Preventing Readmissions
Clinical Approach

June 2017

Hospital readmission occurs when a patient is admitted to a hospital within a specified time period after being discharged from an earlier hospitalization. Medicare uses an “all-cause” definition of readmission, meaning that hospital stays within 30 days of a discharge from an initial hospitalization are considered readmissions, regardless of the reason for the readmission, excluding “elective” admissions for pre-planned procedures.

Essentials

- Preventing readmissions is an important way to improve quality and lower health care spending, accelerated by the incentives and penalties invoked by Centers for Medicare and Medicaid Services (CMS).
- PHS’ best practices to reduce readmissions include a coordinated discharge planning process, proactive post-discharge phone calls, and scaled interventions for high-risk populations.

PHS Success and Impact

Implementation of the LACE Strata of Interventions and the Transition of Care bundle has reduced hospital readmissions in the PHS Central Delivery System (CDS) from 10.0% to 9.0%. With each readmission costing an estimated $4,500, these interventions have resulted in a cost savings of approximately $700,000 per month.

What We Know About Readmissions

Hospitals are making significant progress at reducing readmissions; Centers for Medicare & Medicaid Services (CMS) reported the national readmission rate fell to 17.5 percent in 2013, after holding steady at around 19.5 percent for many years. While not all readmissions can or should be prevented, researchers have found wide variation in hospitals’ readmission rates, suggesting that patients admitted to certain hospitals are more likely to experience readmissions compared to other hospitals. While hospitals are working to reduce readmissions caused by clinical care practices, there are many other factors beyond hospitals’ control—including sociodemographic factors, such as poverty and lack of access to supportive services in the community—that increase the risk of readmission.

An early study showed that 60 percent of all medication errors occurred during times of transition: upon admission, transfer, or discharge of a patient. Medication errors can result in readmissions to the hospital as well as greater use of emergency, post-acute, and ambulatory services and duplication of services that needlessly increase the cost of care. Another study found that 19 percent of discharged patients experienced an adverse event within three weeks of leaving the hospital, and that simple transition of care strategies could have ameliorated or prevented 12 percent of these readmissions.
Incentive to Prevent Readmissions

An emphasis on reducing readmission rates has been accelerated by CMS, which currently modifies reimbursement to acute care institutions based on risk-adjusted readmission rates as a patient quality metric. Medicare’s Hospital Readmission Reduction Program (HRRP), as part of the Affordable Care Act (ACA), imposes financial penalty on hospitals with higher-than-expected readmissions for specific clinical conditions. The HRRP penalties took effect in fiscal year 2013; hospitals can incur a penalty of up to 3 percent of their Medicare payments.

Most U.S. hospitals will get less money from Medicare in fiscal 2016 because too many patients return within 30 days of discharge. Presbyterian Hospital (CDS) was one of 799 hospitals, among more than 3,400 hospitals subject to the Hospital Readmissions Reduction Program, that performed well enough on the CMS' 30-day readmission program to face no penalty. Other Presbyterian facilities, however, are subject to a penalty.

<table>
<thead>
<tr>
<th>Hospital</th>
<th>FY 2016 CMS Readmissions Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plains Regional Medical Center</td>
<td>-0.42%</td>
</tr>
<tr>
<td>Presbyterian Espanola Hospital</td>
<td>-1.16%</td>
</tr>
<tr>
<td>Presbyterian Hospital</td>
<td>0.00%</td>
</tr>
</tbody>
</table>

Furthermore, other key programs, such as Accountable Care Organizations (ACOs), bundled-payment initiatives, and the Independence at Home demonstration, include provider incentives to lower hospital admission and readmission rates, either directly or indirectly. The Community-based Care Transitions Program, also enacted by the ACA, is designed to assess ways that community-based organizations (such as local aging services agencies) might partner with hospitals to improve patients’ transitions to other settings, such as skilled nursing facilities or the patients’ home. Additionally, CMS has recently started allowing physicians to bill Medicare for “transitional care management” after a beneficiary’s discharge from a hospital or other health care facility. These incentives and penalties have collectively caused health systems to implement strategies to prevent unnecessary readmissions.

Risk Stratification

Some readmission reduction programs have focused on characterizing high risk patients using LACE scores. The LACE index has been derived and validated as a method to predict the risk of unplanned readmission within 30 days after hospital discharge in both medical and surgical patients. After a patient is discharged, a score is calculated based on length of stay (L), acuity of admission (A), co-morbidity (C), and emergency department use (E). A higher LACE score suggests a higher probability of patient readmission.

