Overview of the Problem, Promising Approaches and IHI’s Approach to Reducing Readmissions

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Faculty Presenters

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Session Objectives

After this session participants will be able to:

- Understand the context and common problems that contribute to patients being readmitted to the hospital within 30 days of discharge
- Describe IHI’s approach to reducing avoidable readmissions
- Identify successful approaches to engaging staff and clinicians in all clinical settings to create an ideal transition home after an acute care hospitalization

Manifestations of Poor Transitions

- Medication errors
- Absence of follow-up care
- Greater use of hospital and emergency room
- Higher costs of care

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Readmissions Among Patients in the Medicare Fee-for-Service Program

- 1 in 5 Medicare Beneficiaries are readmitted in 30 days
- Among medical patients readmitted at 30 days:
  - 50% no bill for MD service between discharge and readmission
- Among surgical patients readmitted at 30 days:
  - 70% are readmitted with a medical (as opposed to a surgical) DRG


The Revolving Door Of Rehospitalization From Skilled Nursing Facilities

ABSTRACT Almost one-fourth of Medicare beneficiaries discharged from the hospital to a skilled nursing facility were readmitted to the hospital within thirty days; this cost Medicare $4.34 billion in 2006. Especially in an elderly population, cycling into and out of hospitals can be emotionally upsetting and can increase the likelihood of medical errors related to care coordination. Payment incentives in Medicare do not encourage providers to coordinate beneficiaries’ care. Revising these incentives could achieve major savings for providers and improved quality of life for beneficiaries.

Mor V, Intrator O, Feng Z, Grabowski DC. The revolving door of readmission from skilled nursing facilities. Health Aff (Millwood):29:57-64.
“The Billion Dollar U-Turn”

Readmissions are:

- **Frequent**
  - 20% Medicare beneficiaries readmitted within 30 days

- **Costly**
  - $17B in Medicare spending; $25B across all payers annually

- **Actionable for improvement**
  - Up to 76% potentially avoidable
  - CHF, CAP, AMI, COPD lead the medical conditions
  - CABG, PTCA, other vascular procedures lead surgical conditions

- **Highly variable**
  - Medicare 30-day readmission rate varies 13-24% between states
  - Variation greater within states

MedPAC Report to Congress, Promoting Greater Efficiency in Medicare, June 2007
Mark Taylor, The Billion Dollar U-Turn, Hospitals and Health Networks, May 2008
Commonwealth Fund State Scorecard on Health System Performance, June 2009
Confluence of National Attention

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Medicare Payment Advisory Commission (MedPAC)

Three policies to align incentives to reduce readmissions:

1) Public disclosure of hospital 30-day (risk-adjusted) readmission rates [www.hospitalcompare.hhs.gov](http://www.hospitalcompare.hhs.gov)
2) Adjust payment based on performance (i.e., penalties)
3) Bundling payment across hospitals and physicians

Readmission Penalties

**Beginning FY 2013:**
- Heart failure
- AMI
- Pneumonia

**Beginning FY 2015:**
- COPD
- Knee and Hip Joint Replacement
Medicare Post-Acute Care Transformation Act of 2014 (IMPACT)

- Signed into law October 6, 2014
- By 2022, payment rates will be tied to “individual characteristics instead of settings where the patient is treated
- Intended to streamline PAC sector by standardizing assessments - Continuity Assessment Record and Evaluation Item Set (CARE)
- Affects skilled nursing facilities (SNF), home health agencies, inpatient rehabilitation facilities (IRF), and long-term care hospitals (LTCH).

Medicare To Penalize 2,211 Hospitals For Excess Readmissions

By: ABIGAIL BADO
KHN Staff Writer
AUG 13, 2012

More than 2,000 hospitals—including some nationally recognized ones—will be penalized by the government starting in October because many of their patients are readmitted soon after discharge, new records show.

Together, these hospitals will forfeit about $260 million in Medicare funds over the next year as the government begins a wide-ranging push to start paying health care providers based on the quality of care they provide.

With nearly one in five Medicare patients returning to the hospital within a month of discharge, the government considers readmissions a prime symptom of an overly expensive and uncoordinated health system. Hospitals have had little financial incentive to ensure patients get the care they need once they leave, and in fact they benefit financially when patients don’t recover and return for more treatment.

Nearly 2 million Medicare beneficiaries are readmitted within 30 days of release each year, costing Medicare $17.5 billion in additional hospital bills. The national average readmission rate has remained steady at slightly above 18 percent for several years, even as many hospitals have worked hard to lower theirs.

The penalties, authorized by the 2010 health care law, are part of a multipronged effort by Medicare to use its financial muscle to force improvements in hospital quality. In a few months, hospitals also will be penalized or rewarded based on how well they adhere to basic standards of care and how patients rated their experiences. Overall, Medicare has decided to penalize around two-thirds of the hospitals whose readmission rates it evaluated, the records show.
Measuring Hospital Readmission: Far from a Perfect Science

- Numerator/denominator—what should count?
- Related/unrelated admissions?
- Planned/elective admissions?
- Risk adjustment?
- Observation status?
- Nursing home readmissions?

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Transitions of Care Consensus Policy Statement: American College of Physicians, Society of General Internal Medicine, Society of Hospital Medicine, American Geriatrics Society, American College of Emergency Physicians, and Society for Academic Emergency Medicine

Recent Evidence

- Gives us reason for pause
- Results are unimpressive and join growing number of mixed or negative studies in disease management/case management/care coordination
- We need to be careful not to over emphasize assessment, care planning, and patient education compared to patient/family caregiver engagement
- Time to shift from provider-centered care to patient-centered care

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Determinants of Preventable Readmissions

- Preventable readmissions have hallmark characteristics of healthcare events prime for intervention and reform
- Patients with generally worse health and greater frailty are more likely to be readmitted
- Identification of determinants does not provide a single intervention or clear direction for how to reduce their occurrence
- There is a need to
  - Address the tremendous complexity of contributing variables
  - Identify modifiable risk factors (patient characteristics and health care system opportunities)

The Bad News: There are No “Silver or Magic Bullets”!

….no straightforward solution perceived to have extreme effectiveness

Conclusion: “No single intervention implemented alone was regularly associated with reduced risk for 30-day rehospitalization.”


The Major Challenges

- Potentially preventable rehospitalizations are prevalent, costly, burdensome for patients and families and frustrating for providers
- No one provider or patient can “just work harder” to address the complex factors leading to early unplanned rehospitalization
- Problem is exacerbated by a highly fragmented delivery system in which providers largely act in isolation and patients are usually responsible for the own care coordination
- Most payment systems reward maximizing units of care delivered rather than quality care over time
Opportunities

- Many re-hospitalizations are avoidable
- Nationally we are making progress
- Keys to reducing re-admissions include:
  - Not focusing on the hospital alone
  - Aligning financial incentives
  - Addressing systematic barriers
  - Fostering leadership at the multiple levels
What can be done, and how?

There exist a growing number of approaches to reduce 30-day readmissions that have been successful locally

*Which are high leverage?*

*Which are scalable?*

Success requires engaging clinicians, providers across organizational and service delivery types, patients, payers, and policy makers

*How to align incentives?*

*How to catalyze coordinated effort?*

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The Good News: There are Promising Approaches to Reduce Rehospitalizations

- Improved transitions out of the hospital
  - Project RED
  - BOOST
  - IHI's Transforming Care at the Bedside and STAAR Initiative
    - Hospital to Home "H2H" (ACC/IHI)
- Reliable, evidence-based care in all care settings
  - PCMH, INTERACT, VNSNY Home Care Model
- Supplemental transitional care after discharge from the hospital
  - Care Transitions Intervention (Coleman)
  - Transitional Care Intervention (Naylor)
- Alternative or intensive care management for high risk patients
  - Proactive palliative care for patients with advanced illness
  - Evercare Model
  - Heart failure clinics
  - PACE Program; programs for dual eligibles
  - Intensive care management from primary care or health plan
Immediate Steps Your Organization Is Well-Positioned to Take…

