

Reform in Action: How the U.S. Health Care System Can Reduce Avoidable Readmissions

Insights from the Robert Wood Johnson Foundation and Aligning Forces for Quality

In 2010, the Robert Wood Johnson Foundation (RWJF) launched the Hospital Quality Network, a learning network of 120 hospitals to develop and exchange quality improvement tools, strategies, and lessons learned on three core focus areas: improving language services, increasing throughput, and reducing avoidable readmissions. The initiative was part of [Aligning Forces for Quality \(AF4Q\)](#), RWJF's signature effort to lift the overall quality of health care in 16 targeted communities. Lessons from AF4Q and its Hospital Quality Network demonstrate how health care providers can work together and with patients to help them transition out of the hospital.

RWJF'S PERSPECTIVE

Hear from John Lumpkin, MD, MPH, senior vice president and director of the Health Care Group at the Robert Wood Johnson Foundation, on steps patients and caregivers can take to improve transitions from hospital to home.

Patients discharged from U.S. hospitals return far too often. Almost one in five elderly patients released from a hospital is back within 30 days, and more than one in three are back within 90 days.¹ Although some readmissions are part of a patient's treatment plan, many are avoidable. They are the result of a fragmented system of care that too often leaves discharged patients confused about how to care for themselves at home, unable to follow instructions they didn't understand, not taking medications properly or getting the necessary follow-up care, and ultimately leading them to return to the hospital. These unnecessary readmissions negatively affect patients' health, place a burden on their families and caregivers, and cost our country billions of dollars.

Facing the Readmissions Crisis in America

The issue of preventable readmissions has recently come to the forefront in our health care system due to the Medicare penalties imposed on hospitals with excessive rehospitalizations. Under the Affordable Care Act, more than 2,000 hospitals faced penalties in October 2012 because of high readmission rates for heart attack, heart failure and pneumonia, and these penalties will become more severe over time.²

RWJF has supported a wide range of programs to improve care transitions and reduce avoidable readmissions. Most recently, hospitals participating in the AF4Q Hospital Quality Network developed and implemented replicable quality improvement strategies for reducing avoidable readmissions for heart failure patients, resulting in approximately 500 avoided readmissions over an 18-month period.

This brief highlights how the local alliances that lead the AF4Q effort in each community and hospitals participating in the Hospital Quality Network are trying new approaches to help patients get the care they need without returning to the hospital. They are starting conversations in their local communities, targeting patients at high risk for being readmitted, spurring changes within hospitals to streamline processes, and improving coordination between hospitals and outpatient care facilities to help patients receive continuous care.

Additional Resources from RWJF:

[The Revolving Door: A Report on U.S. Hospital Readmissions](#)

[Interactive Map: The Revolving Door Syndrome](#)

[10 Things You Should Know About Care Transitions](#)

[Reducing Avoidable Readmissions Through Better Care Transitions](#)

[Aligning Forces for Quality Hospital Quality Network: What Did the Collaborative Accomplish?](#)

[Health Policy Brief: Improving Care Transitions](#)



Convening the Health Care Community on Reducing Readmissions

Reducing avoidable readmissions is not the sole province of hospitals—patients, caregivers, doctors, nurses and other stakeholders play an important role in addressing this problem. AF4Q alliances are working to engage those who give care, receive care, and pay for care in their communities to help patients transition from hospital to home.

The AF4Q alliance in Cleveland, [Better Health Greater Cleveland](#), has convened a quality improvement network of 11 local and regional hospitals that has identified reducing avoidable readmissions for heart failure patients as a primary goal. As part of the collaborative, nurses, hospital quality improvement staff members and heart failure clinic staff members from different provider groups in the increasingly competitive health care marketplace found common ground to discuss strategies, challenges and successes to address the larger problem of reducing avoidable readmissions. Through its participation in the Hospital Quality Network, Better Health Greater Cleveland has offered new resources, strategies, performance metrics and definitions for benchmarking to participating providers.

