

Reducing Heart Failure Hospital Readmissions From Skilled Nursing Facilities

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ABSTRACT

Purpose/objectives: Readmission rates for heart failure patients are a Center for Medicare & Medicaid and Joint Commission core measure. At this urban Midwestern medical center, the 6-month baseline skilled nursing facility (SNF) readmission rate was 30%. Nurse case management implemented a process to decrease the rate for this population. Follow-up phone calls were in place for patients discharged to home, but a gap remained in those discharged to SNFs. Nurse case management developed a follow-up phone call process within 48 hours of discharge to the registered nurse/licensed practical nurse in the SNFs to verify that:

1. Daily morning weights were ordered.
2. Parameters to contact primary care provider if weight gain was greater than 3 pounds per day or 5 pounds per week.
3. 2 gram sodium restricted diet was ordered.
4. Appropriate diuretic was ordered and reconciled.
5. Follow-up provider visits were made, for patient to be seen within 3 to 5 days following discharge.

Primary practice setting: Acute inpatient care settings.

Findings/conclusions: The phone calls resulted in improved continuity of care and clarification of discharge orders. The opportunity for question-and-answer time between the hospital and the SNF nurse provided just-in-time education; relationships have also been strengthened. Recent data show that the current readmission rate averages 11.32% (a decrease from 30%). This nurse case management–driven process of follow-up phone calls between the hospital and SNF staff to reduce readmission rates in heart failure patients resulted in improved continuity of care and clarification of discharge orders.

Implications for CM practice: This simple, innovative process allowed for improved continuity of care and partnerships between inpatient hospitalization and the SNF, thereby reduced transcription errors and improved patient health outcomes. Enhanced communication between providers allowed for a significant reduction in readmissions from SNFs to the hospital.

Key words: care coordinators, continuity of care, costs, disease management, heart failure, quality, reducing readmission, skilled nursing facilities

Patients with heart failure discharged to skilled nursing facilities (SNFs) are frequently readmitted to the hospital, often due to lack of adequate continuity of care at the time of discharge to the SNF. It has been observed that a high percentage of all hospital readmissions are from patients with heart failure that were discharged to SNFs. The complex, progressive nature of heart failure often results in adverse outcomes, the most costly of which are hospital readmissions (Anderson et al., 2006). Not only are readmissions a hardship for patients, but they also incur high costs to the health care industry. Episodes of hospitalizations for heart failure patients are frequent, expensive, and possibly pre-

ventable in approximately 40% of the cases (Anderson et al., 2006).

With the advances in health care informational technology (IT), electronic medical records (EMRs), and videoconferencing in health care practice, the opportunity for expansion in chronic disease management is bountiful; these innovations will empower patients and health care providers to access health care in a timely efficient manner without having to continually

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It became apparent that heart failure readmissions from SNFs were a hardship for patients, reflected fragmentation of care across the continuum, and was not cost-effective for institutions in terms of long length of stay, readmissions, and impact on patient flow. In addition, when patients are frequently readmitted back to the hospital, it does not reflect well on quality care and “best practice.”

readmit patients to the hospital for services. Improved remote health management access through videoconferencing with heart failure patients in the patient's home ultimately improves health outcomes, optimizes patient care, and increases patient independence, thereby avoiding some hospital stays (Horowitz, 2010). Intervening earlier, before patients are symptomatic, avoids spiraling problems for patients, which often result in increased costs and poor outcomes. This theme of early intervention was translated to our heart failure patients who were transferred to SNFs.

Heart failure is a growing epidemic. From 1990 to 1999 the annual number of hospitalizations increased from approximately 810,000 to over 1 million for heart failure as a primary diagnosis and from 2.4 to 3.6 million for heart failure as a primary or secondary diagnosis. Heart failure is the most common Medicare diagnosis-related group, and more Medicare dollars are spent for the diagnosis and treatment of heart failure than any for other diagnosis (American College of Cardiology Foundation/American Heart Association [ACCF/AHA] Task Force on Practice Guidelines, 2009). Episodes of hospitalization for heart failure patients are frequent, expensive, and possibly preventable in about 40% of the cases (Anderson et al., 2006).

