Improved Care Transitions for Heart Failure Patients Strive to Reduce Hospital Readmissions at HealthPartners

HealthPartners Medical Group, Minneapolis, Minnesota.

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Through the use of health information technology and hospital-based care managers, HealthPartners' discharged heart failure patients are successfully transitioned back home. Then the patient's primary care physician co-manages the patient with a cardiac specialist in the heart failure clinic, using the electronic medical record to facilitate communication and patient reminders.

Excerpted from:

From Commonwealth Fund's Case Study: Organized Health Care Delivery Systems
HealthPartners: Consumer-Focused Mission and Collaborative Approach Support Ambitious Performance Improvement Agenda
By Douglas McCarthy, Kimberly Mueller, and Ingrid Tillmann, Issues Research, Inc.
http://www.commonwealthfund.org/~/media/Files/Publications/Case%20Study/2009/Jun/1250_McCarthy_HealthPartners_case_study_61_for%20PF.pdf

"Improving care transitions. The HealthPartners Medical Group and Regions Hospital are working together to improve care transitions for patients with heart failure. For example, primary care physicians receive an electronic alert when one of their heart failure patients is admitted to Regions hospital. When the patient is discharged, the hospital's care managers notify the medical group's heart failure clinic and telephone the patient at home to ensure that he or she has a follow-up appointment and is taking the proper medications. The patient's primary care physician and a cardiac specialist in the heart failure clinic then co-manage the patient with a jointly agreed-upon follow-up schedule, using the EHR to facilitate communication and patient reminders.

"To promote improved care transitions across its network, HealthPartners health plan recently began reporting on hospital readmissions for heart failure patients for each of its cardiology care groups. As part of its performance incentive program for contracted providers in its network, the plan has set a goal of reducing readmissions within 30 and 90 days of an initial hospitalization to 5 percent and 15 percent of these patients, respectively, from current plan wide rates of 7.9 percent and 17.3 percent during 2005–2007. . . ."

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