The Cleveland alliance also measures potentially avoidable hospitalizations to better inform the community about the need for change. The alliance's 2013 [public report](#) analyzed hospitalizations in Cuyahoga County, Ohio, finding that 2,854 fewer patients were hospitalized for cardiovascular conditions from 2009 through 2011, saving \$20.1 million.³ For the cardiovascular conditions that Better Health Greater Cleveland's initiatives target, the report found that hospitalizations decreased 10.7 percent in 2011, after declining steadily in 2009 and 2010.⁴

In 2012, [Healthy Memphis Common Table](#), which leads the AF4Q effort in Memphis, released a [report](#) showing that timely and appropriate care could have prevented 12,722 hospitalizations in Shelby County, Tenn., saving approximately \$87 million.⁵ The report examined disparities in preventable hospitalizations based on race, sex, access to primary care, and whether a patient had a chronic illness.⁶ Though reports on reducing potentially avoidable hospitalizations do not focus solely on patients returning to the hospital, they help providers identify ways to support patients managing chronic conditions and ensure patients get the care they need outside the hospital—whether they have been hospitalized yet or not.

LEARNING BY EXAMPLE

Watch a video about how Healthy Memphis Common Table is working to prevent potentially avoidable hospitalizations.

The [Oregon Health Care Quality Corporation](#) (Quality Corp), a statewide AF4Q alliance, also raised awareness about this issue in the community by hosting a conference where nearly 100 local health care stakeholders shared lessons on reducing avoidable readmissions. Quality Corp assessed the local landscape by cataloguing local initiatives that are working to reduce avoidable readmissions. Based on this work, the state of Oregon is relying on Quality Corp to identify pilot projects and new strategies that it will test to develop best practice guidelines.

Additional Resources from RWJF:

[Better Care, Better Health, Lower Cost: It Takes a Community Lessons Learned in Performance Measurement: A Community's Approach to Reducing Readmissions Status Report on Efforts to Understand and Create Awareness of Potentially Avoidable Hospitalizations in Memphis and Shelby County, Tennessee](#)
[Oregon Tackles Hospital Readmissions Through Multi-stakeholder Conference](#)

Identifying and Working With At-Risk Populations

Since reducing preventable readmissions is a formidable task, many organizations and hospitals begin to tackle the problem by identifying patients who are most likely to return.

As part of its work with the Hospital Quality Network, the staff at Redington-Fairview General Hospital in Skowhegan, Maine, examined trends across its heart failure patients to determine how to recognize those at higher risk for readmission. The hospital chose to incorporate the hospital “LACE” assessment, which calculates a risk score based on length of stay, acute admission through the emergency department, comorbidities, and emergency department visits in the last six months. For 18 months, Redington-Fairview tested the system by assigning LACE scores to each patient upon admission. If a patient had a high score, care transition nurses closely monitored the patient and provided more comprehensive education. During the 18-month trial, 30-day readmission rates for heart failure patients decreased from 6.9 percent to zero percent.

[Aligning Forces Humboldt](#), the AF4Q community in Humboldt County, Calif., works with St. Joseph Health System-Humboldt County to identify and target patients who are frequently hospitalized and provide them with intensive social services. The alliance estimates that these hard-to-reach patients fill 10–30 percent of hospital beds at St. Joseph, and that physicians often keep them hospitalized longer because socioeconomic challenges prevent them from continuing to get healthier after leaving the hospital. To address this, St. Joseph implemented the “Intensive Transitional Services Program,” which tasks a nurse team and social worker with developing customized plans to help patients overcome barriers for getting care and complying with treatment plans. The team works with community resources to meet patients’ basic needs, such as food, housing and transportation, so patients can better follow their treatment plans and get continuous outpatient care. By providing tailored, one-on-one support, the Intensive Transitional Services Program helps patients, many of whom are homeless, get and maintain jobs and long-term living arrangements. St. Joseph has seen a decrease in readmissions and length of stay, as well as significant cost savings.

Six AF4Q alliances are also leading initiatives to provide support services to patients who receive repeated care in emergency departments and hospitals, known as “super-utilizers.” These patients often have multiple chronic medical problems and social complexities that prevent them from managing their health, leading them to frequently receive care at the hospital, which is an expensive and inefficient way to treat these patients. As part of the program, the alliances review hospital records to identify super-utilizers in their communities, work with care teams to coordinate social and medical services that patients need to stay healthy outside the hospital, and provide coaching and support for primary care practices to help them provide targeted care and case management for super-utilizer patients. The program aims to reduce unnecessary hospitalizations by engaging care teams and primary care practices to work closely with patients to recognize and address barriers for maintaining their health, and coach them on better ways to manage their conditions with their doctors and caregivers.

