Title: *Transitions of Care processes for Seniors Clinic: improving care coordination*

**Abstract:**

**Statement of Problem:** The Hospital Readmission Reduction program reduces Medicare payments for hospitals with excess readmissions. Current research suggests intensive and earlier care management show promise in reducing readmission rates.

**QI-Approach:** Seniors Clinic at the Anschutz Medical Campus Outpatient Pavilion (SC) and the Ambulatory Health Promotion (AHP) team at the University of Colorado, School of Medicine have developed a novel multidisciplinary protocol. During 8/2014 to 8/2015, SC patients discharged from University of Colorado Hospital (UCH) to home were identified by AHP research coordinators and contacted within 2 days of discharge for appropriate follow up. SC pharmacists provided telephone medication reconciliation and a transitions of care appointment was scheduled within 14 days.

**Outcomes:** Intervention occurred with 302 patients over 12 months with 17.8% readmissions, matching UCH Medicare readmission in 2010. 95.7% of patients had medication reconciliation and 57.9% were seen by a geriatrician within 14 days. Patients following up with a specialist instead of a geriatrician had a 1.68 relative risk of readmission. Additionally, 35.1% of readmissions were identified as potentially preventable readmissions (PPR). PPR average time to readmit was 12.15 days which falls within the 14-day window, indicating need for earlier intervention. Multiple variables were identified as risk factors between PPR and non-readmission groups.

**Next Steps:** Identify high risk patients for readmission for earlier and additional interventions. A risk calculator based on preliminary data and high risk intervention protocol are being developed.