



Welcome

Take Home Messages

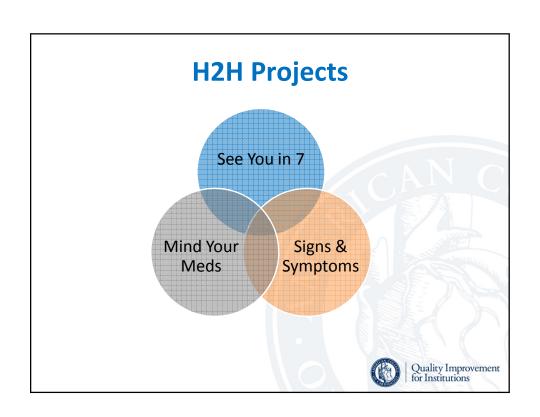
- Understand how to implement the "Signs and Symptoms" strategies and tools in your facility
- Learn lessons from other facilities
- Share your ideas, needs, and experiences through the listserv and website



Webinar Format

Topic	Presenter	Time
Welcome	Shilpa Patel Program Manager, American College of Cardiology	5 min
Success Metrics 2,4,7,8,9: Case Study #1	Jason W. Ryan, M.D., M.P.H Anne Elwell, MPH, RN Anne Niziolek MSN, RN Qualidigm and UConn Health Center	20 min
Success Metrics 5 & 11: Case Study #2	Samer Kazziha, MD, FACC Jacqueline Jones, MSN, ANP-BC Jill Callahan Klaver, RHIA Crittenton Hospital	20 min
Question-and-Answer	All	15 min





H2H Project Components

- 1 topic focus
- Success metrics
- Self-Assessment
- 1 tool kit
- 3 webinars

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



Qualidigm and UConn Health Center



Jason W. Ryan, M.D., M.P.H



Anne Elwell, MPH, RN



Anne Niziolek MSN, RN



"Signs and Symptoms" Case Study #1: Qualidigm and UConn Health Center

Success Metrics Addressed:

- Clinician assesses the patient's ability to perform self-care and activities of daily living and documents in the medical record.
- Clinician communicates in an empathetic, non-judgmental, collaborative manner that establishes and maintains a positive relationship with the patient and caregiver
- Patients/Caregivers participate in developing a self-care plan with their clinician to better manage their condition.
- Patients identify contact name and number if they need to contact their clinician
- Patients/Caregivers bring their daily log and medication list to each and every clinic visit



H2H: Signs and Symptoms Lessons Learned

December 10, 2014

Anne Elwell, RN, MPH
Vice President, Community Relations, Qualidigm

Jason Ryan, MD, MPH
Director, UCONN Heart Failure Center
UConn Health Center | John Dempsey Hospital

Anne Niziolek MSN,RN Nurse Manager, Inpatient Telemetry UConn Health Center | John Dempsey Hospital



What is Heart Talk?

- Educational video series
- Heart Talk
- Standardized for use in all care settings
- Goal: reduce preventable hospital readmissions for patients with heart failure

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A Story...CT's Communities of Care

Qualidigm/CHA Partnership

CHA Collaborative

- 25 hospitals
- Hospital-based PDSA approach

Qualidigm Communities of Care

- 13 hospitals, 67 NHs, 35 HHAs
- Interactive workshops, individual training and support



Communities of Care Members

Why Develop the Videos?

Common challenges identified at community meetings

- Educational chaos: everyone creating materials
- No standardization
- Patients had a poor understanding of heart failure and how to stay well



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Why Develop the Videos? (continued)

- Connecticut is a small state
- Patients make multiple stops along the continuum within the state
- Same message, different terms
- Health literacy concerns



How Were the Videos Developed?

