
**Reducing Readmission Rates
in California Hospitals:
Leadership Summit**

October 6, 2009
Hilton San Francisco Airport
Burlingame, California

Information Packet

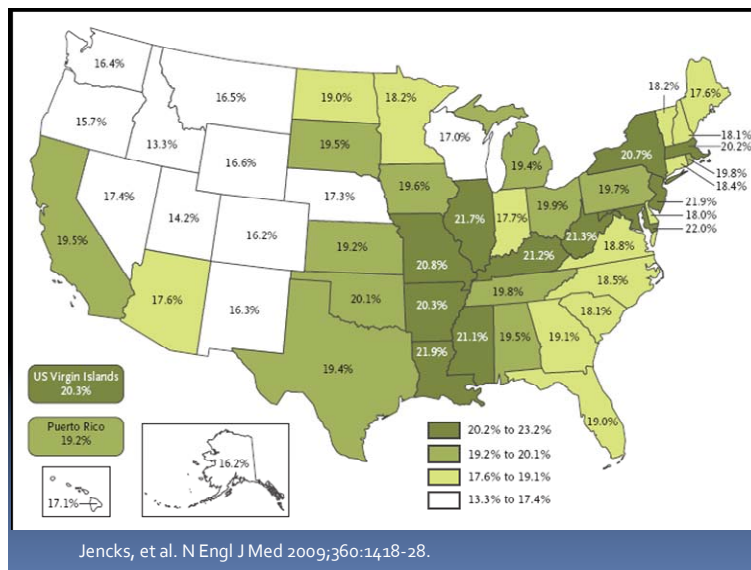
Hospital Readmissions Factsheet October 2009

I. Medicare

Studies have shown that 18-20% of Medicare patients are readmitted to the hospitals within 30 days. [MedPac]

In 2004, an estimated \$17.4B of Medicare’s total spend of \$311B was spent on **potentially avoidable readmissions**. [Jencks 2009] In 2005, an estimated \$12B of \$339B was spent on potentially avoidable readmissions. [MedPac]

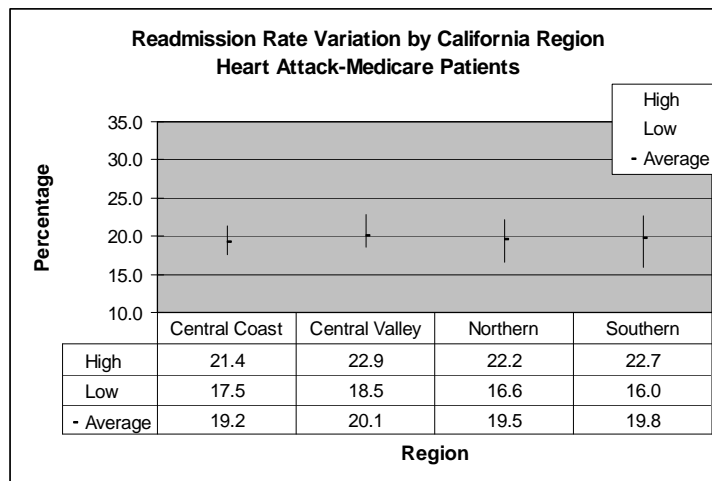
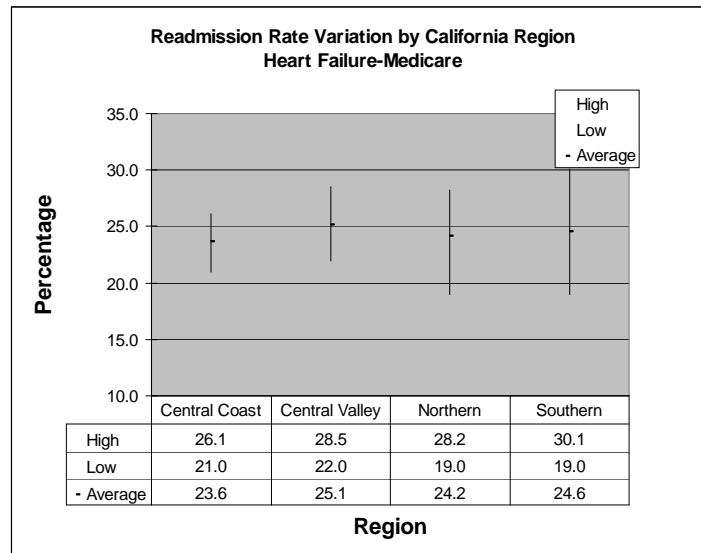
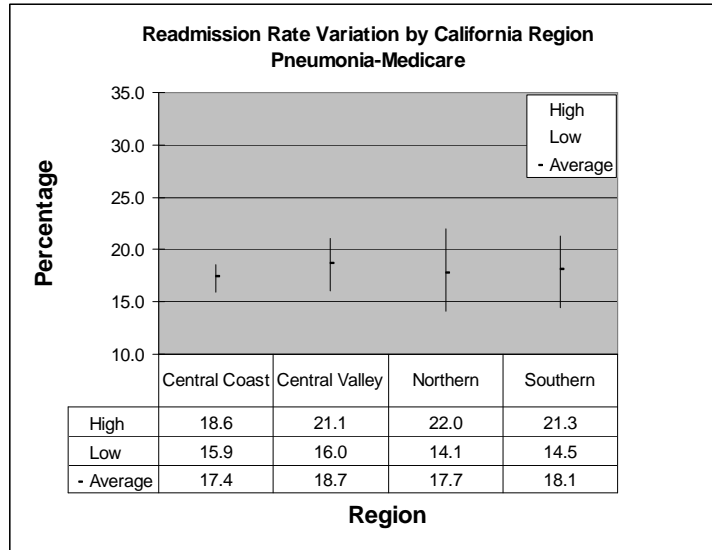
California’s Medicare readmission rate was in the middle of the pack at 19.5%. The national average is 19.6% while the range is 13.3% (Idaho) to 22% (New Jersey).



