

## **PRAIRIE HEART HAS SUCCESS WITH HOSPITAL TO HOME INITIATIVE**

*Transition clinics designed to improve patient outcomes and lower costs*

SPRINGFIELD – Prairie Heart Institute at St. John’s Hospital recently implemented a Hospital to Home (H2H) program in which all patients discharged with Congestive Heart Failure (CHF) or an Acute Myocardial Infarction (heart attack) are offered a follow-up visit with a registered nurse within one-to-two weeks after their hospitalization. The consultation with the nurse is in addition to follow-up appointments patients will have with their physician.

The goal of the Hospital to Home program is to provide cardiac patients with counseling, health education and social service referrals to ensure they are following the instructions they were given upon discharge and avoid re-hospitalization.

“Since we started the Hospital to Home program six months ago, we’ve been able to help over a hundred cardiac patients better understand such things as their dietary restrictions, medication management and what symptoms require a call to their physician,” says Claire Call, RN, manager, Heart Failure Support Clinic at St. John’s. “Because many patients find it difficult to retain all the information they receive during their hospital stay, these clinics give us the opportunity to review that information and identify issues that prevent them from being successful at home due to taking medications incorrectly or struggling with dietary or social concerns.”

Research has shown that the failure to follow discharge care plans can often result in a patient being readmitted to the hospital within 30 days. A recent study found that unplanned re-hospitalizations account for nearly 17 percent of Medicare funding for hospitals. Patients with CHF have higher 30 day readmission rates than patients who suffer from any other disease.

From January to March of this year, St. John’s 30 day readmission rate for CHF was 13.1%, compared to a 22% average for large teaching hospitals across the U.S. during the same three months. In July, 2009 St. John’s was identified as the only Illinois hospital to have CHF readmission rates that were better than the national average. That report showed St. John’s 30 day readmission rate for CHF at 21.2% compared to the national rate of 24.5%.

“The Hospital to Home program is an example of grassroots efforts to reform health care here at the local level by developing more effective protocols for our patients,” adds Call. “In the first few months that we’ve started the program, we’ve seen our readmission rates for CHF

decrease dramatically. While we're proud of our progress in lowering readmission rates, we're extremely pleased that these clinics are helping improve the lives of our patients.”

The concept for Hospital to Home clinics was initiated by the American College of Cardiology. St. John's clinics are held twice a week at Prairie Heart Institute and are staffed by cardiac rehab and heart failure nurse specialists. For more information about the clinics, please call 217-544 6464 x 67828