FONDAZIONE POLIAMBULANZA
Istituto Ospedaliero

Una rivisitazione delle post acuzie

Brescia, 6 maggio 2016
Grg Journal Club

Stefano Boffelli

PER PUNTI:

Definizione
Il punto di vista economico: riospedalizzazioni
Percorsi per pazienti fragili

Meno ospedale, più post acuti (misurare gli outcome)
Il percorso: cosa può fare l'ospedale

Il percorso: cosa deve fare la post acuzie
-organizzazione e requisiti
-pagamento
-procedure e risultati

Post-acuzie con diversi obiettivi
Alcuni risultati

Our vision is of a society of healthy communities where all individuals reach their highest potential for health

American Hospital Association

Many patients receiving care in the inpatient hospital setting require specialized follow-up care known as post-acute care.

Post-acute care covers a wide range of services that facilitate continued recovery with a focus on restoring medical and functional capacity to enable the patient to return to the community and prevention of further medical deterioration.

Post-acute care settings include long-term care hospitals, inpatient rehabilitation facilities, skilled nursing facilities and home health agencies.

The American Hospital Association (AHA) supports enhanced coordination between general acute-care hospitals and post-acute providers to improve overall quality of care and reduce total health spending. Outlined below are some of the ways AHA works on behalf of post-acute care providers to fulfill this vision.

Hospital readmissions have been used increasingly as an outcome measure for assessing performance of the health care system.

For example, Partnership for Patients, a national initiative sponsored by the Department of Health and Human Services, is tracking changes in all-cause 30-day hospital readmissions.

Efforts to reduce hospital readmissions range from reengineering discharge practices and improving care transition to building community-wide partnerships for addressing health and social service needs.

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DOVE CI SIAMO ARENATI FINORA…

LA FUNZIONE DELLE POST ACUZIE E’

LA RIDUZIONE DELLE RIOSPIEDALIZZAZIONI, ERGO

LA RIDUZIONE DEL COSTO DI DEGENZA DELL’OSPEDALE, OVVERO

LA RIDUZIONE DELLE SPESE TOTALI DI GESTIONE DEI PAZIENTI IN AND OUT HOSPITAL

TUTTA LA POST ACUZIE AL SERVIZIO DELL’OSPEDALE, PURCHE’ NON TORNI INDIETRO..

ECONOMIA (SPICCIOLA, SHORT TERM, NON COST-EFFECTIVENESS) VERSUS PERCORSI DI CURA

LA COLPA DEL MALATO DI ESSERE MALATO, QUINDI FRAGILE,CLINICAMENTE INSTABILE, FUNZIONALMENTE DIPENDENTE, MA ANCHE POVERO E SOLO

CHE , QUINDI, RITORNA: HOSPITAL DEPENDENT PATIENT, CHRONIC CRITICAL ILLNESS, ETC…

By Vincent Mor, Orna Intrator, Zhanlian Feng, and David C. Grabowski

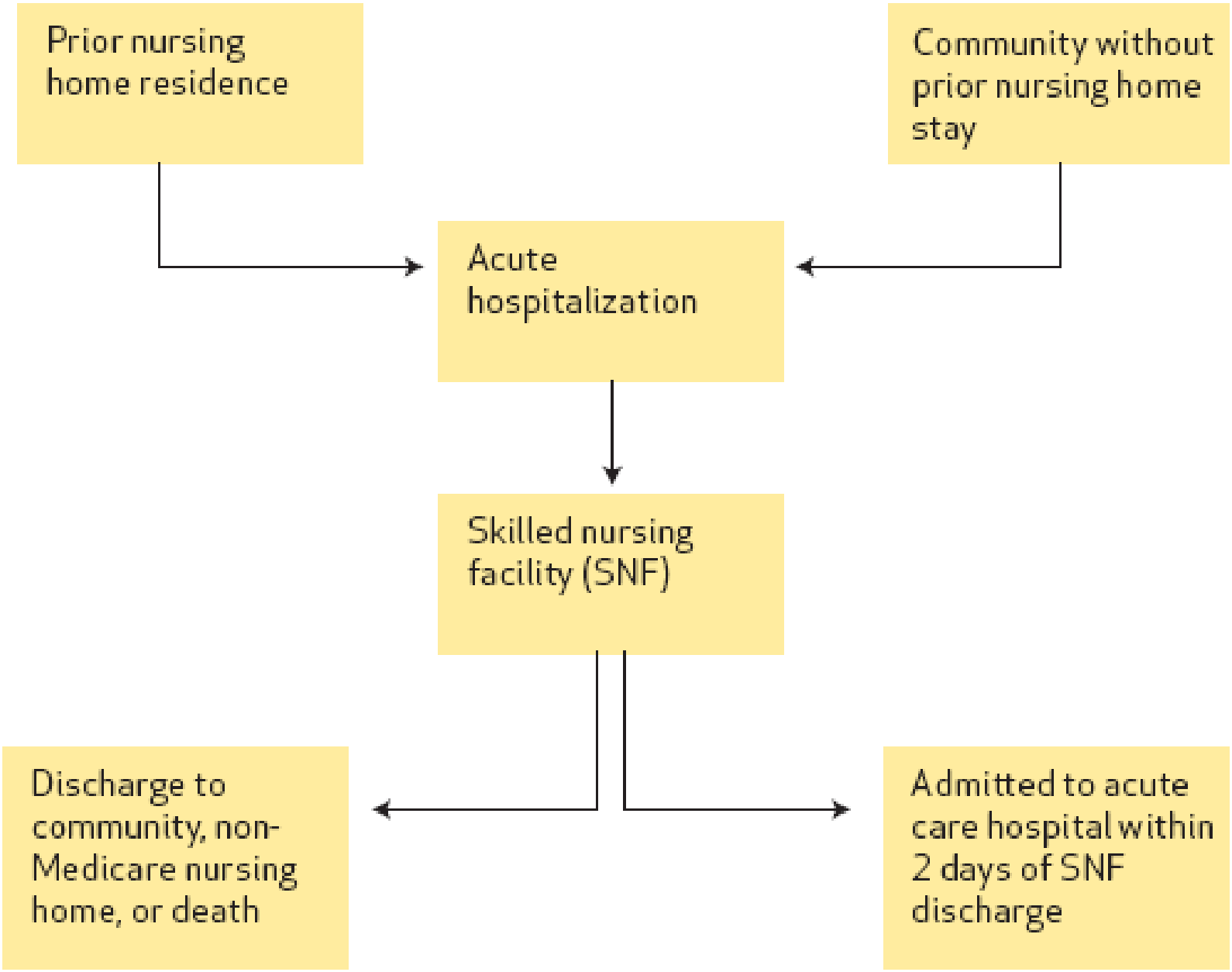
The Revolving Door Of Rehospitalization From Skilled Nursing Facilities

doi: 10.1377/hlthaff.2009.0629
HEALTH AFFAIRS 29,
NO. 1 (2010): 57–64

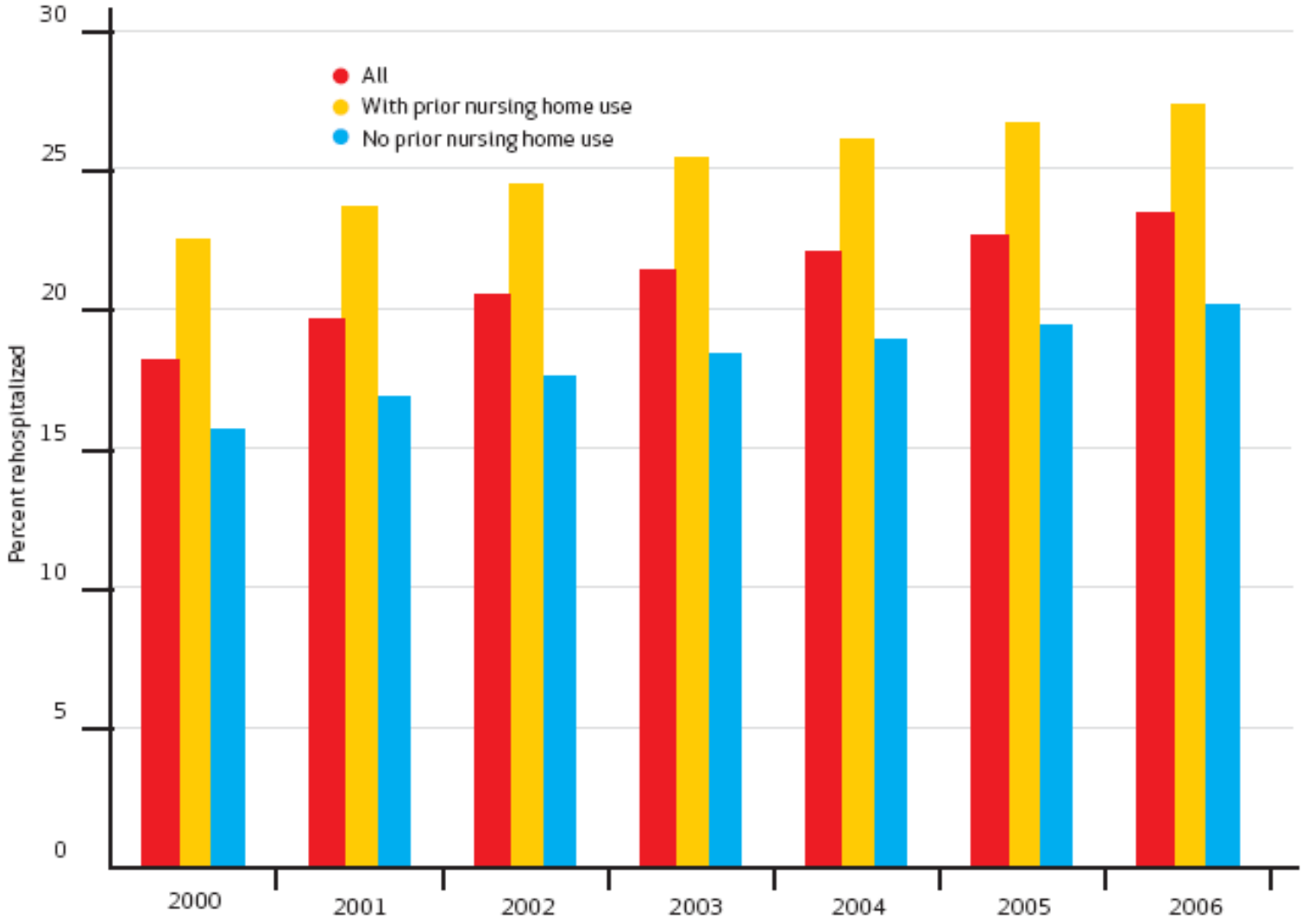
ABSTRACT **Almost one-fourth of Medicare beneficiaries discharged from the hospital to a skilled nursing facility were readmitted to the hospital within thirty days; this cost Medicare $4.34 billion in 2006. Especially in an elderly population, cycling into and out of hospitals can be emotionally upsetting 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.**

Vincent Mor is chair of the Department of Community Health at the Brown University Warren Alpert School of Medicine, Providence, Rhode Island. He formerly served as director of the Brown University Center for Gerontology and Health Care Research.

Orna Intrator is an applied statistician and health services researcher and an


Prior nursing home residence
Community without prior nursing home stay
Acute hospitalization
Skilled nursing facility (SNF)
Discharge to community, non-Medicare nursing home, or death
Admitted to acute care hospital within 2 days of SNF discharge

Trends In Rehospitalization Rates From Skilled Nursing Facilities: 2000–2006



SOURCE Authors' calculations using Medicare inpatient and skilled nursing facility claims and eligibility data and the Minimum Data Set, Centers for Medicare and Medicaid Services.

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Thirty-Day Readmissions — Truth and Consequences

Karen E. Joynt, M.D., M.P.H., and Ashish K. Jha, M.D., M.P.H.

Only a small proportion of readmissions at 30 days after initial discharge are probably preventable, and much of what drives hospital readmission rates are patient- and community-level factors that are well outside the hospital's control.

Furthermore, it is unclear whether readmissions always reflect poor quality: high readmission rates can be the result of low mortality rates or good access to hospital care.

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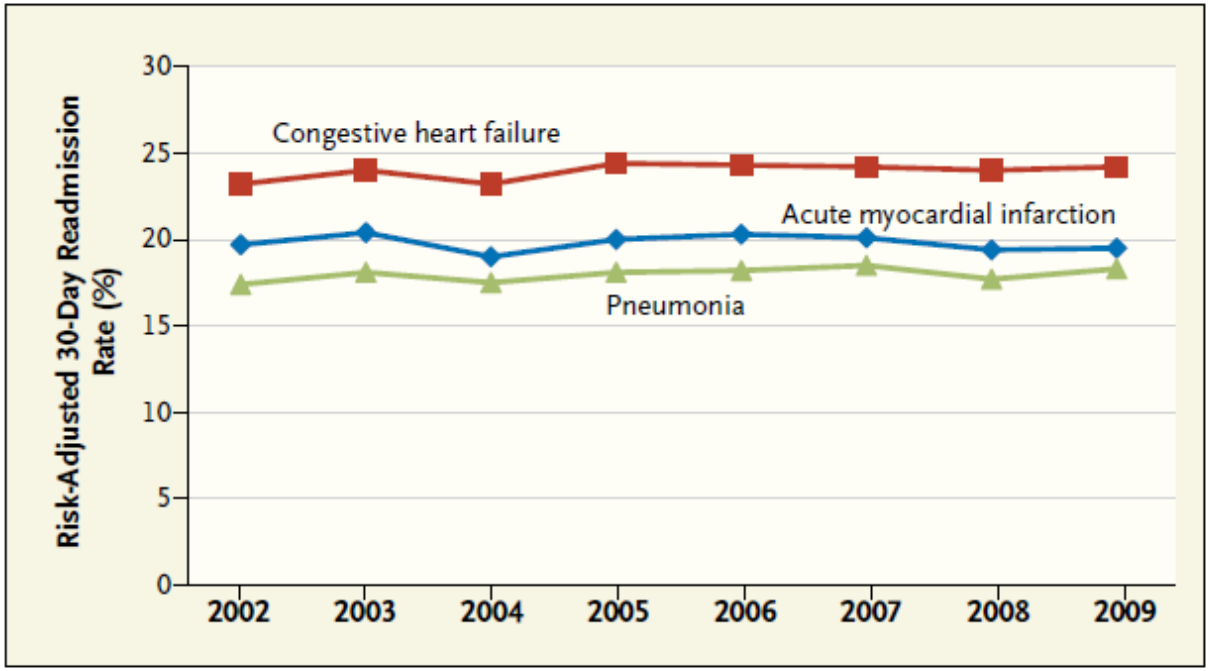
Second, although improving discharge planning and care coordination is a laudable goal, there are better, more targeted policies that are more likely to be effective in achieving it.

Finally, because hospitals are expending so much energy on reducing readmissions, they have probably forgone quality improvement efforts related to more urgent issues, such as patient safety.



National Trends in 30-Day Readmission Rates, 2002–2009.
Rates are authors' calculations based on Medicare data.

An evidence-based, holistic approach to quality improvement is far more likely to achieve what policymakers, clinicians, and the public all want: better care at lower cost.

We know that some of the most important drivers of readmissions are mental illness, poor social support, and poverty, which are often deeply ingrained.

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As clinicians, we recognize that discharge planning and care coordination are often ineffective.

But, over the past decade, we have seen very little improvement in patient safety, and although mortality rates have declined for a few conditions, they remain high for most others. Many of these deaths are preventable.

Yet we are focusing tremendous resources on preventing rehospitalizations for three conditions that account for approximately 10% of all hospital admissions in the Medicare population.

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Medicare's Readmissions-Reduction Program — A Positive Alternative

Robert A. Berenson, M.D., Ronald A. Paulus, M.D., M.B.A., and Noah S. Kalman, B.A.

10.1056/NEJMp1201268 NEJM.ORG

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Hospital readmissions are receiving increasing attention as a largely correctable source of poor quality of care and excessive spending. According to a 2009 study, nearly 20% of Medicare beneficiaries are rehospitalized within 30 days after discharge, at an annual cost of $17 billion.

Causes of avoidable readmissions include hospital-acquired infections and other complications; premature discharge; failure to coordinate and reconcile medications; inadequate communication among hospital personnel, patients, caregivers, and community-based clinicians; and poor planning for care transitions. Although studies have shown that specific interventions, particularly among patients with multiple medical conditions, can reduce readmission rates by 25 to 50%, 30-day readmission rate did not change appreciably between 2004 and 2009. Unless they are at full capacity, hospitals have no economic incentive to reduce readmissions under Medicare's diagnosis related group (DRG) payment approach.

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There is a simple alternative approach. A single-episode price for all services associated with a surgical procedure, such as coronaryartery bypass grafting,
including the initial hospitalization and all related services for 90 days, including any rehospitalizations — in essence, a warranty.
In adapting this approach to focus on readmissions, Medicare could eliminate or reduce payment (perhaps to the variable cost for the admission) for many or perhaps all readmissions within a designated interval after discharge.
We acknowledge that this approach has the perverse effect of further rewarding all admissions other than readmissions that fall within the 15- or 30-day window

Readmissions, Observation, and the Hospital Readmissions Reduction Program.Zuckerman R, Sheingold S, and Arnold M. Epstein N Engl J Med 2016; 374:1543-1551April 21, 2016

The Hospital Readmissions Reduction Program, which is included in the Affordable Care Act (ACA), applies financial penalties to hospitals that have higher-than-expected readmission rates for targeted conditions. Some policy analysts worry that reductions in readmissions are being achieved by keeping returning patients in observation units instead of formally readmitting them to the hospital. We examined the changes in readmission rates and stays in observation units over time for targeted and nontargeted conditions and assessed whether hospitals that had greater increases in observation-service use had greater reductions in readmissions.

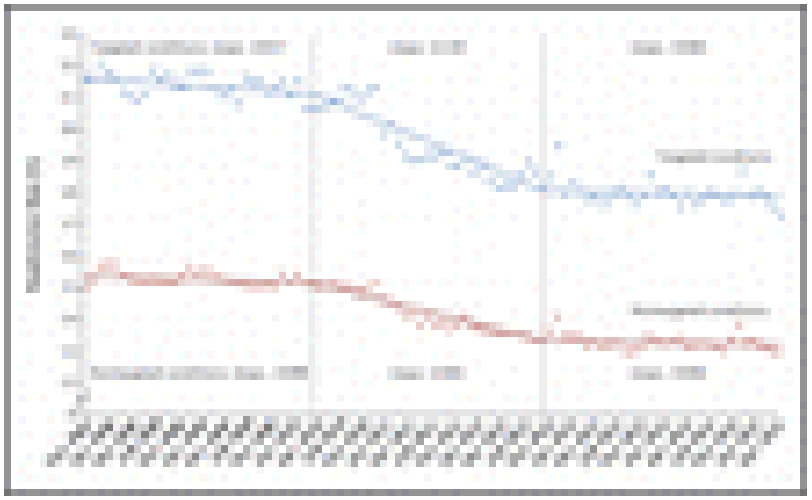
We compared monthly, hospital-level rates of readmission and observation-service use within 30 days after hospital discharge among Medicare elderly beneficiaries from October 2007 through May 2015. We used an interrupted time-series model to determine when trends changed and whether changes differed between targeted and nontargeted conditions. We assessed the correlation between changes in readmission rates and use of observation services after adoption of the ACA in March 2010.