Patients classified in the higher risk strata may then be provided post-discharge transitions of care that include more intensive interventions. For example, these patients may get more frequent visits with their Care Coordinators.

Care Coordination

Care coordination involves the interaction of providers and health plan administrators across a variety of care settings to determine the most appropriate care for a patient. Transitions of care that include care coordination...
have produced positive outcomes for the patients and their caregivers, such as improved functional ability, reduced hospital admissions, and fewer nursing home placements. Formal care coordinators, such as an advance practice nurse supported by a physician, have been shown to be effective in improving post-discharge outcomes among high-risk elderly patients, including reducing readmission and ED utilization.

The National Transitions of Care Coalition (NTOCC) provides guidance regarding care coordination criteria, identified as essential by the National Quality Forum (NQF).

**PHS’ Approach to Preventing Readmissions**

PHS’ best practices to prevent readmissions include:

- a holistically-oriented discharge planning process
- proactive post-discharge phone calls
- scaled interventions to high-risk populations

**Discharge Planning**

Discharge planning is a coordinated service to assure that post-hospitalization follow-up care is appropriate for the member’s recovery and/or rehabilitation, and to prevent premature discharges, inappropriately extended admissions, and unnecessary or unplanned re-admissions. A care plan for each hospitalized patient is handled by an RN Case Manager and/or a Social Worker in collaboration with the multidisciplinary team of physicians, nurses, and rehabilitation professionals. In addition, Nurses are trained to communicate to the patient using the Teach-Back model, which helps the patient understand more fully the details of the treatment plan, including medications and follow up appointments. This evidence-based strategy of confirming understanding results in greater patient engagement and can improve safety during the transition of care.

**Post-Discharge Phone Calls**

A discharge Call Center Nurse calls each patient discharged from hospital or Kaseman SNF. The Nurse provides a phone call to ask the patient questions specifically related to the diagnosis and/or procedure. The Nurse reinforces the discharge instructions, and provides education as needed. The Nurse also helps patients with concerns regarding medications, durable medical equipment, and health issues the patient may be experiencing at time of call. In addition, the Nurse reminds the patient of the follow up appointment(s). The goal is to call high-risk patients (strata 4) within 24 hours and all other discharged patients within 48 hours. (See Discharge Call Center program abstract.)

**Scaled Interventions**

PHS uses LACE scores to identify higher risk patients and provides scaled interventions accordingly. LACE scores are derived using a custom algorithm and calculated automatically by Epic. A patient’s LACE score is generated upon admission (rather than upon discharge). LACE scores stratify into four categories: very low, low, moderate, and high risk for readmission.

Support for the patient is scaled to the stratum of risk, according the table below.
### PHS Risk-Stratified Interventions for Patients Discharged from Hospital

<table>
<thead>
<tr>
<th>Risk Strata</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>LACE Scores</strong></td>
<td>0-5</td>
<td>6-8</td>
<td>9-11</td>
<td>12-19</td>
</tr>
<tr>
<td><strong>Probability of Readmission</strong></td>
<td>Very Low</td>
<td>Low</td>
<td>Moderate</td>
<td>High</td>
</tr>
<tr>
<td>After discharge, Hospitalist sends a discharge summary receiving caregiver (PCP, specialist) within:</td>
<td>7 days</td>
<td>7 days</td>
<td>24 hours (via Epic)</td>
<td>24 hours (via Epic)</td>
</tr>
<tr>
<td>After discharge, Discharge Call Center nurse calls the patient to triage and to confirm PCP or specialist appointment within:</td>
<td>3 days</td>
<td>3 days</td>
<td>2 days</td>
<td>1 day</td>
</tr>
<tr>
<td>After discharge, Transition of Care (TOC) Nurse visits in-home: (for LACE 10+)</td>
<td></td>
<td></td>
<td>within 1-2 days</td>
<td></td>
</tr>
<tr>
<td>PCP or specialist appointment scheduled within:</td>
<td></td>
<td></td>
<td>14 days</td>
<td>7 days</td>
</tr>
<tr>
<td>Patient’s discharge instructions are reinforced via:</td>
<td>Nurse, phone</td>
<td>Nurse, phone</td>
<td>Nurse, phone</td>
<td>Nurse, in-home</td>
</tr>
<tr>
<td>Medication reconciliation delivered via:</td>
<td>Nurse, phone</td>
<td>Nurse, phone</td>
<td>Nurse, phone; Nurse, in-home</td>
<td>Nurse, in-home</td>
</tr>
<tr>
<td>Referral for a Palliative Care consult</td>
<td></td>
<td></td>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Referral to Case Management</td>
<td></td>
<td></td>
<td>✓</td>
<td>✓</td>
</tr>
</tbody>
</table>

These LACE Strata of Interventions were first implemented in September 2014.

