What Works for Preventing Hospital Readmissions?
A review of the current evidence and best practices

Steven M. Riddle, BS Pharm, BCPS, FASHP
Vice President of Clinical Affairs
Pharmacy OneSource/ Wolters Kluwer Health
Clinical Affiliate Professor,
UW School of Pharmacy

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Objectives

• Describe common causes for readmissions and the patient risk factors associated with these events.

• Describe 3 specific service interventions that successful programs have used to reduce hospital readmissions.

• Explain how to build a scaleable model of services that is effective in reducing readmission and sustainable based on successful clinical and fiscally sound practices in place in the US.
Why All the Talk About Readmissions?

**Quality**
- Poor care coordination and use of evidence-based approaches
- Large # of readmissions are preventable

**Safety**
- IOM reports made clear the consequences of poor transitions management

**Cost**
- CMS indicates $13B* in savings or $25B across all US payers

*MedPac 2007 Report to Congress; Promoting Greater Efficiency in Medicare. Chapter 5: Payment Policy for Inpatient Readmissions
The Patient Protection and Affordable Care Act (HR 3590): Title III - Improve the Quality & Efficiency of Care

Value-Based Purchasing (VBP)

- Process of Care Measures (Section 3001)
- Patient Experience Measures
  - HCAHPS (Section 3001)

Efficiency Measures (Section 3001)

Outcomes Measures (Section 3001)

Medicare Reimbursement

- At Risk: 1% in FFY2013 growing annually to 2% in FFY2017

Hospital Acquired Conditions (HAC) (Section 3008)

- At Risk: 1% reduction beginning FFY2015

Readmission Reduction Program (Section 3025)

- At Risk: 1% reduction in FFY2013, Increasing to 3% FFY2015
Value-based Purchasing: Carrot & Stick

CMS rewards hospitals based on meeting new Medicare measures

Well done, sweetie. Here's your brother's piggy bank.

Readmissions is all stick!
CMS Readmissions Reduction Program
Targeted MS-DRGs and Timelines

Reduces Medicare inpatient payments for hospitals with higher than expected risk-adjusted 30-day readmission rates for certain conditions.

**Year 1: FFY2012**
- Heart failure
- Myocardial infarction
- Pneumonia

**Year 3: FFY2014**
- COPD
- CABG
- PTCA & vascular procedures

**Year 4: FFY2015**
- Expand to other conditions

FFY 12  1%
FFY 13  2%
FFY 14  3%
## The Fiscal Impact of Readmissions: CMS Readmissions Reduction Program

<table>
<thead>
<tr>
<th>DRG Penalty Calculations</th>
<th>HF</th>
<th>AMI</th>
<th>PNE</th>
</tr>
</thead>
<tbody>
<tr>
<td># of Patients Treated with MS-DRGs</td>
<td>500</td>
<td>200</td>
<td>800</td>
</tr>
<tr>
<td>Number of Readmissions</td>
<td>142</td>
<td>45</td>
<td>158</td>
</tr>
<tr>
<td>Risk-Adjusted Readmit Rate</td>
<td>28.5%</td>
<td>22.5%</td>
<td>19.8%</td>
</tr>
<tr>
<td>US 30-Day Readmission Rate</td>
<td>24.7%</td>
<td>19.7%</td>
<td>18.5%</td>
</tr>
<tr>
<td>Predicted/Expected Ratio</td>
<td>1.1538</td>
<td>1.1421</td>
<td>1.0702</td>
</tr>
<tr>
<td>P/E Ratio - 1</td>
<td>0.1538</td>
<td>0.1421</td>
<td>0.0702</td>
</tr>
<tr>
<td>Total Medicare DRG Operating Payments</td>
<td>$1,500,000</td>
<td>$775,000</td>
<td>$2,150,000</td>
</tr>
<tr>
<td>Excess Payment Amount</td>
<td>$231,000</td>
<td>$110,000</td>
<td>$151,000</td>
</tr>
<tr>
<td>Total Excess Payment ($ at risk)</td>
<td></td>
<td></td>
<td>$492,000</td>
</tr>
</tbody>
</table>

### Total Medicare DRG Payments

<table>
<thead>
<tr>
<th>Total Medicare DRG Payments</th>
<th>Max Capped Penalty Rate</th>
<th>Amount at Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>$60,000,000</td>
<td>1% (FFY12)</td>
<td>$600,000</td>
</tr>
<tr>
<td>$60,000,000</td>
<td>2% (FFY13)</td>
<td>$1,200,000</td>
</tr>
<tr>
<td>60,000,000</td>
<td>3% (FFY14)</td>
<td>$1,800,000</td>
</tr>
</tbody>
</table>

**Penalty for Future DRG Admits FFY13**

\[
\frac{\$492,000}{\$600,000} = 0.82\% 
\]
<table>
<thead>
<tr>
<th><strong>Other Drivers &amp; Considerations with Readmissions</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Capitated Care or MSSP (ACO)</strong></td>
</tr>
<tr>
<td>• Focus on cost efficiencies</td>
</tr>
<tr>
<td><strong>Bundled Payments for “Episodes of Care”</strong></td>
</tr>
<tr>
<td>• “EPISODE OF CARE” payment includes 30-days post-discharge</td>
</tr>
<tr>
<td><strong>Public Reporting</strong></td>
</tr>
<tr>
<td>• Customer selection</td>
</tr>
<tr>
<td>• Payer contracts</td>
</tr>
<tr>
<td><strong>Hospital Barriers</strong></td>
</tr>
<tr>
<td>• ↓ admission rates…capacity not an issue</td>
</tr>
<tr>
<td>• FFS model still in place</td>
</tr>
<tr>
<td>• Cost of launching new programs for HRRP</td>
</tr>
</tbody>
</table>
Action Steps to Improve Quality around Readmissions

1. Examine your hospital’s current performance
2. Assess and prioritize your improvement opportunities
3. Develop an action plan of strategies to implement
4. Monitor your progress
To Fix It You Have To Know What’s Wrong!

