).

About Qualis Health

Qualis Health is one of the nation’s leading population health management organizations, working with clients throughout the public and private sector to advance the quality, efficiency, and value of healthcare for millions of Americans every day. As the Medicare Quality Improvement Network - Quality Improvement Organization for Idaho and Washington, our team of quality improvement consultants and clinical leaders works with healthcare providers, consumers, and community partners to redesign processes, build sustainable change, and deliver care with improved value, quality, and safety for patients.

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