H2H
HOSPITAL-TO-HOME

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

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

Helping Cardiovascular Professionals Learn. Advance. Heal.

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

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Webinar Format

Topic	Presenter	Time
Welcome	MaryAnne Elma, MPH	5 min
SY7 Tool Kit Implementation	Adrian Hernandez, MD, MHS and Jane Linderbaum RN, CNP, AACC	15 min
Success Measure 1: Case Studies	Washington Hospital Center Cookeville Regional Medical Center	10 min 10 min
Success Measures 3 & 4: Case Study	Harris Methodist Hospital	10 min
Question-and-Answer	All	10 min

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H2H Challenge #1:

Early Follow-up After Discharge

See You in 7

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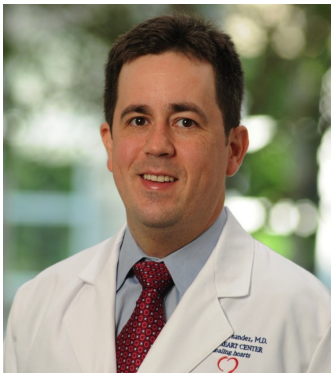
H2H Early Follow-Up Challenge: "See You in 7"

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.

SY7 Success Measures

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 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

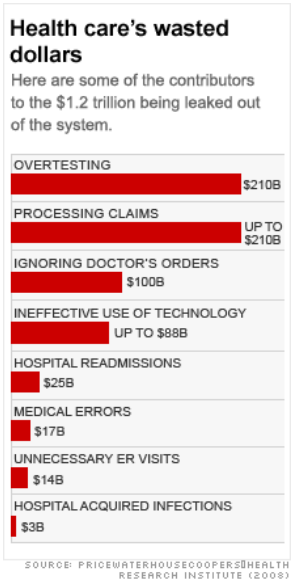
Our journey to reduce heart failure readmissions

George Ruiz MD
Mary-Michael Brown, RN, MSN
Jackie Cadena, NP
Karen Mack, NP
Washington Hospital Center

Washington Hospital Center
MedStar Health

Washington Hospital Center
MedStar Health

A path to bundled payment around a rehospitalization. In: Report to the Congress: reforming the delivery system. Washington, DC: Medicare Payment Advisory Commission, June 2005:83-103.



Washington Hospital Center
MedStar Health

"**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"

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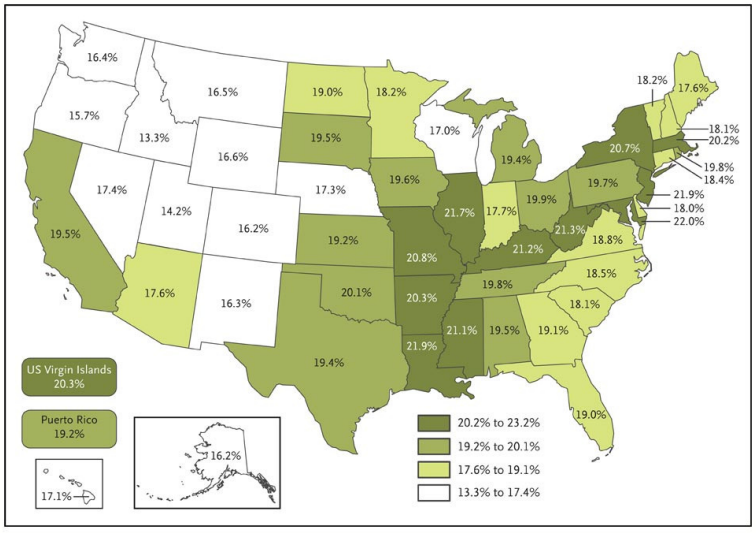
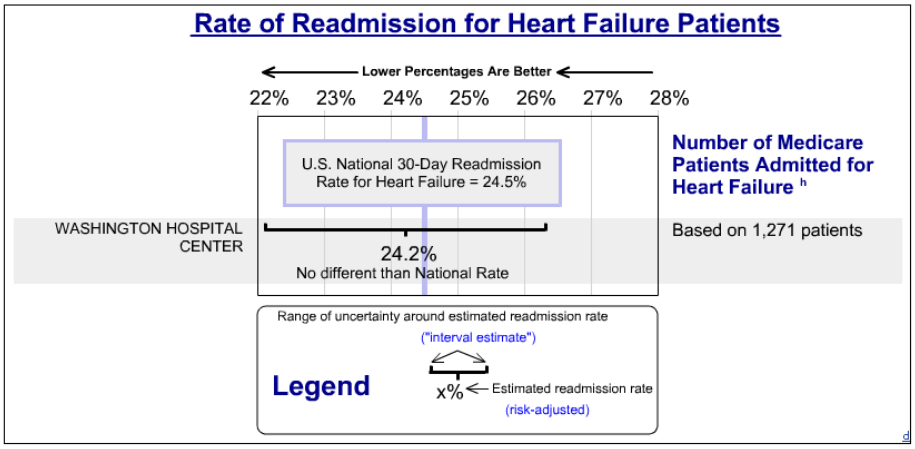