*Understanding YOUR Readmissions Problems*
What are your hospital’s rates for readmissions?

Who is coming back in?
Why are they coming back?

Data Sources
- Internal data
  - Source: Quality, Finance, COO, etc
- External Sources
  - www.hospitalcompare.hhs.gov
  - 3rd parties and payers

Data content considerations
- Rates based on conditions
- Rates based on key causes (e.g., medication-related events)
- Rates per practitioner
- Rates by readmission source (home, SNF, NH)
- Rates per time intervals (7, 15, 30 and 90 days)

★Remember that your internal data will not capture readmissions to other hospitals!
**System Analysis of the Readmission Problem**

**Complex Analysis** (Based on Project RED from Boston Univ. MC)

- Readmissions within 3-6 months
- Hospital Discharge
- Readmission within 3 months

- Probabilistic Risk Assessment
- Process Mapping
- FMEA
- Qualitative Analysis
- Root Cause Analysis

**Simple Analysis** (IHI STAAR Toolkit)

1. Review charts of 5 recent readmissions (abstraction tool)
2. Interview patient/family of 5 current readmissions
3. Evaluate 5 discharge teaching events

Goal is to look for trends, gain insights, challenge assumptions and gain data for deeper evaluations as needed.
High-Level Strategies for Readmissions and Improving Continuity of Care
IHI STAAR Initiative
“State Action on Avoidable Rehosptilizations”

- **Perform Enhanced Admission Assessment for Post-Hospital Needs**
  - Planning/Risk Assessment
  - Med Rec

- **Provide Effective Teaching and Enhanced Learning**
  - Customize education
  - Teach-back technique

- **Conduct Real-Time Patient & Family-Centered Communication**
  - Med Rec
  - Customized care plan

- **Ensure Post-Hospital Care Follow-Up**
  - Follow-up based on risk
The Care Transitions Program

- Medication self-management
  - Medication Discrepancy Tool (MDT)
- Use of a dynamic patient-centered record
- Primary Care and Specialist Follow-Up
- Patient Knowledge of Red Flags

www.caretransitions.org
Project BOOST

“Better Outcomes for Older Adults through Safe Transitions”

<table>
<thead>
<tr>
<th>Patient Centeredness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Empowerment</td>
</tr>
<tr>
<td>Risk Appropriateness</td>
</tr>
<tr>
<td>Team Oriented</td>
</tr>
<tr>
<td>Bridging</td>
</tr>
</tbody>
</table>

http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/html_CC/project_boost_background.cfm
System Strategies for Reducing Readmissions

Goal
• Develop a system-level approach that is both effective and sustainable
• Focus on readmissions that are truly avoidable!

Strategy
• Care transition focused
• Team-based approach
• Patient-centered

Questions
• Which interventions have the greatest impact?
• What is the best timing for interventions?
• Which staff can best address the needs?
Examining Interventions/Programs to Reduce Readmissions
**Trial Population:** 749 hospitalized adults at urban teaching hospital

**Description of Intervention:**

**Inpatient via nurse discharge advocate (DA)**
- Educate patient on diagnosis and condition management
- Make and coordinate post-discharge appointments and testing
- Discuss lab or study results and needed follow-up
- Confirm medication plan (reconcile, educate, access)
- Align care plan with protocols, policies and EBM
- Transmit discharge summary to stakeholders
- Assess patient understanding of care plan (using teach-back)

**Post-Discharge Care Plan (via DA)**
- Provide patient written after-hospital care plan (“AHCP”)

**Post-Discharge Telephone Component (via pharmacist)**
- Call patients 2 to 4 days after discharge to reinforce the discharge plan, review medications and solve problems

**Citation:** Jack et al. A Reengineered Hospital Discharge Program to Decrease Rehospitalization. *Ann Intern Med.* 2009;150:178-187.
Results:

ED Use/Readmissions
30% reduction
• Participants 0.314
• Control 0.451 visit per person per month
[95% CI, 0.515 to 0.937]; P 0.009).

Intervention Cost
Total = $149,995
$412 savings per person
(NNT = 7)
• 33.9% lower observed cost compared to standard care group

Citation: A Reengineered Hospital Discharge Program to Decrease Rehospitalization. Ann Intern Med. 2009;150:178-187.
**Project RED**

<table>
<thead>
<tr>
<th>Timing/Location</th>
<th>Admit, Discharge, Post-Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Care plan, medication management</td>
</tr>
<tr>
<td>Key Players</td>
<td>RN discharge advocate (DA), Pharmacist</td>
</tr>
</tbody>
</table>

### DA Interventions
- Total DA time per participant = 87.5 minutes
  - Direct communication
  - Reviewing EMR and data
  - Contacting other medical personnel

### Pharmacy Interventions
- Median total pharmacist time per participant = 26 minutes.
- Total weekly pharmacist time (following 14 participants per week) = 6.1 hours (0.15 FTE)
- Successfully contacted 228 (62%) of the intervention participants
- Completed medication review with 195 (53%) participants.

Citation: A Reengineered Hospital Discharge Program to Decrease Rehospitalization. *Ann Intern Med.* 2009;150:178-187.
### Project RED

<table>
<thead>
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<td>Key Players</td>
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</tr>
</tbody>
</table>

### Medication Errors Discovered on Day 2 Post-Dsch Call (N=197)

#### Failure to Take Medication

<table>
<thead>
<tr>
<th>Reason</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient did not think he/she needed med</td>
<td>19 (15%)</td>
</tr>
<tr>
<td>Patient did not fill Rx due to cost</td>
<td>21 (17%)</td>
</tr>
<tr>
<td>Patient did not pick up Rx from pharmacy</td>
<td>14 (11%)</td>
</tr>
<tr>
<td>Patient did not get Rx on discharge from hospital</td>
<td>15 (12%)</td>
</tr>
<tr>
<td>Patient self-discontinued due to side effects</td>
<td>14 (11%)</td>
</tr>
<tr>
<td>Patient did not fill because of insurance issues</td>
<td>10 (8%)</td>
</tr>
</tbody>
</table>

