NATIONAL QUALITY FORUM

Meeting Summary

Readmissions Action Team

The National Quality Forum (NQF) convened a web meeting of the Readmissions Action Team on April 29, 2014. An online archive of the meeting is available by clicking here.

Action Team Member Attendance

Readmissions Action Team Members	
Name	**Organization**
Lois Cross (Chair)	*American Case Management Association*
Osman (Ozzy) Ahmed	*Magellan Complete Care,*
Sumita Bhatia	*Kaiser Permanente*
Sarah Callahan	*America's Essential Hospitals*
Pamela Carroll-Solomon	*CHE Trinity Health*
Maureen Dailey	*American Nurses Association*
Elizabeth Davis	*San Francisco General Hospital*
Lisa Freeman	*Patient Advocacy of Connecticut*
Tejal Gandhi	*National Patient Safety Foundation*
Antony Grigonis	*Select Medical*
Sandy Markwood	*National Association of Area Agencies on Aging*
Diane Meier	*Center to Advance Palliative Care*
Stacy Ochsenrider	*Bronson Methodist Hospital*
Thomas Smith	*American Psychiatric Association*
Karen Southard	*The Carolina's Center for Medical Excellence*

Welcome and Overview of Meeting Objectives

Led by Lois Cross, American Case Management Association, Action Team Chair

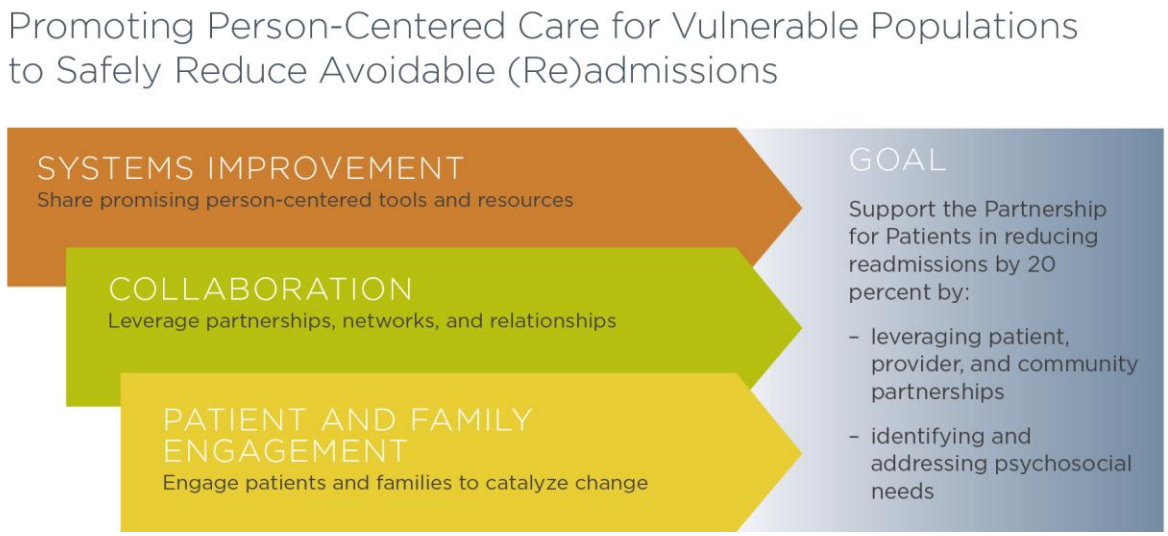
Ms. Cross welcomed the group and reviewed the meeting objectives, which were to:

- Present the Readmissions Action Pathway;
- Feature successes from fellow action team members' work as it relates to the Action Pathway; and
- Share Action Pathway resources and strategies.

Action Team Pathway
Led by Lois Cross

Ms. Cross presented the team's final Readmissions Action Pathway (Figure 1 below), which focuses on promoting person-centered care for vulnerable populations to safely reduce avoidable readmissions. The action team will focus more specifically on leveraging patient, provider, and community partnerships, and on identifying and addressing patients with psychosocial needs. The strategies it will advance include working together across stakeholder groups to enhance systems improvement, collaboration, and patient and family engagement. The group's efforts in sharing and spreading best practices and approaches to improving the quality of care aligned with the aforementioned strategies will serve as a vital driver in fostering both individual and collective efforts to further progress.

Figure 1: Readmissions Action Pathway



Cross-Team Learning
Led by Lois Cross

This session provided an opportunity for action team members to showcase best practices and approaches to improving the quality of care through presentation of their work. This call featured two presentations, offering the following perspectives on best practices:

- **The PACT (Preventable Admissions Care Team) Program**. Maria Basso Lipani provided an extensive overview of Mount Sinai Hospital's PACT Program, a social worker led program starting at admission and continuing through post-discharge. It utilizes assessment and intervention to identify and address psychosocial strains that compound readmission risks, to provide seamless transitions to home and to support the patient in successfully managing care in the community. When done correctly patients are more willing to work with their care team leading to a uniquely crafted intervention that will positively impact the patient's circumstances. The results of the PACT program have been significant – a 43 percent reduction in admissions

and 54 percent reduction in emergency room visits for patients who completed the PACT 5-week intervention.

- **Sharing Community Care Transitions in Rural North Carolina**. Karen Southard and Eleanor Everett, presented the Carolinas Center for Medical Excellence Community-based Care Transitions Program (CCTP). The goals of the CCTP 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. They provided two examples in which community coalition interventions in less affluent counties led to significant results, including a reduction in hospital admissions and readmissions, an increase in the hospital patient satisfaction scores, and improvements in medication adherence.

Discussion: Sharing Resources and Strategies to Reach our Goal

Led by Lois Cross

This session provided an opportunity for individual action team members to share their commitments based on the team's three-part strategy and to identify specific things they can do to raise awareness, model, or build on this work. Ms. Cross began the discussion by offering to share the PACT and North Carolina's transitional care program with the American Case Management Association and the Intermountain led Hospital Engagement Network (HEN) to reduce readmissions. Others mirrored Ms. Cross's example and offered the following commitments:

- Karen Southard offered to endorse the models and facilitate the conversation among the QIOs;
- Sarah Callahan offered to present the models to America's Essential Hospitals HEN network;
- Sandy Markwood offered to spread the models among the National Association of Area Agencies on Aging and identify opportunities to share with other partner groups; and
- Lisa Freeman offered to conduct patient and family engagement workshops in the community and collaborate with other organizations as a patient voice to share resources for preventing readmission.

Opportunity for Member and Public Comment

There were no questions or comments from the public.

Next Steps

Led by Allison Ludwig

The meeting concluded with an overview of next steps, which include:

- Homework assignment highlighting each member's commitment to a specific action related to one or more of our action pathway strategies.
- The next meeting will be our in-person meeting on June 4, in Washington DC.