H2H
HOSPITAL-TO-HOME

H2H "Signs and Symptoms" Challenge

Webinar #1
Thursday, June 21, 2012
11:00 am – 12:00 pm ET

Helping Cardiovascular Professionals
Learn. Advance. Heal.

Webinar Format

Topic	Presenter	Time
Welcome	Mary Anne Elma, MPH	10 min
H2H Challenges	Shilpa Patel	5 min
Signs and Symptoms Evidence	Akshay Desai, MD, MPH Kathy Grady, PhD, APN, FAAN	30 min
Success Metrics	Kathy Grady, PhD, APN, FAAN	5 min
Question-and-Answer	All	10 min

Helping Cardiovascular Professionals
Learn. Advance. Heal.

Welcome

Take Home Messages

- Understand the evidence
- Ask yourself if you/your facility are meeting the success metrics
- Help build the Challenge by asking and answering questions on the listserv

Helping Cardiovascular Professionals Learn. Advance. Heal.

3

H2H
HOSPITAL-TO-HOME

Goal

To reduce 30 day, all-cause, risk standardized readmission rates for patients discharged with cardiac conditions by 20% by Dec. 2012

Core Concept Areas

- Post-discharge medication management
- Follow-up within 1 week of discharge
- Patient recognition of signs and symptoms

Components Include:

- 6-month projects
- 1 topic focus
- 1 tool kit
- 3 webinars
- 1 survey

Community call-to-action to help build tools and strategies to reduce readmissions

Helping Cardiovascular Professionals Learn. Advance. Heal.

H2H Features

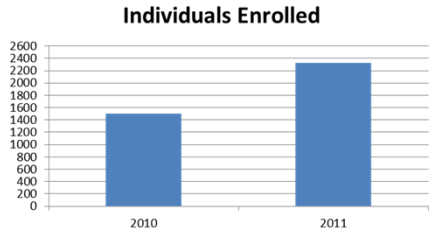
- Listserv – 20 messages per week
- Webinars – 5 webinars in 2011
- Tool Kits
  - Getting Started
  - See You in 7 (8+ tools)
  - Mind Your Meds (27+ tools)
- Improvement Projects
- Website

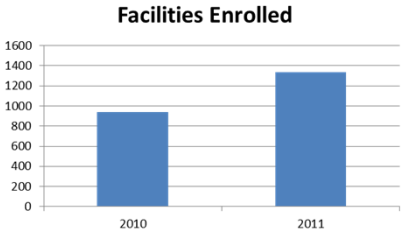
WEBINARS IN 2011

- 450 participants per webinar
- 85% believed good or excellent use of their time
- 90% felt information was valuable

Helping Cardiovascular Professionals Learn. Advance. Heal.

Awareness





Participation 2010 to 2011

- 55% increase in individuals (from 1500 in 2010 to 2323 in 2011)
- 42% increase in facilities (from 937 in 2010 to 1335 in 2011)

Participation as of June 1,2012

- 2704 Individuals
- 1513 Facilities

Helping Cardiovascular Professionals Learn. Advance. Heal.

New to H2H?

Register on the H2H Website

Enrolled in H2H and don't know how to get started?

Review the "Getting Ready Checklist"

Helping Cardiovascular Professionals Learn. Advance. Heal.

H2H Overview

- ❒ Understand the H2H Program Goals
  Attachment 1: H2H Brochure
  Attachment 2: H2H Overview Slides
- ❒ Know the evidence on the H2H three core concept areas for improvem
  Attachment 3a: Early Follow-Up Evidence Slides
  Attachment 3b: Post-Discharge Med Management Evidence Slides
  Attachment 3c: Symptom Management Evidence Slides

Understand the Business Case

- ❒ Know the business case and environmental context
  Attachment 4: Business Case Slide Deck
  Attachment 5: Key Hospital Readmission Provisions in Health Reform L
  Attachment 6: Inclusion-Exclusion Criteria for CMS Readmission Measu
- ❒ Know your current readmission rate
  Hospital Compare Website: http://www.hospitalcompare.hhs.gov

Build your Project

- ❒ Identify other H2H facilities in your state and connect with them
- ❒ Identify physician and nurse champion for your H2H QI effort
- ❒ State the business case to executive and clinical leadership in the hosp
  Attachment 7: Letter to Hospital Leadership
- ❒ Form interdisciplinary team to work on your H2H QI effort

What is a H2H Challenge?