#### Incorrect Administration

<table>
<thead>
<tr>
<th>Error</th>
<th>No. (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wrong frequency/interval for Rx</td>
<td>39 (21%)</td>
</tr>
<tr>
<td>Wrong dose for Rx</td>
<td>33 (18%)</td>
</tr>
</tbody>
</table>

Citation: A Reengineered Hospital Discharge Program to Decrease Rehospitalization. *Ann Intern Med*. 2009;150:178-187.
### Eleven mutually reinforcing components:

1. Medication reconciliation
2. Reconcile discharge plan with National Guidelines
3. Follow-up appointments
4. Outstanding tests
5. Post-discharge services
6. Written discharge plan
7. What to do if problem arises
8. Patient education
9. Assess patient understanding
10. Discharge summary to PCP
11. Telephone Reinforcement

### 2 Key Staff Roles

- **RN**
- **PharmD**

http://www.bu.edu/fammed/projectred/toolkit.html
Evaluating the Options for Reducing Readmissions

**TIMING & LOCATION**
- Admission
- Discharge
- Post-Discharge
- Home / Community

**SERVICE**
- Patient Risk Assessment
- Patient Education & Self-Mgmt
- Medication-related Care
- Care Plan Development
- Communication & Care Coordination

**KEY PLAYERS IN CARE DELIVERY**
- RN
- APN
- Case Manager
- PharmD
- MD
- SW

**RESOURCE NEEDS**
- Low
- Moderate
- High
Getting Started

*Impacting Outcomes…*

*Not Your Budget*
## Low Resource Impact Approaches

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Data/Outcomes</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Risk Assessments (at Hospital Admission or in Clinic Visit) | • Use risk factor criteria to determine RA risk  
  • Stratify patients by risk to better allocate care  
  • IT driven (simple model) or paper-based | • ↓ Hospital RA 20-30%*  
  • ED visits ↓ 63%*  
  *When coupled with basic care intervention aimed at underlying risk | • John Muir Health  
  • Mt Sinai MC  
  • Kaiser Perm Chronic Care Coordination |
| Patient Education Using Teach-back Tool         | • Improve patient understanding of care plan  
  • Encourages patients to relate education back in their own words.  
  • Provides vehicle for educators to consistently evaluate patient comprehension | • No specific data on readmissions | • Project Boost  
  • Project RED |
| Promote Self-Management                        | Using available tools to assist the patient in understanding the disease/condition | • Data indicating up to 10-20% reductions in unnecessary ED visits or readmissions | • Care Transitions Initiative |

RA = “readmission”
## Moderate Resource Impact Approaches

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Data/Outcomes</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Post-discharge Phone Contact</td>
<td>• Contact with high-risk patients within 48-72 hours post-discharge</td>
<td>• 15-24% RA reductions for targeted conditions</td>
<td>• Project BOOST</td>
</tr>
<tr>
<td></td>
<td>• Scripted questions to cover key areas of care</td>
<td></td>
<td>• Care Transitions Program</td>
</tr>
<tr>
<td></td>
<td>• If “red alerts” then patient is triaged to proper care provider</td>
<td></td>
<td>• Dudas et al.</td>
</tr>
<tr>
<td>Standardize Nursing Home</td>
<td>• Partner with primary NH partners to create standardized referral/transfer form.</td>
<td>• No data</td>
<td>• Evercare Care Model</td>
</tr>
<tr>
<td>Discharge Instructions</td>
<td>• Ensure care plan is delivered and consistently interpreted</td>
<td></td>
<td>• Summa Health System</td>
</tr>
<tr>
<td>Conduct Home Visit</td>
<td>Limited post-discharge home visits for highest risk patients</td>
<td>• 20-30% RA reductions for targeted conditions</td>
<td>• HealthCare Partners Medical Group</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• St Luke’s Hosp</td>
</tr>
<tr>
<td>Schedule/Prepare for Post-dsch</td>
<td>• Coordinate and confirm MD visit while patient is in hospital</td>
<td>• 50% of patients that do not see their MD w/in 30 days readmit</td>
<td>• John Muir Health</td>
</tr>
<tr>
<td>MD Visit</td>
<td>• Ensure proper care plan and related info are transferred to MD</td>
<td></td>
<td>• Project RED</td>
</tr>
</tbody>
</table>
### High Resource Impact Approaches

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
<th>Data/Outcomes</th>
<th>Examples</th>
</tr>
</thead>
</table>
| Implement New Multidisciplinary Care Team for TOC | • Creation of transitional care coordinator to manage various staff and resources to ensure quality care and communications  
• HIT infrastructure (ie, EMR) to support | • 18-32% reductions in readmissions | • Transitional Care Model  
• Brightwood Clinic  
• Project RED |
| Implement Comprehensive Discharge Planning    | • Create personalized comprehensive care plan  
• Formalize communication process with outpt providers  
• Reconcile medications and ensure optimal use and safety. Provide med list.  
• Standardize check list for discharge process. | • 25-34% reductions in readmissions  
• Programs generally proven to be cost effective | • Project BOOST  
• Project RED |
Comprehensive Discharge Planning With Post-discharge Support for Older Patients With Congestive Heart Failure

• Reviewed 18 studies from 8 countries looking for outcomes related to QOL, LOS, readmissions & overall mortality

• Results
  – In the pooled analysis fewer intervention patients were readmitted compared with controls
    • 555/ 1590 vs 741/1714 (RR 0.75; 95% CI 0.64-0.88)
    • NNT = 12

“The available evidence did not support the implicit assumption of incremental efficacy with more intensive post-discharge interventions. Comparable benefit resulted from a home visit, home visits and/or frequent telephone follow-up, and extended home care services. Increased clinic visits resulted in a nonsignificant decrease.”