We analyzed data from 3387 hospitals.
From 2007 to 2015, readmission rates for targeted conditions declined from 21.5% to 17.8%, and rates for nontargeted conditions declined from 15.3% to 13.1%.

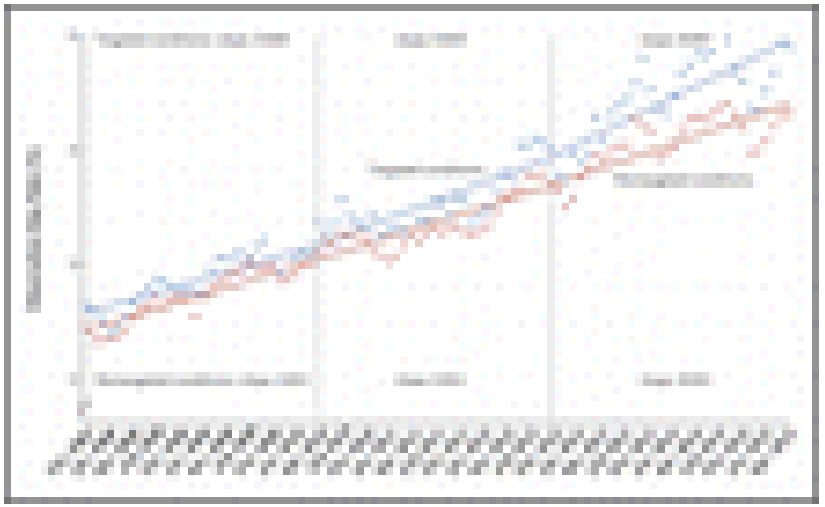
Shortly after passage of the ACA, the readmission rate declined quickly, especially for targeted conditions, and then continued to fall at a slower rate after October 2012 for both targeted and nontargeted conditions.

Stays in **observation units** for targeted conditions increased from 2.6% in 2007 to 4.7% in 2015, and rates for nontargeted conditions increased from 2.5% to 4.2%.
Within hospitals, there was no significant association between changes in observation-unit stays and readmissions after implementation of the ACA.

CONCLUSIONS
Readmission trends are consistent with hospitals' responding to incentives to reduce readmissions, including the financial penalties for readmissions under the ACA. We did not find evidence that changes in observation-unit stays accounted for the decrease in readmissions.



Change in Readmission Rates for Targeted Conditions and Nontargeted Conditions within 30 Days after Discharge.



Change in Observation-Service Use for Targeted Conditions and Nontargeted Conditions within 30 Days after Discharge.

Trends in Hospital Readmissions for Four High-Volume Conditions, 2009-2013

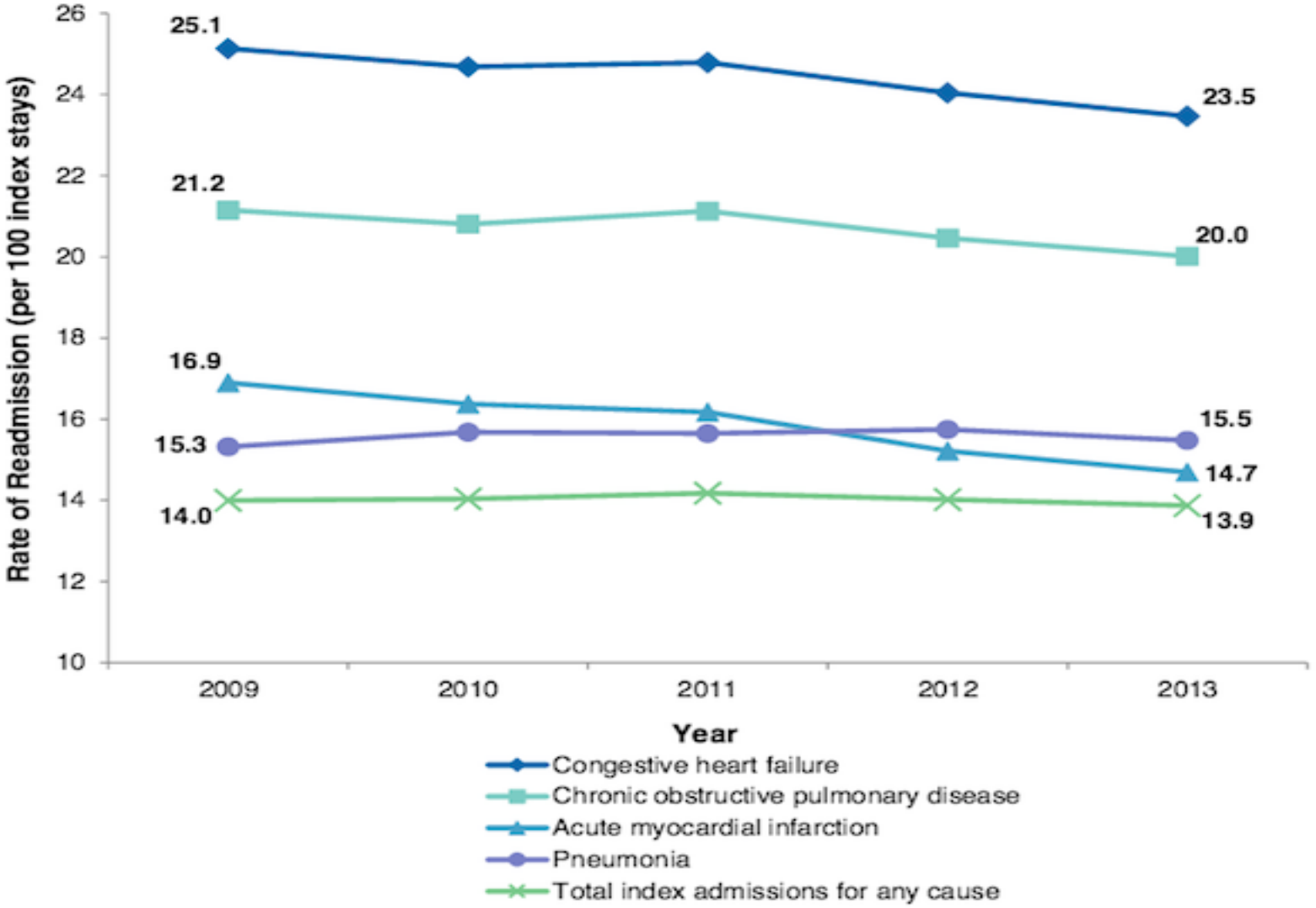
Kathryn Fingar, Ph.D., M.P.H., and Raynard Washington, Ph.D. - November 2015

Hospital readmissions can have negative consequences for patients and the hospitals at which they are treated, and also are costly for both public and private payers. In 2011, Medicare paid for 58 percent of all readmissions, followed by private insurance (20 percent) and Medicaid (18 percent).[1] Readmissions are a significant portion of Medicare spending—37 percent of total Medicare spending is for inpatient care, and 18 percent of all inpatient admissions paid by Medicare are readmitted within 30 days, accounting for $15 billion in costs annually.[2] In addition to these costs, repeat hospitalizations place patients at greater risk for complications, hospital acquired infections, and stress.[3] Because the majority of readmissions are for nonsurgical services, it is unlikely that readmissions are profitable for hospitals.[4]

Although it may be necessary to readmit some patients, the fact that risk-adjusted readmission rates vary considerably across hospitals suggests that **certain readmissions may be prevented through hospital practices, such as improving patient discharge instructions, coordinating postacute care, and reducing medical complications during the initial hospital stay**.

The Affordable Care Act established the Centers for Medicare & Medicaid Services Hospital Readmissions Reduction Program (HRRP) to provide a financial incentive for hospitals to reduce preventable readmissions. Effective in 2013, the HRRP imposes a financial penalty for hospitals with excess rates of readmissions for acute myocardial infarction (AMI), congestive heart failure (CHF), and pneumonia among Medicare beneficiaries. In 2015, penalties also will be calculated based on readmissions for chronic obstructive pulmonary disease (COPD) and hip and knee replacements.[6]

This Healthcare Cost and Utilization Project (HCUP) Statistical Brief examines trends from 2009 through 2013 for all readmissions following an admission for any cause, as well as for readmissions following an admission for four high-volume conditions targeted by the HRRP: AMI, CHF, COPD, and pneumonia. *Readmission* was defined as a subsequent hospital admission for any cause within 30 days following an initial hospital admission, referred to as the *index stay*. Because all-cause readmissions were examined, readmissions may or may not be related to the primary reason for admission during the index stay. Trends in the rate and aggregate cost of readmissions were examined overall and by expected payer of the index stay. Therefore, the expected payer of the readmission may be different from that of the index stay. Aggregate costs are those for the readmission only, not counting the cost of the index stay.



Rate of Hospital Readmission, by Principal Diagnosis of Index Admission Nov 25, 2015

Notes: All-cause readmissions. Principal diagnosis grouped according to the Clinical Classifications Software (CCS).
Data Sources: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), 2013 Nationwide Readmissions Database (NRD), and weighted national estimates from readmissions analysis files derived from the 2009-2012 State Inpatient Databases (SID).
Source: Agency for Healthcare Research and Quality/Healthcare Cost and Utilization Project: *Trends in Hospital Readmissions for Four High-Volume Conditions, 2009-2013*

All-Cause Readmissions by Payer and Age, 2009-2013

Marguerite L. Barrett, M.S., Lauren M. Wier, M.P.H., H. Joanna Jiang, Ph.D., and Claudia A. Steiner, M.D., M.P.H. - December 2015

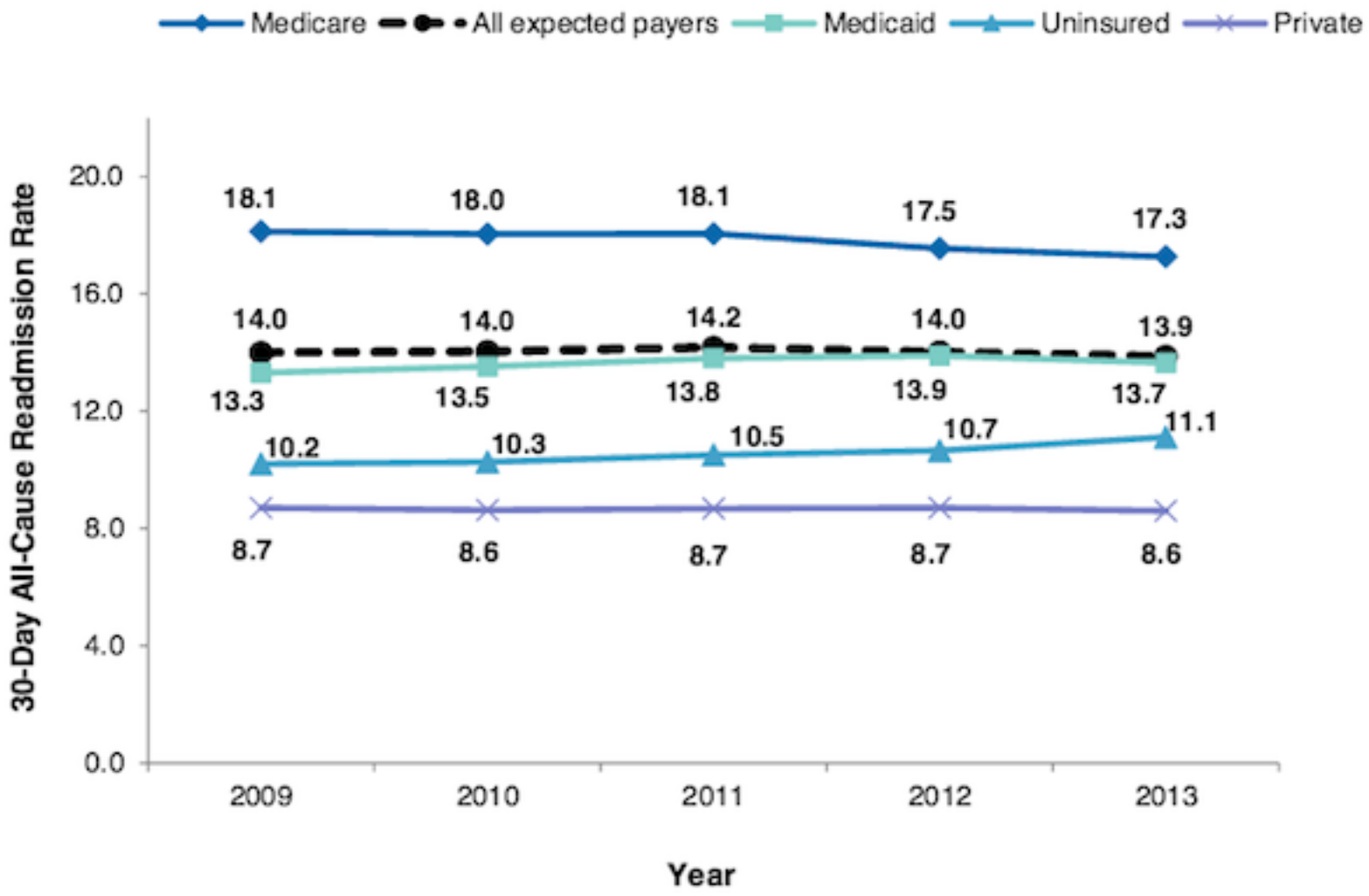
Introduction

Hospital readmissions have been used increasingly as an outcome measure for assessing performance of the health care system. For example, Partnership for Patients, a national initiative sponsored by the Department of Health and Human Services, is tracking changes in all-cause 30-day hospital readmissions.

Efforts to reduce hospital readmissions range from reengineering discharge practices and improving care transition to building community-wide partnerships for addressing health and social service needs.

Developing national benchmarks for hospital readmissions can help identify those patient populations with relatively high readmission rates for targeted improvement efforts. Furthermore, tracking changes in these benchmarks over time allows policymakers to monitor progress made toward reducing readmissions.

This Healthcare Cost and Utilization Project (HCUP) Statistical Brief presents data on 30-day all-cause readmissions among patients aged 1 year and older by expected payer and patient age group. Trends in readmissions by payer are provided from 2009 through 2013. Changes in readmission rates from 2009 through 2013 and costs for index admissions (the initial inpatient stays) and readmissions for 2013 also are presented by payer and age group. The expected payer is determined by the index admission, although the expected payer of the readmission may be different.



Rate of Hospital Readmissions by Expected Payer Dec 23, 2015

Notes: The expected payer is determined by the index admission, not the readmission. Rates by expected payer include all patients aged 1 year and older.

Data Sources: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), 2013 Nationwide Readmissions Database (NRD), and readmissions analysis files derived from the 2009–2012 State Inpatient Databases (SID).

Source: Agency for Healthcare Research and Quality/Healthcare Cost and Utilization Project: *All-Cause Readmissions by Payer and Age, 2009–2013*

Highlights

Readmissions among all patients covered by Medicare declined from 18.1 per 100 admissions in 2011 to 17.3 per 100 in 2013, after being essentially unchanged from 2009 to 2011. In contrast, the readmission rate among patients who were covered by private insurance or Medicaid did not change appreciably from 2011 to 2013.

Among uninsured individuals, both the number and rate of readmissions increased between 2009 and 2013 (10.6 percent increase in readmission count and 8.9 percent increase in readmission rate).

The readmission rate among nonmaternal patients aged 1-20 years increased substantially between 2009 and 2013: 22 percent increase for uninsured patients, 15 percent increase for those with private insurance, and 8 percent increase for Medicaid patients.

The average cost of a readmission was higher than the average cost of an index admission for all types of payers: 5 percent higher for patients covered by Medicare, 11 percent higher for uninsured patients, and about 30 percent higher for patients covered by Medicaid or private insurance.

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Il nucleo del problema si può riassumere in questi termini
Le riospedalizzazioni sono un fenomento legato a:
- Instabilità clinica del malato
- Incapacità di cura completa dell'ospedale per acuti (o degenza troppo breve per stabilizzare)
- Incapacità della rete extraospedaliera nel gestire il malato
- Tutte le precedenti?

Il problema è solo economico o la gestione economica è importante perché un sano risparmio permette di gestire meglio ridistribuendo le energie socio-assistenziali?
Deve esistere un modello di fluidità di cura dove le differenti parti giocano un ruolo coordinato?

