Wrestling Readmissions to the Mat: Evidence and Efforts
LIVE in 5 Minutes

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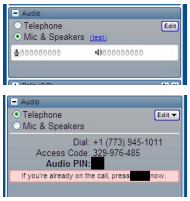

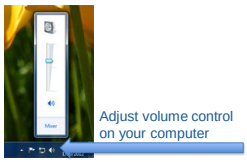

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IMPROVEMENT SCIENCE RESEARCH NETWORK
improving patient outcomes

Wrestling Readmissions to the Mat: Evidence and Efforts
LIVE in 3 Minutes

- Slides are available for download at www.ISRN.net

- Recording will be available in several days www.ISRN.net

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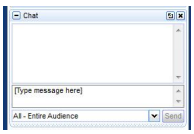
Wrestling Readmissions to the Mat: Evidence and Efforts
LIVE in 1 Minute

- Asking Questions
  - Type your question into the "Chat" box and click Send
  - We will answer as many questions as possible at the end of today's session



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IMPROVEMENT SCIENCE RESEARCH NETWORK
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Wrestling Readmissions to the Mat: Evidence and Efforts

Part 1: Controlling Avoidable Readmissions Effectively (Project C.A.R.E.)

Presented by: **Improvement Science Research Network**
Co-sponsored by: **RHP 6 Readmission Collaborative**

UT Health Science Center

Moderator

Kathleen R. Stevens, RN, EdD, FAAN
Professor and Director
Improvement Science Research Network
University of Texas Health Science Center San Antonio

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UT Health Science Center

ISRN Research Priorities

A. Coordination and Transitions of Care
B. High-Performing Clinical Systems and Microsystems Approaches to Improvement
C. Evidence-Based Quality Improvement and Best Practice
D. Learning Organizations and Culture of Quality and Safety

Improvement Science Research Network (ISRN). (2010). Research priorities. Retrieved from http://www.isrn.net/research.

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Submitting Questions

- When: Anytime during the presentation
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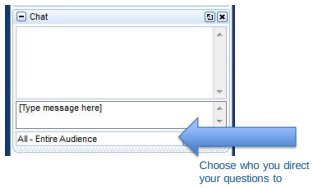

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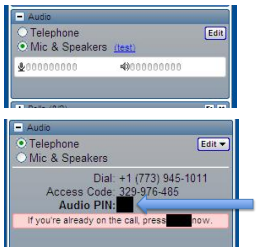

IMPROVEMENT SCIENCE RESEARCH NETWORK
improving patient outcomes

Wrestling Readmissions to the Mat: Evidence and Efforts

Part 1: Controlling Avoidable Readmissions Effectively (Project C.A.R.E.)

UT Health Science Center

Presented by: **Improvement Science Research Network**
Co-sponsored by: **RHP 6 Readmission Collaborative**

Presenters

Carol A. Huber, MBA

Director,
Regional Healthcare Partnership
University Health System

Gulshan Sharma, MD, MPH

Professor
Sealy and Smith Distinguished Chair in Internal Medicine
Director, Division of Pulmonary Critical Care & Sleep Medicine

Texas Healthcare Transformation and Quality Improvement Program

- Medicaid 1115 Waiver valued at $29 billion over a five year period
  - Set to expire September 30, 2016
- Statewide Medicaid Managed care expansion
- Hospital financing component
  - Preserved funding stream known historically as Upper Payment Limit (UPL)
  - Created two incentive pools
    - Uncompensated Care (UC)
    - Delivery System Reform Incentive Payment (DSRIP)

RHP6 Texas 1115 Waiver Improving Health. Transforming Care.

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Delivery System Reform Incentive Payment (DSRIP) Pool

- New incentive program to support coordinated care and quality improvements through 20 Regional Healthcare Partnerships
  - Hospitals, Physician Groups, Mental Health Centers, Public Health
- Goals: transform delivery systems to improve care for individuals, improve health for the population, and lower costs through efficiencies and improvements
- Targets Medicaid recipients and low income uninsured individuals

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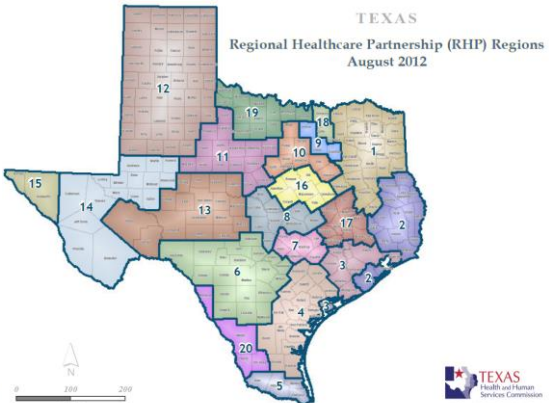

