Welcome

Take Home Messages

• Understand the connection between the success metrics and the tool kit
• Share your ideas, needs, and experiences for meeting success measures on the listserv
• Refer to the Signs and Symptoms Assessment and Tool Kit to help get you started
## Webinar Format

<table>
<thead>
<tr>
<th>Topic</th>
<th>Presenter</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome</td>
<td>Shilpa Patel</td>
<td>5 min</td>
</tr>
<tr>
<td>H2H Overview</td>
<td>Shilpa Patel</td>
<td>5 mins</td>
</tr>
<tr>
<td>Signs and Symptoms Overview</td>
<td>Shilpa Patel</td>
<td>5 mins</td>
</tr>
<tr>
<td>Signs and Symptoms Evidence</td>
<td>Sandra Oliver-McNeil</td>
<td>15 min</td>
</tr>
<tr>
<td>Signs and Symptoms Toolkit</td>
<td>Joy Pollard</td>
<td>15 min</td>
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<tr>
<td>Question-and-Answer</td>
<td>All</td>
<td>15 min</td>
</tr>
</tbody>
</table>

## Speaker Bio

**Sandra Oliver-McNeil DNP, ACNP-BC, CHFN, AACC**

- Academic Heart and Vascular Cardiology Group, Beaumont Health System Royal Oak
- Assistant Professor (Clinical), Wayne State University
- CCA liaison MI chapter ACC
- Doctor of Nursing Practice and Masters of Nursing, Wayne State University
Speaker Bio

Joy A Pollard PhD ACNP-BC

- Cardiology acute care nurse practitioner, St Joseph Mercy - Oakland
- Immediate past CCA liaison MI chapter ACC
- Doctorate in Nursing at the University of Michigan,
- MSN and BSN degrees in Nursing from Wayne State University

H2H Challenge Projects

See You in 7 Challenge
Goal: All patients discharged with a diagnosis of HF and MI have a scheduled follow-up appointment/cardiac rehab referral made within 7 days of discharge

Mind Your Meds Challenge
Goal: Clinicians and patients discharged with a diagnosis of HF/MI work together and ensure optimal medication management.

Signs and Symptoms Challenge
Goal: Actively motivate patients to recognize early warning signs and have a plan to address them.
H2H Challenge Components

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

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

**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.
“See You in 7” Project

See You In 7
The goal of the H2H SY7 Challenge is for all patients discharged with a diagnosis of HF/AMI to have a follow-up appointment scheduled/cardiac rehab referral made within 7 days of hospital discharge.

Project Features

“See You In 7” Assessment
Includes benchmarking data and is designed to identify opportunities for improvement.

“See You In 7” Toolkit
Specific tools and strategies designed to address one general topic area for improvement.

“See You In 7” Success Metrics
Small, actionable actions designed to aid your efforts to improve transitions of care.

“See You In 7” Webinars
Listen to on-demand webinars that review evidence-based toolkits and lessons learned.

Toolkit

Webinars

Shared Stories
Self-Assessment Surveys

- Helps hospitals prioritize QI efforts
- Identifies tools for improvement
- Enables hospital to monitor progress quarterly
- Compares hospitals that have completed the assessment

Assessments Results Comparison Report

After receiving your Assessment Results, you can compare them to previous quarters or to other facilities.

Comparison results will be graphed; your score is compared to:
- Yourself, over time
- Your Facility (Aggregate of other users at your facility)
- All Facilities (Aggregate of other facilities that have taken assessment)
Getting Started with Signs and Symptoms

How you can participate:
1. Review the “Signs and Symptoms” success metrics
2. Complete the online Self-Assessment
3. Identify one or a more metrics for improvement
4. Test one or a combination of strategies/tools for those metrics
5. Agree to a standard collection of data to track your improvement
6. Participate in the webinars
7. Share your best practices and lessons learned through the listserv

Reduce Risk and Cost

Self care for managing signs and symptoms helps to reduce:

- **Hospitalization**: Studies have shown that self-care activities can significantly reduce HF hospitalizations.\(^2\)
- **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.\(^2\)
- **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.\(^2\)
Improve Patient Quality of Life

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

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

Monitoring Symptoms

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

- 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. However, research shows that 50% of HF patients who delay seeking treatment for worsening symptoms did not realize that their health status was deteriorating.
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 severe6
- 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.
Recognizing Symptoms and Self-Care

Patients who are able to recognize early signs and symptoms are more likely to engage in self-care.\textsuperscript{20}

Areas of self-care for HF patients include: \textsuperscript{20,18}

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

Multidisciplinary Teams

A multidisciplinary team can ensure comprehensive care and support for HF/AMI patients and families.\textsuperscript{10}

Team members who can assist patients with recognition of signs and symptoms\textsuperscript{10}:

- Physician
- Nurse
- Social worker
- Occupational therapist
- Pharmacist
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 with patients.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”.

