



# Readmission Management

**5 reasons healthcare organizations  
must reduce preventable readmissions...  
and 10 strategies that get results.**

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## Introduction

Hospitals with excessive preventable readmissions stand to lose millions due to healthcare reform's first pay for performance (P4P) initiative<sup>1</sup>. Exactly how many readmissions can and should be prevented? The number varies from expert to expert, ranging anywhere from 20 to 75 percent.<sup>2</sup> The approximate midpoint of this range, 40 percent, equates to one million re-hospitalizations annually. Considering hospitalizations count for nearly one-third of all healthcare expenditures, the cost of these re-hospitalizations is significant.

Piedmont Hospital, a 481-bed, acute care, Atlanta-based hospital, brings in approximately \$450 million each year. Piedmont's hospital leadership realized Medicare's policy would potentially cost their organization anywhere from \$1 million to \$30 million a year. This projected cost variance is wide because private health plans may follow the CMS' lead on the P4P initiative.<sup>3</sup>

Health plans will likely follow CMS' lead and penalize hospitals with high readmissions. WellPoint, which has 34 million members in its affiliated health plans and serves more than 70 million through its subsidiaries, is establishing a new system to help offset rising costs in 14 states. This new system will withhold pay increases from hospitals that do not score high enough on 51 indicators of treatment quality. One indicator is whether the hospital tries to prevent patients from relapsing after they leave the hospital. WellPoint began testing this new approach in 2004, grading hospitals on whether they created discharge plans that promoted medication adherence and physician follow-up appointments. Preventable readmissions, notes WellPoint, can cost a hospital \$2 million a year.<sup>4</sup>

But penalties aren't the only reason to implement a plan to reduce preventable readmissions. Most hospital leadership and clinicians agree it's not even the best one. Reducing preventable readmissions is tied to the overarching goal of healthcare reform: quality, affordable healthcare for all Americans.

*The objective is to reduce readmissions that could be prevented by taking steps during and following the inpatient stay.*

## Readmission Management

In the context of this paper, readmission management is any initiative by hospitals to help reduce potentially preventable readmissions that occur within the first 30 days of discharge. While a standard or best practice readmission management plan does not yet exist, most hospitals with success stories have several commonalities, which are outlined in the Top 10 list.

Because the ultimate goal of healthcare reform is to improve quality of care, it is important to note that hospitals are not being tasked with reducing all readmissions. Rather, the objective is to reduce readmissions that could be prevented by taking steps during and following the inpatient stay. By reducing these preventable readmissions, an organization will improve care for all patients, including those whose readmissions were necessary and unavoidable. In short, readmission management is a patient-centered initiative that drives positive financial results. In addition to facilitating the best care for each patient, it helps hospitals avoid penalties and use resources more effectively.

# Five reasons why organizations must reduce preventable readmissions

## 1) To avoid CMS reimbursement penalties

In its 2008 recommendation to Congress, the Medicare Payment Advisory Commission (MedPAC) reported that in 2005, 17.6 percent of admissions were readmitted within 30 days of discharge. That same year, potentially preventable readmissions accounted for \$12 billion in Medicare spending, equating to an average payment of approximately \$7,000 per case.

To address this problem, the Patient Protection and Affordable Care Act (PPACA) statute penalizes hospitals with higher than expected readmission rates. Beginning in Federal Fiscal Year (FFY) 2013, which began October 1, 2012, the Centers for Medicare and Medicaid Services (CMS) will have the authority to withhold reimbursements from hospitals with excessive readmission rates. CMS' initial focus will be on readmissions of congestive heart failure (CHF), acute myocardial infarction (MI) and pneumonia; however, by 2015, CMS penalties will most likely extend to all of the top seven conditions that accounted for 30 percent of Medicare readmission spending in 2008. (See Figure 1.)

CMS can withhold a percentage of a hospital's aggregate Medicare payments, so the resulting penalties will be potentially quite high.