- Funded by CMS
- Input from voluntary community providers from across the continuum
- Collaboration with educational and quality improvement consultants



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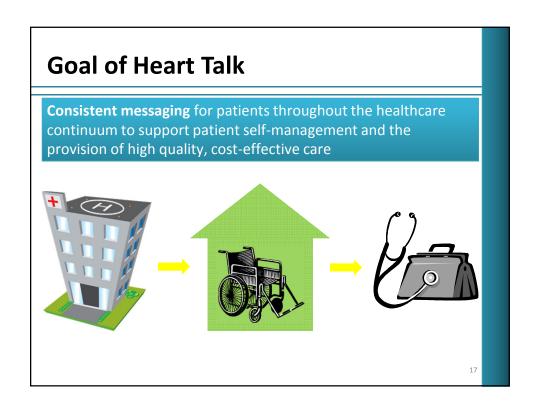
Heart Talk Team

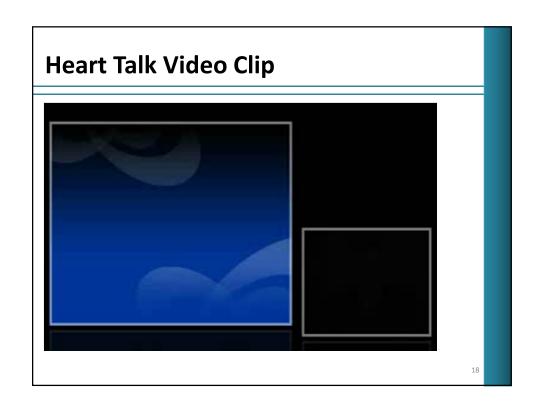
- Cardiologist
- Community volunteers
- QIO
- Academic institution



Process Reviewed what was already available Received input from larger team Met on a weekly basis Developed script and revised (revised, revise) Worked with academic institution for literacy and health literacy guidance







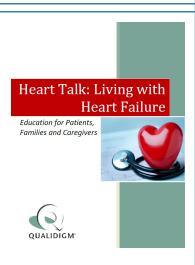
Patient Education Booklet

Designed for Providers

- Customizable cover
- Emergent care planning (i.e. zones)
- Weight Chart

Three Languages

• English, Spanish, Polish



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Patient Education Materials

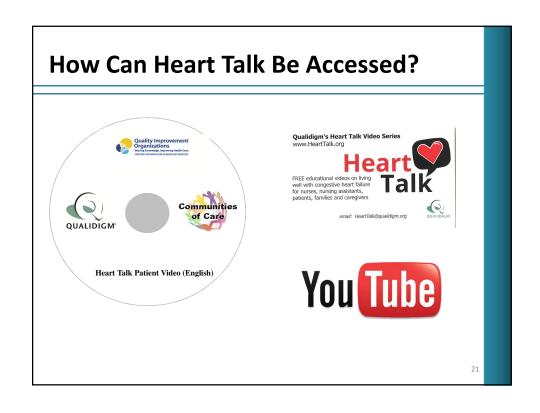
Are you in the Correct Heart Failure Zone? Use these Zones To Help Manage Your Heart Failure

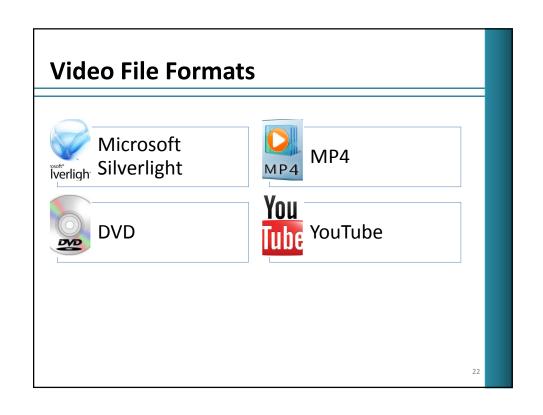


Daily Weight and Zone Chart

Use this chart or a calendar to keep track of your weight and see which zone you are in each day. Share this with your doctor at your appointments.

