Why the Focus on Care Transitions?

- Significant number of readmissions
  - 1 out of 5 Medicare patients, many preventable readmissions

- Significant harm:
  - 1 out of 5 of patients have an Adverse Event after discharge

- Regulatory Pressures
  - PPACA contains penalties for hospitals with “excess” readmissions
Objectives

- Describe how we got here
- Demonstrate variability in rates of rehospitalization
- Outline key healthcare reform legislation components
- Review options to BOOST the hospital discharge transition

Health Care Costs Rising Faster than CPI
BIG piece of the $3.5 Trillion Government Pie - 2010

- Social Security: $754.2
- Treasury: $444.3
- Defense: $666.7
- CMS: $729.1
- Other: $861.5

Source: U.S. Treasury

Nation’s Health Care Dollar 2010

- Private Insurance: 32.3¢
- Medicare: 20¢
- Medicaid: 16¢
- Out-of-Pocket: 11.4¢
- Other Private: 7.1¢
- Other Government Programs: 13.2¢

Source: CMS/DACH

- CMS - 48 cents of every dollar received by hospitals
- 28 cents of every dollar spent on physicians services
How Long Will the Trust Funds Last?
Number of years the Medicare and Social Security trust funds are estimated to remain solvent.

Sources: Centers for Medicare and Medicaid Services; Social Security Administration

The Cost of a Long Life
June 2007 MedPAC Report

- Medicare pays for ALL admissions regardless
  - Initial stay or readmission for same condition
- 17.6% of admissions result in re-admissions within 30 days (6% in 7 days)
  - = $15 billion in spending
- Future
  - Public Disclosure of readmission rates
  - Lower case payments for readmissions

HospitalCompare.hhs.gov

Welcome to Hospital Compare. In this tool you will find information on how well hospitals care for patients with certain medical conditions or surgical procedures, and results from a survey of patients about the quality of care they received during a recent hospital stay. This information will help you compare the quality of care hospitals provide. Talk to your doctor about this information to help you, your family and your friends make your best hospital care decisions.

www.hospitalcompare.hhs.gov
Rehospitalizations among Patients in the Medicare Fee-for-Service Program

Stephen F. Jencks, M.D., M.P.H., Mark V. Williams, M.D., and Eric A. Coleman, M.D., M.P.H.

- 1 in 5 Medicare patients rehospitalized in 30 days
- Half never saw outpatient doc
- 70% of surgical readmissions—chronic medical conditions
- Costs $17.4 billion


Rates of Rehospitalization within 30 Days after Hospital Discharge
Abstraction: Almost one-fourth of Medicare beneficiaries discharged from the hospital to a skilled nursing facility were readmitted to the hospital within thirty days; this cost Medicare $4.34 billion in 2006. Especially in an elderly population, cycling into and out of hospitals can be emotionally upsetting and can increase the likelihood of medical errors related to care coordination. Payment incentives in Medicare do not encourage providers to coordinate beneficiaries’ care. Revising these incentives could achieve major savings for providers and improved quality of life for beneficiaries.

Trends in Length of Stay and Short-term Outcomes Among Medicare Patients Hospitalized for Heart Failure, 1993-2006

- Observational study of 6,955,461 Medicare FFS hospitalizations for HF; 1993 and 2006, with 30-day f/u.
  - Mean age = 80
  - 52% Htn, 38% DM, 37% COPD
  - LOS 8.8 days down to 6.3
- Discharges to SNF increased from 13% to 20%
  - Discharge to home decreased from 74% to 67%
- 30 day readmission increased from 17.2% to 20.1%
  - Post-discharge mortality increased from 4.3% to 6.4%
- In-hospital mortality declined from 8.5% to 4.3%
- 30-day mortality declined from 12.8% to 10.7%
A Problem for a long time

- Rosenthal, J. M. and D. B. Miller
  "Providers have failed to work for continuity." Hospitals 53(10): 79-83.

- Continuity of patient care between different health care settings has been advocated for nearly 20 years, but little has been done to affect it. The study described here emphasizes the current lack of effort by health care providers in hospitals and nursing homes to find a workable solution.

Eric Coleman, MD, MPH

- Director, Care Transitions Program
  University of Colorado Denver

- Reducing readmissions “jumps off the page as an area where we could see enormous savings in national health expenditures.”