### Seven Conditions Account for Almost 30 Percent of Readmissions Spending

| Condition                  | Type of hospital admission | Number of admissions with readmissions | Readmission rate | Average Medicare payment for readmission | Total spending on readmission |
|----------------------------|----------------------------|--|------------------|--|-------------------------------|
| Heart failure              | Medical                    | 90,273                                 | 12.5%            | \$6,531                                  | \$590,000,000                 |
| COPD                       | Medical                    | 52,327                                 | 10.7%            | 6,587                                    | 345,000,000                   |
| Pneumonia                  | Medical                    | 74,419                                 | 9.5%             | 7,165                                    | 533,000,000                   |
| AMI                        | Medical                    | 20,866                                 | 13.4%            | 6,535                                    | 136,000,000                   |
| CABG                       | Surgical                   | 18,554                                 | 13.5%            | 8,136                                    | 151,000,000                   |
| PTCA                       | Surgical                   | 44,293                                 | 10.0%            | 8,109                                    | 359,000,000                   |
| Other vascular             | Surgical                   | 18,029                                 | 11.7%            | 10,091                                   | 182,000,000                   |
| Total for seven conditions |                            | 318,760                                |                  |  | \$2,296,000,000               |
| Total DRGs                 |                            | 1,134,483                              |                  |  | \$7,980,000,000               |
| Percentage of total        |                            | 28.1%                                  |                  |  | 28.8%                         |

Note: Analysis for readmissions within 15 days of discharge from the initial inpatient stay. Readmissions are identified using 3M's software that defines potentially preventable readmissions.

Source: "Payment Policy for Inpatient Admissions," Chapter 5, Report to Congress: Promoting Greater Efficiency in Medicare, MedPAC, June 2007. The data in this MedPAC report are from a 3M analysis of 2005 Medicare discharge claims data. To view the entire report, visit [www.medpac.gov](http://www.medpac.gov).

**Figure 1**

The financial impact to hospitals will be substantial: CMS can withhold up to one percent of all inpatient Medicare payments starting in FFY 2013 (October 2012), up to two percent of payments in FFY 2014 (October 2013), and up to 3 percent in FFY 2015 (October 2014) and thereafter. These percentages will be calculated on a hospital's aggregate Medicare payments for all discharges, not just the targeted condition, so the resulting penalties will be potentially quite high.

Clinical outcomes in FFY 2012 (October 2011) will dictate the penalties levied in FFY 2013. This means that patients discharged as early as October 1, 2011, can influence reimbursements. To that end, hospitals must take steps now to reduce preventable readmissions.

## 2) To promote Patient-Centered Medical Home

The goal of the national Patient-Centered Medical Home (PCMH) movement is to improve healthcare for each individual by facilitating partnerships between patients, their personal physicians and care team, and when appropriate, the patient's family. If patients have a "medical home"—their place of primary care through which all of their care is coordinated—they will experience better coordinated care, have a greater understanding of the continuum of care, and be able to become more proactive in their care.

According to CMS, one-third of readmitted patients have one of seven conditions such as CHF and pneumonia, all of which require ongoing healthcare managed by a primary care provider (See Figure 2). By facilitating PCMH partnerships in this patient population, hospitals can reduce their risk of preventable readmissions. Consider how readmission management can help promote several of the Joint Principles of the Patient-Centered Medical Home<sup>5</sup>.

| Condition at hospital discharge       | Readmission rate |
|---------------------------------------|------------------|
| Heart failure                         | 26.9%            |
| Psychosis                             | 24.6%            |
| Vascular surgery                      | 23.9%            |
| Chronic obstructive pulmonary disease | 22.6%            |
| Pneumonia                             | 20.1%            |
| Gastrointestinal problem              | 19.2%            |
| Nonmajor hip or femur surgery         | 17.9%            |
| Major bowel surgery                   | 16.6%            |
| Cardiac stent placement               | 14.5%            |
| Major hip or knee surgery             | 9.9%             |

Source: "Rehospitalizations among patients in the Medicare fee-for-service program," *The New England Journal of Medicine*, April 2, 2009 ([www.ncbi.nlm.nih.gov/pubmed/19339721](http://www.ncbi.nlm.nih.gov/pubmed/19339721))

Figure 2

By facilitating PCMH partnerships in this patient population, hospitals can reduce their risk of preventable readmissions.

