The PAVE Project
(Preventing AVoidable Episodes)
Smoothing the Way For Better Transitions

THE HEALTH CARE IMPROVEMENT FOUNDATION
Building Partnerships For Better Health Care

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Readmissions on the Forefront

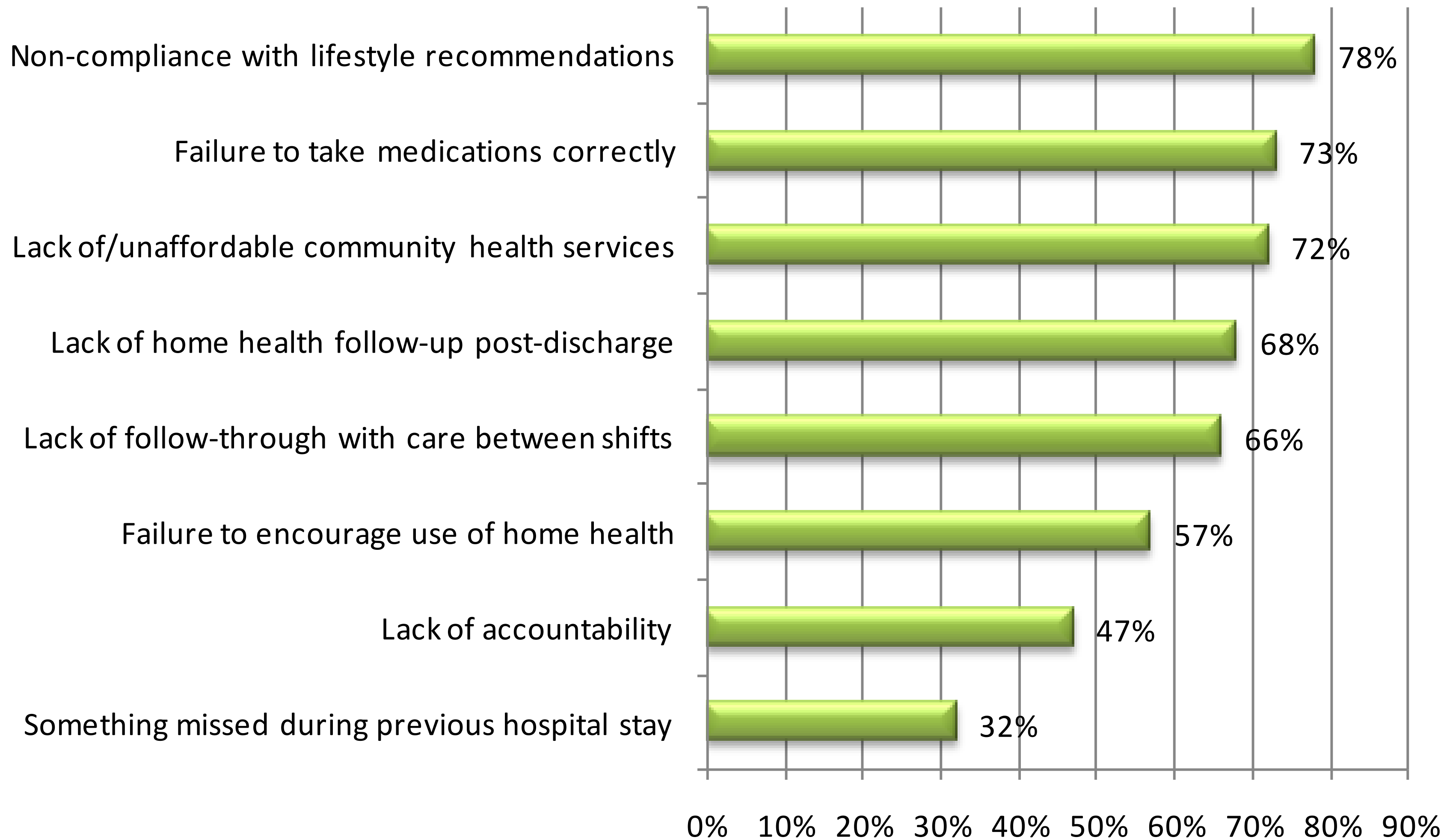
- Healthcare reform discussions by our national leaders.
- Centers for Medicare & Medicaid Services (CMS) and its discussions about limiting reimbursement for readmissions.
- Numerous initiatives with national and regional scopes are underway.
  - Institute for Healthcare Improvement (IHI)
    - Reducing Readmissions by Improving Transitions in Care Collaborative
    - Hospital to Home (H2H), co-sponsored by the American College of Cardiology for cardiovascular patients
  - Care Transitions Program
  - Project RED (Re-Engineered Discharge)
  - Transitional Care Model
  - STAAR Initiative (State Action on Avoidable Rehospitalizations)
  - Project BOOST (Better Outcomes for Older adults through Safe Transitions)