- “We’re pretty good at identifying who’s at risk of readmission, but it’s harder to say who’s at modifiable risk.”
Reform – It’s here!

- H.R. 3590, the Patient Protection and Affordable Care Act
  - H.R. 4872 the Health Care and Education Reconciliation Act
- Paying for quality instead of quantity
- Demonstration projects

Donald Berwick, MD, MPP
Administrator for CMS

- “High quality health care does not necessarily mean the most expensive health care.”
- CMS aims to become a leader in health care improvement and reward delivery of value in health care.
Quality versus Quantity

May 9, 2009

Hospitals Pay for Cutting Costly Readmissions

By REED ABELSON

It is one of the biggest avoidable costs on the nation’s medical bill.

“As Congress debates health care, some policy experts say no meaningful improvement can be made without changing the payment system so medical centers have more financial incentive to help people stay out of the hospital.”

Reducing Readmissions = Reducing Revenue?

- Asthma Prevention Program at Children’s Hospital of Boston
  - 62% reduction in ER visits
  - 82% reduction in hospitalizations
  - $1300 cost savings per child over 2 years
  - ROI of 1.46

- Savings to society and insurers

- Hospital “loses” revenue and pays for program
Affordable Care Act and Reducing Readmissions

### §3026
- Beginning in FY 2011
- Community-Based Care Transitions Program

### §3501
- For Period FY 2011-2014
- AHRQ funding for projects related to QI research and technical assistance. Topics identified include reducing readmissions.

### §399KK
- March 2012
- Program for eligible hospitals to improve their readmission rates through Patient Safety Organizations

### §3025
- Beginning in FY 2013
- Hospitals with higher than expected readmissions rates will experience decreased payments for Medicare discharges

Section 3025 of ACA

- **Hospital Readmissions Reduction Program**
  
  Financial penalties on hospitals for “excess” readmissions vs. “expected”

- **All DRG** payment amounts in hospitals with excess readmission are reduced by a factor determined by the level of “excess, preventable readmissions”
  - HF, AMI, Pneumonia; Effective FY2013
  - Excess = ratio of actual to expected (risk-adj)
  - Reduction of up to 1%, 2%, 3% first 3 years
  - $7.1 billion in savings over 10 years
Hospital Discharge - currently

“Random events connected to highly variable actions with only a remote possibility of meeting implied expectations.”

Roger Resar, MD
Agent of Tremendous Change
and Global Innovation Seeker
Luther Midelfort – Mayo Health System
Senior Fellow, IHI

Dangers of Discharge

Annals of Internal Medicine

The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital

• 19% of patients had a post discharge AE
  - 1/3 preventable and 1/3 ameliorable

Adverse events among medical patients after discharge from hospital

• 23% of patients had a post discharge AE
  - 28% preventable and 22% ameliorable
**Dangers of Discharge**

**Improving Patient Care**

**Patient Safety Concerns Arising from Test Results That Return after Hospital Discharge**

Christopher L. Roy, MD; Eric G. Porey, MD, MPH; Andrew S. Karon, MD, MPH; Zahra Ladeh-Merchant, BDS, MPH; Robin E. Johnson, BA; Savero M. Marigóba, MD, MSc; and Tejpal K. Gandhi, MD, MPH


- 1095 of 2644 (41%) inpatients discharged with test result pending
  - 191 (9.4%) potentially required action
  - Survey of MDs involved: almost 2/3 unaware of results
  - Of these: 37% actionable and 13% urgent

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**Dangers of Discharge**

**Tying Up Loose Ends**  *Arch Intern Med. 2007;167:1305-1311*

Discharging Patients With Unresolved Medical Issues

Carlton Moez, MD; Thomas McGinn, MD, MPH; Ethan Holm, MD, MPH

- ¼ of discharged patients require additional outpatient work-ups
- > 1/3 not completed
- Increased time to post-discharge f/u associated with lack of work-up completion
- Availability of discharge summary increased likelihood of work-up being done
Medication Reconciliation

Results of the Medications At Transitions and Clinical Handoffs (MATCH) Study: An Analysis of Medication Reconciliation Errors and Risk Factors at Hospital Admission