- Ongoing relationship with personal physician — Can facilitate relationship via outreach that coaches the patient to engage with her primary care physician (PCP), or help the patient find a PCP and set up an initial appointment
- Physician-directed medical practice — Encourages post-discharge patients to engage with PCP regarding their hospital experience, thus ensuring the PCP is truly directing the patient's ongoing care
- Whole person orientation — Identifies when non-physician care activities are required (e.g., self-care, hospice, therapy) and facilitates these care activities through inpatient communication and post-discharge phone outreach
- Coordinated care across the health system — Promotes better post-discharge care transitions to ensure each patient remains on the path to better health and optimal care after leaving the hospital

## 3) As part of an accountable care strategy

Reducing preventable readmissions is a logical component of accountable care, which establishes incentives to manage the care of a specific patient population to improve care, keep the population as healthy as possible, and create cost-reducing efficiencies. By identifying the population of patients at risk for readmissions, hospitals can intervene and potentially save thousands or millions of dollars. Readmission management not only identifies at-risk patients, but also improves their care and decreases the chance for preventable readmissions via specific initiatives such as post-discharge follow-up outreach. Sixty percent of hospital leadership indicated that they are evaluating technology and processes to prepare for their potential involvement in an accountable care organization (ACO).<sup>6</sup>

Readmission management also facilitates another key component of accountable care strategy: the concept of risk-sharing with health plans. Under the accountable care model, hospitals receive incentives for taking on risk and performing well. By taking on risk, a hospital may expose itself to significant additional costs. Through readmission management, hospitals can avoid preventable readmissions that may cost their organization an average of \$5,000 to \$10,000 per case.

Lastly, many hospitals participating in accountable care systems are experiencing common challenges. Two of these challenges are identifying gaps in a patient's care and implementing reporting to show meaningful use. Readmission management can help address both. First,

A comprehensive readmission management program can identify gaps in care — and help close them.

a comprehensive readmission management program sets the stage for identifying gaps in care early, while patients are in the hospital or even before they are admitted. It can also help close these gaps. For instance, if a CHF patient isn't engaging in self-care measures such as regular weight checks, hospital staff can conduct post-discharge phone calls to remind and coach patients about this critical activity. Second, a readmission management plan supported by technology can link activities to avoid preventable readmissions (e.g., outreach phone calls) to an at-risk patient's care plan. If each CHF patient receives outreach calls after discharge that help him adhere to medication, follow up with his primary care physician (PCP) and monitor weight, the hospital will have a record to show how its readmission management plan is improving patient outcomes and reducing readmissions.

#### **4) To reduce unnecessary ED visits**

*The link is clear: if a recently discharged patient does not follow up with his PCP, he's more likely to return to the ED.*

Ten years ago, the American Hospital Association reported that 90 percent of hospital emergency departments perceived they stayed at or over operating capacity<sup>7</sup>. In the past decade, ED visits have increased by 11 percent<sup>8</sup>. General consensus among clinicians and health leaders is that a sizable number of ED visits are for non-urgent conditions, which could be treated more cost-effectively by PCPs. In addition to the high cost of ED treatment for non-urgent conditions, unnecessary ED visits cause overcrowding, delays, an increase in Left Without Being Seen (LWBS) and the ED's potentially compromised position to cope with a surge.

The link between preventable ED visits and preventable readmissions is clear. If a recently discharged patient does not follow up with his PCP and then has a relapse or recurrence of symptoms, he'll return to the ED. Two readmission management processes can help circumvent this scenario. First, promote timely PCP visits after discharge. Only half of readmitted patients had contact with an outpatient doctor after discharge from their initial hospitalization, according to CMS. Many of these readmitted patients might have avoided an ED visit (and possibly a second inpatient stay) if they had followed up with a physician per their discharge instructions. Second, flag at-risk patients for readmissions as early as possible; for instance, before the patient has moved from the ED to an inpatient bed.

#### **5) Because it's best for the patient**

*Readmission management can improve clinical outcomes for the entire patient population.*

When asked why their organization was addressing readmission management, more than 70 percent of hospital leaders replied, "to improve patient outcomes."<sup>9</sup> Overwhelmingly, hospitals are addressing readmission management because it's the right thing to do for their patients, a sentiment that isn't just documented in mission statements, but is pervasive throughout the entire organization. People who work in healthcare, from leadership to clinicians to staff, genuinely care about patients.

