



Lessons Learned in Performance Measurement:

# A Community’s Approach to Reducing Readmissions

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## Introduction

As part of the *Aligning Forces for Quality* (AF4Q) initiative, hospitals, ambulatory care providers, community health centers and other state and local agencies are working together to improve quality and reduce costly hospital readmissions. Prior briefs described lessons learned from early work developing public reports, including the importance of gaining physician support for these efforts, the need to carefully choose the performance measures to be reported and Alliances’ early efforts to report cost and efficiency measures. Those briefs can be accessed [here](#).

This paper builds on the previous ‘lessons learned’ paper about reporting cost and efficiency measures by focusing on local AF4Q Alliances’ efforts to reduce hospital readmissions. Most of the Alliances indicated efforts to report readmission rates as one of

their key strategies for addressing cost and efficiency – a key Aligning Forces goal. In line with the Alliances’ work to spur improvement through public reporting and performance measurement, this paper details Alliances’ efforts to reduce readmissions in their communities and showcases the work of three Alliances. For more information about Aligning Forces for Quality, visit us online at [www.forces4quality.org](http://www.forces4quality.org).

## Hospital Readmissions

Rates of hospital readmission are important outcome measures for assessing the performance of the health care system. While some hospital readmissions may be necessary and appropriate, many are considered unnecessary or avoidable, and serve as indicators of poor care, poor coordination of care and/or inefficient use of health care resources. Multiple factors may contribute to avoidable hospital readmissions, such as poor quality inpatient care, premature discharge, poor transitions between providers and poor care coordination post-discharge. Regardless of the cause, unplanned hospital readmissions in the United States are frequent and costly. In 2008, nearly one in five Medicare patients (approximately 19 percent), one in four Medicaid patients (24 percent) and more than one in 10 privately insured patients (12 percent) were rehospitalized within 30 days of a prior hospital admission.<sup>1</sup> Researchers estimate that readmissions cost Medicare approximately \$17.4 billion in 2004.<sup>2</sup> Hence, reducing hospital inpatient readmissions is a key strategy for improving health care quality while reducing costs.

The Patient Protection and Affordable Care Act (ACA) made reducing readmissions a national priority for health care. Under the ACA, hospitals will be penalized when Medicare patients are readmitted after treatment for heart failure, heart attack or pneumonia. Many of the Alliances in AF4Q report or plan to report readmissions rates for hospitals in their communities in public reports of health care quality. While reducing readmissions is a key priority in all of the Alliances, many different causes may underlie readmissions across various populations, creating the need for multiple strategies that are customized for different communities. Each Alliance takes a unique approach tailored for its setting and circumstances and taking advantage of the available resources in the communities. Three are profiled in this paper.

## Lessons Learned from AF4Q: Common Strategies for Reducing Hospital Readmissions

Care coaches for patients with high likelihood of readmission

In-home visits following hospitalization by nurses and other professionals to ensure appropriate follow-up and medication adherence

Use of risk-stratifying tools to identify patients with high likelihood of readmission

Use of educational materials adapted to appropriate literacy levels

Payment reforms to incentivize providers to reduce readmissions

Use of standardized discharge care planning

## Cleveland...

The Cleveland Alliance, known as [Better Health Greater Cleveland](#) has used a collaborative quality improvement approach to reduce readmissions in its community. Better Health Greater Cleveland has developed a network of 11 local and regional hospitals that are working together to improve care for heart failure, diabetes and stroke patients in Cleveland. The Alliance has been particularly successful in engaging hospitals to collaborate in a way that they were not accustomed to doing in the past.

*“Everyone’s struggling with a lot of the same things, and the solutions and resources are being freely shared. It’s exciting to see the potential.”—Diane Solov, Program Manager, Better Health Greater Cleveland*

As part of its focus on heart failure, the network is working on ways to reduce readmissions for heart failure diagnoses. Nurses, quality improvement staff and heart failure clinic staff from the participating sites meet on a monthly basis to discuss strategies, challenges and success stories related to reducing readmissions in their settings. The opportunity for hospitals in Cleveland to participate in the Aligning

Forces for Quality Hospital Quality Network (AF4Q HQN) (See Box 1: AF4Q Hospital Quality Network) has served to further energize the Alliance's network by providing additional resources and the opportunity to participate in a national learning collaborative. Better Health *Greater* Cleveland has leveraged participation in AF4Q HQN as an opportunity to expand its network of local and regional hospitals engaged in quality improvement efforts. AF4Q HQN has also provided participating hospitals with common strategies, performance metrics and definitions for benchmarking within the Cleveland network.