All Arenas

- Include patients and family caregivers as partners in the care team
- Identify their specific learning needs and limitations (language, literacy, cognition)
- Support them in their self-care roles—build confidence and skills through simulation
Hospital Arena

- Do away with term “discharge”
- Facilitate opportunity for receiving care providers to engage in 2-way communication
- Set expectation that summaries be available within 72 hours

Ambulatory Arena

- Provide clear instructions on how to access after hours care
- Create access for hospital follow-up visits

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Home Health Care

- Consider making first visit before patient has left the hospital or nursing home
- Within rules and regulations, try to have one home care nurse work with a given ambulatory practice

QAPI Toolkits and Resources

QAPI at a Glance
- QAPI process tools
- QAPI topic tools
- Online learning modules
- Evidence & best practices
- Case Studies
- Online resource library

http://go.cms.gov/Nhqapi
Medications

- Support patients in medication reconciliation
- Encourage use of a single pharmacy
- Provide the indication for each medication
- Print a copy of the medication list after each encounter or modification/reconciliation

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Timely/Accurate Information Transfer

- Review and understand HIPAA
- Develop community standards for the content and format for information transfer
- Information transfer should proceed the patient’s physical transfer to the next setting

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Health Information Technology to Support Care Transitions

- Identify baseline cognitive and physical function
- Identify advance directives
- Identify family caregivers

Measure Performance

- Identify opportunities for improvement
- Include metrics on recidivism
- Include patient perspective
- Reward performance
Health Literacy and Activation to Promote Patient Engagement

- The importance of health literacy and activation to fully engage our patients is under appreciated.
- There is a strong evidence base for the value of routinely identifying health literacy and patient activation and then customizing our patient instructions and care plans.

How Much do Health Literacy and Patient Activation Contribute to Older Adults Ability to Manage their Health?

Judith Hibbard
Jessica Greene
University of Oregon
Institute for Policy Innovation and Research

Funding from AARP public Policy Institute
Activation Is Developmental

Level 1: Starting to take a role
Patients do not yet grasp that they must play an active role in their own health. They are disposed to being passive recipients of care.

Level 2: Building knowledge and confidence
Patients lack the basic health-related facts or have not connected these facts into larger understanding of their health or recommended health regimen.

Level 3: Taking action
Patients have the key facts and are beginning to take action but may lack confidence and the skill to support their behaviors.

Level 4: Maintaining behaviors
Patients have adopted new behaviors but may not be able to maintain them in the face of stress or health crises.

Increasing Level of Activation

Health Literacy and Activation are Related, but are not the same

Correlation = .2, p < .001, r-square = .035

Health Literacy

Patient Activation

(c) Judith Hibbard, PhD University of Oregon
Literacy vs Patient Activation

- For most of the behaviors, activation plays an equal or larger role than literacy.
- Taking on and maintaining new behaviors requires self-efficacy as well as knowledge.
- Taking on new behaviors also requires a belief that this is one’s “job” to manage health.
- Where information is the primary requirement (e.g. making Medicare choices), literacy plays a larger role.

Judith Hibbard, PhD University of Oregon

For More Information on the PAM

www.insigniahealth.com
## Changing Paradigms

<table>
<thead>
<tr>
<th>Traditional Focus</th>
<th>Transformational Focus</th>
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<tbody>
<tr>
<td>Immediate clinical needs</td>
<td>Whole person needs</td>
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<tr>
<td>Patients</td>
<td>Patient &amp; family members</td>
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<td>LOS &amp; timely discharge</td>
<td>Post-acute care plan for comprehensive needs</td>
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<td>Handoffs</td>
<td>Co-design of “handovers”</td>
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<tr>
<td>Clinician teaching</td>
<td>Patient &amp; family learning</td>
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<td>Location teams</td>
<td>Cross-continuum team</td>
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“We can’t solve problems by using the same kind of thinking we used when we created them.”