Readmission rates vary by condition. In these three conditions, California on average is close to the national rates. However, there is significant regional variation within the state.

	Heart Attack	Heart Failure	Pneumonia
National Readmissions Rate	19.9	24.5	18.2
California Readmissions Rate	19.7	24.5	18.1

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II. Commercial and All-Payer

Large scale studies show **rates of potentially avoidable readmissions** from 5.2% for 30 day to 19% for 6 month. The **cost** of these readmissions in the latter study was \$730M (\$1.4B in 2008 dollars). [Halfon, P. et. al. Medical Care 2006, Friedman, B., Basu, J. 2004]

Nationally, the number of avoidable admissions **and** readmissions was 4.4 M. The **cost** of avoidable admissions **and** readmissions was \$30.8 B, 10% of hospitals expenditures. [AHRQ Apr 2009].

Similarly to Medicare, commercial readmissions and costs vary by condition. A 2009 study by Prometheus Payment on knee and hip replacements in a large commercially insured population showed the major driver of potentially avoidable costs was readmissions.

Cost of Potentially Avoidable Readmissions	Hip Replacement	Knee Replacement
Percent	5.6%	5.9%
Dollars	\$3.1M	\$5.4M

Based on 4.5M commercial members

III. Multi-payer Comparisons

Readmission rates vary by payer in a four-state analysis that included New York, Pennsylvania, Tennessee, and Wisconsin:

Rate of readmissions within 6 months							
Age Group	Medicare	Medicaid	Private	Self-Pay	No Charge	Other	Over-all
0-18		11.4	7.5	9.9		7.9	9.2
19-64	26.7	21.8	12.6	11.3	17.3	15.9	17.4
65+	23.2	23.6	21.6	16.1		24.4	23.0

Adults with *Medicare* have higher likelihood of readmission than with other insurance

Children and seniors with *Medicaid* have higher likelihood of readmission than with other insurance.

[Friedman, B., Basu, J. 2004]