The American Heart Association noted that as of 2006, 4.8 million people in the United States were diagnosed with heart failure (American Heart Association, 2010). There has been substantial growth regarding the heart failure population. As our elderly population ages further, it is likely that the number of heart failure patients will continue to grow. Four hundred thousand new heart failure cases are diagnosed every year (Council of Accountable Physician Practices, 2004), and it is estimated that 550,000 additional cases are expected each year (Mack, 2006).

Reducing heart failure readmission rates is a Centers for Medicare & Medicaid Services and Joint Commission core measure. Hoyt and Bowling (2001) stated that the prevalence of heart failure was continuing to rise and resulted in an annual expenditure of \$10 billion for diagnosis and treatment. Studies concluded that readmissions for heart failure could have been prevented in at least 40% of cases. Unnecessary readmissions contribute significantly to the cost of this disease (Hoyt & Bowling, 2001).

Heart failure rehospitalizations from SNF Medicare patients continually rose from 1999 to 2002. In 1999, 3.2% of heart failure Medicare patients in SNFs were readmitted for potentially avoidable conditions. In 2000, this increased to 3.3% and continued to rise to 3.7% over years 2001 and 2002. The Medicare Update of July 10, 2009, stated that the U.S. national 30-day readmission rate for heart failure was 24.5% (Schneider, 2009). This vulnerable population and the epidemic growth of heart failure has created a significant interest in heart failure disease management and finding innovative approaches to managing heart failure exacerbations, with the goals of improving quality care and reducing cyclic readmissions to the hospital.

Advocating for optimal patient care, especially in such a large and fragile population as that of patients with heart failure, is not only important for patients and their families, but also has a tremendous financial and patient flow/access impact on hospitals. More than 5 million Americans are living with heart failure. While this chronic condition can be managed with appropriate medication and lifestyle changes, many patients experience acute exacerbations that result in trips to the emergency room. Heart failure is one of the most common reasons people are admitted to a hospital and the most common reason for readmission (Hostetter, 2008). Over 550,000 patients are diagnosed with heart failure for the first time each year, and heart failure is the primary reason for 6.5 million hospital days (ACCF/AHA, 2009).

THE HEART FAILURE INITIATIVE

As a member of the heart failure committee at United Hospital (Allina Hospitals & Clinics) in St. Paul, Minnesota, it became apparent that heart failure readmissions from SNFs were a hardship for patients, reflected fragmentation of care across the continuum, and was not cost-effective for institutions in terms of long length of stay, readmissions, and impact on patient flow. In addition, when patients are frequently readmitted back to the hospital, it does not reflect well on quality care and “best practice.”

Improvements to optimize patient care and quality of life for this population appeared to be in high demand at this hospital. At the inception of this initiative, the heart failure readmission rate at United Hospital from SNFs in January 2009 (first month of the baseline) was 50%. The system-wide readmission goal for all patients with heart failure was less than 17%, which was set after careful nationwide review of other health care facilities. It was noted that the Baylor Health System had a readmission rate of 15.4%, so the goal was modestly set to achieve less than 17%.

The expertise and practice of registered nurse (RN) care coordination/case management is about collectively using resources to collaboratively enhance patient care and improve patient outcomes. Thus, the purpose of this quality improvement initiative was to forge partnerships, provide optimal continuity of care across the continuum from inpatient to outpatient systems, improve transparency, and streamline care delivery for heart failure SNF patients.

To enhance quality patient outcomes at discharge and reduce the frequent cyclic readmission

pattern, it became apparent that there was a need to create a quality improvement initiative that improved partnerships with SNFs, thus enhancing patient health outcomes. This initiative included development of a format to optimize accurate discharge orders, improve continuity, and enhance quality of care. This resulted in a reduction of readmissions to the hospital for patients with heart failure.

