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## Reducing Your Rehospitalization Rate the QAPI Way

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## Session Objectives

- Review why and how rehospitalization is on the forefront of our industry's consciousness
- Understand the 5 key elements of Quality Assurance Performance Improvement (QAPI) in Nursing Homes
- Understand best practices for achieving compliance with QAPI standards
- Describe three key steps needed to apply QAPI elements to your Facility's Rehospitalization Reduction Program

## The Issue



- Cost of rehospitalization is around \$17 billion for Medicare recipients
- Almost 20% of all Medicare hospital stays result in readmission within 30 days of discharge
  - 20-40% of re-hospitalizations are avoidable
- Rehospitalization is a symptom of care fragmentation
- Current momentum for change, including legislation is in place

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## A Little History Lesson on Rehospitalization.....

- Medicare Payment Advisory Commission (MedPAC) 2005 Study
  - Reported increased rehospitalization rates for Medicare beneficiaries within 30 days of hospital discharge
  - Identified five conditions for which rehospitalization is potentially avoidable in nursing homes
    - Congestive Heart Failure
    - Respiratory Infection
    - Urinary Tract Infection
    - Sepsis
    - Electrolyte Imbalance
  - Endorsed addition of quality measures specific to short-stay residents including rehospitalization

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## A Little History Lesson.....

- Care Transitions
  - QIO work on Care Transitions- 9th and 10th SOW
  - ACA: Community-based Care Transitions Program (Section 3026)
- Pay For Performance (P4P) Demonstration November 2008
  - ACA: Value-based purchasing (Section 3006)
- Affordable Care Act implementation in 2010 had further provisions that impact subacute and long term care:
  - Bundled Payments initiative (Section 3023)
  - Medicare Shared Savings Program (Section 3022)
  - Hospital Readmissions Reduction Program (Section 3025)

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## PPACA/ACA – 10 Sections (Titles)

- |  |   |
|--|---|
| • Quality, Affordable Coverage for All Americans (private health insurance)              | • Transparency and Program Integrity (fraud and abuse etc.)                         |
| • The Role of Public Programs (Medicaid)   | • Improving Access to Innovative Medical Therapies (biopharmaceutical similars)     |
| • Improving the Quality and Efficiency of Health Care (Medicare and quality improvement) | • CLASS Act (disability support) 10/14/2011 removed                                 |
| • Prevention of Chronic Disease and Improving Public Health                              | • Revenue Provisions  |
| • Health Care Workforce  | • Strengthening Quality, Affordable Health Care for All (amendments to titles I-IX) |

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## Geographic Hospitalization Patterns



## Hospitalization Readmission Reduction Program (HRRP) Penalizes Hospitals with High Readmission Rates

Section 3025 of ACA added section 1886(q) to the Social Security Act establishing the Hospital Readmissions Reduction Program, which requires CMS to reduce payments to IPPS hospitals with excess readmissions

- High rates of hospital readmissions have gained scrutiny due to cost and quality concerns
  - Nearly 1 in 5 Medicare patients discharged from the hospital is readmitted within 30 days at a cost of over \$15 billion every year \*
  - Wide variation in readmission rates suggest readmissions can be reduced

\* MedPAC June 2007

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## HRRP Penalizes Hospitals with High Readmission Rates

CMS has been calculating (and publishing) hospital readmission rates for hospital quality reporting, HRRP links payments to performance on their measures

- The HRRP began October 1, 2012
  - Payment reduction determined by an adjustment factor based on an assessment of readmissions, with a maximum payment reduction of 1 percent in 2013, 2 percent in 2014, and 3 percent in 2015 and beyond
  - For each hospital, an excess readmissions ratio will be calculated based on measures of readmissions currently used in the hospital inpatient quality report (IQR) program

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## Three Conditions Targeted for FY 2013 and Expanded in FY 2015

### FY 2013

- Acute Myocardial Infarction
- Heart Failure
- Pneumonia

***These three conditions made up approximately 10% of hospital discharges in 2009***

### FY 2015

- Chronic Obstructive Pulmonary Disease
- Coronary Artery Bypass Graft
- Percutaneous Transluminal Coronary Angioplasty
- Other Vascular Conditions

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## Three Conditions are All the Rage!

