

Heart Failure Policy Proposal

As part of the hospital's quality assurance program Mercy Medical Center of Shakopee, Minnesota has previously completed a review and analysis of their performance dashboard data including review of benchmark comparisons. Mercy Medical Center's leadership team recognizes the hospital's heart failure readmission rate of 40% is above the national benchmark of 37%. The failure to meet benchmark standards is a significant concern for the hospital leadership team in two ways. First off, the high rate of heart failure readmissions within 30 days is a concern related to the quality of care heart failure patients are receiving because the patient outcomes are not as successful as the leadership team would like. Secondly is the negative financial impact on the hospital caused by the high rate of heart failure readmission rates within 30 days of hospitalization. This negative financial impact is due to the Hospital Readmission Reduction Program (HRRP) established by the Affordable Care Act (ACA) in 2012. HRRP requires The Centers for Medicare & Medicaid (CMS) to make payment reductions to hospitals with excessive 30-day readmission rates for patients with the primary diagnosis of heart failure (Readmissions-Reduction-program, 2018). The leadership team is ultimately charged with the responsibility to provide quality care to the population it serves which has led the leadership team to request an evidence-based policy proposal to address this gap in service and reduce heart failure readmission rates.

Heart Failure Data

One might ask why heart failure readmission rates are so closely monitored by CMS? Why is the quality of care and patient outcomes related to heart failure so important to the population's health and well-being? Significant to the entire population is data supplied by Framingham identifies a one in five lifetime risk of developing heart failure with one in fifteen

individuals between the ages of 65 to 74 years developing heart failure (Lemay & Azad, 2014). Heart failure is also one of the most common reasons for hospital admissions and readmissions in patients 65 years of age and older (Causes of Heart Failure, 2017). Wan, Terry, Cobb, McKee, Tregerman, & Barbaro (2017) also state that heart failure is one of the leading causes of hospital admissions and health care costs in the United States with nearly 5.1 million Americans diagnosed with heart failure. Sadly, approximately one-half of those individuals diagnosed with heart failure die within the first 5 years after diagnosis (Wan, Terry, Cobb, McKee, Tregerman, & Barbaro, 2017) and a one-year mortality rate of 33% to 35% (Lemay & Azad, 2014). According to Mohammadzadeh (2015), in 2010 there was approximately \$39.2 billion spent on heart failure related care and treatment in the United States.

Evidence-Based Strategies

Review of the statistics related to heart failure indicates the importance in providing quality care and outcomes to patients with heart failure. This quality of care and outcomes includes reducing hospital readmission rates through evidence-based strategies and interventions both in the hospital and post hospital discharge. According to Lemay & Azad (2014), approximately half of heart failure readmissions are associated with co-morbidities, poly pharmacy, and heart failure associated disabilities. More specifically poor adherence with medications and lack of lifestyle changes are high on the list of causes leading to hospitalizations and readmissions. Multiple studies have concluded evidence-based intervention strategies which are focused on the human factors specific to the patient such as assessment and education, exercise, and dietary changes significantly reduce the rate of readmission in heart failure patients. One study found that heart failure patients were 1.4 to 6.8 times less likely to be

readmitted to the hospital when single or combined human factor interventions were put into place (Wan, Terry, Cobb, McKee, Tregerman, & Barbaro, 2017).

Summary of Policy

The policy changes recommended to the leadership team of Mercy Medical Center is one which requires the implementation of an interdisciplinary team who will be assigned to each patient admitted to the hospital with a primary diagnosis of heart failure. The interdisciplinary team will be made up of a RN, a dietician, and a Physical Therapist who will work with the patient's primary care physician as needed. This interdisciplinary team will work one on one with the patient during the period of hospitalization and will follow the patient post discharge for a period of six weeks. The chosen time of six weeks was determined based on the estimated time it will take to assess the patient, educate the patient, and for the patient to begin forming new habits and self-management strategies under a guiding hand. The interdisciplinary group would focus on the root cause of the admission such as poor medication adherence or dietary choices while working with the patient to provide continuing education on medications, lifestyle changes, dietary changes, and appropriate exercise programs. Providing each patient with an individualized approach will allow the patient to build trust in the team, learn self-management strategies, and will provide each patient with culturally appropriate care. Overall all this policy will improve the quality of care given to heart failure patients, improve patient outcomes, reduce readmission rates, and allow the hospital to meet HRRP and CMS requirements. Please note there is a detailed copy of the policy attached.

Analysis of Environmental Factors

Environmental factors will need to be addressed for education settings; as well as, addressing potential environmental factors which could affect the success of intervention

strategies. As with the strategic interventions, environmental factors associated with the effectiveness of strategic interventions in the care of heart failure patients will be specific to each patient. Each patient's environment needs to be assessed and recommendations for needed changes made when possible. These recommendations will also need to include the physical and financial means to make the needed changes. Environmental factors will include things such as location and transportation to follow-up appointments; a safe home environment free of fall risks; a safe location for exercise programs and related transportation issues; a clean and safe area for food storage, cooking, and eating; and a plan for how and where to purchase foods including the use of food pantries or ministries to assist financially. These are just a few of the possible environmental factors which have the potential to affect the success of strategic interventions. Every patient will have their own factors which will become known through assessment of the home and conversations with the patient and of course families as applicable.

The diagnosis of heart failure is common and scary for the population; the diagnosis also comes with a high cost and high morbidity rate. Patients are easily overwhelmed by the information associated with heart failure including general education, treatment options, follow-up appointments, new medications, dietary changes needed, and recommended changes in lifestyle. Patients who are overwhelmed and who do not properly understand this information are at a higher risk of non-compliance, increased emergency room visits, and increased rate of admissions and readmissions to the hospital. The best way for Mercy Medical Center to improve the quality of care given to heart failure patients is through the implementation of the recommended policy for interdisciplinary teams to provide individualized education and planning during the patient's hospitalization and for 6 weeks post discharge.

References

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