METHODS

The emphasis of this initiative was to improve care efficiency, reduce transcription errors, and customize and standardize communication with SNFs. A partnership was formed with the Clinical Nurse Specialist, who reviewed the intent of this initiative. Following this review, a strategic plan was introduced to “bridge care” from inpatient to SNFs and to formulate a process that was efficient, simple, and direct (see Table 1). Once the process was developed, it was reviewed and approved by the shared decision-making committee at United Hospital. Following this approval in June 2009,

TABLE 1

Follow-Up Call for Discharge Process and Documentation Related to Heart Failure Patients Sent to SNF

Heart failure nurse will contact RN Care Coordinators daily to get list of patients sent to SNF on preceding day.

Retrieve the “After Discharge Orders” set. Identify the SNF to which the patient was discharged. Contact SNF facility, and review heart failure discharge orders (diuretic, diet, weight ordered and physician follow-up appointment set/to be seen in 3–5 days) with nurse at facility.

Confirm that order transcription is complete and that appointment has been made with primary physician if patient is not being seen by NP or MD at facility. If patient is to be seen at facility by NP or MD, confirm that the patient is scheduled to be seen within same timeframe (3–5 days of admission to SNF).

After phone confirmation is done, document the encounter in the patient’s chart (see below).

To Document the Encounter in Excellian (Process):

1. Locate patient chart.
2. Go under Patient Care tab to telephone encounter.
3. Under Provider, list your “A” number.
4. Under Contacts, click on “outgoing.” Under Place, put which TCU you are calling, and type in phone number. Hit “accept.”
5. Under Reason for Call, type “follow-up,” then hit “next.”
6. Documentation: free text/comment your phone conversation.
7. Scroll to the bottom of the page to “Authenticate encounter,” and it files the above as an encounter. (To double-check that the above is done, you can look at “Chart Review” following and see the encounter charted.)

***We must also log these phone calls to identify facility trends.

***Please chart your phone call to facility in the Facility Call Log.

To Access Facility Call Log:

1. Go to My Computer.
2. Scroll to S Drive.
3. Select Metro.
4. Select UNI.
5. Choose RN Care Coordinator icon.
6. Click on heart failure Follow Up calls folder.
7. Choose Facility Call Log.
8. Chart information on Excel Sheet.

two RN Care Coordinators/Case Managers began daily connections with facilities across the cities, bridging care from inpatient to outpatient systems.

Prior to the project initiation, a clear and concise letter of intent was submitted to over 200 facility Directors of Nursing (DONs) (see Table 2). This letter explained the quality improvement initiative process and encouraged DONs to inform their staff of the follow-up calls starting within a short time period. The letter noted that the goal was to enhance continuity of care and optimize patient outcomes. This informational letter was intended to improve SNF staff “buy-in” for this initiative, emphasize “best practice” partnerships, and enhance quality patient care outcomes.

At United, a group of RNs designated as “heart failure RNs” identify patients who have gone home with home care or to an SNF. On a daily basis, the heart failure RNs identify which patients were discharged to a SNF and email those patient names and medical record numbers (MRNs) to the RN Care Coordinators/Case Managers. Upon receiving these names, the patient’s chart is accessed through the EMR and a review of the discharge orders is completed. At this time, the RN Care Coordinator identifies the facility to which the patient was discharged and obtains SNF contact information.