One of the hospitals in the Cleveland network is implementing a pilot with 30 eligible patients to improve the discharge process and transition from hospital to home. The goal is to ensure patients have smooth transitions from hospital to home and are seen by a primary care provider within 10 days of discharge. The hospital has developed a risk-stratifying tool to identify patients on admission who are at risk for 30-day readmissions in order to provide enhanced case management. Caseworkers' roles are reconceptualized as "transitional coaches" responsible for establishing relationships with patients while they are in the hospital and scheduling follow-up appointments prior to discharge. Caseworkers also target all high-risk patients through follow-up calls within 48 hours of discharge. The pilot was successful, with only one readmission within 30 days among the participating patients. The program is now being expanded to other units throughout the hospital.

Another health system in Cleveland is focusing on standardizing care plans for stroke patients to reduce readmissions. The health system conducted a survey among its hospitals that focused on the discharge process for patients with chronic illness and found that follow-up appointments were not routinely scheduled prior to discharge. The program is focusing on standardizing care plans, improving patient education materials and ensuring all patients receive follow-up calls post-discharge. The standardized care plans include scheduling post-discharge appointments for both primary and neurological care. The health system has shared its tools and strategies with other hospitals within the Alliance's regional network.

Better Health *Greater* Cleveland is also drawing on the capabilities of many of its clinical partners to access summaries on their patients' recent encounters at other health systems to reduce readmissions. Many of the health systems in Cleveland are linked through a common electronic health record system provider, Epic, which allows providers to access a summary of patient hospitalizations and ambulatory visits. This helps providers avoid redundant tests, as well as provide greater care continuity. One Cleveland health system that has established a medical home program for its uninsured patients uses its electronic health record system to identify participating patients to

better manage care and utilization. When a medical home patient seeks care outside of the medical home, the patient's primary care provider is alerted. This new functionality ensures that the primary care provider can coordinate the patient's care and follow-up, reducing avoidable hospital admissions.

### **Box 1: AF4Q Hospital Quality Network**

To improve quality locally, 120 hospitals are participating in the AF4Q Hospital Quality Network. Member hospitals engage health care providers at all levels within a hospital to improve the quality and safety of patient care, identify potential disparities and craft plans to ensure equity. Participating hospitals are a part of a learning network of institutions that develop and exchange quality improvement (QI) tools, strategies and lessons learned. They aim to develop and encourage the spread of effective and replicable QI strategies, models and resources within the hospital, across Aligning Forces communities and across the country.

1. Reduce 30-day readmission rates following heart failure hospitalization by 20 percent from baseline by March 2012;
2. Achieve and maintain 95 percent on the heart failure Measure of Ideal Care (a measure determining whether heart failure patients received all recommended therapies);
3. Standardize the collection of race, ethnicity and language data during registration using the U.S. Office of Management and Budget categories; and
4. Identify potential disparities in the quality of care and develop plans to ensure equity as a core component of quality.

## Oregon...

The Oregon AF4Q Alliance, known as the [Oregon Health Care Quality Corporation](#) (Quality Corp), is involved in several initiatives to reduce readmissions related to congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD). The state of Oregon is committed to reducing readmissions and has sought guidance from Quality Corp as it invests in pilot projects and initiatives to test new strategies and develop best practice guidelines. The Alliance has leveraged this opportunity to orchestrate readmission planning efforts and share best practices for reducing readmissions across the state.

Quality Corp's first initiative was to catalogue the activities already underway in Oregon to reduce readmissions. The Alliance began by generating a summary of efforts underway to reduce readmissions within the state and subsequently expanded this effort to produce a detailed environmental scan of all related projects. From this detailed catalogue, Quality Corp intends to identify and prioritize successful strategies to implement broadly across the state as well as additional interventions to be tested in specific pilot projects.

Twelve hospitals in Oregon are engaged in the AF4Q Hospital Quality Network Reducing Readmissions collaborative (See Box 1: AF4Q Hospital Quality Network). Many of the hospitals participating in AF4Q Hospital Quality Network in Oregon are located in rural communities that lack sufficient resources for reducing readmissions and find value in participating in this virtual collaborative. Through AF4Q Hospital Quality Network, hospitals aim to reduce 30-day all-cause readmission rates following hospitalization for heart failure and increase the number of patients who obtain all of the care they are eligible to receive. Participating hospitals receive technical assistance from nationally recognized experts, access to interventions that have been successful in prior initiatives and coaching and analysis of data to improve performance and identify and reduce disparities.

Quality Corp serves on the steering committee for the Transitional Care Collaborative sponsored by the Department of Human Services, Seniors & People with Disabilities, focused on best practices for improving care transitions. Staff from hospitals, skilled nursing facilities, home health agencies, physician practices, community-based long-term care settings and Area Agencies on Aging are working together to improve care transitions.

