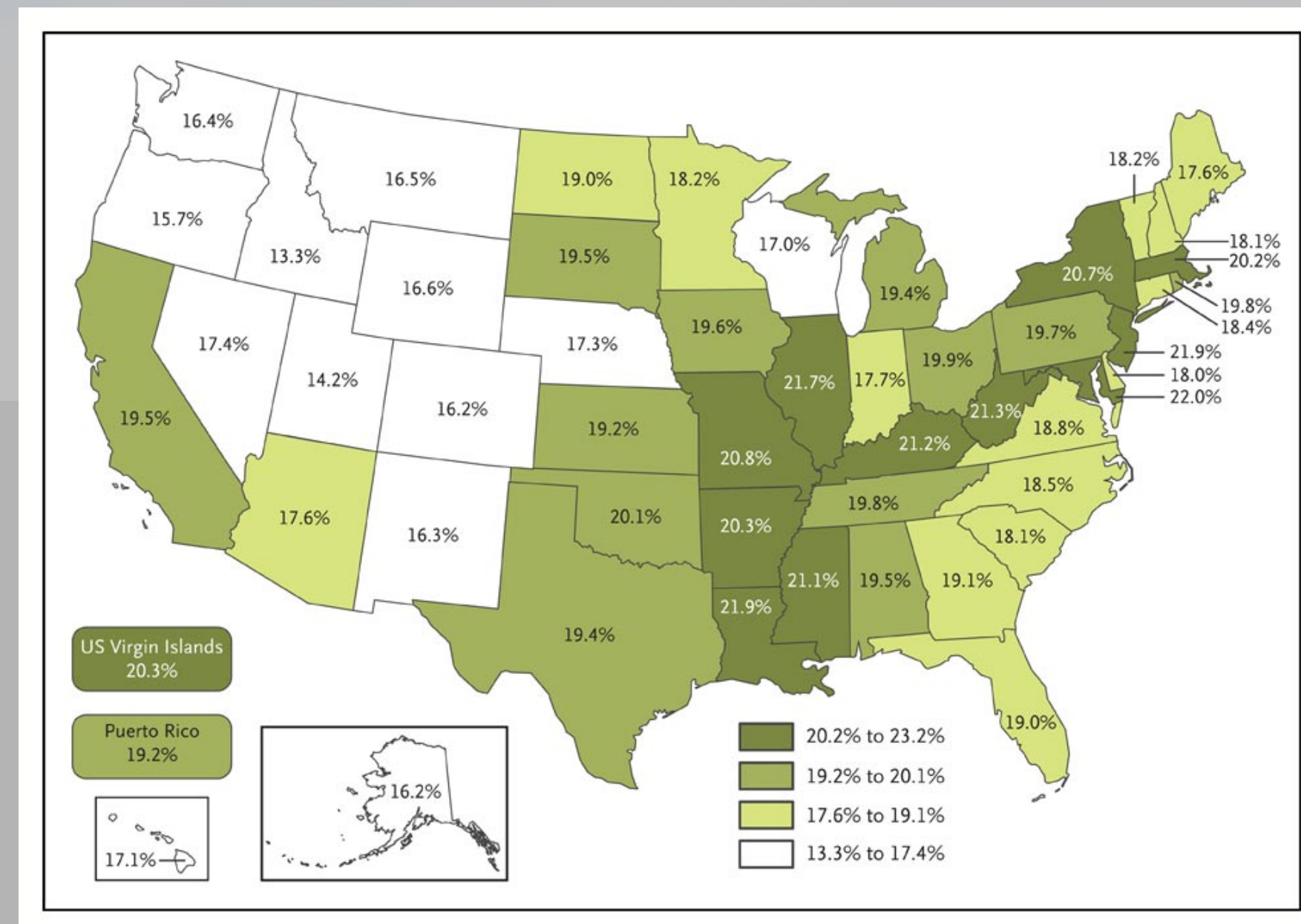


BACKGROUND

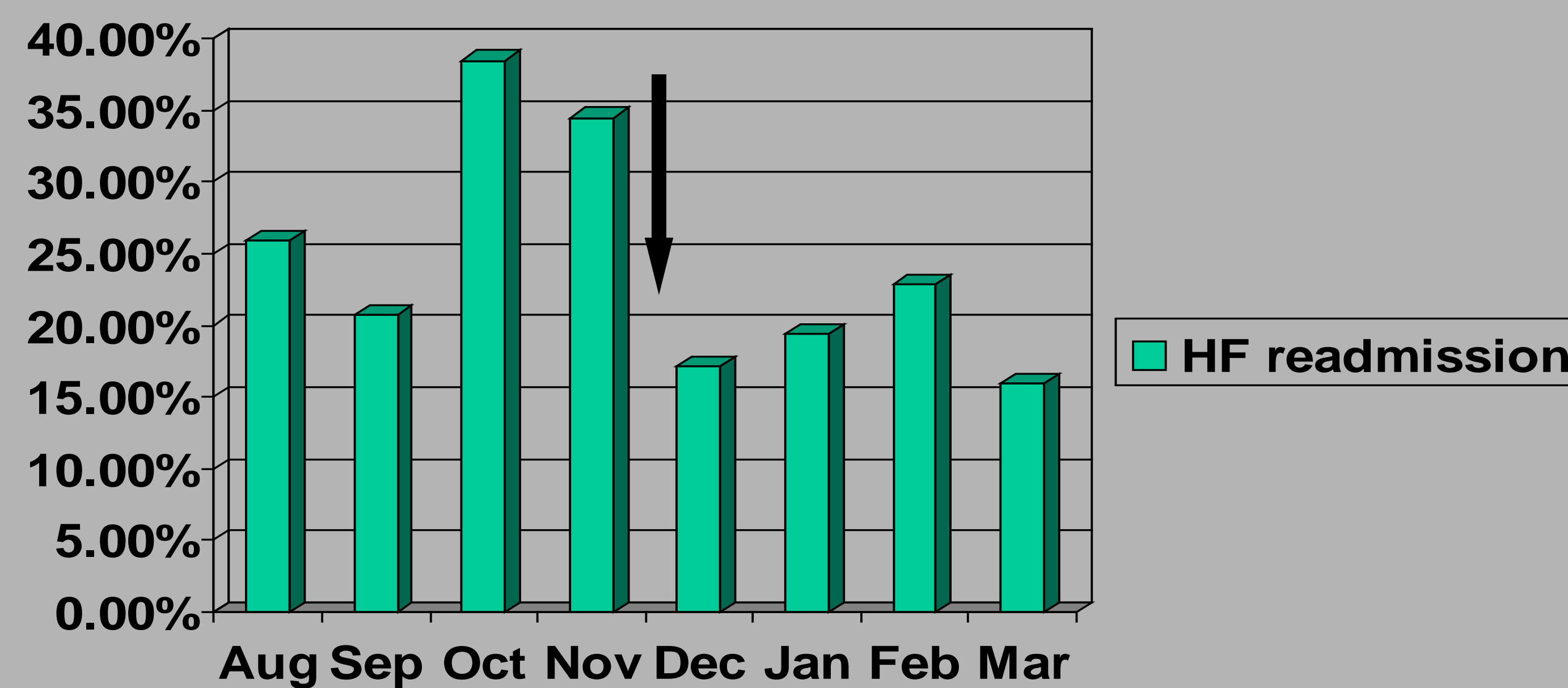
- **CQI AIM : To reduce CHF readmissions at our community teaching hospital (Sinai Grace Hospital).**
- Congestive heart failure (CHF) is the most common indication for hospitalization in adults aged >65 years in the United States (1).
- In 2016, more than 2,610 hospitals across the USA will face Centers for Medicare and Medicaid Services penalties for high HF readmission rates within 30 days of discharge (2)
- HF accounts for \$38 billion of healthcare spending annually(3) and is primarily attributed to frequent hospital readmissions due to decompensation (4).



RESULTS

Pre-Intervention Data: Four months prior to intervention, the average rate for heart failure patients being readmitted within 30 days of discharge was 29.87%.

Condition at Index Discharge	30-Day RH Rate	Reason for Rehospitalization (RH) (Percent of all RH within 30 Day Discharge)				
		Proportion of all RH	Most frequent	2 nd most frequent	3 rd most frequent	4 th most frequent
All	21.0	77.6	HF (8.6)	Pneumonia(7.3)	Psychosis (4.3)	COPD (3.9)
Heart Failure (HF)	26.9	7.6	HF (37.1)	Pneumonia (5.1)	Renal Failure(3.9)	Nutrition-related
Pneumonia	20.1	6.3	Pneumonia (29.1)	COPD (6.1)	COPD (6.1)	Septicemia (3.6)
COPD	22.6	4.0	COPD (36.2)	HF (5.7)	HF (5.7)	Pulmonary Edema (1.6)
Psychosis	24.6	3.5	Psychosis (67.3)	Drug or alcohol misuse (4.3)	Drug or alcohol misuse (1.6)	Pneumonia (1.6)
GI problems	19.2	3.1	GI problems (21.1)	GI problems (3.3)	Pneumonia (4.3)	HF (4.2)



Intervention:

- The high risk HF patients who were readmitted were further examined with Transition Coaches, and any barriers they faced were identified.
- Post-discharge, a home visit was conducted within 48 hours by a nurse followed by weekly phone calls by resident physicians.
- 1st contact- In hospital with the hot spotting team- One resident, Transition nurse, attending, pharmacist, social worker.
- 2nd, contact- at home after 48hrs of discharge by transition coach
- 3rd, 4th, 5th and 6th contact- telephone call by resident at week 1, 2, 3 and 4 after discharge.