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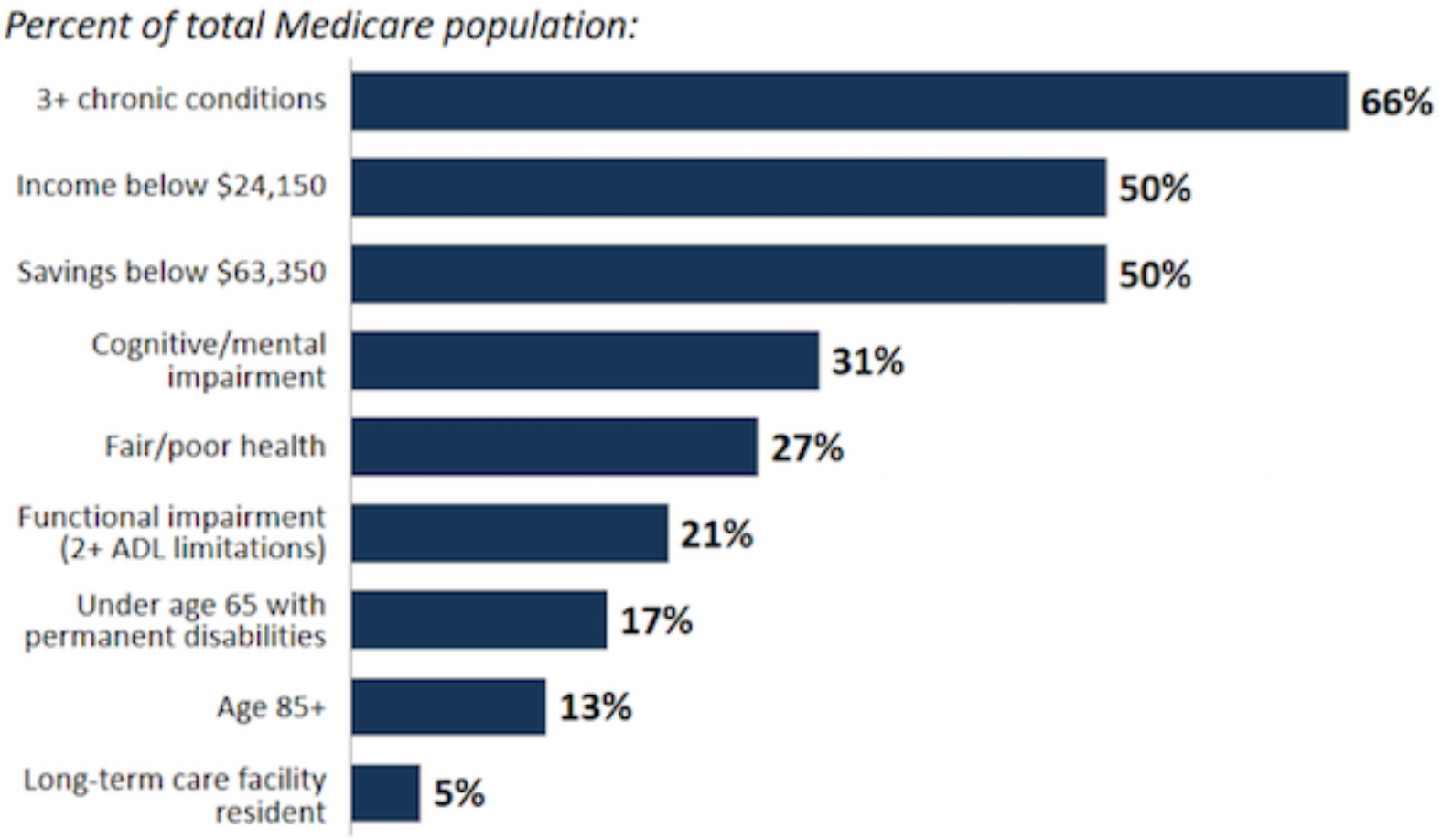
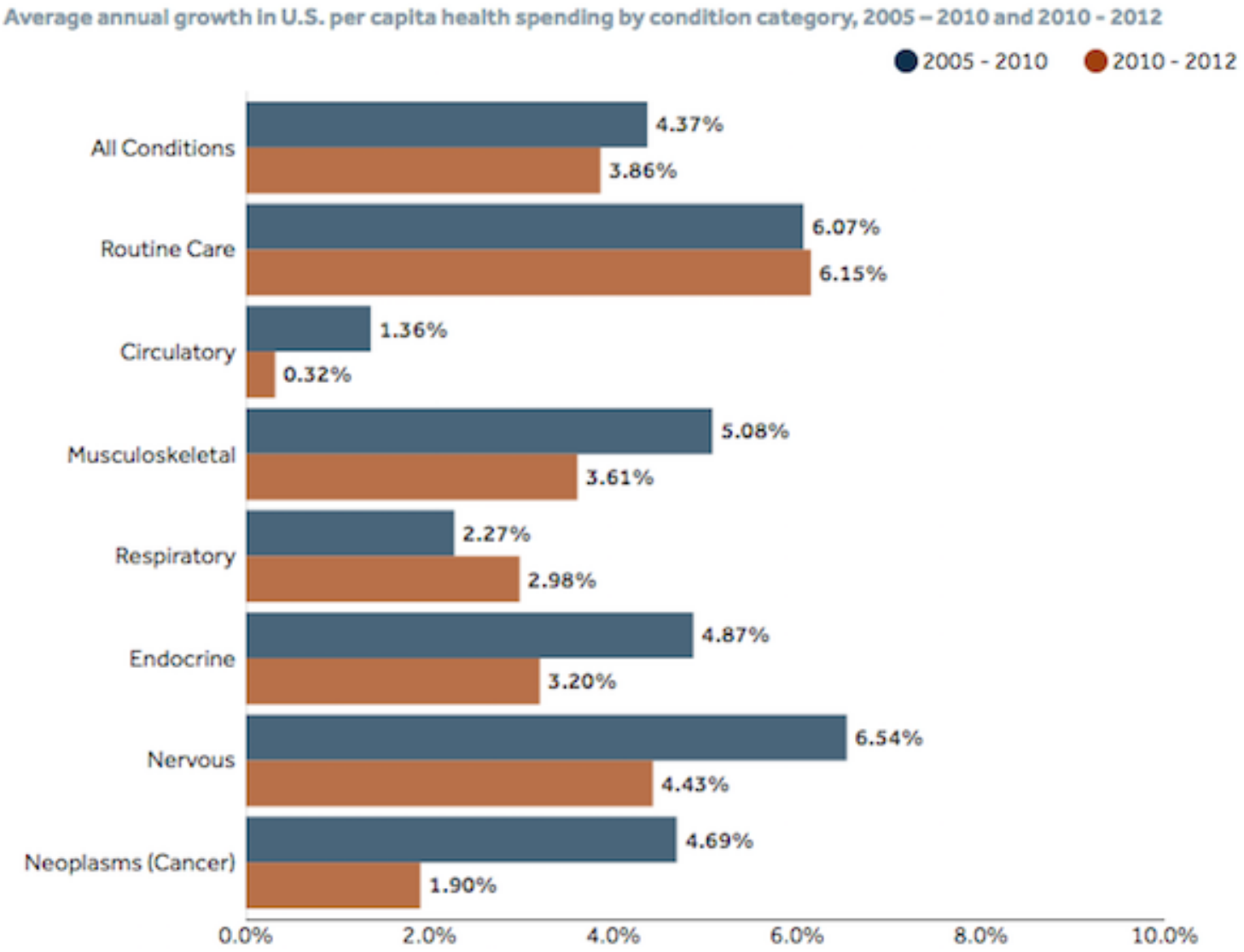


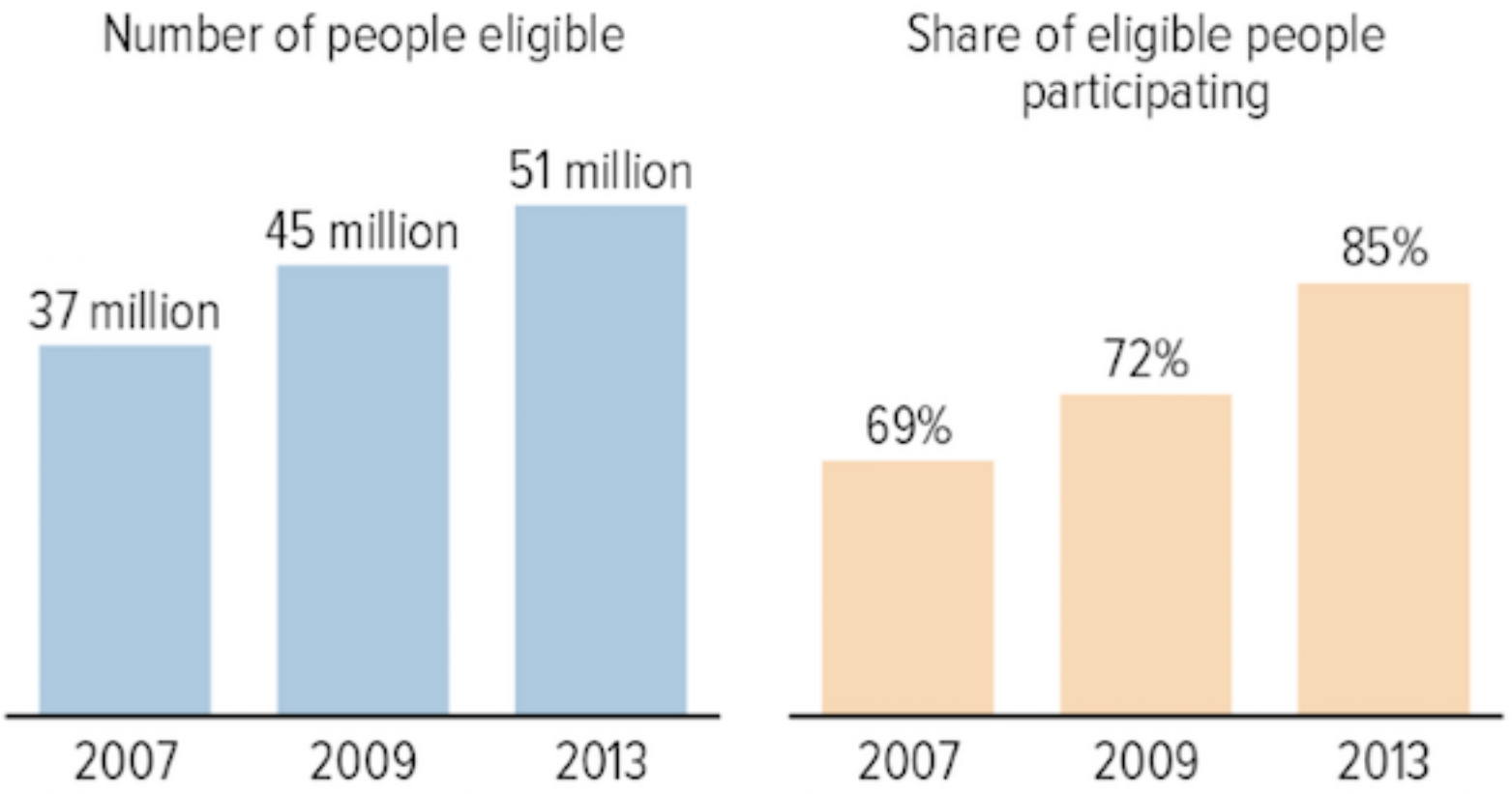
Characteristics of the Medicare Population Apr 13, 2016

Note: ADL is activity of daily living.
Data Sources: Kaiser Family Foundation analysis of the Centers for Medicare & Medicaid Services Medicare Current Beneficiary 2011 Cost and Use file; Urban Institute and Kaiser Family Foundation analysis, 2015 (for income and savings).
Source: Kaiser Family Foundation: *An Overview of Medicare*



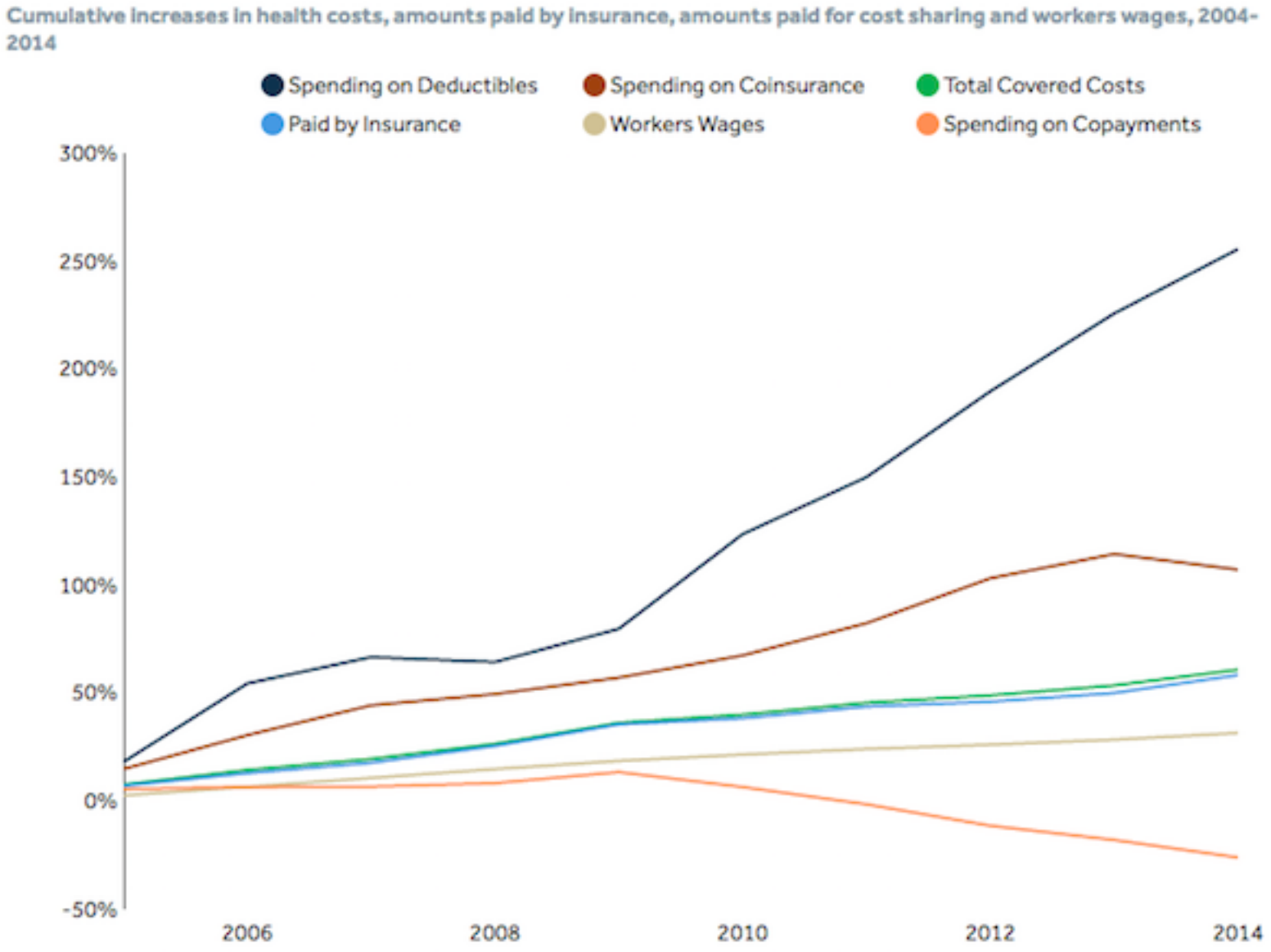
Cost Growth by Disease
Apr 06, 2016

Data Source: Kaiser Family Foundation and Bureau of Economic Analysis (BEA) analysis of BEA's Health Care Satellite Account (Blended Account), which combines data from the Medical Expenditure Panel Survey and large claims databases.
Source: Peterson-Kaiser Health System Tracker: *A new way of measuring health costs sheds light on recent health spending trends*



SNAP Eligibility and Participation Mar 23, 2016

Notes: SNAP stands for Supplemental Nutrition Assistance Program.
This figure uses annual Agriculture Department (USDA) estimates of eligible and participating individuals. USDA revised the methodology for these estimates starting with the 2010 estimates, so the 2007, 2009 and 2013 estimates are not directly comparable. The revised methodology does not change the underlying trends.
Data Source: USDA Food and Nutrition Service, "Supplemental Nutrition Assistance Program Participation Rates: Fiscal Year 2010 to 2013" August 2015, and earlier reports in the series.
Source: Center on Budget and Policy Priorities: *SNAP Costs and Caseloads Declining*



Patient Cost Sharing and Covered Costs Apr 20, 2016

Data Sources: Kaiser Family Foundation analysis of Truven Health Analytics MarketScan Commercial Claims and Encounters Database, 2004-2014; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey, 2004-2014 (April to April).
Source: Peterson-Kaiser Health System Tracker: *Payments for cost sharing increasing rapidly over time*

