Background
The historical rate of 30 day readmissions at AAMC for heart failure was 29%. Therefore, a new initiative to address heart failure readmissions was introduced. The program included the collaboration of a heart failure navigator nurse, a transition nurse from Anne Arundel County Department of Aging, and a local skilled nursing facility. The objective of this presentation is to summarize the interventions on the Heart and Vascular Unit (HVU) to reduce the 30 day readmission rate of heart failure patients between September 2011 and June 2012.

Success Story
A female patient who was readmitted every 15 days for heart failure received many of these interventions. After several visits with her, it was revealed that she could not read. As this program developed, we were able to provide the guidance to teach her to take a more active role in maintaining her health. Through the partnership with the Anne Arundel County Department of Aging, the hospital staff, and her caregivers, we scheduled her doctor’s appointments and ensured transportation. As a result of phone follow-up and home visits, she began managing her medications with a pill box and weighing daily. She called her physician several times to inform him that she gained over 3 pounds, thus allowing the physician to take action without the patient going to the emergency room. The patient stated “I now feel comfortable enough knowing that I don’t have to go to the hospital every time something happens.”

Interventions

Navigator Nurse
• Assessment of high risk patients
• Identify financial/living status, compliance, dietary habits
• Provided bathroom scales and pill boxes
• Awareness of symptoms of disease and when to call a physician (Symptom Signals)
• Make follow-up physician appointments prior to discharge
• Follow-up phone calls via Ask AAMC within 24hrs
• Referred patients for CHF camp at a Skilled Nursing Facility

Bedside Nurse
• Daily interdisciplinary rounds on HVU to discuss patient needs
• Review heart failure education

Transition Nurse
• Home Visits
• Medication reconciliation
• Identify transportation needs
• Reinforcement of education

Comparison Data

<table>
<thead>
<tr>
<th>MONTH</th>
<th>PATIENTS</th>
<th>READMISSION RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 2011</td>
<td>21</td>
<td>32%</td>
</tr>
<tr>
<td>October 2011</td>
<td>37</td>
<td>22%</td>
</tr>
<tr>
<td>November 2011</td>
<td>25</td>
<td>17%</td>
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<td>December 2011</td>
<td>23</td>
<td>14%</td>
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<tr>
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<td>March 2012</td>
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<td>April 2012</td>
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<td>May 2012</td>
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<tr>
<td>June 2012</td>
<td>24</td>
<td>13%</td>
</tr>
<tr>
<td>Anne Arundel (Current Average)</td>
<td>23%</td>
<td></td>
</tr>
</tbody>
</table>

*Maryland Average 26%
*National Average 24%

Lessons Learned

“Unfortunately, few interventions reduce heart failure readmission rates”. Although, “hospitals with the highest rates of early follow-up after discharge had decreased rates of readmission within 30 days”.

-Journal of Hospital Medicine May/June 2012

References


