Academic Center for Evidence-Based Practice

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**Multidisciplinary Intervention Reduces 30 Day Heart Failure Readmissions**
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**Problem:** Allen Hospital, primarily serving elderly community dwellers and a Dominican working population had higher hospital readmission rates compared to other New York Presbyterian (NYP) sites. For unclear reasons.

**Evidence:** After attending evidence based practice workshop at New York Academy of Medicine, an interdisciplinary team representing emergency and family medicine, hospitalist, cardiology, administration, nursing and e-resources appraised available evidence through literature searches, practice and staff surveys, and chart reviews. 75% of readmissions occurred within 14 days of discharge. Literature review showed the need for complex multifaceted intervention.

**Strategy:** Our multifaceted protocol spanned ED, admission and post-discharge periods. A heart failure nurse coordinator (HFNC) was hired. Information Technology contributed a daily work list of HF patients. Strategies included early education, daily clinical follow up and phone call assessments post discharge. Patients were given a bilingual education booklet and scales for post discharge weight monitoring.

**Practice Change:** A heart failure protocol was implemented in late 2010 and included daily weight, nutrition counseling, early patient/family education, and scheduling of a follow up appointment prior to discharge. Involvement of HFNC and monthly team meetings sustained the multidisciplinary approach.

**Evaluation:** Primary outcome was 30 day readmission rates. Secondary outcomes were protocol adherence and Core Measures improvement.

**Results:** 30 day readmission decreased from 28.4% (2010) to 19.2% (2011) (RRR = 0.32; 95% CI 0.08, 0.51). Elsewhere, NYP readmissions decreased by 11% (RRR = 0.11; 95% CI -0.03, 0.20). HFNC connected to >97% of patients during hospital stay and reached over 95% by post discharge phone calls. Readmission rates were higher for patients not seen during high volume periods. Core measures improved from variable to uniform adherence.

**Recommendations:** Ongoing efforts emphasize continued profiling of readmitted patients including social situation, consideration of end of life care and complex medication reconciliation issues.

**Lessons Learned:** Linking a quality improvement initiative to evidence based training of a multidisciplinary team resulted in dramatic improvement of readmission rates.

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Bibliography:
