Case Study: **Standardization and Collaborative Initiatives Lead to Reduction in CHF Readmission Rates**

Challenge: High Congestive Heart Failure Readmission Rates

This 350-bed hospital with annual ED volume of over 37,000 was identified as having the highest 30-day readmit rate for Chronic Heart Failure (CHF) of any SCP Health (SCP) client, with a 23.5% rate. Hospital executives were also routinely balancing a common mix of issues: medical staff engagement, Medicare compliance, service line deployment, market share, and cost management.

Key reasons for patient readmissions included missed appointments due to lack of transportation, medication changes, or the need for hospice care. The client was in need of better post-acute care options, and although the hospital had robust resources they were underutilized and the ED was not engaged.

The facility had also experienced:

- Steadily increasing readmission rates
- Readmission penalties
- Frequent ED bouncebacks
- ED throughput challenges

Approach:

The team conducted a thorough operational analysis with a review of more than 300 EM and HM cases of CHF at the facility. They set the following measurable goals to increase quality outcomes:

- Collaborate between EM/HM through a **Joint Operations Committee**
- Cost-effective care
- Avoid penalties
- Decrease practice variation

Our team collaboratively worked with the administration at the facility to implement the following initiatives to achieve those goals:

- Agree on objectives
- Assemble the team
- Chart a pathway
- Engage patients in their healthcare pathway
- Create multi-disciplinary collaboration
- Create and implement a CHF Toolkit
- Use the ED to initiate solutions
- Communicate and collaborate
- Course-correct
- Continue the process

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Solution:

The plan resulted in four strategic hospital initiatives, which included:

1. Pre-ED Care: Addressing transportation issues, dialysis coordination, missed PCP appointments, medication refills, and chronic CHF management.
2. ED Care: CHF order sets added to EMR, patient education checklists, automatic post discharge appointments scheduled.
3. HM Care: Consistent use of core measure checklist, EM/HM Playbook, JOC with standing agenda and team members, sourcing under utilized hospital resources such as dietary, pharmacy, rehab and palliative care.
4. Post Care: Summaries to PCP, follow up, telemedicine initiative, and transition clinic.

The team realized that when EM and HM work together as part of a Joint Operations Committee (JOC), there are better connections, better outcomes, and lower costs. These initiatives also procured the use of cardiopulmonary rehab scales with telehealth capabilities and pharmacy Lasix sliding scales, in addition to patient education and coaching, with case management's early intervention and planning. Within the first quarter of implementation, readmission rates were reduced from 23.5% to 14.7%, a total of 8.3% below benchmark.

Summary

Standardization of processess addressed cost-effective treatment, patient and provider engagement, post-acute care, and cost effective utilization. In doing so, the hospital addressed financial challenges, governmental mandates, patient safety and quality, patient satisfaction, access to care and population health (congestive heart failure patients).