CASE STUDY

Collaborative care leads to a reduction in HF readmissions

Monongahela Valley Hospital

Amedisys Home Health Care | Havencrest | Residence at the Hilltop

Overview

Problem

Reduce the rate of heart failure readmissions.

Solution

Form a collaborative with:

- MVH case management team
- MVH dietician and pharmacist
- Havencrest skilled nursing facility
- Residence at the Hilltop personal care home
- Amedisys Home Health Care

Key Interventions

- Care Transitions
- Point of Care
- Mercury Doc
- RN Visits within 24 hours of Start of Care
- Primary Care Appointment
- Medication Management
- Telemonitoring
- Transfer Process
- HF Standing Protocols
- Quarterly Review of Patients Readmitted within 30 Days

Result

HF readmissions reduced by 13 percentage points, from 27% in 2010 to 14% in 2011.

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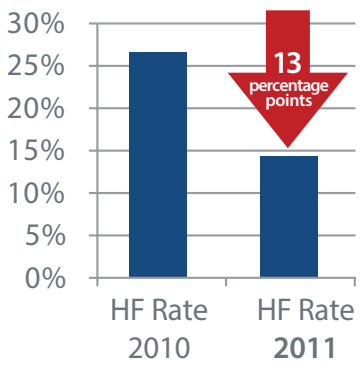
Monongahela Valley Hospital (MVH) is a 226-bed, full-service health care facility with a 220-member medical staff representing more than 40 medical specialties. With the enactment of the Affordable Care Act in 2010 and a heightened focus on reducing avoidable readmissions, MVH was prudent in preparing to tackle its heart failure readmission rate, which in 2010 was 27% – nearly 3% higher than the national average.

In September 2010, it formed a collaborative focused on improving care and reducing readmissions for MVH heart failure patients. The collaborative included the hospitals case management team, an MVH dietician and pharmacist, the Havencrest skilled nursing facility, the Residence at the Hilltop personal care home and Amedisys Home Health care.

Integrating with post-acute care providers was mission critical. MVH realized that in order to ensure patients were following their care plan, connecting with their primary care physician, reconciling their medications and sticking to their diet, a care team needed to follow the patients home with skilled clinical care.

As a result, the MVH collaborative was able to reduce its readmissions from 27% in 2010 to 14% in 2011.



5 Key Lessons Learned

1. Medication reconciliation between cross-settings is mission critical
2. Majority of HF patients require post-hospital intervention in the home
3. Sharing a transfer summary across settings greatly improves communication
4. Pre-determined standing protocols across the continuum make an impact
5. It takes a community working together to reduce 30-day readmits

"Because of the open dialogue, constant communication and shared vision for the program we had with our post-acute care partners, our hospital has been able to tackle our heart failure challenge and succeed. Post-acute care is mission-critical to us and we look forward to expanding this focus to our COPD patients."

– Merijo Rohrer, RN, CHF Case Manager Monongahela Valley Hospital