Hospital readmissions are a major source of health care spending. So when Wisconsin hospitals announced last fall they had reduced readmissions by 22 percent — exceeding the Centers for Medicare and Medicaid Services (CMS) goal of 20 percent— it was good news for patients and payers alike. A new report from CMS showed that after holding constant at 19 percent from 2007 to 2011 and decreasing to 18.5 percent in 2012, the Medicare all-cause 30-day readmission rate has decreased to approximately 17.5 percent in 2013 (1).

Wisconsin is one of the top ten performing states in CMS’ Hospital Readmissions Reduction Program for the second year in a row(2). For FFY 2014, 63 percent of eligible hospitals will see no reduction in their payments and no hospitals will receive a penalty greater than one percent. This improvement work has eliminated readmissions for an estimated 3,556 patients in Wisconsin. Even though the CMS goal was met in 2013 this important work will continue in 2014. In addition, WHA will publicly report readmission rates on its quality reporting website, www.WiCheckPoint in 2014 so patients and the public have access to individual hospital results.

The work of reducing readmissions is not new to Wisconsin. Hospitals here have been working to reduce this unnecessary care for several years. However, a concerted effort to collaborate began in late 2011, with the Wisconsin Hospital Association (WHA) convening a one-day event. Designed to bring together hospitals, long-term care organizations, aging and disability resources, home health agencies and others, the event provided a forum for communities to meet in person with other local caregivers, some for the first time. Pat Rutherford from IHI served as the keynote presenter and she emphasized the importance of local and statewide collaboration. This event drew 200 attendees and a statewide collaborative to reduce readmissions was born.

With the launch of CMSs’ Partnership for Patients, and the QIO 10th Scope of Work, WHA and MetaStar, Wisconsin’s QIO, convened a group of leaders from various associations with a stake in reducing readmissions. Two long-term care associations, the Wisconsin Department of Health Services, the state pharmacy society, and many others began meeting monthly chartering an agreement to refrain from duplicating efforts and to wisely use financial and other resources for the benefit of all. Kelly Court, WHA chief quality officer, sums it up this way. “Different organizations provide different types of services to patients and the public within our communities. The Transitions of Care Committee has created an ongoing structure to gather and align the perspectives of these different organizations that can impact readmissions. Through this group we now have a better understanding of what each type of organization has to offer and we can work together to leverage the unique assets of each.”
Wisconsin Hospitals Tackle Readmissions …continued

Beginning the Work

Reducing readmissions remains one of the hardest projects to tackle due to the number of potential root causes. Hospitals continue to work on strategies to prevent a recently discharged patient from an unplanned return to the hospital within 30 days of discharge. This is a complex issue, and the reasons for a readmission vary greatly. These include difficulty understanding discharge instructions, difficulty getting to a follow-up appointment, forgetting a new prescription, or little support for care at home among other factors. This measure is also greatly impacted by the progression of a patient’s disease process, which may be unpreventable. Readmissions account for one of the largest opportunities to drive unnecessary cost out of the health care system. An average readmission costs $9,600(3).

The start of CMS Partnership for Patients Hospital Engagement Network provided a timely platform for engaging a large number of hospitals in a collaborative improvement effort. The WHA Partners for Patients Kick-Off event in May 2012 resulted in 87 hospitals enrolling in the first wave of a nine-month webinar series. In the first cohort, the hospitals achieved a 12 percent improvement. With the second wave launching in March 2013, fifteen more hospitals joined the statewide initiative and the focus became on better root cause analysis and selection of process measures to report on a monthly basis. While teaching evidence-based practices, and providing a forum for hospitals to learn and share – WHA also emphasizes the “how to” involve care giving staff in changing their work processes and getting “buy-in” to change.

Inside/Outside Strategy

WHA’s engagement method is primarily based on webinars to facilitate learning the tools in evidence-based improvement models such as STAAR, Project RED, BOOST, and INTERACT. Rather than settling on one model, WHA led hospitals through a process to borrow the best from any and all of the approaches. “We made a conscious decision to avoid being too prescriptive” says Stephanie Sobczak, WHA quality manager and readmissions lead. “Several hospitals had already gravitated to one or the other – but mainly we wanted to avoid stifling any innovation – which can happen when trying to adhere to a single approach.” The role of WHA’s quality staff is to facilitate connections among hospitals; package the evidence base into short, high content webinars for Wisconsin hospitals; and to provide information about national hospital engagement network webinars that are offered on readmissions and other topics.