Upon calling the SNFs, the RN Care Coordinator/Case Managers and the staff nurse caring for this patient discuss the discharge orders. The

Care Coordinator explains that the hospital is following up on patients who are discharged with heart failure; this call also provides an opportunity to answer questions and clarify orders. Issues discussed in the follow-up calls include the following:

1. Does the patient have daily morning weights ordered? Are there parameters to contact the physician if the patient has a weight gain of 3 pounds per day or 5 pounds per week?
2. Is the patient on a 2-g sodium-restricted diet?
3. Is the patient scheduled to see a physician in 3 to 5 days of discharge? If so, who is that the physician, and when will the patient be seen?
4. Is the patient on a diuretic? An abbreviated version of medication reconciliation is done at this time, confirming the name of the diuretic the patient was discharged on and verifying correct medication dose, frequency, and route.

Upon the completion of the call, the conversation is documented on a specially developed Excel spreadsheet to keep a record of patient’s names, MRN, name of SNF, contact person, and when the call was made (date and time). This tracking tool was developed to identify trends of which SNFs patients were discharged to, and assist with which SNF patients were being readmitted from. With this information, next steps would be to identify areas of improvement with these SNFs, to further improve the process.

TABLE 2

Letter to Facility Directors of Nursing Explaining the Quality Improvement Initiative

Name of Facility

Address of facility

City / State

Date, 2009

Dear [Insert Director of Nursing/Administrator/Name of facility]:

Our goal at United Hospital is to facilitate optimal patient care across the continuum. We are fortunate to have our patients continue their care at your facility upon discharge. We are working diligently to optimize therapy for our patients with heart failure to reduce the risk of recurrent heart failure symptoms and therefore readmissions.

With this goal, we have implemented a new initiative to follow up on patients with heart failure who have been discharged to [insert name of facility]. We will be making a follow-up phone call to your facility in 1–2 days after discharge. These follow-up phone calls will be done by our RN Care Coordinators, who will contact the staff nurse at your facility to review and confirm that the heart failure patient’s discharge orders have been transcribed appropriately and return appointments have been set up and answer any questions needed.

This new initiative is intended to provide optimal patient outcomes and enhance the continuity of care for our patients with heart failure. Our hope is to develop a partnership with you so that together we can provide the optimal care and improve patient outcomes.

We look forward to working with you and your staff in upcoming days. Please feel free to contact us for questions or concerns.

Sincerely,

St Paul Heart Clinic Physician

RN Care Coordinator

RN Clinical Nurse Specialist

RN Care Coordinator

The phone conversation with the licensed staff at the SNF was documented as a “telephone encounter” in the patient’s EMR chart. This again verified our conversation, noting the foregoing discussion items and the staff’s responses to our questions. This documentation became a part of the patient’s legal chart and assisted with bridging communication.

Only two RN Care Coordinators made these follow-up phone calls to SNFs. The number of RN Care Coordinators making the calls was limited in order to reduce variation in phone delivery and allow a more accurate picture of our “process” success. There was discussion about rolling this project out to the Care Coordinator team (12 RNs); however, it was decided to continue the process with limited callers for better reliability at this time.

RESULTS

As stated, in January 2009 the overall heart failure readmission rate from SNFs back to United Hospital was at 50%, with a goal of less than or equal to

17%. During the baseline time frame (January to June 2009), the heart failure readmission rate from SNFs averaged 30%. From July through December 2009, after implementing this new process, the heart failure readmission rate from SNFs was reduced to 11.32% (see Table 3).

