



Traditionally, efforts to reduce readmissions have focused on hospitals, but it is becoming clear that many factors along the care continuum influence readmissions. These innovative projects are taking a broader view of care transitions, and implementing a variety of interventions aimed at reducing readmissions.

# REDUCING AVOIDABLE READMISSIONS THROUGH BETTER CARE TRANSITIONS



**1 in 5:** number of Medicare patients discharged from a hospital who are readmitted within 30 days



**4 in 5:** number of patients about whom hospitals and primary care physicians have no direct communication after they leave the hospital



**October 2014:** date when hospitals with excessive readmissions will experience Medicare payment penalties of up to 3 percent



**\$500M:** amount set aside by the Affordable Care Act for hospitals with high readmission rates to improve care transitions for Medicare patients

## Care Transitions Intervention

Developed by Eric Coleman MD, MPH, and the University of Colorado, the Care Transitions Intervention is a four-week program in which a transition coach teaches patients with complex conditions how to manage their medications and how to respond if their condition gets worse. The model has been adopted by 750 organizations, including 34 communities that are part of the Centers for Medicare and Medicaid Services' Community-Based Care Transitions Program.

## Project RED (Re-Engineered Discharge)

Project Re-Engineered Discharge is a research group at Boston University Medical Center that develops and tests strategies to improve the hospital discharge process in a way that promotes patient safety and reduces re-hospitalization rates. RED relies on 12 discrete, mutually reinforcing components that have been proven to reduce re-hospitalizations and yields high rates of patient satisfaction, including access to primary and follow up care, language assistance, post-discharge outpatient services, and telephone support.

## Guided Care

Developed by the Roger C. Lipitz Center for Integrated Health Care at the Johns Hopkins Bloomberg School of Public Health, Guided Care puts nurses in partnership with physicians and others in a primary care practice to provide coordinated, patient-centered, cost-effective care to patients with multiple chronic conditions. The nurse conducts in-home assessments, facilitates care planning, promotes patient self-management, monitors conditions, coordinates the efforts of all care professionals, smoothes transitions between sites of care, educates and supports family caregivers, and facilitates access to community resources.

## Transitional Care Model

Developed by Mary Naylor PhD, FAAN, RN, and colleagues at the University of Pennsylvania, the Transitional Care Model (TCM) provides comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults hospitalized for common medical and surgical conditions. Transitional care nurses, who offer the skills of a nurse, care manager and patient advocate, are at the center of the model.

## Project BOOST

A national initiative of the Society of Hospital Medicine, Project BOOST (Better Outcomes by Optimizing Safe Transitions) combines multidisciplinary mentors with existing models to improve the care of patients as they transition from hospital to home. Mentors coach sites for a year on how to get institutional support, use data and integrate BOOST tools into their own organizations.

## CMS Community-based Care Transitions Program

The Community-based Care Transitions Program (CCTP), created by Section 3026 of the Affordable Care Act, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. Part of the Partnership for Patients, its goals are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high-risk beneficiaries, and to document measurable savings to the Medicare program. There are currently 82 organizations participating in the CCTP.