*Albert Einstein*
IHI’s approach to reducing avoidable readmissions

IHI’s Framework: Improving Care Transitions

- Transition from Hospital to Home or other Care Setting
- Transition to Community Care Settings and Better Models of Care
- Supplemental Care for High-Risk Patients

Key Design Elements
- Patient and Family Engagement
- Cross-Continuum Team Collaboration
- Health Information Exchange and Shared Care Plans
The quality of patients’ experience is the “north star” for systems of care.”  

–Don Berwick
Strategic Roles for Executive Leaders

- Include reducing the hospital’s readmission rate in strategic priority for the executive leaders at your hospital
- Know your hospital’s 30-day readmission rate
- Clarify your understanding of the problem
- Assess the financial implications of potential decreases in reimbursement from
- Declared your improvement goals
- Assess organizational capability to make improvements
- Specify how will you provide oversight for improvement initiatives, learn from the work, and spread successes

Co-Design of Handover Communications
Cross Continuum Teams

A team of hospital and community-based clinicians along with patients and family members:

- Provide oversight and guidance
- Help to connect improvement efforts across all care settings
  - Identify improvement opportunities
  - Facilitate collaboration to test changes
  - Facilitate learning across care settings
- Provide oversight for the initial pilot unit work and establish a dissemination and scale-up strategy

CCTs:

- Are one of the most transformational changes in IHI’s work to improve care transitions
- Reinforce the idea that readmissions are not solely a hospital problem
- Need engagement at two levels:
  1) Executives remove barriers and develop overall strategies for ensuring care coordination
  2) Front-line leverages the power of “senders” and “receivers” co-designing processes to improve transitions of care

Collaboration across care settings is a great foundation for integrated care delivery models (e.g. bundled payment models, ACOs)
Diagnostic Case Reviews

- Provide opportunities for learning from reviewing a small sampling of patient experiences
- Engage the “hearts and minds” of clinicians and catalyze action toward problem-solving:
  - Teams complete a formal review of the last five readmissions every 6 months (chart review and interviews)
  - Members from the cross-continuum team hear first-hand about the transitional care problems “through the patients’ eyes”

Rebecca’s Story

Rebecca Bryson lives in Whatcom County, WA and she suffers from diabetes, cardiomyopathy, congestive heart failure, and a number of other significant complications; during the worst of her health crises, she saw 14 doctors and took 42 medications.

In addition to the challenges of understanding her conditions and the treatments they required, she was burdened by the job of coordinating communication among all her providers, passing information to each one after every admission, appointment, and medication change.

http://www.ihi.org/offerings/Initiatives/STAAR/Pages/Materials.aspx#videos
Rebecca Bryson

Rebecca dreams of an ideal tool that would help her keep her care team all on the same page.

She described typical medical records as “location or process centered, not patient-centered.” She also describes how difficult it can be for patients to navigate a large health care system.

Rebecca summarizes her experience in this way – “Patients are in the worst kind of maze, one filled with hazards, barriers, and burdens.”

http://www.ihi.org/offerings/Initiatives/STAAR/Pages/Materials.aspx#videos
Four Guides on Transitions

- Senders:
  - From Hospital to SNF or Home

- Receivers:
  - Office Practice
  - Home Care
  - Skilled Nursing Care Facilities

How-to Methods

http://www.ihi.org/resources/Pages/Tools/HowtoGuideImprovingTransitionstoReduceAvoidableRehospitalizations.aspx

Key Changes to Achieve an Ideal Transition from Hospital (or SNF) to Home

1. Partner with Patient and Family to Identify Post-Hospital Needs
2. Provide Effective Teaching and Facilitate Learning
3. Create and Activate a Post-Hospital Follow-up Plan
4. Provide Real-Time Handover Communications
Systematic Review of Risk Prediction Models

**Conclusions:** Most current readmission risk prediction models that were designed for either comparative or clinical purposes perform poorly.

