Quality Improvement Initiative
Heart Failure Readmissions
Agency Summit on Care Transitions for Heart Failure Patients and Readmission
March 30, 2010

Issue:

- Heart failure (HF) is a major and growing public health problem, affecting over 5.3 million people with approximately 660,000 new cases diagnosed each year in the United States.

- HF is the underlying cause for 12 to 15 million office visits and 6.5 million hospital days each year.

- In Maine, there are over 3 thousand hospitalizations annually due to heart failure, at an annual cost of over $24 million.

- HF has the highest rate of readmissions of any condition and is the most frequent reason for re-admissions and

- HF is the most frequent cause of readmission for patients after any medical or surgical hospitalization.

- Nationally, the 30-day readmission rate for HF patients is 24.5%. In Maine, the rate range is 21.2 – 27.2%.

- All-cause readmissions cost Medicare $15 – 18.3 billion annually.

- Federal Administration and Med PAC have recommended reducing payments to hospitals with high readmission rates.

Publically Reported Data:

Heart failure readmissions are monitored quarterly and posted on CMS' Hospital Compare website.

MQF tracks and reports:

- Care Transition Measures
    - 3-question patient survey evaluates patient perception of pre-discharge preparedness after discharge
    - Strongly associated with post-discharge ED and hospital use
    - On average, 65% of Maine patients felt "well prepared" for discharge (with large variations)
- CMS indicator "HF – 1"
    - Discharge instructions to patients which include 6 elements:
        - Medications
        - Diet
        - Activity

        - Follow-up
        - Weight monitoring
        - Management of worsening symptoms
    - Maine average 88% (little variation); national top 10% = 98%
- There is no correlation between performance on these measures and readmission rates for Maine hospitals.

Prevention Strategies:

Hold a day long summit highlighting strategies to reduce the rate of HF readmissions in the State of Maine.

Review performance of Maine hospitals on Care Transition Measures and HF-1 indicators.

Explore strategies used by high-performing hospitals on HF care.

Keynote speaker and the discharge planning model Boston Medical Center has developed endorsed by NQF.

There were 250 attendees from all Maine acute care hospitals as well as many long term care facilities and home health agencies.

Re measurement after the Summit:

The impact of the conference will be measured in a reduction of the rate of readmissions of heart failure patients within one year