Preventing 30 Day Readmission for Patients with Heart Failure

PICO: In heart failure patients, how does utilizing post-discharge interventions decrease 30 day hospital readmission rates compared to not receiving follow-up interventions?

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Purpose
Our goal is to determine if post-discharge interventions are effective in reducing 30 day readmission rates for heart failure patients.

Background
Heart failure is a chronic, progressive condition in which the heart muscle is unable to pump enough blood to meet the body’s needs for blood and oxygen (American Heart Association, 2019).

The Hospital Readmissions Reduction Program (HRRP) is a Medicare value-based purchasing program that reduces payments to hospitals with excessive readmissions. The program supports the national goal of improving healthcare for Americans by linking payment to the quality of hospital care.

Heart failure ranks in the top 10 most expensive inpatient conditions in the United States. Researchers predict this expense to escalate as the country’s population ages. Annual direct medical costs are projected to increase from $24.7 billion to $77.7 billion (Hospital Readmissions Reduction Program for Heart Failure, 2016).

The 30 day readmission rates for Heart Failure patients at UM Baltimore Washington Medical Center is 25.8%. The national average is 22% (Readmission Rates at University of MD Baltimore Washington Medical Center, 2019).

Current Practice
- Patient discharge instructions include information on diagnoses
- Medication reconciliation and review completed
- Follow-up appointments made to Transitional Care Center (TCC)
- Referrals made to Transitional Care Program
- All patients with heart failure are referred
- Referral is based on physician’s decision

Literature Review
Level IA - 4 Studies:
- Guirguis-Blake et al. (2010) research shows positive outcomes when high-intensity (increased time spent and frequency) home visiting programs, telephone support, and multidisciplinary heart failure programs are utilized.
- High-intensity, face-to-face delivery, and multidisciplinary team involvement appear to be key elements of successful interventions, regardless of intervention type.

Level IB - 1 Study:
Parshati et al. (2013) found that socioeconomic factors including race and age, as well as comorbidities and being covered under Medicare, were large predictors of heart failure readmission.

Level II A - 1 Study:
Waller et al. (2017) reported that heart failure patients who received a discharge education intervention had lower readmission rates compared to those who did not.

Level II B - 2 Studies:
The findings suggest that transcript and HF discharge volume may negatively impact care processes. Increasing the odds of hospital readmission. "The discharge period is a vulnerable point in care transition that warrants further investigation."

Level III A - 2 Studies:
The findings suggest that the benefits of HF discharge volume may negatively impact care processes. Increasing the odds of hospital readmission. "The discharge period is a vulnerable point in care transition that warrants further investigation."

Level IV - 2 Studies:
Clinical guidelines from American Heart Association considering heart failure patients and the statistical importance of these guidelines.

Recommendations For Practice Change
- Connect patients to resources, primary care providers and specialists in their community prior to discharge
- Individualize patient education about chronic conditions and medications
- Include discharge follow-up phone calls, individualized patient education to include nutritional journaling, daily weights, and medication education beyond the hospital setting
- Follow up appointments scheduled prior to discharge from the hospital
- Nurse-driven protocol to make referrals to transitional care:
  - Education to new and current nurses on transitional care and how it is implemented
  - During rounds with physicians, RN addresses whether transitional care should be utilized
  - Addition of transitional care staff member to multidisciplinary care team
  - In-service semi-annually speaking to staff about transitional care

Conclusion
Many studies have shown that transitional care interventions “promote patient safety and contribute to other positive outcomes,” but more research is needed to clarify what the interventions should be and which benefit the patient the most. Transitional care is available at UM BWMC and needs to be utilized more frequently. One way this could be achieved would be through a nurse-driven protocol. This would give nurses the autonomy to refer patients to transitional care if it is deemed necessary. Another way transitional care use can be increased is through the addition of a transitional staff member to the multidisciplinary team. This would ensure communication between case management and other members to ensure the best possible patient outcomes.

Research Method / Terms Searched
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Inclusion: 2015 - current; peer-reviewed journals
Keywords: heart failure; readmission rates; transitional care; heart failure nutrition; heart failure care coordination; “patient engagement in discharge care”

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