Strategies to Reduce 30 Day Readmissions for Acutely Decompensated Heart Failure and Acute Coronary Syndrome Patients – A Discovery Project

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Scope of Problem

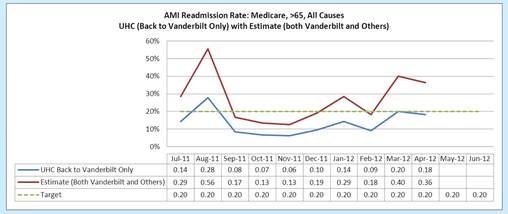
- **Readmissions are center specific.**
- **A detailed analysis must be employed in order to identify the key problems and develop specific interventions.**

National trend:

- **One in five elderly patients is readmitted to the hospital 30 days after leaving.**
- **2.3 million re-admissions.**
- **$17 billion in annual Medicare costs.**

Vanderbilt trend:

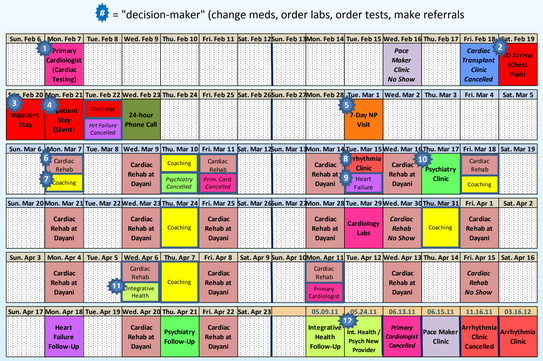
- **21 to 29% (2008-2011) heart failure patients were re-admitted back to Vanderbilt.**
- **18% (2008) & 13% (average for July 2011 until April 2012) of acute coronary syndrome patients were re-admitted back to Vanderbilt.**
- **10% of patients undergoing PCI have a 30 day readmission rate. This is associated with a higher risk of 1-year mortality.**
- **Days 1-15 are crucial, as these are the days that are most prevalent to re-admission.**



	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12
UHC Back to Vanderbilt Only	0.14	0.28	0.08	0.07	0.06	0.10	0.14	0.09	0.20	0.18		
Estimate (Both Vanderbilt and Others)	0.29	0.56	0.17	0.13	0.13	0.19	0.29	0.18	0.40	0.36		
Target	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20	0.20

Why Is This Important to Vanderbilt?

- **Congress gave CMS the power under the Patient Protection and Affordable Care Act to cut hospitals' pay by up to 1% *if they exceed a to-be-determined* estimated 30-day readmission rate for patients with heart failure, heart attack or pneumonia.**
- **There are many dynamics that influence readmission.**
- **Patient care is complex:**
  - **Involves many members of the healthcare team = creates several standard of care opinions.**
  - **Involves a lot of data = potential to miss key data points.**
- **Current Initiatives:**



VHVI Care Transitions Projects: *Transition Management Coordinating Care Across the Continuum*

Project (start time)	Description
Post-Discharge 24-Hour Phone Call.	• Identify problems or misunderstandings that have occurred since discharge & develop a plan with accountability to resolve issues
Post-Discharge 3 -7-Day Visit.	• Confirm & adjust medical plan of care to maximize patient adherence; emphasis on teaching, esp. medications
Health Literacy, Teach-Back & Health Coaching Principles.	• Teach care teams how to apply the teach-back methodology and health coaching principles as part of every patient/family interaction
Post-Acute Handovers.	• Solidify "warm hand-over" plan; apply best practice for information flows & patient flows
Transition Huddles.	• Structured, interdisciplinary huddle to review every patient, every day & manage transitions
Inpatient Teaching Teams Best Practice.	• Standardize teaching rounds incorporating best practice for transitions in care
Risk Modeling.	• Explore using clinical and psycho-social risk factors to differentiate care delivery based on risk level / categories; ties into huddles, calls & visits
Valve Bundle Implementation Team	• Assuming future launch of bundled reimbursement, team will design implementation based on CMS application

Strategies to Reduce Readmissions

- **Formulate a database that would risk stratify individuals.**
- **Develop an accessible flow sheet that could be used by all Vanderbilt providers as a central form of communication.**
- **Consider a Mortality and Morbidity conference to understand the qualitative measures that influence readmissions.**
- **Make changes to the discharge plan:**
  - **Re-review patient demographics: patient contact information and primary care provider.**
  - **Capture referrals: Home health and cardiac rehab.**
  - **All patients get heart failure education.**
  - **Medication education with teach back methodology**
  - **Every patient has business card of the provider with a number to call.**
  - **Every patient leaves the building with an appointment here at Vanderbilt or at an outside clinic facility.**
  - **Discharge summary is sent within 48hours to the referring provider.**