

Creating a Cardiac Care Continuum

By Geri Aston

To improve quality and cut readmissions, hospitals step up efforts to keep heart failure patients out of danger long after discharge

Spending a half-hour on the phone going over recipes in Russian with a newly released heart failure patient's wife isn't in the typical job description for a recovery room nurse. But that's just what Izabella Gioiosa, a Forest Hills (N.Y.) Hospital nurse, recently found herself doing as part of the facility's new heart failure patient follow-up program.

"That was a big deal for this wife, who now could adjust the meals she was giving to her husband and potentially keep him out of the hospital," says Rita Mercieca, the facility's chief nurse.



Forest Hills launched its program, which aims to keep heart failure patients from bouncing back into the hospital, as part of a larger effort by its parent organization, North Shore-Long Island Jewish Health System. The system asked member hospitals to conduct call-backs, but left implementation decisions up to individual institutions.

At Forest Hills, the recovery room nurse manager took it on as her project. She and her two nurses typically make the calls during their morning down time before patients come out of surgery or when surgeries are moved or canceled. During the calls, which last between 10 and 20 minutes, the nurses go over the patient's diet, medications and weight, and answer any questions. The nurses make the calls within the first two days of patient discharge, and they average about 40 a week.

The follow-up calls, which began in August 2009, generated quick results. The 30-day heart failure patient readmission rate fell from 32 percent to 14 percent in December 2009, where it remains.

The nurses take great pride in the program. "They really feel terrible when someone gets readmitted," Mercieca says. "They've put their hearts into it."

The new health reform law could spur more hospitals to develop programs like Forest Hill's effort. Beginning in October 2012, most types of hospitals will face Medicare payment penalties if they have higher-than-expected readmission rates for heart failure, as well as pneumonia and heart attack.

In addition, the law creates a hospital value-based purchasing initiative that includes heart failure measures. Bonuses for meeting the performance standards will be funded by inpatient DRG payment withholds of 1 percent in fiscal year 2013 that gradually rise to 2 percent in 2017 and beyond.

The reform law's provisions, combined with the Centers for Medicare & Medicaid Service's decision to post 30-day readmission rates on the Hospital Compare website, have made heart failure rehospitalization "a big deal," says Edward Winslow, M.D., associate vice president at Sg2, a health information company.

In-and-Out Strategy

Hospitals looking to improve their rates for financial and quality improvement reasons should look at patient care both in the hospital and after discharge, Winslow and others insist.

The first steps on the inpatient side are to determine what the heart failure readmission rate is and then develop standard treatment protocols and order sets that work for the bulk of patients, Winslow says.

Because a number of guideline sets are available, it's important to work with the nursing and medical staffs to forge agreement on the best option.

For physician buy-in, it's also necessary to allow doctors to deviate from the guidelines for the minority of patients for whom the standard of care isn't working, Winslow adds.

At St. Luke's Episcopal Hospital in Houston, which began its formalized program in 1998, heart failure patients are treated primarily in two units, both with specially trained nurses. The standardized inpatient order set runs the gamut of testing, medications and other treatment, and monitoring, says Valarie Arkadie, nurse manager of the heart failure inpatient unit and the outpatient heart failure clinic. The hospital also has an order set for the emergency department so the staff can quickly begin IV diuretic drugs. The expected length-of-stay is five days or less.

Standard education materials for hospitalized patients also can help reduce readmissions, Winslow says.

At Forest Hills and other North Shore-LIJ facilities, heart failure patients get a pamphlet explaining a system of green, yellow and red zones they can use to evaluate their condition after discharge, Mercieca says. Green is good, yellow means the patient is developing symptoms and needs to call his or her doctor, and red means the patient needs to go to the ED. Nurses start explaining the zones to patients upon admission.

The biggest potential for a gap in care is during the handoff of the patient from the hospital to home or another care setting. "Patients can be labeled as non-compliant when they really didn't understand what they were supposed to be doing [after discharge]," Winslow says.