Post-Intervention Data:

➤ In this quality improvement initiative four months post-intervention the rate of re admissions was 18.86% (p < 0.043).

DISCUSSION

Goals: Telephone call (Week-1, 2, 3 and 4)

- ? - How are you Feeling?
- Discharge instructions
- Questions?
- Script filled?
- Patient compliant w/meds?
- Meds Reconciled?
- Pt knows weight gain allowed?
- Pt knows food to avoid?
- Pt knows symptoms to report?
- Pt knows who to call?
- Pt has an appointment with PCP
- Pt has plan to get there?
- Support available in home?
- Pt can manage at home?

Strengths:

- ✓ Cost- effective
- ✓ Patient friendly/ uncomplicated

Limitations:

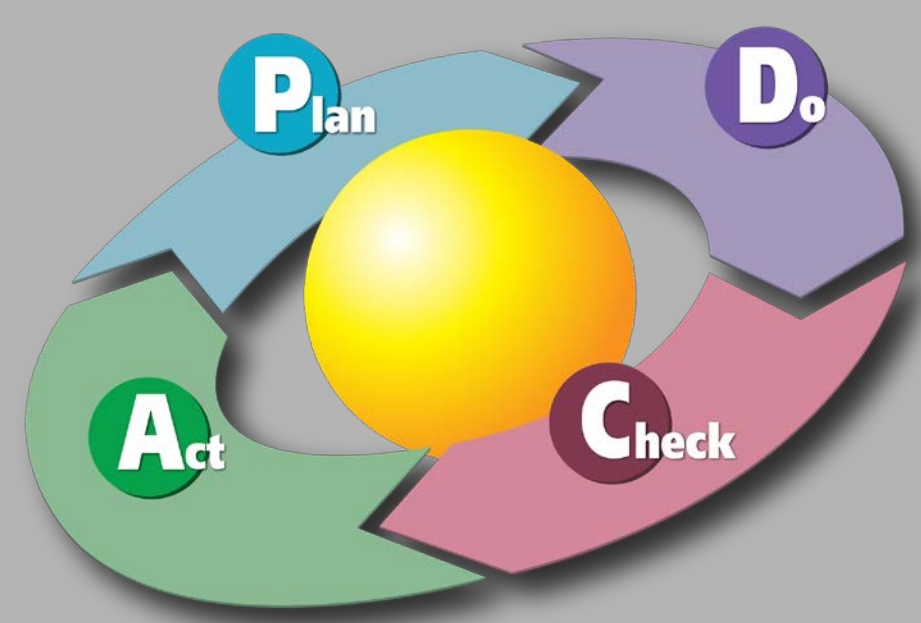
- ✓ Reducing the number of patients who are lost to follow up.

Future goals for improvement

- ✓ Expanding program to include post-acute care facilities and include other diagnoses of interest (pneumonia, AMI and COPD)
- ✓ Partner with community physician and physician groups.
- ✓ Have a standardized process in place to send all discharges or electronic summaries directly to the patient's PCP.
- ✓ Assign staff to follow up on the patient after discharge and increase awareness by educating the nurses and nurse practitioners to ensure safe transition.

METHODS

- We utilized the Plan-Do-Check-Act cycle for quality improvement, resident physicians tracked patients enrolled in the RHS program.
- Statistical Package for Social Science (SPSS) Version 22 software was used for data analyses. In addition to standard descriptive statistics, the Mann-Whitney U Test was applied to continuous variables to ascertain significance. All p-values were two tailed.



Study Design and Patient Demographics Conducted at our community teaching hospital: Sinai-Grace.

- Prospective study.
- Sample Size: 13
- Age distribution: 66-90; Avg age=74
- Co-morbidities: CAD, HTN, COPD, CKD, Depression.
- Loss to follow up: 1
- Most common Primary insurance provider: Medicare.
- Patient education: HF manuals and videos by RN/ transition coach.
- Loss to follow up: 1

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