Reducing Heart Failure Readmission Rates Using Multiple Strategies
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### Problem
Potential financial penalties for excessive 30 day HF readmission rates.

### Areas of Focus

<table>
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<tr>
<th>Risk Screening</th>
<th>Care Management Inpatient/Outpatient</th>
<th>Team Collaboration Interdisciplinary HF Team</th>
<th>Patient/Family Education Medication Reconciliation</th>
<th>Care Transitions</th>
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<tbody>
<tr>
<td>Early identification of readmission risk</td>
<td>Daily interdisciplinary progression rounds</td>
<td>Inpatient rounding service</td>
<td>Improved HF book with 5 key messages</td>
<td>Partnerships with SNF/ALF, home health care, congregational nurses, MD offices, EMS, hospice and palliative care, and LTACs</td>
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<td>Early planning and referrals for home care</td>
<td>Disease management and advanced therapies</td>
<td>HF video</td>
<td>Sharing of patient education materials</td>
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<td>Community case management for high risk patients</td>
<td>Comprehensive discharge planning for high risk social issues</td>
<td>Adopted “Teach Back” method</td>
<td>SNF and HH order sets</td>
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<td>Social work consult for depression screening</td>
<td>Referral to outpatient heart failure clinic</td>
<td>WISH scales grant</td>
<td>34 day supply of free meds for at risk patients</td>
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### Strategies

- Early identification of readmission risk
- Daily interdisciplinary progression rounds
- Inpatient rounding service
- Disease management and advanced therapies
- Comprehensive discharge planning for high risk social issues
- Referral to outpatient heart failure clinic
- Improved HF book with 5 key messages
- HF video
- Adopted “Teach Back” method
- WISH scales grant
- Multidisciplinary teaching- RD, RPH
- Partnerships with SNF/ALF, home health care, congregational nurses, MD offices, EMS, hospice and palliative care, and LTACs
- Sharing of patient education materials
- SNF and HH order sets
- 34 day supply of free meds for at risk patients
- HF Clinic
- Schedule follow up appointments before discharge
- Follow up appointment within 5-7 days

### Outcomes

- Our multi-faceted strategy was successful in exceeding our 20% reduction goal for HF readmission rates. We began the project with a rate of 8% on our HF to HF readmission rate in October 2011 and concluded FY13 at 6%. For HF to All Cause Readmissions, our initial metric in October 2011 was 22%, with a reduction to 13% as of October 2013.
- Out of 65 hospitals in NC, Cone Health is one of 27 facilities that avoided a 2% readmission penalty for 2013, saving as much as $2.7M in penalties, while receiving up to $500,000 in incentives.
- The efforts of our multidisciplinary team have totally re-designed the care of our HF patients. Initial pilots on our primary HF Department have been rolled out to the entire health system supporting our significant overall improvement in readmission rates.

### Goal
Reduce Heart Failure Re-admissions