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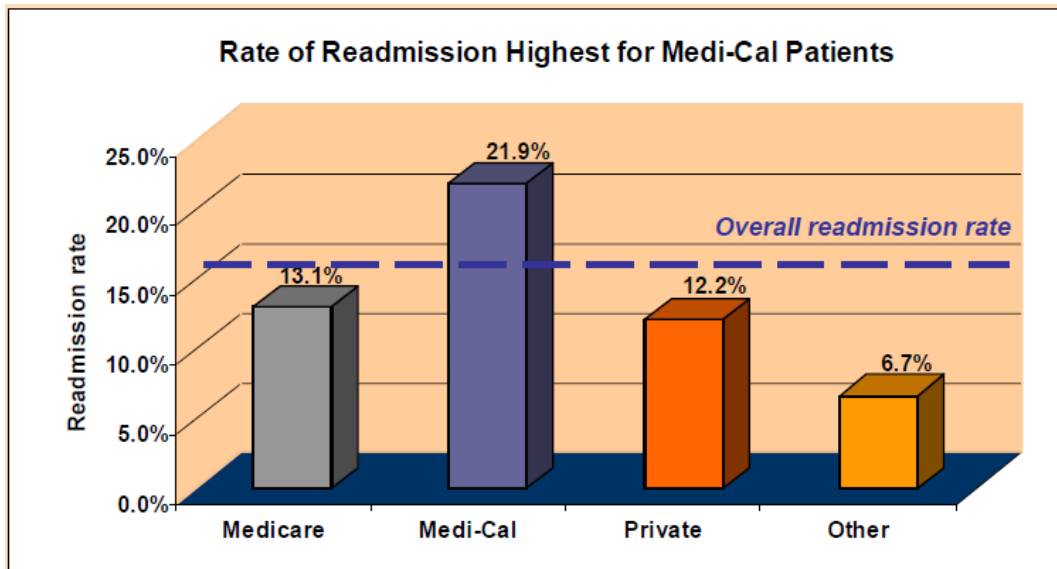
The Florida Agency for Healthcare Administration began publishing comparisons of hospitals' avoidable readmission rates in 2008. **Potentially avoidable readmission rates** using 2004-2005 data in three time periods:

Rate by Timeframe	
Within 7 days	5.05%
Within 15 days	7.86%
Within 30 days	11.03%

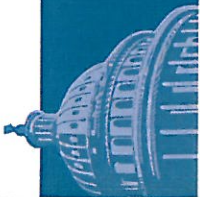
Based on 3.09 million admissions

Depending on the condition, the readmission rate varies by payer. For example, for CHF, the 15-day readmission rate for CHF is highest for Medicaid at 14.9%, followed by Medicare at 12.9%, and lowest for commercial at 9.5%. [Goldfield, et. al., 2008]

At UCSF Medical Center, the rate of **potentially avoidable readmissions** was 4% and varied by payer.



[Allaudeen and Vidyarthi, poster http://hospital-sandbox.ucsf.edu/dhmfac/improve/meetings_progress_updates/readmissions/readmission_poster.pdf accessed 9/16/09]



FOCUS *on* Health Reform



SIDE-BY-SIDE COMPARISON OF KEY MEDICARE PROVISIONS IN 2009 HEALTH REFORM LEGISLATION: H.R. 3200 and Senate Finance Committee Chairman's Mark

This document provides a description of key Medicare provisions of 2009 health reform legislation, including H.R. 3200, America's Affordable Health Choices Act, as introduced July 14, 2009 and amended by the House Committee on Ways & Means and the House Committee on Energy & Commerce¹ and the Senate Finance Committee Chairman's Mark of the America's Healthy Future Act of 2009, as introduced on September 16, 2009. The document describes the major provisions relating to Medicare benefit changes, Medicare Advantage, the Medicare Part D prescription drug benefit, physician and other provider payment reforms, and other health system reforms. It also includes ten-year cost estimates for these provisions, in billions of dollars, as provided by the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT).² The summary will be updated to incorporate changes made during the legislative process. For more information about health reform legislation, see www.kff.org/healthreform/sidebyside.cfm. For a one-page summary of key Medicare provisions, see www.kff.org/healthreform/7948.cfm.

H.R.3200: America's Affordable Health Choices Act of 2009 (as introduced on July 14, 2009 and amended)

Senate Finance Committee Chairman's Mark: America's Healthy Future Act of 2009 (as introduced on September 16, 2009)

OTHER HEALTH SYSTEM REFORMS

Reducing potentially preventable hospital readmissions

Reduces Medicare payments to PPS and critical access care hospitals based on each hospital's ratio of actual risk-adjusted readmissions to risk-adjusted expected readmissions for specified clinical conditions effective in 2012, reduction limited to 1% in 2012, 2% in 2013, 3% in 2014, and 5% beginning in 2015 and subsequent fiscal years. When the readmission is from a post-acute care provider (SNF, inpatient rehabilitation facility, home health agency, or long-term care hospital), the payment to that provider would be reduced 0.4% in 2012, 0.7% in 2013, and 1.0% in 2014. [Sec. 1151; -\$19.1 billion]