Sunday	Date:	Date:	Date:	Date:
	Weight:	Weight:	Weight:	Weight:
	Zone:	Zone:	Zone:	Zone:
Monday	Date:	Date:	Date:	Date:
	Weight:	Weight:	Weight:	Weight:
	Zone:	Zone:	Zone:	Zone:
Tuesday	Date:	Date:	Date:	Date:
	Weight:	Weight:	Weight:	Weight:
	Zone:	Zone:	Zone:	Zone:
Wednesday	Date:	Date:	Date:	Date:
	Weight:	Weight:	Weight:	Weight:
	Zone: 💹 🔛	Zone:	Zone:	Zone:
Thursday	Date:	Date:	Date:	Date:
	Weight:	Weight:	Weight:	Weight:
	Zone:	Zone:	Zone:	Zone:
Friday	Date:	Date:	Date:	Date:
	Weight:	Weight:	Weight:	Weight:
	Zone:	Zone:	Zone:	Zone:
Saturday	Date:	Date:	Date:	Date:
	Weight:	Weight:	Weight:	Weight:
	Zone:	Zone:	Zone:	Zone:





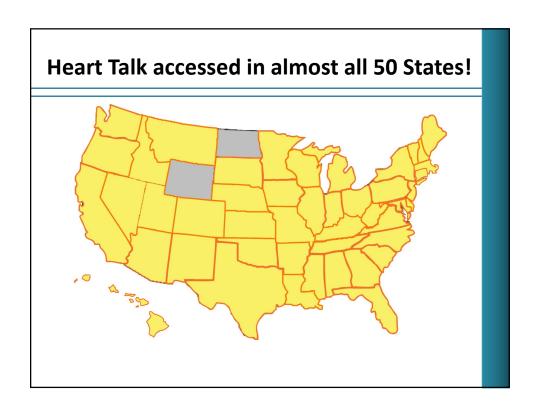
From January 2012 - December 2014

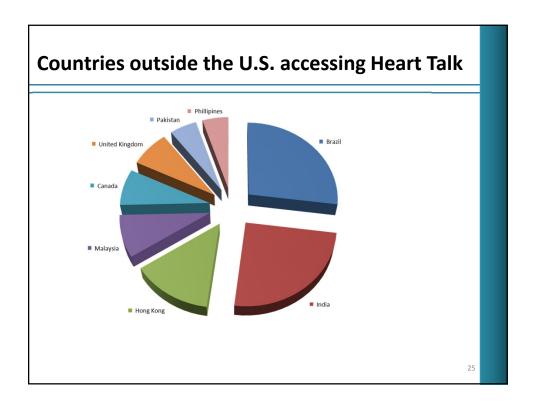
5,040 8,068

Total Views on YouTube Unique website visits to HeartTalk video download page

DVDs distributed by Qualidigm

*Several facilities have created and customized their own DVDs for distribution.





Uses of Heart Talk

- Streaming through facilities of CT's largest provider of healthcare and retirement living communities for seniors
- Used as competency testing for nurses and nursing assistants
- Post-test created by user



Heart Talk at UCONN Health

Professionals Video incorporated into mandatory on-line training modules for nursing staff in hospital and clinic settings

Non-licensed Video incorporated into mandatory on-line training modules for nursing assistants and medical assistants in the hospital and clinic settings

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Heart Talk at UCONN Health

Patient Video

- Added to hospital television system in every patient room
- Nurses ensure patients watch videos during their hospital stay
- HeartTalk videos burned onto DVD, sent home with patients at discharge
- Heart Failure Clinic staff also have ability to provide DVDs to patients during a clinic visit

Testimonials

"I just viewed your videos on CHF and thought they were the best I've seen in a long time."

"We've been searching the web for great educational tools, and we have discovered your site, which is, simply put, amazing! We are especially impressed with your "Heart Talk" booklet on CHF for patients and families."