RHP 6 Community Needs Addressed through DSRIP Projects and Collaboration

Quality of care in Texas is below the national average	High rates of chronic conditions require improved management and prevention	Poor access to medical and dental care	Lack of integrated behavioral health services
52 projects	59 projects	52 projects	45 projects

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Texas DSRIP Projects

- 1,458 active DSRIP projects
- 298 providers
  - Hospitals
  - Physician groups
  - Community mental health centers
  - Local health departments
- Over $4.5 billion earned through January 2015

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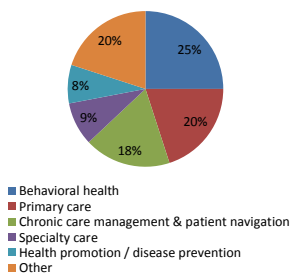
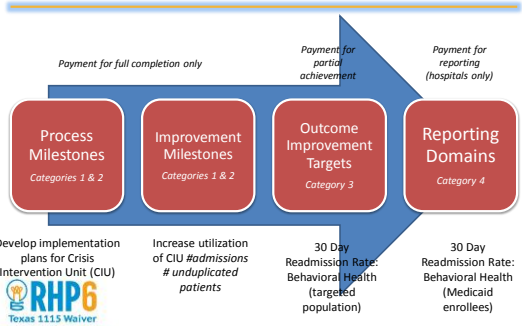
Major Project Focus



HHSC May 7, 2015

Performance Improvement Measurement Continuum



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Transformation is…

Collaboration among providers and stakeholders

Common Aim

Address project challenges

"Actionable" Project List

Networking Opportunities

Bexar County Mental Health Consortium

Health Collaborative
Bexar County's Community Health Leadership

Dec 2013 & March 2104 | *June 2014* | *Fall 2014 +*

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RHP 6 Readmissions Learning Collaborative

- Follows Institute for Healthcare Improvement Breakthrough Series model
- Teams set goals to reduce readmissions 5% by end of DY4.
  - Pre-work Summer 2014
  - Completed two Learning Sessions (November 2014 and February 2015)
- Learning Collaborative Summit – July 20, 2015
  - Register at www.TexasRHP6.com

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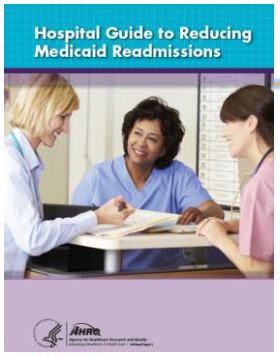
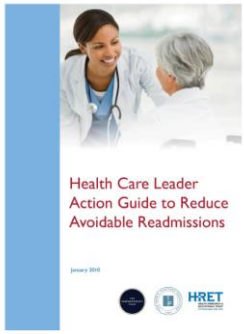
Change Packages





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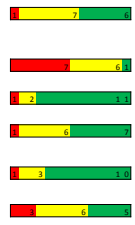
Top Ten Evidence-Based Strategies

- Enhanced admission assessment of discharge needs and begin discharge planning upon admission
- Formal assessment of risk of readmission
- Accurate medication reconciliation at admission, at any change in level of care and at discharge
- Patient education
- Identify primary caregiver, if not the patient and include with education and discharge planning
- Use teach-back to validate patient and caregiver's understanding



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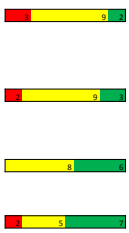
Improving Health. Transforming Care.

Not Implemented | Partially Implemented | Fully Implemented

Top Ten Evidence-Based Strategies

- Send discharge summary and after-hospital care plan to primary care provider (PCP) within 24 to 48 hours of discharge
- Collaborate with post-acute care and community based providers
- Before discharge, schedule follow-up medical appointments and post-discharge tests / labs.
- Conduct post-discharge follow-up calls within 48 hours of discharge



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Improving Health. Transforming Care.

Not Implemented | Partially Implemented | Fully Implemented

http://www.patientcarelink.org/uploadDocs/1/Read---Top-Ten-Check-List.pdf

For more information on DSRIP

- RHP 6: www.TexasRHP6.com
  - Tip! Look for the interactive tool under "RHP Plan"
- Texas Health and Human Services Commission
  - http://www.hhsc.state.tx.us/1115-waiver.shtml
- Centers for Medicare & Medicaid Services
  - http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html

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Improving Health. Transforming Care.

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University Health System
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(210) 358-8792

Controlling Avoidable Readmissions Effectively (Project C.A.R.E.)