Citation: Phillips et al. JAMA. 2004;291:1358-1367
### Table 2. Readmission Rates With Comprehensive Discharge Planning Plus Postdischarge Support Compared With Usual Care

<table>
<thead>
<tr>
<th>Source</th>
<th>Duration of Follow-up, mo</th>
<th>Intervention Events/ Patients (%)</th>
<th>Control Events/ Patients (%)</th>
<th>Absolute Risk Reduction, %</th>
<th>Relative Risk Reduction (95% CI)</th>
<th>P Value for Heterogeneity</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Single home visit</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stewart et al. 1998</td>
<td>6</td>
<td>24/49 (49)</td>
<td>31/48 (65)</td>
<td>16</td>
<td>0.76 (0.53-1.08)</td>
<td></td>
</tr>
<tr>
<td>Stewart et al. 1999</td>
<td>6</td>
<td>40/100 (40)</td>
<td>51/100 (51)</td>
<td>11</td>
<td>0.78 (0.58-1.07)</td>
<td></td>
</tr>
<tr>
<td>Jaaraasma et al. 1999</td>
<td>9</td>
<td>31/84 (37)</td>
<td>47/95 (49)</td>
<td>12</td>
<td>0.75 (0.53-1.06)</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td>95/233 (41)</td>
<td>129/243 (53)</td>
<td>12</td>
<td>0.76 (0.63-0.93)</td>
<td>.97</td>
</tr>
<tr>
<td><strong>Increased clinic follow-up and/or frequent telephone contact</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cline et al. 1998</td>
<td>12</td>
<td>22/60 (26)</td>
<td>43/110 (39)</td>
<td>13</td>
<td>0.70 (0.46-1.08)</td>
<td></td>
</tr>
<tr>
<td>Rainville 1999</td>
<td>12</td>
<td>4/17 (24)</td>
<td>10/17 (59)</td>
<td>35</td>
<td>0.40 (0.16-1.03)</td>
<td></td>
</tr>
<tr>
<td>Oddone et al. 1999</td>
<td>6</td>
<td>124/222 (56)</td>
<td>97/221 (44)</td>
<td>12 (+)</td>
<td>1.27 (1.05-1.54)</td>
<td></td>
</tr>
<tr>
<td>McDonald et al. 2002</td>
<td>3</td>
<td>1/51 (2)</td>
<td>11/47 (23)</td>
<td>21</td>
<td>0.08 (0.01-0.62)</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td>151/370 (41)</td>
<td>161/395 (41)</td>
<td>0</td>
<td>0.64 (0.32-1.28)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td><strong>Home visit and/or frequent telephone contact</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Naylor et al. 1994</td>
<td>3</td>
<td>16/72 (22)</td>
<td>23/70 (33)</td>
<td>11</td>
<td>0.68 (0.39-1.17)</td>
<td></td>
</tr>
<tr>
<td>Naylor et al. 1999</td>
<td>6</td>
<td>18/52 (35)</td>
<td>26/56 (46)</td>
<td>11</td>
<td>0.75 (0.47-1.19)</td>
<td></td>
</tr>
<tr>
<td>Serxner et al. 1999</td>
<td>3</td>
<td>15/55 (27)</td>
<td>27/54 (40)</td>
<td>23</td>
<td>0.55 (0.33-0.91)</td>
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</tr>
<tr>
<td>Blue et al. 2001</td>
<td>12</td>
<td>47/64 (56)</td>
<td>49/81 (60)</td>
<td>4</td>
<td>0.92 (0.71-1.20)</td>
<td></td>
</tr>
<tr>
<td>Riegel et al. 2002</td>
<td>6</td>
<td>56/130 (43)</td>
<td>114/228 (50)</td>
<td>7</td>
<td>0.86 (0.68-1.09)</td>
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</tr>
<tr>
<td>Krumholz et al. 2002</td>
<td>12</td>
<td>16/44 (36)</td>
<td>23/44 (52)</td>
<td>16</td>
<td>0.69 (0.43-1.13)</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td>168/437 (38)</td>
<td>262/533 (49)</td>
<td>11</td>
<td>0.79 (0.69-0.91)</td>
<td>.59</td>
</tr>
<tr>
<td><strong>Extended home care services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rich et al. 1993</td>
<td>3</td>
<td>21/63 (33)</td>
<td>16/35 (46)</td>
<td>12</td>
<td>0.73 (0.44-1.20)</td>
<td></td>
</tr>
<tr>
<td>Rich et al. 1995</td>
<td>12</td>
<td>41/142 (29)</td>
<td>59/140 (42)</td>
<td>13</td>
<td>0.69 (0.50-0.95)</td>
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</tr>
<tr>
<td>Harrison et al. 2002</td>
<td>3</td>
<td>21/92 (23)</td>
<td>31/100 (31)</td>
<td>8</td>
<td>0.74 (0.46-1.19)</td>
<td></td>
</tr>
<tr>
<td>Laramee et al. 2003</td>
<td>3</td>
<td>49/141 (35)</td>
<td>46/146 (32)</td>
<td>3 (+)</td>
<td>1.10 (0.79-1.53)</td>
<td></td>
</tr>
<tr>
<td>Subtotal</td>
<td></td>
<td>132/438 (30)</td>
<td>152/421 (36)</td>
<td>6</td>
<td>0.82 (0.68-1.00)</td>
<td>.19</td>
</tr>
<tr>
<td><strong>Day hospital services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capomolla et al. 2003</td>
<td>12</td>
<td>9/112 (8)</td>
<td>37/122 (33)</td>
<td>25</td>
<td>0.25 (0.15-0.44)</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>555/1590 (35)</td>
<td>741/1714 (43)</td>
<td>8</td>
<td>0.75 (0.64-0.88)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Death or readmission</td>
<td></td>
<td>250/567 (44)</td>
<td>354/587 (60)</td>
<td>16</td>
<td>0.73 (0.62-0.87)</td>
<td>.02</td>
</tr>
<tr>
<td>CHF or CVD readmission</td>
<td></td>
<td>118/522 (23)</td>
<td>210/631 (33)</td>
<td>10</td>
<td>0.65 (0.54-0.79)</td>
<td>.06</td>
</tr>
</tbody>
</table>
Services & Interventions to Reduce Readmissions

What works?
## What are the most effective service components of a readmissions program?