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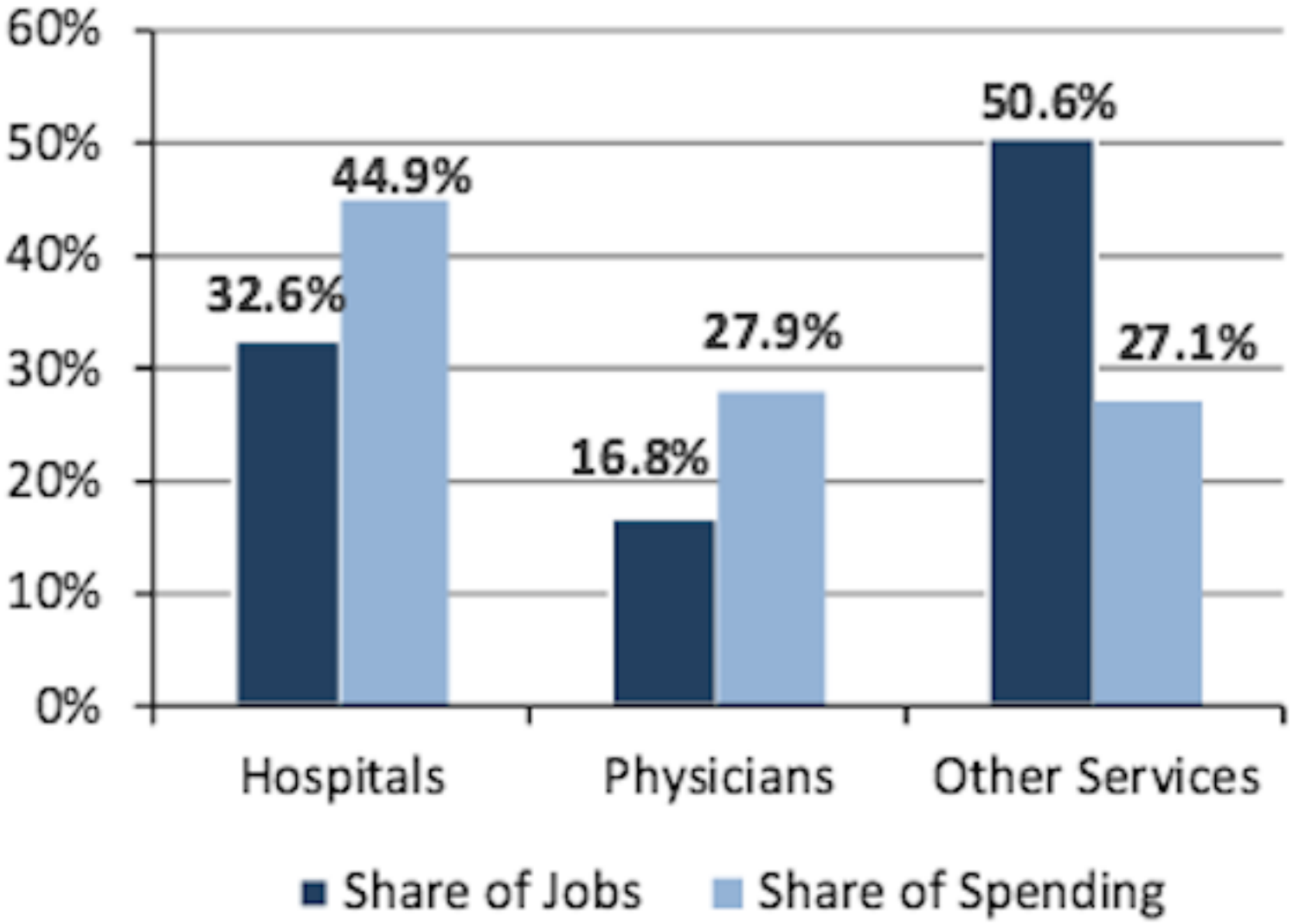
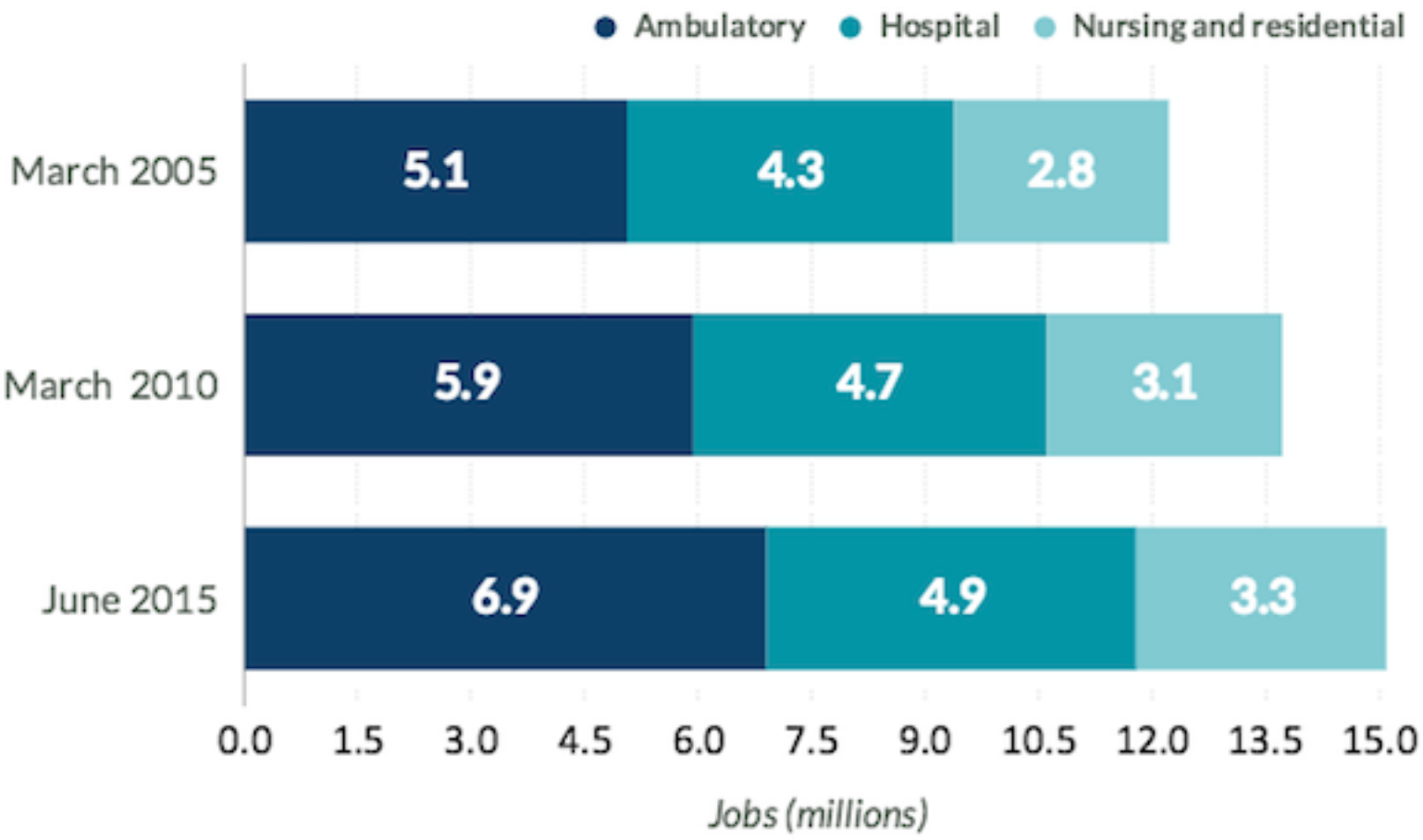


Distribution of Health Services Spending and Jobs in 2014; Jan 06, 2016

Note: Other services include nursing homes, home health, dentists, and other ambulatory services.
Data Source: Altarum Center for Sustainable Health Spending analysis.
Source: Altarum Institute: *Health Sector Trend Report, December 2015*



Jobs in the Health Care Sector; Feb 10, 2016

Data Source: U.S. Bureau of Labor Statistics. Seasonally adjusted establishment, June 2015 Preliminary, July 5, 2015.
Source: The Commonwealth Fund: *The Affordable Care Act and the U.S. Economy: A Five-Year Perspective*

Standardizing Patient Outcomes Measurement

Article · March 14, 2016

NEJM Catalyst

The arc of history is increasingly clear: health care is shifting focus from the volume of services delivered to the value created for patients, with "value" defined as the outcomes achieved relative to the costs.

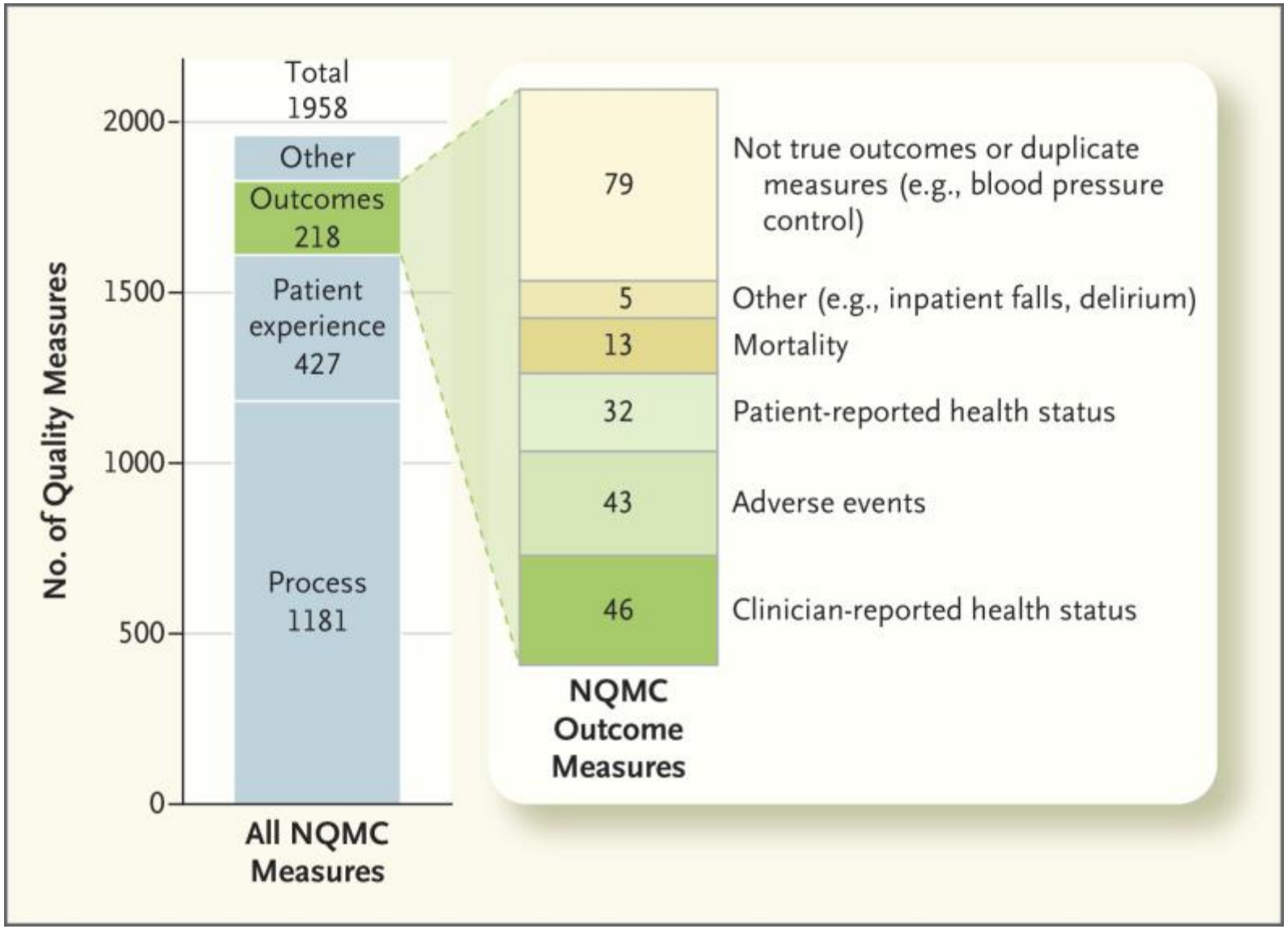
First, in health care we've allowed "quality" to be defined as compliance with evidence-based practice guidelines rather than as improvement in outcomes. (see table slide). Yet process measurement has had limited effect on value. Such measures receive little attention from patients, who are interested in results.

Second, the limited outcomes measurement that has occurred has been led overwhelmingly by specialty societies. But outcomes are not strictly related to individual specialties or procedures; they reflect the overall care for a patient's medical condition, in which multiple specialties are usually involved. What generally matters to patients are outcomes that encompass the whole cycle of care — including health status achieved (e.g., survival, functional status, quality of life); the time, complications, and suffering involved in getting care; and the sustainability of benefits achieved (e.g., time until recurrence).

Third, efforts at outcomes measurement have overwhelmingly focused on clinical status (e.g., survival and "objective" outcomes that are readily captured by laboratory tests) **and left out functional status**, even though improving functional status is why patients seek care. Billing data also don't capture suffering due to the delays, chaos, confusion, and complications that often characterize health care.

Finally, progress on outcomes measurement has been slowed dramatically by the **"let a thousand flowers bloom"** approach, in which each organization reinvents the wheel, tweaks existing measures and risk factors, or invents ones of their own.

This history **has led to a patchwork** of inconsistent outcomes measures and definitions used by various provider organizations, specialty societies, payers, countries, and even individual clinicians.



Of the 1958 quality indicators in the National Quality Measures Clearinghouse, for example, only 139 (7%) are actual outcomes and only 32 (<2%) are patient-reported outcomes

NEJM Catalyst

International Consortium for Health Outcomes Measurement's Standardized Outcome Sets.*

Standard Sets Complete			Under Consideration for 2016 and Beyond
2013	2014	2015 (Final Approval Pending)	
1. Localized prostate cancer	5. Parkinson's disease	13. Breast cancer	22. End-stage renal failure
2. Lower back pain	6. Cleft lip and palate	14. Dementia	23. Oral health
3. Coronary artery disease	7. Stroke	15. Frail elderly	24. Brain tumors
4. Cataracts	8. Hip and knee osteoarthritis	16. Heart failure	25. Drug and alcohol addiction
	9. Macular degeneration	17. Pregnancy and childbirth	26. Bipolar disorder
	10. Lung cancer	18. Colorectal cancer	27. Burns
	11. Depression and anxiety	19. Overactive bladder	28. Melanoma
	12. Advanced prostate cancer	20. Craniofacial microsomia	29. Head and neck cancer
		21. Inflammatory bowel disease	30. Pediatric oncology (conditions to be determined)
			31. Rheumatoid arthritis
			32. Liver transplantation
			33. Congenital hand malformations
			34. Chronic rhinosinusitis
			35. Congenital hemolytic anemia
			36. Rotator cuff disease
			37. Malaria

* The standard outcomes sets completed or pending in the first 3 years cover conditions accounting for 45% of the global burden of disease.

There is also a new institutional approach that offers a promising proof of the concept that standardization of outcomes-measure sets can be achieved rapidly for a growing range of conditions.

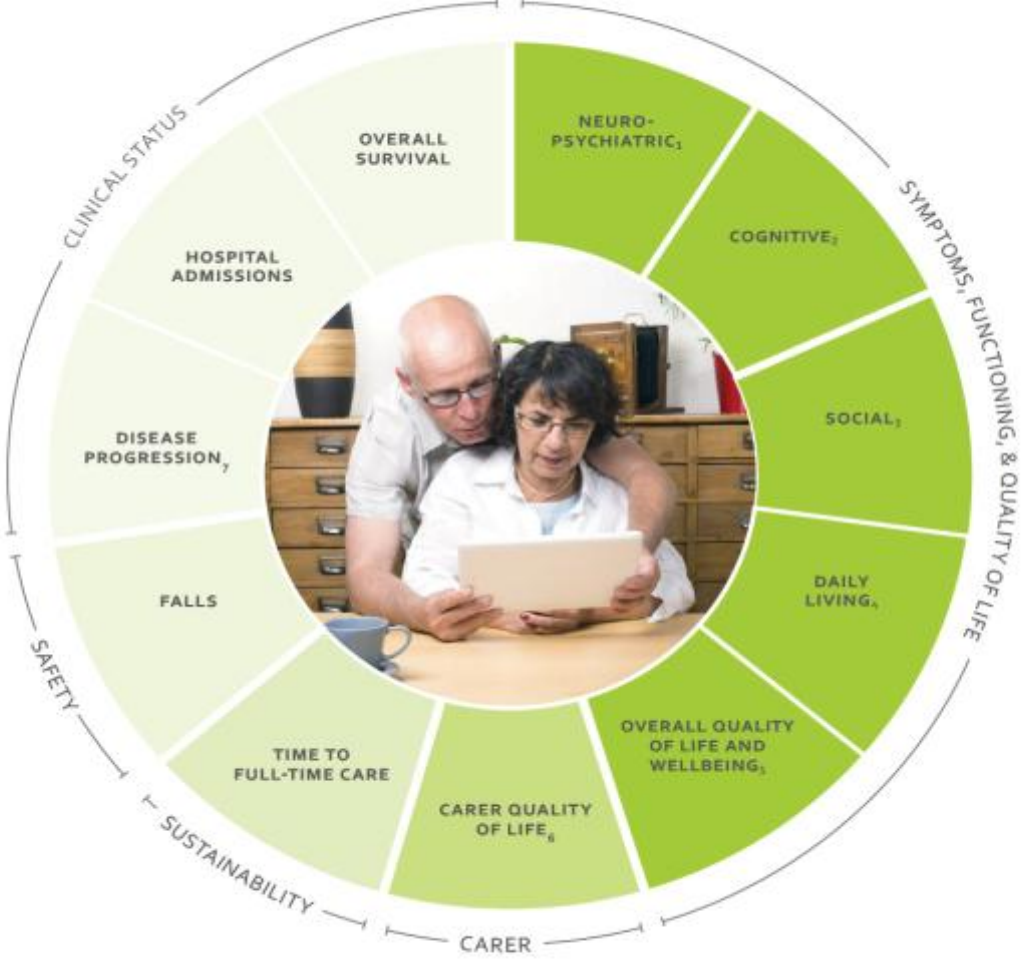
ICHOM working groups understand that their role is not to devise new outcomes measures but to agree on which well-validated ones, including patient-reported measures, everyone should use.

NEJM Catalyst

Parkinson disease

1 Includes cognitive impairment, hallucinations and psychosis, depressed mood, anxious mood, apathy, and features of dopamine dysregulation syndrome. Collected with Part 1A of the MDS-UPDRS.
2 Includes sleep problems, daytime sleepiness, pain and other sensations, urinary problems, constipation problems, lightheadedness on standing, fatigue, sweating, and sexual function. Collected with Part 1 of the MDS-UPDRS.
3 Includes speech, saliva and drooling, chewing and swallowing, eating tasks, dressing, hygiene, handwriting, doing hobbies and other activities, turning in bed, tremor, getting out of a bed, a car, or a deep chair, walking and balance, and freezing. Collected with Part 2 of the MDS-UPDRS.
4 Recommended to track via the Parkinson's Disease Quality of Life Questionnaire (PDQ-8).

Dementia



1 Includes anxiety, depression, behavior, apathy, and psychosis. Tracked via the Neuropsychiatric Inventory (NPI).
2 Includes memory, orientation, verbal fluency, and executive function. Tracked via the Montreal Cognitive Assessment (MoCA).
3 Includes community affairs and relationships.
4 Includes instrumental and basic activities of daily living. Tracked via the Bristol Activity Daily Living Scale (BADLS).
5 Includes finance, enjoyment of activities, pain, and side effects of medication. Tracked via the Quality of Life-AD (QOL-AD) and Quality of Wellbeing Scale-Self Administered (QWB-SA).
6 Tracked via the EuroQol-5D (EQ-5D).
7 Tracked via the Clinical Dementia Rating (CDR).

PER PUNTI:

Definizione
Il punto di vista economico: riospedalizzazioni
Percorsi per pazienti fragili

Meno ospedale, più post acuti (misurare gli outcome)
Il percorso: cosa può fare l'ospedale

Il percorso: cosa deve fare la post acuzie
-organizzazione e requisiti
-pagamento
-procedure e risultati

Post-acuzie con diversi obiettivi
Alcuni risultati

Research article

A predictive score to identify hospitalized patients' risk of discharge to a post-acute care facility

Martine Louis Simonet*†[1,2], Michel P Kossovsky†[2,3], Pierre Chopard[1,2,4],

Abstract

Background: Early identification of patients who need post-acute care (PAC) may improve discharge planning. The purposes of the study were to develop and validate a score predicting discharge to a post-acute care (PAC) facility and to determine its best assessment time.

Methods: We conducted a prospective study including 349 (derivation cohort) and 161 (validation cohort) consecutive patients in a general internal medicine service of a teaching hospital. We developed logistic regression models predicting discharge to a PAC facility, based on patient variables measured on admission (day 1) and on day 3. The value of each model was assessed by its area under the receiver operating characteristics curve (AUC). A simple numerical score was derived from the best model, and was validated in a separate cohort.

Results: Prediction of discharge to a PAC facility was as accurate on day 1 (AUC: 0.81) as on day 3 (AUC: 0.82). The day-3 model was more parsimonious, with 5 variables: patient's partner inability to provide home help (4 pts); inability to self-manage drug regimen (4 pts); number of active medical problems on admission (1 pt per problem); dependency in bathing (4 pts) and in transfers from bed to chair (4 pts) on day 3. A score ≥ 8 points predicted discharge to a PAC facility with a sensitivity of 87% and a specificity of 63%, and was significantly associated with inappropriate hospital days due to discharge delays. Internal and external validations confirmed these results.

Conclusion: A simple score computed on the 3rd hospital day predicted discharge to a PAC facility with good accuracy. A score > 8 points should prompt early discharge planning.