### Transition of Care Programs

Hospitalized patients in the CDS, who have been identified as higher risk for readmission may be offered a bundle of services by one of the Transition of Care (TOC) programs, in which a Nurse provides care coordination through a series of visits, pre- and post-discharge. All patients seen by Transition of Care Nurses have LACE scores between 10 and 19 (strata 3 and 4). In addition, TOC nurses will visit all PHP Medicare Advantage patients in their home after a SNF stay regardless of LACE score or age/diagnosis. (See [Transition of Care Programs abstract](#).)

### Who Qualifies?

Either the Discharge Call Center or the Transition of Care Programs (or both) will provide follow up support after discharge. The type of transition of care support is determined by the patient’s age, LACE score, home location, payer, and engagement, according to the table below.
<table>
<thead>
<tr>
<th>Discharged from</th>
<th>Age</th>
<th>Risk Index</th>
<th>Patient or Member Location</th>
<th>Post-discharge Support Program</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>≥64</td>
<td>Stratum 4</td>
<td>Outside CDS</td>
<td>• Discharge Call Center</td>
<td>o Phone call w/in 24 hours</td>
</tr>
<tr>
<td>Hospital</td>
<td>&lt;64</td>
<td>Stratum 4</td>
<td>CDS Non-PMG</td>
<td>• Discharge Call Center</td>
<td>o Phone call</td>
</tr>
<tr>
<td>Hospital</td>
<td>&lt;64</td>
<td>Stratum 4</td>
<td>Outside CDS</td>
<td>• Discharge Call Center</td>
<td>o Phone call</td>
</tr>
<tr>
<td>Hospital</td>
<td>&lt;64</td>
<td>Lace 10+</td>
<td>Outside CDS</td>
<td>• Discharge Call Center</td>
<td>o Phone call</td>
</tr>
<tr>
<td>Hospital</td>
<td>18+</td>
<td>Lace 10+</td>
<td>PMG PHP capitated</td>
<td>• Discharge Call Center</td>
<td>o 30 days of follow up:</td>
</tr>
<tr>
<td>Hospital</td>
<td>18+</td>
<td>Strata 3, 2, 1</td>
<td>CDS</td>
<td>• Discharge Call Center</td>
<td>o Phone call</td>
</tr>
<tr>
<td>Hospital</td>
<td>18+</td>
<td>Strata 3, 2, 1</td>
<td>Outside CDS</td>
<td>• Discharge Call Center</td>
<td>o Referral (optional)</td>
</tr>
<tr>
<td>SNF</td>
<td>18+</td>
<td>Lace 10+</td>
<td>PMG PHP capitated</td>
<td>• Transition of Care Program</td>
<td>o In hospital visit</td>
</tr>
<tr>
<td>SNF (Kaseman only)</td>
<td>18+</td>
<td>Strata 4,3,2,1</td>
<td>All</td>
<td>• Discharge Call Center</td>
<td>o Phone Call</td>
</tr>
</tbody>
</table>

**Other Interventions that Prevent Readmissions**

A patient may be offered other support services, regardless of LACE scores, depending on the patient’s eligibility. These interventions include referrals to:

- Case Management for patients who, because of their risk stratum, may benefit from post-discharge care coordination
- A consultation for a New Mexico Orders for Scope of Treatment (MOST), for patients who are being referred to long term care (LTC) facility, according to the Advanced Healthcare Planning process
- Home and Transition Services (HATS) programs, including a home care assessment, assistance for the patient to return to some level of independent function, and access to House Calls Physicians. Some patients may enroll in specific home health programs:
  - **Complete Care**: personalized, in-home care, including prevention interventions and acute care management, for individuals with advanced illness; for Presbyterian Senior Care HMO (a Medicare Advantage Plan) members.
  - **Palliative Care Program**: specialized medical care for people with serious illnesses; available as inpatient, outpatient, and home care settings in the Central Delivery System.
### Key Tools

Midas is a data-capturing software for documenting opportunities for improvement, used in quality reporting and utilization review.

