Beth Israel Lahey Health
Beth Israel Deaconess Medical Center

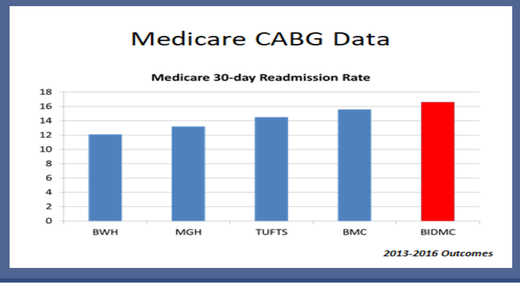
Decreasing Readmissions in Cardiac Surgery

TAP TO GO BACK TO KIOSK MENU

Marjorie Serrano MS, RN

Introduction/Problem

Readmissions are expensive and often avoidable patient care outcomes. Annual Medicare costs related to potentially preventable readmissions are estimated at $17 billion. In 2017, CMS began assessing a penalty for excessive readmissions for CABG/Medicare patients. The cost of this penalty for BIDMC in 2018 was almost $900,000. Between 2013 and 2016, BIDMC was an outlier, with a readmission rate of 16.6%, compared to a national rate of 13.8%. We had a higher rate of readmissions than the rates of our academic medical center neighbors.



Aim/Goal

The goal of the project is to decrease the readmission rate of CABG/Medicare patients at BIDMC. CMS updates the data each July, with the current lookback period from 7/1/2014-6/30/2017. We began the project in October, 2016.

The Team

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The Interventions

- Real-time analysis of readmissions and data at our monthly meeting
- Clinical
  - Prevent symptomatic volume overload/depletion after discharge
    - Standardize diuresis medications while inpatient
    - Extend length of stay for volume management
    - Standardize time of weight measurement and documentation of weights on Farr 8
    - Cardiology consult for heart failure patients while on Farr 8
    - Two week post-discharge cardiology follow-up for heart failure patients
  - Prevent symptomatic atrial fibrillation (AF) after discharge
    - Literature search for pharmacological prophylaxis
    - Standardize management of inpatient and ED management of patients with AF
    - Evaluate risk factors for AF
  - Prevent readmissions due to anticoagulation issues
    - Closer telephonic monitoring after discharge
    - Review best practices
  - Prevent readmissions due to surgical site infections
    - Develop criteria for use of Prevena dressing
    - Work with infection control to assess current practices and implement updated regimens and practices
- Follow-up
  - Create preferred provider network of skilled nursing facilities (SNFs) and visiting nurse associations (VNAs)
  - New position for office-based nurse to provide closer follow-up for discharged patients
  - Utilize CDAC for management of patients with volume and rhythm issues, instead of inpatient admissions
  - PACT program
  - Care Transitions program
  - Encourage discharge home instead of SNF for patients who live alone
- Other interventions
  - Preoperative risk assessment for targeted interventions
  - Investigate best practices at other medical centers and Advisory Board recommendations

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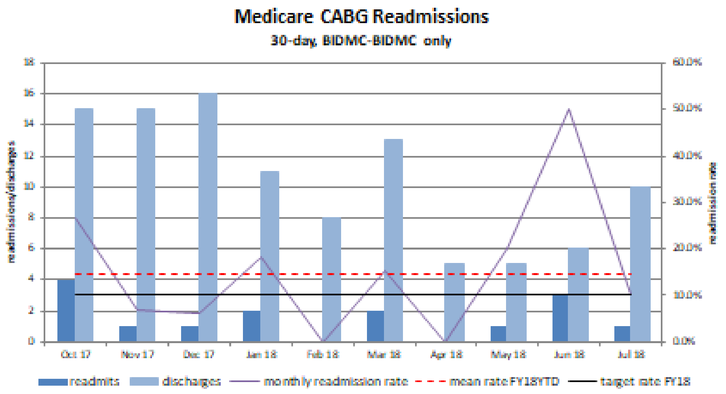
Results/Progress to Date

Medicare CABG Readmissions
(FY18 thru July discharges)



Performance gap = 5 "excess" readmissions over 10 months

The actual number of readmissions is small. The rate varies, depending upon the volume of CABG/Medicare cases (the denominator) for the month. A rise in surgical site infections had a large effect on the readmission rate. Through July, 2018, we have not reached our target rate.

CABG Medicare
BIDMC-BIDMC Readmissions*

Fiscal Year	Readmissions	Discharges	Readmission %
2016	14	114	12.3%
2017	15	116	12.9%
2018	17	125	13.6%
2019 YTD (thru Feb 19)	9	66	13.6%

*Discharged from BIDMC after CABG, non-elective readmission to BIDMC within 30 days

These rates include readmissions only to BIDMC. CMS includes all cause readmissions to any hospital.

Lessons Learned

- Lack of real-time data from CMS makes it difficult to assess interventions. Small changes in the numbers of readmissions have a large effect on the rate. Because of the 3 year rolling look-back, it takes a long time for the CMS metric to reflect improvement.
- The interventions cover many of the reasons for readmissions, making the scope of this project enormous.
- We have developed relationships with our SNF preferred providers. We now have improved follow-up of our patients who go to these facilities.

Next Steps

- Continue all current interventions and evaluate their effectiveness.
- Expand preferred provider network to VNAs.
- Give preferred provider pamphlet to targeted patients preoperatively.
- Direct postoperative patients who need SNF placement to preferred providers.

For more information, contact:

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