Although in certain settings such models may prove useful, efforts to improve their performance are needed as use becomes more widespread.


IHI’s Approach: Assess the Patients Medical and Social Risk for Readmission

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<tr>
<th>High-Risk</th>
<th>Moderate-Risk</th>
<th>Low-Risk</th>
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<tr>
<td>• Admitted two or more times in the past year&lt;br&gt;• Patient or family caregiver is unable to Teach Back, or has a low confidence to carry out self-care at home</td>
<td>• Admitted once in the past year&lt;br&gt;• Patient or family caregiver is able to Teach Back most of discharge information and has moderate confidence to carry out self-care at home</td>
<td>• No other hospital stays in the past year&lt;br&gt;• Patient or family caregiver has high confidence and can Teach Back how to carry out self-care at home</td>
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When are patients being readmitted?

- Initial readmissions spike within 48 hours of discharge
- 66% of readmissions occur within 15 days

Post-acute Follow-up Care: Prior to Discharge

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<th>Moderate-Risk</th>
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<tr>
<td>• Schedule a face-to-face follow-up visit within 48 hours of discharge. Assess whether an office or home health care is the best option for the patient.</td>
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<tr>
<td>• If a home care visit in 48 hours, also schedule a physician office visit within 5 days.</td>
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<tr>
<td>• Initiate intensive care management as indicated (if not provided in primary care or in outpatient specialty clinics)</td>
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<td>• Provide 24/7 phone number for advice about questions and concerns.</td>
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<tr>
<td>• Initiate a referral to social services and community resources as needed.</td>
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<tr>
<td>• Schedule a follow-up phone call within 48 hours of discharge and a physician office visit within 5 to 7 days.</td>
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<tr>
<td>• Initiate home health care services (e.g. transition coaches) as needed.</td>
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<td>• Schedule follow-up phone call within 48 hours of discharge and a physician office visit as ordered by the attending physician.</td>
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Key Changes for Improving Transitions to the Clinical Office Practice

1. Ensure timely and appropriate care following hospitalization
2. Prior to the visit: Prepare patient and clinical team
3. During the visit: Review or initiate care plan
4. At the conclusion of the visit: Communicate and coordinate on-going care plan to other team members
Key Changes for First Home Health Care Visit Post-discharge

1. Meet the patient, family caregivers, and inpatient caregivers in the hospital and review transition home plan
2. Assess the patient, initiate plan of care, and reinforce patient self-management at first post-discharge home health care visit
3. Engage, coordinate, and communicate with the full clinical team

Key Changes for Improving Transitions to Skilled Nursing Facilities

1. Ensure SNF Staff Are Ready and Capable to Care for the Resident
2. Reconcile Treatment Plan and Medications
3. Engage the Resident and Family in a Partnership to Create an Overall Plan of Care
Post-acute Plan of Care for Residents Transitioning to SNFs or Rehab

- a reliable transition of care after the resident is discharged from the hospital (review plan of care, medication reconciliation, etc.)
- continuity of care with an MD or APN
- proactive advanced illness planning with the patient and family members
- reliable evidence-based care in the SNFs (fall prevention, care of patients with HF, etc.)
- timely assessment of changes in clinical status of residents and a plan to address common conditions

Lessons Learned

- Local learning about the process failures and problems that exist is core to success
- Knowledge of patients’ home-going needs emerges throughout hospitalization
- Family caregivers and clinicians and staff in the community are important sources of information about patients’ home-going needs
- Through Teach Back we learn what patients know about their conditions and self-care needs
Lessons Learned

- Cross-continuum team partnerships transform care processes together
- “Senders” and “receivers” partnerships agree upon and design the needed local changes
  - Vital few critical elements of patient information that should be available at the time of discharge to community providers
  - Written handover communication for high risk patients is insufficient; direct verbal communication allows for inquiry and clarification

Lessons Learned

- Appropriate and timely follow-up care is dependent on availability and payment for services
- There are no universally agreed-upon risk assessment tools
  - We need a much deeper understanding of how best to meet the needs of high-risk patients
  - Use practical methods to identify modifiable risks
Lessons Learned

- Reducing readmissions is dependent on highly functional cross-continuum teams and a focus on the patient’s journey over time
- Providing intensive care management services for targeted high risk patients is critical
- Reliable implementation of changes in pilot units or pilot populations require 18 to 24 months

Contemporary Evidence about Hospital Strategies for Reducing 30-day Readmissions

- Cross-sectional study of hospitals enrolled in the Hospital to Home (H2H) initiative to determine prevalence of practices being implemented or patients with HF or AMI
- Although most hospitals had a written objective of reducing preventable readmissions, the implementation of recommended practices varied widely
  - 49.3% of hospitals partnered with community MDs
  - Inpatient and outpatient prescription records were electronically linked in 28.9% of hospitals
  - Discharge summary was sent to the primary care doctor in 25.5% of hospitals
  - On average, 4.8 of 10 recommended practices were implemented

Ohio Hospital Association Work Results in Hospital Readmission Reductions

AUGUST 2, 2012

OHA’s Quality Institute worked to decrease hospital readmissions through the Ohio State Action on Avoidable Rehospitalizations (STAAR) Initiative. Eighteen hospitals participated, and results showed an eight percent greater reduction in STAAR hospitals’ readmissions than other Ohio hospitals’. The Columbus Dispatch reported that hospital readmissions in Ohio dropped six percent in 18 months and accredited the STAAR program as a factor in the decrease.

prepared at the request of the Center for Medicare and Medicaid Innovation (CMMI)
An Early Look at a Four-State Initiative to Reduce Avoidable Hospital Readmissions

By Amy E. Boutwell, Marlin Bihrlie Johnson, Patricia Rutherford, Sam R. Watson, Nancy Vecchiano, Bruce S. Attkisson, Paul Grives and Patricia Noga, and Carol Wagner

Abstract: Launched in 2009, the State Action on Avoidable Rehospitalization initiative, known as STAAR, aims to reduce rates of avoidable rehospitalization in Massachusetts, Michigan, Ohio, and Washington by mobilizing state-level leadership to improve care transitions. With the program two years into its four-year cycle, 148 hospitals are working in partnership with more than 500 cross-continuum team partners. Although there are no publicly available data on whether the project is achieving its primary goal of reducing avoidable rehospitalizations, the effort has so far been successful in aligning numerous complementary initiatives within a state, developing statewide rehospitalization data reports, and mobilizing a sizable number of hospitals to work on reducing rehospitalizations. More than 90 percent of participating hospitals have formed teams to routinely review rehospitalizations with their community-based colleagues.
Summary

- Rehospitalizations are frequent, costly, and actionable for improvement.
- The IHI approach acts on multiple levels – engaging hospitals and community providers, communities, and state leaders in pursuit of a common aim to reduce avoidable rehospitalizations.
- Working to reduce rehospitalizations focuses on improved communication and coordination over time and across settings:
  - With patients and family caregivers;
  - Between clinical providers;
  - Between the medical and social services (e.g. aging services, etc.).
- Working to reduce rehospitalizations is one part of a comprehensive strategy to promote patient-centered care and appropriate utilization of health care resources.

Care Transitions Resources

- www.caretransitions.org
- www.NTOCC.org
- www.nextstepincare.org
- www.hospitalmedicine.org/BOOST
- www.ihi.org/explore/Readmissions/Pages/default.aspx
- www.pacdemo.rti.org
- www.hospitalcompare.hhs.gov
- www.teachbacktraining.com
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Co-Principal Investigators, STAAR Initiative
Institute for Healthcare Improvement

http://www.ihi.org/IHI/Programs/StrategicInitiatives/STateActiononAvoidableRehospitalizationsSTAAR.htm

BREAK