Requires CMS to calculate national and hospital-specific data on the readmission rates of Medicare participating subsection (d) hospitals and for hospitals paid under section 1814 (b)(3) for eight conditions that the Secretary selects based on spending and readmission rates. Requires the Secretary, starting in 2012, to share these data with hospitals, and publicly report data on the Hospital Compare website. Starting in 2013, reduces payments to hospitals with readmission rates above a certain threshold by 20% if a patient with a selected condition is re-hospitalized with a preventable readmission within 7 days and by 10% if a patient with a selected condition is re-hospitalized with a preventable readmission within 15 days. [Title III, Subtitle A, Part III, page 98; -\$2.1b]

¹The House Committee on Education & Labor adopted the bill with no amendments to Medicare-related provisions.

² Available at [<http://www.cbo.gov/doc.cfm?index=10464>], [<http://www.cbo.gov/doc.cfm?index=10572>], [<http://waysandmeans.house.gov/media/pdf/111/hr3200r.pdf>] and [<http://www.jct.gov/publications.html?func=startdown&id=3580>]

Three Electronic Tools to Assist Care Transitions

1. Continuity of Care Record

Continuity of Care Record (CCR) is a health record standard specification developed jointly by ASTM International, the Massachusetts Medical Society, the HIMSS, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP) and other informatics vendors.

The CCR standard is a patient health summary standard. It is a way to create flexible documents that contain the most relevant and timely core health information about a patient, and to send these electronically from one care giver to another. It contains various sections such as patient demographics, insurance information, diagnosis and problem list, medications, allergies and care plan. These present a “snapshot” of a patient’s health data that can be useful or possibly lifesaving, if available at the time of clinical encounter. The ASTM CCR standard is designed to permit easy creation by a physician using an electronic health record (EHR) system at the end of an encounter.

Because it is expressed in the standard data interchange language known as XML, a CCR can potentially be created, read and interpreted by an EHR software application. A CCR can also be exported in other formats, such as PDF and Office Open XML (Microsoft Word 2007 format).

Website: www.ccrstandard.com

2. CMS CARE Instrument

The continuity Assessment Record and Evaluation (CARE) instrument is the internet-based, assessment instrument that consists of a standardized set of data elements that will enable a variety of health care providers to uniformly measure and compare Medicare beneficiaries’ health and functional status across settings over time. CARE and its supporting application will allow authorized clinicians with a need to know, to electronically view their patients’ recent medical history (from previous setting) and allow them to record and rapidly communicate their patients’ current health status to the next care setting.

CMS is leveraging the insights gained from the development and piloting of the CARE instrument to move CMS forward with developing a single, uniform., interoperable data set to measure and compare quality, outcomes, cost and value across provider settings, and over time.

Website: www.cfmc.org/caretransitions/care.html

3. Shared Care Plan

The Shared Care Plan is a free, easy-to- use, web based record that lets the patient organize and store vital health information. It is also a self management care plan. The information it racks include: medications; allergies, reactions, and drug interactions; diagnoses and immunizations; hospitalizations, surgeries, and procedures; health indicators such as blood pressure, cholesterol and blood sugar.

Web site: www.sharedcareplan.org

Provided by Health Services Advisory Group

Reducing Hospital Readmission RESOURCES

The Problem of Hospital Readmissions – Financial and Clinical Implications

- 1) *CBO Options for Controlling the Cost and Increasing the Efficiency of Health Care before the Subcommittee on Health Committee on Energy and Commerce. U.S. House of Representatives, Mar 10, 2009.*
www.cbo.gov/ftpdocs/100xx/doc10016/03-10-Health_Care.pdf

This report provides background information on the relationship between cost and quality of care, specifically mentioning readmissions; reform recommendations are provided.

- 2) *Jencks S.F., M.V. Williams, and E.A. Coleman, Rehospitalizations among patients in the Medicare fee-for-service program, New England Journal of Medicine 360:14, April 2, 2009.*
<http://content.nejm.org/cgi/content/short/360/14/1418>

Almost 1/5 of Medicare beneficiaries discharged from the hospital were rehospitalized within 30 days; 34.0% were rehospitalized within 90 days. Article estimates that cost of unplanned rehospitalizations in 2004 was \$17.4 billion.