A structured improvement project…

	See You in 7: Early Follow-up within 7 days	Mind Your Meds: Medication Management	Patient Signs and Symptoms
Webinar #1: Intro to Evidence	Mar 2011	Oct 2011	Jun 2012
Tool Kit	Jun 2011	Dec 2011	Sep 2012
Webinar #2: Tools and Strategies	Jun 2011	Dec 2011	Sep 2012
Webinar #3: Lessons Learned	Sep 2011	Apr 2012	Dec 2012

Helping Cardiovascular Professionals Learn. Advance. Heal.

8

Success Metrics and Tools

Reducing readmissions is possible if-

- The clinician does…
- The patient does…

To help the clinician and patient be successful, H2H provides *tools* for each metric.

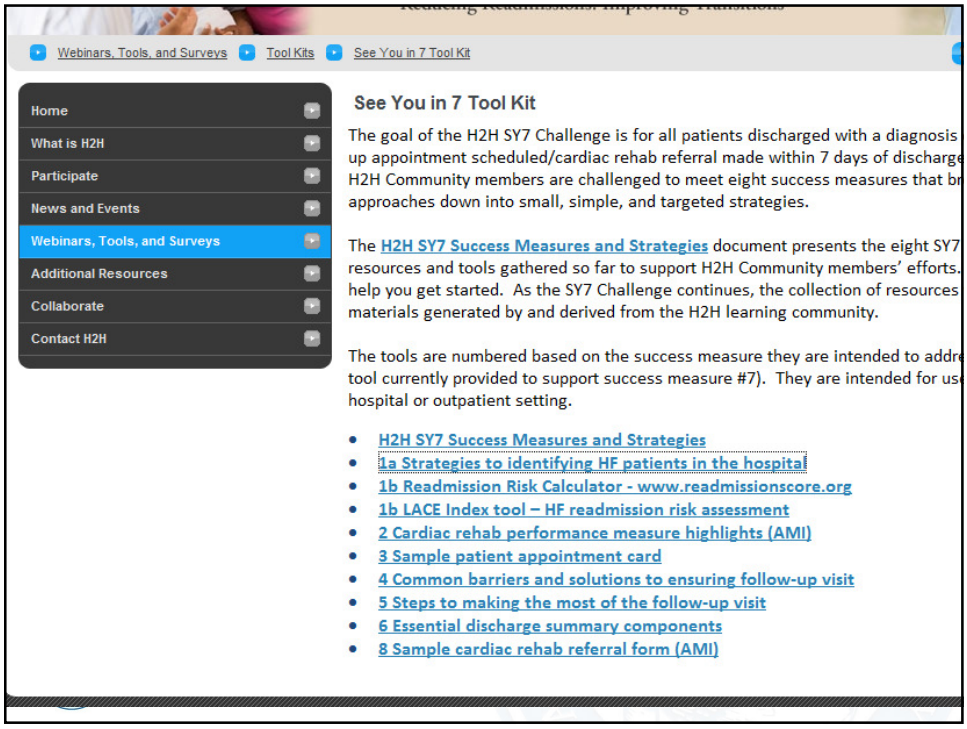
H2H Early Follow-Up Challenge: "See You in 7"

Goal:

All patients discharged with a diagnosis of HF or MI have a follow-up appointment/cardiac rehab referral scheduled within 7 days of discharge

Lessons Learned:

- Seven days is a "best practice" with most hospitals ranging from two days to two weeks
- Most hospitals used tools to identify HF and AMI patients in the hospital before discharge



H2H Post Discharge Medication Management: "Mind Your Meds"

Goal:

The goal of the "Mind Your Meds" Challenge is for clinicians and patients discharged with a diagnosis of HF/MI to work together and ensure optimal medication management.

Lessons Learned:

- Have a pharmacist dedicated to medication reconciliation and education
- Partnership between care team and patient and family team is essential

"Mind Your Meds" Tool Kit

The **H2H MM Tool Kit** consists of **11 success measures** and over **30 resources and tools** gathered together in one place. The tool kit was derived from the H2H learning community and external organizations. Each tool/strategy is linked to a particular success metric for process improvement.