The rates include all patients in fee-for-service Medicare programs who were discharged between October 1, 2003, and September 30, 2004. The rate for Washington, DC, which does not appear on the map, was **23.2%.**

Jencks S et al. N Engl J Med 2009;360:1418-1428

July 1, 2005-June 30, 2008
Hospital Compare



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Risk Factor Screen

Congestive Heart Failure (CHF) Risk for Readmission Screening and Orders

- The risk factors below predispose a patient with CHF to readmission within 30 days of discharge.
- The definition of these risk factors and recommended interventions are explained on the back of this form.
- Please order consults and interventions on this prescriber order sheet.

Readmission Risk Factors Screen—*check all that apply and total the score on Admission & Discharge*

Risk Factor	ADM	DC	Risk Factor	ADM	DC
1. Lacks Primary Provider and/or Follow-Up Appointment			5. Financial Need		
2. Recent Hospitalization (in last 6 months)			6. Lacks Social Support		
3. Lacks Knowledge about CHF			7. Psychiatric Impairment		
4. Immobility			8. Lacks Transportation (for medical care)		
Total Score 0-9 — Admission:_____ Discharge_____			9. Significant Physiological Impairment		

Team Approach Tailored to Patient Risk

Nutrition

Palliative Care

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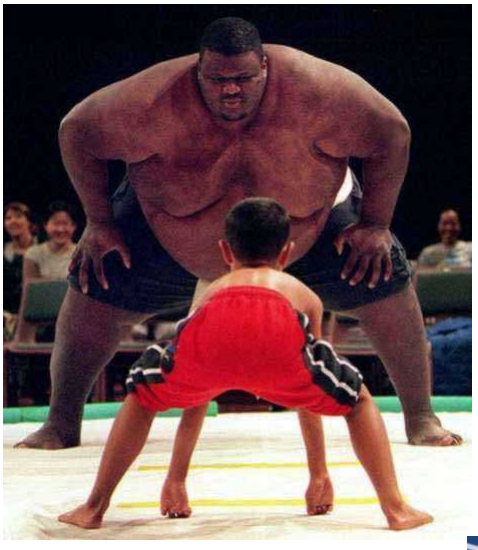

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7 day promise

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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

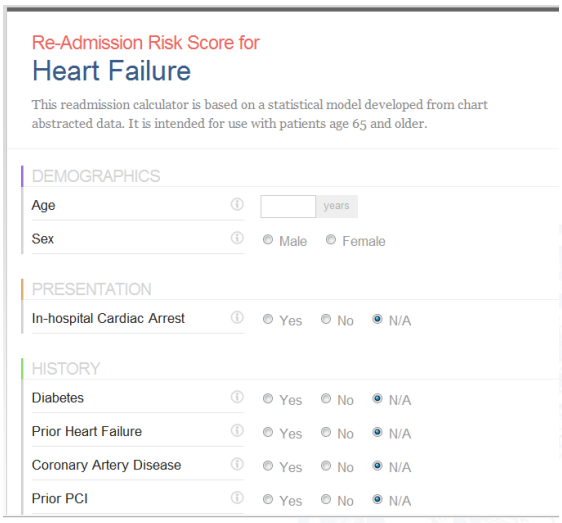
Environmental Barriers

- Transportation
- Costs

Personal Barriers

- Patient forgets about appointment
- Patient self-care

Yale Risk Assessment Calculator



SY7 Case Study

The hospital discharge process is successful if:

1. HF and MI patients are identified prior to discharge and risk of readmission is determined.
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4. **Possible barriers to keeping the appointment are identified in advance, addressed, and documented in the medical record.**

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

DATE_____ **SHIFT_____** **WHAT IS CHF?**	**DATE_____** **SHIFT_____** **DAILY WEIGHT**	**DATE_____** **SHIFT_____** **SODIUM DIET**	**DATE_____** **SHIFT_____** **FLUID INTAKE**
• Causes • Signs and Symptoms (edema, SOB, weight gain, lack of energy) • Zones *RN to give patient Red HF packet	• Weigh in the morning before breakfast • Record weight • Alert: weight gain of 3 pounds in one day or 5 pounds in a week	• Eat low sodium and low fat diet • Know what foods contain salt • Do not use added salt *RN to use patient handout on sodium restricted diet	• Know how much fluid you are drinking in 24 hours • Record intake
	• Teach back What is CHF	• Teach back What is CHF and Daily weight	• Teach back what is CHF, daily weight, and sodium diet
7A-7P Nurse_____ 7P-7A Nurse_____	7A-7P Nurse_____ 7P-7A Nurse_____	7A-7P Nurse_____ 7P-7A Nurse_____	7A-7P Nurse_____ 7P-7A Nurse_____

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

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