Optimizing triage and hospitalization in adult general medical emergency patients: the triage project

Schuetz et al. BMC Emergency Medicine 2013, 13:12
http://www.biomedcentral.com/1471-227X/13/12

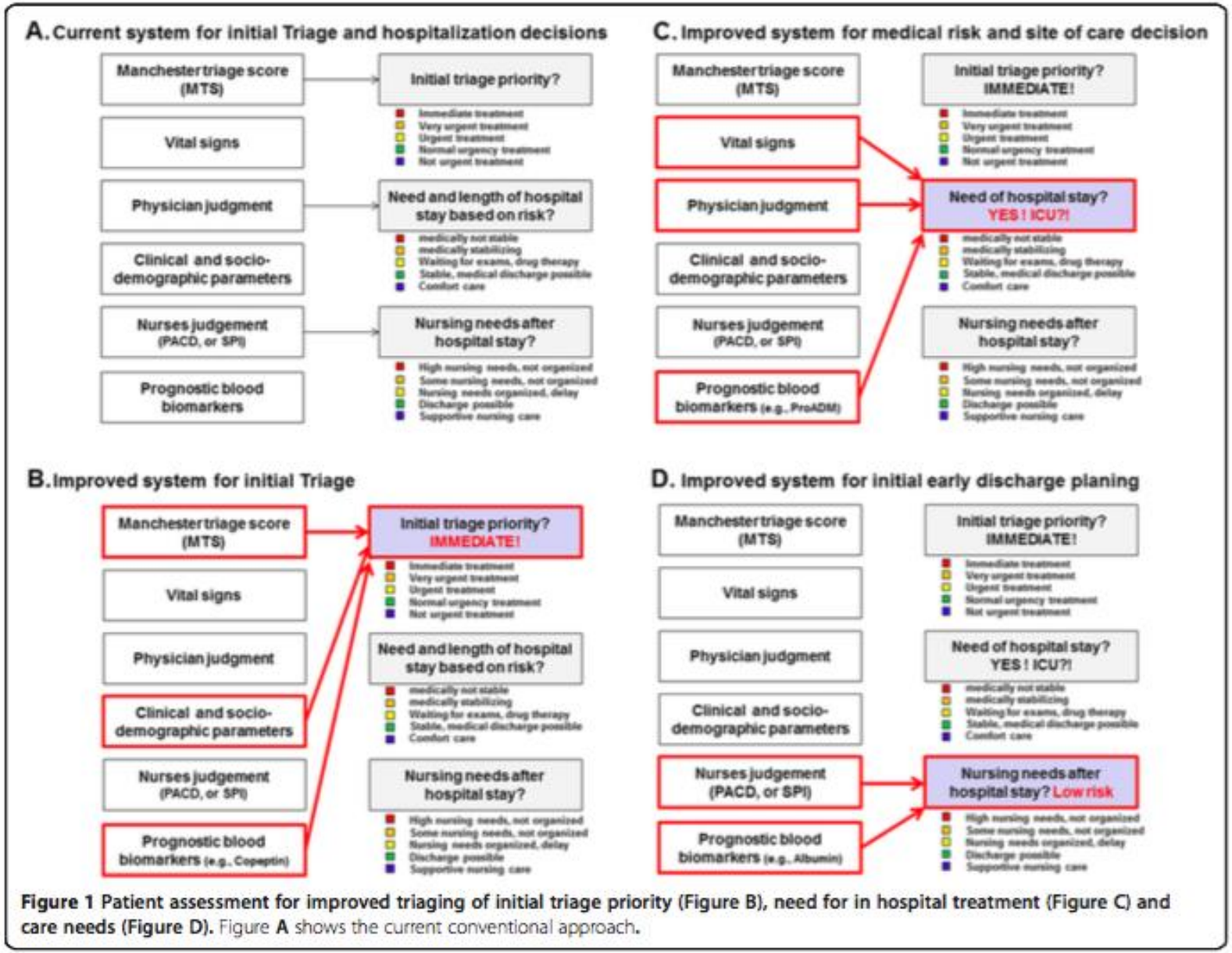


Figure 1 Patient assessment for improved triaging of initial triage priority (Figure B), need for in hospital treatment (Figure C) and care needs (Figure D). Figure **A** shows the current conventional approach.

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AMERICAN HOSPITAL ASSOCIATION
DECEMBER 2015

TRENDWATCH

The Role of Post-Acute Care in New Care Delivery Models

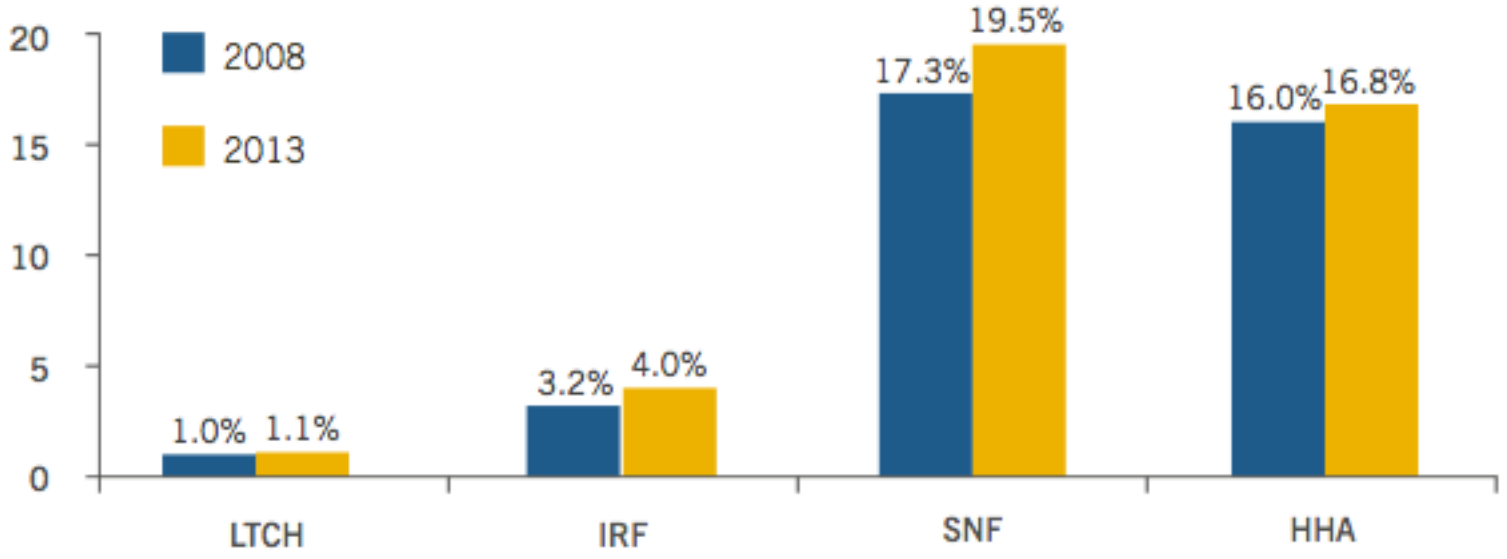
PAC has been of increased interest to policymakers as a result of a 2013 Institute of Medicine (IOM) report that identified the sector as the source of 73 percent of the variation in Medicare spending. As a result, hospitals, health systems, PAC providers, payers and other stakeholders have taken steps to learn more about and improve PAC services, which are used by almost 42 percent of Medicare beneficiaries discharged from a hospital.

A primary cause of the variance in PAC payments relates to the initial care setting that follows hospitalization in a short-term acute-care hospital. Average per discharge payments to PAC providers vary considerably by venue.

For example, average Medicare payment for a 30-day episode for a patient with congestive heart failure (CHF) whose post-acute discharge site was an LTCH was more than twice the payment for a patient who was discharged to a SNF, and about 27 percent more than that for a patient whose initial post-acute venue is an IRF. However, these data do not account for differences in severity of illness across the PAC settings.

The percentage of Medicare beneficiaries discharged from a hospital to a PAC setting increased between 2008 and 2013.

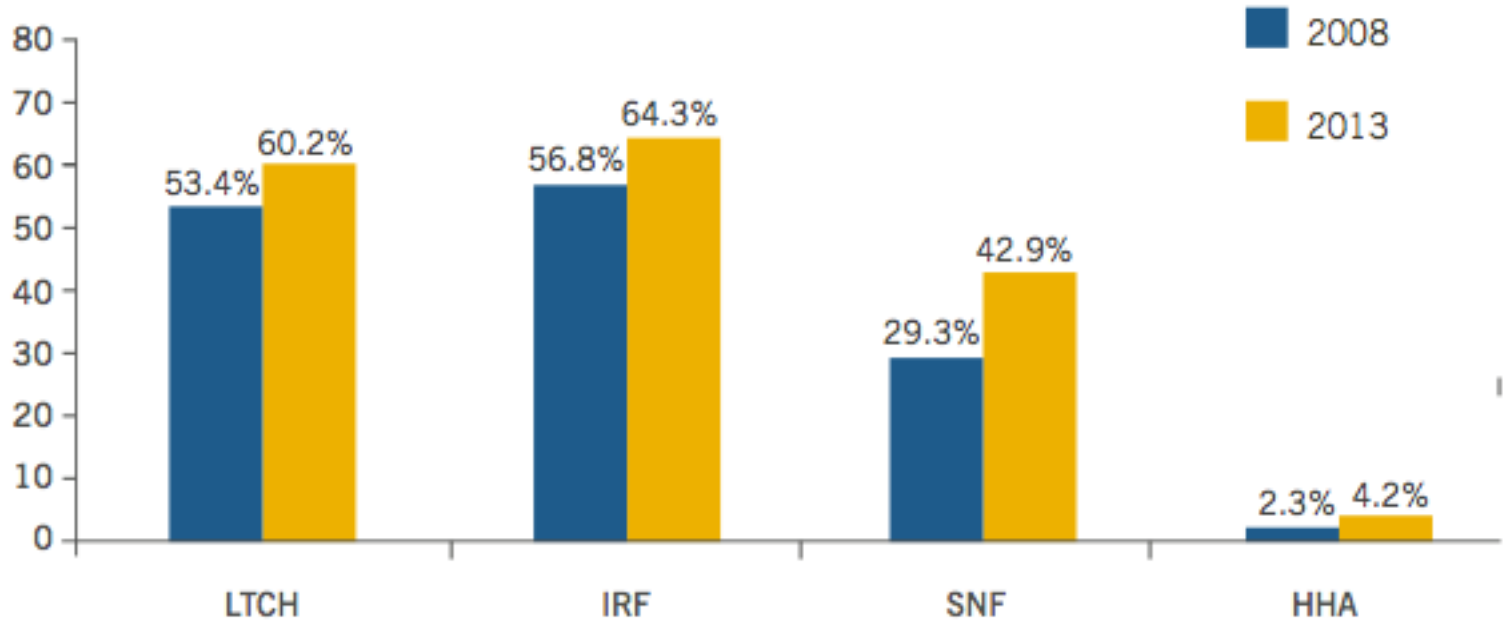
Chart 1: Patients Discharged from Hospital to PAC Setting, 2008 and 2013



Sources: Medicare Payment Advisory Commission. (June 2008). *A Data Book: Health Care Spending and the Medicare Program.* Washington, DC. Medicare Payment Advisory Commission. (2015). *March Report to the Congress: Medicare Payment Policy.* Washington, DC.

A majority of patients admitted to PAC are later transferred to a second PAC setting.

Chart 2: Percent of Patients that Progress to a Second PAC Setting, from Initial PAC Setting, 2008 and 2013



Sources: Medicare Payment Advisory Commission. (June 2008). *A Data Book: Health Care Spending and the Medicare Program.* Washington, DC. Medicare Payment Advisory Commission. (2015). *March Report to the Congress: Medicare Payment Policy.* Washington, DC.

Brooks' care redesign model focuses on the longitudinal needs of a patient and collaboration across multiple provider types.

Chart 5: Brooks Care Redesign Approach

Select the Right First Setting	Patients are placed in the least-expensive setting that will meet their needs
Standardize Care Across Settings	Tests are standardized so that the patient is monitored against the same assessments no matter where they receive care
Longitudinal Care Planning	A 60-day care plan takes into consideration patients' needs across every setting of care
Nurse Care Navigators	Nurse care navigators help patients transition from one setting to the next and ensure that all care is coordinated

Bundled Payment and PAC

In a bundled payment model, a designated entity is responsible for a targeted spending level that covers the expected costs of all services needed to treat a patient for a specified condition or episode of care. If actual spending is below the targeted level, the at-risk entity keeps the difference as savings. If actual costs exceed the target, the at-risk entity may need to return the difference to the payer.

Innovations:

LTACH and bundle over 180 days
Telemonitoring and reaccess
Model 2 and 3 (avere moduli con diverso pagamento ed utilizzarli per pazienti con differente impegno clinico/organizzativo)
Markets owning acute, post-acute and managed care
Additional requirements for the hospital discharge planning process, protocols

Typical Post-acute Care Criteria for Provider Networks:

A compilation of common PAC criteria used by health system and ACO provider networks:

- Easy access for hospitals' patient discharges:
  - Geographic access for all patients
  - Admissions allowed 24/7
  - Start of home care within 24 hours of hospital discharge
- Compliance with federal and state regulations
- Lower-than-average survey deficiencies
- For SNFs:
  - At least three-star quality rating
  - Separate unit for PAC patients, with ACO or health system physician serving in the SNF
  - 24/7 RN care provider and at least one RN for every 15 patients in post-acute unit
  - Use of INTERACT 3.0 tools—these tools, developed by Joseph Ouslander, M.D., under a contract with CMS, include forms and processes designed to enhance critical thinking among nursing staff in SNFs to reduce hospital readmissions and improve patient outcomes
- For HHAs:
  - Equal to or better scores than state average on Medicare Home Health Compare website
  - Recertification rates at state average
  - Patient satisfaction ratings at or better than median reported on the Home Health Consumer Assessment of Healthcare Providers and Systems (HHCAHPS)
- Common outcomes measures, that may be collected monthly, and may be aggregated for comparison purposes
  - 30-day hospital readmission rates
  - Patient/family satisfaction ratings
  - Emergency room visits, especially within three days of admission to the PAC venue
  - Scheduling of primary care visit within seven days after discharge from the PAC venue

PAC providers that have difficulty meeting expected achievement levels may receive additional staff education, and/or may be suspended from the network until they can comply.

SNF Strategies to Become High-value Partners

Many SNFs, particularly those in markets with an ACO, are modifying their physical plant and clinical operations to demonstrate they are a high-value provider. Such SNF initiatives include:

- Sub-acute units with private rooms and separate gyms and dining areas;
- All registered nurse (RN) coverage for PAC units or buildings, as opposed to a mix of RNs and licensed practical nurses (LPNs).
- Rehabilitation therapies provided six or seven days a week and physical or occupational therapy home visits to determine modifications necessary in order for the patient discharged to home to be successful in maintaining functional status.
- "SNFist" physician management of PAC units or buildings, with daily on-site coverage by Advanced Practice Nurses (APNs) and at least weekly visits by the primary care physician.
- Transitional care nurses who help patients and families navigate between hospital and SNF, and between SNF and home.
- Telephonic communication between the hospitalist and SNF physicians during the hospital discharge process, and between the nurse manager of the hospital unit and the nurse manager in the SNF.
- Cross-setting linkages for electronic medical records.
- Specialty rehabilitation programs for joint replacement, cardiac care or respiratory care.
- Standardized clinical care protocols for hospitals and PAC partners
- SNF acquisition of home health and hospice providers to improve patient transitions.

Additional regulatory waivers in emerging care models would reduce barriers to innovation.

Chart 6: Requested Regulatory Policy Waivers for BPCI and ACO Participants

PAC Type	Current Policy that Would be Waived
HHA	**Homebound Requirement:** In addition to having a skilled need, Medicare requires that a patient be homebound in order to qualify for HHA services (waivers available for next-generation ACOs)
IRF	**Three-hour Rule:** IRF patients must receive at least three hours of therapy at least five days per week **60% Rule:** At least 60 percent of all IRF patients (both Medicare and non-Medicare) must have conditions or diagnoses that fall within the list of 13 specific diagnostic categories, either as a primary diagnosis or as a qualifying co-morbidity
LTCH	**25-day LOS Rule:** LTCHs are required to have an average length of stay of greater than 25 days **25% Rule:** LTCHs receive a reduced payment for certain patients based on the volume of patients transferred to an LTCH from a particular general acute-care hospital

CMS Proposed Rule:

Revising the Requirements for Discharge Planning

Dec. 1, 2015

American Hospital Association

CMS proposes that hospitals and CAHs implement effective discharge planning processes that:

- ✓ address the patient's goals, needs and treatment preferences
- ✓ prepare patients and their caregivers to be active partners/participants in post-discharge care
- ✓ promote effective transitions, and
- ✓ reduce the factors that lead to preventable readmissions.

Timing. Hospitals and CAHs would need to:
begin to identify discharge needs for patients within 24 hours
after admission/registration
regularly re-evaluate a patient's condition to identify necessary modifications of the discharge plan, and
complete the discharge planning process in a timely manner, prior to discharge or transfer.
The process must not unduly delay the patient's discharge or transfer.

People involved in the development of individual discharge plans. CMS proposes that:
A registered nurse, social worker or other personnel qualified in accordance with the hospital's/CAH's discharge planning policies would need to coordinate the discharge needs evaluation and development of the discharge plan.
The practitioner responsible for the care of the patient must be involved in the ongoing process of establishing the patient's goals and treatment preferences that inform the discharge plan. The patient and caregiver/support person also must be involved in the development of the plan and informed of the final plan.

Discharge Plans

Criteria for the evaluation of discharge needs. CMS outlines numerous factors that must be considered in evaluating discharge needs, such as:

caregiver/support person and community-based care availability
the patient's or caregiver's capability to perform required care
admitting diagnosis or reason for registration
relevant co-morbidities and past medical and surgical history
anticipated ongoing care needs and readmission risk
relevant psychosocial history
communication needs
the patient's access to non-health care services, and
the patient's goals and treatment preferences.

Discharge Instructions. CMS proposes that discharge instructions be provided to patients and/or caregiver/support persons as well as any post-acute care providers. Components include:

instruction on post-discharge care
written information on warning signs and symptoms that may indicate the need to seek immediate medical attention
prescriptions (and for hospitals, over-the counter medications) that are required after discharge
reconciliation of all discharge medications with the patient's pre- hospital/CAH admission medications, and
written instructions regarding the patient's follow-up care.