Gulshan Sharma, MD, MPH
Sealy & Smith Distinguished Chair
Professor and Director, Division of Pulmonary Critical Care & Sleep Medicine
Associate Chief Medical Officer
University of Texas Medical Branch, Galveston TX

POLL QUESTION

Objectives

- Familiarize with key interventions that have shown to reduce readmission rates
- Understand elements of project BOOST and its implementation using Health IT
- Examine early lessons learned on readmission project under DSRIP 1115 waiver in Region 2 of state of Texas

HOSPITAL READMISSIONS IN THE MEDICARE POPULATION

GERARD F. ANDERSON, PH.D., AND EARL P. STEINBERG, M.D., M.P.P.

Abstract In order to examine the proportion of Medicare expenditures attributable to repeated admissions to the hospital, we assessed the frequency with which 270,286 randomly selected Medicare beneficiaries were readmitted after hospital discharge between 1974 and 1977. Twenty-two per cent of Medicare hospitalizations were followed by a readmission within 60 days of discharge. Medicare spent over $2.5 billion per year (24 per cent of Medicare inpatient expenditures) on such readmissions between 1974 and 1977. Analogous expenditures in 1984 could approach $8 billion.

Even a small decrease in the readmission rate could result in substantial savings for the Medicare program. The recently enacted prospective-payment legislation, however, creates economic incentives that could increase readmission rates. Attempts by professional review organizations or others to develop hospital readmission profiles will need to control for patient and hospital characteristics that are correlated with the likelihood of readmission. Further study of such characteristics could help identify high-risk patient groups for whom increased outpatient supports might prove cost effective. (N Engl J Med 1984; 311:1349-53.)

Table 2. Interval between Discharge and Readmission among Medicare Beneficiaries Discharged between 1974 and 1977.

Interval, no. of days	Percentage of Cases	Cumulative Percentage
<1	2.4	2.4
1–5	5.1	7.5
6–30	10.2	15.6
31–60	6.8	22.5
61–365	27.3	49.7

Interventions to reduce 30-day-Rehospitalization

Predischarge Intervention

- Patient education
- Discharge Planning
- Medication Reconciliation
- Appointment scheduled before discharge

Post Discharge Intervention

- Timely follow-up
- Timely PCP communication
- Follow-up telephone call
- Patient hotline
- Home visit

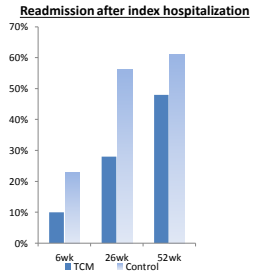
Intervention Bridging the transition

Transition Coach
Patient centered discharge instruction
Provider continuity

Hansen et al. Ann Intern Med. 2011

Comprehensive Discharge Planning and Home Follow-up of Hospitalized Elders: A RCT

- Randomized 363 patients age > 65
- "Comprehensive discharge planning" and home follow-up with Advance Practice Nurses
  - ~70% completion rate
- Readmissions at 26 weeks 28% vs. 56%
  - Reduced multiple readmissions 6.2% vs. 14.5%
  - Prolonged time to first readmission
  - Medicare reimbursements cut in half ($1.2M vs. $0.6M)



Naylor et al. JAMA.1999;281(7):613-620

The Care Transitions Intervention

- Elderly patients transitioning to SNF/home
- Randomized: Intervention group paired with "Transition Coach" vs. standard care. N=750
- Empowerment and education: 4 pillars
  - Facilitate self management/adherence
  - Maintain a personal health record
  - Timely follow-up
  - Knowledge and management of complications
- Education during hospitalization
- Phone calls and personal visits by TC post D/C
- Reduced 30d readmission rate (8.3% vs. 11.9%): OR 0.59.
- Savings at 90d = $497/case

Coleman et al. Arch Intern Med 2006;166:1822-1828

A Reengineered Hospital Discharge Program to Decrease Rehospitalization

- RCT with N = 749 pts
- Single Center
- Outcomes:
  - ED + 30d Readmit
  - Assessed at 30d
    - Phone call to pt
    - EMR review
- Intervention
  - RN Discharge Advocate
  - Clinical Pharmacist
  - Follow-up phone call

Jack et al. Ann Intern Med 2009

Primary Outcome:

Hospital Utilization within 30d after Discharge

	Usual Care (n=368)	Intervention (n=370)	P-value
Hospital Utilizations *			
Total # of visits	166	116	
Rate (visits/patient/month)	0.451	0.314	0.009
ER Visits			
Total # of visits	90	61	
Rate (visits/patient/month)	0.245	0.165	0.014
Readmissions			
Total # of visits	76	55	
Rate (visits/patient/month)	0.207	0.149	0.090

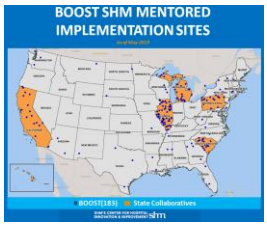
* Hospital utilization: ER visits+ readmissions