#	Success Measures	Tool
	The clinician is successful if:	
1	The right meds are prescribed	▪ PINNACLE Heart Failure Practice Solutions ▪ Qualidigm Heart Failure Module 1
2	Med rec at admission and discharge	▪ American Society of Health System Pharmacists Med Rec Tool Kit ▪ National Transition of Care Coalition Med Rec Elements ▪ BOOST Med Rec Resources ▪ AHRQ Med Rec Tool Kit
3	Environmental barriers to getting meds addressed	▪ H2H Key Questions at Admission, a Stay, and Discharge ▪ H2H Common Barriers and Solutions to Med Management
4	Patient barriers to taking meds addressed	▪ H2H Key Questions at Admission, a Stay, and Discharge ▪ H2H Common Barriers and Solutions to Med Management ▪ Home Health QI Staff Education on Barriers and Roles ▪ Home Health QI Social Worker Med Management Checklist ▪ Home Health QI Med Management Care Planning Tool ▪ H2H Health Literacy Tools Chart
5	Patient has medication documentation	▪ CardioSmart Patient Resources ▪ Heart Failure Society of America Patient Medicines Module 1 ▪ AHRQ Improve Med Adherence and Accuracy ▪ Med Action Plan for Heart Failure

H2H
HOSPITAL-TO-HOME

H2H Challenge #3:

Signs and Symptoms

Goal:

The goal of the "Signs and Symptoms" Challenge is for clinicians to activate patients to recognize early warning signs and have a plan to address them.

"Signs and Symptoms"

Akshay Desai, MD, MPH

- Associate Physician in the Advanced Heart Disease Section of the Cardiovascular Division, Brigham and Women's Hospital and an Instructor of Medicine at Harvard Medical School
- Undergraduate education at Princeton University
- Awarded a Rhodes Scholarship for study at Oxford University,
- Dr. Desai currently divides his time between clinical care of patients with advanced heart disease and clinical research in cardiovascular clinical trials, with an emphasis on the pathophysiology and pharmacologic treatment of patients with heart failure.

"Signs and Symptoms"

Kathy Grady, PhD, APN, FAAN

- Administrative Director of the Center for Heart Failure within the Bluhm Cardiovascular Institute and Associate Professor of Surgery in the Feinberg School of Medicine at Northwestern University
- Dr. Grady received her Bachelor of Science in Nursing from Mercy College of Detroit, Master of Science from the University of California, San Francisco, and doctoral degree from Loyola University of Chicago.
- Dr. Grady has authored 70 scientific publications, 72 published abstracts, and 12 web-based articles or book chapters on heart failure, heart transplantation, and ventricular assist devices.

H2H
HOSPITAL-TO-HOME

The Importance of Patient Recognition of Signs and Symptoms for Reducing Readmissions

Reduce Risk and Cost

HF often requires frequent hospitalizations for symptom management.[5] Patient failure to recognize and respond to worsening symptoms before they reach an acute level is a common cause of preventable readmissions[15,16]

Self care for managing signs and symptoms helps to reduce:

- **Hospitalization:** Studies have shown that self-care activities can significantly reduce HF hospitalizations.[20]
- **Mortality:** HF patients who carry out self-care at an above average level are much less likely than patients who are below average in self-care ability to die or be admitted to the hospital.[20]
- **Cost:** HF patients who are confident in their ability to perform self-care have lower inpatient costs than patients who do not perform self-care or those with low confidence.[20]

Improve Patient Quality of Life

Successful management of heart failure requires patient behavior change through healthy choices.[23] Symptom management is key to managing heart failure and improving patient quality of life.

Most HF patients have poor symptom recognition.[16, 21] HF Patients need to have the ability to recognize symptoms in order to successfully manage their heart failure.[16] Patients who can recognize symptoms are able to participate in other self-care behaviors successfully.[16]

Signs and Symptoms of Heart Failure and Patient Recognition

Signs and Symptoms of Heart Failure

Symptom management should address the frequency and severity of symptoms, and the distress level of patients while experiencing these symptoms.[28]

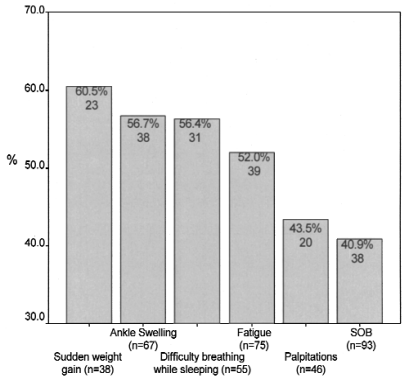
Common HF Symptoms can include:[28,1,23,25]

Dyspnea
Fatigue
Pain
Orthopnea
Edema
Loss of appetite
Anxiety
Depression
Sleep disruption
Changes is weight
Dizziness
Confusion
Increased swelling in hands or feet
Constipation
Nausea
Cough
Impotence
Muscle cramps
Weakness
Coldness
Palpitations
Gout
Effects on eye sight
Hot flashes
Unsteadiness
Decreased urination

