Potentially Avoidable Hospital Readmissions Report and Recommendations

May 21, 2014
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Background Information

Problem Statement
The estimated national cost for unplanned Medicare hospital readmissions was $17.4 billion in 2004.1 Readmission rates are increasingly seen as a marker of a local health care system’s ability to coordinate care for patients across settings.2 High hospital readmission rates are often a sign of inadequate discharge planning and lack of community-based care.2 Drivers of poor transitions from the hospital to the community are lack of standard and known processes at the hospital (e.g., patient discharge, handover, internal work flow), lack of information transfer, especially across-settings to the primary care provider (e.g., delays, inaccuracies, missing information), poor communication between provider and patient, and lack of patient and family activation (e.g., health literacy, self-management skills and tools, motivation, locus of control).3,4,5 Poor transitions can lead to adverse events post discharge, which can be common.6,7 One study found that 49% of discharged patients experienced at least one medical error and were then 6.2 times more likely to be rehospitalized within three months of discharge.8

National Hospital Readmissions Data
The 2011 Dartmouth Atlas report found that little progress has been made in reducing 30-day readmission rates from 2004-2009 despite significant effort and identified a link between high hospital utilization and readmission rates, Figure 1.2 For many parts of the country, rates are increasing, indicating an opportunity to improve patient care, outcomes, and lower costs.

Figure 1. Percent of Patients Readmitted within 30 Days of Discharge

Nationally, hospital readmissions vary widely between states, see Figure 1, and Figure 2 for Medicare-specific rates. This variation is at least partially attributable to characteristics of the community in which the hospital is located rather than individual hospital characteristics, indicating the importance of community engagement in any intervention meant to reduce hospital readmissions.\textsuperscript{10}

**Figure 2. Rates of Rehospitalization within 30 Days after Hospital Discharge\textsuperscript{1}**
Includes patients discharged between October 1, 2003, and September 30, 2004 in Medicare fee-for-service programs.

[Image of a map showing rates of rehospitalization across the United States.]


**Washington State Readmissions Data**
While some studies indicate hospital readmission rates to be lower in Washington when compared with other states, readmission rates are highly variable within Washington.\textsuperscript{1} Analysis of the 2011 Comprehensive Hospital Abstract Reporting System (CHARS) index hospitalizations 30-day, all-cause rehospitalization rates at Washington state hospitals shows this high degree of variation. The average readmissions rate for Washington State is 10.8% (95% CI 10.2% to 11.3%). Excluding hospitals with less than 500 hospitalizations and without risk adjusting, individual hospital rates range from 6.3% (95% CI 5.0% to 7.5%) to 16.9% (95% CI 15.7% to 18.1%).


Washington hospitals performed well on the Dartmouth Atlas readmission report.\textsuperscript{2} With the exception of Pierce County, readmission rates remained the same or decreased compared with many other parts of the country which were increasing.\textsuperscript{11}
Within the Medicare population, 2010 data show patients with diabetes or heart failure as being at highest risk of readmission, Table 1. Medicare 30-day hospital readmissions in 2012 were 35 per 1,000 beneficiaries, the median all-state being 45 per 1,000 beneficiaries, while the best state’s rate was 26 per 1,000 beneficiaries. This is no change from the 2008 rate of 38 per 1,000 beneficiaries according to the Commonwealth Fund’s definition of at least 0.5 standard deviations. Washington State’s readmission rate for short-stay nursing home residents readmitted within 30 days of hospital discharge to nursing home was 17% in 2010, no meaningful change from the 2006 rate of 16%, lower than the all-state median of 20%, and higher than the best state’s rate of 12%.

Table 1: Washington State Medicare Conditions with Highest Readmission Rates

<table>
<thead>
<tr>
<th>Condition</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>25.8%</td>
</tr>
<tr>
<td>Heart Failure</td>
<td>24.2%</td>
</tr>
<tr>
<td>Pulmonary/Embolism w/o mcc</td>
<td>22.5%</td>
</tr>
<tr>
<td>Renal Failure</td>
<td>22.4%</td>
</tr>
<tr>
<td>COPD</td>
<td>20.3%</td>
</tr>
</tbody>
</table>

Medicare fee-for-service claims and enrollment data show that although Washington State is performing relatively well as ranked against other state-specific data, 13th lowest in 2012 at 16.1%, this population also has high readmission rates, especially when broken out by patient characteristics including having multiple chronic conditions, being under age 65 disability, and being dually eligible for Medicare and Medicaid, Figure 3.

Figure 3: Readmission Rates across Patient Characteristics, 2012

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4
Hospital-level Medicare dual eligible fee-for-service claims and enrollment data also show variation between hospitals, ranging from a low of 13.8% to a high of 28.1%, **Figure 4**.