See: www.ahrq.gov/qual/projectred

project BOOST

Better Outcomes by Optimizing Safe Transitions

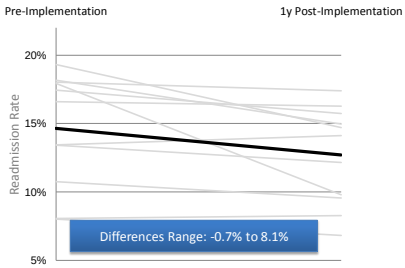
- Mentored implementation (QI not "Research")
  - QI/TOC experts
- Toolkit/Web resources
  - Risk identification with targeted interventions
  - Patient-centered communications
  - Team development
  - Data tracking
  - BOOST Community
- Our published data



www.hospitalmedicine.org/BOOST
BOOST@hospitalmedicine.org

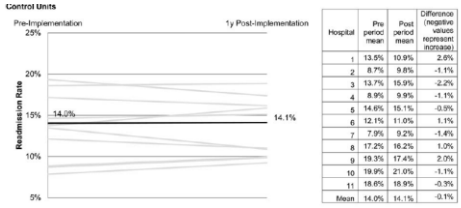
BOOST Tools

- 8P's risk scale (identify, mitigate, communicate)
- General Assessment Preparedness (GAP)
- Patient Preparation to Address Situations Successfully-PASS (after Discharge)
- Teach back
- Interprofessional Rounds
- Medication Reconciliation
- Follow-up phone calls
- Follow-up appointment



Project BOOST units in Pilot Cohort
(11 of 30 hospitals reporting)

37



Hospital	Pre period mean	Post period mean	Difference (negative values represent increase)
1	13.5%	10.9%	2.6%
2	8.7%	9.8%	-1.1%
3	13.7%	15.9%	-2.2%
4	8.9%	9.9%	-1.1%
5	14.6%	15.1%	-0.5%
6	12.1%	11.0%	1.1%
7	7.9%	9.2%	-1.4%
8	17.2%	16.2%	1.0%
9	19.3%	17.4%	2.0%
10	19.9%	21.0%	-1.1%
11	18.6%	18.9%	-0.3%
Mean	14.0%	14.1%	-0.1%

Balance of patient workload and capacity

Workload

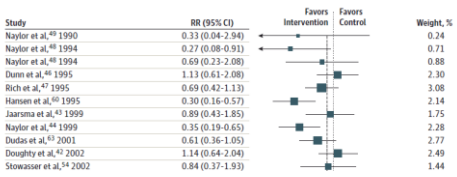
- Understanding of plan of care
- Making clinic apts. and self care

Capacity

- Social and financial resources
- Literacy
- Cognitive function

Workload > Capacity
=
poor health outcomes/readmissions

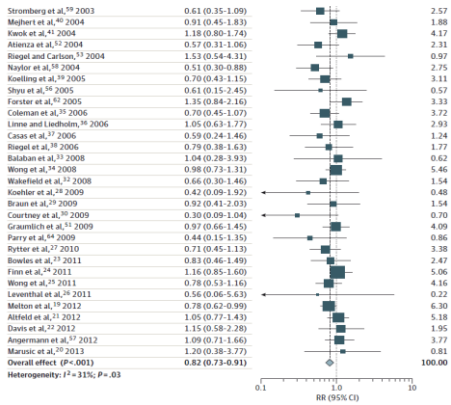
Preventing readmission: Role of Cumulative complexity model



Study	RR (95% CI)	Weight, %
Naylor et al,[48] 1990	0.33 (0.04-2.94)	0.24
Naylor et al,[48] 1994	0.27 (0.08-0.91)	0.71
Naylor et al,[48] 1994	0.69 (0.23-2.08)	0.88
Dunn et al,[46] 1995	1.13 (0.61-2.08)	2.30
Rich et al,[47] 1995	0.69 (0.42-1.13)	3.08
Hansen et al,[60] 1995	0.30 (0.16-0.57)	2.14
Jaarsma et al,[43] 1999	0.89 (0.43-1.85)	1.75
Naylor et al,[44] 1999	0.35 (0.19-0.65)	2.28
Dudas et al,[61] 2001	0.61 (0.36-1.05)	2.77
Doughty et al,[42] 2002	1.14 (0.64-2.04)	2.49
Stowasser et al,[54] 2002	0.84 (0.37-1.93)	1.44

Year 2002 or before

Leppin et al. JAMA Int Med. 2014;174(7):1095-1107



Effects of Comprehensive Support in Metaregression analysis

	No. of studies	Readmission, Relative Risk (95%CI)	P-value
Comprehensive Support Category			
1 (0 points)	15	1 (reference)	
2 (1 or 2 points)	20	0.82 (0.66-1.02)	0.07
3 (3 or 4 points)	7	0.63 (0.43-0.91)	0.02
Publication in 2002 or after	33	1.47 (1.10-1.96)	0.01