*“We’ve noticed that a lot of groups in the state are working toward the same goal and doing different things. One of our focuses is to bring groups together and leverage value where we can. There’s a need to share best practices, measure activities and make changes. There’s no shortage of activity.” – Summer Boslaugh, Program Manager, Quality Corp*

Five community teams across six counties are collaborating and sharing their interventions, experiences and data through interactive learning sessions, conference calls and e-newsletters. Each community team is developing its own intervention to share with collaborators across the state. Interventions include specialized electronic personal health records, educational materials and metrics for monitoring transitions across settings.

The Alliance is also engaged in several hospital-to-home pilot projects across the state based on efforts pioneered by care transitions expert Eric Coleman and his Care Transition Program (See Box 2: The Care Transitions Program), which are also sponsored by the Department of Human Services, Seniors & People with Disabilities. The projects focus on reducing unplanned re-hospitalizations by using coaches to engage patients to take a more active role in managing their care. The aim is to reduce 30-day unplanned readmission for patients discharged with heart failure, COPD or pneumonia. The intervention includes one or more home visits and follow-up phone calls with specially trained coaches who focus on medication reconciliation, signs and symptoms for patients to monitor, follow-up appointments with primary care providers or specialists and a personal health record.

Quality Corp is collaborating with a health care business firm, Performance Health Technology (PHTech), which provides administrative and operational support to regional health plans throughout Oregon, to test a payment reform model to reduce readmissions. The model will incentivize medical practices to reduce admissions for heart failure and COPD diagnoses. Using a physician-designed, program-oriented claim payment engine, care teams will be compensated based on their collective ability to reduce admissions. The increased payment opportunity is adjudicated in real time, based on historical data. By summer 2011, two health plans and 100 providers will begin executing this new payment model for heart failure and COPD.

## Humboldt County...

The Humboldt County Alliance has been working to reduce readmissions in its community for a number of years.

The Community Health Alliance has tailored its approach to reducing readmissions to meet the specific needs of their small, rural, close-knit community. The Alliance's readmissions efforts are led by the St. Joseph Health System-Humboldt County, a two-hospital provider in the community.

Through research on the causes of readmissions in its community, the Humboldt County Alliance found that the primary factors leading to readmissions were related to lack of follow-up with primary care providers and specialists once patients were discharged from



the hospital and poor self management, such as maintaining medication regimens. The discharge process did not sufficiently equip patients to manage their conditions as they transitioned from hospital to home. Additionally, the Alliance found that poverty, social illness and other socio-behavioral factors were significant contributors to readmissions. Even with excellent discharge planning and support, socioeconomically disadvantaged patients were not able to follow through with the recommended course of treatment and self-management since they lacked basic necessities and supports.

Given this community context, Humboldt County decided on a two-tiered approach to reducing readmissions, incorporating both a traditional strategy to reduce readmissions using Eric Coleman’s Care Transitions Program (See Box 2: The Care Transitions Program) and a more customized approach targeting, high-risk, hard-to-reach patients through their Intensive Transitional Services component. St. Joseph’s began the Care Transitions Program (CTP) four years ago. Working in partnership with the local university, they adapted the Coleman model using senior level nursing students as transition coaches. The transition coaches work with all patients who have been admitted to the hospital and who are not receiving follow-up through home health, hospice or a nursing home. Transition coaches assist patients with medication management, linking them with primary care providers, and help them to understand their disease process and self-management needs. This set of interventions is known as the Core Services component of the Care Transitions Program.

As it has evolved, the CTP has included utilization of a patient feedback tool known as the Patient Activation Measure<sup>3</sup> developed by consumer engagement expert Judy Hibbard and colleagues at the University of Oregon. Staff have found that establishing a relationship and rapport with patients before they leave the hospital is essential to successful transitional services. Originally, the CTP’s Core Services component identified patients through referrals from the hospital discharge planners, the emergency department and by mining the ED record and then “cold calling” patients. The team quickly found that patients did not respond well to the cold calls, which was an inefficient use of the transition coaches’ time. Instead, the hospital team found that developing a relationship with patients while still in the hospital is a much more effective use of transition coaches’ time and resources. To this end, transition coaches visit patients several times before they even leave the hospital. Transition coaches also follow up with phone calls for all patients within 24 hours of discharge. Additionally, transition coaches provide at least one home visit for patients after

*“Reducing readmissions requires examining what your community looks like, what your resources are, and what you can do to serve your population.” Tory Starr, Regional Director of Case Management & Care Transitions, St Joseph Health System-Humboldt County*



discharge. The team has found home visits to be essential for reconciling patients' medication regimens and establishing a solid management framework.

In addition to its CTP Core Services, the Humboldt County Alliance has also targeted patients with frequent admissions by developing an Intensive Transitional Services component of the CTP. In Humboldt County, the hospitals recognized that many of their patients with frequent admissions faced socioeconomic challenges that did not support recuperation within the community. Instead, physicians were keeping patients in the hospital for lengthy stays to ensure full recovery before discharge because they felt the patients would fail in an outpatient setting. Hence, on any given day, this group of patients comprised between 10 and 30 percent of all inpatient stays.