Individually, readmission management improves quality of care for a patient via 1:1 communications that help ensure he's taking the right steps to heal or manage his health. Organizationally, readmission management improves clinical outcomes for the entire patient population by ensuring critical resources such as inpatient and ED beds are available for the patients who need them most.

While high readmission rates have long been considered an outcome of lower-quality care, most hospitals either recently implemented readmission management strategies or are in the planning stages. As a result, no standard best practice readmission management plan exists. There are, however, some key lessons learned from experts and early adopters.

# 10 ways to create a proactive readmission management strategy

## 1) Evaluate broken or less-than-optimal processes

According to CMS, several broken or ineffective processes drive preventable readmissions:

- a) Poor transfer of information to patients, particularly related to medication adherence and the symptoms or warning signs that warrant an emergency call to EDs
- b) Poor transfer of information to ambulatory caregivers such as nursing home staff and PCP
- c) Lack of timely post-discharge physician follow-up due to the PCP's unawareness of the patient's hospitalization or the patient's lack of a PCP
- d) Poor patient knowledge and non-disclosure of current prescriptions and/or inadequate medication reconciliation

Assess your current processes in these areas, evaluating the resources and technology involved. Are the optimal departments and resources responsible? Do they rely on technology or manage these processes manually?

## 2) Begin at the beginning, or even before

When it comes to managing readmissions, a fundamental component is identifying at-risk patients as early as possible. In fact, 60 percent of hospital leadership surveyed believes that pre-discharge readmission management initiatives are more critical than post-discharge<sup>10</sup>, a belief supported by the many early readmission management programs that emphasize at-risk identification prior to or near the beginning of the inpatient visit.

Baylor Jack and Jane Hamilton Heart and Vascular Hospital in Dallas begins readmission management at the moment of admission, when the nurse reviews all of the patient's home medications.

During discharge preparation, the physician may order new or modified medications and will review this information with the patient. Later, the nurse reviews this same information with the patient before discharge<sup>11</sup>.

An effective readmission management plan establishes processes for identifying at-risk patients for readmissions as soon as possible — either prior to admissions or early in the patient's stay.

## 3) Implement a logic-based post-discharge outreach initiative

An optimal readmission management incorporates education and coaching at various stages in the continuum of care, which gives patients many opportunities to ask questions and absorb information. This requires consistent but customized communication at defined touch points during and after the patient's hospital stay.

Post-discharge communication is an essential component of a readmission management plan for several reasons:

- After discharge, most patients go from an environment with 24x7 clinician monitoring to their homes, where they have zero monitoring and accountability for critical tasks such as taking medications.
- Discharge can be a confusing and stressful time for patients. They are often medicated, tired and preoccupied, and are apt to forget or misplace discharge instructions.
- If discharge instructions include a follow-up physician visit, patients without a PCP are much less likely to adhere.

While any post-discharge communication can facilitate improvements, outreach that is targeted and specific to each patient's situation will prove most beneficial. Consider developing or leveraging a logic-based workflow that will help ensure each patient is asked the right questions per their condition. As a result, your readmission management outreach will be more robust, tailored and effective.

*Pre-discharge readmission management initiatives are more critical than post-discharge.*

*Outreach that is targeted and specific to each patient's situation will prove most beneficial.*



#### 4) **Have a centralized approach for tracking and managing readmission management**

A second key to success is a centralized hub for tracking and managing readmission management activities. Hospitals with readmission management plans are placing this hub where it makes the most sense; for many, it resides in case management. Others have tasked nurses from various departments but have centralized tracking and reporting via technology. Whether readmission management communication is handled by one department or many, a centralized hub can make tracking and monitoring patient progress easier. It can also enable easier analysis of trends and facilitate Meaningful Use reporting requirements.

#### 5) **Make medication adherence a top priority**

According to CMS, nearly 66 percent of post-discharge adverse events among Medicare patients are related to medications. A robust readmission management plan addresses patient outreach regarding care transitions and coordination, physician follow-up appointments, self-care and education. However, the simple act of following up with patients after discharge to make sure they understand and are complying with medication instructions can have a great impact.

#### 6) **Leverage disease management and patient education programs**

CMS penalties target readmissions within the first 30 days after discharge; however, many of the top seven conditions require longer term actions by the patient. If your organization has the following programs, consider integrating them into your readmission management plans.