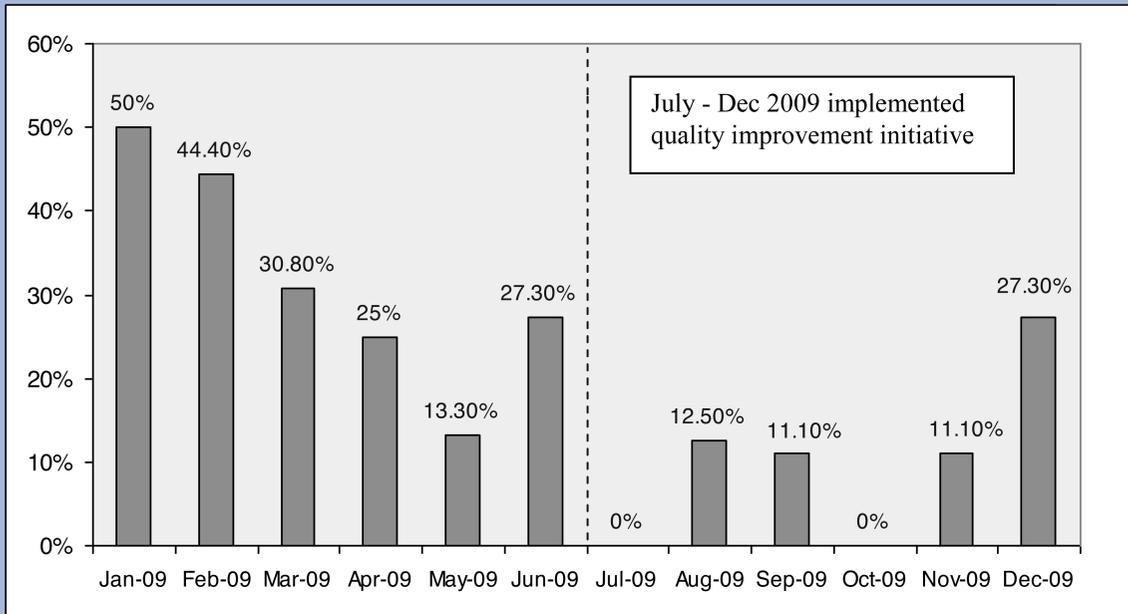
During the implementation process, in five of the six months readmission rates reached the goal of 17%. In essence, enhanced communication, consistency of phone contacts, and partnership building with Minnesota and Wisconsin SNFs were all key elements to the success of this process.

The initiative called for contact with the SNFs within 24 to 48 hours of discharge from the hospital. On average, calls were made on one to two patients per day. From July through December 2009, over 170 calls were made. In the follow-up call period, the following trends were noted:

- SNFs had variations of orders regarding daily morning weight monitoring and parameters to call the provider for specific weight gain.

TABLE 3

Letter to Facility’s Director of Nursing, Explaining the Quality Improvement Initiative



Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
5 of 10	4 of 9	4 of 13	3 of 12	2 of 15	3 of 11	0 of 5	1 of 8	1 of 9	0 of 10	1 of 10	3 of 11
50%	44.40%	30.80%	25%	13.30%	27.30%	0%	12.50%	11.10%	0%	11.10%	27.30%
January–June 2009 readmission rate 30%						July–December readmission rate 11.32%					
1 of 6 months had less than 17% readmission						5 of 6 months had less than 17% readmission					
21 readmits out of 70 discharges to SNF = 30%						6 readmits out of 53 discharges to SNF = 11.32%					

p value = .01319

Note. The quality improvement initiative was implemented July–December 2009.

The purpose of this quality improvement initiative was to forge partnerships, provide optimal continuity of care across the continuum from inpatient to outpatient systems, improve transparency, and streamline care delivery for heart failure SNF patients.

- Some facilities did not have a 2-gram sodium diet available at their facility.
- Follow-up appointments were not always made or were not made in a timely manner.

These calls provided an opportunity to confirm that orders were transcribed accurately and were understood correctly. A dialogue often ensued that opened doors for nurses to better understand the importance of these items for patients with heart failure. Verifying heart failure discharge orders with SNFs upon discharge from the hospital provided solid evidence of improved communication. This innovative practice optimized patient quality of care across the continuum. Double-checking the orders at the SNF facility with a licensed provider resulted in reducing transcription errors and opened an avenue for question and answers that enhanced optimal patient care. If orders at the facility were not correct, it allowed an opportunity to prompt the SNF employee to contact the provider for clarification of orders or to add additional heart failure discharge order recommendations.