The Need for Action

- Nearly 20% of all Medicare hospital admissions result in a readmission within 30 days.
- More than one third (34%) are readmitted within 90 days.
- 50.2% of medical patients who were readmitted did not visit their physicians' offices between admissions.
- Readmission average length of stay for the same diagnosis was longer by 0.6 days.
- Estimated $17.4 billion dollars spent on preventable readmissions.

Source: SF Jencks, et al. "Readmissions among Patients in the Medicare Fee-for-Service Program" NEJM. April 2, 2009.

Top 30-Day Readmission Causes



Source: Cote, B, et al. "Reducing Hospital-SNF 30-Day Readmissions." CM Peer Review. January 2010.

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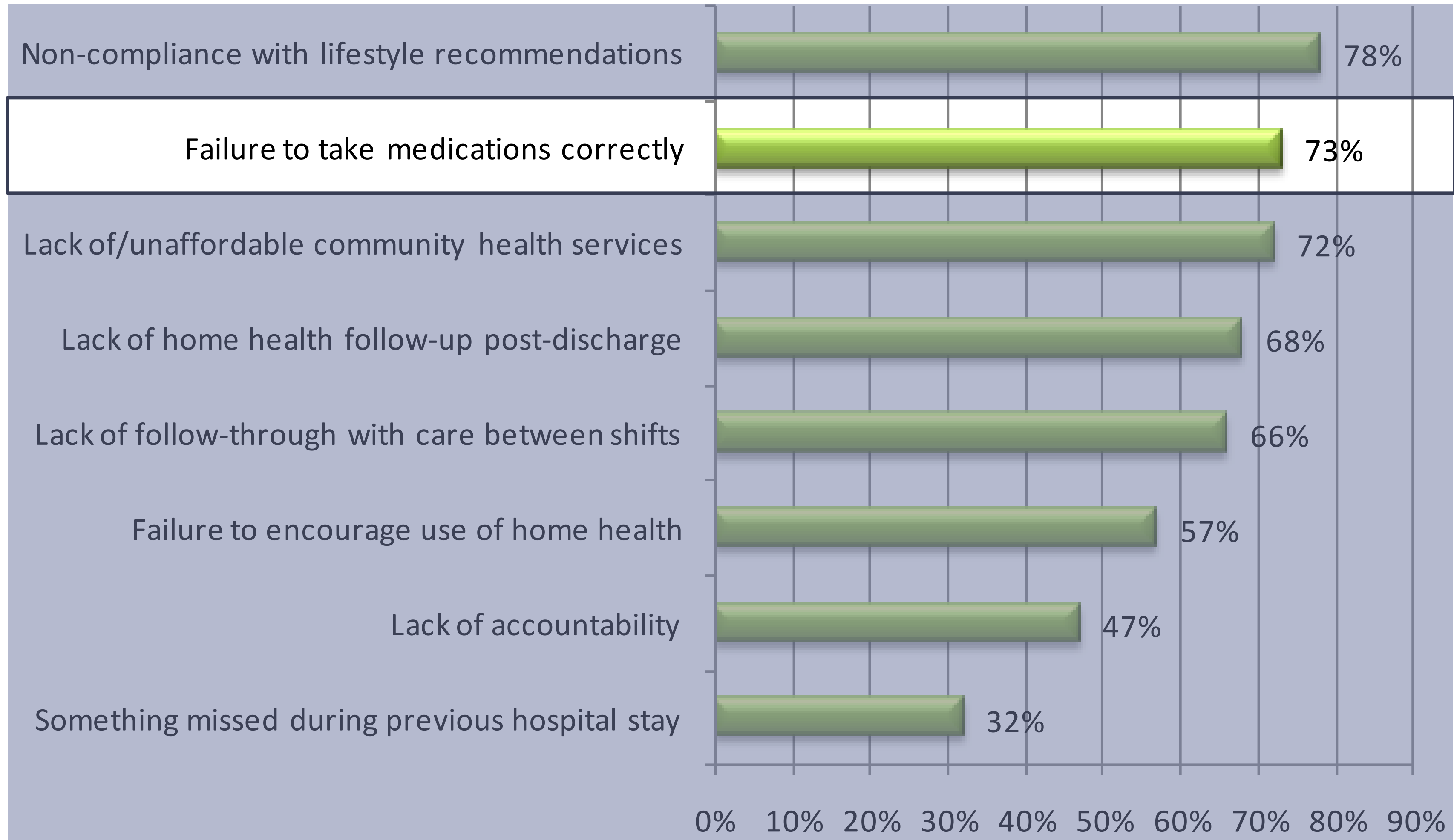

