REDUCING UNNECESSARY HEART FAILURE READMISSIONS

Promising Results from Miami

Care Transitions Update
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Care Transitions Project Director
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Objectives

- Project background – Care Transitions
- Root-cause findings
- QIO recommended interventions
- Heart failure findings
- Moving forward
“Making the healthcare delivery system work reliably for very sick Medicare beneficiaries requires linking all clinical care providers and ensuring that transitions are thoroughly reliable. This work can only succeed when all of the community is engaged and working together, so the QIOs will serve to catalyze and coordinate the work across all care settings in the community.”

Barry M. Straube, MD
Director & Chief Clinical Officer
Office of Clinical Standards & Quality for CMS
Heart Failure (HF) Prevalence

- Prevalence is increasing due to increased survival rates
- Expected to affect 6 million Medicare beneficiaries by 2020
- Each year 500,000+ are admitted to an acute care hospital with 27% readmitted within 30 days of discharge
- Estimated United States HF 2010 costs - $39.2 billion
The HF Problem

30-day Readmission Rate

<table>
<thead>
<tr>
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<th>2008</th>
<th>2009</th>
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<tbody>
<tr>
<td>Florida</td>
<td>24.8%</td>
<td>26.0%</td>
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<tr>
<td>Miami Community</td>
<td>24.9%</td>
<td>30.0%</td>
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NOTE: Data is validated through Medicare claims. The actual rates (weighted and unadjusted) are based on 12-month periods ending in December.
Root-Cause Findings
2008 vs. 2009
Non-Contributable Findings

- Age in years
- Mortality rate
- Length of inpatient stay in days
Contributable Findings: General

- Increased number of HF discharges
- Increased incidence of HF discharges and readmissions among all of the discharges/readmissions
- Higher poverty rates within the county
Contributable Findings: Discharge Status

- Increased number of HF discharges to home/ALF; increased 30-day readmission rate
- Decreased number of HF discharges to post-acute care settings; increased 30-day readmission rate
- Increased number of HF patients that did not see a physician; increased 30-day readmission rate
Contributable Findings: Co-Morbidities

Increase in patients presenting with co-morbid conditions*

- Diabetes/diabetes complications
- Iron deficiency & other unspecified anemias/blood disease
- Other gastrointestinal disorders
- Depression
- Other eye disorders

* Statistically significant differences. Co-morbid conditions present in year prior to index hospitalization; accounts for patients presenting with the highest number of co-morbid conditions.
Contributable Findings: Care Transition Intervention℠

- Inconsistent discharge information
- Inadequate patient self-management skills
- Frequent medication discrepancy events
- Intentional non-compliance
QIO-Recommended Interventions Aimed at Reducing Avoidable Hospital Readmissions
Improve HF Awareness

- Formalize a process to flag patients with HF primary and secondary diagnoses
- Prioritize care needs for patients with high risk co-morbidities
- Develop plan to identify HF-diagnosed patients after admission
- Expand HF readmission reviews to incorporate patient interviews; trend patient-identified reasons for the readmission
Evaluate Patient Education Processes

- Standardize HF patient education throughout hospital
- Revise patient education tools to incorporate self-management skills
- Provide education frequently throughout the patient stay
- Incorporate teach-back into patient care practices
Improve Post-Discharge Care Needs

- Make referrals to appropriate post-acute care setting
- Incorporate HF-specific education into post-discharge follow-up calls to patients
- Improve clinician hand-over communications
- Consider implementing other post-discharge interventions
Improve Patients’ Rate of Post-Discharge Physician Visits

- Assist patients with prioritizing and scheduling physician follow-up appointments
- Inform primary care physicians of the need for timely follow-up visits after a patient’s discharge
- Provide timely discharge summaries to physicians
HF Champion

- Understand typical general perception – hospital performance is good
- Recognize quality improvement is “the right thing to do”
- Identify champion(s) - can be anyone or a group of people
- Raise awareness and get commitment from leadership – share successes
Palliative Care

- Plan by stages
  - Frequent Emergency Room visits and/or hospitalizations over the last 6 months
  - Semi-comatose state
  - Minimal oral intake (or receiving continuous IV hydration or tube feeding)
  - Inability or difficulty with taking oral medicines

- Major decline in functional status with no identified reversible cause
  - Mottling of extremities
  - Primary diagnosis of metastatic cancer
  - Primary diagnosis of advanced dementia
  - Existing DNR order
Concurrent Monitoring

“Concurrent monitoring and data collection provide an opportunity to impact care at the time care is being delivered.”

**American Heart Association**
**Get With The Guidelines**
Findings
30-Day HF Readmission Rates Among Participating Hospitals
(Data reflects 6-month periods ending in specified month)
Physician Follow-Up Status of HF Patients
(Data reflects 6-month periods ending specified month)
Care Transition Intervention

- Coached patients were readmitted at a 4.7% lower 30-day readmission rate than the community.

- Coached patients who also received nutritional support were readmitted at a 19.2% lower 30-day rate than the community.
Final Checklist

- Establish community collaboratives to expand patient care pathways – admission through discharge & beyond
- Encourage patient activation by standardizing patient education practices; include patient teach-back
- Maintain consistent discharge practices
- Engage physician
- Monitor patient satisfaction
Moving Forward
The Community–Based Care Transitions Program

- Mandated by section 3026 of the Affordable Care Act, provides funding to test models for improving care transitions for high risk Medicare beneficiaries:

- Seeks to correct care transitions deficiencies by encouraging communities to come together and work together to improve quality, reduce cost, and improve patient experience.
Meaningful Use
Electronic Health Records

- Electronic health record financial incentive programs for the meaningful use of certified technology to achieve health and efficiency goals
- Results in reduction in errors, availability of records and data, reminders and alerts, clinical decision support, and e-prescribing/refill automation
- Eligible professionals, eligible hospitals, and critical access hospitals (CAHs)
References


