

A JOURNEY TO DECREASED CHF READMISSIONS

Mercy Health- Fairfield Hospital

Denna Dietrich MSN, CNP, CHFN
Jennifer Bittner BSN, RN, CNML
Rita Cassidy MSN RN, CMSRN, CHFN
Jacqueline Smith BSN, RN

Mercy Health

Mercy Health-Cincinnati has served greater Cincinnati for more than 160 years. Brings state-of-the-art technology, and expert care to Five award winning hospitals, senior living communities and physician practices. Our mission is to give selflessly, listen patiently, care purposefully and heal expertly.




WHO WE ARE

Fairfield Hospital has been nationally recognized as:


- Bariatric Surgery Center of Excellence®. Top 100 Hospital overall,
- Top 50 Heart Hospital
- Top 10 Community Hospital.
- Designated as Magnet in 2014.




Mercy Health Patient Centered Care Delivery System



Mercy Health Professional Practice Model



By creating SYNERGY with all aspects of the caregiver-patient relationship, Mercy Health extends the healing ministry of Jesus by improving the health of our communities with emphasis on people who are poor and under-served.

 **MERCYHEALTH**

Meet the Team



•The team consists of:

- Jennifer Bittner BSN, RN - Director of Cardiovascular services
- Jacqueline Smith BSN, RN- Nurse Manager of Telemetry, Heart Failure
- Denna Dietrich CNP- Lead Nurse practitioner
- Susan Radcliffe CNP-Nurse practitioner
- Rita Cassidy MSN, RN- Navigator
- Lynne Wagoner, MD- Regional lead physician for Heart Failure
- Gena Hoskins – Medical Assistant

What is the expected financial impact of CHF BY 2030?

An estimated 5.8 million Americans are currently living with Heart Failure with projections estimating a rise to over 8 million by 2030. What are the estimated costs associated by HF by 2030?³

A. 70 Million Dollars

B. 10 Billion Dollars

C. 10 Million Dollars

D. 70 Billion Dollars

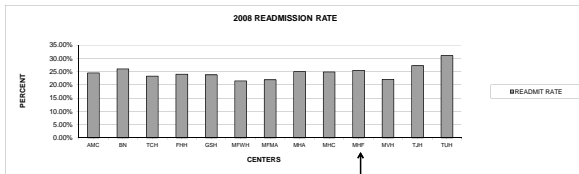
Background- National View

- The Affordable Care Act established the Hospital Readmissions Reduction program.
- Readmissions included any patient readmitted within 30 days and is all cause; the second admission does not have to be due to heart failure.²

Background- Mercy Health

- Growing population of HF patients
- Growing cardiology team
- Identified the need to merge inpatient care and outpatient care for a more seamless transition.

Gap Analysis



Phases of Development:

- Phase 1: Getting Started
- Phase 2: Inpatient Development
- Phase 3: Outpatient Development
- Phase 4: Shared Medical Visits
- Phase 5: Growth & Future Plans

Phase 1: Getting started

- Arrival of Lynne Wagoner
- Hiring of Denna Dietrich
- Addition of first heart failure navigator
- Utilization of EMR (Epic)

Implementation:

- Hiring of Denna Dietrich CNP
- Workload was too much for one person
- NP absorbed into cardiology office
- A need developed for someone to bridge inpatient and outpatient care.
- Needed someone in the hospital setting.

The 1st Nurse HF Navigator

Hired April 2011 as part time. Transitioned to full time 1 year later

Job Description: Establish an inpatient support to educate and transition the patient into the outpatient setting.

Program Mission Statement

The Mercy Heart Failure program strives to improve the quality of life for patients and their caregivers through empowerment, knowledge, spiritual support and community outreach. The process is an interdisciplinary effort to meet the variety of needs for our clients.

Utilization of EMR

- Used to identify CHF population
- Bridges communication gap between providers
- MyChart allows for communication with patients.
- More comprehensive medication reconciliation

Phase 2: Inpatient Development

- Development of interdisciplinary team
- Inpatient classes
- Patient education materials
- Nurse education
- Scheduling follow-up appointments prior to discharge

Interdisciplinary Approach

One designated representative from each discipline met biweekly to identify gaps and educational needs from each discipline's perspective.

The program was then developed with each discipline providing input for growth and implementation ideas.