<table>
<thead>
<tr>
<th>Component</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk Assessment</strong></td>
<td>• Assess likelihood of readmission based on key risk factors.</td>
</tr>
<tr>
<td></td>
<td>• Stratify intensity of care based on results.</td>
</tr>
<tr>
<td><strong>Medication-related Care</strong></td>
<td>• High rate of readmissions due to ADEs and therapeutic omissions</td>
</tr>
<tr>
<td></td>
<td>• Reduce medication discrepancies.</td>
</tr>
<tr>
<td></td>
<td>• Improve adherence via access, simplification, education.</td>
</tr>
<tr>
<td></td>
<td>• Focus on high-risk medications, new therapies and/or complex regimens.</td>
</tr>
<tr>
<td><strong>Patient Education /Self-Management</strong></td>
<td>• Use teach-back tool and focus on patient management of condition</td>
</tr>
<tr>
<td></td>
<td>• Provide proper self-care &amp; disease mgmt instructions based on competency</td>
</tr>
<tr>
<td></td>
<td>• Empower the patient to navigate the healthcare system</td>
</tr>
<tr>
<td><strong>Care Plan</strong></td>
<td>• Anticipate needs and prepare appropriately; particularly for TOCs</td>
</tr>
<tr>
<td></td>
<td>• Detailed plan for home health representative, and PCP. Provide a discharge summary or high quality discharge instruction form.</td>
</tr>
<tr>
<td></td>
<td>• PCPs and key specialists are included in the plan (roles and action items)</td>
</tr>
<tr>
<td><strong>Communication &amp; Care Coordination</strong></td>
<td>• Appointments with PCPs and key specialists should be made prior to departure from the hospital and then ensure these are kept. Transparency between providers and patient/caregivers</td>
</tr>
<tr>
<td></td>
<td>• A formal process for connecting to and communicating relevant information in a timely based on patient risk stratification.</td>
</tr>
</tbody>
</table>
## Focus on the Patient Risk Evaluation

<table>
<thead>
<tr>
<th>Site (Ref)</th>
<th>Service</th>
<th>Where</th>
<th>Who</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parkland Health &amp; Hospital (TX)</td>
<td>Predictive model for risk of RA developed by clinical researchers.</td>
<td>Admission – <em>daily notification</em></td>
<td>Used by case managers and clinicians</td>
<td>↓ 33% Medicare and 20% all HF RA</td>
</tr>
<tr>
<td>Mount Sinai MC (NY)</td>
<td>Predictive model for risk of RA developed by clinical researchers for program placement</td>
<td>• Admission – <em>daily list from IT</em>&lt;br&gt;• High risk clinic</td>
<td>Social-work and NP-led teams</td>
<td>RA ↓ from 30% to 12%.&lt;br&gt;ED visits ↓ 63%</td>
</tr>
</tbody>
</table>
Example of Risk Factors for Readmission

**Patient Factors**
- Age > 80
- Hx of depression
- ESRD
- ≥ 5 Chronic Conditions
- High-risk DRG conditions (ie, HF, AMI, COPD)

**Event Factors**
- Previous admission(s) within 30 days
- No patient/family education with initial discharge
- No post-discharge appointment with PCP ≤ 30 days
- LOS >2x DRG

**Medication-related**
- ADEs related to high-risk agents (ie, warfarin, antiplatelets, hypoglycemics)
- Presence of medication discrepancies
- > 5-10 routine medications
- Poor adherence

<table>
<thead>
<tr>
<th>Risk Assessment: 7P Screening Tool (Check all that apply.)</th>
<th>Risk Specific Intervention</th>
</tr>
</thead>
</table>
| **Problem medications** (anticoagulants, insulin, aspirin & clopidogrel dual therapy, digoxin, narcotics) | □ Medication specific education using Teach Back provided to patient and caregiver  
□ Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin)  
□ Specific strategies for managing adverse drug events reviewed with patient/caregiver  
□ Follow-up phone call at 72 hours to assess adherence and complications |
| **Punk (depression)** (screen positive or diagnosis) | □ Assessment of need for psychiatric aftercare if not in place  
□ Communication with aftercare providers, highlighting this issue if new  
□ Involvement/awareness of support network insured |
| **Principal diagnosis** (cancer, stroke, DM, COPD, heart failure) | □ Review of national discharge guidelines, where available (e.g. CHF)  
□ Disease specific education using Teach-Back with patient/caregiver  
□ Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms  
□ Discuss goals of care and chronic illness model discussed with patient/caregiver |
| **Polypharmacy** (>5 more routine meds) | □ Elimination of unnecessary medications  
□ Simplification of medication scheduling to improve adherence  
□ Follow-up phone call at 72 hours to assess adherence and complications |
| **Poor health literacy** (inability to do Teach Back) | □ Committed caregiver involved in planning/administration of all general and risk specific interventions  
□ Aftercare plan education using Teach-Back provided to patient and caregiver  
□ Link to community resources for additional patient/caregiver support  
□ Follow-up phone call at 72 hours to assess adherence and complications |
| **Patient support** (absence of caregiver to assist with discharge and home care) | □ Follow-up phone call at 72 hours to assess condition, adherence and complications  
□ Follow-up appointment with aftercare medical provider within 7 days  
□ Involvement of home care providers of services with clear communications of discharge plan to those providers |
| **Prior hospitalization** (non-elective; in last 6 months) | □ Review reasons for re-hospitalization in context of prior hospitalization  
□ Follow-up phone call at 72 hours to assess condition, adherence and complications  
□ Follow-up appointment with aftercare medical provider within 7 days |
<table>
<thead>
<tr>
<th>Site (Ref)</th>
<th>Service</th>
<th>Where</th>
<th>Who</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sacred Heart MC (WA)</td>
<td>Med Rec combined with a new Pharmacotherapy Clinic for high-risk patients</td>
<td>• Hosp admission</td>
<td>PharmD, Pharm Tech, RN</td>
<td>• 30-day RA ↓ 9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Hosp discharge</td>
<td></td>
<td>• 30-day ED visits ↓ 30%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Community (outpt visit)</td>
<td></td>
<td>• Med access/adherence</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Med discrep: 6 corrections/pt</td>
</tr>
<tr>
<td>Wilkinson et al. (2011)</td>
<td>Med rec, discharge counseling to high risk, adult patients using Project Boost criteria</td>
<td>• Hosp discharge</td>
<td>PharmD</td>
<td>• 30-day RA for intervention = 15.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• 30-day RA for controls = 21.6% (p=0.04)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Cost avoidance for med discrepancy corrections = $1655 per pt</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Note: average time of 37 min per patient</td>
</tr>
</tbody>
</table>
Trail Design:
• 110 patients recently discharged home from large academic medical center randomized to receive intervention. Patients were mailed a satisfaction survey 2-6 weeks after discharge.