**Figure 4: Washington PPS Hospitals Readmit Rates for Dual Eligible Patients**

Medicaid data also show variation in Washington State’s readmission rates. Rehospitalization rates from the 18 states participating the Medicaid Medical Directors Learning Network for patients hospitalized in 2009 for reasons other than childbirth who were readmitted with 30 days of initial hospital stay ranged from 5.5% to 11.8% with an average of 8.8%. Washington State total payments for hospital readmissions within 30 days in 2010 were $86,269,191, or 15.7% of total payment for acute hospital care; higher than the 18-state average hospital payment for 30-day readmissions of $75,439,833, or 12.5% of total payment for acute hospital care. The top five diagnostic categories, accounting for 52% of all readmissions, are found in **Table 2**.

**Table 2: Readmission Rates for Medicare’s Top Five Diagnostic Categories**

<table>
<thead>
<tr>
<th>Diagnostic Category</th>
<th>Washington Readmission Rate</th>
<th>17-State Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Endocrine, Nutritional &amp; Metabolic, and Immunity</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>Diseases of the Digestive System</td>
<td>19%</td>
<td>21%</td>
</tr>
<tr>
<td>Diseases of the Respiratory System</td>
<td>16%</td>
<td>19%</td>
</tr>
<tr>
<td>Injury and Poisoning</td>
<td>17%</td>
<td>17%</td>
</tr>
<tr>
<td>Disease of the Circulatory System</td>
<td>17%</td>
<td>14%</td>
</tr>
</tbody>
</table>

* Alabama was not included.
Interventions
Interventions to reduce hospital readmission rates have found success through multi-faceted approaches, the majority of which focus on facilitated care during the transition from the hospital to community or other care setting, patient education and self-management, patient management by a multidisciplinary team, and end of life planning.\textsuperscript{16} Many include a combination of coordinating discharge plans, educating patients, reconciling medication, following-up with individual patients, and comparing data across project sites.\textsuperscript{17}

Project Re-engineered Hospital Discharge (RED), which utilizes nurse discharge advocates to administer the in-hospital component of the program and a clinical pharmacist to call participants two to four days post discharge, saw hospital utilization within 30 days decrease by about 30\% in the intervention group.\textsuperscript{18} The Better Outcomes for Older Adults through Safe Transitions (BOOST) includes mentoring between sites, team development, patient teach-back, and written discharge instructions.\textsuperscript{16,19} Implementation of the BOOST program in 11 hospitals resulted in a relative rehospitalization reduction of 13.6\%.\textsuperscript{20} The Care Transitions intervention includes medication self-management, patient understanding of the medical record, recommending a primary care visit post discharge, and educating the patient about red flags (e.g., condition is worsening) and resulted in lower rehospitalization rates in control patients (8.3 vs 11.9) 30 days post-discharge.\textsuperscript{21}

The Reducing Readmissions Care Transitions Toolkit, developed by the Washington State Hospital Association, Pierce County Pilot was conducted from August 2012 to September 2013 in seven hospitals.\textsuperscript{22} Selected practices tested components of the toolkit, including:

- Admit notification to the patient’s primary care provider. All of the notifications occurred via Epic inbasket to the primary care providers affiliated with the system. If the notification is incorrect, the clinic responds to the hospital and the hospital corrects the information in the system.
- Discharge summary: Outpatient clinics can access case management discharge summaries and risk assessment score
- Making follow-up appointments. Follow-up appointments with the primary care provider are made for all of the intensive and high risk patients prior to the patient leaving the hospital.
- Making follow-up phone calls, prioritized based on risk.
- Add on risk for readmission assessment.

Table 3: Data from the Reducing Readmissions Care Transitions Toolkit Pilot\textsuperscript{22}

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Intensive</td>
<td>16</td>
<td>0.0%</td>
<td>286</td>
<td>74</td>
<td>25.9%</td>
<td></td>
</tr>
<tr>
<td>High</td>
<td>72</td>
<td>1.4%</td>
<td>2,338</td>
<td>490</td>
<td>21.0%</td>
<td></td>
</tr>
<tr>
<td>Medium</td>
<td>155</td>
<td>3.9%</td>
<td>5,836</td>
<td>817</td>
<td>14.0%</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>213</td>
<td>3.3%</td>
<td>5,108</td>
<td>421</td>
<td>8.2%</td>
<td></td>
</tr>
<tr>
<td>No Risk Entered</td>
<td>220</td>
<td>1.8%</td>
<td>10,780</td>
<td>457</td>
<td>4.2%</td>
<td></td>
</tr>
</tbody>
</table>

Zabari M. November 21\textsuperscript{st}, 2013. Reducing Readmissions Care Transitions Toolkit: Pilot Project Update. Presentation at the Bree Collaborative Meeting, Seattle, WA.
State-Wide Readmission Efforts in Washington

- **Care Transitions Project**: A 2011 Centers for Medicare and Medicaid Services (CMS) initiative in 14 communities, including Whatcom County in partnership with Qualis Health, with the goal of eliminating unnecessary hospital readmissions. Qualis Health has been using learning from this work to help other communities build the infrastructure to support reduction in readmissions.
  
