Preventing Readmissions: Creating Systematic Solutions

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Broad Categories of Interventions

- Improve communication: "defragment" the system
  - Transition of care
    - Teach back
    - Medication reconciliation
  - IT interfaces
- Provide the proper intensity of care (in the right setting)
  - Use the SNF/TCU as an alternative to admission
  - Urgent Care v. ED
  - Shared decision making: informed choice
  - Home care
  - Case Management/Disease Management (must have a component of face to face interaction)

Stratifying Patients into the Appropriate Programs

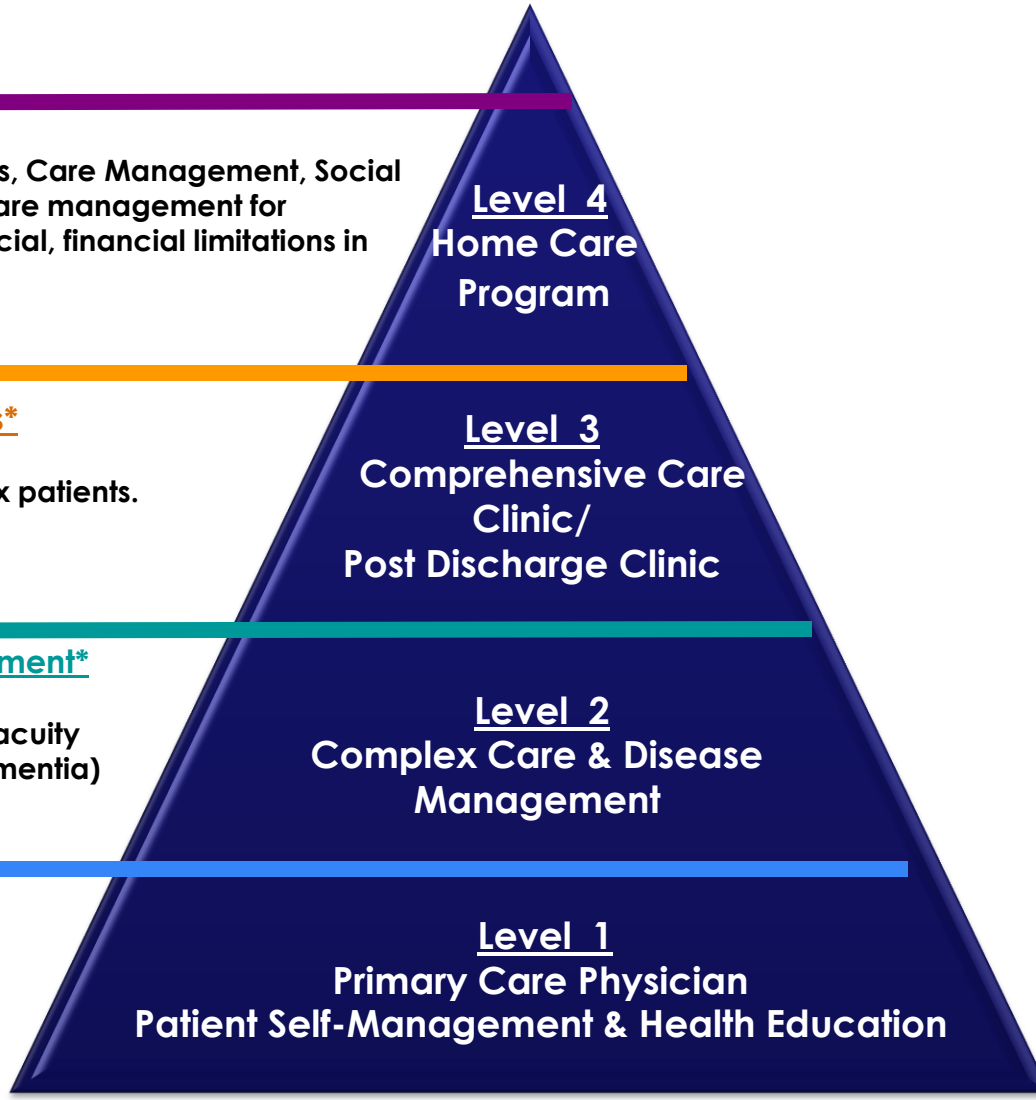
Hospice/Palliative Care

Home Care Program*
Multidisciplinary team (Physicians, Nurse Practitioners, Care Management, Social Workers) provides in-home medical and palliative care management for chronically vulnerable patients (physical, mental, social, financial limitations in accessing outpatient care)
*Most aspects can be done within a PCMH

Comprehensive Care and Post Discharge Clinics*
Intensive one-on-one physician /patient care
case management for the highest risk, most complex patients.
When stable, patients are transitioned to Level 2
*Can also be done within a PCMH

Complex Care Management / Disease Management*
Provides long-term enhanced care oversight & multidisciplinary team approach for complex, high acuity patients (diabetes, COPD, CHF, CKD, depression, dementia)
Can also be done within a PCMH

Primary Care Physician
Motivates, educates & engages patients to get involved in their care & self-management with their PCP & Care Team



Medical Management Programs