Description of Intervention:
Patients received phone call from a pharmacist within 2 days of discharge and were asked…
• How they had been feeling
• If they had any questions about their recent hospital stay
• If they were able to obtain all their medications
• If they understood how to take all their medications
• If they had experienced any possible medication adverse effects
• If they had any other questions or concerns
Pharmacists intervened to correct any medication related problems
Pharmacists communicated problems to the medical team

Citation: Dudas et al. The Impact of Follow-up Telephone Calls to Patients After Hospitalization. *Am J Med.* 2001;111(9B):26S–30S.
### Results:

1. **Patient Satisfaction:** \% very satisfied with medication care instructions
   - Control = 61\%
   - Intervention = 86\%  \( p = 0.007 \)
2. **ED visits within 30 days of discharge**
   - Control = 27 (24\%)
   - Intervention = 11 (10\%)  \( p = 0.005 \)
3. **Hospital Readmissions**
   - Control = 25\%
   - Intervention = 15\%  \( p = 0.07 \)

### Discussion:

- Key finding was that 19\% of patients had difficulty obtaining all their discharge medications.
- Standard pharmacy medication counseling discharge process takes 30 minutes. Home phone call required an additional 10 minutes on average.

Citation: Dudas et al. The Impact of Follow-up Telephone Calls to Patients After Hospitalization. *Am J Med.* 2001;111(9B):26S–30S.
Trail Design:
Retrospective quality improvement study in recently discharged hospital patients comparing patients receiving intervention to those not receiving.

Description of Intervention:
Medication reconciliation by an ambulatory pharmacist for 281 high-risk patients within 3-7 days post-discharge. Goal was to complete reconciliation and identify and resolve medication-related problems.

Outcomes measures included:
- Hospital Readmission Rates
- ED Visits
- Financial Savings to GHC
- Type and Rate of Medication Discrepancies Encountered

Reference: Poster. Group Health Cooperative (GHC) Pharmacy (Seattle), Meg Kilcup, kilcup.m@ghc.org
Results:

- **14 Day Readmission Rates:**
  - No Clinical Pharmacist Medication Reconciliation: 8%
  - Clinical Pharmacist Medication Reconciliation: 4%

- **Patient Safety**
  - 80% of patients had at least 1 medication discrepancies identified
    - 1% - Potentially Lethal, 10% - Serious, 27% - Significant

- **Financial**
  - Estimated $3 million savings
  - $37,000 savings per 100 patients

Reference: Poster. Group Health Cooperative (GHC) Pharmacy (Seattle), Meg Kilcup, kilcup.m@ghc.org
## Focus on “Patient Ed / Disease & Self Management”

<table>
<thead>
<tr>
<th>Site (Ref)</th>
<th>Service</th>
<th>Where</th>
<th>Who</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jovicic et al. meta-analysis (6 trials) (2006)</td>
<td>Self-management interventions for HF with limited follow-up (&lt; 1 year, typically q3m contacts)</td>
<td>• Discharge • Post-Dsch</td>
<td>• RN (primarily)</td>
<td>• 56% ↓ HF RA • 41% ↓ All-cause RA • Cost: savings $1300-7515 per pt/year</td>
</tr>
<tr>
<td>Gwadry-Sridhar et al. syst. Review (8 trials) (2004)</td>
<td>Self-management program for HF with follow-up limited to &lt; 1 year, typically q3m contacts</td>
<td>• Discharge • Post-Dsch <em>Immediate f/u via phone or home visit</em></td>
<td>• RN (primarily)</td>
<td>• 21% ↓ HF RA</td>
</tr>
<tr>
<td>VanSuch et al. (2006)</td>
<td>Single session care management directions for HF (part of all of CMS HF composite of 6 directions)</td>
<td>• Discharge</td>
<td>• RN</td>
<td>• ↓ Probability of RA for HF (p=0.042) • ↓ Probability of RA for any cause (p=0.004) • More components = less risk of RA</td>
</tr>
</tbody>
</table>
### Trail Design:
- Prospective, case control for HF patients, age > 65 discharged from 263-bed community hospital (TX).

### Description of Intervention:
- 3-month program focused on transitional care
- Home visit within 72 hours of hospital discharge & 8 total visits
- Social support evaluation
- Disease management: protocols, care goals, patient education
- 7-day a week availability via phone

### Results:
- 48% reduction in 30-d readmission rates for HF
- Overall impact on cost of care = $ (227) per patient on “contribution margin”

Citation: Stauffer BD et al. Effectiveness and Cost of a Transitional Care Program for Heart Failure. Arch Int Med. 2011;171(14):1238-1243.
Trial Design:
- Randomized controlled trial at large IDN involving 75 community dwelling enrollees admitted to study hospital for any of 11 conditions.

