Heart failure (HF) is the leading cause of hospitalization among adults > 65 years, with highest readmission rates occurring within 30 days of discharge. Costs for heart failure (HF) patient care in the US are expected to increase to $53 billion by 2030. Total economic burden that includes direct and indirect costs of care is projected to reach $70 billion in the next 16 years, at which time 1 out of every 33 Americans will have HF.2 Nationwide, medical centers are instituting evidence-based strategies to improve HF patient transitions from hospital back to the community and reduce 30-day all-cause readmissions. Patients discharging to skilled nursing facilities or home with home health services are generally recognized as more vulnerable and at heightened risk for rehospitalization after discharge.

AIM

- Institute a collaborative partnership between one academic medical center and local skilled nursing facilities (SNF) and home health agencies (HHA) to create a community standard for heart failure (HF) patient care based on the evidence
- Align quality care practices across the continuum, share metrics, identify care gaps and develop improved processes for patient care transitions

BACKGROUND

- Heart failure (HF) is the leading cause of hospitalization among adults > 65 years, with highest readmission rates occurring within 30 days of discharge.1 Costs for heart failure (HF) patient care in the US are expected to increase to $53 billion by 2030.2 Total economic burden that includes direct and indirect costs of care is projected to reach $70 billion in the next 16 years, at which time 1 out of every 33 Americans will have HF.2 Nationwide, medical centers are instituting evidence-based strategies to improve HF patient transitions from hospital back to the community and reduce 30-day all-cause readmissions.
- Patients discharging to skilled nursing facilities or home with home health services are generally recognized as more vulnerable and at heightened risk for rehospitalization after discharge.

METHODS

- HF nurse specialists led monthly multidisciplinary meetings with local SNF and HHA participants. In these meetings, the collaborative refined interventions for patient care transitions, for example: patient handover, patient education and medication safety strategies.
- Two heart failure patient volunteers participate regularly in the monthly forum and provided frank input from patient perspective
- Aging Adult Services and local outside medical clinic also participate
- Medical center process and outcome metrics are routinely reviewed
- Medical center developed educational tools are shared with the collaborative
- HF nurse specialists provided outreach support with on-site training of SNF staff on guideline-based strategies to improve HF patient care and promoting self-management skills
- Community facilities share their innovations on improving patient transitions and patient and caregiver education
- Readmissions cases analyzed to identify and address gaps in care
- Data drill-down by specific facility facilitated more focused collaboration for solutions

Comparing baseline 1 year data to 1 year post implementation of our intervention bundle, total 30-day HF readmissions to our center declined from 20% to 13% (by 32%), while 90-day rehospitalizations improved from 30% to 24%.
- 30-day rehospitalizations for HF patients improved more dramatically, from 18% to 9% (50% reduction) and from 24% to 19% (21% reduction) for those going home with home health services following the index admission.
- Smaller improvements were seen in 90-day readmission rates for patients returning to hospital from SNF (from 29% to 25%) and for those who had discharged home with home health services (from 25% to 24%).

CONCLUSION

- Incorporating community partners into care transition planning is essential for successful patient outcomes, particularly in light of new bundled payment models
- Building relationships with community partners is critical to success in reducing readmissions and sustaining improved patient outcomes. Nurses are well positioned to plan and lead such collaborative work
- Quality care across the continuum demands everyone be “on the same page”, delivering consistent messages to patients/families on self-management skills, medication safety, etc. and communicating optimally at care transitions.

REFERENCES

4) No such thing as extending your hospital walls to prevent readmissions. Hosp Case Manage. 2012 Sep;28(5):12-15