Additional Resources from RWJF:

[Promising Practices for Reducing Hospital Readmissions](#)

[How to Avoid Being Readmitted to the Hospital](#)

[Hospital Discharge Checklist and Care Transition Plan](#)

[Hospital Uses “LACE” Assessment to Reduce Readmissions](#)

[Robert Wood Johnson Foundation Awards \\$2.1 Million in Grants to Improve Care, Reduce Costs for Most Expensive Patients](#)

[Better Care for Super-Utilizers](#)

LEARNING BY EXAMPLE

Watch a video about how the P2 Collaborative of Western New York is implementing a care transitions program to give patients one-on-one support after leaving the hospital.

Refining Processes in Hospitals for Smoother Transitions

AF4Q alliances are working alongside local hospitals to identify processes that can be improved to help patients transition home. Aligning Forces Humboldt has supported St. Joseph Health System-Humboldt County in changing its discharge processes to ensure patients identified as high risk for readmission get needed follow-up care with primary care physicians and specialists. St. Joseph's [Care Transitions Program](#) engages nurses to serve as transition coaches, assisting patients with medication self-management, educating them on their conditions and the importance of keeping a personal health record, and linking them with primary care providers. The transition coaches work with patients several times before they leave the hospital. Since patients in the program are not receiving follow-up care through home health, hospice, or a nursing home, transition coaches follow up by calling patients within 24 hours of discharge and making a home visit shortly thereafter. Since 2009, St. Joseph's has cut its readmission rate by 20 percent.

Additional hospitals that participated in the Hospital Quality Network employed similar quality improvement strategies to improve care transitions. Marymount Hospital in the Cleveland Clinic network in Garfield, Ohio, implemented "Heart Failure Care Advocates" to help patients manage their conditions after leaving the hospital. Care advocates acted as intermediaries between patients, physicians, hospital staff, and caregivers to ensure that patients received recommended care while in the hospital and were given comprehensive discharge plans, including medication and dietary instructions. Care advocates also confirmed that a family member or caregiver would assist the patient at home and made follow-up calls to check on patients soon after discharge. During the program, Marymount reduced its 30-day all-cause readmission rate by 13 percent and maintained 100 percent compliance with core measures for heart failure care.

Samaritan Albany General Hospital in Albany, N.Y., focused on reducing preventable readmissions for heart failure patients by implementing a comprehensive patient education program. The hospital standardized its congestive heart failure education materials, distributed "Heart Failure Care Kits" to patients soon after being admitted, and implemented the teach-back method, which asks patients to repeat instructions in their own words. Samaritan Albany General also began making follow-up calls after discharge, and engaged different providers, such as pharmacists and nutritionists, to meet with patients and answer questions during their initial hospital stay. Through the program, the hospital reduced heart failure readmissions from 23.6 percent to 11 percent.

Oregon Health & Science University (OHSU) in Portland, Ore., also worked to help patients understand their discharge plans better. After learning that patients were overwhelmed with paperwork after leaving the hospital, OHSU staff members engaged a health literacy expert to simplify and minimize discharge instructions to make them patient-friendly. Discharge instructions were consolidated from an eight-page document written at a 12th-grade reading level to a more easily understood one-page document written at a 6th-grade reading level. The hospital also asked nurse practitioners to use the teach-back method during discharge, and offered a disease-specific education booklet to heart failure patients. Over the 18-month program, OHSU reduced readmissions for heart failure patients by 11 percent.

Additional Resources from RWJF:

[Care Transitions Program Reduces Readmissions in Humboldt County](#)

[Nurse Care Advocate Improves Heart Failure Care](#)

[Samaritan Albany General Hospital Improves Patient Education](#)

[Heart Failure Education Reduces Readmissions](#)

LEARNING BY EXAMPLE

Watch a video about how St. Joseph's Health System in Humboldt County, Calif., improved care transitions for patients.