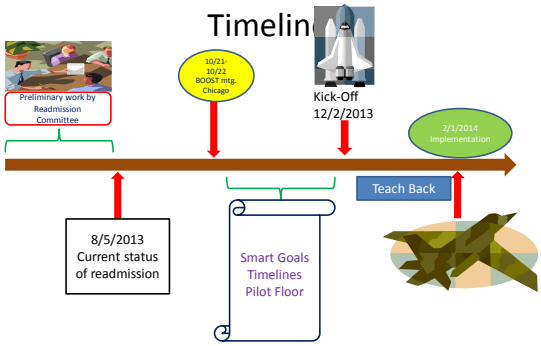
1 point each for interventions that
a) were related to increase patient capacity,
b) had ≥ 5 unique intervention activities
c) had ≥ 5 meaningful patient interactions and
d) had ≥ 2 individuals involved in its delivery

Leppin et al. JAMA Int Med. 2014;174(7):1095-1107

Summary

For **mixed patient population** **multicomponent care transition interventions** that reduced patient workload and increases capacity has shown to reduce early readmission when studied by highly **motivated investigators supported by skilled staff** (case manager, RN's, clinical pharmacist etc.)

POLL QUESTION



6/10/2015 G.Sharma 46

Multidisciplinary Team

- Linsday Sonstein
- Leah Low
- Carlos Clark
- Saleh Elsaid
- Jennifer Zirkle
- Jennifer Nelson
- Chelita Thomas
- Rick Trevino
- Steven Maxwell
- Stacy Avina
- Alison Glendenning-Napoli
- Craig Kovacevich
- Fernando Lopez
- LaDonna Strait
- Susan Seidensticker
- Leon McGrew
- Martha Livanec
- Tammie Collins
- Josette Armendariz

PREPARE (Partnership for Reliable Efforts to Prevent Avoidable Readmissions Experiences)

PURSUE (Preventing Unnecessary Readmissions through Safe transitions and Utilization of Education for patients & staff)

STAR Mission
(Stop The Avoidable Readmissions)

Slogan:
Shoot for the STARS with Project BOOST

Theme: Space, Galaxy

Controlling
Avoidable
Readmissions
Effectively

care

nautical theme for UTMB. Project (or Team) OCTOPUS:
- Optimizing
- Care
- Transition
- Outcomes for
- Patients in the
- UTMB
- System

Could get somebody to draw an octopus as the logo and put it on posters, t-shirts, whatever. Maybe have the octopus holding a stethoscope, computer keyboard, thermometer, prescription, crutch, etc...?

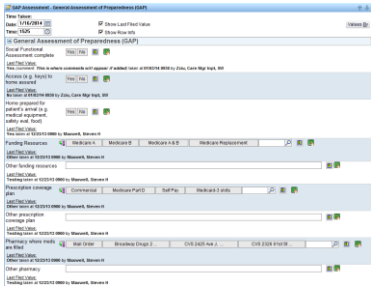
Working together.....
.....for safer discharge

"Give Our Patients a BOOST"

Teach back

- >600 nursing staff, care managers, social workers, Patient care facilitators
- IM house staff
- Family Medicine House staff

General Assessment Preparedness (GAP)



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(SERVICE TEAMS:30827) Discharge Summary

Date of Service: ***

ADMIT DATE: @ADMITDT@
DISCHARGE DATE: ***
ATTENDING MD: ***
RESIDENT MD: ***
PCP: ***

REASON FOR ADMISSION
***

FINAL DIAGNOSIS: (the reason, after study, for admitting the patient to the hospital)
***

SECONDARY DIAGNOSIS: (any diagnosis that, on this admission, required clinical evaluation, therapeutic treatment, diagnostic procedures, extended hospital stay, or additional nursing care/monitoring)
{Secondary Diagnosis:300000039}

@DIAGX@

CONSULTING SERVICES: ***

PROCEDURES:
{NONE:24087}

SIGNIFICANT LAB/X-RAYS:
Lab results:

53

ACTIVITY:
{as tolerated/bed rest/no strenuous activity/no heavy lifting/weight bearing as tolerated/touch down weight bearing on/non weight bearing on/other:300000031}

DISCHARGE MEDICATIONS:
@PTMEDDISCHARGE@

COUMADIN:
Is the patient being discharged on coumadin? {NO/YES:30848}.