  More information: [www.cfmc.org/integratingcare](http://www.cfmc.org/integratingcare)

- **Community Based Care Transitions**: Twenty-three communities across the United States have launched with programs to reduce readmissions with the support of CMS. Qualis Health has been helping communities apply for the funding. Area Agency on Aging are leading this work in Pierce County, Southeast Washington, and potentially several other communities. These groups will be working closely with the Washington Hospital Association (WSHA) and Partnership for Patients.
  

- **Leading Edge Advanced Practice Topics (LEAPT)** – CMS contract with the WSHA Hospital Engagement Network – Currently working with eight hospitals focusing on care transitions with skilled nursing facilities (SNF) and advance care planning. The goal of this work is to reduce 30-day readmissions from SNFs by 10% in the next nine months by implementing standardized communication bundles.
  
  More information: [www.wsha.org/0609.cfm](http://www.wsha.org/0609.cfm)

- **Hospital Compare**: Readmission rates are public on the Hospital Compare web site and WSHA web site. Additional work is underway by the National Quality Forum to adopt additional readmission measures.
  

- **Medicaid Medical Directors Learning Network**. A program led by the Agency for Healthcare Research and Quality is focused on sharing best practices nationally since 2005. Learning communities allow State Medicaid medical directors to learn from one another, share data, and implement quality improvement projects.
  

- **Partnership for Patients**: A Centers for Medicare and Medicaid Services initiative targeting preventable injuries and hospital-acquired conditions in ten areas including readmission. In 2011, WSHA, the Washington State Medical Association (WSMA), and the Washington Health Alliance have convened three community groups in Pierce, Spokane, and Yakima as pilot sites designed to test care transition practices. The learnings from these groups has been used to develop the WSHA Care Transitions Toolkit. New community groups recently started in Seattle and Vancouver. This collaboration has been a contributor in a 23 percent reduction in readmissions per 1000 Medicare beneficiary.
  
  More information: [http://www.wsha.org/partnershipforpatients.cfm](http://www.wsha.org/partnershipforpatients.cfm)

- **State Action on Avoidable Rehospitalization (STAAR) Project**: The Institute for Healthcare Improvement's STAAR project goal is to reduce rehospitalization rates by 30 percent and
improve patient satisfaction with care coordination. Four states, Washington, Michigan, Ohio, and Massachusetts, were selected. WSHA is the lead in Washington State, focusing on coordinating discharge process and creating landmark reports in collaboration with Qualis Health to inform improvement work. These efforts have involved providers from across setting and purchases through the state-wide steering committee. Early results from the program are promising.23


- State Demonstrations to Integrate Care for Dual Eligible Individuals: Washington State Department of Health is working to design new approaches to better integrate care for dual eligible patients as part of a CMS funded 15 state pilot program.


- Washington State Rehospitalization Steering Committee: A statewide committee, assembled by WSHA, consisting of payers, providers from settings along the continuum, state agencies and other stakeholders, is meeting to drive forward improvement and coordinate work between organizations working in this area. Core focus is alignment of payment incentives, data and analysis, and improvement including smooth transitions.

Potentially Avoidable Readmissions Workgroup

The Collaborative approved the Potentially Avoidable Readmissions (PAR) workgroup charter in May 2012. See Appendix A for the original PAR workgroup charter and roster.

The workgroup met from May to September 2012 and identified three strategies:

1. Alignment with Local Readmissions Activities: Identify alignment opportunities where the Collaborative can promote and augment current evidence-based, quality improvement initiatives aimed at reducing PARs including effective communication, coordination of care, and ‘patient hand-offs’ during transitions in care settings.


3. Accountable Payment Model: Research and recommend components and structures essential to creating a successful PAR accountable payment model that aligns incentives, including warranty pricing, bundled payments, and other innovative payment methodologies.