St. Luke's addresses that problem not only with standardized patient education, but also with discharge planning by unit-specific case managers and social workers, Arkadie says. Patients don't leave the hospital without knowing when their follow-up physician visit is. In addition, the unit nurses call to check on patients within 72 hours of discharge.

Two of the most important indications to check post-discharge are patient weight and medications. Weight gain is an indication that the patient is retaining fluids and could be headed toward kidney failure.

Inpatient heart failure treatment can include a change in patients' medications. However, notes Mercieca, "When patients go home, often they just go back to whatever is in their medicine cabinet and start taking whatever meds they were on before." That's why follow-up phone calls must include a discussion of medications.

Mercieca gives the example of one follow-up call in which a patient told the nurse that he was taking Digoxin, a medication that slows the heart rate. When the nurse checked the medications the patient was taking in the hospital, Digoxin was not on the list.

A call to the patient's physician determined that it was prescribed in error. "The patient could have had some very adverse outcomes had that phone call not been made," Mercieca says.

Keeping Patients Out of the Hospital

Efforts to prevent readmissions may have to reach beyond the hospital because some heart failure patients require home care or are discharged to a skilled nursing facility. "You may have to work with [the

other providers] to help them understand and treat these patients better or you may have to penalize them by not sending them patients," Winslow says.

At Forest Hills, Mercieca is working with a nursing home affiliate to put the hospital's post-discharge patient monitoring and patient education programs in place. The program will then be rolled out to other nursing home affiliates.

St. Luke's has coordinated with independent home health agencies to ensure the home health staff calls the St. Luke's team when a patient falls outside his or her weight or blood pressure parameters, says Bambi Henson, a nurse practitioner with the hospital's outpatient heart failure clinic.

St. Luke's also offers regular disease management through its heart failure clinic, which has between 400 and 450 active patients. "Our goal is to improve the patients' quality of life," Henson says. "We try to keep patients out of the hospital the best we can." The clinic works to improve patients' health through medical management, and exercise and nutrition counseling.

Education, including symptom recognition, is part of the program. "Information is power, so we really try to equip patients with the tools to be able to self-monitor and know when to call into their team," says Linda Lemus, a registered nurse at the clinic.

Clinic patients are typically seen once a month. If a patient is hospitalized, the nurses see him or her within a week of discharge and then check in over the phone at least once a week until the condition is stable. Those calls are in addition to the post-discharge follow-up handled by the unit nurses.

The clinic maintains an open line of communication with the Texas Heart Institute at St. Luke's Episcopal Hospital, which provides the heart and cardiovascular care at St. Luke's and which has a strong research component. The nurse coordinators for physicians specializing in heart failure treatment at the institute keep the clinic staff apprised of any new trials that might benefit clinic patients, Lemus says.

The hospital's efforts to stem heart failure rehospitalization has resulted in an average 30-day readmission rate of 12 percent, says Elizabeth Melinder, director of St. Luke's cardiovascular service line. By comparison, nearly 27 percent of all Medicare beneficiaries with a diagnosis of heart failure at discharge are readmitted within 30 days, according to an article in the April 2, 2009, *New England Journal of Medicine*, which was based on Medicare claims data from 2003 and 2004. Patients' heart failure was the most common reason for readmission (37 percent of rehospitalizations), followed by pneumonia (5 percent).

Although heart failure programs are making strides in reducing readmission rates, they aren't generally profitable. "Heart failure is not one of those aspects of our services line that we rely on to drive our profitability," says St. Luke's Melinder, noting that Medicare is not generous with reimbursement.

Typically, the financial goal is to not lose money on heart failure patients either on inpatient DRGs or on post-discharge care. The trick, Winslow says, is to balance efforts to reduce lengths of stay with initiatives to prevent readmissions. This balancing act will be particularly important once the Medicare payment penalties for rehospitalizations kick in.

"If you have very short lengths of stay but you don't do everything right to make sure the patient understands and you don't have follow-up, you'll make money on one admission, but lose it on the readmission," he warns.

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