- a) **Chronic Care Management** — Establish processes to flag patients who are a good fit for your existing disease management or chronic care management programs; for instance, for CHF or smoking cessation/lung health. Before the patient's readmission management plan patient ends, transition her into the appropriate program. This will help her manage her condition while also keeping her engaged with your organization.
- b) **Patient Education** — Tie existing patient education initiatives such as class registration and call center phone or e-mail education into your readmission management plan. This not only utilizes existing resources, but also gives patients broader opportunities to learn about their condition and be more proactive about their health.

#### 7) **Manage transitional care**

Patients often assume new, health-related responsibilities after they are discharged. If your organization has a high number of patients at risk for readmissions, and if your patient demographic consists of a high percentage of elderly or underserved, the transition coach model might be effective.

The Agency for Healthcare Research and Quality (AHRQ) reports that the Care Transitions Program through the University of Colorado at Denver utilized transition coaches to encourage Medicare patients who had been hospitalized for 11 common complex conditions to take a more proactive role in their post-discharge care. The 750-patient, random-controlled trial demonstrated transition coaches' effectiveness: Program participants had 20 to 40 percent lower overall hospital readmission rates than the control group and were 50 percent less likely to be re-hospitalized for the same condition<sup>12</sup>.

The Care Transition Program coaches conducted several steps with each patient:

- a) Initial inpatient meeting to establish rapport, introduce the personal health record (PHR) and arrange a home visit.
- b) Post-discharge home visit and recurring telephone contact for the first 30 days after discharge
- c) Maintenance of the patient's PHR

AHRQ provides a Care Transitions Program Toolkit at:  
<http://www.innovations.ahrq.gov/content.aspx?id=147>

*Transition coaches are effective at encouraging patients to proactively assist in their post-discharge care.*



## 8) Create a multi-disciplinary team for evaluation and planning

High readmission rates can be the result of many different factors; therefore, the best strategic planning committee will consist of a diverse, multi-disciplinary team that represents areas such as quality, case management, clinical leadership and operations. “Our leaders and our staff were all sitting at the table together...all bringing different strengths to create the process,” says Nancy Vish, RN, president and chief nursing officer of Baylor Jack and Jane Hamilton Heart and Vascular Hospital<sup>13</sup>. While your team may ultimately decide that a specific department should have ownership of readmission management, you’ll lay the foundation with a broad, well-rounded strategy.

## 9) Use existing resources creatively

*Hospital call centers are a low-cost resource dedicated to phone outreach — an ideal resource for readmission management.*

Piedmont Hospital leverages clinicians to identify high-risk patients early in the process; however, it’s the hospital administrative assistants who conduct post-discharge calls to check on patients and help schedule physician appointments if necessary. Dr. Schrieber notes, “This is a business call. It’s more like a quiz for the patient.” The calls, conducted within 72 hours of discharge, are scripted to quiz patients on why they were in the hospital, what symptoms they should be looking for, what medications they’re taking and the date of their next doctor’s appointment<sup>14</sup>.

Another option is to leverage your hospital call center for post-discharge outreach. Triage nurses and call center representatives are trained to conduct phone surveys, educate patients and guide them toward the optimal healthcare choices. They are also accustomed to documenting calls, which can facilitate tracking and analysis. While the early trend is to utilize floor nurses and case managers, the call center’s position as a low-cost, centralized group dedicated to phone outreach makes it an ideal resource for readmission management.

## 10) Develop a strategy to leverage technology

*Hospitals must establish metrics and reporting to track progress and establishment trends.*

As with many cross-departmental initiatives, a readmission management plan is more susceptible to errors, delays and missed hand-offs if not supported by technology. Here are a few:

- **EHR** — In the inpatient setting, identifying at-risk patients is the crucial first step in readmission management. Modify your EHR so that once a clinician has flagged an at-risk patient, it can be noted in that patient’s record. In addition, if you use readmission management workflow software, create an interface to your EHR. This will enable a more seamless process from identifying the at-risk patient through pre-discharge education and post-discharge outreach.
- **Workflow Management** — No matter who is responsible for readmission management in your organization, workflow management software can help drive consistent, documented processes around patient education, outreach and post-discharge assistance. While this software can be customized per a hospital’s unique processes and goals, it provides a framework to drive communications with patients who were admitted for one of CMS’ top seven conditions and are readmissions risks.
- **Reporting** — CMS does not require hospital reporting on readmission management activities; rather, the agency will simply penalize hospitals on preventable readmissions. However, hospitals must establish metrics and reporting that enables clinicians and leadership to track progress in a specific timeframe, per patient or per condition.

