H2H Early Follow-up Challenge: “See You in 7”

Webinar #3- Lessons Learned
Thursday, September 1, 2011
3:00 pm – 4:00 pm ET

Welcome

Take Home Messages
• Understand how to implement the SY7 strategies and tools in your facility
• Learn lessons from other facilities
• Share your ideas, needs, and experiences with the SY7 Challenge
## Webinar Format

<table>
<thead>
<tr>
<th>Topic</th>
<th>Presenter</th>
<th>Time</th>
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<tbody>
<tr>
<td>Welcome</td>
<td>MaryAnne Elma, MPH</td>
<td>5 min</td>
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<tr>
<td>SY7 Tool Kit Implementation</td>
<td>Adrian Hernandez, MD, MHS and Jane Linderbaum RN, CNP, AACC</td>
<td>15 min</td>
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<tr>
<td>Success Measure 1: Case Studies</td>
<td>Washington Hospital Center</td>
<td>10 min</td>
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<td>Cookeville Regional Medical Center</td>
<td>10 min</td>
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<tr>
<td>Success Measures 3 &amp; 4: Case Study</td>
<td>Harris Methodist Hospital</td>
<td>10 min</td>
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<tr>
<td>Question-and-Answer</td>
<td>All</td>
<td>10 min</td>
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### H2H Challenge #1:
Early Follow-up After Discharge

**See You in 7**
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

• HF patients have an appointment to see any healthcare professional within 7 days
• MI patients have a referral within 7 days to go to cardiac rehab (when appropriate)

SY7 Implementation

Adrian Hernandez, MD, MHS

• Dr. Hernandez is a cardiologist at Duke University Medical Center and an Associate Professor of Medicine at the Duke Clinical Research Institute.
• He is actively involved in clinical research from quality of care to clinical trials with a focus on heart failure.
• Dr. Hernandez earned his MD from University of Texas-Southwestern.
• He completed residency at the University of California-San Francisco and fellowship at Duke University.
The hospital discharge process is successful if:

1. HF and MI patients are identified prior to discharge and risk of readmission is determined.
2. Follow-up visit or cardiac rehab referral within 7 days is scheduled and documented in the medical record.
3. Patient is provided with documentation of the scheduled appointment (e.g., appointment card).
4. Possible barriers to keeping the appointment are identified in advance, addressed, and documented in the medical record.

SY7 Success Measures

SY7 Listserv Highlights

Highlights from the SY7 questions:

1. Many readmission risk assessment calculators exist – using clinical factors AND non-clinical factors on the assessment seem to be the most useful
2. Average cardiac rehab follow-up was 2 weeks!
3. Providing patient with documentation of the follow-up appointment in multiple formats is a standard practice
4. Few H2H Community members offered information about identifying possible barriers and solutions
SY7 Implementation

Jane Linderbaum RN, CNP, AACC

- Ms. Linderbaum is a Cardiovascular Nurse Practitioner and an Assistant Professor of Medicine at Mayo Clinic in Rochester, Minnesota. She also serves as Associate Medical Editor for AskMayoExpert.
- She participates on the ACC’s Core Curriculum faculty and planning team, in addition to S-T Elevation MI and Stable Ischemic Heart Disease guideline writing groups.
- Ms. Linderbaum earned her nursing degree from the University of Iowa and her MS degree from Winona State University.

SY7 Success Measures

The follow-up clinic or cardiac rehab referral is successful if:

5. HF patient arrives at follow-up appointment or AMI patient is referred to cardiac rehab, within 7 days of discharge from hospital.

6. Discharge summary (including summary of hospitalization, updated medication list) available to follow-up clinician.

7. Patient brings his/her medications or a medication list to clinic visit.

8. Reason for referral available to cardiac rehab center and patient brings referral letter or clinician prescription.
SY7 Listserv Highlights

Highlights from the SY7 questions:

5. A follow-up phone call to the patient was the most common practice in ensuring patient made it to their appointment

6. EHR and fax were the most common methods used for making the discharge summary available to follow-up clinician

7. Few H2H Community members mentioned any facility instructions were given to patients about what to bring to their appointment

8. (Listserv results still being gathered)

SY7 Case Studies

The hospital discharge process is successful if:

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Washington Hospital Center
Risk Assessment Form

George Ruiz, MD
Director, Pulmonary Hypertension Unit
Advanced Heart Failure Service
Chair, Heart Failure PI Team

Mary-Michael Brown, DNP, RN
Director, Outcomes Measurement

Jacqueline Cadena, RN, MSN, FNP-BC
Outpatient Advanced Heart Failure Program

Karen Mack, MS, MBA, ACNP-BC
Nurse Practitioner
Bridging the Gap
Our journey to reduce heart failure readmissions

George Ruiz MD
Mary-Michael Brown, RN, MSN
Jackie Cadena, NP
Karen Mack, NP
Washington Hospital Center
Health care’s wasted dollars

Here are some of the contributors to the $1.2 trillion being leaked out of the system.