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Post-Hospital Medication Discrepancies

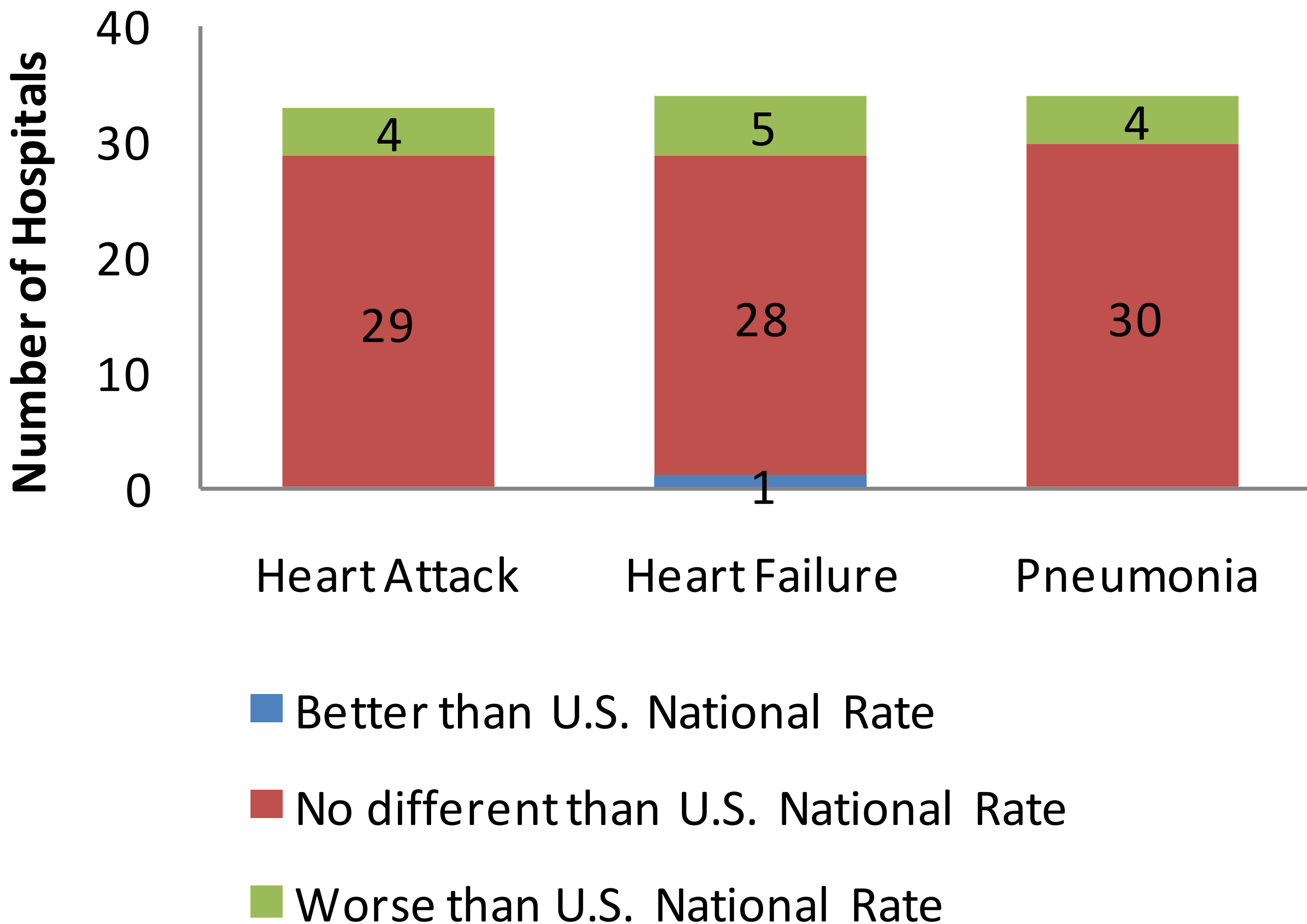
- 14.1% of the 375 patients included in the study experienced at least one medication discrepancy
  - 50.8% characterized as patient-associated
    - Non-intentional nonadherence (33.9%)
    - Financial barriers (5.6%)
    - Intentional nonadherence (4.8%)
    - Did not fill prescription (4.8%)
    - Others (1.6%)
  - 49.2% characterized as system-associated
    - Discharge instructions incomplete, inaccurate, illegible (16.1%)
    - Conflicting information (14.5%)
    - Duplication (8.1%)
    - Others (10.4%)