Understanding Symptoms

- Heart failure patients often do not have adequate knowledge about the causes, symptoms, and effects of chronic heart failure.[6,20] Studies have shown that over 50% of HF patients did not know the cause of their symptoms.[5,16] Similarly, one-third of HF patients attributed their HF symptoms to unrelated conditions.[5]
- This may be because HF symptoms may be subtle at first and easily mistaken with normal signs of aging or drug side effects.[16] Because of their lack of knowledge about what causes symptoms, patients are unable to prevent intensification of symptoms. [6,20]

Patients reporting an inability to easily recognize their symptoms as evidence of heart failure [2]



Monitoring Symptoms

- HF patients often delay seeking care after HF symptoms begin.[20] They may wait days or weeks after symptoms appear to seek medical attention.[20,23] The cause of the delay may be due to patients not monitoring their symptoms or not being able to recognize their HF symptoms.[5,15,6] Patients report that they rarely monitor their symptoms.[3]

- In a study about heart failure patients seeking medical care based on symptoms, though 87% of HF patients believed their symptoms could be serious, 80% waited for the symptoms to disappear.[5] However, research shows that 50% of HF patients who delay seeking treatment for worsening symptoms did not realize that their health status was deteriorating.[15,16]

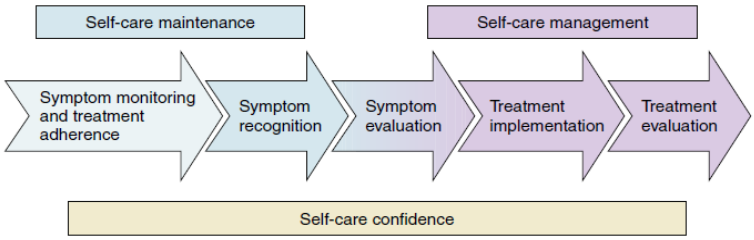
Patient Self-care

Defining Self-Care

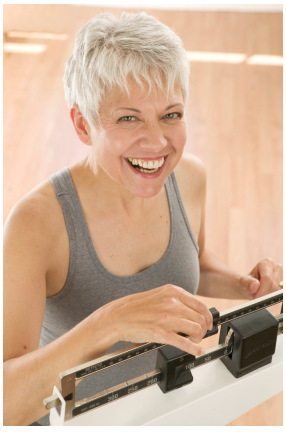
Self-care is the decision making process that patients use in the real world regarding behaviors such as monitoring and responding to symptoms, and adhering to treatment.[20,2] Self care includes the recognition of classic and atypical symptoms.[23]

Patients may find it difficult to engage in self-care due to the necessary behavior changes.[20] "Such changes may include altering diet, alcohol intake and smoking behaviors, and adapting everyday routines to accommodate regular exercise."[21]

SELF-CARE OF HEART FAILURE MODEL[20,2]



Self-Care Model of Heart Failure



- **Maintenance** entails symptom monitoring and treatment adherence. Patients who monitor themselves are more likely to seek treatment in a timely manner. [16]
- **Symptom recognition** entails recognizing when HF symptoms have changed. This will help patients better respond to serious issues more quickly. [16]
- **Symptom evaluation** describes the process a patient uses to distinguish between important and unimportant symptom changes. [16]
- **Treatment implementation** entails taking action in response to change in symptoms. Action may require guidance from healthcare providers. [16]
- **Treatment evaluation** will ensure that patients are receiving the most effective treatments.[16]

Recognizing Symptoms and Self-Care

Patients who are able to recognize early signs and symptoms are more likely to engage in self-care.[20]

Areas of self-care for HF patients include: [20,18]

- Dietary Adherence
- Fluid Restriction
- Alcohol Restriction
- Weight Loss
- Exercise
- Smoking Cessation
- Preventive Behaviors
- Nonprescriptive Medication

Foundation for Self-Care

- **Skill Development:** People may need to learn how to prepare healthy meals, or read food labels.[20]
- **Behavior change:** Motivational interviewing creates an increased confidence and understanding of HF in patients.[20]
- **Family support:** Social support is associated with increased medication adherence and reduced readmission rates. HF patients lacking social support more often have psychological distress, which contributes to poor self-care.[20,16]
- **Systems of care:** Disease management and care coordination can ease patient transitions into different care settings.[20]

Health Literacy and Patient Readiness

Health Literacy

Health literacy describes an individual's cognitive and social skills determining their motivation and ability to gain access to, understand, and use information for improving and maintaining health. Health literacy creates empowerment through increasing access to health information and a person's ability to use that information.[26]

In a study that measured the effects of a self-care program, including symptom management and self-monitoring for heart failure patients, found that patients who received a health literacy-raising intervention within the program had better outcomes than those who did not.[4]

Assess Patient Readiness

Patients need to feel ready and able to make healthy changes in order to adhere to their treatment. A healthcare professional should take the time to establish whether a patient is motivated to change their habits and accept a new form of therapy.