WOUND CARE:
{NONE:24087}

CODE STATUS:
{full code/DNR and OOH DNR signed/other:300000027}

OXYGEN (is patient being discharged on oxygen):
{Y (# of liters)/N:300000028}

CORE MEASURES:
{ACUTE MI/HF CORE MEASURES:30966}

VACCINES:
1. Pneumonia Vaccination> 65 years of age or high risk {YES/NO:30968}
2. Influenza Vaccine >18 years of age. {YES/NO:30970}

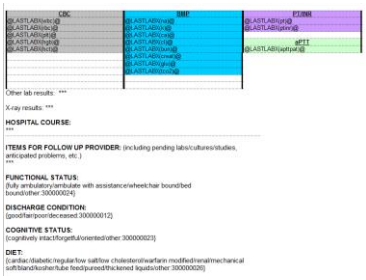
PATIENT EDUCATION PROVIDED:
{Diabetes Mellitus/medications/Heart Failure/wound care/catheter care/ostomy care/feeding tube care/tracheostomy care/other:300000030}

DISCHARGE:

{home self care/home health/skilled nursing facility or nursing home/rehab facility/LTAC/deceased/AMA/eloped/transferred/other:300000032}

FOLLOW-UP APPOINTMENT:
@UTMIFUTUREAPPTS@

54



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8P's

- Problem medications
- Polypharmacy
- Principal diagnosis
- Patient Support
- Psychological
- Poor health literacy
- Prior hospitalization
- Palliative care

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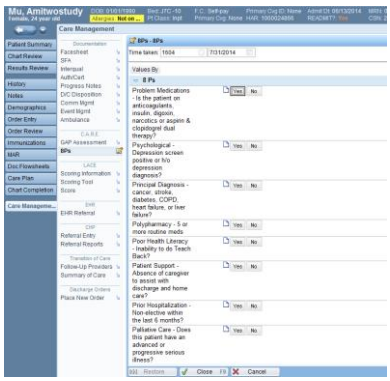

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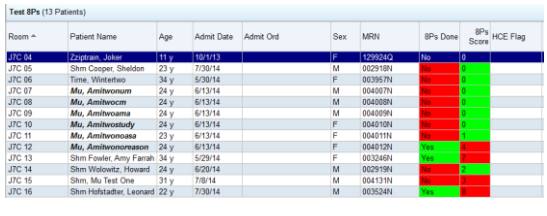

Test 8Ps (13 Patients)

Room	Patient Name	Age	Admit Date	Admit Ord	Sex	MRN	8Ps Done	8Ps Score	HCE Flag
J7C 04	Zziptrain, Joker	11 y	10/1/13		F	129924Q	No	0	
J7C 05	Shm Cooper, Sheldon	23 y	7/30/14		M	002918N	No	0	
J7C 06	Time, Wintertwo	34 y	5/30/14		F	003957N	No	0	
J7C 07	***Mu, Amitwonum***	24 y	6/13/14		M	004007N	No	0	
J7C 08	***Mu, Amitwocm***	24 y	6/13/14		M	004008N	No	0	
J7C 09	***Mu, Amitwoama***	24 y	6/13/14		M	004009N	No	0	
J7C 10	***Mu, Amitwostudy***	24 y	6/13/14		F	004010N	No	0	
J7C 11	***Mu, Amitwonoasa***	23 y	6/13/14		F	004011N	No	1	
J7C 12	***Mu, Amitwononreason***	24 y	6/13/14		F	004012N	Yes	3	
J7C 13	Shm Fowler, Amy Farrah	34 y	5/29/14		F	003246N	Yes	3	
J7C 14	Shm Wolowitz, Howard	24 y	6/20/14		M	002919N	No	2	
J7C 15	Shm, Mu Test One	31 y	7/8/14		M	004131N	No	3	
J7C 16	Shm Hofstadter, Leonard	22 y	7/30/14		M	003524N	Yes	3	

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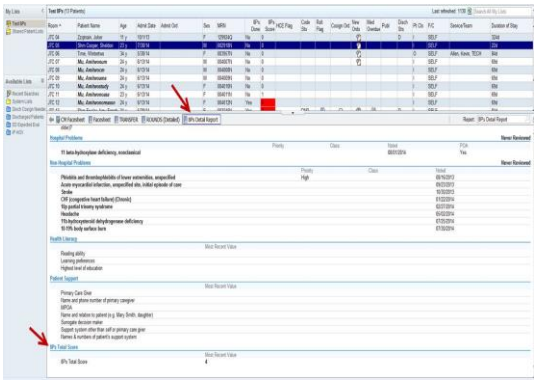

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utmb Health Quality & Healthcare Safety

8Ps

Assessment	
Problem Medications	Is the patient on anticoagulants, insulin, digoxin, narcotics, or aspirin & clopidogrel dual therapy?
Psychological	Depression screen positive or h/o depression diagnosis?
Principal Diagnosis	Cancer, stroke, diabetes, COPD, heart failure, or liver failure?
Polypharmacy	5 or more routine meds
Poor Health Literacy	Inability to do Teach Back?
Patient Support	Absence of caregiver to assist with discharge and home care?
Prior Hospitalization	Non-elective within the last 6 months?
Palliative Care	Does this patient have an advanced or progressive serious illness?