Strategies to Reduce Unplanned Hospital Readmissions

- 1) *CHCF Report – “Homeward Bound: Nine Patient-Centered Programs Cut Readmissions”, Sept 2009.*
<http://www.chcf.org/topics/chronicdisease/index.cfm?itemID=134064>

Case studies of nine programs describing strategies that are being used in California and nationally to reduce hospital readmissions and improve coordination of care.

- 2) *C Coleman, E.A., C. Parry, S. Chalmers, S.-J. Min. “The Care Transitions Intervention: Results of a Randomized Controlled Trial.” Archives of Internal Medicine 2006;166: 1822 – 1828.* Article Link:
<http://archinte.ama-assn.org/cgi/content/abstract/166/17/1822>

An RCT intervention with four key components, including coaching chronically-ill older patients and their caregivers during patient care transitions, indicated great potential to reduce the rates of rehospitalization. This model is being replicated nationally in a major CMS demonstration project involving 14 QIOs. Website (www.caretransitions.org) offers tools and information.

- 3) *C Jack B et al, “A reengineered hospital discharge program to decrease rehospitalization,” Annals of Internal Medicine 2009; 150:178 –187.*
<http://www.annals.org/cgi/content/full/150/3/178>

Discharge services offered at Boston Medical Center – including a nurse discharge advocate, patient education, and telephone follow-up – significantly reduced 30-day hospital readmissions.

- 4) *C Medicare Payment Advisory Commission Report to Congress: Reforming the Delivery System, June 2008*
www.medpac.gov/documents/jun08_entirereport.pdf

A report detailing MedPac’s recommendations for policy reform to incentivize greater collaboration across the health care system and to reduce readmissions and preventable hospitalizations.

Reducing Hospital Readmission RESOURCES

- 5) C Naylor, M.D., "Transitional care for older adults hospitalized with heart failure: A randomized, controlled trial," *Journal of the American Geriatrics Society*, 2004; 52:675 – 684.
www.ncbi.nlm.nih.gov/pubmed/15086645

A comprehensive transitional care intervention for elders hospitalized with heart failure reduced rehospitalizations and decreased healthcare costs, demonstrating promise for improving clinical and economic outcomes.

Additional Resources:

"The Transitional Care Model: Translating Research into Practice": www.queri.research.va.gov/chf/
Description of St. Luke's program: www.queri.research.va.gov/chf/docs/HF_Program_Naylor.ppt

- 6) C Society of Hospital Medicine, *BOOSTing Care Transitions Resource Room*;
www.hospitalmedicine.org/BOOST/

The BOOSTing (Better Outcomes for Older adults through Safe Transitions) Care Transitions resource room provides a wealth of materials based on principles of quality improvement and evidence-based medicine, as well as personal and institutional experiences.

- 7) *CDD State Action on Avoidable Rehospitalizations (STAAR) Initiative*
www.ihl.org/IHI/Programs/StrategicInitiatives/STateActiononAvoidableRehospitalizationsSTAAR.htm

This initiative aims to reduce rehospitalizations by working across organizational boundaries in three states, Massachusetts, Michigan, and Washington, by engaging payers, state and national stakeholders, patients and families, and caregivers at all clinical interfaces.

- 8) *Summa Health System Care Coordination Network (CCN); Commonwealth Fund profile, Aug 2007*:
www.commonwealthfund.org/Content/Innovations/Case-Studies/2007/Aug/Summa-Health-Systems-Care-Coordination-Network.aspx

AHRQ Innovations Exchange profile, October 2008:
<http://www.innovations.ahrq.gov/content.aspx?id=2162>

Increasing demand for acute care beds led the Summa Health System in Ohio to establish a network to improve transitional care and communication between its hospitals and local post-acute care facilities.

Readmissions Summit: Pre-Conference Survey Results

Survey Name: "Current Practices Survey"

Total Respondents: 52

What county(ies) does your organization serve?

17 respondents - Bay Area
 3 respondents - Northern CA
 3 respondents - Central Valley
 3 respondents - Sacramento
 5 respondents - Los Angeles
 5 respondents - Orange
 2 respondents - San Diego
 1 respondent - Southern CA
 10 respondents - Statewide

Do you have any focused efforts to reduce readmissions, or anything planned?