Epic is used to calculate of LACE scores, perform medication reconciliation, and manage discharge orders.

### Leadership

| Process Owner(s) | Juanita Venable, RN, BSN, ACM - Executive Director, IMM Case Management  
Ber nadette Melvin, RN, MSN - Manager, Discharge Call Center |
|------------------|----------------------------------------------------------------------------------------------------------------------------------|
| Clinical Champions | Debra Karl, RN - Director of Case Management  
Judy Sanchez, MSN, RN, NEA-BC - Director of Patient Care, Presbyterian RMC  
Brenda Perea RN, BSN, CCM - Manager of PMG Clinic Case Managers  
Renee Romero RN, BSN, CCM - Manager of PMG Clinic Case Managers  
Valerie Lotz, BSN, RN, CCM - Manager, Transition of Care |
| Governance Bodies | While no singular governing body oversees transition of care during discharge, distinct elements of the discharge process have involved specific work groups:  
- Case Management Clinical Advisory Workgroup  
- Nursing Clinical Advisory Workgroup and Forms committee  
- Physician Accountability Council  
- Physician Clinical Advisory Work Group  
- Primary Care Council (PCC)  
- Utilization Management Committee (UMC) |

### Measures of Success

<table>
<thead>
<tr>
<th>Objective</th>
<th>Measure</th>
<th>Actual Apr 2017</th>
<th>Target</th>
<th>Aligns with Aim</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce Hospital</td>
<td>CMS 30-Day Readmissions Condition Specific (Central Delivery System)</td>
<td>8.0%</td>
<td>8.3%</td>
<td>Better Health</td>
</tr>
<tr>
<td>Readmission Rate</td>
<td></td>
<td></td>
<td></td>
<td>Cost</td>
</tr>
<tr>
<td></td>
<td>• THA, TKA 30-day readmissions (PCNM)</td>
<td>3.9%</td>
<td>3.8%</td>
<td>Leadership</td>
</tr>
<tr>
<td></td>
<td>• AMI 30-day readmissions, age &gt;64 (PCNM)</td>
<td>6.8%</td>
<td>8.1%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• CHF 30-day readmissions, age &gt;64 (PCNM)</td>
<td>15.2%</td>
<td>14.4%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• CABG readmissions (Heart Service Line)</td>
<td>4.8%</td>
<td>8.0%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• PN 30-day readmissions, age &gt;64 (PCNM)</td>
<td>11.8%</td>
<td>15.2%</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• COPD 30-day readmissions, age &gt;64 (PCNM)</td>
<td>12.2%</td>
<td>17.3%</td>
<td></td>
</tr>
</tbody>
</table>

Readmission measures for specific conditions are calculated by CMS from claims submitted for Medicare Fee for Service patients. These specific conditions are: elective total hip/knee arthroplasty (THA, TKA), acute myocardial
infarction (AMI), heart failure (HF), coronary artery bypass graft (CABG), pneumonia (PN), and chronic obstructive pulmonary disease (COPD).

The Quality department reports monthly the CMS 30-Day Readmissions for CDS on PHS/PHP Board Quality Committee scorecard and on each of the CDS facility scorecards. In addition, THA/TKA readmissions are reported on the Surgery Service Line Scorecard; AMI, CHF, and CABG readmissions are reported on the Heart Service Line Scorecard; and readmissions for PN and COPD are reported on the Adult Medicine Service Line and Operational Scorecard.

Control Plan Metrics
A set of metrics regarding risk-stratified patients is analyzed, hospital-by-hospital, by the Population Health team and reported monthly to Case Management, Discharge Call Center, In-patient nursing, Hospitalists, and Primary Care. These metrics include:

Readmission Rate for Patients 65 and Older.
Patients in this population are likely to benefit from interventions offered by the Transitions of Care Programs.

LACE Scoring Completion.
Scores are generated automatically in Epic, but must be entered manually into each hospitalized patient’s medical record.

Discharge Summary Completion.
How soon after the patient is discharged the attending physician completes a Discharge Summary is tracked via Epic.

Coleman Discharge Preparation Checklist Completion.
Prior to discharge, a Nurse uses this patient education tool (derived from the Coleman model) to review information about care and treatment that is important for the patient to understand. The patient initials the checklist, and the completed form is scanned into Epic.