Kirstine M. Gleason, RPh1,7, Molly R. McDaniel, PharmD1,5, Joseph Feinglass, PhD2,3, David W. Baker, MD, MPH2,3, Lee Lindquist, MD, MPH2,3, David Liss, MA2,5, and Gary A. Noskin, MD3,4

- 21 minute Pharmacist interviews – 36% order errors
  - ¼ required increased monitoring or intervention
  - 10% harmful
- 49% omission error, 30% wrong dose; 11% frequency
- Elderly and larger # of meds increased risk
- Medication List protective to avoid errors

Hospitalist to PCP

- Info transfer and communication deficits at hospital discharge are common
  - Direct communication 3-20%
  - Discharge summary availability at 1st post-discharge appt 12-34%; 51-77% at 4 weeks
  - Discharge summaries often lack info
    - Dx test results (33-63%), hospital course (7-22%), discharge meds (2-40%), pending test results (65%)
    - Follow-up plans (2-43%), Counseling (90-92%)

Kripalani S, LeFevre F, Phillips CO, Williams MV, Basaviah P, Baker DW
JAMA 2007;297:831-41.
Discharge Summary

Adequacy of Hospital Discharge Summaries in Documenting Tests with Pending Results and Outpatient Follow-up Providers

Martin C. Were, MD MS1,2, Xiaochun Li, PhD1,2, Joe Kesterson, MA2, Jason Cadwallader, MD1, Chifu Asawa, MD1, Babar Khan, MD1, and Marc B. Rosenman, MD1,2

Indiana University School of Medicine, Indianapolis, IN, USA; 1Regenstrief Institute, Inc., Indianapolis, IN, USA;
J Gen Intern Med 2009;24:1002-6

BACKGROUND: Poor communication of tests whose results are pending at hospital discharge can lead to medical errors.

OBJECTIVE: To determine the adequacy with which hospital discharge summaries document tests with pending results and the appropriate follow-up providers.

Discharge summaries are grossly inadequate at documenting both tests with pending results and appropriate f/u providers.

Consensus Principles and Standards for Managing Care Transitions

<table>
<thead>
<tr>
<th>Principle</th>
<th>Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability</td>
<td>All transitions must include records that contain necessary required elements. schlul elements should also be included.</td>
</tr>
<tr>
<td>Responsibility</td>
<td>At every point during care transitions, patients (and their families) must have roles who are responsible for care and how to contact those persons. Transition responsibility belongs to the sending clinics and organizations until the receiving providers confirm assurance of responsibility.</td>
</tr>
<tr>
<td>Coordination of Care</td>
<td>As the hub of care, coordinating clinicians must provide timely communication to other care providers.</td>
</tr>
<tr>
<td>Family Involvement</td>
<td>Patients and families must be involved in and retain ownership of transition records, including information needed to identify patients' medical care homes and coordinating clinicians.</td>
</tr>
<tr>
<td>Communication</td>
<td>Clinicians or institutions must provide a clear and direct communication infrastructure, including transition records, treatment plans, and follow-up expectations.</td>
</tr>
<tr>
<td>Timeliness</td>
<td>Transition teams must provide information feedback and lead forward based on transition settings, patient circumstances, level of severity, and transition responsibilities.</td>
</tr>
<tr>
<td>National standards and metrics</td>
<td>Standardized communication formats for care transitions should be adopted, implemented, and used for accountability and continuous quality improvement. Standardized methods of measuring outcomes should be implemented across healthcare settings.</td>
</tr>
</tbody>
</table>

Minimum required information in the transition record:
- Principal diagnosis and problem list
- Admission and discharge date
- Specific action of the coordinating physician/midlevel and contact information
- Transfer code
- The results and pending test results

*Full information in the transition record plus all additional required information
- Emergency plan and contact person, including telephone number
- Treatment and diagnostic plan
- Physiologic and goals of care
- Advance directives, power of attorney, and agent
- Manual interventions and other critical topics

1,2,3 National standards and metrics

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Post discharge - follow-up by RN or MD

- Naylor et al: RN visit post d/c for geriatric medical patients
  *decreased rehospitalizations*
  - 10% vs. 23% (p = 0.04) @ 6 wks
  - N/S by 12 weeks

- Anderson et al: MD visit post d/c for stroke decreased rehospitalizations
  - 26% vs. 44% @ 6 months

Who would pay for this?