Source: EA Coleman, et al. Posthospital Medication Discrepancies, Arch Intern Med/Vol 165, Sep 12, 2005

Public Reporting of Readmission Rates

- Pennsylvania Health Care Cost Containment Council (PHC4) reports readmission rates:
  - All Causes
  - Due to Complications and Infections
- Centers for Medicare & Medicaid Services (CMS) reports 30-day hospital all-cause readmission rates for Medicare patients for three conditions:
  - Heart failure
  - Heart attack
  - Pneumonia
  - Proposed: Percutaneous coronary intervention in 2012

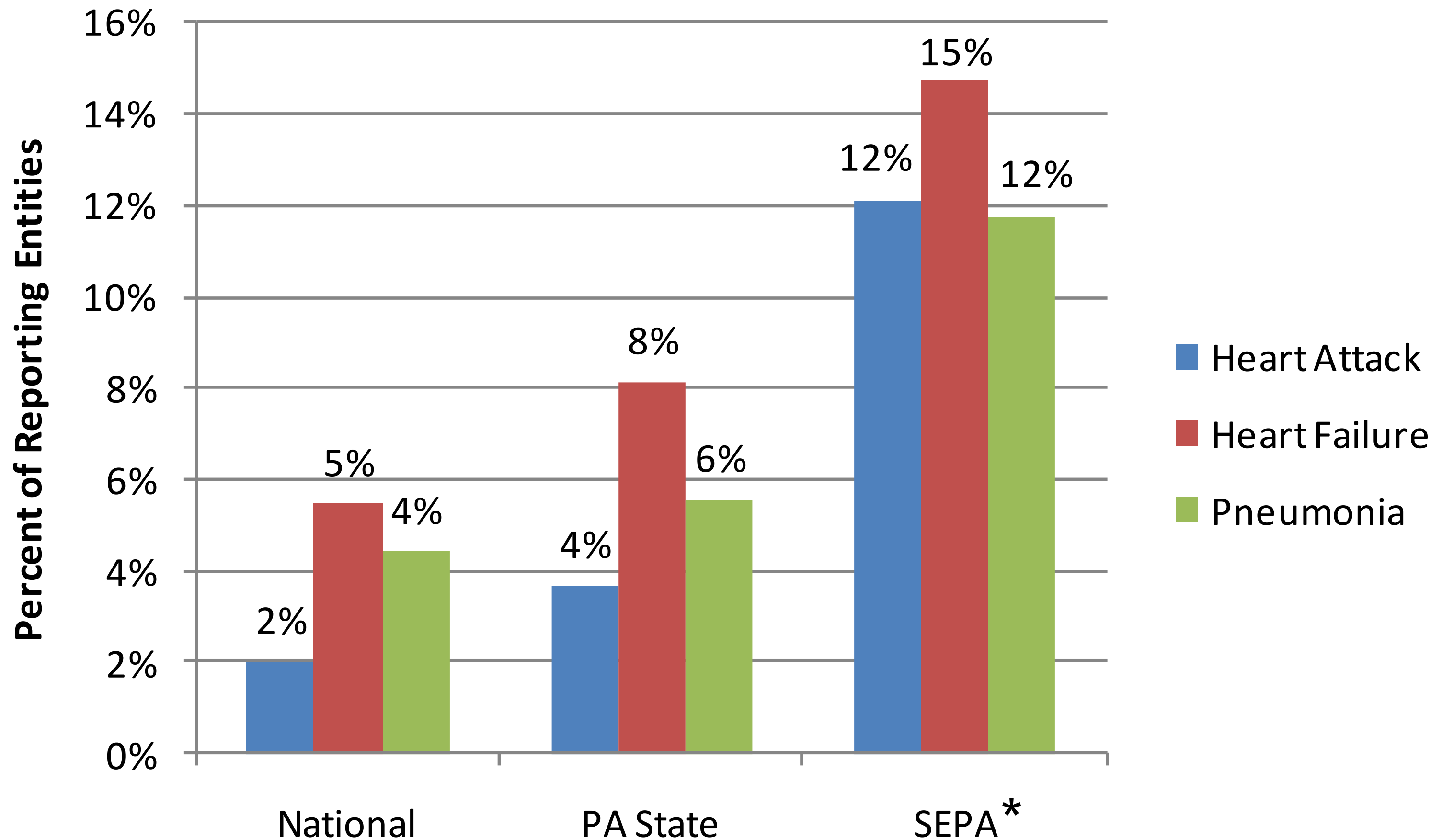
Entities in Southeastern Pennsylvania* By Results Category