Patient Satisfaction.
The Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), also known as the CAHPS Hospital Survey, is a survey instrument and data collection methodology for measuring patients' perceptions of their hospital experience. Specific questions on the HCAHPS pertain directly to the discharge experience and transition of care (originating from the Coleman Model). A random sample of patients receives an HCAHPS after discharge. Responses to these questions are analyzed Press Gainey and reported monthly to process owners.

Readmission Questionnaire Completion.
Patients re-admitted to a hospital outside the Central Delivery System within 30 days of discharge are offered an optional questionnaire based on the Cleveland Clinic Readmission Patient Interview Form. This questionnaire provides data toward understanding the root cause(s) of the readmission.
Future Work

The Discharge Planning managers will look for ways to improve documentation and communication. The Discharge Call Center managers will identify ways to improve the call completion rate.

In addition, the Population Health team will pursue data regarding specific readmission prevention interventions:

- Measure Medication Reconciliation via Epic, resulting in improved medication reconciliation compliance.
- Measure MOST completion rate for patients entering a long-term care facility, thus increasing the number of avoidable readmissions.
- Fully implement the Readmission Questionnaire (Cleveland Clinic); analyze responses; and report regularly. This data will help PHS isolate the root cause(s) of readmissions.
- Measure the use of the Discharge Summary in communicating to non-PMG primary care clinics, resulting in improved communications with the non-PMG primary clinics.

Finally, these interventions will be assessed for their direct impact on readmission rates.

Glossary

care plan
A documented plan developed between the Care Coordinator, the patient/member and other pertinent members of the care team to assist the patient/member to manage their condition, maintain or improve their health status, maintain a safe environment, coordinate treatments, services and care, and to help the patient/member to achieve individual goals, objectives, and desired health, functional, and quality of life outcomes.

care coordination
Care coordination is a broad, complex process, involving collaboration among the patient, Providers, and health plan administrators, to determine the most appropriate plan of care for a patient. Typically, this encompasses an assessment of a patient’s needs, development and implementation of a plan of care, and evaluation of the care plan. Care coordination involves but is not limited to the following: planning treatment strategies; facilitating access to services; coordinating visits with specialists; organizing care to avoid duplication of diagnostic tests and services; monitoring outcomes and resource use; sharing information among healthcare professionals and family; actively managing transition of care such as hospital discharge; training caregivers; and ongoing reassessment and refinement of the care plan. Care coordination is member-centered, consumer-directed and family-focused, culturally competent, and strengths-based, and identifies medical and behavioral health needs.

Care Coordinator
“Care Coordinator” is an encompassing title that recognizes the Nurse Navigator, Care Manager, Case Manager, Social Worker, Behavioral Health Care Coordinator, or other licensed professional who works directly with the patient and family caregiver(s) to improve the quality of care and to reduce cost. All of these workers may serve as a patient’s Care Coordinator at some point in the continuum of care. As member of the multidisciplinary care team, the Care Coordinator:

- Facilitates timely access to appropriate care
- Ascertains the patient’s needs, via Health Risk Assessment and/or Comprehensive Needs Assessment
• Creates a care plan and promotes adherence to it, developed collaboratively with the patient and the Provider(s)
• Provides medication reconciliation
• Assists the patient’s comprehension through culturally and linguistically appropriate education
• Develops the patients’ ability for self-management and shared decision-making
• Promotes the utilization of preventative care
• Augments the continuity of care by managing relationships with tertiary care providers, transitions of care, and referrals
• Connects patients to relevant community resources

A Complex Care Coordinator works with chronically ill or high-risk patients: identifying them, tracking them over time, and aiming to keep them out of the hospital. Oftentimes, this involves triaging patients to lower-acuity settings that are appropriate to their needs. Case Managers assist patients by providing support advocacy, adherence assessment, motivational intervention, resource coordination, patient self-management coaching, and care planning. Case Managers ensure that information related to the patient’s current symptoms, medication list, advanced directives, adherence assessment, literacy, knowledge/comprehension, motivation, readiness to change, functional limitations, cognitive ability, coping ability, informal caregiver information, and professional caregiver contacts are stipulated in an accessible record. Case Managers working collaboratively with emergency department physicians, residents, hospitalists, community practitioners, managed care administrators, health plans, pharmacists, and employers have the opportunity to coordinate care by overseeing the transfer of information through any transitions. Case Managers utilize the Standards of Practice for Case Management from the Case Management Society of America, as well as base their practice within the Self-care Deficit Theory of Dorothea Orem. Within Presbyterian, PHP Case Managers, PMG Case Managers, and Home Health Case Managers may provide distinct services for specific populations of patients.