Description of Intervention: Focused on “4 pillars” …
- Assistance with medication self-management
- A patient-centered record owned and maintained by the patient
- Timely follow-up with primary or specialty care
- A list of “red flags” indicative of a worsening condition and instructions on how to respond to them.

Intervention Process:
- TC meets patient during inpatient stay, develops rapport, initiates PHR
- Arrange home visit (48-72 hours) post-discharge
- Home visit: Pharmacist and TC visit patient. Reconcile medications using the Medication Discrepancy Tool and educate patient on self-management

Citation: Coleman et al. The Care Transitions Intervention: Results of a Randomized Controlled Trial. Archives of Internal Medicine 2006;166:1822-8.
CTI
Colorado

Results:

- **30-day Readmissions:** ↓ 22%
- **Annual Cost Savings:** Projected at nearly $300k

Comments: Positive outcomes despite readmission rates in control group at well below national averages.

Citation: Coleman et al. The Care Transitions Intervention: Results of a Randomized Controlled Trial”. Archives of Internal Medicine 2006;166:1822-8.
CTI in Rhode Island

<table>
<thead>
<tr>
<th>Timing/Location</th>
<th>Hospital Admit, Post-Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service</td>
<td>Self-management, Medications, Communication/Care Plan</td>
</tr>
<tr>
<td>Key Players</td>
<td>APN (Transitions Coach)</td>
</tr>
</tbody>
</table>

**Trial Design:**
- Quasi-experimental prospective cohort study
- 257 Medicare patients from 6 Rhode Island Hospitals (all diagnosis)

**Description of Intervention:** Focused on “4 pillars” …
- “Transitions Coach”…“empowered individuals to manage their own care and communicate effectively with providers”
- Assistance with medication self-management
- A patient-centered record (PHR) owned and maintained by the patient
- Timely follow-up with primary or specialty care
- A list of “red flags” indicative of a worsening condition and instructions on how to respond to them.

**Intervention Process:**
- 30-days for total intervention
- TC meets patient during inpatient stay, develops rapport, initiates PHR
- x1 home visit (3 days post-dc): medication discrepancies, condition monitoring
- x 2 phone calls (@ 7-10 days and by day 30): importance of PCP follow-up

Citation: Voss et al. The Care Transitions Intervention. Arch Intern Med. 2011;171:1232-1237.
CTI in Rhode Island

<table>
<thead>
<tr>
<th>Timing/Location</th>
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</tr>
<tr>
<td>Key Players</td>
<td>APN (Transitions Coach)</td>
</tr>
</tbody>
</table>

Results:

- **30-day All-Cause Readmissions**

<table>
<thead>
<tr>
<th>Group</th>
<th>30-day All Cause Readmissions</th>
<th>95% CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>CTI Group</td>
<td>12.8%</td>
<td>95% CI= 0.42-0.88</td>
</tr>
<tr>
<td>Control Cohort</td>
<td>20%</td>
<td>Risk Red = 36%</td>
</tr>
</tbody>
</table>

- **Resource Use**: CTI Coaches worked PT (18-24 hr/wk) and averaged 12-15 patients per coach

Citation: Voss et al. The Care Transitions Intervention. Arch Intern Med. 2011;171:1232-1237.
## Focus on Post-Discharge Services

<table>
<thead>
<tr>
<th>Site (Ref)</th>
<th>Service</th>
<th>Where</th>
<th>Who</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Alliance Plan (MI)</td>
<td>CIS notifies RN upon disch of high-risk pt. Contact HF pts within 48 hr of dsch, focus on: • Med review • Home care needs • Sched MD appt • Arrange transportation</td>
<td>Post-discharge phone calls. If medication problems noted, then RN home visit. (5-10 sessions typical to correct issues)</td>
<td>Nurse “health coaches”</td>
<td>• 37% ↓ HF 30d RA for HMO members • 45% ↓ HF 30d RA for Med Advantage patients</td>
</tr>
<tr>
<td>WellPoint</td>
<td>Phone call within 2 weeks of discharge for high-risk patients by CS. Transfer to RN if screening questions indicate risk. Ongoing care mgmt as needed for complex pts</td>
<td>Post-discharge (Home)</td>
<td>• Cust. Service  • Nurses</td>
<td>• 4% absolute ↓ HF 30d-RA (from 16→12)</td>
</tr>
</tbody>
</table>
## Focus on “Post-Discharge” Services

<table>
<thead>
<tr>
<th>Site (Ref)</th>
<th>Service</th>
<th>Where</th>
<th>Who</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Mt Sinai Hosp. (NY) PACT (Preventable Admission Care Team) | • Inpt 75 min psychosocial eval.  
• Follow with 5 week post-dscht coordination plan.  
• Target diverse patients and perform home safety, med reviews, soc support, diet review. | • Hosp (assessment)  
• Home & phone & visits | • Social workers (4)  
• NP (2) | • 18% ↓ HF 30d RA  
• 43% ↓ overall admissions for PACT  
• 70% ↓ ED visits |
## Focus on Comprehensive Care

<table>
<thead>
<tr>
<th>Site (Ref)</th>
<th>Service</th>
<th>Where</th>
<th>Who</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metro Health Hosp (WY)</td>
<td>• HF education materials delivered by RN.</td>
<td>• Hosp admission</td>
<td>• RN</td>
<td>HF 30-day RA decreased from 15.5 to 7.4% (↓46%)</td>
</tr>
<tr>
<td></td>
<td>• PCP F/U appts sched by hosp staff prior to dsch</td>
<td>• Hosp Discharge</td>
<td>• Clinical Secretary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• PCP received clear &amp; concise info packet on patients</td>
<td>• Post dsch</td>
<td>• Case manager</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Case manager phone call within 24-48h discharge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rush Univ MC (IL)</td>
<td>Enhanced Discharge Planning Program (EDPP):</td>
<td>• Hosp Admit (risk</td>
<td>• RN</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• IT risk assessments for RA</td>
<td>assess)</td>
<td>• SW</td>
<td>↓ 15% in 30-day RA</td>
</tr>
<tr>
<td></td>
<td>• SW provides post-dsche phone call to ensure proper care is delivered.</td>
<td>• Post-dsche</td>
<td></td>
<td>↓ 24% in 60-day RA</td>
</tr>
<tr>
<td></td>
<td>Provide weekly f/u for 30 days as needed.</td>
<td></td>
<td></td>
<td>↓ 23% in 90-day RA</td>
</tr>
</tbody>
</table>
## Focus on Comprehensive Care