Signs and Symptoms Success Metrics

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.
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 questions or about their condition with clinician.

11. Patient/Caregiver is knowledgeable about and uses community resources for health care, as needed.

Success Metrics and Tools

H2N "Signs and Symptoms" Tool Kit
Success Metrics and Strategies

The H2N "Signs and Symptoms" Challenge gathers the expertise and experience of H2N Community members and leaders around one topic proven to reduce unnecessary hospital readmissions and improve transitions of care for patients with H1N1 and A(H1N1). 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. To achieve this goal, H2N Community members are challenged to meet success metrics that breakdown improvement approaches down into small, simple, and targeted strategies.

How to use this document:
1. Select at least one success metric.
2. Identify barriers to being successful in that measure.
3. Select at least one strategy that addresses the barrier and helps you be successful.
4. Test the strategy you selected.

<table>
<thead>
<tr>
<th>#</th>
<th>Success Metric</th>
<th>Barrier to meet the success metric</th>
<th>Strategy to help meet the success metric</th>
</tr>
</thead>
</table>
| 1 | Clinician assesses the patient’s knowledge of condition, learning style, cognitive level, emotional status, support systems, and motivation. | Poor health literacy, role assignments often unclear, limited time | 1a. H2N Health Literacy Tools Chart (PDF)  
1b. Impact of Subjects of Birmingham Cultural Competency for Mental Practice (COMP) |
| 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 (bathing, cooking, performing light housework, etc.) and documents in the medical record. | Role assignment often unclear, limited time, lack of time to perform an assessment, contextual conditions, lack of social support input, lack of time to talk to the patient, etc. | 2a. PHRASER-HEART Patient Practice Solutions  
2c. Creating Evidence-Based Guidelines for Health Care Professional Training (ECP)  
2d. National Institute for Health Research Index for Independence in ADLs |
Success Metric 1

Clinician assesses the patient’s knowledge of condition, learning style, cognitive level, emotional status, support system, and motivation.

<table>
<thead>
<tr>
<th>Tool Name</th>
<th>Time to Administer</th>
<th>Pros</th>
<th>Cons</th>
<th>Scoring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duke-UNC Functional Social Support Questionnaire</td>
<td>Self-assessment</td>
<td>• Assess social support needs</td>
<td>• Social support needs are not addressed</td>
<td>Quality improvement in social support needs is assessed</td>
</tr>
</tbody>
</table>

| Success Metric and Tool |

Instruments to Assess Health Literacy

- Duke-UNC Functional Social Support Questionnaire
- Medication Knowledge Survey
- Modified Morisky Scale
- Newest Vital Sign
- Readiness Ruler
- Rapid Estimate of Adult Literacy in Medicine, Revised
- Short Assessment of Health Literacy for Spanish Speaking Adults
- Test of Functional Health Literacy in Adults (long and short versions)
**Success Metric and Tool**

**Success Metric 3 & 7**

- Clinician provides the patients/caregivers 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.

- Patients/Caregivers participate in developing a self-care plan with their clinician to better manage their condition. (Patients keep a daily log and record symptoms, weight, medications, diet and activities when directed by their clinician).

<table>
<thead>
<tr>
<th>Success Metric</th>
<th>Available Tools</th>
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<tbody>
<tr>
<td></td>
<td>Patient Tools:</td>
</tr>
<tr>
<td></td>
<td>• Established Patient-Provider Relationship</td>
</tr>
<tr>
<td></td>
<td>• Motivate patient to engage in self-care strategies</td>
</tr>
<tr>
<td></td>
<td>•槽出 the patient perspective and guide into self-care</td>
</tr>
<tr>
<td></td>
<td>• Develop treatment plan that takes into consideration patient's religious/cultural beliefs</td>
</tr>
<tr>
<td></td>
<td>• Use the teach-back method to ensure patient understanding of medications</td>
</tr>
<tr>
<td></td>
<td>CardioSmart Heart Explorer iPad App:</td>
</tr>
<tr>
<td></td>
<td>• Cardiac graphics and animations of the heart’s anatomy</td>
</tr>
<tr>
<td></td>
<td>• Interactively review and discuss common heart problems and treatment options with patients and their caregivers</td>
</tr>
<tr>
<td></td>
<td>CardioSmart Med Reminder, Powered by Drugs.com:</td>
</tr>
<tr>
<td></td>
<td>• Easy-to-use app helps patients take and refill medications as prescribed</td>
</tr>
<tr>
<td></td>
<td>• Also functions as personal medication record</td>
</tr>
<tr>
<td></td>
<td>• Patients can set reminders, save notes, access drug data and more</td>
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</table>