In a positive and patient tone:[17]

- Ask the patient about their understanding of their condition.
- Ask about their personal reasons and specific goals for wanting to recover or control their condition.
- Ask what you can do to help.
- If a patient is not ready to make change, it is best to educate them more on their condition and benefits of symptom management.
- If a patient is not sure if they are ready to change, remind them why change is important and educate them on the skills and tools to achieve behavior change.
- If a patient is ready to make changes to improve their health, help them to set goals, create a medication plan. Continue to motivate them and recognize their achievements during each visit.

Patient Activation

Education and Counseling can help to individualize a patient's barriers and provide the opportunity to address a patient's misperceptions about the management of their condition.[16,24] Education should include an assessment of a patient's knowledge, learning abilities, learning styles, cognitive level, and motivation.[18]

Education and Counseling for patient and family/ caregivers should include:[16]

- Normal symptoms vs. symptoms of worsening condition
- Self-monitoring
- What to do if symptoms increase
- Dietary recommendations
- Medications and possible side effects
- Management of activities and exercise
- Methods of decreasing risk, such as smoking cessation or weight control

Methods and Tools:[16]

The teach-back method has shown positive results in patient self-management. Visual aids such as medication schedules have shown improving patient understanding, reducing in medication errors, and improving health outcomes.

Symptom Management

General Symptom Management Tips

Few HF patients routinely monitor their symptoms and / or weigh themselves daily.[20]

Strategies for enabling patients to perform self-care activities for recognition of signs and symptoms include:[16,7]

- Teach skills in early symptom recognition and interpretation of symptoms when they occur
- Provide a list of signs and symptoms, including when it is necessary to contact the office or go to the ER
- Encourage patients to keep daily logs of symptoms, weight, and medications
- Teach methods for monitoring weight

Patients who are adept at early symptom recognition are more likely to initiate a treatment strategy[20]

Monitoring Weight

It is important for HF patients to weigh themselves and record their weight daily. [20,8] However, fewer than half of HF patients report doing so.[20]

Patients may not understand that monitoring weight is related to fluid gain and not "dieting".[20]

Increases in HF patient body weight are associated with hospitalization for heart failure.

- Weight gain generally begins at least 1 week before admission for serious symptoms.
- If patients monitor their weight daily they can identify this high-risk period early.[3]

Clinicians must educate patients on the importance of weighing themselves daily, how to do so, and what to do if they rapidly gain weight.

Clinicians can provide patients with a large, digital scale and encourage them to place it in an convenient location and weigh themselves at the same time every day.[16,7]

Self-care Activities and Symptom Monitoring and Management

Patient Medication Management

Medication management includes ensuring that self-administered medications are safely and accurately administered.[19]

Provide patients and caregivers with information about

- what medication to take,
- when and how much medication to take,
- purpose and adverse effects, and
- action to take when monitoring adverse effects.

Follow-up to monitor treatment related adverse effects.[19]

Immediate post-discharge medication management includes medication reconciliation (again), discussion of medication adherence and side effects, and ongoing medical monitoring/evaluation as necessary.[14]

Outpatient Medication Management includes:

- Medication reconciliation
- Medication adherence
- Optimal medication therapy
- Identifying barriers to medication adherence (e.g., Health literacy)

Diet

In a study about heart failure patient misconceptions, patients did not realize that restricting salt intake could help relieve HF symptoms.[6] As such, patients may need clinician assistance to learn behavioral skills, adherence strategies, and overcome barriers related to a change in diet.[16]

Patient dietary self-care behaviors:

- Follow basic healthy diet by eating fruits and vegetables, whole grains and protein.[25]
- Restrict sodium to less than 2 to 3 g daily.[8,16] Reading food labels, cooking at home, using spices, herbs and other seasonings can help to reduce sodium intake.[25]
- Reduce fluid intake as per clinician recommendations.[16, 6]
- Restrict or limit alcohol intake to no more than 1 drink per day, as per clinician.[16]

Clinicians should teach patients:

- Salt = sodium.
- About high and low sodium foods.[16,6]
- How to make low-sodium choices while eating out[6]
- How to follow a low-sodium diet, acknowledging cultural and religious influences.[16,6]
- Provide patients with a daily sodium tracker.[16,6]

Exercise

- Patients should be encouraged to be active. This includes activities that are related to daily living, work and leisure, exercise programs, and sexual activity.[16]
- Engaging in an exercise program has been shown to ease the rate of progression of HF.[8] In a study on the long-term effects of physical conditioning in patients with HF, exercise was associated with a reduction in the risk of hospitalization and death.[8]
- Exercise should be advised for all stable HF patients who are physically able. Exercise training can compliment drug therapy and a healthy diet.[8]