Accountable Payment Models Workgroup

In November 2012, the Collaborative formed an Accountable Payment Model (APM) subgroup to make recommendations to the PAR workgroup in the third focus area. The APM workgroup started by creating an accountable payment model for total knee and hip replacements (TKR/THR) surgery. The model is an attempt to align purchasing and payment with best practices that lead to safe care, better outcomes, and lower costs. The final products will serve as a guide for quality- and value-based purchasing for both public and private sectors. The surgical bundle defines the expected components of pre-operative, intra-operative, and post-operative care needed for successful TKR/THR surgery. It includes both clinical
components (disability due to osteoarthritis despite conservative therapy, fitness for surgery, repair of the osteoarthritic joint, and post-operative care and return to function) and quality standards. The Bree Collaborative formally adopted the TKR/THR Surgery Bundle at the November 21st, 2013 meeting.


The TKR/THR warranty defines complications and time-frames after surgery during which complications should be attributed to the original surgery. The purpose of the warranty is to track clinical and financial accountability for the extra care needed to diagnose, manage, and resolve those complications. The intent is to distribute financial risk across professional and facility components in proportion to the revenue generated by the procedure. The warranty was formally adopted by the Bree Collaborative at the July 18th, 2013 meeting.


Both the TKR/THR surgical bundle and warranty were approved by the Health Care Authority Director in April 2014.


**Dissolution**

By September 2013, four of the nine original members, including the Chair, left the Bree Collaborative or no longer served on the workgroup. Replacement members were not identified and no Bree Collaborative members volunteered to serve as the new workgroup chair. This substantially decreased the effectiveness of the workgroup causing the PAR to meet only twice in 2013.

In this time, the workgroup made two recommendations approved by Collaborative members:

1. Endorsing the Washington State Hospital Association (WSHA) and its community partners’ work to develop a standardized toolkit and process that both hospitals and community providers can use to reduce the rate of readmissions.
2. Requesting that 30-day, all-cause readmission results, by hospital, be publicly available.

The Washington Health Alliance hosted a meeting in July 2013 to review hospital-specific, unblinded 30-day, all-cause readmissions CHARS data, purchased by the Foundation for Health Care Quality from the Washington State Department. Collaborative staff hired a statistician to conduct analysis. The Collaborative elected to add sample sizes and confidence intervals to the charts before further distribution and approved posting a final version of the unblinded, hospital-specific data on the Collaborative website on September 25th, 2013.

Additionally, the APM subgroup posted blinded CHARS readmissions data following TKR/THR surgery. Hospitals can request unblinded information for their institution by contacting Bree Collaborative staff at bree@qualityhealth.org.


In May 2013, the Potentially Avoidable Hospital Readmissions workgroup reported a hiatus and a plan to wait for the WSHA toolkit to be finalized and pilot results to be known before supporting operationalization and development of incentives to encourage standardized implementation of the Toolkit across Washington State. The group also supported the work of the APM subgroup. At the November 21st, 2013 Bree Collaborative meeting, the APM subgroup was promoted to a workgroup and encouraged to continue work beyond the total knee and total hip replacement topic.

The PAR workgroup was dissolved at the November 21st, 2013 meeting with unanimous support of Collaborative members. Rick Goss, MD, Medical Director at Harborview Medical Center and Bree Collaborative member, volunteered as PAR champion to work with Bree Collaborative staff to identify potential opportunities for the Bree Collaborative to support WSHA’s toolkit and pilots and the work done by Qualis Health.

Reconvening
The PAR work was reconvened after the March 19th, 2014 Bree Collaborative meeting and met in April 2014, chaired by Dr. Goss. See Appendix B for a list of members. The workgroup voted to endorse three primary items:

I. Support for the collaborative model as used in Washington State.

II. Support for the tools and techniques to reduce readmissions in Washington State, especially the Washington State Hospital Association’s Care Transitions Toolkit (Appendix C), the work done by Qualis Health (Appendix D), and the work done by the Washington Health Alliance.

III. Measurement of the percent of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition) for which there is:
   a. Patient discharge information summary sent to the primary care provider (PCP) or aftercare provider within two days of discharge.
   b. A documented follow-up phone call within two days of discharge.
Recommendations

Collaborative Model

Groups collaborate to reach common goals, in the case of reducing potentially avoidable readmissions, the goal is to improve safety during transitions through learning from different facilities and optimally using collective knowledge. Collaboratives will be recognized by:

1. Formally writing a charter, see appendix E for a draft charter, that includes a list of participating organizations, shared expectations for best practices, and measures of success
2. Demonstrating evidence of participation in recurring meetings
3. Recognition by WSHA or Qualis Health as an active member

Ideally, collaboratives will work to follow the Institute for Healthcare Improvement’s (IHI) collaborative model as defined in the Breakthrough Series: IHI’s Collaborative Model for Achieving Breakthrough Improvement, which defines “Collaborative” as including the following elements:

- Choosing an area of interest through use of data, examination of an evidence base, and stakeholder analysis.
- Recruiting technical experts to identify and review suggested changes and metrics.
- Recruiting organizations and/or teams with pre-work calls that include buy-in from organizational leadership. The pre-work calls should clarify expectations, the collaborative’s process, create aim statements, and determine goals.
- Learning sessions, traditionally face-to-face, during which the teams submit data, learn from one another, and learn how to test and implement a change package with specific, actionable, testable changes associated with each topic, (e.g., increasing patient activation/engagement as a change concept, using teach back as a suggested change). Suggestions for optimal learning sessions are as follows:
  - Three learning sessions with an optional fourth “outcomes congress.”
  - The first and second learning sessions are about eight weeks apart, second – third three months apart; an outcomes congress often three – six months after learning session three and includes a standard agenda.
  - Learning sessions are often a whole day in length.
  - The standard learning session agenda includes review of progress on measures, change concept overview by the collaborative chair (a technical expert); all-teach, all-learn presentations by teams, storyboard review, “team time” in which teams sit together to plan next plan-do-study-act (PDSA) cycles, and quality improvement concept review (e.g., MFI, PDSA, metrics, spread/sustainability)
  - Specific roles for faculty members at each learning session (e.g., system leader, collaborative chair, day-to-day leader, metrics support, administrative support).
- Action periods between learning sessions in which the teams test, implement, and collect data. Optimally, reports of the data are generated monthly that also includes summary of the PDSA cycles and case studies of what has worked exceptionally well at particular sites. There may also be phone calls, webinars, or peer site visits between learning sessions.
- The IHI recommends the Model for Improvement, an approach for organizing improvement work that includes four components:
  - Specific, measurable aims,
  - Tracking measures for improvement over time,
  - Changes to the system or process to result in improvement, and
  - Multiple testing cycles.
Endorsement of Tools and Techniques Used in Washington State

The Bree Collaborative acknowledges the work of the Washington State Hospital Association to develop, disseminate, and support the Care Transitions Toolkit; Qualis Health’s data reports and technical assistance; and the Washington Health Alliance’s work to increase data transparency to reduce potentially avoidable hospital readmissions and supports the continuation of this work.

Washington State Hospital Association
The Washington State Hospital Association (WSHA) is a membership organization representing hospitals and other health-related organizations. WSHA has many programs, including the Patient Safety program that works with hospitals to adopt evidence-based protocols to improve safety and increase quality. The Care Transitions Toolkit, second edition, includes learnings from community projects to reduce hospital readmissions and is intended as a resource for hospitals and primary care providers. The toolkit can be found here:
www.wsha.org/files/177/CareTransitions_Toolkit_Version2_Feb%2024%202014_Final.pdf
More information: www.wsha.org

Qualis Health
Qualis Health has been working to reduce avoidable hospital readmissions through care transitions quality improvement since 2008 with community engagement as an area of focus. Qualis Health provides data reports at community, hospital, skilled nursing facility and home health agency level quarterly. Data is used as a prompt to do further local analysis, identify highest risk, and other quality improvement activities. Qualis Health then facilitates community building and engages in direct one-to-one technical assistance (e.g., teach back, INTERACT).
More information: www.qualishealth.org

Washington Health Alliance
The Washington Health Alliance works to share data on health care quality and value in Washington State to help providers, patients, employers and union trusts make informed decisions about health care. The Alliance is part of the Robert Wood Johnson Foundation’s Aligning Forces for Quality initiative, disseminates the annual Community Checkup report that “highlights health care quality and value at medical groups and hospitals in Washington State,” and is part of the Choosing Wisely campaign.
More information: www.wahealthalliance.org
More information: www.wacommunitycheckup.org
More information: http://oyh.wacommunitycheckup.org/choosingwisely/
**Recommended Measurement**

Two measures are recommended: Discharge Information Summary and Follow-up Phone Call.

Measurement of the percent of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition) for which there is:

- Patient discharge information summary sent to the primary care provider (PCP) or aftercare provider within two days of discharge.
- A documented follow-up phone call within two days of discharge.

**Discharge Information Summary**

This can be the in the form of the medical discharge summary (preliminary is acceptable if it is noted on the document) or another form of documentation as consistent with the Joint Commission requirements that includes:

- The reason for hospitalization
- The care, treatment, and services provided
- The patient’s condition and disposition at discharge
- Information provided to the patient and family
- Provisions for follow-up care
- Pending test results
- Medications on discharge

**Numerator:** Number of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition) for which there is a discharge information summary sent to the primary care provider (PCP) or aftercare provider within two days of discharge.