Interdisciplinary Approach

- Pharmacy★
- Dietary★
- Cardiac Rehab ★
- Social Work/Discharge Planning
- Cardiology
- Palliative Care

Coming together is a beginning; keeping together is progress;
working together is success

-Henry Ford

Inpatient Classes

- Inpatient classes for patient and their caregivers.
- Interdisciplinary approach included: pharmacy, dietary, cardiac rehab, cardiology.
- Each specialty spends 15-20 minutes teaching the class.
- Patients are provided an educational book, magnet with signs & symptoms, scale and disease management resources.

AHA and Get with the Guidelines recommends at least 60 min of education to ensure patients understand post discharge instructions.¹

Education Materials



Patient education: Book for newly diagnosed patients and caregivers, calendar with



Quick read flyers



Weight management Calendar with Red, yellow and green signs



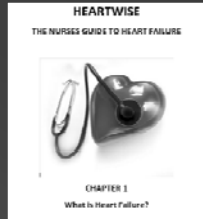
Magnet with symptom reminder

Nurse Education

- Aligned with our Professional Practice Model to improve nursing competency to meet the needs of our HF patients
- The goal was to impact patient outcomes, patient satisfaction, employee satisfaction.
- Administration fully supported Heart failure training

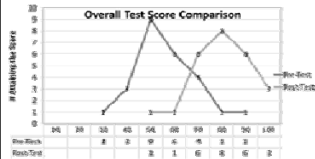
Nurse Education

- Education packets were given weekly for 3 weeks
- Packet topics included:
 - What is HF
 - HF medications
 - Patient assessment
- Physician provided educational lecture with multiple dates for attendance.
- Yearly competencies for all nursing staff (ilearn)
- Resource binder for each unit



Nurse education cont.

Nurses were provided with a pre and post test to assess knowledge



Employee Engagement: Gallup Q6 There is someone at work who encourages my development

	2012	2013
Employee Engagement: Gallup Q6 There is someone at work...	4.67	4.74

Follow-up appointment

Patients are scheduled for follow-up appointments by nursing staff prior to discharge with following physician (PCP, cardiology, etc)

If a patient is not associated with cardiology and unable to obtain a 1 week follow-up they are placed with HF NP if agreeable

Phase 2: Key Points

- Anybody can recommend a patient for class
- Encourage caregivers to attend inpatient class and participate in bedside education.
- Offer classes more than once per week
- Accessible classroom (bariatric chairs, O2 ready, Near a bathroom)
- Education to improve the nurse competencies to meet the needs of the patient
- Nursing can order HF Navigator Consult without physician approval
- Administration buy-in and a physician champion.

What places patients at risk for readmissions?

Which of the following are associated with an increased risk of readmissions in CHF patients?⁷

- A. Anemia
- B. Socioeconomic status
- C. BNP
- D. Health Literacy

Phase 3: Outpatient Development

- Discharge phone calls
- HF Resource Line
- Medication access program
- Outpatient Infusion Clinic
- Expanded Home Health Care alliances
- Extended Care Facility Education
- Initiation of support group

Discharge Phone Calls

AHA Guidelines recommends a telephone follow up within 72 hours of discharge.¹

WHO: Patients who participated in inpatient classes, who were seen as a consult or who deemed high risk.

WHEN: Called within 24-48 hours after discharge.

WHAT: Symptoms, discharge weight, medications, dietary restrictions and follow-up appointments are reviewed with the patient

HF Resource Line

- The number is available Monday- Friday 8 am-5 pm.
- The resource line is answered by HF navigator, NP's, MA's
- After hours and weekend emergency calls are directed to the cardiology office and routed to the physician on-call
- For inpatient needs the Navigator carries a portable phone for direct contact
- Allows RNs and providers to be more accessible to patients, families, and caregivers.

Medication access

Affordability and medication access was a constant barrier for many patients. A medication assistance program was established with the assistance of our pharmacy.

Who Qualifies:

- Patient's must meet with financial counselor during hospitalization
- Current or future patients of shared medical visits.

What is provided:

- 30 day supply with 1 refill from hospital's outpatient pharmacy.
- Patient is discharged with their medications in hand.
- Mail order of medication while enrolled in visits and may be continued on a case-by-case basis.

Outpatient Infusion Clinic

- Able to treat patient's acutely without hospitalizations.
- Infusion Clinic is able to administer:
 - IV diuretics
 - Inotrope infusions
 - Draw labs
 - IV iron infusions
 - Blood administration
 - IV fluids

Reaching out..