WHA encouraged hospitals to approach readmissions with both an inside, and outside, strategy. Hospitals engaged their front-line caregivers to learn about the day-to-day challenges working with patients at risk for readmissions. They were taught methods to find root causes of inpatient process failures that contribute to readmissions. At the heart of the improvement is instruction in the practical application of IHI’s Model for Improvement. Andy, by using AHA-HRET’s best practices checklists (4), hospitals then identified one or two key processes to improve, with a strong emphasize on well designed small tests of change. To expand the understanding of processes outside the hospital’s walls, quality and nursing leaders were actively encouraged to participate in fledgling community Transition of Care coalitions launching around the state.

Macro/Micro Strategy

While hospitals and other providers work to improve their internal processes they also recognize they cannot solve this problem on their own. They are leading local initiatives to create new partnerships within their community by forming work groups and coalitions with long term care and home health providers and other groups such as local agencies on aging.

The Wisconsin Transitions of Care Coordinating Committee first marshaled resources to host one-day workshops for the purpose of convening local coalitions. A primary strategy in the 10th Scope of Work, MetaStar provides support to the local coalitions. In 2013, a total of 400 people representing the local “care continuum” came together in one of four regional workshops to learn about readmission trends in their areas, practice mapping local drivers of readmissions, and to examine potential collaborations that could be used to reduce readmissions.

As of early 2014, there were 20 active community coalitions around the state. They range in size from one hospital and one skilled nursing facility in a rural county, to regions with 3 or 4 large hospitals participating. The coalition leaders bring data to the table which begins the process of determining the local drivers of readmissions. The organizations responsible for addressing their opportunities for improvement work with others to improve the process. Here are a few examples from Wisconsin hospitals and healthcare organizations:

- The Coalition in Kenosha County, a consortium of 12 organizations active since 2012, connected with the local Aging and Disability Resource Center to design post-discharge home follow-up visits with high risk patients. Area hospitals likewise devoted additional FTE’s to care transitions coordination as a result of this partnership.
Wisconsin Hospitals Tackle Readmissions … continued

- Vernon Memorial Hospital, Viroqua, is a critical access hospital that leads a local coalition. VMH has limited pharmacist resources, so they worked with the Wisconsin Pharmacy Society to bring retail pharmacies to the table and discuss options for medication reconciliation outside of the inpatient setting.
- The Coalition in Menomonee Falls led by Froedtert & the Medical College of Wisconsin’s Community Memorial Hospital recently engaged WHA quality staff to teach coalition partners methods of process redesign when multiple organizations are involved.

Other multi-organization partnerships are convened to address a specific need. When skilled nursing facilities showed interest in spreading the INTERACT Toolkit(5), the Care Transitions Committee came up with a solution. With funding from the Aligning Forces for Quality grant in Wisconsin(6), MetaStar provided the clinical expertise and WHA contributed the Model for Improvement content to launch a free webinar series on the INTERACT model. This toolkit is designed to address the particular needs of nursing homes and long-term care settings to reduce the likelihood of resident readmissions.

Through this important partnership with MetaStar and Wisconsin’s long-term care associations – LeadingAge Wisconsin and the Wisconsin Health Care Association - WHA has helped address care transitions challenges for these settings.

There are continued opportunities to enhance the ‘micro strategy’ through more actively engaging patients and families in process re-design, improving health literacy, and raising awareness of community resources such as the Aging and Disability Resource Centers – which were expanded under the Affordable Care Act. The Wisconsin Transitions of Care Committee is sponsoring a reconvening event in the fall of 2014 to again bring together providers across the continuum of care to continue the good work.

In Summary

Health care leaders across Wisconsin made a commitment over a decade ago to raise quality statewide by sharing best practices, committing to quality improvement and promoting transparency. The goal was to ensure that no matter where a patient may seek medical services in Wisconsin, they would receive the highest standard of care possible. Achieving this high level of collaboration and improved clinical performance does not happen by chance. It takes openness and trust among associations and provider organizations to set the tone. It takes organizational commitment and human and financial resources to design and improve processes that drive out harm and reduce waste. And, most importantly, it takes keeping the needs of our patients and communities at the center of the work to continuously improve.

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(3) AHA/HRET Hospital Engagement Network cost estimate
(4) AHA/HRET Checklists to Improve Patient Safety: http://www.hpoe.org/resources/hpoehretaha-guides/1398
(5) INTERACT: http://interact2.net/
(6) TCAB is a project of Aligning Forces for Quality, which is supported by the Robert Wood Johnson Foundation through a grant to the Wisconsin Collaborative for Healthcare Quality. In Wisconsin, Aligning Forces for Quality is a joint project of the Wisconsin Collaborative for Healthcare Quality, Wisconsin Hospital Association, and other organizations.