- Clinicians can provide guidelines for activity that are tailored to individual patient needs, abilities, and preferences.
- Clinicians can assist patients to identify strategies to overcome barriers and increase adherence to an exercise program.[16]
- A pedometer may increase motivation.[7]

Putting it Altogether

- Patients should be encouraged to keep a daily log and record symptoms, medications, and diet and activities.[25] Learning about heart failure zones and accompanying symptoms can prove helpful.[9]

It is important that patients know who to call if they experience new or worsening symptoms. They can keep a physician contact card in a convenient location so they know who to call when necessary.[25]

Medical Contact:_____

Telephone Number: _____

Pager/Afterhours: _____

Alternate Contact (If first contact is unavailable):

Contact: _____

Telephone Number: _____

Pager/Afterhours: _____

Barriers

Patient Barriers to Recognizing Signs and Symptoms

Potential barriers to symptom recognition include:[6]

- Lack of symptom monitoring
- Lack of understanding the importance of symptoms
- Belief that symptoms are not severe[6]
- Belief that symptoms are not related to heart failure
- Lack of self empowerment: Patients may not know that they are capable of managing their symptoms

Potential barriers to self care for HF patients include:[20]

- Co-morbid conditions
- Mental illness (e.g., depression and anxiety)
- Age (younger [vulnerable] and elderly [cognitive impairment])
- Sleep disturbances
- Poor health literacy
- Issues with healthcare system
- Lack of social support

Patient Barriers to Receiving Care

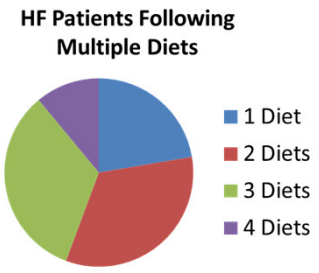
Common barriers to patients receiving care for signs and symptoms of HF include.[6, 20]

- Patients may not recognize worsening HF symptoms and delay seeking care.
- Patients who recognize worsening symptoms often do not know how to obtain medical care outside of the ER, and patients may want to avoid going to the ER.
- If patients try to contact their physician, they may wait hours to days for a response or weeks to get an appointment.
- Patients seeing multiple physicians may be unsure who to contact for a symptom.
- Patients may be too debilitated to go to their physician's office.
- Patients may be concerned about the cost.
- Patients may not follow-up with an appointment to see a HF specialist.

The Effect of Comorbidities on Self-Care

Comorbidities effect patient self-care:

- Patients with HF and comorbidities might be taking over a dozen pills per day and don't necessarily understand what they are taking and why.[20,23]
- It can be more difficult for a patient with comorbid conditions to adhere to a low sodium diet because of dietary restrictions for other conditions.
- Symptom monitoring is more difficult when symptoms may be caused by other conditions.[20]
- Patients might not understand how to manage their comorbidities or might not understand instructions on caring for all conditions. [20]



One-third of HF patients are attempting to adhere to 2 different diets, one-third are attempting to adhere to 3 different diets, and 11% are supposed to be following 4 different diets.[23]

Facilitators: The Importance of a Team Approach

Multidisciplinary Teams

A multidisciplinary team can ensure comprehensive care and support for HF patients and families.[10]

Team members who can assist patients with recognition of HF signs and symptoms[10]:

Physician

Nurse

Social worker

Occupational therapist

Pharmacist

The Roles of Physicians and Nurses

The role of the Physician :

Physicians can be a key source of support for HF patients. Many patients struggle with negative emotions and the complexity of their self-care regimen. ***Physicians have an important role in providing support to patients and increasing their motivation*** to engage in healthy behaviors.[21]

It is also important for physicians to ***encourage HF patient contact with nurses, social workers, counselors,*** and other care providers who can provide support to patients.[21]

The role of the Nurse:

Nurses play a key role in support and patient education.[1]

In a study of chronic cardiovascular disease, readmission rates were 4 times higher in patients who did not receive education from a nurse prior to hospital discharge and in follow-up.[1]

Developing a trusting relationship with a nurse facilitates HF patient self-care.[1]

The Roles of Social Workers, Occupational Therapists, and Pharmacists

The role of the Social Worker:[13]

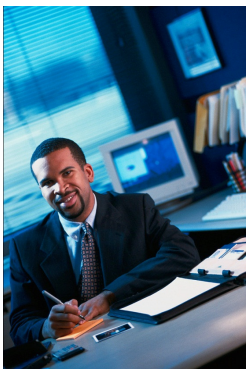
- Explaining health-care resources to HF patients and family/ caregivers.
- Helping plan for post-hospital patient needs.
- Helping patients and families receive needed follow-up care and other resources.