CardioSmart Heart Explorer iPad App:

- Cardiac graphics and animations of the heart’s anatomy
- Interactively review and discuss common heart problems and treatment options with patients and their caregivers

CardioSmart Med Reminder, Powered by Drugs.com:

- Easy-to-use app helps patients take and refill medications as prescribed
- Also functions as personal medication record
- Patients can set reminders, save notes, access drug data and more
Success Metric and Tool

Success Metric 4

Clinician communicates in an empathetic, non-judgmental, collaborative manner that establishes and maintains a positive relationship with the patient and caregiver.

Teach Back Checklist

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver Name:</td>
<td>Clinician:</td>
</tr>
</tbody>
</table>

The purpose of this checklist is to help the clinician work with the patient to ensure that the patient has a full understanding of how to properly manage their health. It allows the clinician to document the patient’s response and understanding of the information given to them.

How to use this tool:
1. Ask the patient a question.
3. Use teach back to ensure clarification and provide more information to the patient.
4. Have the patient repeat back to you what you have told them.
5. Document if the patient has full understanding.

- **Specific Teach-back Question**: What should you weigh yourself each morning after you go to the bathroom, just before you eat.
- **Teach-back Expectation**: You should weigh yourself each morning after you go to the bathroom, just before you eat.
- **Teach-back Script**: Ask patient to be more engaged during the discussion.
- **Teach-back Response**: Yes, patient should weigh themselves each morning after they go to the bathroom, just before they eat.

AHRQ Communication Tips

Qualidigm Teaching Patients Module

Kaiser’s Clinician-Patient Communication Module
Success Metric and Tool

Success Metric 10
Patients/Caregivers discuss challenges or questions about their condition with clinician

AHRQ Patient Health Priorities Tool

<table>
<thead>
<tr>
<th>My Health Priorities Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Driving to clinic or doctor</td>
</tr>
<tr>
<td>Cooking meals</td>
</tr>
<tr>
<td>Shopping for groceries</td>
</tr>
<tr>
<td>Taking medicines</td>
</tr>
<tr>
<td>Managing household chores</td>
</tr>
<tr>
<td>Keeping track of medications</td>
</tr>
<tr>
<td>Communicating with others</td>
</tr>
<tr>
<td>Finances</td>
</tr>
<tr>
<td>Home care</td>
</tr>
<tr>
<td>Recreation</td>
</tr>
</tbody>
</table>

Success Metric and Tool

Success Metric 5 & 11
- Clinician provides the patient/caregiver with community resources for health care.
- Patients/Caregivers are knowledgeable about and use community resources for health care, as needed.

How to Locate Elderly Patient Transportation Guide

Welcome to the Eldercare Locator, a public service of the Elderly Administration on Aging connecting you its services for older adults and their families.

Find Help in Your Community
You can start your search by selecting 14 codes for the city/area topic.

Search by Location: or
Search by Topic: or

1. Enter the geographic area, such as city, county, state, zip code.
2. Enter the keywords for transportation using the search terms.

Search Terms: DESCRIPTIONS
- Public Transportation
- Dial-a-Ride
- Community transportation
- Transportation for the Elderly
- Transportation for Seniors
- Transportation for Disabled
- Transportation for Other Needs

Stop & Enrich
1. Enter the geographic area, such as city, county, state.
2. Enter the keywords for transportation support services using the search terms.

Search Terms: DESCRIPTIONS
- Public Transportation
- Dial-a-Ride
- Community transportation
- Transportation for the Elderly
- Transportation for Seniors
- Transportation for Disabled
- Transportation for Other Needs
Getting Started

Participate in the Signs and Symptoms Challenge:
1. Complete the online Assessment
2. Try a suggested strategy or tool
3. Participate in the webinars
4. Share ideas or questions through the listserv
5. Tell us your strategies for improvement

What can you do next?

1. Activate your ACC Quality Improvement for Institutions account
2. Visit CVQuality.acc.org/H2H for more resources
3. Tune in for the next webinar in December 2014: “Lessons Learned”
Moderated Question-and-Answer Session

*Please submit your question online at this time.*

Thank you!

H2H

[HOSPITAL-TO-HOME](#)

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.