Transfers. When transferring patients, hospitals and CAHs would be required to provide the following specific medical
information to the receiving facility. *Note – no specified format.*
Demographic information
Contact information for the practitioner responsible for the care of
the patient, and the patient's caregiver(s)/support person(s), if applicable
Advance directive, if applicable; Course of illness/treatment
Procedures, diagnoses, and laboratory tests, and the results of
pertinent laboratory and other diagnostic testing
Consultation results
Functional status assessment
Psychosocial assessment, including cognitive status; Social supports

Behavioral health issues
Reconciliation of all discharge medications with the patient's prehospital
admission/registration medications
All known allergies, including medication allergies ; Immunizations
Smoking status; Vital signs
Unique device identifier(s) for a patient's implantable device(s)
All special instructions or precautions for ongoing care
Patient's goals and treatment preferences; and
All other necessary information, including a copy of the patient's
discharge instructions, the discharge summary and any other documentation as applicable,
to ensure a safe and effective transition of care that supports the post-discharge goals
for the patient.

Improving focus on Behavioral Health. CMS states that hospitals and critical access hospitals (CAHs) should improve their focus on psychiatric and behavioral health patients, including patients with substance use disorders. CMS does not propose, but mentions its expectations, that hospitals and CAHs must:

identify the types of services needed upon discharge, including options for tele-behavioral health services as available/appropriate

identify organizations offering community services in the psychiatric hospital or unit's community, and try to establish partnerships

arrange, as applicable, for the development and implementation of a specific psychiatric discharge plan for the patient as part of the patient's overall discharge plan, and

coordinate with the patient for referral for post-acute psychiatric or behavioral health care.

CMS proposes that HHAs implement effective discharge planning processes that:

- ✓ prepare patients to be active partners in post-discharge care
- ✓ promote effective transitions to post-HHA care, and
- ✓ reduce the factors that lead to preventable readmissions.

CMS issues Medicare IRF, SNF and hospice proposed rules for 2017
AHA News Now Apr 21, 2016

The Centers for Medicare & Medicaid Services today issued proposed rules for inpatient rehabilitation facilities, skilled nursing facilities and hospice providers for fiscal year 2017.
For IRFs, CMS proposes a net payment increase of 1.6%, or $125 million, compared to FY 2016. This includes a 2.7% market basket that would be offset by cuts of 0.5% for productivity and a further Affordable Care Act-mandated cut of 0.75%, as well as an increase of 0.2% for high-cost outlier cases. The SNF proposed rule would implement a net payment increase of 2.1%, or $800 million, compared to FY 2016, after accounting for a 2.6% market-basket update and a 0.5% productivity reduction mandated by the ACA.

In FY 2017, hospice payments would increase by 2.0% overall, a $330 million increase compared to FY 2016, after accounting for a 2.8% market-basket update and reductions of 0.5% for productivity and 0.3% as required by the ACA. In addition, the hospice cap for FY 2017 would be updated by 2.0%. CMS also proposes new measures and other changes to the hospice, IRF and SNF quality reporting programs, as well as the SNF value-based purchasing program. CMS will accept comments on the proposed rules through June 20. AHA members will receive more information on the proposed rules.

Overview- Key Steps in the Process

Modificare fattori extraclinici di rericovero? Rifare il bagno…

American Hospital Association

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Alcuni risultati

CMS Final Rule: Comprehensive Care for Joint Replacement Bundled Payment Program

American Hospital Association

Final Rule: Hip & Knee Bundled Payment

- **90-day episode**
  - **Triggered by MS-DRG 469 + 470**
    - All diagnoses falling into both MS-DRGs
    - No risk adjustment
  - **Includes all related Part A & B care**
    - No unrelated hospital readmissions
    - No unrelated Part B services
    - All post-acute care

Center for Medicare & Medicaid INNOVATION

American Hospital Association

Final Rule: Hip & Knee Bundled Payment

- **Retrospective payment methodology**

✓FFS payments continue
✓Settle up to variable discount
✓Quality measurement
✓Stop-loss and stop-gain

Composite Quality Score

Score based on:

– Elective hip/knee complications within 90 days – HCAHPS (all patients, not just hip/knee)
– Voluntary patient-reported outcome measure HCAHPS and complications points based on national percentile of performance
– Credit for significant improvement
PRO measure points for reporting data (not level of performance)

The HCAHPS survey contains 21 patient perspectives on care and patient rating items that encompass nine key topics: communication with doctors, communication with nurses, responsiveness of hospital staff, pain management, communication about medicines, discharge information, cleanliness of the hospital environment, quietness of the hospital environment, and transition of care.

Composite Quality Score

Percentile	Complications Points	HCAHPS Points
≥ 90th	10.00	8.00
≥ 30th to < 90th	5.50 - 9.25	4.40 – 7.40
< 30th	0.00	0.00

+

Data submitted?	PRO Measure Points
Yes	2.00
No	0.00

}

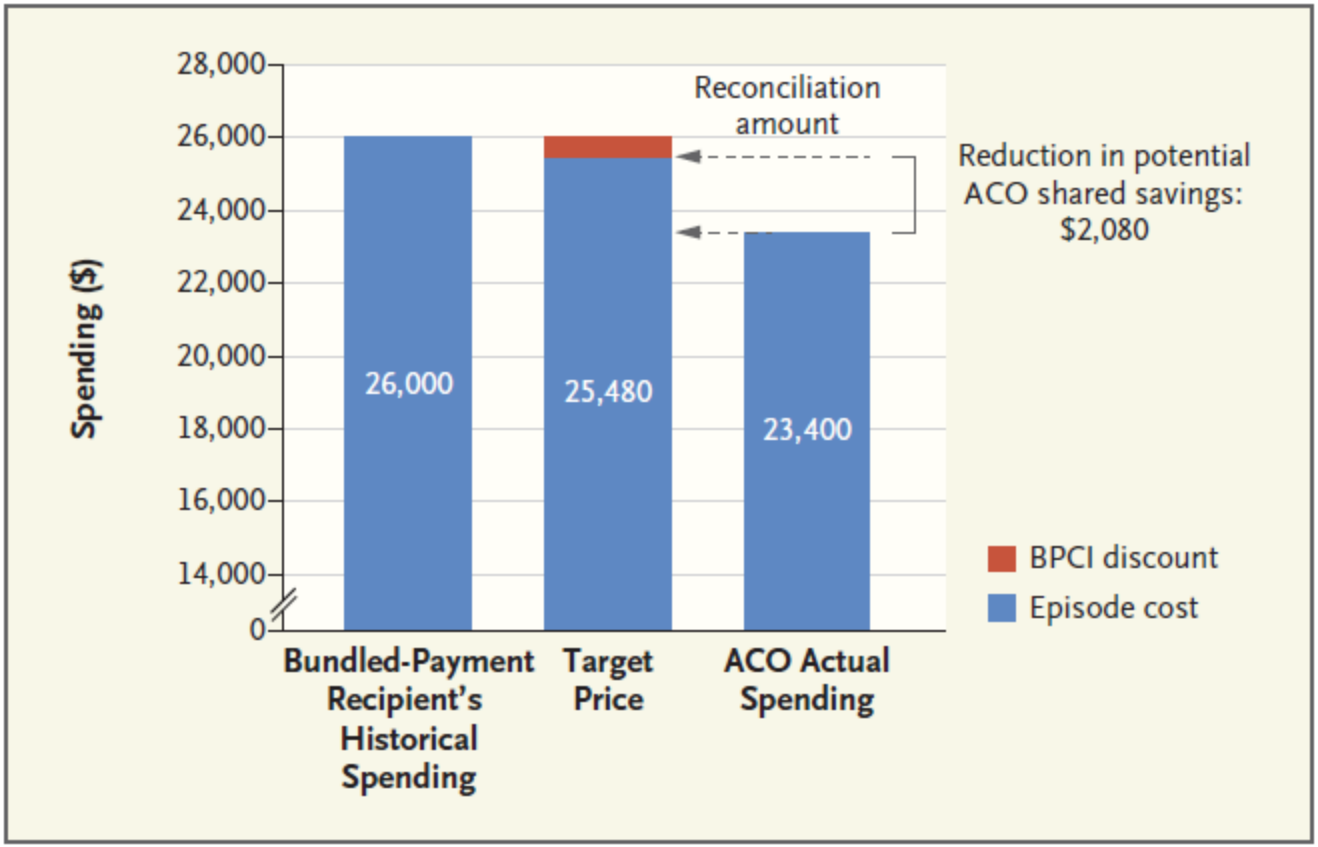
Composite Quality Score	Quality Category
< 4.0	Below Acceptable
≥ 4.0 to < 6.0	Acceptable
≥ 6.0 to ≤ 13.2	Good
> 13.2	Excellent

American Hospital Association

When New Medicare Payment Systems Collide

Robert E. Mechanic, M.B.A.

N ENGL J MED 374;18 NEJM.ORG MAY 5, 2016



Sample Interaction between BPCI and ACO Financial Reconciliation: Spending for a 90-Day Joint-Replacement Episode.

For accountable care organization (ACO) payment reconciliation, CMS sets ACO spending on episodes of care that involve providers receiving bundled payments at the target prices for those episodes. ACO shared-savings awards are generally 50% of actual savings, but they can be up to 100% in some models. BPCI denotes Bundled Payments for Care Improvement.

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Alcuni risultati

Cosa deve fare una post acuzie
John Morley, JAMDA 2014

Department of Health and Human Services
ADVERSE EVENTS IN SKILLED NURSING FACILITIES:

February 2014

Table 8: Costs of Hospitalizations Associated With Adverse Events

Hospitalization Type	Estimated Number of Hospitalizations	Estimated Average Costs	Estimated Total Spending
Hospitalizations for medication events	7,203	$8,372	$57,729,935
Hospitalizations for resident care events	7,511	$8,967	$67,350,098
Hospitalizations for infections events	5,679	$14,599	$82,899,180
Hospitalizations Associated With All Events	**20,393**	**$10,276**	**$207,979,213**

Source: OIG analysis of SNF stays for 653 Medicare beneficiaries discharged in August 2011.

Table 3: Adverse Events Identified Among Medicare SNF Residents by Category

Types of Adverse Events	Percentage*
Events Related to Medication	**37%**
• Medication-induced delirium or other change in mental status	*12%*
• Excessive bleeding due to medication	*5%*
• Fall or other trauma with injury secondary to effects of medication	*4%*
• Constipation, obstipation, and ileus related to medication	*4%*
• Other medication events	*14%*
Events Related to Resident Care	**37%**
• Fall or other trauma with injury related to resident care	*6%*
• Exacerbations of preexisting conditions resulting from an omission of care	*6%*
• Acute kidney injury or insufficiency secondary to fluid maintenance	*5%*
• Fluid and other electrolyte disorders (e.g., inadequate management of fluid)	*4%*
• Venous thromboembolism, deep vein thrombosis (DVT), or pulmonary embolism (PE) related to resident monitoring	*4%*
• Other resident care events	*14%*
Events Related to Infections	**26%**
• Aspiration pneumonia and other respiratory infections	*10%*
• Surgical site infection (SSI) associated with wound care	*5%*
• Urinary tract infection associated with catheter (CAUTI)	*3%*
• *Clostridium difficile* infection	*3%*
• Other infection events	*5%*
Total	**100%**

*The percentages for conditions listed within the clinical categories do not sum to 100 percent because of rounding.
See Appendix D for percentage estimates and confidence intervals.
See Appendix F for a complete listing of all adverse events identified by the reviewers.
Source: OIG analysis of SNF stays for 653 Medicare beneficiaries discharged in August 2011.

Cosa NON DEVE fare una post-acuzie:

Aumentare i costi (avere un hospitalist aumenta I costi di lab e non riduce le cadute nè le riammissioni)
Gloth, Jamda 2011;12-384-386

-Ricevere i pazienti non adeguati (hospice care vs SNF for terminal illness); WANG, Jamda 2016

-NON essere in rete (tutte le post acuzie) per la scelta del migliore luogo post-acuto (unico pagatore, offerta di servizi non in concorrenza, bundle payment); Burke et al, Jamda 2016, 17:364-369

-Allettare i pazienti; favorire il sonno diurno; sfavorire il sonno notturno (less functional recovery); Alessi, Sleep 2008; Martin, Sleep 2011; Dierzewsky, Jags 2014

-rifiutare i pazienti con delirium; Jones, Jamda 2010
-defilarsi sui fragili (black, female, old, low income, hispanic); Freburgeer, Arch Ph Med 2013

Cosa DEVE fare una post-acuzie: -assessment (all articles)

-Curare i malati secondo le linee guida
(scompenso cardiaco, recente IMA); Nazir Jamda 2015:825-831
(infezioni e antibiotici) ; Temkin Antib Res 2015
(review dei farmaci); Runganga Clin Interv Aging 2014
(Chronic crit ill); Kahn , Med Care 2013
(nutrizione e disfagia); Heckert, Stroke 2009
(BPCO); Van Dam, Prim Care 2014

-Ridurre i rischi di riospedalizzazione da riacutizzazione/problemi incidenti (SCC 25%, falls/ortopedics 11% , GI 7%); Inzitari, Jamda 2014: 687

-Prevedere un percorso specifico per pazienti molto gravi
(Severe dementia: rehosp 44%, or NH 24%, 24% home, 8% dead) Nahanishi, Jamda 2016:92

-Attenzione alla diagnosi e cura del delirium non segnalati da Hosp (30% fratture, 20% ortop non frattura, 24% infezioni)
Elalem, Jamda 2015; Marcantonio, Jags 2010 (from 46 to 12%)

Cosa DEVE fare una post-acuzie:

-Aumentare comunicazioni tra il personale (67% readmission per polmonite risparmiate)

-High presence model (enhance, activate): LOS from 28 to 12 days, less riadm; Deveraux, Jamda 2106

-Curare la depressione ed insonnia; Martin Am J Ger Psy 2012

-Tracking frequency of locomotion (min/die, functional assessment of results)

-Considerare la funzione premorbosa nella predittività del recupero (1 year before); Buurman, Jamda, 2016,17:225-231

-Transition to home
(follow up telefonico: reduced readmission from 36 to 12%)
(attivare il territorio con AS)
Jamda, 2014 e 2016

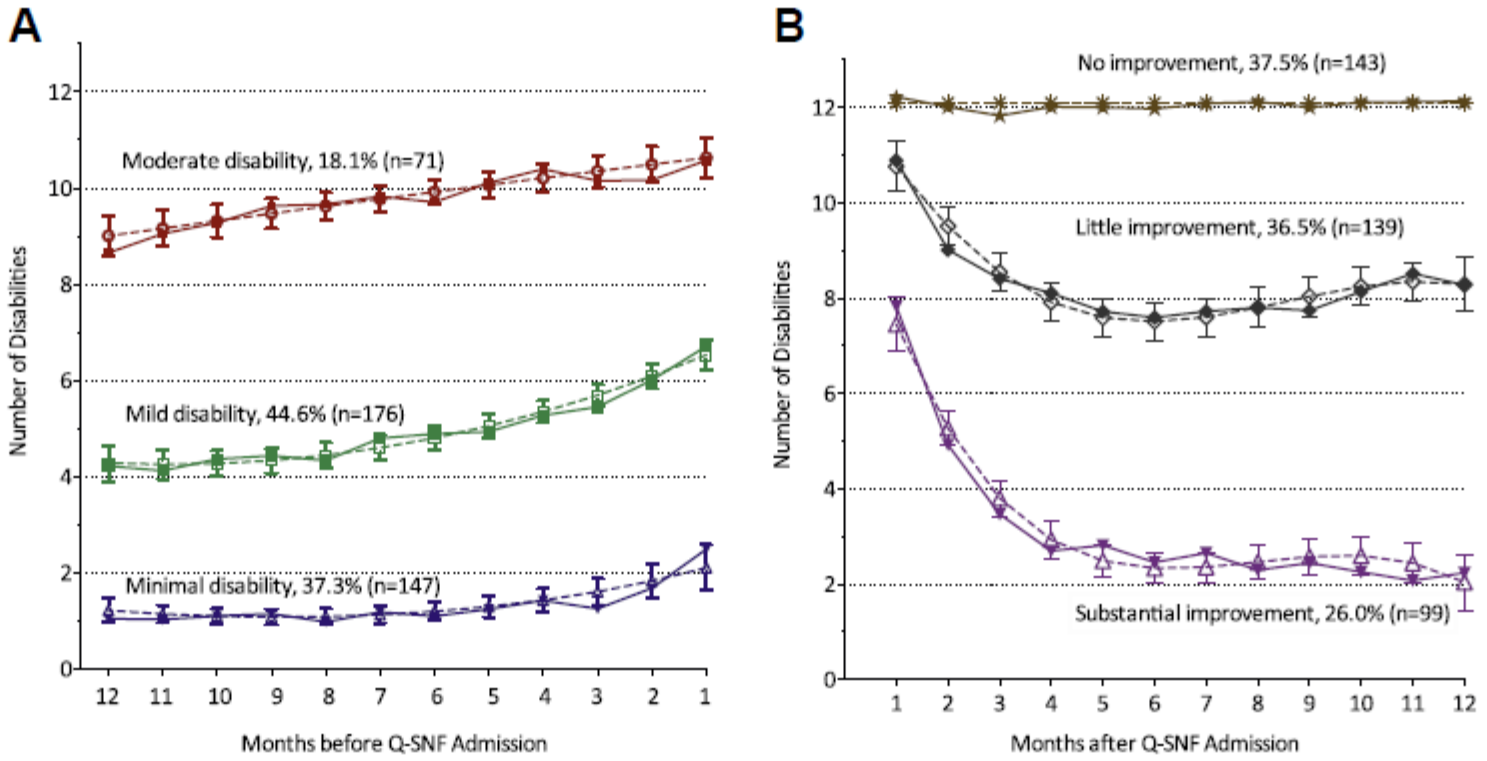

Fig. 1. Disability trajectories before (A) and after (B) a Q-SNF admission. Number and percentage of participants for each trajectory are shown in parentheses. The nu disabilities ranged from 0 to 13 based on 4 basic activities (bathing, dressing, walking inside the house, and transferring from a chair), 5 instrumental activities (sh housework, meal preparation, taking medications, and managing finances), and 4 mobility activities (walking a quarter mile, climbing a flight of stairs, lifting or carrying 10 driving). Solid lines indicate observed trajectories; dashed lines indicate predicted trajectories. The error bars represent 95% confidence intervals for the predicted sev disability. The dual model was adjusted for age, sex, race, educational level less than high school, number of chronic conditions, physical frailty, cognitive impairment, dep symptoms, and acute admission, using information available just before or at the time of hospital admission. Panels 1A and 1B are interconnected; of the participants with m disability before the pre–Q-SNF admission (n = 147), 52% (n = 83) transitioned to substantial improvement, 32% (n = 38) to little improvement, and 16% (n = 20 improvement. A, Before Q-SNF-admission; B, after Q-SNF admission.