Reporting can also show readmission management trends across a hospital or health system, which can facilitate ongoing and incremental improvements.

## The Bottom Line

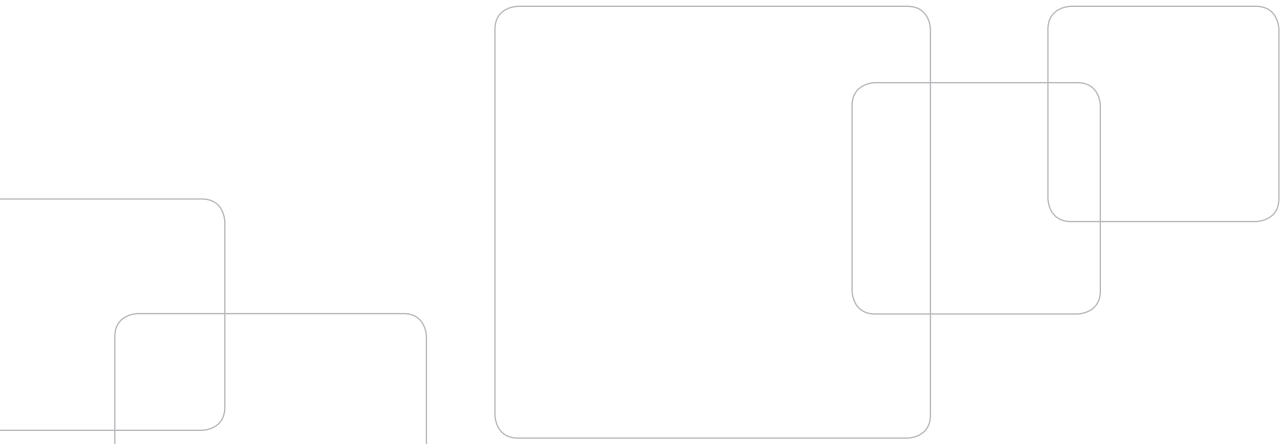
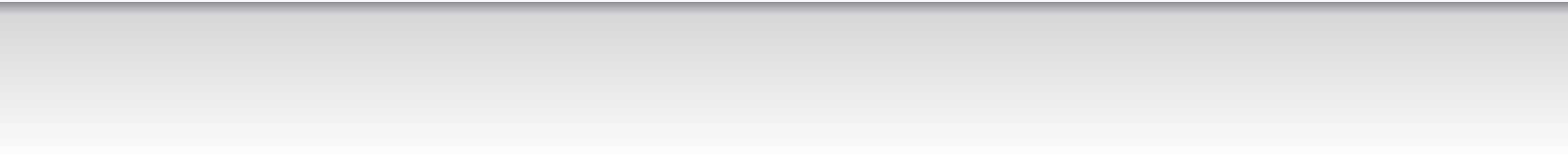
Preventable readmissions are an increasingly hot topic because healthcare leaders see the urgency of tackling the problem now. More importantly, a high number of preventable readmissions interfere with a hospital's overall quality of care.

In addition, readmission management exemplifies several shifts in healthcare. Perhaps the most tangible is financial; with WellPoint leading the way, health plans will begin compensating hospitals based on quality of care, not their volume of tests and treatments per Diagnostic Related Grouping (DRG) codes<sup>15</sup>. Another notable trend is cross-departmental collaboration that breaks down hospital silos. Reducing preventable readmissions requires multi-disciplinary planning, which often results unprecedented and creative solutions that get results. Lastly, readmission management addresses the ongoing, whole health of the patient, ensuring that he is engaged and informed throughout the continuum of care. And that's likely the most important point. Readmission management is about much more than avoiding reimbursement penalties. It's about clinical outcomes and doing what is best for each patient.

*Readmission management addresses the ongoing health of the patient, ensuring that he is engaged throughout the continuum of care.*

## Footnotes

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