To better serve these patients and ensure efficient use of resources, the hospital first hired a psychiatric nurse to assist the staff in caring for this population. More recently, they have also implemented the Intensive Transitional Services component of the CTP through funding from the state County Medical Services Program and St. Joseph Hospital. The program is administered by a social worker and nurse team experienced in working with hard-to-reach populations. The goal is to help patients live within the community by providing case management services as well as meeting more basic needs such as for food, housing and transportation. The hospital has contracted with a clean and sober house and a motel to provide transitional housing, supplies bus passes and cab vouchers for transportation and supports cell phone minutes to ensure ongoing communication with their clients. The team handles each client by developing a customized care plan focusing on the barriers to compliance with their treatment plan and has been very successful keeping patients out of the hospital and in more appropriate care settings.

*“We’ve found it’s very difficult to give health information in the hospital. It’s too loud and there are frequent distractions. It’s better to visit, establish a relationship with the patient in the hospital, and do the education afterwards.” –Tory Starr, Regional Director of Case Management & Care Transitions, St Joseph Health System-Humboldt County*

## Box 2: The Care Transitions Program

The Care Transitions Program was developed by Eric Coleman to improve care transitions by providing patients and their caregivers with tools and support to encourage them to actively participate in the transition from hospital to home. Patients with complex care needs and family caregivers receive specific tools and work with a “Transition Coach,” to learn self-management skills that will ensure their needs are met during the transition from hospital to home. The intervention focuses on four key pillars:

- 1) Medication self-management: Patient is knowledgeable about medications and has a medication management system.
- 2) Use of a dynamic patient-centered record: Patient understands and utilizes the Personal Health Record (PHR) to facilitate communication and ensure continuity of care plan across providers and settings. The PHR is managed by the patient or informal caregiver.
- 3) Primary Care and Specialist Follow-Up: Patient schedules and completes follow-up visit with the primary care physician or specialist physician and is empowered to be an active participant in these interactions.
- 4) Knowledge of Red Flags: Patient is knowledgeable about indications that their condition is worsening and how to respond.

The four pillars are operationalized through two mechanisms: 1) a Personal Health Record (PHR) and 2) a series of structured visits and phone calls with a Transition Coach. Both of these mechanisms are designed to empower and educate older patients to meet their health care needs and ensure continuity of care in the transition(s) following discharge from a hospital.

Through its two-tiered Care Transitions Program aimed at reducing readmissions, the hospital has seen major cost savings, more than double the cost of the program and reduction in length of stay. In addition to saving money by decreasing readmissions, they have also seen patients in their Intensive Transitional Services Program sustain jobs and graduate from homelessness into long-term, stable living arrangements.

1 Wier LM, Barrett M, Steiner C, Jiang J. All-cause readmissions by payer and age, 2008. Healthcare cost and Utilization Project. AHRQ. Statistical Brief #115, June 2011.

2 Jencks SF, Williams MV, Coleman EA. Rehospitalizations among Patients in the Medicare Fee-for-Service Program. N Engl J Med 2009; 360:1418-1428.

3 Hibbard JH, Stocard J, Mahoney ER, Tusler M. Development of the Patient Activation Measure (PAM): Conceptualizing and Measuring Activation in Patients and Consumers. Health Services Research 2004 39(4):1005-26.

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**About the Author:**

This paper was prepared by the **Center for Health Care Quality** within the Department of Health Policy at The George Washington University School of Public Health and Health Services, which serves as the national program office for Aligning Forces for Quality. Marsha Regenstein and Ellie Andres authored this publication.

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*Aligning Forces for Quality* is the Robert Wood Johnson Foundation’s signature effort to lift the overall quality of health care in targeted communities, as well as reduce racial and ethnic disparities and provide tested models for national reform. In 16 Aligning Forces regions, people who get care, give care and pay for care are working to rebuild local health care systems, so they work better for everyone. The program intends to drive change in local health care markets that will result in measureable improvements by 2015. When Aligning Forces began in 2006, the idea of diverse local stakeholders linking approaches to enhance quality was novel. Since then, the program’s emphasis on 1) engaging consumers, 2) measuring the performance of local providers and reporting it publicly, 3) improving the quality and equality of care, and 4) exploring how to improve the health care payment and reimbursement system has taken hold, with many others joining the field. Learn more about RWJF’s efforts to improve quality and equality of care at [www.rwjf.org/qualityequality](http://www.rwjf.org/qualityequality). Learn more about Aligning Forces for Quality at [www.forces4quality.org](http://www.forces4quality.org).