- Randomized 363 patients age > 65
- “Comprehensive discharge planning” and home follow-up with APNs
- ~70% completion rate
- Readmissions at 24 weeks 20% vs 37%
  - Reduced multiple readmissions 6.2% vs 14.5%
  - Prolonged time to first readmission
  - Medicare reimbursements cut in half
Elderly patients transitioning to SNF/home
Randomized: Intervention group paired with “Transition Coach” vs. standard care
Empowerment and education: 4 pillars
  - Facilitate self management/adherence
  - Maintain a personal health record
  - Timely follow-up
  - Knowledge and management of complications
Education during hospitalization
  - including meds and med reconciliation
Phone calls and personal visits by TC post discharge
N=750

Results

<table>
<thead>
<tr>
<th></th>
<th>Interv</th>
<th>Cont</th>
<th>P(adj)</th>
<th>OR (95%CI)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehospitalization</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Within 30d</td>
<td>8.3</td>
<td>11.9</td>
<td>0.048</td>
<td>0.59 (0.35-1.00)</td>
</tr>
<tr>
<td>Within 90d*</td>
<td>16.7</td>
<td>22.5</td>
<td>0.04</td>
<td>0.64 (0.42-0.99)</td>
</tr>
<tr>
<td>Within 180d*</td>
<td>25.6</td>
<td>30.7</td>
<td>0.28</td>
<td>0.80 (0.54-1.19)</td>
</tr>
</tbody>
</table>

Costs($)

<table>
<thead>
<tr>
<th></th>
<th>Interv</th>
<th>Cont</th>
<th>Unadj</th>
<th>Log Transformed</th>
</tr>
</thead>
<tbody>
<tr>
<td>At 30d</td>
<td>784</td>
<td>918</td>
<td>0.048</td>
<td>0.06</td>
</tr>
<tr>
<td>At 90d</td>
<td>1519</td>
<td>2016</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>At 180d</td>
<td>2058</td>
<td>2546</td>
<td>0.04</td>
<td>0.049</td>
</tr>
</tbody>
</table>

*Also significantly improved for “Rehospitalization for same diagnosis as index admission.”
A Comprehensive Pharmacist Intervention to Reduce Morbidity in Patients 80 Years or Older

A Randomized Controlled Trial  Arch Intern Med. 2009;169(9):894-900

Ulrika Gillepste, MSc Pharm; Anna Alasaaad, MSc Pharm; Dan Henrik, MD, MSc, Pharm;
Hans Garmo, PhD; Margareta Hammarslund-Ulman, PhD; Henrik Toss, MD, PhD;
Asa Kettnis-Lindblad, PhD; Hakan Melhus, MD, PhD; Claes Morlin, MD, PhD

- Swedish ward-based pharmacists
- 16% reduction in hospital visits
- 47% reduction in ER visits
- Drug-related readmissions reduced 80%
- Intervention group cost < control

A Reengineered Hospital Discharge Program to Decrease Rehospitalization

A Randomized Trial

Brian W. Jask, MD; Venziga K. Chetly, PhD; David Anthony, MD, MSc; Jeffrey L. Groenwald, MD; Gail M. Saracca, PharmD, BCGP;
Anna E. Johnson, RN; Shaila K. Forsythe, MA, MPH; Julie K. O'Donnell, MPH; Michael K. Plassche-Orlow, MD, MA, MPH;
Christopher Wannestall, MD; Stephen Martin, MD, MIt; and Larry Calpepper, MD, MPH

Background: Emergency department visits and rehospitalization are common after hospital discharge.

Objective: To test the effects of an intervention designed to mitigate hospital utilization after discharge.

Design: Randomized trial using block randomization of 6 and 8. Randomly assigned index cards were placed in opaque envelopes labeled consecutively with study numbers, and participants were assigned a study group by revealing the index card.

Setting: General medical service at an urban, academic, safety-net hospital.

Patients: 749 English-speaking hospitalized adults (mean age, 49.9 years).

