Hospital System Lowers Heart Failure Readmission Rates

Heart Failure Accreditation enabled Shire Ridge Health[1] to improve a number of factors influencing the care of heart failure patients at the hospitals within their health system.

About Shire Ridge

Shire Ridge Health[1] is a community-based network of physician practices, hospitals and care centers located in the U.S. southeast. The 2,145-bed network of hospitals includes Shire Mill Regional Medical Center which is the system's flagship hospital and one of the largest tertiary facilities in the region; Tri-Village Memorial Hospital; South Harbor Hospital; Cold Cove Hospital; and Midtown Metro Hospital, and other specialized treatment facilities.

Challenge

Prior to engaging with ACC Accreditation Services, Shire Ridge Health faced the challenge of lowering heart failure readmission rates. But since the hospitals within the Shire Ridge Health system do not share identical programs, they deployed different methods of process improvement to address the issue. They did, however, move through accreditation process as a system, which made it easier to share materials, processes, and ideas. As a result, they experienced a high level of camaraderie, especially since coordinators from the various hospitals met and shared as one system.

At Shire Mill Regional Medical Center and Tri-Village Memorial Hospital, it was determined that patients either did not understand or were not compliant with their heart failure medications. Many patients simply chose which medications to take, and that presented a huge problem, especially since the medications fall into multiple classes.

The professionals at South Harbor Hospital experienced an overall lack of communication with the patients. In many instances, patients either did not comply with their discharge instructions or they simply were not willing to accept their diagnosis. It was an ongoing challenge to reinforce the importance of follow-up care.

As the volume of heart failure readmissions at Cold Cove Hospital continued to increase, the hospital's professionals struggled to determine the cause. Was the population aging, or were they simply better able to identify the heart failure patients? They started to use the ACC's Heart Failure Accreditation Service, which asks: Are you minimally providing the patients with an in-house education session as well as written discharge instructions when they leave the hospital? But those were questions they couldn't answer because they were not accurately tracking or documenting their patient education.

Similarly, the professionals at Midtown Metro Hospital utilized Heart Failure Accreditation to take a closer look at the patient education process and its effectiveness. Is the education being documented? Is it reinforced on a daily basis? Or is it simply a one-and-done approach? They discovered that they needed to work more closely with their partners at skilled nursing facilities.

Solution

Studies show that 24 percent of heart failure patients return to the hospital because of dietary noncompliance while another 24 percent return because they do not take their prescribed medications. These two populations alone make up nearly half of all heart failure readmissions. At both Shire Mill Regional Medical Center and Tri-Village Memorial Hospital, they used medication reconciliation to address this problem.

To address these factors, both hospitals adopted bedside pharmacy consultations. This internal process alerts the pharmacy when a patient is about to be discharged. The heart failure pharmacist then goes to the patient's bedside to provide heart failure medication education, including information about the different classes of heart failure medications. In addition to receiving the education at bedside, each patient is sent home with a medication guide and is encouraged to follow up with blood pressure monitoring and proper weight management. At the same time, a nurse navigator is assigned to each heart failure patient to provide additional education and assist with establishing outpatient resources. The goal is to improve patient outcomes through greater understanding of the disease process and the prescribed medications. This in turn improves patient compliance, resulting in better overall outcomes.

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South Harbor Hospital focused on improving communication. They implemented a telephonic discharge process and stepped up their communication with the cardiac rehabilitation unit. Weekly follow-up calls now occur during the 30 days after patient discharge, and they include patient reminders and assistance with scheduling physician follow-up appointments, along with reminders to complete daily body weight measurements.

At Cold Cove Hospital, they used videos and booklets to enhance patient education, and they implemented a method for documenting their educational efforts. When the number of heart failure readmissions almost doubled from 342 patients to 531 patients across a three-year period, they realized it was time to closely examine their materials and processes. They discovered that the quality of their educational materials was severely lacking. In fact, the materials consisted of more than 20 pieces of loose-leaf, black-and-white printed pieces. To help remedy the problem, they upgraded the printed materials and videos to make them friendlier and more visually pleasing. This brought the materials in line with what the other Shire Ridge Health hospitals were offering and helped to ensure that patient education is consistent throughout the system.

Cold Cove Hospital hired a heart failure program navigator to help ensure that patient education materials are appropriate, applicable and current, and to place a greater emphasis on the coordination of care. To better identify heart failure patients, they started using visual icons on patient charts.

When the health professionals at Midtown Metro examined their heart failure readmission rates, they realized that many of the patients were coming from local skilled nursing or extended care facilities. For this reason, they assumed a posture of complete transparency with these facilities by sharing issues, goals, and educational materials. When they received feedback from the facilities that much of the information being shared was not particularly useful, they altered their course to create a clean and transparent communication loop. They also created a clinical program coordinator role to follow the heart failure patient after discharge.

Results

At Shire Mill Regional Medical Center and Tri-Village Memorial Hospital, the overall medication error rate is still being monitored, but that rate has dropped significantly at Tri-Village Memorial Hospital. To demonstrate the significance of its process improvement effort, the error rate/pharmacy intervention rate at Tri-Village Memorial Hospital was as high as 48% at the beginning of a two-year timeframe and improved to as low as 4% at the end of the period being monitored. By placing a strong emphasis on the bedside pharmacy consultation, they were able to greatly improve patient compliance at these hospitals.

"ACC held our hands throughout the process of accreditation to make sure we were turning in everything that we needed and making the appropriate changes to our program in order to qualify for accreditation," commented a cardiology nurse practitioner in the heart failure area at Shire Ridge Health. "The whole process of accreditation really helped us look at things in a way that has allowed us to continue to improve our program."

South Harbor Hospital focused on improving the post-discharge coordination of care, and in doing so they were able to successfully reduce readmissions from 23.92% to 10.30% across a two-year period.

At Cold Cove Hospital, after they improved their educational materials, hired a program navigator and added heart failure patient identification, their heart failure readmission rate dropped from 28% to 12% across an eighteen-month period.

By greatly improving the line of communication with skilled nursing and extended care facilities, the professionals at Midtown Metro Hospital successfully reduced their heart failure readmissions by 45%.

The specialists from ACC met with the Shire Ridge Health teams on a weekly to monthly basis to help them progress through the accreditation process and to provide the hospitals' teams with guidance in areas where they felt they needed improvement or resources to further improve their program. "Sometimes you get focused on what your hospital is doing and what you've been doing and you miss the bigger picture. It's nice to have someone who can look at your processes and provide feedback," commented one Shire Ridge Health participant.

Look to ACC Accreditation Services

Hospitals that are intent on connecting quality and cost with outcomes and patient satisfaction look to ACC Accreditation Services to help them create cardiovascular communities of excellence. Achieving accreditation status improves a hospital's productivity, patient throughput, and the quality and consistency of care. In short, it better positions a hospital as a preferred provider of cardiovascular care.

1) The names of all facilities referenced in this case study are pseudonyms for the actual health system and associated hospitals.

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