**Denominator:** Total number of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition).

**Follow-up Phone Call**

Documentation of a discharge phone call to patient or caregiver after discharge. If patient or care provider was not available, documentation of attempt as consistent with the hospital’s protocol (e.g., call three times).

**Numerator:** Number of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition) for which there is a documented follow-up phone call.

**Denominator:** Total number of inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition).
Inclusions
All inpatients with diagnosis of acute myocardial infarction, heart failure, community acquired pneumonia, chronic obstructive pulmonary disease, and stroke (consistent with the CMS definition).

Exclusions
- Patient discharged against medical advice. The patient has signed a document acknowledging they are leaving against medical advice.
- Elopement. Patient leaves without knowledge of care team or hospital staff.
- Patient expiration. Patient expires during current medical stay.
- Patients admitted for a short stay surgical procedure - Short-stay surgery encompasses an entire surgical procedure, from beginning to completion on a same-day basis, without the anticipation of an overnight hospitalization. Typical short-stay surgery patients are individuals who are healthy except for the condition that necessitates their elective surgery and for whom serious complications are highly unlikely.
- Patients admitted for obstetric services.

Data will be submitted to WSHA for presentation on the public website.
References


3 Eloranta S. Care Transitions Update. April 23, 2014. Presentation at the Potentially Avoidable Hospital Readmissions Workgroup, Seattle, WA.


10 Herrin J, St Andre J, Kenward K, Joshi MS, Audet AM, Hines SC. Community Factors and Hospital Readmission Rates. Health Serv Res. 2014 Apr 9.


Appendix A: Potentially Avoidable Readmissions Charter and Roster

(Updated 10/26/12)

Problem Statement

Potentially avoidable readmissions (PARs) are common and costly events. It is estimated that nationally, the cost for unplanned or PARs in 2004 was $17.4 billion. The PAR rate is increasingly seen as a reflection of a local health care system’s ability or inability to coordinate care for patients across the health care continuum, and a high PAR rate is often a sign of inadequate discharge planning during transitions of care. Reducing PAR is an opportunity to improve quality and reduce health care costs in Washington State.

Aim

To reduce the number of potentially avoidable readmissions in Washington State.

Purpose

The purpose of the PAR workgroup is to propose recommendations to the full Bree Collaborative on how to reduce PARs within the following three general strategies identified by the Bree Collaborative:

1. **Alignment with local readmissions activities.** Identify alignment opportunities where the Bree Collaborative can promote and augment current evidence-based, quality improvement initiatives aimed at reducing PARs, including effective communication, coordination of care and ‘patient hand-offs’ during transitions in care settings.

2. **Measurement, Transparency, and Reporting.** Support use of current process and outcome measures for reducing PARs and transparency of methodologies and readmissions rates, by hospital and physician group, in a semi-public manner.*

3. **Accountable Payment Model.** Research and recommend components and structures essential to creating a successful PAR accountable payment model that aligns incentives, including warranty pricing, bundled payments, and other innovative payment methodologies.

Duties & Functions

The PAR workgroup shall:

- Report directly to the Bree Collaborative; present recommendations in a report.
- Provide updates at Bree Collaborative meetings.
- Research national and regional readmissions quality improvement initiatives and strategies that better align incentives, reduce costs, and improve quality of care.
- Consult members of WSHA, WSMA, other stakeholder organizations and subject matter experts for feedback.
- Create and oversee subsequent subgroups to help carry out the work.
Post recommendations on the Bree Collaborative website for public comment prior to sending to the Bree Collaborative for approval and adoption.

*Semi-public refers to the direct sharing of results with provider organizations, purchasers of health care (employers, union trusts), health plans and other health-related organizations directly working on these initiatives. It does not include posting results to a public website or other distribution vehicles that result in the information being broadly shared with the general public.

Structure
The PAR workgroup will consist of individuals appointed by the chair of the Bree Collaborative, and confirmed by the Bree Collaborative steering committee. Individuals must have in-depth knowledge and expertise in at least one of the following: readmissions, payment reform, the health care delivery system, benefit design, and quality improvement. There must be at least one representative from each stakeholder group: employer, health plan, hospital, provider (including a specialist), and quality improvement organization.

The chair of the PAR workgroup will be appointed by the chair of the Bree Collaborative.

The Bree Collaborative project manager will staff and provide management and support services for the PAR workgroup.

Less than the full PAR workgroup may convene to: gather and discuss information; conduct research; analyze relevant issues and facts or draft recommendations for the deliberation of the full workgroup. A quorum shall be a simple majority and shall be required to accept and approve recommendations to the Bree Collaborative.

Meetings
The PAR workgroup will hold meetings as necessary.

The PAR workgroup chair will conduct meetings and arrange for the recording of each meeting, and will distribute meeting agendas and other materials prior to each meeting.
<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
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<tbody>
<tr>
<td>Susie Dade</td>
<td>Deputy Director</td>
<td>Puget Sound Health Alliance</td>
</tr>
<tr>
<td>Sharon Eldoranta, MD</td>
<td>Medical Director, Quality and Safety Initiatives</td>
<td>Qualis Health</td>
</tr>
<tr>
<td>Joe Gifford, MD</td>
<td>Chief Strategy and Innovation Officer for Western Washington</td>
<td>Providence Health and Services</td>
</tr>
<tr>
<td>Mary Gregg, MD</td>
<td>Director, Quality and Patient Safety</td>
<td>Swedish Health Services</td>
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<tr>
<td>Tony Haftel, MD</td>
<td>VP Quality &amp; Associate Chief Medical Officer</td>
<td>Franciscan Health Systems</td>
</tr>
<tr>
<td>Bob Mecklenburg, MD</td>
<td>Medical Director, Center for Health Care Solutions</td>
<td>Virginia Mason Medical Center</td>
</tr>
<tr>
<td>Kerry Schaefer</td>
<td>Strategic Planner for Employee Health</td>
<td>King County</td>
</tr>
<tr>
<td>Peter Valenzuela, MD</td>
<td>Medical Director</td>
<td>PeaceHealth Medical Group</td>
</tr>
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**Committee Staff**

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Steve Hill</td>
<td>Chair</td>
<td>Bree Collaborative</td>
</tr>
<tr>
<td>Rachel Quinn</td>
<td>Project Manager</td>
<td>Bree Collaborative</td>
</tr>
</tbody>
</table>
### Appendix B: Reconvened Workgroup Roster

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rick Goss, MD, MPH (Chair)</td>
<td>Medical Director</td>
<td>Harborview Medical Center</td>
</tr>
<tr>
<td>Sharon Eloranta, MD</td>
<td>Medical Director, Quality and Safety Initiatives</td>
<td>Qualis Health</td>
</tr>
<tr>
<td>Stuart Freed, MD</td>
<td>Medical Director</td>
<td>Wenatchee Valley Medical Center</td>
</tr>
<tr>
<td>Leah Hole-Marshall, JD</td>
<td>Medical Administrator</td>
<td>Washington State Department of Labor and Industries</td>
</tr>
<tr>
<td>Dan Lessler, MD, MHA</td>
<td>Medical Director</td>
<td>Washington State Health Care Authority</td>
</tr>
<tr>
<td>Bob Mecklenburg, MD</td>
<td>Medical Director, Center for Health Care Solutions</td>
<td>Virginia Mason Medical Center</td>
</tr>
<tr>
<td>Amber Theel, RN, MBA, CPHQ</td>
<td>Director, Patient Safety Practices</td>
<td>Washington State Hospital Association</td>
</tr>
</tbody>
</table>

### Committee Staff

<table>
<thead>
<tr>
<th>Name</th>
<th>Title</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ginny Weir</td>
<td>Program Director</td>
<td>Bree Collaborative, Foundation for Health Care Quality</td>
</tr>
</tbody>
</table>
Appendix C: Washington State Hospital Association’s *Reducing Readmissions: Care Transitions Toolkit, Second Edition*

Due to size issues this document has been posted separately. The document is available:


OR

Here: [www.wsha.org/files/177/CareTransitions_Toolkit_Version2_Feb%2024%202014_Final.pdf](www.wsha.org/files/177/CareTransitions_Toolkit_Version2_Feb%2024%202014_Final.pdf)
Appendix D: Qualis Health Community Organization Profile

Qualis Health is one of the nation’s leading healthcare consulting organizations, partnering with clients across the country to improve care for millions of Americans every day. Qualis serves as the Medicare Quality Improvement Organization (QIO, the largest federal network dedicated to improving health quality at the community level, for Idaho and Washington.

Qualis has been working in care transitions since 2008, beginning in Whatcom County as a CMS pilot looking at Medicare fee-for-service; all cause 30 day readmissions/1000 beneficiaries with the community as the focus of efforts.

Figure 1: Engaging Communities to Reduce Readmissions

![Map of communities](image)

14 communities defined by zip code cover 86% of WA Medicare beneficiaries

Table 1: Relative Improvement per 1000 Medicare Beneficiaries
10/1/10-3/31/11 compared to 7/1/13-12/31/13

<table>
<thead>
<tr>
<th>Community</th>
<th>Admissions</th>
<th>Readmissions</th>
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<tr>
<td>Statewide</td>
<td>16.7%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Central Yakima</td>
<td>22.9%</td>
<td>29.1%</td>
</tr>
<tr>
<td>CHOICE</td>
<td>18.4%</td>
<td>24.1%</td>
</tr>
<tr>
<td>East King</td>
<td>12.0%</td>
<td>17.2%</td>
</tr>
<tr>
<td>Kitsap</td>
<td>18.5%</td>
<td>20.6%</td>
</tr>
<tr>
<td>Olympic</td>
<td>17.7%</td>
<td>24.2%</td>
</tr>
<tr>
<td>Seattle</td>
<td>14.0%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Skagit</td>
<td>15.4%</td>
<td>23.9%</td>
</tr>
<tr>
<td>South King</td>
<td>18.7%</td>
<td>28.3%</td>
</tr>
<tr>
<td>Spokane</td>
<td>18.2%</td>
<td>23.3%</td>
</tr>
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</table>
Figure 2: Identify Variation and Opportunities across Zip codes within Communities
Readmission rate shows a relationship to the poverty level.

Figure 3: Assess Variation across Care Providers and Cross Continuum Settings
Washington PPS Hospitals Readmit Rates for Dual Eligible Patients
Figure 4: Hospital Readmission Disparities in Washington State
Community Coalition Charter
(Template – please adjust as needed for your community)
(10th SOW Section C.1.C.2.b)

Article I – Name

The name of this Coalition shall be [name].

Article II – Mission & Vision

The mission of the [Coalition Name] is...

The coalition will...
[Include commitment to reduce 30 day readmission rates by 20% over three years & consider adding a statement about whether the community intends to apply for a formal care transitions program]

Article III – Purpose

Examples:
1. To build and sustain a community coalition with a focus on improving transitions of care for Medicare beneficiaries
2. To be a vehicle for the patient and family voice
3. To encourage person-centered and person-directed models of care
4. To collaborate and encourage efforts of organizations with shared visions
5. To advance public policies that further the vision

Article IV – Participation

Section I – Collaboration
Participation in the [Coalition Name] is open to organizations and individuals interested in fostering the vision by actively engaging in the planning and work of the Coalition.

Charter members should join in a commitment to:
- Share best practices and knowledge
- Mentor partners and providers
- Share data and support analyses
- Promote implementation of evidence-based interventions

Participant categories may include:
- Healthcare Providers (hospitals, skilled nursing facilities, physician practices, home health agencies, dialysis facilities, hospice organizations, palliative care organizations, etc.)
- Provider Associations
- Consumer Advocacy Organizations
- Government Organizations (Health department, Area Agency on Aging, etc.)
- Quality Improvement Organizations
- Educational Organizations
- Professionals
- Consumers
- Funding Organizations
- Academics
Section II – Coalition Participant Responsibilities

**Meeting Attendance.** Coalition Members agree to attend in person or by teleconference a minimum of fifty (50) percent of scheduled meetings each year with not more than two (2) consecutive unexcused absences.

**Committees.** Coalition Members agree to actively participate in committee work, and are expected to volunteer their services for Coalition projects.

Article V – Committees

**Section 1.** The activities of the Coalition will take place within its committees and all Active Participants are expected to select the committee or committees on which they wish to serve during any given year.

**Section 2.** The standing committees of the Coalition are [list committees]. Other Task Forces may be formed on an ad hoc basis as needed.

**Section 3.** Committees are chaired by Active Participants, chosen by the Coalition.

**Section 4.** The term of service for the committee chairs shall be one year. In the event a chair cannot complete a term, the Coalition shall appoint a replacement to complete the term of office.

**Section 5.** No member shall hold more than one committee chairmanship at a time.

Article VI – Meetings

**Section 1. Annual Meeting**
There shall be an Annual Meeting of the Coalition, at which time the Coalition will review membership, committee reports, develop annual goals, and other business.

**Section 2. Regular Meetings**
Meetings of the Coalition shall be held at least quarterly. Meetings may take place in person or remotely.

Article VII – Procedural Policies

**Section 1. Conflicts**
No one may profit financially from membership in the Coalition by sales or solicitation at meetings or workshops. Participants will disclose any actual or potential conflicts of interest to QIO or other designee.

**Section 2. Decision Making**
In the spirit of the [Coalition Name] vision, all Coalition business shall be conducted based on the philosophy of mutual respect. Simple majority rules will apply. Coalition Participants are entitled to one vote per member.

**Section 3. Voting**
Voting on the business of the Coalition may be conducted by those in attendance at the meeting either in person or by teleconference. Proxy voting via email is permissible.
Signatures [please revise as needed for your community]:

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