Intervention: A nurse discharge advocate worked with patients during their hospital stay to arrange follow-up appointments, confirm medication reconciliation, and conduct patient education with an individualized instruction booklet that was sent to their primary

Outcomes were self-reported preparedness for discharge and frequency of primary care provider follow-up within 30 days of discharge. Research staff doing follow-up were blinded to study group assignment.

Results: Participants in the intervention group (n = 370) had a lower rate of hospital utilization than those receiving usual care (n = 379) (0.314 vs. 0.451 visits per person per month; incidence rate ratio, 0.695; 95% CI, 0.515 to 0.937; P = 0.009). The intervention was most effective among participants with hospital utilization in the 6 months before index admission (P = 0.014). Adverse events were not assessed; these data were collected but are still being analyzed.

Limitation: This was a single-center study in which not all potentially eligible patients could be enrolled, and outcome assessment sometimes relied on participant report.

Conclusion: A package of discharge services reduced hospital utilization within 30 days of discharge.
Project RED

- RCT of 749 hospitalized adults
- Intervention
  - Nurse Discharge Advocate
    - F/U appt, Medication Reconciliation
    - Patient education
  - Individualized instruction booklet
  - Pharmacist call 2-4 days post-discharge
    - Review medications
- Limitations
  - Urban, academic, safety net hospital

Project RED Outcomes

<table>
<thead>
<tr>
<th></th>
<th>Intervention (n = 370)</th>
<th>Control (n = 368)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ER Visits*</td>
<td>16.5%</td>
<td>24.5%</td>
</tr>
<tr>
<td>Rehospitalization**</td>
<td>15%</td>
<td>21%</td>
</tr>
<tr>
<td>PCP f/u in 30 days*</td>
<td>62%</td>
<td>44%</td>
</tr>
<tr>
<td>Prepared for Discharge*</td>
<td>65%</td>
<td>55%</td>
</tr>
</tbody>
</table>

*p < 0.05
**p = 0.09

Mean age = 50
Mean LOS = 2.6 to 2.8 days
Exclusions: Admitted from SNF
Discharged to SNF
Low-cost Intervention

Redefining and Redesigning Hospital Discharge to Enhance Patient Care: A Randomized Controlled Study

Richard B. Balaban, MD, Joel S. Weissman, PhD, Peter A. Samuel, BS, and Stephanie Woolhandler, MD

1. “user-friendly” Patient Discharge Form
2. Telephone outreach from a nurse post-discharge
3. Improved outpatient follow-up
4. Reduced ER visits and rehospitalizations from historical controls

Original Research

Reduction of 30-Day Postdischarge Hospital Readmission or Emergency Department (ED) Visit Rates in High-Risk Elderly Medical Patients Through Delivery of a Targeted Care Bundle

1. Med Rec by PharmD
2. RN Care Coordinator D/C Planning
3. Phone Follow-up
4. PHR, Supplemental Discharge Form

Reduced ER visits, Reduced Readmission
Project BOOST
Improving Hospital Care Transitions

Mark V. Williams, MD, FACP, FHM
Professor & Chief, Division of Hospital Medicine
Northwestern University Feinberg School of Medicine
Principal Investigator, Project BOOST

Tina Budnitz, MPH
Project Director, Project BOOST

June 1, 2011

www.hospitalmedicine.org/BOOST

Project BOOST

California HealthCare Foundation
The John A. Hartford Foundation

www.hospitalmedicine.org/BOOSTCA
Advisory Board

Chair: Eric Coleman, MD, MPH
Co-Chair & PI: Mark Williams, MD

with organizational representatives from:

- Social work
- Case management
- Clinical pharmacy
- Geriatric medicine
- Geriatric nursing
- Health IT
- Blue Cross/Blue Shield
- United Health
- Health systems
- NQF
- AHRQ
- TJC
- CMS
- National Consumer’s League
- Other content experts
Key Components

- BOOST Tools & Intervention
  - Available for free at: www.hospitalmedicine.org/BOOST
  - Project Management tools
    - Clinical Tools:
      - Comprehensive risk assessment on admission—8Ps
      - Risk specific interventions during stay & at discharge
      - Patient centered discharge process
        - Teachback
        - F/U appt scheduled prior to discharge
        - Standardized PCP communication
        - 72 hour follow-up call for high risk patients