<table>
<thead>
<tr>
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<th>Where</th>
<th>Who</th>
<th>Outcomes</th>
</tr>
</thead>
</table>
| Transitions Home for Patients with HF (St Lukes Hosp, Iowa) | • HF patients discharged from hospital  
• Med rec & mgmt  
• Pt ed using teach-back method | • Hosp Admit  
• Hosp Dsch  
• Post-Dsch home visit and phone call | • RN | • ↓30d RA from 14% to 4%.  
• Improved teach-back rates dramatically (>90%). |
| Transforming Chronic Care (TCC) Program (John Muir Physician Network, Contra Costa, CA) | • Eligible, frail patients; HF, COPD and/or diabetes.  
• Use CTI process for initial 4 weeks post-discharge  
• As needed case-manager for LTC. | • Post-dsch  
• Home | •RN (transitions coach) | • 50% ↓30d RA rates compared to patients not in program |
| Health Care Partners (HCP) Medical Group, San Diego, CA | Focus on frail elders:  
• Patient education,  
• Palliative care  
• Disease management  
• Psychosocial barriers. | • Hosp  
• Post-dsch  
• Home/Community | • Case manager  
• RN  
• Physician  
• Disease specialists | • ↓30d RA by 18% in highest risk group. |
Summary: Readmissions Pearls

- Many successful strategies for reducing readmissions
- It is critical that you understand the underlying problems related to readmissions for YOUR institution and patients
- Initiating simple, low-cost, focused interventions in sequence may be wise to ensure you can measure the impact
- Align readmissions efforts around current QI practices such as patient satisfaction, disease management, etc
- Even resource intensive programs have been shown to be cost effective
Tools and Resources
# IHI Readmission Risk Assessment Tool

## Re-Hospitalization Risk Assessment

**Purpose:** Screening tool to identify those at risk of re-hospitalization

<table>
<thead>
<tr>
<th>Date: ______________</th>
<th>Anticipated Date of Discharge: ______________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Physician: ______________</td>
<td></td>
</tr>
</tbody>
</table>

**Prior pattern:** Check all that apply

- [ ] > 3 hospitalizations or ER visits in past 3 months
- [ ] History of falls

**Chronic conditions:** Check all that apply

- [ ] CHF
- [ ] Diabetes
- [ ] COPD
- [ ] Renal Failure

**Risk factors:** Check all that apply

- [ ] More than 2 secondary diagnoses
- [ ] Pressure or Stasis Ulcer
- [ ] Low social economic status or limited financial resources
- [ ] Poor Prognosis
- [ ] Lives alone
- [ ] Short life expectancy
- [ ] Limited support network
- [ ] Help with managing medications needed
- [ ] ADL assistance needed
- [ ] Non-compliance with medication regimen
- [ ] Home safety risks
- [ ] Difficulty reading
- [ ] Dyspnea
- [ ] Confusion

**Total # of checked boxes is ______.**

5 or more risk factors may indicate that the patient is at a high risk of re-hospitalization.
Discharge Preparation Checklist

Before I leave the care facility, the following tasks should be completed:

☐ I have been involved in decisions about what will take place after I leave the facility.

☐ I understand where I am going after I leave this facility and what will happen to me once I arrive.

☐ I have the name and phone number of a person I should contact if a problem arise during my transfer.

☐ I understand what my medications are, how to obtain them and how to take them.

☐ I understand the potential side effects of my medications and whom I should call if I experience them.

☐ I understand what symptoms I need to watch out for and whom to call should I notice them.

☐ I understand how to keep my health problems from becoming worse.

☐ My doctor or nurse has answered my most important questions prior to leaving the facility.

☐ My family or someone close to me knows that I am coming home and what I will need once I leave the facility.

☐ If I am going directly home, I have scheduled a follow-up appointment with my doctor, and I have transportation to this appointment.
• Studies have shown that 40-80 percent of the medical information patients receive is forgotten immediately and nearly half of the information retained is incorrect.

• **Teach-back is a way to confirm that you have explained to the patient what they need to know in a manner that the patient understands. Patient understanding is confirmed when they explain it back to you.**

• Web site includes:
  – Video instruction
  – PowerPoint
  – Handouts
  – Self-evaluation

Readmissions Information Sources

- IHI (STAAR Initiative)
  - [http://www.ihi.org/IHI/Programs/StrategicInitiatives/STateActiononAvo
dableRehospitalizationsSTAAR.htm](http://www.ihi.org/IHI/Programs/StrategicInitiatives/STateActiononAvo
dableRehospitalizationsSTAAR.htm)
- IHI Transforming Care at the Bedsite (TCAB)
  - [http://www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm](http://www.ihi.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm)
- CMS
  - Affordable Care Act: Readmission payment reform
  - Community Care Transitions Program (CCTP)
Readmissions Information Sources

• Care Transitions Project
  – Information and tools, including the Med Discrepancy Tool

• Project Boost
  – Robust info site with tools, etc on care transitions
  – [http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm](http://www.hospitalmedicine.org/ResourceRoomRedesign/RR_CareTransitions/CT_Home.cfm)

• Project RED

• National Priorities Partnership
  – 7 key targets, including “Continuity of Care”

• Patient Disease/Self-Management
Questions and Discussion

steve.riddle@pharmacyonesource.com