WE HAVE A CLEAR VISION FOR VALUE IMPROVEMENT
WE IMPROVE VALUE THROUGH INTERDISCIPLINARY TEAMS
ORGANIZATIONAL CULTURE
WE GROUND OUR IMPROVEMENT IN A CLEAR BENEFIT TO OUR PATIENTS
WE PROVIDE ACTIONABLE PERFORMANCE DATA
PATIENTS

TEAMS

READMISSIONS

PORTNEUF’S HEART FAILURE READMISSIONS

PROGRAM TEAM & PROJECT SCOPE

Team
Ben Call, M.D. (lead), Robie Menno, Angela Treasure, Aaron Hobbs, Brad Rogers, Marna Sorenson, Leslie Bean, Cynthia Barron, Robyn Harling

Scope
Heart failure 30 day readmissions

MEASURES & MONITORING

<table>
<thead>
<tr>
<th>Type</th>
<th>Measure</th>
<th>Baseline</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality</td>
<td>Reduce 30 day readmissions for Heart Failure</td>
<td>14.93%</td>
<td>8.00%</td>
</tr>
<tr>
<td>Quality</td>
<td>No increase in Heart Failure mortality</td>
<td>11.40%</td>
<td>11.40%</td>
</tr>
<tr>
<td>Service</td>
<td>No decrease in HCAMS (“Definitely Recommend”)</td>
<td>69%</td>
<td>≥89%</td>
</tr>
<tr>
<td>Cost</td>
<td>Mean length of stay days</td>
<td>5.1 days</td>
<td>≤5.1 days</td>
</tr>
</tbody>
</table>

PROBLEM & GOAL STATEMENTS

Problem
30 day Readmission rate for Heart Failure (DRGs per CMS definition) was 14.93% for the 24 months ending May 30, 2015.

Goals
1. Reduce Heart Failure Readmissions to 8.0% by September 30, 2016 (this is a 47% decrease)
2. No decrease in HCAHPS by June 30, 2016
3. No increase in length of stay by June 30, 2016

ANALYSIS & INVESTIGATION

Database analysis found high risk areas are (a) Discharge to Skilled Nursing Facility (SNF), (b) after hours, and (c) without Cardiology involvement.

Expanded Findings:
1. No standardized medical care pathways for nursing or physicians
   • Role of Cardiology consult in care and discharge planning is inconsistent
2. Difficult discharge process
   • Have difficulty anticipating discharges to allow timely discharge planning
   • Difficult process scheduling and communicating follow-up for off-hours discharge
3. Inconsistent patient education process and content leading to poor compliance
   • Polypharmacy challenges quality and educational objectives
4. Patients do not perform daily Heart Failure cares; keep appointments, weigh daily, diet
5. Patients do not perform daily Heart Failure cares; keep appointments, weigh daily, diet
6. Patients do not perform daily Heart Failure cares; keep appointments, weigh daily, diet
7. Patients do not perform daily Heart Failure cares; keep appointments, weigh daily, diet
8. Patients do not perform daily Heart Failure cares; keep appointments, weigh daily, diet
9. Patients do not perform daily Heart Failure cares; keep appointments, weigh daily, diet
10. Patients do not perform daily Heart Failure cares; keep appointments, weigh daily, diet

IMPROVEMENT DESIGN & IMPLEMENTATION

1. Discharge Process Improvements Underway:
   • Establishing nursing certification and competency for Heart Failure teaching; include Home Health nurses
   • Creating standardized patient education and follow-up packet
   • Creating new patient materials to facilitate involvement, understanding, and compliance
   • Pre-discharge cardiologist consult by cardiology Nurse Practitioner for all Heart Failure discharges, CM to trigger.
   • Providing scales for patients in need to encourage daily weights
   • In process: bring a test patient into the process
   • Use Pre-discharge Planning Sheet
   • Use LACE score to anticipate high risk discharges needing extra attention

2. Medical and Nursing Care Improvements:
   • Taskforce of hospitalists, cardiologists and nursing to create care pathway
   • Create Standard Work for those doing discharge and discharge follow-up
   • Post Discharge Cares:
     • HFC scheduling template revised
     • Clarification of protocols for use of Heart Failure Hotline phone during after-hours
     • Establish relationship with preferred Home Health agency

NEXT STEPS

Portneuf is committed to tackling Heart Failure readmissions—not just as a health care system—as a community. The analysis work conducted as part of this program has generated system-wide engagement in addressing heart failure readmission rates. Business planning analysis is currently underway to examine expanding the Pre-Discharge Task Force to include a dedicated Medical Staff Task Force, which will address development of care pathways, as well as a broad multidisciplinary Post-Discharge Task Force to address gaps in care transitions that will be provider-driven and value focused.

Support for this program was provided by a grant from the Robert Wood Johnson Foundation.