utmb Health Quality & Healthcare Safety

8Ps

Interventions

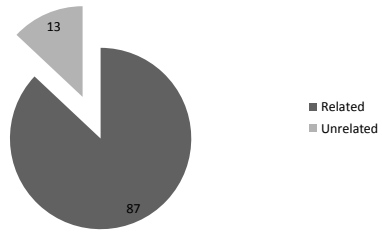
1. Elimination of unnecessary medications
2. Simplification of medication scheduling to improve adherence
3. Follow-up phone call at 72 hours to assess adherence and compliance
4. Follow-up appointment with aftercare medical provider within 7 days
5. Teach Back
6. Discuss goals of care and chronic illness model discussed
7. Action plan reviewed with patient caregivers regarding what to do and who to contact in the event of worsening or new symptoms
8. Link to community resources for additional patient/caregiver support
9. Involvement of home care providers of services with clear communications of discharge plan to those providers
10. Assess need for palliative care services

Preliminary Readmission Chart Review Tool

Where was the patient admitted from	
Pt Name, UH Numer, Age	
Payer	
Admission Date	
Admission Diagnosis	
Discharge Diagnosis	
Readmission Date	
Readmission Diagnosis	
1. WHY? -	
2. WHY? -	
3. WHY? -	
4. WHY? -	
5. WHY? -	

	Yes	No
Medication related issue?		
Was teachback documented?		
Follow-up phone call 48-72 hours p/discharge?		
Was clear discharge plan documented?		
Did social conditions contribute to discharge?		
Is patient non-adherent with discharge plan?		
Did patient have Home Health/DME?		
Did HH see pt. prior to readmission?		
Did they receive the ordered DME post discharge?		
Consider Palliative Care Referral?		
Is the patient a potential referral (4 or greater readmissions) to Community Outreach?		

Review of 100 readmissions



Financial class

Financial Class	N	%
Medicare	46	49%
Managed Medicare	3	
Managed Medicaid	15	24%
Medicaid	4	
Medicare/Medicaid	5	
Self Pay	12	16%
Medicaid Pending	4	
Commercial	9	9%
VA	1	1%
County Hospital District	1	1%

26 (30%) are hospital dependent patients (6 or more admissions in last 1 year)

- Of the 61 remaining
  - 26 (43%) were medication related
    - Eg. Pt took 60U of insulin instead of 40U and admitted with BS32
  - 19 (31%) Psychosocial
  - 19 (31%) Non adherent

CARE Team Readmission Case Reviews				
	Categories	# of Cases	Total # of Cases	%
	Unrelated Readm	20	155	13
	Related Readm	135	155	87
	Readm w/in 7 days	41	155	26
	Readm 8-15 days	56	155	36.5
	Readm >15 days	58	155	37.5

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	Non-Preventable Readmissions			
	Hospital Dependent (6 or more Adms)	44	135	33
	Potentially Preventable Readmissions			
Patient Issues	Psych/Social issues	34	91	37
Patient Issues	Medication Related Issues	32	91	35
Patient Issues	Non adherent to D/C plan	32	91	35
Process Measures	Community Outreach Referral	20	91	22
Process Measures	Palliative Care Referral	9	91	10

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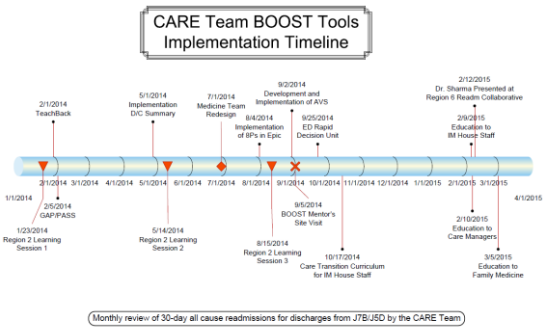
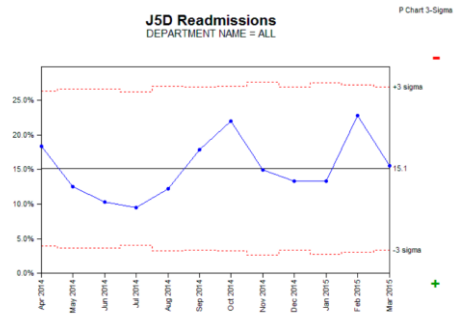
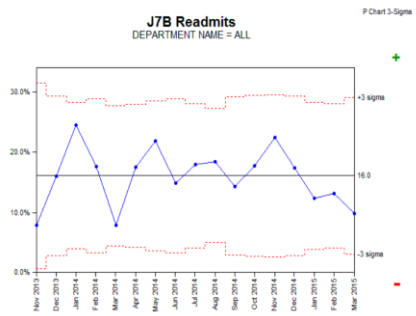