Coleman Model
Developed by Eric Coleman, MD, MPH, a member of the NTOCC advisory task force, the Care Transitions Intervention (CTI) is a transitions self-management model that encourages patients and caregivers assert a more active role during this vulnerable time. CTI not only prepares patients and caregivers for the immediate transitions but also simultaneously prepares them for future transitions. The intervention is low-cost, low intensity and yet as been shown to produce a sustained effect, reducing hospital readmissions.

LACE score
Derived in 2010 by a group of clinicians in Ontario, Canada, the LACE index is an objective measure used widely to predict the risk of unplanned readmission or death within 30 days after hospital discharge in both medical and surgical patients. It includes the length of hospitalization stay (“L”), acuity of the admission (“A”), comorbidities of patients (“C”), and emergency department use of patients (“E”). Studies of the LACE index have shown that a higher LACE score predicts a higher probability of patient readmissions; the scale is 0 to 19.

medication reconciliation
Whenever new therapy is ordered or new information becomes available, the patient’s medication regimen may be evaluated, with the goal of reducing potential harm related to medication utilization. This comparison addresses duplications, omissions, and interactions. This process may occur at any time during the patient’s care, including transitions when new medications are ordered and when existing orders are rewritten or adjusted.
Generally speaking, a hospital readmission occurs when a patient is admitted to a hospital within a specified time period after being discharged from an earlier (initial) hospitalization. For Medicare, this time period is defined as 30 days, and includes hospital readmissions to any hospital, not just the hospital at which the patient was originally hospitalized. Medicare uses an “all-cause” definition of readmission, meaning that hospital stays within 30 days of a discharge from an initial hospitalization are considered readmissions, regardless of the reason for the readmission; admissions for planned procedures that are not accompanied by an acute diagnosis do not count as readmissions in the measure outcome.

**Skilled Nursing Facility (SNF)**

A nursing facility that provides 24-hour non-acute nursing, medical, and rehabilitative care. SNFs are recognized by Medicare and Medicaid as meeting long term health care needs for individuals who have the potential to function independently after a limited period of care, as compared to the residential nature of a long-term care facilities or nursing homes. Most patients are admitted to a SNF facility after a hospital discharge to facilitate access to intensive rehabilitation services and/or ease their transition home. Presbyterian Kaseman Hospital has two inpatient SNF units.

**strata**

To facilitate care coordination, Presbyterian’s Population Health (previously called Integrated Care Solutions) team has objectively stratified LACE scores into four risk profiles, low (1) to high (4); PHS patients are offered post-discharge interventions based upon the stratum in which they are classified. For example, patients assigned to stratum 4 have the highest LACE scores (from 12 to 19) and the highest (≥97%) probability of readmission. These patients would be provided the most intensive interventions, such as in-home care within 24 hours plus Case Management services. Patients assigned to stratum 3 (LACE 9 to 11) have a fairly high probability of readmission (88%-96%), and would be eligible for high-level interventions, such as Case Management services. The most appropriate intervention for patients in stratum 2 (LACE 6 to 8) may be supported self-care. The stratum 1 (LACE 0-5) patients are generally low-risk, healthy patients who may need the least amount of post-discharge care.

**transition of care**

A transition of care, sometimes called a “hand-off”, occurs any time a patient leaves one care setting (i.e. hospital, skilled nursing facility, assisted living facility, primary care physician care, home health care, or specialist care) and moves to another setting or back to the patient’s home. This transition often involves several people, including the patient, family or other caregivers, nurses, social worker, case manager, pharmacist, physician, and other Providers. Transitions of care affect not only the patient but the health care professionals as well.

**References**

**Clinical Care Model**

- Advance Healthcare Planning Summary
- Complete Care
- Discharge Call Center
- Palliative Care
- Transition of Care Programs

**Additional Resources**

- CAHPS® Hospital Survey
- Care Transitions Intervention (CTI)®
- Institute for Healthcare Improvement: Reduce Avoidable Readmissions
- National Transitions of Care Coalition (NTOCC)
- Reducing Avoidable Readmissions Effectively (RARE)
- The Nationwide Readmissions Database