- Identify top 5 Extended care facilities
- Arranged group meetings. We traveled to them to provide education
- Established a face-face relationship with hotline access for employees
The majority of readmissions in our organization were from ECF's

Plan for improvement

- The process worked so well that it was then duplicated with home healthcare teams

Home Care Collaboration

The screenshot shows a form titled 'Home Care Collaboration' with various sections for patient information, care plan, and discharge instructions. The form is filled out with handwritten and printed text, including patient name, address, and specific care instructions.

Met with HHC Agency which is partnered with the healthcare system to develop a Continuum of Care form upon discharge.

Can be used for HHC as well as ECF discharge.

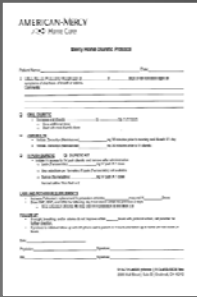
Improving upon transitional care can reduce avoidable re-hospitalizations³

Home Care Collaboration

Need for acute treatment of CHF led to development of a Home Diuretic Protocol

Patients are discharged from the hospital with "IV Lasix Emergency Kit"

Protocol allows for quick response. Patients in acute CHF can receive immediate treatment vs. waiting for physician response



H.E.A.R.T

Heart Education And Recreation Team

The support group is organized by the HF navigator and includes interdisciplinary guest speakers. Currently meets quarterly and averages 6-10 attendees



- Topics include:
- Low sodium cooking demonstration
 - Heart & Lung connection
 - Easy Gardening
 - What is CHF
 - Medication management and resources

Phase 3 Key points for success:

- Offer a support group with varying topics & guest speakers.
- Face to face meetings with other care provider teams (ECF, HHC, Palliative care)
- Provide other teams with HF resource line.
- Know your community resources. Patients have different needs.

How well do patients retain education?

40-80% of all medical information provided by healthcare providers is forgotten immediately. What percentage of the information remembered is correct?⁴

- A) 25%
- B) 50%
- C) 75%
- D) 85%

Phase 4: Shared medical visits

- Shared medical visits are appointments within a group setting that allows for education utilizing a multidisciplinary team in addition to a cardiology appointment.
- Started out of cardiology office in October 2013.
- Moved to larger community room to accommodate up to 12 persons

Shared Medical Visits

Objectives:

- Deliver extensive patient education and self management instructions
- Provide clinical assessment and medical management of the heart failure patient.
- Allow patients with similar illnesses an opportunity to interact with and learn from one another.
- Collaborate with the primary care physicians and the primary Cardiologists



Shared Medical Visits

- 4 Sessions with a different educational topic each time
- Set day and time
- Patients attend biweekly and rotate through all 4 sessions
- Patient can enter at any session, will receive education on all 4 topics.
- Patient is encouraged to attend with caregiver, spouse, or friend.
- Confidentiality is maintained throughout

Shared Medical Visits

- Inclusion criteria:**
- Patient has a diagnosis of CHF (systolic or diastolic)
 - Recent hospitalization for CHF
 - Been evaluated by a cardiologist
 - Patient has a primary care provider
 - Patient is willing and capable to participate
- Exclusion criteria:**
- Patient does not have a diagnosis of CHF
 - Patient requires 1:1 care
 - Patient has difficulty hearing or other communication barriers
 - Does not consent to participate in group setting or to maintain confidentiality outside of the group visit.

Workflow of Visits

- Patient's weight, vitals, and medication reconciliation occurs during initial check-in
- Patient fills out questionnaire each session.
- Guest speakers discuss that session's topic.
- Questions addressed regarding other issues than that week's topic.
- Patient assessment by the Nurse Practitioners.

Shared Medical Visits Data

- ~100 patients seen in the clinic
- ~4% readmits within 30 days while in the program
 - 1patient due to CHF exacerbation and 1 patient needed CABG
- Youngest: 32 Oldest: 80
- Diastolic: 50% Systolic: 50%

Patient Experience Data

- Minnesota Living with Heart Failure Questionnaire Evaluation at the first session and last session
- 96% of patients seen reported an improvement in their quality of life at the end of the sessions.