Adattare il trattamento riabilitativo allo stato premorboso

Table 2
Change in ADL Self-Performance Scores Between Admission and Discharge

	Mean Change (SD)	% No Change, Stable	% Improved
Long-form ADL Scale 0–28			
Full sample	3.35 (4.43)	26.1	64.9
Discharged home	3.86 (4.48)	22.8	70.4
Hip fracture	3.80 (4.52)	23.3	69.6
Early loss (dressing and personal hygiene) 0–8			
Full sample	0.96 (1.53)	48.9	45.9
Discharged home	1.11 (1.56)	44.5	51.2
Hip fracture	1.08 (1.54)	46.9	49.4
Mid/late loss (bed mobility, transfer, eating, toilet use) 0–16			
Full sample	1.78 (2.56)	35.9	56.1
Discharged home	2.05 (2.59)	32.6	61.2
Hip fracture	1.98 (2.58)	33.3	60.0
Walking (in room and corridor) 0–8			
Full sample	1.32 (1.98)	45.6	49.2
Discharged home	1.52 (2.02)	41.1	54.5
Hip fracture	1.74 (2.13)	39.5	57.1
Locomotion (on and off unit) 0–8			
Full sample	1.20 (1.93)	47.4	46.8
Discharged home	1.37 (1.97)	43.5	51.5
Hip fracture	1.42 (1.99)	43.9	51.6

Table 2. Residents had a mean ADL change of 3.4 points between admission and discharge based on the long-form ADL scale. Individuals who were discharged home had a mean ADL change of 3.9 points, and individuals who had a hip fracture on admission had a mean ADL change of 3.8 points; these subsamples demonstrated greater improvement in ADL self-performance compared with the full sample across all scales. There were few individuals who declined in ADL self-performance during their stay.

HHAs:
Development of the Plan

People involved. The rule would require that:

- the physician responsible for the home health plan of care be involved in the ongoing process of establishing the discharge plan, and

- the patient and caregiver(s) be involved in the development of the discharge plan and informed of the final plan.

American Hospital Association

Perspective (and patient's perspectives)

Death Takes a Weekend

Perri Klass, M.D. N Engl J Med 2015; 372:402-405

Karl VF, 95 anni, rifiuta le assistenti, vorrebbe vivere solo

BPCO, Insuff respiratoria in LTOT, SCC, malnutrizione

CDR 0, Barthel 80/100

Visita del 3-5-2016

"Buon giorno..la trovo molto meglio. Domani torna a casa. Ha qualche disturbo?"

"Sono ancora vivo…"

Influence of a Transitional Care Clinic on Subsequent 30-Day Hospitalizations and Emergency Department Visits in Individuals Discharged from a Skilled Nursing Facility

The Post Discharge Clinic (PDC) at James A. Haley Veterans Affairs Hospital (JAHVAH) was created to oversee care transitions of veterans admitted to SNFs for postacute care and subsequently discharged to the community. The PDC intervention consisted of a one-time, approximately 2-hour visit shortly before discharge from the SNF, during which a trained nurse practitioner, under supervision of a geriatrician, conducted medication reconciliation (covering preadmission, hospital, and SNF discharge), ordered medical supplies and equipment and home health services if needed, provided individual or caregiver education, and communicated the information to individual's primary outpatient care provider through electronic medical records.

Table 3. Thirty-Day Hospital Use After Skilled Nursing Facility Discharge

Characteristic	Total, N = 351	Pre-PDC, n = 134	PDC, n = 217	*P*-Value
Number of rehospitalizations, n (%)				
0	290 (83)	103 (77)	187 (86)	.02
1	51 (15)	28 (21)	23 (11)	
2	9 (3)	2 (1)	7 (3)	
≥3	1 (<.5)	1 (1)	0 (0)	
Inpatient days per 1,000 patient follow-up days, (n)		60	33	<.001
ED visits at Veterans Affairs hospital, n (%)				
0	267 (76)	93 (69)	174 (80)	.08
1	62 (18)	31 (23)	31 (14)	
2	19 (5)	9 (7)	10 (5)	
3	2 (1)	0 (0)	2 (1)	
4	1 (<.5)	1 (1)	0 (0)	
≥1 ED visits, n (%)		41 (31)	43 (20)	
ED visits per 1,000 patient-days, (n)		13	9	.03

For all subjects, 30-day post-SNF discharge was used in calculation of follow-up days, except the 10 who died. For the 10 subjects who died, follow-up was limited to the number of days to death.
PDC = postdischarge clinic; ED = emergency department.

Transforming Primary Care — We Get What We Pay For

John Z. Ayanian, M.D., M.P.P., and Mary Beth Hamel, M.D., M.P.H.

This article was published on April 13, 2016, at NEJM.org.

Primary care is the foundation of effective health care systems.[1] At their best, primary care physicians provide comprehensive, well-coordinated, patient-centered care for many acute and chronic health problems while also promoting prevention and wellness for a wide range of patients.[2] As we know from our own experiences as primary care physicians, patients and physicians value continuity in their primary care relationships, which can last many years.

Despite the importance of these priorities, primary care physicians have been under siege for more than a decade.[3] As compared with phy-

We believe that more effective coordination of financial incentives between primary care physicians and specialists will also be key as Medicare moves from volume-based fee-for-service care to new value-based payment models.[9] Patient-centered medical homes can enhance primary care, but broader provider networks and organizations are needed to align financial incentives and coordinate systems that integrate ambulatory primary and specialty care with care delivered by hospitals and other providers. These new models of health care payment, such as accountable care organizations, may have only limited effects initially,[10] but the cost savings and qualitative benefits of more integrated global payment models can grow over time as health care organizations adapt to new financial incentives.[11]

Two-Year Costs and Quality in the Comprehensive Primary Care Initiative

Stacy Berg Dale, M.P.A., Arkadipta Ghosh, Ph.D., Deborah N. Peikes, M.P.A., Ph.D.,

This article was published on April 13, 2016, at NEJM.org.

BACKGROUND

The 4-year, multipayer Comprehensive Primary Care Initiative was started in October 2012 to determine whether several forms of support would produce changes in care delivery that would improve the quality and reduce the costs of care at 497 primary care practices in seven regions across the United States. Support included the provision of care-management fees, the opportunity to earn shared savings, and the provision of data feedback and learning support.

CONCLUSIONS

Midway through this 4-year intervention, practices participating in the initiative have reported progress in transforming the delivery of primary care. However, at this point these practices have not yet shown savings in expenditures for Medicare Parts A and B after accounting for care-management fees, nor have they shown an appreciable improvement in the quality of care or patient experience. (Funded by the Department of Health and Human Services, Centers for Medicare and Medicaid Services; ClinicalTrials.gov number, NCT02320591.)

Mandatory Medicare Bundled Payment — Is It Ready for Prime Time?

Robert E. Mechanic, M.B.A.

N ENGL J MED NEJM.ORG August 27, 2015

Bundled payment creates financial incentives for providers to coordinate care over the full continuum of services and eliminate spending that doesn't benefit patients. Avenues for potential

The Institute of Medicine concluded that variation in post-acute care spending is the single largest factor behind geographic variation in Medicare spending per beneficiary,[2] and substantial savings may be achievable by directing patients to more cost-effective settings — home care rather than institutional care when appropriate, and higher-quality, more efficient facilities when institutional care is required.[3] But bundled payment is complex to administer, and many professionals worry about its effect on their livelihood.

The chief technical challenge of bundled payment is mitigating the random variation in average spending per episode that results from patient heterogeneity combined with small case volumes.

will be challenging. CMS will need to work closely with the medical community to refine episode-payment methods, develop effective risk-adjustment tools, and design new experiments that are coherent, transparent, and supportive of providers that want to deliver better care at a lower cost.

Toward Increased Adoption of Complex Care Management

Clemens S. Hong, M.D., M.P.H., Melinda K. Abrams, M.S., and Timothy G. Ferris, M.D., M.P.H. N ENGL J MED 371;6 NEJM.ORG AUGUST 7, 2014

Many observers of U.S. health care are now convinced that improved management of the care of patients with complex, high-cost conditions is an essential part of the solution to our health care cost problem. Increasing evidence supports the use of specially trained, primary care–integrated, complex care management (CCM) teams to improve outcomes and reduce costs by addressing the needs of the small proportion of patients who account for a majority of health care expenditures.[1] For example, CCM is to become a ubiquitous approach to reducing health care costs, we will need to overcome some substantial barriers. Addressing the financial, organizational, technical, and workforce barriers described above will require new policies and practices, but increased adoption can be achieved without increasing the total cost of care. Successful CCM not only pays for itself, it also directly addresses our tripartite goal of lower costs, improved care, and improved patient experience. It is time to accelerate the adoption of CCM within our health care system.

PER PUNTI:

Definizione
Il punto di vista economico: riospedalizzazioni
Percorsi per pazienti fragili

Meno ospedale, più post acuti (misurare gli outcome)
Il percorso: cosa può fare l'ospedale

Il percorso: cosa deve fare la post acuzie
-organizzazione e requisiti
-pagamento
-procedure e risultati

Post-acuzie con diversi obiettivi
Alcuni risultati

Tutti fanno tutto?
Individualizzare il servizio ed il trattamento in base alle richieste cogenti
In base alla tipologia di post acuzie:
geografica,
sociale,
clinica,
Funzionale
avverrebbe una diversa

Tipologia di rimborso economico:
Fee for service
Severity based
Outcome based

Arch Phys Med Rehabil. 2013 April ; 94(4): 622–629
Does Post-Acute Care Site Matter? A longitudinal study assessing functional recovery after a stroke

Journal of Aging Research & Clinical Practice©
Volume 4, Number 4, 2015

J Aging Res Clin Practice 2015;4(4):218-225
Published online December 2, 2015, http://dx.doi.org/10.14283/jarcp.2015.75

COMPARISON OF ITALIAN AND NORWEGIAN POSTACUTE CARE SETTINGS FOR OLDER PATIENTS IN NEED OF FURTHER TREATMENT AND REHABILITATION AFTER HOSPITALIZATION

J.F. Abrahamsen[1], R. Rozzini[2], S. Boffelli[2], A. Cassinadri[2], A.H. Ranhoff[3], M. Trabucchi[4]

Hospitalization for acute disease or injury may, in older home- dwelling patients, be associated with functional decline and increasing dependency. Some patients are not able to return to their own home after acute hospitalization and need further multidimensional geriatric based care to regain their functional capacity.

There are numerous facilities that offer this kind of care, different terms are used, different patients are selected and different kind of care is offered.

The 19-bed Italian SAC unit was established in 2011 as part of the geriatric department at the Fondazione Ospedale Poliambulanza in Brescia, Italy . In addition to treating and rehabilitate patients after an acute hospital admission, this treatment option was also available for home dwelling elderly patients with chronic disease to avoid early flare-up, relapse and acute hospitalization.

The 19-bed Norwegian IC unit was established in 2005 as a collaboration between the municipality of Bergen, and the two hospitals serving the town. Emphasis was put on selecting patients from the acute medical and orthopaedic hospital departments that had a treatment and rehabilitation potential, and that the treatment period should be rather short, preferably ≤14 days, to allow a rather high turnover of patients that were able to receive CGA based treatment and care.

Table 1

Inclusion criteria and treatment options for older patients receiving hospital subacute care (SAC) in Italy and nursing home intermediate care (IC) in Norway

	Italian Subacute Care	Norwegian Intermediate Care
Inclusion criterias		
Similar		
Home dwelling before acute hospitalization	yes	yes
In need of multidisciplinary geriatric based treatment that do not have to be performed in an acute hospital ward, but neither can be performed at home	yes	yes
Have been diagnosed and started treatment in the acute hospital ward	yes	yes
Not terminally ill	yes	yes
Respiratory and circulatory stable	yes	yes
Considered to have a rehabilitation potential	yes	yes
Rather similar		
Transferred from acute hospital ward	mainly (>90%)	yes
Only patients aged ≥ 70 years	mainly (>80%)	yes
Different		
Patients should be able to return home within 14 days	No, upper limit 40 days	yes
Patients with acute delirium	yes	no
Admitting patients with moderate/ severe cognitive impairment*	Yes	no

Table 1

Inclusion criteria and treatment options for older patients receiving hospital subacute care (SAC) in Italy and nursing home intermediate care (IC) in Norway

	Italian Subacute Care	Norwegian Intermediate Care
Treatment options		
Comprehensive geriatric assessment	yes	yes
Examination by doctor and nurse on admission	yes	yes
Individual assignment to therapy	yes	yes
Critical evaluation of medication and drug interactions	yes	yes
Fixed panel of blood samples on admission and availability of additional blood sample	yes	yes
Weekly intervention team meetings for goal setting	yes	yes
Nurse and health care worker present 24h and all days/week	yes	yes
All patients assessed by physiotherapist	When needed	yes
Ward-round to all patients with doctor and nurse	daily	2/week + when needed
Individual nutritional intervention	yes	yes
Meals served in separate dining room	no	yes
Availability of radiological examination	yes	by transfer to hospital
Doctor available 24 h and all days/week	yes	No†
Staffing (full positions)		
Doctors	2	2
Geriatricians	2	1
Nurses	12	15
Physiotherapists	0.5	1.2
Occupational therapist	0	0.8
Health care workers	10	8

Table 2

Characteristics of Italian patients treated in a hospital subacute care unit and Norwegian patients treated in a nursing home intermediate care unit

	Italian patients n= 664	Norwegian patients n=961
Demographics		
Age (mean ±SD)	82 (6,1)	84 (6.2)
Male sex	294 (44%)	304 (32%)
Live alone	217 (33%)	644 (67%)
Years of education	5 (0-24)	-
Patients transferred from		
Acute internal med / pulm / cardiology / geriatric dep.	411 (62%)	628 (65%)
Orthopaedic dep.	28 (4%)	352 (37%)
General + vascular surgery dep.	60 (9%)	0
Other hospital or hospital dep.	233 (34%)	-
Own home	34 (5%)	0

Geriatric assessment		
2 weeks before hospitalization		
Barthel Index pre admission	85 (0-100)	-
I-ADL pre- admission	3/8 (0-8)	-
CDR	0 (0-4)	-
During postacute admission		
More than 5 diagnosis	616 (96%)	567 (59%)
Use more than 5 drugs	572 (92%)	760 (79%)
CIRS -severity	1.7 (0-4)	-
CIRS- comorbidity	2 (0-9)	-
Acute delirium at admission	124 (19%)	0
Acute delirium at discharge	7 (1%)	-
MMSE	25 (0-30)	26 (8-30)
Barthel index admission	40 (0-100)	75 (10-100)
Barthel index discharge	60 (0-100)	85 (15-100)
I-ADL admission	3/8 (0-8)	-
Geriatric depression scale*	3/15 (0-15)	7/30 (0-29)
MNA-SF		10 (2-21)
Blaylock scale	21 (4-36)	-
Tinetti scale admission	6 (0-28)	-
Tinetti scale discharge	18 (0-29)	-

Table 3

Outcome at discharge in Italian patients treated in a hospital subacute care unit and Norwegian patients treated in a nursing home intermediate care unit

	Italian patients n=664	Norwegian patients n=961
Improvement of functional status		
Patients with improvement in BI	510 (79%)	623 (67%)
Improved units on BI	20 (0-75)	5 (0- 70)
Improved units of Tinetti scale	8 (0-26)	-
Resolved acute delirium	117/124	
Days in postacute care (mean , ±SD)	16.7 (9.7)	13.5 (3.75)
Discharged home	420 (64%)	785 (82%)
Without assistance, except family	399 (74%)	446 (29%)
with nurse assisted home care	45 (8%)	515 (71%)
with private care at home	99 (18%)	0
Discharged to nursing home	58 (9%)	132 (14%)
Discharged to rehabilitation	85 (13%)	14 (1.2%)
Transferred to acute hospitalization	41 (6%)	26 (2.7%)
Discharge to hospice	9 (1.4%)	0
Dead during postacute treatment	47 (7%)	2 (0.2%)

Abbreviations: CIRS, Cumulative Illness Rating Scale, MMSE, Mini-Mental-Status Examination; I-ADL, Instrumental Activities of Daily Life, MNA-SF, Mini Nutritional Assessment- Short Form, CDR, Clinical Dementia Rating. Categorical variables are described as numbers and % of patients

Table 4

Simple and multiple logistic regression for predictors of return to own home in Italian patients treated in a hospital-subacute care unit and Norwegian patients treated in a nursing home intermediate care unit

	Italian SAC unit						Norwegian IC unit					
	Univariate			Multivariate			Univariate			Multivariate		
	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p	OR	95% CI	p
BI admission*	1.03	1.02-1.05	<0.001	1.04	1.02-1.05	<0.001	1.06	1.05-1.07	<0.001	1.08	1.06-1.10	<0.001
BI improvement†	9.41	5.75-15.39	<0.001	16.72	7.74-36.14	<0.001	1.57	1.08-2.19	0.02	4.21	2.84-7.14	<0.001
MSSE*	1.07	1.04-1.10	<0.001	0.99	0.93-1.05	0.73	1.15	1.10-1.93	<0.001	1.07	1.01-1.13	0.02
GDS*	0.80	0.74-0.87	<0.001	0.86	0.78-0.94	0.001	0.95	0.92-0.97	<0.001	0.98	0.94-1.02	0.24
Age*	1.01	0.99-1.04	0.31	-			0.97	0.95-1.00	0.03	1.02	0.98-1.06	0.28

SAC= Sub Acute Care, IC= Intermediate Care, OR= odds ratio, CI=confidence interval, BI, Barthel index, MMSE, Mini Mental State Examination, GDS, Geriatric; Depression Scale. OR were estimated using logistic regression models and adjusted for the covariates as described in the Methods section; *Variables are per unit increase, †Experienced any BI improvement during postacute care

We conclude that some caution should be taken when clinical outcomes from different countries and societies are compared, because end-points, like the ability to return to home and the use of NH, is influenced by health care and sociodemographic differences.

Both the Italian hospital SAC model and the Norwegian NH IC model presented in this article are feasible and good alternatives, but more firm inclusion criteria based on knowledge about the long term clinical outcome of both patient groups may further optimize the selection of patients suitable for these different PAC options.