*Southeastern PA 5-county region

Source: CMS, July-05 thru Jun-08

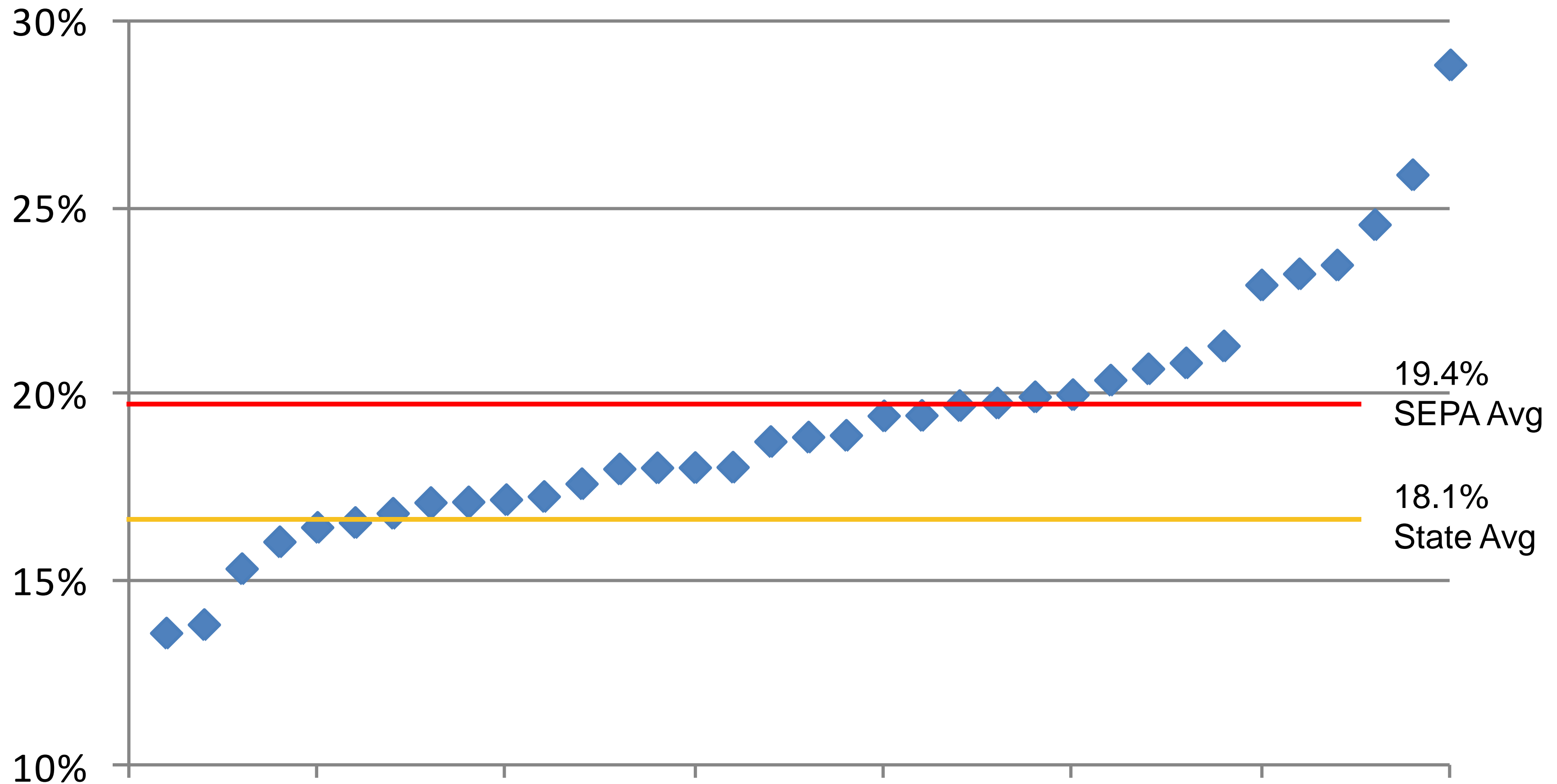
Percent of Entities "Worse Than US National Rate"



*SEPA=Southeastern PA 5-county region

Source: CMS, July-05 thru Jun-08

Hospitals By Readmission Rate All Causes For Reported Conditions



Source: PHC4 Hospital Performance Report Winter 2008 Update

Regional Symposium

The PAVE Project: Preventing AVoidable Episodes (PAVE)

- Wednesday, May 26, 2010 in Philadelphia, PA
- Three nationally-known keynote speakers
  - Eric Coleman, MD, MPH
    - Director of the Care Transitions Program at the University of Colorado Denver
  - Brian Jack, MD
    - Project RED Principal Investigator at Boston Medical Center
  - Mary Naylor, PhD, RN, FAAN
    - Director of the Center for Transitions and Health at the University of Pennsylvania, School of Nursing
- Legislative Update
- Topic-Specific Breakout Sessions

High-Level Timeline: The PAVE Project

Activity	1Q10	2Q10	3Q10	4Q10	1Q11	2Q11	3Q11	4Q11
Project Planning	*Feb-Mar*	*Apr-May*						
Kick-Off: Regional Symposium		*May*						
Hospital Recruitment		*June*						
Baseline Data Collection		*June*	*July*					
Convene Topic-Specific Workgroups			*Aug*					
Strategy Development Period			*Sep*	→	→	→	*Aug*	
Re-Measure and Share Successes								*Sep-Dec*

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