# Health System Prioritization Further Decreases Heart Failure Readmission

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## BACKGROUND

- In 2009, the Center for Medicare and Medicaid Services (CMS) began reporting readmission rates for heart failure (HF)
- In 2012, CMS instituted the Hospital Readmission Reduction Program linking reimbursement to readmission rates
- With a multidisciplinary team in place, our institution has reduced HF readmission to ~ 14% since 2013
- In February 2017, Ascension's national health leadership provided support to its ministry at St. Vincent Indianapolis to further improve performance

## METHODS

**Multidisciplinary Team Expansion**

- Administrative support used to identify constraints on improvement
- Prioritize constraints
- Expand team to include members to remove or mitigate constraints
  - Members included acute, post-acute, and long term care clinicians

**Root Cause Analysis**

- Each Heart Failure readmission underwent analysis
- Critical components to readmission identified
- Address Inaccurate Diagnoses
  - EMR diagnosis leveraged
  - Education provided for documentation errors

**LEAN/A4E Process Implementation**

- Standardize post-acute care
  - <72 hour post discharge patient contact
  - Standardized post-hospital appointments

**Tests of Change**

- Continuous evaluation
  - Weekly review of watch metrics
  - Monthly evaluation of process by all members of committee

## FIGURES

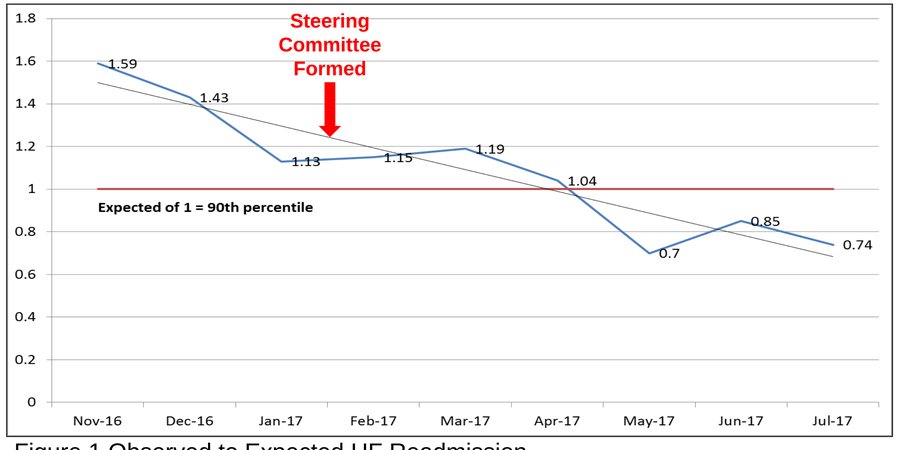



Figure 1 Observed to Expected HF Readmission

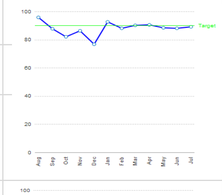
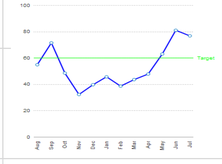
| | Metric | | Target % | R12 Month Total | YTD | Apr-17 | May-17 | Jun-17 | Jul-17 |
|---|---|---|---|---|---|---|---|---|---|
| 2 | **Post-Discharge Appointment within 7 days for Heart Failure Patients**<br>The % of patients for whom a follow-up appointment was scheduled post-discharge and documented including location, date, and time. (GWTG, TJC) |  | 90%<br>GWTG 90th Percentile | 87.7%<br>(565/644) | 89.8%<br>(335/373) | 90.3%<br>(56/62) | 88.2%<br>(45/51) | 88.0%<br>(44/50) | 91.3%<br>(42/46) |
| 6 | **Post-Discharge Evaluation For Heart Failure Patients (ACHF-06)**<br>The % of patients who receive a re-evaluation for symptoms worsening and treatment compliance by a program team member within 72 hours Post Discharge. (TJC) |  | 60%<br>*changed 03/17*<br>Mean GWTG=40 % | 52.1%<br>(352/676) | 55.5%<br>(216/389) | 47.7%<br>(31/65) | 63.0%<br>(34/54) | 80.8%<br>(42/52) | 76.6%<br>(36/47) |

Figure 2 Longitudinal Care Watch Metrics

## RESULTS

- An Observed: Expected (O:E) Ratio over time was used to allow for variation in patient acuity
- When measured against the 90th percentile of similar hospitals, significant, sustained reductions in readmissions have been achieved (Figure 1)
- Individual watch metrics have been tracked monthly to assess post-acute care service standardization improvements (Figure 2)
  - Post discharge appointments within 7 days have improved to the goal metric of > 90% of patients
  - Post discharge 72 hour patient evaluation has sustained at > 60%, meeting target metric
- Corresponding FY 2017 readmission rates have decreased from 14.1% to 11.8%

## DISCUSSION

- **With health system and institutional prioritization, a multipronged approach focused on the continuum of care for HF patients can improve targeted outcomes**
- **Gauging HF outcomes by using O:E ratios may be more reflective performance indicators than readmission rates**