The role of the Occupational Therapist:[12]

- Customizing treatment programs so HF patients can carry out activities of daily living.
- Providing information on adaptation to daily life with heart failure.

The role of the Pharmacist:

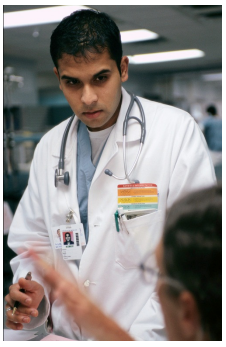
- Teach patients and families about medications, including OTC drugs and herbal remedies
- Perform medication knowledge and adherence assessments



Provider Interventions to Promote Self-care

Provider Communication

- Healthcare professionals can encourage self-care and address self-care barriers by ***helping patients to understand HF & HF symptoms, reviewing treatment plans (e.g., re medications and lifestyle), and establishing a positive relationship*** withpatients.[27]
- Providers should, "***communicate in an empathetic, non-judgemental, collaborative way*** and ask open-ended questions."[17]
- Studies have shown that improved communication between providers and patients result in a 16% reduction in mortality and a 31% decrease in HF related rehospitalizations.[19, 22]
- Providers should treat patients and family/ caregivers as partners when communicating about self-care.[19]
- Thus, it's all about "adherence" and not "compliance".



Ways Clinicians can Promote HF Self-care[20]

- Provide structured and individually reinforced education during all clinical encounters. Consider literacy level and cultural background
- Teach skills (e.g., how to monitor and evaluate symptoms when they occur) rather than simply providing information
- Screen routinely for barriers to self-care (e.g., inability to afford medicines) so that solutions can be developed before poor self-care is evident
- Simplify the medication regimen when possible. Use once daily medicines whenever possible. Assess for OTC medications and herbal remedies and drug interactions.
- Screen routinely for depression, anxiety, and cognitive impairment. Treat depression and anxiety immediately, without waiting for symptoms to wane on their own
- Include family in education and counseling activities
- Individualize treatment based on prognosis, quality of life, and patient values, goals, and preferences

A Comprehensive Intervention

A successful comprehensive intervention should include the following: [17,16,1,11,20]

- Identification of target patients who are at high risk for rehospitalization
- Multidisciplinary team approach
- Positive relationships with healthcare providers
- Ongoing reinforcement, motivation, and support at every step in the health care system
- Multidisciplinary education about symptom management, medications and lifestyle
- Ongoing assessment and intervention on factors that affect the patient's ability to engage in self-care
- Patient involvement in the decision-making process and determining treatment goals
- Social support, include family members and caregivers in education, monitoring symptoms, and patient self-care

"Signs and Symptoms" Success

The clinician is successful if:

1. **Clinician assesses the patient's** knowledge of condition, learning style, cognitive level, emotional status, support system, and motivation.
2. **Clinician assesses the patient's ability to perform self-care** (monitoring signs and symptoms, contacting clinicians if deterioration in signs and symptoms occur, and taking medications as prescribed, etc.) and **activities of daily living** (walking , cooking, performing light house work, etc.)and documents in the medical record.
3. Clinician provides the patient/caregiver **with written and verbal information on their condition** that includes education on treatment regimen (self-care plan), including warning signs and when to call their healthcare provider.
4. Clinician communicates in an empathetic, non-judgmental, collaborative manner that **establishes and maintains a positive relationship with the patient and caregiver.**
5. Clinician provides the patient/caregiver with **community resources** for health care.

"Signs and Symptoms" Success

The patient is successful if:

6. Patient/Caregiver demonstrates their knowledge **of condition-related signs and symptoms (i.e.,** frequency and severity of symptoms) **and management**.
7. Patient/Caregiver participates in **developing a self-care plan with their clinician** to better manage his/her condition. (Patient keeps a daily log and records symptoms, weight, medications, diet and activities when directed by their clinician).
8. Patient **identifies contact name and number** if he/she needs to contact his/her clinician (e.g., about signs and symptoms).
9. Patient/Caregiver **brings his/her daily log and medication list** to each and every clinic visit (when directed by their clinician).
10. Patient/Caregiver **discusses challenges** or questions about their condition with clinician.
11. Patient/Caregiver is knowledgeable about and uses **community resources** for health care, as needed**.**

How this will work

Timeline

Activity	Date
Webinar #1: Introduction	Thu Jun 21
Webinar #2: "Signs and Symptoms" Tool Kit	Sept*
Webinar #3: Lessons Learned	Dec*

* Exact dates to be determined.