Condition at Hospital Discharge	30-Day Rehospitalization Rate
AMI (Heart Attack)	19.9
Heart Failure (HF)	24.7
Pneumonia	18.3

U.S. Department of Health and Human Services, Quarter 2, 2012

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## How the Rates Are Calculated: CMS Uses an Excess Readmissions Ratio

- The ratio examines the hospital's expected and actual impact on readmissions
- The performance is measured against an average hospital with similar patients
- These data are converted into numerator and denominator for the excess readmission ratio:

Actual Adjusted Readmissions

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Expected Readmissions

- With risk adjustment, it is possible for a hospital to have a high observed readmissions rate, but a favorable excess readmissions ratio

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## Hospital Readmission Reduction Recap

- Beginning in FY2013, reduced payments to hospitals based upon potentially preventable Medicare readmission
- Uses National Quality Forum risk-adjusted measures: heart failure, acute MI and pneumonia
  - Secretary has the authority to expand the policy to additional conditions
- Hospital Compare publishes rehospitalization rates
- Medicare will penalize poorly performing institutions-started October 2012
  - Withhold a percentage of their payments, starting at 1% and rising to 3% within three years as part of the 'value-based purchasing initiative'
- THE SO WHAT ? What will hospitals do to decrease readmissions?
  - Ideally: correctly match the care needs of the patient to the SNF setting?
  - Or simply to those with the lowest rehospitalization rates...

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## But What About Me?



True or False:

- HRRP Impacts Only Acute Care/VA Hospitals?

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## Drivers of Rehospitalization

- Fragmentation of patient information
- Inappropriate end-of-life care
- Medication issues
- At-risk patients not properly identified at discharge
- Lack of post-discharge follow up
- Lack of disease-specific protocols
- Patient non-adherence to the plan of care
- Patient/family knowledge deficit

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## The SNF Challenge: Definition, Volume & Consistency

- There is NO CMS endorsed SNF rehospitalization metric today
- Most Medicare patients who do not directly return to home are discharged to SNFs
  - Of those, more than 20% return to hospital within 30 days
  - A majority of these rehospitalizations (90%) are unplanned
- The 30-day rehospitalization rates vary greatly between SNFs – some have rates over 40% and others have rates under 10%.

**Why is there such a range?**  
**Is it all about the quality of care delivered in these nursing homes?**

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## Analysis: The Relationship of Patient Acuity on Rehospitalization Experience...

- Patient acuity plays a major role in the SNF's ability to prevent rehospitalization
- Acuity, diseases and conditions all impact this experience
- PointRight modeled the 30-day rehospitalization risk for individual Medicare SNF admissions using MDS 3.0 data from over 2000 facilities
- Independent variables were stable indicators present on first MDS assessment
- Using the model to calculate an expected rate, we computed an adjusted rate:
  - **(Observed rate/expected rate)\*(national average rate)**

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## ... Does Not Explain the Large Differences between Facilities

- Acuity-adjusted 30-day rehospitalization rates still varied widely; many facilities have adjusted rates over 25% or less than 15%.
- Significant variability was seen within small geographical areas, suggesting that state-to-state and local differences in medical practice patterns, while important, do not account for the differences either.

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## Risk-adjusted rehospitalization rates under AHCA Outcome Measures (Rehospitalization) Report

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## Rehospitalization Rate in Context

Facility 10				Division:	Corp	PR National
PointRight ID		CMS		Division II		
Group of Patients	Number of Medicare Admissions	Observed Readmission Rate	Adjusted Readmission Rate	Adjusted Readmission Rate	Adjusted Readmission Rate	Adjusted Readmission Rate
All Patients	244	27.5%	27.9%	22.7%	24.96%	20.4%
CHF	68	27.9%	23.5%	22.3%	24.84%	20.5%
COPD	43	37.2%	33.1%	26.7%	25.41%	20.8%
CVA	32	21.9%	20.5%	21.5%	23.13%	19.7%
Diabetes	81	27.2%	23.8%	20.2%	24.58%	20.4%
Pneumonia	15	6.7%	6.4%	21.4%	22.22%	22.7%
Recent Surgery	39	23.1%	21.5%	18.0%	23.25%	20.4%
High Risk	46	37.0%	22.9%	22.8%	23.33%	20.4%
Medium Risk	156	26.3%	28.3%	20.8%	25.42%	20.4%
Low Risk	42	21.4%	42.0%	30.4%	30.63%	20.4%
Strong points:		Pneumonia,				
Weak points:		CHF, COPD, CVA, Diabetes, Recent Surgery, High Risk, Medium Risk, Low Risk,				
Major effect of risk adjustment:		CHF, COPD, Diabetes, High Risk, Low Risk,				

"Boldface type " is used to indicate a readmission rate calculation based on a small sample size of less than 40

