Reduction in 30 Day Heart Failure to Heart Failure Readmission Rates After the Initiation of Multidisciplinary Interventions

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BACKGROUND

Health Central Hospital's Heart Failure readmission rate exceeded the national average by greater than 10%. Due to this and potential pending financial penalties related to readmission rates, a multidisciplinary Heart Failure (HF) program was initiated in January 2012, with the goal of reducing all-cause readmission rate by decreasing HF to HF readmission rate.

METHODS

This program included 100% of the heart failure population, including self pay patients. The plan was to initiate multiple multidisciplinary initiatives, including:

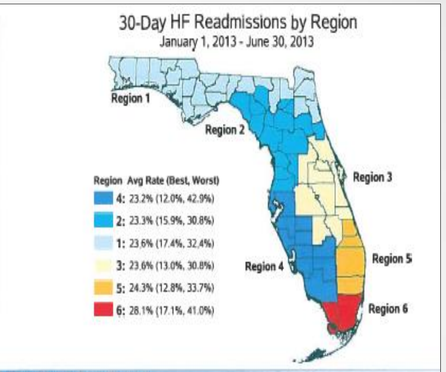
- Development of a multidisciplinary team consisting of cardiology medical staff, nursing, cardiac rehabilitation, administration, and pharmacy
- Barrier identification
- Creation of daily HF patient list
- Completion of a patient needs assessment
- Patient education specific to the needs of the heart failure patient, including a Pharmacist visit when needed
- Provision of supplies at discharge (blood pressure cuffs, scales, free outpatient lab work, free clinic follow up appointment, and a 30-day supply of medication)

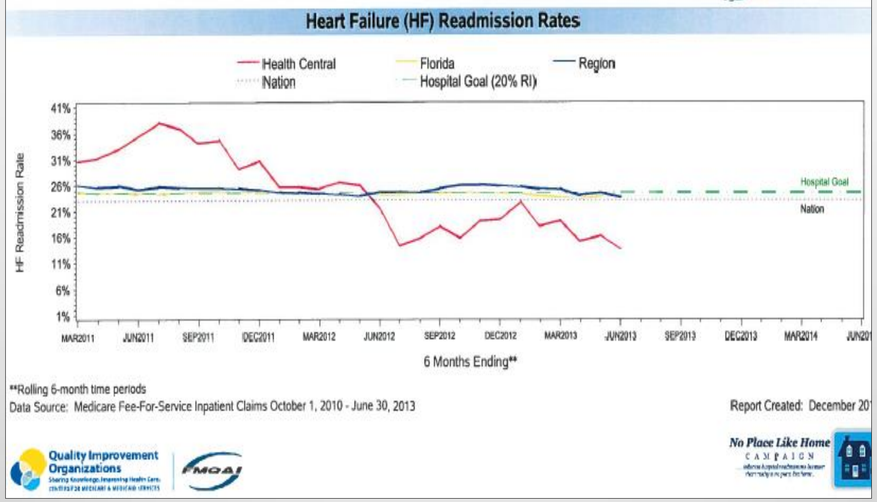
RESULTS

HF Readmission Rates

	Baseline Oct2010 - Mar2011	Current Jan2013 - Jun2013	Year 1 Goal: 20% Relative Improvement
Health Central	30.7% 31/101	13.7% 10/73	24.6% Goal met or exceeded
Region 3	26.0% 1,065/4,092	23.6% 859/3,634	
Florida	24.8% 4,709/18,976	23.8% 4,008/16,834	
Nation[2]	23.0%		

[2]Data Source: Medicare.gov for discharges July 1, 2009 - June 30, 2012





CONCLUSIONS

The incorporation of a multidisciplinary process allowed the heart failure team to execute the dichotomous goal of implementing excellent clinical practice while providing patient's and their family member's complimentary education in order to prevent an avoidable readmission. The team initiated many strategies to help achieve these goals. Health Central has successfully decreased HF readmission rate from 30.7% - 13.7%

SUSTAINABILITY

To sustain these positive improvements, Health Central continues to provide the services of the multidisciplinary team. In addition, Health Central has included the availability of a Social Worker and Dietician during the free clinic follow up appointment. Also, Health Central has contracted with Mederi Home Health Care to provide post discharge phone calls and support to the patient for 31 days post-discharge to ensure the patient is following the discharge plan. This allows the patient to get back on track in their own home instead of returning to the hospital. Providing these programs not only has prevented readmissions, but has provided the patient with additional knowledge and skills to take care of themselves.