Improving How Health Care Providers Work Together

Changes driven solely by the hospital are not silver bullets for preventing avoidable hospitalizations—doctors, nurses and staff across all settings of care must work together for lasting change. For instance, Central Maine Medical Center (CMMC) in Lewiston, Maine, a participant in the Hospital Quality Network, began working with Androscoggin Home Care & Hospice to provide needed, individualized follow-up care. Nurses made home visits to every heart failure patient discharged from CMMC within a week of leaving the hospital. After implementing this tactic, the hospital's 30-day all-cause heart failure readmission rate dropped from 22.8 percent to 17 percent.

Regions Hospital in St. Paul, Minn., also worked with care providers to ensure patients get necessary follow-up care as part of its work in the Hospital Quality Network. After examining its discharge practices, the hospital found that not only were heart attack patients responsible for scheduling their own cardiac rehabilitation appointments, but also that the hospital did not have a consistent system in place to recommend and track these follow-up appointments. Regions Hospital worked with its IT staff to include a recommendation for cardiac rehab in discharge orders for heart attack patients. The hospital used posters to engage nurses to notify the rehab staff of a discharge order recommending cardiac rehab so they can then visit the patient's bedside to schedule their first appointment. After making these changes, referral rates to cardiac rehab at Regions Hospital rose to 60 percent higher than the national average.

Del Sol Medical Center in El Paso, Texas, also faced the issue of heart failure patients not receiving recommended care and returning to the hospital too often. Since heart failure was a common diagnosis in the mostly Latino community, the hospital established a heart failure center to bridge inpatient and outpatient care as part of RWJF's [Expecting Success](#) program. Nurses at the outpatient center identified and visited heart failure patients in the hospital to educate them about tracking symptoms, maintaining a healthy diet, monitoring weight and blood pressure, and taking medications consistently. They provided diagnosis information in the patient's preferred language, referred patients to the heart failure center, and made follow-up calls after discharge to schedule a visit. At the heart failure center, patients and caregivers could attend nutrition and health education classes and receive helpful tools, such as a heart healthy cookbook, a scale, and bilingual calendars and diaries for monitoring blood pressure, weight, and symptoms. After establishing the clinic, Del Sol's 30-day readmissions for heart failure decreased from 16 percent to 7 percent over two years.

LEARNING BY EXAMPLE

Watch a video about how Androscoggin Home Care & Hospice in Maine worked with patients to help them transition out of the hospital.

Additional Resources from AF4Q:

- [Coordinated Home Care Reduces Readmissions](#)
- [Improving Care Coordination by Streamlining Patient Referrals](#)
- [Combining Better Systems and Intensive Patient Education for Better Heart Care](#)

The initiatives in this brief prove that no one agent—not a health care organization or hospital—can reduce avoidable readmissions on its own. Hospitals, primary care providers, local organizations, patients and caregivers must all work together to coordinate care across entire communities to help patients leave the hospital better informed and in a better position to get continuous care outside of the hospital, so they do not need to return.

For more information about Aligning Forces for Quality, visit www.rwjf.org/qualityequality/af4q.



Robert Wood Johnson Foundation

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1 Jencks SF, Williams MV and Coleman EA. "Rehospitalizations Among Patients in the Medicare Fee-for-Service Program." *New England Journal of Medicine*, 360(14): 1418–1428, 2009.

2 Burton R. "Health Policy Brief: Care Transitions," *Health Affairs*, September 2012, www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401314 (accessed February 2013).

3 *Better Care, Better Health, Lower Cost: It Takes a Community*. Cleveland: Better Health Greater Cleveland, 2013, www.betterhealthcleveland.org/BetterHealth/files/81/8143a2d9-ab59-462b-a194-8e7c83c2dedd.pdf (accessed February 2013).

4 Ibid.

5 *Status Report on Efforts to Understand and Create Awareness of Potentially Avoidable Hospitalizations in Memphis and Shelby County, Tennessee*. Memphis, Tenn.: Healthy Memphis Common Table, 2012, www.healthymemphis.org/upload/media/HMCT_TCFBH_PAH_Report_WEB.pdf (accessed February 2013).

6 Ibid.