<table>
<thead>
<tr>
<th>Issue</th>
<th>Amount</th>
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<tbody>
<tr>
<td>Overtesting</td>
<td>$18b</td>
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<tr>
<td>Processing Claims</td>
<td>up to $18b</td>
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<tr>
<td>Ignoring Doctor’s Orders</td>
<td>$1000</td>
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<tr>
<td>Ineffective Use of Technology</td>
<td>up to $35b</td>
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<td>Hospital Readmissions</td>
<td>$25b</td>
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<td>Medical Errors</td>
<td>$17b</td>
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<td>Unnecessary ER Visits</td>
<td>$1b</td>
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<tr>
<td>Hospital Acquired Infections</td>
<td>$3b</td>
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“Right now hospitals, they are not penalized if there are constant readmission rates from patients that have gone through the hospital.

If you go to a — if you go to a car company or a auto shop, if you say, “Can I have my car repaired?”, you get your car repaired — if two weeks later it’s broken down again, if you take it back, hopefully they’re not going to charge you again for repairing the car. You want them to do it right the first time. And too often we’re not seeing the best practices in some of these hospitals to prevent people from being readmitted. That costs a lot of money. So those are the kinds of changes we’re talking about.”

The rates include all patients in fee-for-service Medicare programs who were discharged between October 1, 2003, and September 30, 2004. The rate for Washington, DC, which does not appear on the map, was 23.2%.

July 1, 2005-June 30, 2008
Hospital Compare

Rate of Readmission for Heart Failure Patients

<table>
<thead>
<tr>
<th>Lower Percentages Are Better</th>
<th>22%</th>
<th>23%</th>
<th>24%</th>
<th>25%</th>
<th>26%</th>
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<td>U.S. National 30-Day Readmission Rate for Heart Failure = 24.5%</td>
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<td>Number of Medicare Patients Admitted for Heart Failure *</td>
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<td>Based on 1,271 patients</td>
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Legend

Range of uncertainty around estimated readmission rate
("interval estimate")

X% ← Estimated readmission rate
(risk-adjusted)
Risk Factor Screen
Team Approach Tailored to Patient Risk
7 day promise

Cookeville Regional Medical Center
Brenda Davis-Bryant, RN
• Accreditation Coordinator
• Cookeville Regional Medical Center
• Cookeville, Tennessee
• +23 yrs experience (17 years CVICU)
Common Patient Barriers

System Barriers
• Appointment access within 7 days

Environmental Barriers
• Transportation
• Costs

Personal Barriers
• Patient forgets about appointment
• Patient self-care

Yale Risk Assessment Calculator

Re-Admission Risk Score for Heart Failure

This readmission calculator is based on a statistical model developed from chart abstracted data. It is intended for use with patients age 65 and older.

DEMOGRAPHICS
Age
Sex

PRESENTATION
In-hospital Cardiac Arrest

HISTORY
Diabetes
Prior Heart Failure
Coronary Artery Disease
Prior PCI
The hospital discharge process is successful if:

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Harris Methodist Hospital

Heart Failure Patient Teaching

Nancy Gardner, RN
- Performance Improvement Coordinator for Heart Failure and Pneumonia
- Texas Health Harris Methodist Hospital Hurst-Euless-Bedford (Approximately 300 bed not-for-profit acute care facility providing a variety of medical, surgical, obstetric, emergency and psychiatric services)

Megan Brandt, RN, BSN
- Registered Nurse, Express Admissions and Discharge Unit (EADU) (Specialty unit providing nursing admission assessments and initiation of plans of care)
- Texas Health Harris Methodist Hospital Hurst-Euless-Bedford

Jiji Andrews, RN, BSN, PCCN
- Nursing Supervisor, Cardiac Step-down Unit (23 bed cardiac medicine specialty floor)
- Texas Health Harris Methodist Hospital Hurst-Euless-Bedford
Heart Failure Patient Teaching
Nancy Gardner, RN
Megan Brandt, RN, BSN
Jiji Andrews, RN, BSN, PCCN

Heart Failure Champions
- Committee of nurses created to work on HF readmissions
- Heart Failure “Red Folders” created
- Additional ideas offered
- Ideas piloted by units
- Feedback from pilots form final process
**Development Process for the Teach Back Method**

- Needed a new process for educating HF patients
- Teach back method discussed
- Discussed key education ideas for CHF
- Created HF education pathway (learning tool)
- Added to HF Folders and Educated staff

**Buy in from Nursing Staff**

- Education done primarily through UBC/staff meetings
- Less teaching for admission nurse and discharge nurse
- Accountability of RN staff
- Patients actually learn and retain information
**Challenges and Benefits of New Method**

- Resistance to change
- Creating reminders for new method
- Hardwiring the method
- Patients seem receptive to method
- Still too early to know benefits

**HEART FAILURE TEACHING PATHWAY**

<table>
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<tr>
<th>DATE________</th>
<th>SHIFT_______</th>
<th>WHAT IS CHF?</th>
<th>DATE________</th>
<th>SHIFT_______</th>
<th>DAIRY WEIGHT</th>
<th>DATE________</th>
<th>SHIFT_______</th>
<th>SODIUM DIET</th>
<th>DATE________</th>
<th>SHIFT_______</th>
<th>FLUID INTAKE</th>
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Upcoming Activities

- SY7 Diagnostic Survey – Sept/Oct
- Post-Discharge Medication Management Introductory Webinar – October

The H2H SY7 Challenge Introductory Webinar on March 3, 2011 is available online

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

Moderated Question-and-Answer Session
Please submit your question online at this time.
Thank You

H2H
HOSPITAL-TO-HOME