Latest News – December 2014



Heart Talk incorporated into Hospital 2 Home (H2H) campaign



New! **LungTalk video series** launched July 2014



"Signs and Symptoms" Case Study #2: Crittenton Hospital

Success Metrics Addressed:

- Clinician provides the patient/caregiver with community resources for health care.
- Patients/Caregivers are knowledgeable about and use community resources for health care.



Addressing a Barrier to Prompt Follow-up Care: Transportation



Samer Kazziha, MD, FACC Jacqueline Jones, MSN, ANP-BC Jill Callahan Klaver, RHIA



Goal of "See You in 7" Collaborative: Identify and Address Barriers to Keeping Appointments

- Educated guess on transportation as a barrier
 - HF patient age
 - Suburban service area with limited public transport
- Surveyed Cardiologists and Internists (and practice managers) about barriers to prompt follow-up appointments, as reported by patients
- Access to transportation was #1

Get Better Here



Developing the Guide

- Consulted social work: known resources
 - Only 4 private van services (name and number)
- Started investigating
 - Internet
 - Phonebook
 - Area agencies on aging
- Compiled data on hours, service areas, prices
 - Wheelchair vans
 - Volunteer transportation providers
 - Medicaid beneficiary: free provider
 - Taxi services
 - Transport and accompany services
- Developed PDF

Get Better Here



Distributing the Guide

- Social Work to replace prior list
- · Heart Failure Nurse Practitioners
- Small printed supply to each Cardiology and Internal Medicine practice, with instructions on how to download/print more
- Put on hospital website (under "patient resources")

Get Better Here

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Use of the Guide

- Initial print budget only \$250 ran out quickly!
- Put PDF on hospital intranet (for staff) and website (for patients and public) – is printable from there
- Social workers use whenever transportation is a barrier
- Medical Staff Relations coordinator includes in packet left during physician practice visits (primary care)
- Community Health & Education coordinator
- Cancer Committee asked for presentation to oncologists; they were seeing same barrier to follow-up
- · Marketing now maintains/updates the file
- Inbound calls from new transportation services

Get Better Here™

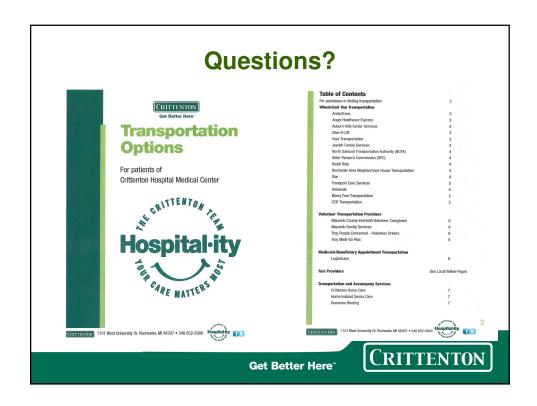


To See Full Version of Guide

- www.crittenton.com
- Click on "Patients & Visitors"
- · Click on "Patients"
- Click on "Helpful Forms and Checklists" tab
- Click on "download a list of transportation options"

Get Better Here

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What can you do next?

- 1. Activate your ACC Quality Improvement for Institutions account
- 2. Visit CVQuality.acc.org/H2H for more resources
- Share your experiences with the H2H Community



Activate with Quality Improvement for Institutions



Program Website: CVQuality.acc.org/H2H

- ACC program integrating registries, initiatives, and toolkits under one umbrella
- Website to access H2H Initiative resources
- Free for NCDR hospitals
- Non-NCDR hospital have a \$5K fee





Moderated Question-and-Answer Session

Please submit your question online at this time.



Thank you!



hospital2home@acc.org CVQuality.acc.org/H2H





The Quality Improvement for Institutions program combines the ACC's NCDR data registries with toolkits and proven hospital-based quality improvement initiatives like Hospital to Home, the D2B Alliance and Surviving MI.

Release the power of your data at CVQuality.acc.org.