	Number of Response(s)	Response Ratio
No	10	19.2%
Yes, we have a program underway	33	63.4%
Yes, we are planning a program	9	17.3%
No Responses	0	0.0%
Total	52	100%

What type(s) of patients does your initiative or planned initiative target? (Please check all that apply)

	Number of Response(s)	Response Ratio
Medicare	37	71.1%
Medicaid	27	51.9%
Commercial (e.g., Blue Cross)	29	55.7%
Other	13	25.0%
Total	52	100%

Comments:

Statewide analysis of readmission patterns across payers

All other patients including indigent

Senior HMO

All persons who receive care

Uninsured

All CA public hospital users

culturally diverse

By Dx: CHF, Anticoagulation, etc

Healthy San Francisco, Self Pay, etc

Does your program or planned program target patients by condition/diagnosis (e.g., heart attack)?

	Number of Response(s)	Response Ratio
Yes	28	53.8%
No	13	25.0%
No Responses	11	21.1%
Total	52	100%

What patient condition(s) does your program target?

21 respondents - Congestive Heart Failure; COPD; Heart Failure

5 respondents - Diabetes

4 respondents - Pneumonia

3 respondents - Cancer

2 respondents - Hip and Knees

"We publicly report inpatient mortality indicators (Acute Stroke; Gastrointestinal Hemorrhage; Hip Fractures; AMI; Pneumonia; CHF; Esophageal Resection; Pancreatic Resection; Craniotomy; Carotid Endarterectomy; PTCA; AAA). Decision pending about which Patient Safety Indicators we will report. We also report CABG and PTCA provider level ratings."

"SCIP, VTE; ESRD, Back pain, CHF, CAD, patients with high acuity scores, NICU babies, Cancer; Stroke; COPD; depression; Chronic conditions: CAD, COPD, Asthma, Diabetes, KHypertension/Stroke, End stage Cancer"

"frail elderly and patients with multiple comorbidities are discharged into our complexist program. They are served by a team of discharge planners case managers and dedicated nursing support. Expedited follow up with primary care and specialist is overseen by the case managers."

"chf, post surgical, dm, members with multiple diagnosis, with more than 2 medications from the same class on discharge or significant change in meds from admission, combination of physiologic compromise, poverty, behavioral health issues, and lack of caregiver."

"CHF, ESRD, Diabetes and other chronic conditions"

Program Summary: Please provide a brief (1-3 sentence) description of your program (or

33 Response(s)

Post Discharge calls and case management for all patients admitted who are experiencing their third admission in 12 months. These members get a phone call 2-4 days after discharge and active case management in the 30-90 days post discharge.

Safety Net Institute LEAN Core Measures initiative is a collaborative aimed at using LEAN management principles to improve CHF care, compliance with core measures, and reduce readmission rates.

(1) Targeted interventions on general medicine and heart failure patients. (2) Data analysis to better understand readmissions for all services/diagnoses so as to target interventions.

We make discharge phone calls to all patients. we have standard scripts that hospitalist send to PCP's for patient follow up. Patients with conditions like diabetes, CHF are referred to disease management programs/case management.

Modeling after Project RED

Would like to see our hospital's post-acute care services (Acute inpatient rehab, SNF, Home Health, Outpatient Therapy and Adult Day Care Services) incorporated and better utilized as a significant part of our hospital's re-admission reduction program.

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We do daily readmission rounds to do "real-time" review all readmits within 30 days of prior D/C for all Dx & all LOBs. Our goal is to identify potential root cause and determine interventions to prevent further readmissions. We are also focusing on hand-off/transitions of care from IP (Acute & SNF) to OP (i.e. PCP, ACM & DM).

OSHPD collects inpatient, emergency dept, and ambulatory surgery patient-level data, and facility-level financial and utilization data from around 5000 facilities. OSHPD produces more than 100 report, data sets (some confidential and some public), and other products with this data.

This is a basic Case Management program aimed at providing appropriate discharge planning and support. We do focus on our Medi-cal Managed Care population most heavily.

Several health centers run frequent user programs aimed at ER use reduction but also reduces readmissions and overall hospital days.

There are 2 programs. The hospital based program is for CHF which involves id of patient admissions with OP follow-up. Complex patients receive a post discharge call with medication reconciliation and confirmation of MD follow-up.

