Below is the content that will appear in the VITAL2015 poster compendium and on your VITAL2015 poster. Please review and **use track changes** to make any edits or comments, as well as to address any questions or comments from America’s Essential Hospitals staff.   
  
America’s Essential Hospitals staff will create and print your poster for you. You will receive a pdf of your poster by April 1 for final approval.

**Return your review and any accompanying materials to** [**Kristin Sinko**](mailto:ksinko@essentialhospitals.org) **no later than 5 pm ET, Friday, March 20.**Compendium abstract:  
**Olive View-UCLA Medical Center**

**ProACTive Care Transition Communication Reduces Repeat ED Visits**

About 20 percent of Medicare patients and 10 percent of Medicaid and uninsured patients revisit the emergency department (ED) within 30 days of discharge. These return visits contribute to higher health care expenses and poor outcomes. Limited English proficiency and sociodemographic factors put indigent and minority patients at greater risk for readmissions during transition to their patient-centered medical home.

Olive View Medical Center aimed to reduce high ED readmission rates through its Prospective Actions in Care Transitions (ProACT) Program. Using admission-discharge-transfer electronic transactions, an email containing patient information, including identifiers, demographic information, and ED visit date, was automatically sent to a patient’s medical home care manager. As a result of the intervention, the hospital found lower ED readmissions for the studied group.

Poster content:  
**Olive View-UCLA Medical Center**

**ProACTive Care Transition Communication Reduces Repeat ED Visits**

**Overview**

Approximately 20 percent of Medicare patients and 10 percent of Medicaid and uninsured patients return to the emergency department (ED) within 30 days of discharge. These return visits contribute to higher health care expenses and poor outcomes. Limited English proficiency and sociodemographic factors put indigent and minority patients at greater risk for readmissions during transition to their patient-centered medical home. By implementing ProACTIVE, a new care transitions program, the hospital reduced ED readmissions rates.

**Premise/Problem**

Olive View aimed to reduce high readmissions rates in its ED through its care transitions program.

**Methodology**

To study the effect of the care transition program on ED revisits, patients were randomized to have their primary care medical home (PCMH) receive automated emails or not. The hospital collected data from the electronic health record.

**Intervention/Innovation**

Using admission-discharge-transfer electronic transactions, emails containing patient information, including identifiers, demographic information, and ED visit date, were automatically sent to a patient’s PCMH care manager.

**Success/Outcomes**

The hospital found that patients who participated in ProACTIVE returned to the emergency department less than those who were not a part of the program.