

## Reducing Readmissions

Readmission of patients recently discharged after hospitalization represents an expensive and all-too-common lapse in the quality of care delivered in the U.S. health care system. National data reveal that nearly 24.5% of Medicare patients admitted for chronic diseases such as heart failure (HF), pneumonia and gastrointestinal problems will return to the hospital within 30 days and that the government is estimated to be paying an extra \$12 to \$17 billion a year for this unnecessary care. The Centers for Medicare & Medicaid Services (CMS) has proposed financial penalties beginning in late 2012 for hospitals with “excess” readmissions when compared to expected levels. Performance will be based on the 30-day heart failure readmission measure that is currently part of the Medicare pay-for-reporting program.

The Oregon Health Care Quality Corporation and the Oregon Association of Hospitals and Health Systems are partnering with the Robert Wood Johnson Foundation's *Aligning Forces for Quality* (AF4Q) initiative to present the Hospital Quality Network: *Reducing Readmissions*. All Oregon hospitals are invited to join; **participation is free**.

Hospitals that participate will receive 18-months of expert consultation, coaching and tools to help them:

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

Hospitals who participate in the AF4Q Hospital Quality Network will employ rapid-cycle quality improvement tests to meet the specified goals. They will be provided with a wide variety of interventions, strategies, approaches, tools and actions that have been effective in changing hospital processes that led to improved quality and clinical outcomes at pilot hospitals. Hospitals may use interventions from these previous pilots or identify strategies of their own.

Performance measures that will be assessed through *Reducing Readmissions* are:

1. Number of patients who received all of the care they were eligible to receive – taken from the heart failure core measure set (called “Measure of Ideal Care”);
2. 30-day all-cause readmission rates following hospitalization for heart failure;
3. 30-day readmission rates for heart failure following hospitalization for heart failure.

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