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Alcuni risultati

Provenienza dai reparti di acuzie dei 242 pazienti ricoverati in UCSA

Proviene da:	%
Geriatria	41.3%
Medicina	23.8%
Chirurgia generale	10.6%
Casa	8.1%
Cardiologia	4.4%
Neurologia	3.8%
Ortopedia	2.5%
Altro Ospedale	2.5%
Altro (RSA, PS)	3%

Motivo principale di ricovero in UCSA (n.242)

Diagnosi principale ingresso			%	
Malattia respiratoria			25.2	
Sepsi e altro (*)			25.8	
Malattia cardiovascolare			16.6	
Malattia gastrointestinale/epatica			16.0	
Delirium			6.7	
Malattia neurologica			3.7	
Malattia genito-urinaria			4.9	
Artrosi			0.6	
Intervento ortopedico			0.5	

(*)= jatrogenesi: disturbo del cammino, sindrome da allettamento, disidratazione, subocclusione

Condizione abitativa precedente il ricovero (n.242)

Vive con:		%		
Solo		31.1%		
Coniuge		48.2%		
Altri parenti		12.8%		
Badante		6.7%		
Comunità religiosa/RSA		1.2%		

Caratteristiche dei pazienti ricoverati in UCSA (n.242)

	%	Media	Ds
Genere (M)	51.2%		
Età (anni)		80.2	7.2
Scolarità (anni)		7.7	4.2
MMSE Ingresso (0-30)		21.5	8.1
GDS score (0-15)		3.99	2.8
IADL f. perse (0-8)		5.7	2.1
Barthel Index premorboso		77.6	24.6
Barthel Index ingresso (0-100)		37.7	23.3
Tinetti totale ingresso (0-28)		7.4	7.0
Numero malattie		10.3	3.4
CIRS comorbilità		2.6	1.3
CIRS severità		1.7	0.3

Caratteristiche cognitive dei pazienti (n.242)

	%	Media	Ds
MMSE Ingresso (0-30)		21.5	8.1
SCALA 4 AT (0-12)		2.6	3.7
4AT >4/12 (delirium/demenza)	27.9 %		
4AT <4/12 (no delirium)	72.1%		
Delirium diagnosi ingresso	19 %		
Demenza (CDR score ≥1)	23%		
(CDR score 1)	11%		
(CDR score 2)	4%		
(CDR score 3 e 4)	8%		

Confronto fra gruppi per punteggio 4AT (cut off 4/12)

4AT Negativa se < 4/12	4 AT negativa	4 AT positiva	Sig.
Età (anni)	79.3±7.06	82.5±7.0	*
MMSE ingresso (0-30)	24.5±4.5	11.9±9.6	*
MMSE dimissione (0-30)	25.6±3.9	14.6±8.4	*
Barthel premorboso (0-100)	83.8±18.7	60.9±30.3	*
Barthel ingresso (0-100)	43.2±20.7	22.9±23.8	*
Tinetti ingresso (0-28)	8.8±7.0	3.6±5.5	*
Tinetti dimissione (0-29)	20.0±7.5	9.3±9.2	*
Indice intensità assistenziale	2.8±0.3	2.9±0.2	ns
CIRS comorbilità	2.5±1.3	2.9±1.3	ns
BRASS (bisogno sociale)	18.2±4.4	22.9±4.9	*
* = p <.05			

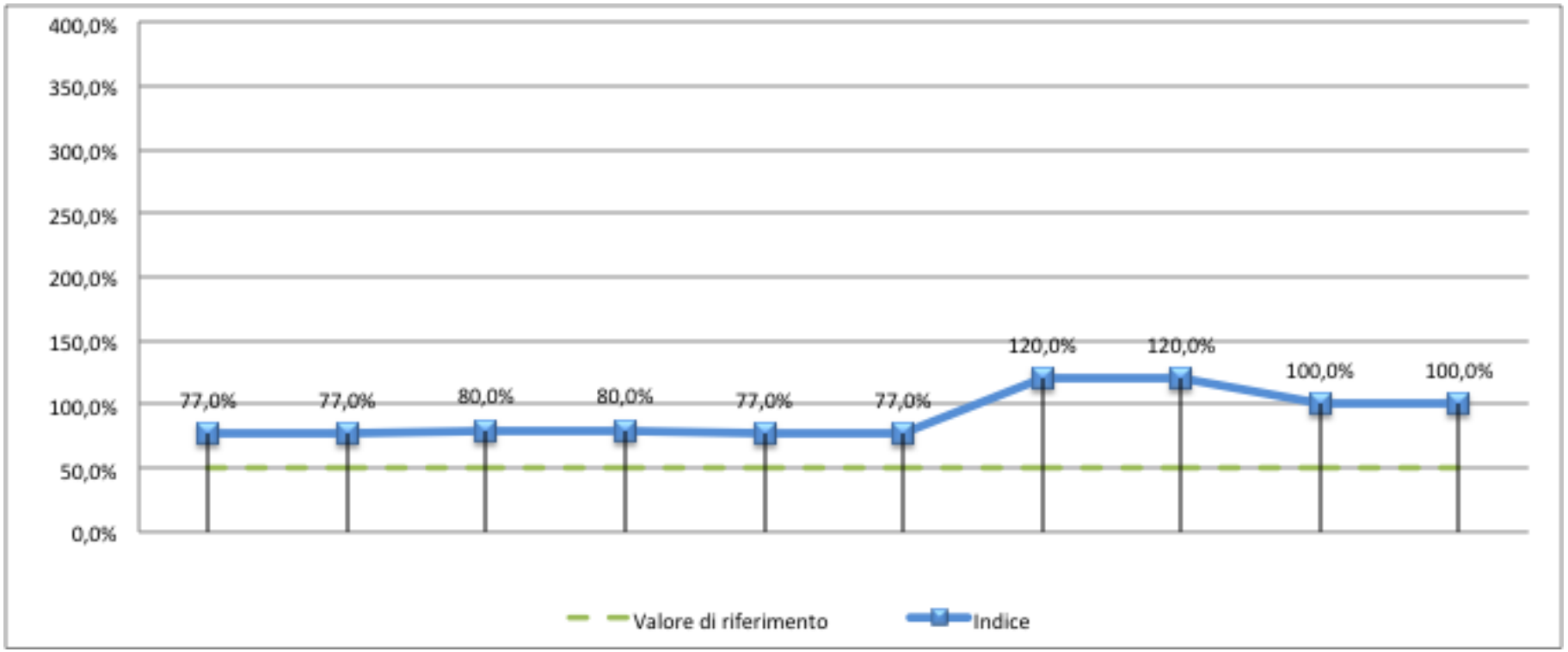
Caratteristiche dei 242 pazienti alla dimissione

		%	Media	Ds
MMSE ingresso (0-30)			21.5	8.1
MMSE dimissione			23.1	7.0
Delirium alla dimissione		0.6%		
GDS score ingresso (0-15)			3.99	2.8
GDS score dimissione			2.0	2.1
Barthel Index ingresso (0-100)			37.7	23.3
Barthel Index dimissione			63.2	29.6
Tinetti ingresso (0-28)			7.4	7.0
Tinetti dimissione			17.3	9.2

Outcome dei pazienti: totale e per gruppi (n.242)

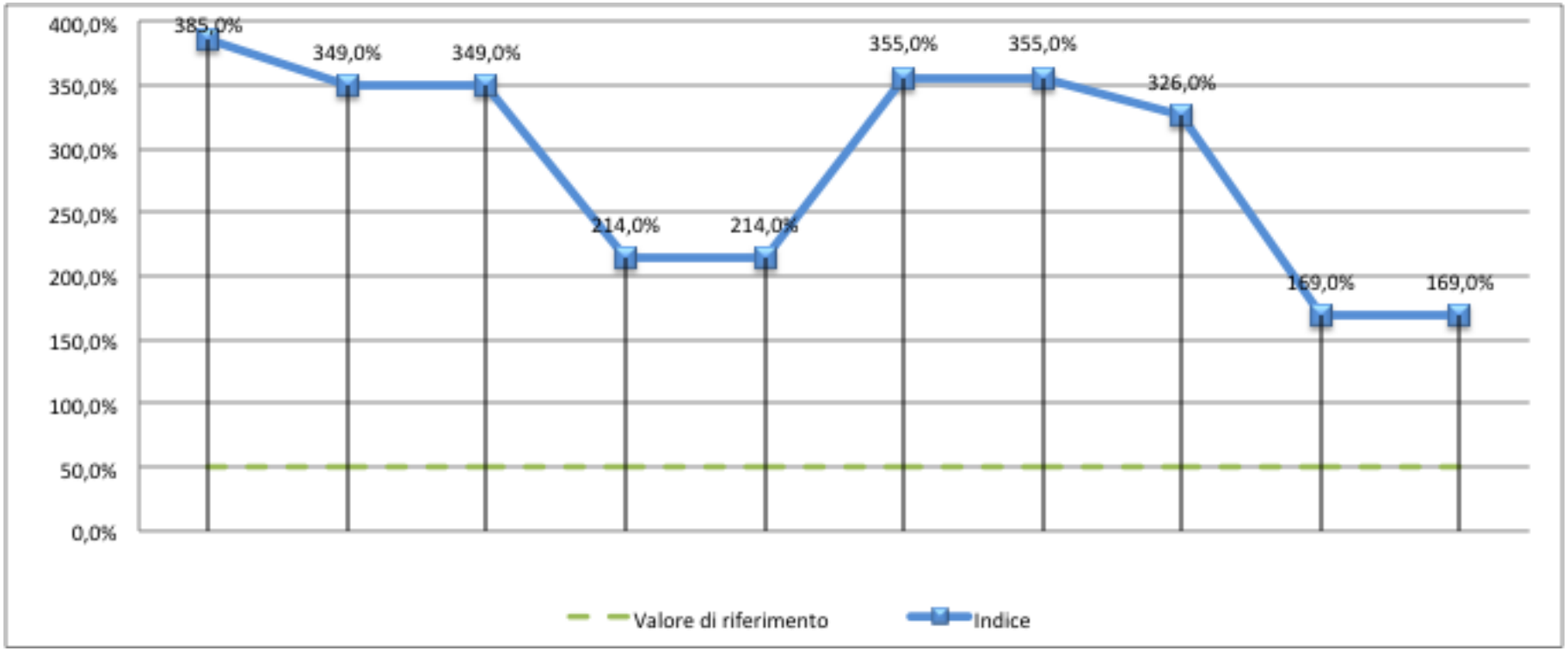
Dove va:	Totale (242)	4 AT neg (177)	4 AT pos (65)
Casa	71.8%	76.8%	56.8%
Riabilitazione	11.4%	11.6%	10.8%
RSA	9.4%	4.5%	24.3%
Ospedale (riacut/programma)	4.0%	4.5%	2.7%
Hospice	0.7%	0.9%	0.0%
Lungodegenza	2.7%	0.9%	5.4%
ADI dimissione (casa)	2.1%	0.9%	5.9%
Badante dimissione (casa)	14.1%	11%	21%
Barthel dimissione	63.2±29.6	70.6±25.5	40.4±30.3
Durata degenza (giorni)	15.1±9.8	15.1±10.4	15.0±8.2
Decesso	7%	3.4%	17%

Mortalità totale intraospedaliera - UCSA



Si intende numero dei pazienti deceduti sul totale dei dimessi (dal 7 al 12% max)

Ricoveri ripetuti entro l'anno dopo UCSA



Si intende un ricovero successivo ad un altro ricovero dello stesso paziente che avviene nella stessa o in un'altra struttura ospedaliera entro l'anno di dimissione considerato, e per lo stesso MDC (dal 3.85 al 1.69%)

PER PUNTI:

Conclusioni

Il futuro è nel percorso di continuità di cura:
Un solo ente gestore/pagatore fra ospedale, post-acuzie, territorio
Pagamento a pacchetti
Valutazione dei risultati e premio sugli outcome

Ma..non dimentichiamoci della sana e vecchia convalescenza a casa..
Per chi riesce, per chi può permetterselo..

Missing words: che fine ha fatto la convalescenza?

DANIELE VILLANI PSICOGERIATRIA 2015; 3: 97-98

Ci sono poi, all'opposto, alcune parole che, usate quotidianamente nel mondo della medicina, sono state estromesse dagli ambulatori e dalle corsie ospedaliere in modo così subdolo e inapparente da non percepirne quasi la sparizione. Una di queste è la parola convalescenza. Non è necessario essere centenari per ricordare ottimi medici di famiglia e ottimi primari che, al termine di una malattia defatigante,consigliavano ai loro pazienti un adeguato periodo di convalescenza.Tutti sapevano e tutti capivano.

Nessuno pensava a "cambiare reparto", nessuno chiedeva di prolungare in altro luogo la malattia. Un adeguato periodo di convalescenza significava qualche giorno (o anche più) trascorso in casa, al riparo dalle intemperie, in parte a letto, in parte in poltrona, magari leggendo"Topolino"o riviste e libri trascurati,in base all'età del malato (la parola "malato" non suonava scorretta). All'uscita dalla malattia si apriva, per bambini, giovani e vecchi, un lasso di tempo fatto di un lento e piacevole ritorno delle forze, di cibi leggeri, pasti piccoli e frazionati, **progressiva uscita dal letto e riappropriazione di tempi, abiti, attività e cibi usuali. Quante volte oggi usiamo o sentiamo usare la parola convalescenza?**

Ed ecco allora il proliferare delle soluzioni intermedie.

Posto che l'ospedale si occupa solo dell'acuzie, tutto quello che viene dopo si disperde, come il delta di un grande fiume, in unità di offerta a contorni sfumati: cure intermedie,subacuti, riabilitazione a bassa intensità, mantenimento, reinserimento, posti in solvenza (notturna, diurna), ricoveri di sollievo, dimissioni più o meno protette, moduli e scale valutative diverse a tre chilometri di distanza, telefoni che non rispon- dono, fax che non funzionano... e con declinazioni numerose quanto numerose sono le regioni del nostro paese.

Si apre così – si è già aperto – uno scenario fatto di: dimissioni ospedaliere precoci e affrettate; richieste caotiche di trasferimento (il grande motore è liberare il posto letto ospedaliero) verso un *altrove*, qualunque esso sia, che garantisca ancora un periodo di recupero-riabilitazione- consolidamento-mantenimento-protezione; poi la casa, o magari le *revolving doors* che riaprono porte ospedaliere appena chiuse.

Ed è qui, in questa terra di nessuno, che segue l'evento acuto e la dimissione ospedaliera, che potrebbe giocare un ruolo umanizzante (stavolta sì, usiamo la parola) la convalescenza.

Far passare il messaggio che dalle malattie non si guarisce all'istante, e che il seguito della malattia può trovare il suo ideale milieu in un ambiente domestico, accogliente, famigliare, fatto di piccoli gesti e piccoli guadagni. Provare dunque a far capire che non tutto è sanità, non tutto è riabilitazione, non tutto è macchinari, farmaci.

Ricordare che l'attenzione, l'affetto, la cura, il prendere per mano e far camminare, l'accompagnare in bagno piuttosto che a fare tre passi in giardino: tutto ciò è patrimonio dell'uomo, non delle ASL o degli Ospedali.

Proviamo a consigliare la convalescenza. Senza moduli. Senza test.

Dati Preliminari

Ucsa Poliambulanza: Follow Up (10-2014)

Pazienti Ricoverati In Ucsa Dal 11-2011 Al 11-2012:

Pazienti UCSA	N. 280	%	% valida
Responders	195	69.6	100
Vivi	103	36.8	52.8
Deceduti	92	32.8	47.2
Lost	85	30.4	--

Pazienti UCSA	N. 195	% valida	RSA
Deceduti	92	47	
A 3 mesi	34	17	
A 6 mesi	47	24	
A 12 mesi Media 9.04 ± 7.9	63	32	39/195 (20%)

Dati Preliminari

Ucsa Poliambulanza: Follow Up (10-2014)

Pazienti Ricoverati In Ucsa Dal 11-2011 Al 11-2012:

Pazienti UCSA	280	N.	%
Responders		195	
Rericoverati		121	62.1
Non rericoverati		74	37.9

	Deceduto (N, %)	Non deceduto (N, %)	%
Rericoverati	65 (53.7)	56 (46.3)	121
Non rericoverati	27 (36.5)	47 (63.5)	74
	92	103	

Frequenza dei rericoveri nei pazienti esaminati (n.121)			
Numero rericoveri	frequenza	%	% cum.
0	74	37.5	37.5
1	58	31.3	68.8
2	27	14.1	82.8
3	13	6.8	89.6
4	17	8.9	98.4
5	1	0.5	99.0
>5	2	1.0	100

Caratteristiche dei pazienti in base al decesso (n. 195)			
Variabile	NON DECEDUTI (n.103)	DECEDUTI (n.92)	P
Età	74.6+13.6	81.2+9.0	.00
MMSE dimissione	26.6+7.9	20.5+8.1	.00
BADL dimissione	65.9+29.1	48.1+29.0	.00
Tinetti dimissione	17.6+9.7	12.6+9.5	.00
CIRS severità	1.7+0.3	1.9+0.3	.00
CIRS comorbilità	2.7+1.4	3.3+1.6	.00
LOS (days)	19.3+11.0	21.2+11.0	.21
BRASS	20.6+5.8	23.2+5.3	.00
Barthel ingr-dim	-20.8+16.3	-14.8+18.0	.00
Barthel prem-dim	12.4+22.5	22.2+24.0	.00
Hb	11.3+1.6	10.4+1.4	.00
Albumina	3.2+0.4	2.8+0.4	.04
Frailty index	1.4+0.8	1.9+1.1	.00

DECESSO CORRELA:

Variabili sociali (age, living status)

Cognitive (demenza e delirium)

Cliniche (n. diseases, comorbilità)

Funzionali (IADL, BADL, delta barthel)

Biologiche (Hb album, colest)

Variabili frailty (Geppo frailty index)

Caratteristiche dei pazienti in base al re-ricovero (n. 195)

Variabile	NOT READMISSION (n.74)	READMISSION (n.121)	P
Età	78.1+11.9	77.5+12.2	-
MMSE dimissione	22.6+8.0	21.9+8.3	-
BADL dimissione	60.4+28.6	55.7+31.4	-
Tinetti dimissione	16.0+10.0	14.8+9.8	-
CIRS severità	1.7+0.3	1.8+0.3	.03
CIRS comorbilità	2.8+1.5	3.1+1.6	-
N. Malattie	10.2+4.0	11.5+3.8	.02
LOS (days)	18.1+8.9	21.5+12.0	.02
BRASS	21.6+6.2	22.0+5.3	-
Cadute (si/no)	1.1+0.3	1.4+0.4	0.1
Fratture (si/no)	1.0+0.1	1.2+0.3	0.0
Vestirsi (0,1,2)	0.6+0.8	1.0+0.8	0.4
Bagno	0.7+0.8	1.1+0.7	0.1
Cammino	0.6+0.7	0.9+0.7	0.2