- Mentored Implementation
  - Longitudinal coaching throughout planning and implementation
  - Ongoing educational opportunities
  - BOOST Community/Collaborative

TARGET Assessment Tool - The 8Ps
Tool for Addressing Risk: a Geriatric Evaluation for Transitions

- Prior hospitalization
- Problem medications
- Psychological
- Principal diagnosis
- Polypharmacy
- Poor health literacy
- Patient support
- Palliative care

- Risk Specific Checklist
- GAP: General Assessment of Preparedness
The General Assessment of Preparedness: The GAP

- Caregivers and social support circle for patient
- Functional status evaluation completed
- Cognitive status assessed
- Abuse/neglect
- Substance abuse
- Advanced care planning addressed and documented

On Admission

- Understanding of dx, treatment, prognosis, follow-up and post-discharge warning S/S (using Teach Back)
- Transportation to initial follow-up

At Discharge

Nearing Discharge

Patient PASS
Patient Preparation to Address Situations (after discharge) Successfully

I was in the hospital because

Important contact information:
1. My primary doctor:
   
2. My hospital doctor:
   
3. My visiting nurse:
   
4. My pharmacy:
   
5. Other

My appointments:
1. On __/__/__ at __:__ am/pm
   For:
2. On __/__/__ at __:__ am/pm
   For:
3. On __/__/__ at __:__ am/pm
   For:
4. On __/__/__ at __:__ am/pm
   For:

Tests and issues I need to talk with my doctor(s) about at my clinic visit:
1. 
2. 
3. 
4. 
5. 

Other instructions:
1. 
2. 
3. 

I understand my treatment plan. I feel able and willing to participate actively in my care.

Patient/Caregiver Signature

Provider Signature

Date
• Discharge Patient Education Tool

• DIAGNOSIS
  – I had to stay in the hospital because: ________
  – The medical word for this condition is: ________
  – I also have these medical conditions: ________

• TESTS
  While I was in the hospital I had these tests:
  which showed:

• TREATMENT
  While I was in the hospital I was treated with:
  The purpose of this treatment was:

FOLLOW-UP APPOINTMENTS
  After leaving the hospital, I will follow up with my doctors.
  Primary Care Doctor: __________________________ Phone Number: __________________________
  DATE: __________, __ __ __, 200__ TIME: __:__ __m
  Specialist Doctor: __________________________ Phone Number: __________________________
  DATE: __________, __ __ __, 200__ TIME: __:__ __m

FOLLOW-UP TESTS
  After leaving the hospital, I will show up for my tests.
  TESTS
  LOCATION
  DATE
  TIME

  __________, __ __ __, 200__ __:__ __m

Call your Primary Care Doctor for the following:

  WARNING SIGNS
    1)
    4)

LIFE STYLE CHANGES
  After leaving the hospital, I will make these changes in my activity and diet.
  Activity: __________________________, because __________________________
  Diet: __________________________, because __________________________

NEW CONCEPT: Health Information, Advice, Instructions or Change in Management

Teach Back

Assess Patient Recall & Comprehension Ask Patient to Demonstrate

Explain / Demonstrate New Concept

Patient Recalls and Comprehends/ Demonstrates Mastery

Re-assess Recall & Comprehension Ask Patient to Demonstrate

Clarify & Tailor Explanation

Adherence/ Error Reduction

Life-Cycle Project BOOST

Training & Preparation

Individualized Mentoring

6-9 months 9-12 months

Training

2 Day Training

Intervention Toolkit
Teach-back Training
Peer-learning Project Planning
Mentor reviewed action plan

Redesign care processes
Staff education
Tailor tools
Develop policies, procedures, order sets
Evaluation Plan

Implement intervention
Keep stakeholders informed
Monitor core elements

Surveillance
Analyze data
Adjust intervention components
Report to stakeholders
Spread gains

26
Mentored Implementation

- Secret Sauce for Project BOOST
- Target hospitalists at sites
  - QI effector arm
- Mentor conference calls with hospital QI team
  - Email follow-up
- Mentor
  - experienced physician with QI expertise

Beyond BOOST

- Some patients need more attention and support beyond the foundation provided by Project BOOST
- Frail elderly patients with multiple medical problems, multiple medications and potentially multiple social issues
References

- Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital.
- Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital.
References