The average length of stay (ALOS) at United Hospital for patients with heart failure was 4.36 days. Using this ALOS and the net savings figure of \$388 per day for medical surgical and telemetry beds, it was computed that as a result of this initiative 9.9 admits were averted, equivalent to 43.164 hospital days, resulting in a net savings of \$16,748 for United Hospital over a 6-month period. This figure annualized equates to a projected savings of over \$32,000.

There is another level of cost savings opportunity as well. Those averted heart failure readmissions allow other hospital admissions to be placed. This resulted in improving patient access to inpatient care and ultimately impacted patient flow within the hospital.

DISCUSSION

The goal to reduce heart failure readmission rates not only resulted in more cost savings, it also impacted patient flow in the hospital and allowed patients to maintain quality health care in a subacute arena. This project's focus was about quality by pro-

viding a more stable consistent disease management process. The long-term goal was to reduce the cyclic heart failure hospital readmission rate and improve partnerships between the hospital and Minnesota and Wisconsin SNFs.

During the initiative, it became apparent that when heart failure discharge order sets were used in this hospital, patients had better outcomes. This order set, which was a part of our facility's EMR, prompts physicians to order daily morning weights, lists parameters to call providers for weight gain, recommends a 2-gram sodium diet, requires the patient to be seen by a provider in 3 to 5 days of discharge and to be on a scheduled diuretic. The phone calls to the SNFs helped to ensure that the patients received this care once discharged from the hospital.

The heart failure readmission initiative was developed to advocate for optimal quality patient outcomes. The advocacy related to reducing errors, verifying that orders were transcribed appropriately, and improving quality and continuity of care. It was a simple and direct initiative and opened communication, allowing a partnership to form from the hospital to the next level of care (SNF). This process was well received at the SNFs, as the initiative was patient centered and aimed at promoting best practice.

Not only does this process touch on advocacy, best practice, quality, and optimal continuity of care, but it also touches on improving employee engagement and patient satisfaction. All of these factors are significant and noteworthy, for they are prime reasons that RN Care Coordinators/Case Managers go into health care—to see positive impacts of their work and make a difference for patients health. Not only are we stewards to patients and families, but we also are responsible for being good stewards of health care dollars in a time when health care is facing many changes.

Optimal care provides financial benefits to the health care industry and allows nurses to practice prevention versus chase an unstable condition. Unstable, out-of-control disease processes are often more costly and have worse outcomes. By optimizing communication, reducing errors, and anticipating condition symptoms, case managers are providing optimal patient-centered care. These conscious actions prevent readmissions and hardships for patients and their families.

CONCLUSION AND NEXT STEPS

This innovative, exciting initiative not only reduced readmissions for heart failure patients from SNFs, but truly engaged employees by empowering them to think outside the box. As noted in *Crossing the Quality Chasm*, fundamental changes are needed to

transform health care in America. Trying harder will not work, but changing systems of care will (Institute of Medicine, 2001). The focus must remain patient centered and about excellence. If one loses sight of why one became a health care provider, then quality will deteriorate and our patients will suffer.

As one travels through the transformational period of health care reform, there is a dynamic need to be creative and energized. Problems need to be approached as challenges, seen as opportunities and emphasize importance of being fiscally responsible. The focus should never deter us from our primary responsibility: our patients. As health care stewards, we must maintain optimal, efficient, and safe quality care for our patients. By doing so, we all participate in an optimal health care delivery system. By utilizing every resource possible, advancing in the growing health IT system, and improving EMR compatibility, we can promote exceptional access for continuity of care and positively impact quality health care delivery. Optimizing technology will improve turnaround time for care delivery while reducing errors. Intervening earlier, anticipating needs, and using our resources efficiently each contributes to high-quality, safe health care delivery for our patients.

The next step of this quality initiative is to track and observe trends, identifying which SNF(s) these patients are being readmitted from, and partner with those SNFs to identify factors that are causing these readmissions. With that information, we can promote another opportunity for education and optimal patient care.

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