Readmission Rounds Mon-Fri with inpatient CM and Hospitalists to determine whether readmission was preventable and why; Data analysis to change processes to prevent readmissions in the future. High Risk visits by MD/NP within 48 hours of discharge using Coleman model and 5 pillars to manage the transition of care. Home visit program with RN/LCSW.

Technical consultant for California's Aging, Disability, Resource Centers (Federal Real Choice Systems Change Grant) - two sites are implementing Coleman Care Transitions Intervention. Former Project Manager for the California HealthCare Foundation's Improving Care Transitions Project.

The Lean Core Measures Improvement Initiative at 4 CA public hospitals uses Lean as a management strategy to streamline processes and create a more patient-focused environment. The first phase of the project seeks to improve reliable delivery of discharge processes for CHF patients and reduce their preventable re-hospitalizations.

Redesign the processes for discharge and follow-up care.

Currently we are using our Coordination of Care unit to do follow-up phone calls for all hospital discharges and ED visits.

Disease management, case management, directed at specific diseases and individual patients.

Multiple facets: (1) Day before discharge planning Orders, (2) Improved Med Recon Process, (3) Core Measure Teams for CVAs, AMI, CHF, PNA (4) Upgrading a Care Transition system-more integration, (5) Improve transfer of pt info to f/u clinicians (outpt MD, lab, home health,...)

Discharge planners and case managers work with the hospitalist to identify patients complicated conditions to be referred into our Complexist program. Internist accustomed to high risk care over see the care either until they determine the patient can go back to their PCP

The proposed program garners learnings from our MHS program with the goal of decreasing the time from discharge to the first follow-up doctor's visit. To accomplish this, a programmatic framework is being considered that targets P4P, Benefit Design, Panel Management & EHR tools with a focus on achieving targeted health goals across the continuum.

We are in the early planning phase and still determining design - we want to focus on the hand off at time of discharge and linkages to community agencies that are both culturally competent and prepared to address patient needs after discharge.

Reduce 30-day readmissions for elder CHF patients]

Still in planning stages on CHF. May consider Coumadin Clinic for anticoagulation.

Focused on transitions in care for congestive heart failure patients, including medication management at home, palliative care.

We contact all senior upon discharge from the acute care or SNF to coordinate transition to the outpt setting

Targeted outreach to members at risk for readmissions based on 5 diagnosis (CHF, DM, COPD/Pn, Stroke, CA); outreach to close gaps in care that may lead to readmissions, address home care needs, including home health. Case managers introduced in hospital setting to assist with all of above

Received grant funding from Moore Foundation, initiating our Heart Failure Project and focusing on IHI four key components to create an ideal transition home for patients and the caretakers to improve understanding and compliance to treatment, and thus preventing readmission.

Heart Failure Continuum of Care: a program that provides continuous care from inpatient to outpatient breaking down silos of care. Provide a risk based interventions inpatient and outpatient with telemangement & specialty home visits in the outpatient care setting.

We call every discharge patients and ask whether they have an appointment with their PCP, have their medications and whether they can make it to their PCP. If they answer "no" to any of the questions, we try to help them.

Multidisciplinary team assembled. 2 Heart Failure Nurse Coordinators hired to cover 7 days a week. Reached out to Home Care and Skilled Nursing Facilities to assure they could follow through on daily weights, low salt diets etc. Patient Advisory Council formed. Educational Summit for caregivers, patients and families.

Enroll patients 60 years or older from General medicine wards, cardiology service of family medicine ward teams. From time of admission through discharge, specially trained nurses will perform education, at time of disharge will perform targetted educations. NPs will make follow up phone calls at day 3 and 10 post hospitalization

General: case review of all readmissions at monthly hospitalist meetings, discharge calls within 48 hours of discharge, disease management programs targeting CHF, COPD, diabetes

Two post discharge calls made on day 3 and day 7-10 by a nurse-coach. The nurse knows the diagnosis and minimal details of hospitalizaton, but no specifics about discharge plans

14 d rate is viewed as a failure analysis of inpatient action that took place or omitted. 30 day rate is viewed as a analysis of care coordination between inpatient and outpatient system. Focus is given to services in the hospital, discharge planning with care gaps, post discharge events to address those gaps, and service delivery post discharge.