Everything will be available online at http://www.h2hquality.org

Accept the H2H Challenge

Over the next 6 months:

1. Review the "getting ready checklist"
2. Post to the listserv
3. Use the success metrics as a guide
4. Test one or a combination of tools
5. Participate in the webinars

Moderated Question-and-Answer Session

Please submit your question online at this time.

References

1. Albert. (2008). Improving medication adherence in chronic cardiovascular disease. Critical Care Nurse, 28:54-64.
2. Carlson. 2001. Self care abilities of patients with heart failure. Heart and lung, 30(5): 351-359.
3. Chaudry et al. (2007). Patterns of weight change preceding hospitalization for heart failure. Circulation, 116: 1549-1554.
4. Evangelista et al. (2010). Health literacy and the patient with heart failure – Implications for patient care and research: A consensus statement of the heart failure society of america. Journal of Cardiac Failure, 16(1): 9-16.
5. Gravely-Witte et al (2010). Length of delay in seeking medical care by patients with heart failure symptoms and the role of symptom-related factors: a narrative review. Euro J of HF, 12:1122-1129.
6. Horowitz et al. (2004). A story of maladies, misconceptions, and mishaps: Effective management of heart failure. Social sciences and medicine, 58: 631-643.
7. Horowitz et al. (2011). Heart failure self-management. Up to Date.
8. Hunt et al. (2005). ACC/AHA Guideline update for the diagnosis and management of chronic heart failure in the adult. Circulation, 112: e154-e235.
9. IHI website. United Hospital/Allina Hospitals and Clinics Minneapolis, Minnesota, USA
10. Kripilani et al. (2007). Promoting effective transitions of care at hospital discharge: A review of key issues for hospitalists. Society of Hospital Medicine, 2(5): 314-323.
11. Kripilani et al (2008). Medication use among inner-city patients after hospital discharge: Patient-reported barriers and solutions.
12. Mayo Clin Proc, 83(5): 529-535.Mayo Clinic. Occupational Therapist Career Overview. http://www.mayo.edu/mshs/ot-career.html
13. Mayo Clinic. Social Work Career Overview. http://www.mayo.edu/mshs/msw-career.html
14. Medication Management. Nebraska Department of Health and Human Services. http://www.hhs.state.ne.us/med/medication.pdf

References

15. Moser et al (2010). Symptom variability, not severity, predicts rehospitalization and mortality in patients with heart failure. Euro J of Cardiovascular Nursing, 10:124-129.
16. Moser, D.K. and Riegel, B. Chapter 59: Disease Management in Heart Failure.
17. Oyekan et al (2009). The B-SMART appropriate medication-use process: A guide for clinicians to Help patients – Part 1: Barriers, solutions, and motivation. The Permanente Journal, 13(1): 62-69.
18. Paul. (2008). Hospital discharge education for patients with heart failure: What really works and what is the evidence. Critical Care Nurse, 28: 66-84.
19. Rich, D.S. (2004). New JCAHO medication management standards for 2004. Am J Health-Syst Pharm, 61: 1349-58.
20. Reigel. (2009). Promoting self-care in persons with heart failure scientific statement from the american heart association. Circulation, 120:1141-1163.
21. Riegel and Carlson. (2002). Facilitators and barriers to heart failure self-care. Patient Education and Counseling, 46: 287-295.
22. Roccaforte et al. (2005). Effectiveness of comprehensive disease management programmes in improving clinical outcomes in heart failure patients. A meta-analysis. The Euro J of HF, 7: 1133-1144.
23. Rogers et al. (2002). A qualitative study of chronic heart failure patients' understanding of their symptoms and drug therapy. European J Heart Failure, 4: 283-287.
24. Sarkar et al (2010). Patient-physcians' information exchange in outpatient cardiac care: Time for a heart to heart? Patient Education and Counseling, (epub ahead of print).
25. The Washington Home Center for Palliative Care Studies. (2002). Living with Advanced Congestive Heart Failure: A Guide for Family Caregivers.
26. World Health Organization (1998). Health Literacy. Retrieved from: http://www.who.int/hpr/NPH/docs/hp_glossary_en.pdf
27. Wu et al. (2008). Factors influencing medication adherence in patients with heart failure. Heart & Lung, 37(1): 8-16.
28. Zambroski et al. (2005). Impact of symptom prevalence and symptoms burden on quality of life in patients

Thank You

H2H
HOSPITAL-TO-HOME