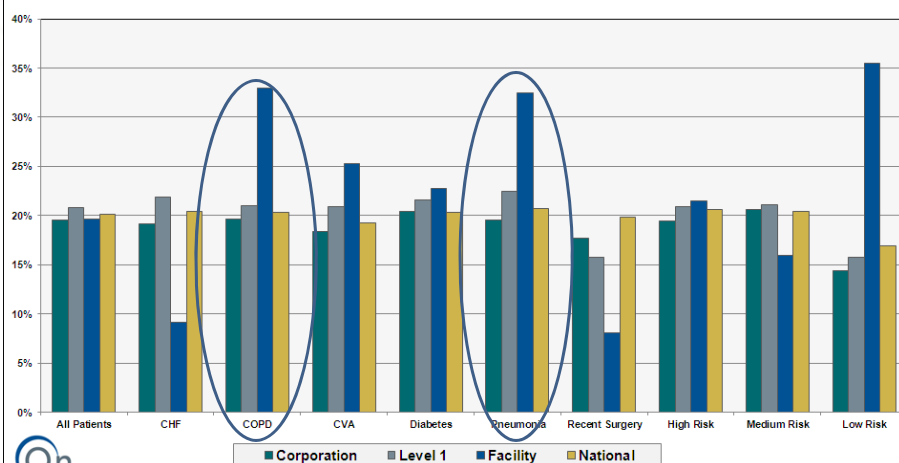
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## Rehospitalization Rates by Clinical Category

Facility Level 30-Day Rehospitalization Rates for Medicare Admissions by Diagnosis and Risk Group



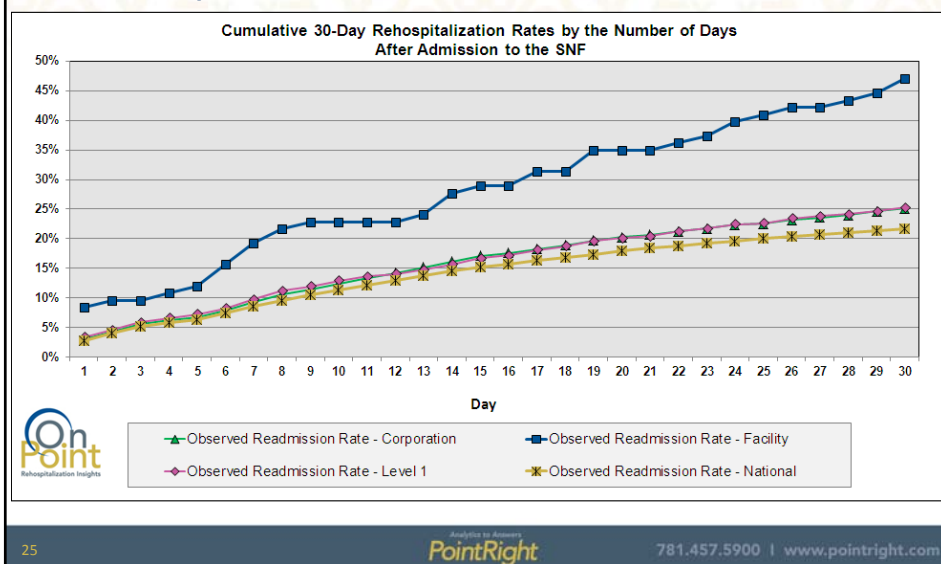
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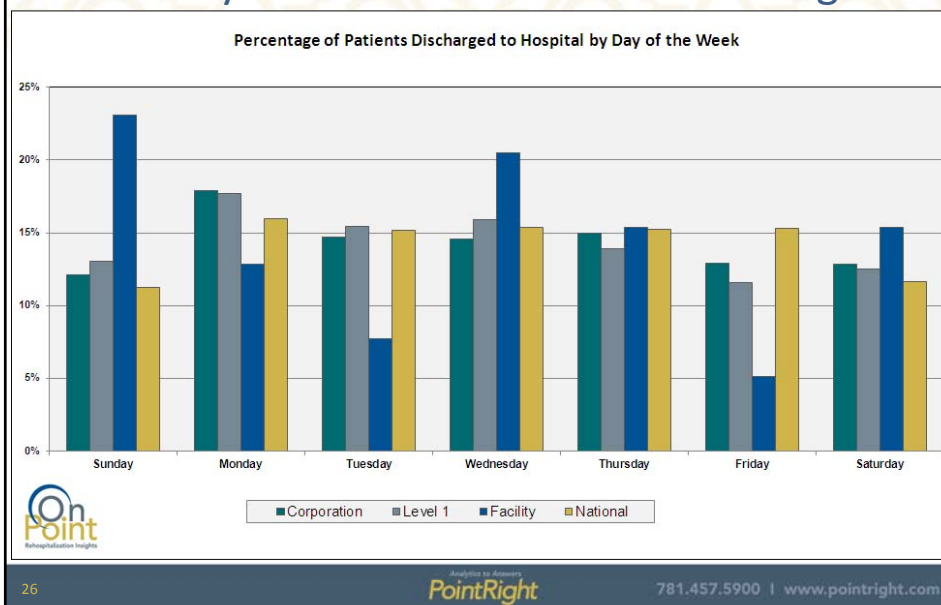
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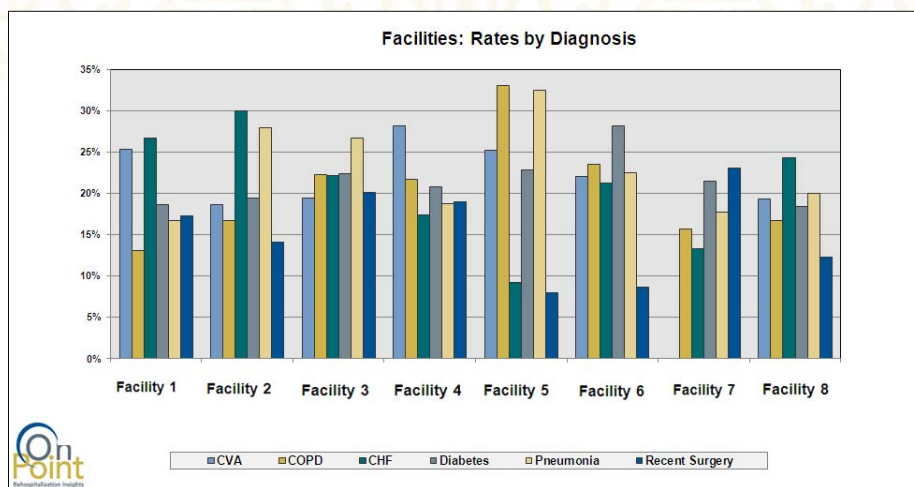
## First 30-Day Insight-Cumulative Rehospitalization Rate