We have programs that target CHF, ESRD, Diabetes and other chronic conditions

Do you have any results from your work?		
	Number of Response(s)	Response Ratio
Yes	18	34.6%
No	18	34.6%
No Responses	16	30.7%
Total	52	100%

What results have you seen?
16 Response(s)

Identification of gaps in care as well as improved engagement rate if outreach occurs after discharge.

Very early results and too soon to validate impact.

Improved awareness of the measures reported by healthcare providers, consumers, policymakers and others.

Reduction in ER and hospital use for uninsured and MediCal frequent user populations.

Decreasee readmissions in Senior and Commercial patient populations.

Informally, the 10-site CHCF Improving Care Transitions identified reduced readmissions for intervention participants - John Muir Medical Center and Marin County's Project Independence. San Mateo Health Plan has undertaken a second phase of the care transitions project and will be tracking readmissions for member participants in the intervention.

The Lean Core Measures Improvement Initiative at 4 CA public hospitals uses Lean as a management strategy to streamline processes and create a more patient-focused environment. The first phase of the project seeks to improve reliable delivery of discharge processes for CHF patients and reduce their preventable re-hospitalizations.

Initial downward trend HF readmissions for any cause within 30 and 90 day. Past two months shows a rapid upward trajectory. Increased patient understanding of symptoms.

In the past we reported up to a 50% decrease in CHF admissions over our CHF population. Unfortunately although the program continues unchanged we can no longer document outcomes. We have great difficulty documenting outcomes for any of our DM or CM programs.

Not in a format that I can share

We have seen small decreases in all-cause readmissions compared to a control group in our MHS program; proposed program is still being developed.

Focused on transitions in care for congestive heart failure patients, including medication management at home, palliative care.

We are tracking re-admits

Up and down. The 90 days readmission rate for our Heart Failure All Cause is trending downward, but most data points are above our set target. The 30 days readmission rate, though inconsistent, has more data points better than target.

Decreases in both "heart failure" and "all-cause" readmission rates.

We started our project 11 months ago. We have seen that the SNF did not weigh patients and one did not have a low salt diet. We have seen that involving palliative care is beneficial. We have seen that the readmissions bounce around and are looking forward to see the results of the next 6 months.

Results are not discriminating enough to separate preventable admissions from required care and do not tell if the changes are due to a specific action(s) in the program.

Lower readmissions by condition

Are you collaborating with other organizations or entities?		
	Number of Response(s)	Response Ratio
Yes	20	38.4%
No	16	30.7%
No Responses	16	30.7%
Total	52	100%

Which other organizations or entities are you collaborating with?
16 Response(s)

Safety Net Institute collaborative

Medicine program is collaborating through the BOOST network.

Partner facilities have been informed of our efforts. We are still working on specifics with regard to how we can collaborate with our partner facilities more effectively.

Clinical experts, healthcare purchasers, providers, and consumers.

Public and private hospitals, health departments, housing and homeless programs.

Alta Bates Summit Medical Center

California Health and Human Services Agency, CMS, CalOptima, Mission Hospital, Orange County Area Agency on Aging, Dale MacIntosh Center, Riverside County Area Agency on Aging, Community Access Center

Alere

We have made grants for pilot programs at El Camino Hospital and O'Connor, but these were responsive grants and will be used to inform our program design.

Moore Foundation

Our local hospital, MPHS

Moore Foundation, IHI, 3 other Moore Heart Failure grant recipients

The Gordon and Betty Moore Foundation and the IHI

Project Red in Boston, Gordon and Betty Moore Foundation

local hospitals

medical groups

IHI, Kaiser Division of Research

Would your organization be interested in collaborating on a regional initiative to reduce readmission rates?

	Number of Response(s)	Response Ratio
Yes	46	88.4%
No	1	1.9%
No Responses	5	9.6%
Total	52	100%

Which region(s) would you be interested in? (Please check all that apply.)

	Number of Response(s)	Response Ratio
Sacramento Area	12	23.0%
Bay Area	29	55.7%
Los Angeles Area	13	25.0%
Orange County Area	15	28.8%
San Diego Area	9	17.3%
Other	11	21.1%
Total	52	100%

Other:

4 respondents - statewide

6 respondents - Central Valley

Summit Sponsors:



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Program Organizers:

