



## LESSONS LEARNED

# Closing the Gap

*AF4Q hospitals develop ways to improve the quality and equality of care for patients*

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## Introduction

Although the quality of health care is poor for many Americans, some specific racial and ethnic groups continue to experience lower-quality health care when compared to White patients. Even when access to care is equal, research consistently shows this to be true. Convincing evidence of these disparities can be seen in cardiovascular care where, for example, Black patients with coronary artery disease or heart attacks are significantly less likely than White patients to receive appropriate procedures or therapies.<sup>1</sup>

The Robert Wood Johnson Foundation (RWJF) has made addressing racial and ethnic disparities an integral part of *Aligning Forces for Quality* (AF4Q), its signature program to lift the overall quality of health care in targeted communities and provide real models for reform.

## Goals and Results

Over 18 months, eight participating hospitals worked as part of a “learning collaborative” to test strategies, quantify results, and share lessons learned. This included two in-person meetings of the collaborative, site visits, monthly calls, and regular progress reports. Participants submitted aggregated data stratified by REL and reported on seven

key measures monthly to the AF4Q National Program Office (NPO), located at the George Washington University School of Public Health and Health Services. Measures tracked included:

### 1. Percent of patients who received all recommended acute myocardial infarction (AMI) care and percent of patients who received all recommended heart failure (HF) care

- Compliance with the Measures of Ideal Care (MIC) showed whether a given patient received all of the core components of care they were eligible to receive as prescribed by the American College of

### About Aligning Forces for Quality

*Aligning Forces for Quality* (AF4Q) 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 real models for national reform. The Foundation’s \$300 million commitment to improve health care in 16 AF4Q communities is the largest effort of its kind ever undertaken by a U.S. philanthropy. AF4Q asks the people who get care, give care and pay for care to work together to improve the quality and value of care delivered locally. The Center for Health Care Quality in the Department of Health Policy at George Washington University School of Public Health and Health Services serves as the national program office. Learn more about AF4Q at [www.forces4quality.org](http://www.forces4quality.org). Learn more about RWJF’s efforts to improve quality and equality of care at [www.rwjf.org/qualityequality/af4q](http://www.rwjf.org/qualityequality/af4q).

<sup>1</sup> Smedley BD, Stith AY, Nelson AR. “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care.” Washington, DC: Institute of Medicine, 2003.

Cardiology and the American Heart Association evidence-based guidelines for the treatment of HF or AMI.

- Over the course of the collaborative, the majority of hospitals met or exceeded compliance with the collaborative target of 95 percent MIC for both the AMI and HF measures. Six achieved 100 percent compliance for AMI MIC over three consecutive months and one hospital achieved and maintained 100 percent for five consecutive quarters.
- Five of the eight hospitals saw improvement in their HF MIC measure with the most improved hospital improving by 22 percentage points.

## **2. Percent of patients who received cardiac rehabilitation referral**

- A key component of reducing cardiac mortality from AMI and HF is patient participation in an outpatient cardiac rehabilitation program. Utilization of these programs is improved through the appropriate and timely referral of patients, which is generally while the patient is hospitalized. The collection of data on outpatient cardiac rehabilitation referrals prior to hospital discharge was a new measure for participating hospitals and presented significant challenges because it had not been routinely tracked before in many institutions.
- One hospital improved referral rates by nearly 60 percent while three exceeded the program's goal of 75 percent referral compliance.

## **3. Average length of stay for AMI patients; Average length of stay for HF patients**

- The length of time patients stay in a hospital for AMI and HF is a generally accepted indicator of hospital efficiency and resource allocation. Reducing length of stay can support the care continuum, moving patients to the next levels of care and supporting recovery without adversely affecting outcomes.
- For both the AMI and HF, two hospitals in the collaborative were able to reduce the length of stay for their patients.

## **4. 30-day readmissions for HF discharges**

- Readmission of patients who were recently discharged after hospitalization with HF is an expensive and often preventable adverse outcome. The risk of readmission can be modified by the quality and type of care provided to patients in the hospital, at discharge and in facilitating their transition to outpatient status. Despite health care facilities everywhere focusing on reducing readmissions, HF remains the most frequent reason for rehospitalization.<sup>2</sup>
- Meeting the program's goals of reducing 30-day HF readmission rates for any reason (all-cause) was not easy. Two hospitals achieved reductions of more than 15 percent in all-cause heart failure readmission rates from baseline.

### **Goals**

In October 2009, AF4Q launched a collaborative network of hospitals interested in improving the quality of care delivered to all patients with acute myocardial infarction (AMI) and heart failure (HF) while also reducing racial and ethnic disparities in care. The effort had three goals:

1. Improve cardiovascular care for Black, Hispanic and other minority populations;
2. Standardize the collection of race, ethnicity and preferred language (REL) data at registration; and
3. Develop effective, replicable quality improvement strategies, models and resources.

<sup>2</sup> Jencks, S.F., Williams, M.V., & Coleman, E.A. (2009). Rehospitalization among patients in Medicare fee-for-service program. *New England Journal of Medicine*, 360(14), 1418–1428.

# Three Keys to Success

The experiences of participating hospitals demonstrated that they could successfully improve the quality of care delivered and collect REL data. Program administrators noted three recurring lessons for hospitals exploring similar initiatives to address quality improvement and equity:

- 1. Collecting REL data is a catalyst for innovation and adaptation – not a burden.** For the hospitals in the collaborative, collecting patient REL data opened the door to increased awareness and dialogue of disparities. Implementing a standardized system for collecting REL data gave quantifiable insight into their patient populations and the quality of care they were receiving. It also led to increased conversations about diversity and equity throughout the health systems and the development and/or expansion of committees to explore the issues.
- 2. Hospitals need a champion to successfully tackle quality improvement and disparities.** Involving physicians as champions of quality improvement, disparities reduction and REL data collection proved to be crucial. Hospitals that gained physician support cited this as an impetus for improvement, while hospitals lacking this support cited it as a major roadblock.
- 3. Measuring progress each quarter raises awareness and leads to quality improvement.** While health care quality improvement has traditionally been driven by data collection, it has not always been a priority in many hospitals. Hospitals participating in this collaborative reported that the focus on measurement was the catalyst for increased awareness and a key starting point for other quality improvement initiatives.

## Participating Hospitals

### *Promising Practices from the Field*

Hospitals participating in AF4Q's equity collaborative identified and implemented interventions suited to the needs of their particular institutions and most likely to succeed in helping them improve performance on the key measures.

#### **Erie County Medical Center (Buffalo, N.Y.)**

Examining some of the barriers to HF and AMI patients following discharge instructions, the team at Erie County Medical Center (ECMC) found that patients often lacked the knowledge and/or resources to follow their at-home discharge instructions. To address this barrier, the ECMC team revised patient education materials to include recommended heart-healthy recipes, added information on outpatient dietary classes and arranged for the donation and distribution of bathroom scales for those who could not afford them. Additionally, ECMC began the process of case management making post-discharge follow-up phone calls to HF patients to provide answers to questions about their medical condition or medications. They are currently evaluating a computerized customer service callback program that will track metrics serially for enhancement of the program and outcomes.

#### **Mercy Health Partners (Muskegon, Mich.)**

At Mercy Health Partners, participation in the collaborative led to increased understanding and discussion among patients and staff of the importance of REL data in quality performance and medical outcomes. The team relied on the hospital's already active Equity Steering Committee for support which allowed for greater oversight, organization and collaboration between existing equity projects, as well as the opportunity for staff from disciplines across the institution to provide input. They credit this structure with helping them identify and address challenges quickly and more efficiently as well as facilitating a greater sense of group ownership for the initiative. One focus of the hospital was on validating self-reported REL data through direct observation of the registration process, two follow-up telephone surveys and correlation of the results with Press-Ganey information. This multifaceted approach ensured accuracy of information being collected.

### **Methodist North Hospital (Memphis, Tenn.)**

Approaching the collaborative as a community initiative rather than a hospital-only effort, Methodist North Hospital involved key local businesses, the faith community and civic leaders to raise awareness of health care equity. Data collected and analyzed from the collaborative provided evidence of disparities in the community and sparked a call to action for the hospital. The results so far show a long-term commitment to improving care and reducing disparities, including a partnership with Rhodes College to create a course specifically designed to focus on social determinants of cardiac health and disease management. Together they developed an instrument to conduct interviews with HF and heart attack patients to explore socioeconomic factors that may affect disease management and readmissions and actively collaborated with 265 area faith communities to brainstorm local solutions to health disparities. This launched a new Health Equity Committee, led by the CEO of Methodist Le Bonheur Healthcare, which was commissioned to continue the collaborative's disparities work.

### **Regions Hospital (St. Paul, Minn.)**

To improve compliance with AMI and HF MIC, Regions Hospital developed a medication boot camp program. An innovative approach to assess the patients understanding of their discharge medications, in the "boot camp" a pharmacist tests the patient's ability to set up home medications correctly using a multi-day, multi-dose pill sorter, test discharge instructions and colored M&Ms. Patients are given test discharge instructions and asked to correctly 'load' the pill sorter with the correct number of pills in the correct slots. Patients who are unable to correctly load the sorter are given a referral to home health care for medication assistance.

### **Saint Luke's Hospital of Kansas City (Kansas City, Mo.)**

Seeking to improve referrals to outpatient cardiac rehabilitation for discharged patients, the team at Saint Luke's Hospital utilized a flow map process to identify key stakeholders and opportunities for improvement. Through this process they implemented several small changes that had a big impact, including a concurrent review process, the creation of a "Cardiovascular Referral" sticker and broadened coverage by the CV rehab nurse. The result was an improvement in referral rates from 53 percent to 82 percent by the end of the collaborative.

### **Truman Medical Center (Kansas City, Mo.)**

Compared to all other Truman Medical Center (TMC) patients, those with HF were found to have twice the number of emergency department visits, five times the number of hospitalizations and five times the cost. To tackle this issue, TMC implemented a standardized approach to HF education at discharge, called "Living with Heart Failure." A health coach uses this to reinforce self-management skills during post-discharge follow-up calls. For those who also have multiple co-existing chronic illnesses and social complexity, TMC has implemented the "Guided Chronic Care" program, a comprehensive approach for improving HF quality of life and mitigating social barriers so patients can take advantage of care offered to them. A nurse and social worker support these patients across the continuum, in the space between encounters, act as advocates for them as needed, but consistently promote self-management skills at whatever level the patient is ready. Patient and family needs are assessed and supported where appropriate and possible, shared goals are established and consultants engaged, such as initiation of a pharmacy consultation for patients with five or more medications, when a pharmacy consultation is initiated.

While the promising practices described focus on specific interventions that were unique to the individual institutions, the program administrators consistently saw the impact of the three keys to success across the program hospitals. Moving forward, participating hospitals are taking steps to share these promising practices with others in their communities, through new learning networks and in other AF4Q equity services initiatives such as the reducing readmissions focus of the AF4Q Hospital Quality Network.

### **For more information**

For more information about *Aligning Forces for Quality* and its Equity Quality Improvement Collaborative, visit [www.rwjf.org/qualityequality/af4q/](http://www.rwjf.org/qualityequality/af4q/). An online toolkit is available that includes how-to-guides, videos and tools at [www.rwjf.org/goto/estoolkit](http://www.rwjf.org/goto/estoolkit).

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