## Weekday Distribution Of Acute Discharges



## Corporate Managers: Know Your Facilities' Differences



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## Risk Adjustment: Take Away Message

- Many facilities that excel in preventing rehospitalization in one cohort are challenged in others
- A non-case mix adjusted rehospitalization rate, that is not disease specific challenges goals for networking with hospitals and ACOs
- Facility rehospitalization rates are NOT the same as hospital rates; need to manage your cohorts and know your strengths and weaknesses
- Set up processes to easily identify resident conditions and the reason/diagnosis for returning to the hospital
  - Investigate RCA of poor outcomes
- Enhance clinical programming and staff competencies

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## So, What Do You Do?

- High Rehospitalization Rate
  - You know it's there
  - You know it's a problem
- Addressing the problem requires focus, structure and a systems approach that is data-driven
- The framework: QAPI

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## QUALITY ASSURANCE PERFORMANCE IMPROVEMENT (QAPI)

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## Quality Assurance Performance Improvement (QAPI) Background

- Part of 2010 ACA Sec.6102 (c), establishes standards for QAPI program in NHs
  - Provide technical assistance to nursing homes for meeting new standards (was to be available in 2012)
  - 17 state demonstration project- Sept 2011 to Aug 2013; nursing home questionnaire
- QAPI regulation is in process (June 2012 S&C memo)
  - Facilities are required to have written QAPI plans one year after promulgation of regulations
- QAPI regulations will be in addition to current QAA guidelines at F520
  - Identifying and correcting quality issues
  - DON, a physician and three staff members
  - Meet minimally quarterly
- S&C memo 12-14-2012- “QAPI at a Glance”
  - Materials to be posted by February 2013

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## Systems Approach

- QAPI shifts the focus of QAA to organization-wide involvement in continuous improvement activities that are data-driven
- Five Elements of QAPI:
  - 1) Design and Scope
  - 2) Governance and Leadership
  - 3) Feedback, Data Systems and Monitoring
  - 4) Performance Improvement Projects (PIPs)
  - 5) Systematic Analysis and Systemic Action
- Performance is measured and managed in order to report on how well an organization meets and sustains its quality, operational, and financial goals
- The nursing homes QAPI Plan needs to address all five elements
  - Simultaneous process
  - Particular to nursing homes’ own programs and services

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## Five Elements of QAPI

### Element 1: Design and Scope

- Written plan is comprehensive, deals with full range of services offered by the facility, all departments. Should address all systems of care and management practices and always include the areas of:
  - Clinical quality
  - Quality of life
  - Resident choice
- Current standards of practice, evidenced-based to define and measure goals

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## Five Elements of QAPI (cont.)

### Element 2: Governance and Leadership

- Governing body and/or administration develops and leads the program
- Input from staff, residents and families
- Combine culture of safety with resident-centered choice
- Strive for a “Just” environment that promotes accountability without blame and shame
- Success requires a top-down approach that empowers individuals to act within a known set of standards
- Staffing and Resources: Appropriate staffing patterns and tools to carry out day to day work

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## Five Elements of QAPI (cont.)