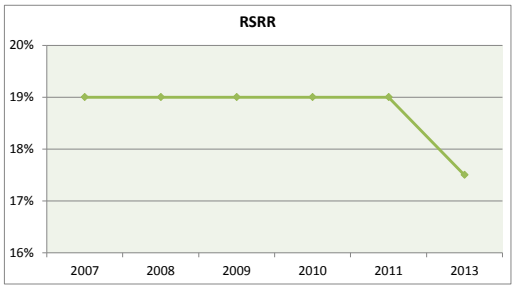




Comparison of 30-day readmission, LOS, mortality and number of admissions by month 2013-2014

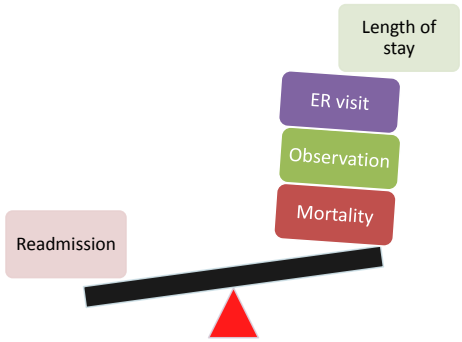
	30-day readmission		Mortality index		LOS		Admissions	
	2013	2014	2013	2014	2013	2014	2013	2014
Jan	18.23%	15.00%	0.77	0.67	3.6	3.67	2087	2014
Feb	15.78%	15.97%	0.76	0.61	3.7	3.55	1653	2011
Mar	14.42%	16.48%	0.5	0.99	3.2	3.29	2096	2158
Apr	15.04%	16.91%	0.95	1.06	3.4	3.21	2136	2223
May	15.28%	14.52%	1.22	0.52	3.8	3.43	2084	2236
Jun	14.56%	11.05%	1.09	0.83	3.9	3.22	2069	2230
Jul	16.97%	12.81%	0.82	0.99	3.9	3.27	2229	2419
Aug	15.99%	13.99%	1.24	0.79	4.1	3.17	2152	2404
Sep	13.78%	14.29%	1.08	0.92	3.8	3.61	2177	2465
Oct	14.68%	14.01%	0.77	0.81	3.8	3.29	2329	2521
Nov	12.21%	14.53%	1.28	0.83	3.8	3.3	2159	2136
Dec	13.78%	12.68%	0.9	0.9	3.8	2.96	2248	2388
Total	15.06%	14.35%	0.95	0.83	3.73	3.33	2118	2267
Net		**0.71**		**0.12**		**0.4**		**149**

Impact of HRRP on RSRR



http://innovation.cmc.gov/files/reports/patient-safety-results.pdf. Accessed Jun2014

Balancing measures



Summary

- 20% of readmissions are potentially preventable
- Interventions required to reduce readmissions are multidisciplinary and multicomponent and span across care sites
- 360º view of patients care should include balancing measures

When it comes to readmission there is no…….

Wrestling Readmissions to the Mat: Evidence and Efforts

Part 1: Controlling Avoidable Readmissions Effectively (Project C.A.R.E.)

Carol A. Huber, MBA

Gulshan Sharma, MD, MPH

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IMPROVEMENT SCIENCE RESEARCH NETWORK improving patient outcomes

Closing Remarks

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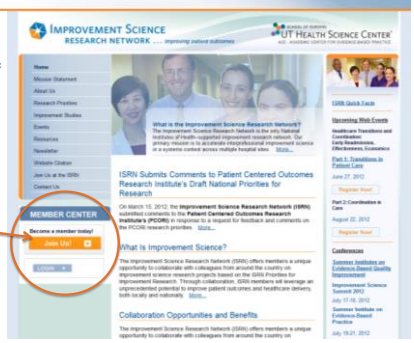
- Join Us!
  - For information on the ISRN or to become a member please visit our website: www.ISRN.net



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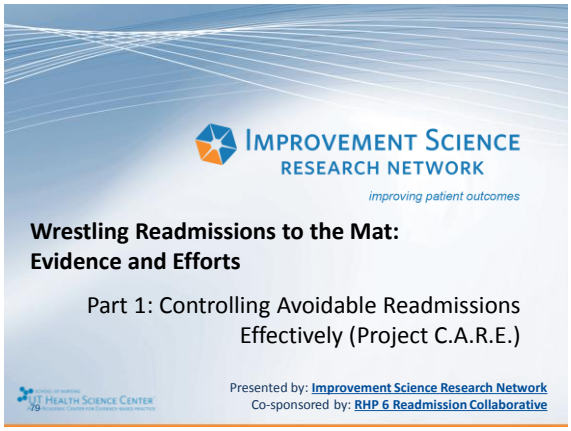
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