### Element 3: Feedback, Data Systems and Monitoring

- Systems for gathering and analysis of data from multiple data sources
  - Staff, Residents, Families
  - Tracking and monitoring adverse events (each time they occur)
  - Wide range of processes to track performance compared to internal and external benchmarks; set appropriate goals and re-measure

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## Five Elements of QAPI (cont.)

### Element 4: Performance Improvement Projects (PIPs)

- PIPs are conducted by facility to examine and improve care or services in areas needing attention
- Concentrated effort on a particular problem; one area or facility-wide

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## Five Elements of QAPI (cont.)

### Element 5: Systematic Analysis and Systemic Action

- Systems approach to performance improvement
  - Highly structured approach to determine cause of problems
  - Will need to develop policies on Root Cause Analysis (RCA); CQI and similar principles apply
  - Plan, Do, Study, Act (PDSA) applies to systemic action and PIPs

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## QAPI at a Glance

- S &C: 13-05-NH- December 14, 2012
  - Preview of Nursing Home QAPI materials
- “QAPI at a Glance: A Step by Step Guide to Implementing Quality Assurance and Performance Improvement (QAPI) in Your Nursing Home”
  - Draft of guide
- Expected to have this core set of materials posted to the QAPI website by February 2013; final version and materials by Spring 2013
- Operative word “embed”- processes into day to day work of providing quality care and services

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## QAPI at a Glance

### Twelve Action Steps to QAPI

- Step 1: Leadership Responsibility and Accountability
- Step 2: Develop a Deliberate Approach to Teamwork
- Step 3: Take your QAPI “Pulse” with a Self-Assessment
- Step 4: Identify Your Organization’s Guiding Principles
- Step 5: Develop Your QAPI Plan
- Step 6: Conduct a QAPI Awareness Campaign
- Step 7: Develop a Strategy for Collecting and Using QAPI Data
- Step 8: Identify Your Gaps and Opportunities
- Step 9: Prioritize Quality Opportunities and Charter PIPs
- Step 10: Plan, Conduct and Document PIPs
- Step 11: Getting to the “Root” of the Problem
- Step 12: Take Systemic Action

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## Quality Assurance/Performance Improvement (QAPI)

- QAPI will be in the forefront for all systems – risk, reimbursement and compliance
- Takes reasonable steps to achieve compliance with its standards, such as by ***utilizing monitoring and auditing systems...***
- Proactive system versus reactive system
- Involves all members of organization to continuously identify opportunities for improvement and address gaps in systems (culture shift)

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## QAPI AND REHOSPITALIZATION

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## Systems Approach: Care Transitions and Acute Change in Condition

- Organizational Commitment
  - Know your rate
  - Leadership accountability in service delivery
    - Equipment needs, Diagnostics, Partnerships, Staff
- Care Transitions and Acute Change in Condition Policies and Protocols
  - Many different tools out there
  - Be consistent
- Education – Staff, Resident/Family
- Staffing Patterns
- Quality Improvement Metric
  - Rehospitalization rate

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## QAPI and Rehospitalization

- Facility QAPI committee identifies increased trend in residents being rehospitalized within 30 days of admission
  - Further research reveals rehospitalization rate has increased above national benchmark
  - PIP is chartered and PIP team assembled
    - Nurse manager, Admissions director, Social worker, Medical Director, CNA

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## QAPI and Rehospitalization

- Analysis of prior rehospitalization data to identify areas of focus
  - Diagnoses of discharged residents
  - Day of discharge
  - Length of Stay-cumulative rehospitalization rate
- Identify gaps in the system and areas for improvement

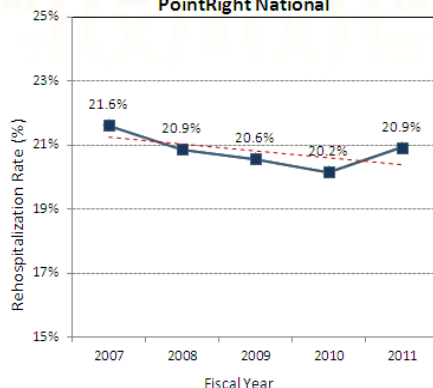
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## Do You Know Your Rehospitalization Rate?

Trend Analysis of Medicare 30-Day for PointRight National



- Medicare 30-day rate
  - Denominator- Medicare/PPS admissions (5-day or return assessment) to the SNF from an acute care hospital
  - Numerator- Those Medicare admissions that return to an acute care hospital within 30 days of entry to the SNF
  - Rates usually yearly
    - Rolling 12-month rate
- Resident Roster
- Root cause analysis

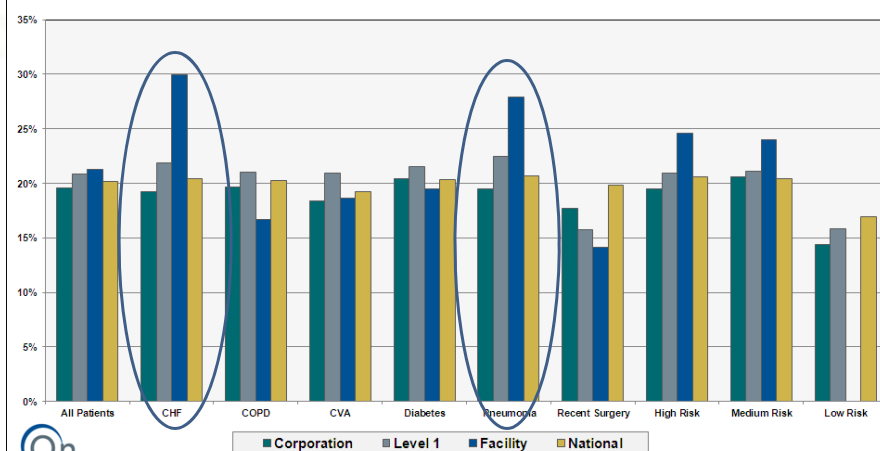
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## Diagnoses-Strengths and Weaknesses

Facility Level 30-Day Rehospitalization Rates for Medicare Admissions by Diagnosis and Risk Group



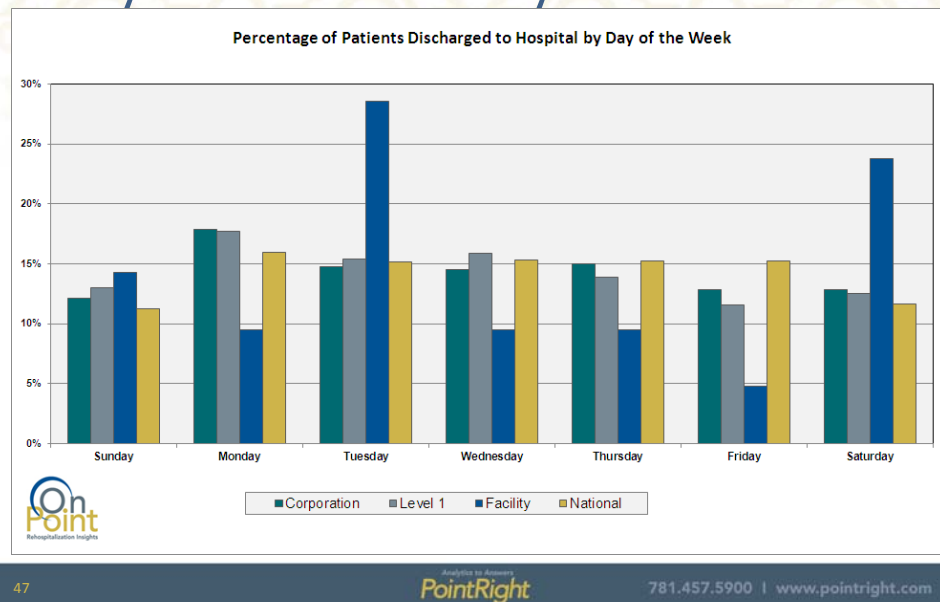
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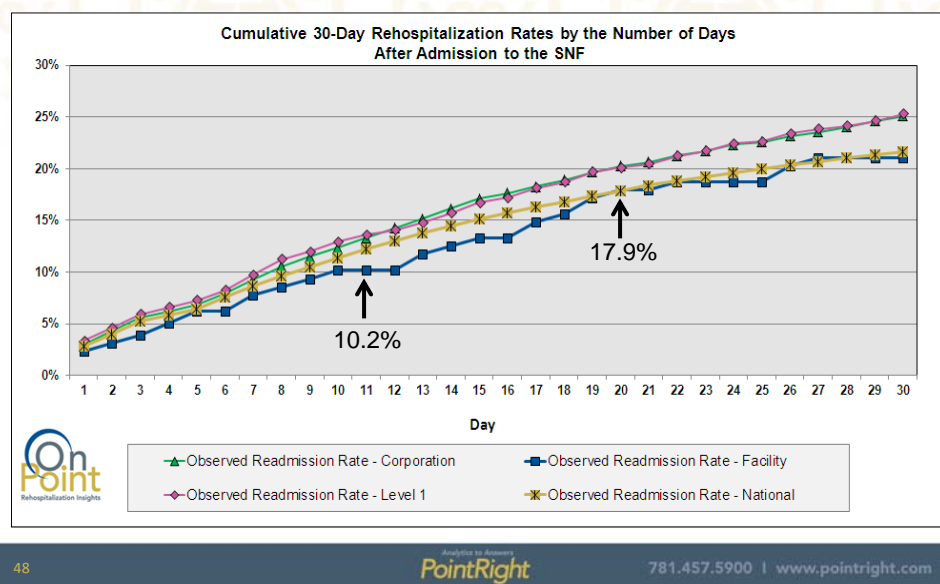
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## Day of the Week-Any Patterns?



## Cumulative Trend-Systemic Issues?



## What Next?

- Problem areas found:
  - CHF/Pneumonia diagnoses
  - Tuesdays and Saturdays-highest number of discharges to hospital
  - Upward trend in cumulative rehospitalization rate between days 10-20 of resident's stay
- Now What?

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## Root Cause Analysis (RCA)

- Assemble your team
  - Administrator, DON, Unit Managers, Medical Director to start
  - Additional members as needed: therapy, pharmacy, PCPs, NPs, discharge planners, etc.
- Analyze high rehospitalization rate within 30 days of admission: Why?
  - Assess internal discharge planning process and systems to identify and act on early change in condition
  - How involved are PCPs?
  - What is the relationship with acute care facility?
  - Target problem diagnoses to start with

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## Root Cause Analysis (RCA) cont.

- Assess Staffing (RNs, LPNs)
  - Staff competencies
    - Assessment skills: Respiratory/Cardiac, Functional
    - Technical skills: IV/other parenteral administration
    - CNA Skills: Vital Signs, Weights, Intake/output
- Other resources: Pharmacy, Radiology, etc.
- Physicians, Physician Extenders, NPs
  - Availability and reliability
  - Response to staff
- Families
  - Understanding of disease processes
  - Communication about when to hospitalize

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## What Did You Find?

- Systemic issues:
  - New admission protocols dropped off after first week
    - Weights, I&O monitoring
  - Contracted services
    - Stat X-rays, stat med orders not available
  - Internal staffing
    - Lack of RN coverage nights/weekends

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## PDSA



- **Plan:** Identifying and analyzing the problem
  - Identify exactly what the problem is using lookback trends and any patterns that have been identified
  - Draw together any other information your team needs that will help start sketching out solutions (RCA)
- **Do:** Developing and testing a potential solution
  - Generate possible solutions
  - Select the best of these solutions
  - Implement as a pilot or with a select group
- **Study:** Measuring how effective the test solution was, and analyzing whether it could be improved in any way
  - Measure how effective the pilot solution has been
  - Gather together any learning from it that could make it even better
- **Act:** Implementing the improved solution fully
  - Implement your solution, but remember that the process is ongoing
  - Loop back and reevaluate to continuously improve

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## Test Solutions

- Revise/reinforce new admission protocols for CHF/pneumonia admissions
  - Staff competency evals and education
- Revise contracts with X-ray and pharmacy
  - Availability of stat services
  - Communicate stat protocols to MDs and staff
- Rearrange staffing to provide more RN coverage
  - Start with current staff before looking into per diem/contract

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## Use Available Process Tools and Resources

- Internal Tools
  - Admission data
  - Shift Communication/Change of Condition forms
- Interact II
  - Early Warning Tool
  - “Stop and Watch”
  - SBAR Communication Tool and Progress Note
  - Quality Improvement Tool For Review of Acute Care Transfers
  - Advance Care Planning Tools
- QIO Support
  - NJ QIO: Healthcare Quality Strategies, Inc.
    - Communities in Action program
- AHCA LTC Trend Tracker
  - Free resources for AHCA members
    - Risk adjusted rehospitalization rate

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## Moving Forward-The “PI” in QAPI

- What do I do?
  - Implement hospitalization predictive analytics
  - Consider membership in one of the local or national initiatives
  - Partner with referring hospital(s) to implement an interoperable EHR to freely (while HIPAA compliant) exchange health information including:
    - Admitting Diagnoses/Relevant Medical History
    - Labs & Radiology
    - Surgery & Rehab notes
    - Pharmacy
- Why is this important?
  - Predicting hospitalization helps focus on right resident and direct feedback loop for improvement
  - This level of communication with other care providers has the best possibility for reducing hospitalization
- Who is in charge of this?
  - EVERYONE – and then some

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## How to Impact your Rate

- Determine membership in QI team to spearhead the initiative
- Drive the use of data , including predictive analysis for risk
  - Do you know who's at risk?
- Know your rehospitalization rate and what is influencing it
  - Use AHCA or PR risk adjusted metric
- Communicate your success stories with referring hospitals
- Partner in community on programs needing improvement

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## Moving Forward: Care Transitions and Acute Change of Condition Protocols- the Right Way

### Helpful Principles

- Not all rehospitalizations should be prevented
  - Acute care may be medically necessary in many situations
  - Accurate assessment of care needs is critical
  - Need to watch carefully for inappropriate “observation care” at hospital
    - CMS looking into this area
- Watch for premature hospital discharge and ensure your facility can provide the necessary care
- Admit to your scope of services; know your capabilities
  - Strong facility admissions coordinator gathering consistent information on care needs
  - Establish a process for this “new admission” review by the clinical team; be prepared for the resident (treatments, supplies etc.)
- Collaboratives and partnerships may allow for better feedback to referring hospital

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## Moving Forward: Staffing Patterns

- Staffing patterns
  - Appropriate number and type of staff ?
    - Are you staffing to acuity? Five Star levels? RUG acuities? Something else?
    - Consistent assignments
    - RN support and oversight
    - LN with adequate competencies
  - Collaborative interdisciplinary team for care planning;
  - Managing risk assessment results- risk of imminent death, risk of rehospitalization
- Physician / Physician Extender support
  - Evaluate your process for patient/resident evaluation by physician/physician extender
- Multidisciplinary team adequacy
  - Adequate admission process

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## Moving Forward: Education

- Staff Education
  - Elements for all staff levels
  - Orientation
  - Competencies updated and reviewed
    - Clinical skill sets
    - “Transition-specific care competencies”
  - Bring consultants and medical services on board with the quality focus
  - Provide “background” information to put into context
- Resident and Family Education
  - Ensure resident and families have opportunity to contribute
  - Materials specific to resident and families
    - End of life- advance directives etc.
    - Disease conditions
- Community Collaboration
  - Partner with health care professionals in community

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## The Data of Healthcare Reform It's About Being Measurably Successful

### Your Data House...

- Discharge Disposition
- Functional/Clinical Outcomes
- Error Rate
- Satisfaction
- Cost Information
- Survey Performance
- Staffing

### ...and What "They" Know About You

- Discharge Disposition
- Functional/Clinical Outcomes
- Error Rate
- Satisfaction
- Cost Information
- Survey Performance
- Staffing

**What is the difference: Timeliness, Accuracy, Context**

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## Thank You!

- Questions?
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## Care Transitions and Acute Change of Condition (ACOC) Management Systems

- Interact II <http://interact2.net>- Evidence-based care transitions interventions
- AMDA- Clinical Practice Guidelines in the Long Term Care Setting [www.amda.com/tools/guidelines.cfm](http://www.amda.com/tools/guidelines.cfm)
  - Acute Change of Condition; COPD Management; Diabetes Management; Pain Management; Dehydration and Fluid Management , and many more.....
- AGS- Guidelines and Tools [www.americangeriatrics.org](http://www.americangeriatrics.org)
  - Pain; Diabetes; Psychosis and Behavioral Aspects of Dementia, and more.....
- BOOST- Better Outcomes for Older Adults Through Safe Transitions [www.hospitalmedicine.org/BOOST](http://www.hospitalmedicine.org/BOOST)
- Project RED- RE-Engineered Discharge [www.bu.edu/fammed/projectred/](http://www.bu.edu/fammed/projectred/)
- Bridge Model- first and only social work based approach to transitional care [www.transitionalcare.org/the-bridge-model](http://www.transitionalcare.org/the-bridge-model)
- Transitional Care Nursing Model- a master's prepared nurse with advanced knowledge and skills is primary coordinator of care to assure continuity throughout acute episodes of care [www.transitionalcare.info](http://www.transitionalcare.info)
- POLST or MOLST- Physician (Medical) Orders For Life Sustaining Treatment [www.ohsu.edu/polst/](http://www.ohsu.edu/polst/)
- National Hospice and Palliative Care Organization [www.nhpco.org](http://www.nhpco.org)

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## Resources:

- Boutwell, A. Effective Interventions to Reduce Rehospitalizations: A Survey of the Published Evidence. Cambridge, MA: Institute for Healthcare Improvement, March 2009.
- CMS Innovations <http://www.innovations.cms.gov/>
- Care Transitions - Colorado Foundation for Medical Care <http://www.cfmc.org/integratingcare/>
- Coleman, Eric. What Will It Take to Ensure High Quality Transitional Care? The Care Transitions Program. 2011 <http://www.caretransitions.org/>
- Hospital to Home, National Quality Improvement Initiative <http://h2hquality.org/>
- Interact 2 <http://interact2.net/>
- Jencks et al. Rehospitalization among Patients in the Medicare Fee-for-Service Program. NEJM, 2009;360:1418-28.
- Jacobson et al. Medicare Spending and Use of medical Services for Beneficiaries in Nursing Homes and Other Long-Term Care Facilities: A Potential for Achieving Medicare Savings and Improving the Quality of Care. The Henry j. Kaiser Foundation. October 2012
- More Nurses in Nursing Homes Would Mean Fewer Patients Headed to Hospitals//CMA. <http://www.medicareadvocacy.org>
- National Transitions of Care Coalition <http://www.ntocc.org/>
- Reducing Rehospitalizations...The Right Way//CMA <http://www.medicareadvocacy.org>

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