What patients are saying about shared medical visits:

"I liked that it was practical, gave me knowledge and more control"

"I liked talking to everybody who had the same thing as you. You can get some good ideas from them"

"Thank you so much! This program is so needed. I had a lot of fear not knowing or understanding what was happening to me or why and what my future was going to be. This eased those fears"

"Calmed my fears, answered all concerns, strong support team, helped me feel confident, great information moving forward"

Phase 4 key points for success

- Provide schedule in advance for patients and other disciplines
- Encourage patients to interact. They can learn from one another!
- Network with physicians/ providers to increase non inpatient referrals.
- Proper screening of patients who are appropriate for group sessions
- Location can make a difference

How many new heart failure patients are diagnosed yearly?

On average, what is the number of patients diagnosed with heart failure?

- A. 1,000,000
- B. 660,000
- C. 150,000
- D. 60,000

Reference: Heart Disease and Stroke Statistics: 2008 update. Circ: Journal of the American Heart Association. Dallas, TX: American Heart Association; 2008. Available at www.heart.org

Phase 5: Growth & Future Plans

- Regionalization of HF care & education
- Addition and orientation of navigators for additional Mercy Health sites
- Initiation of Regional Heart failure team meetings
- CHF Accreditation
- Observation Unit

Observation unit

Development of an observation unit

- Allows patients to be seen in an inpatient setting without a full admission and therefore missing readmit qualifications
- Outpatient in a bed ability for quick lasix pushes, tele monitoring, and lab work.
- Allows patients to be seen by HF navigator and provider as needed.

Regional Goal

The goal for the regional Heart Failure team is to create a system of patient care that allows heart failure patients to receive the same level of care no matter which Mercy Health facility they walk into.

Having a team at each location will allow us to initiate small tests of change for improvement and then roll the new process out to other sites.

Regionalization of the Navigator

- Mercy Health wanted to expand the CHF Nurse Navigator role into all hospitals in the Cincinnati Region.
- Currently there is a Nurse Navigator in all locations: North, West, East, and Central hospitals.
- Nurses trained on site with Mercy Health Fairfield Nurse Navigator.
- Program is expanding, not only with Navigator but with care and follow up as well.

Regionalization

CHF Nurse Navigators meet monthly to:

- Standardized education
- Discuss Barriers
- Share resources
- Explore new initiatives
- Plan future educational opportunities for staff and the heart failure team

LVAD SHARED CARE SITE

MHF become a shared care site in 2011. Allowing us to care for patients at all levels of heart failure.

Goal:

- Expand in number of patients maintained by the HF team.
- Expand to other sites





"Alone we can do so little; **together** we can do so much."
~ Helen Keller

References

1. Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA Guidelines for the management of heart failure; Executive summary. A report of the American College of Cardiology Foundation/American Heart Association task force on practice guidelines. *Circ*. 2013
2. Centers for Medicare and Medicaid services. Retrieved from: <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html>
3. Go AS, Mozaffarian D, Roger VL, et. al AHA Statistical update: Heart disease and stroke statistics- 2013 Update. *Circ*. 2013; e1- 245. Available at: <http://circ.ahajournals.org/content/129/1/e28>
4. Kessels RPC. Patients' memory for medical information. *Journal of the Royal Society of Medicine*. 2003;96(5):219-222.
5. Rutherford P, Nielsen GA, Taylor J, Bradke P, Coleman E. *How-to Guide: Improving transitions from the hospital to community settings to reduce avoidable rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.Hi.org
6. American Academy of Family Physicians "Shared Medical Appointments/Group Visits" Retrieved from <http://www.aafp.org/about/policies/all/shared-medical.html>
7. Haron P, Rohyans L. Heart Failure Patients at High Risk for Readmission *The Connection* 2014; 40: 11-18
8. Heart Disease and Stroke Statistics: 2008 update. *Circ: Journal of the American Heart Association*. Dallas, TX: American Heart Association; 2008 Available at www.heart.org

Questions

Jacqueline Smith
Mercy Health Fairfield Hospital
jaquelinesmith@mercy.com

Jennifer Bittner
Mercy Health Fairfield Hospital
jlbittner@mercy.com

Rita Cassidy
Mercy Health Fairfield Hospital
rcassidy@mercy.com

Denna Dietrich
Mercy Health Fairfield Hospital
dxdietrich@mercy.com

Readmission statistics

Year	2012	2013	2014	Nat'l Avg 2014
Percent Readmits	17.91%	16.066%	17.167%	22%
Total Patients	586	666	699	
Number of Readmits	105	107	120	



Changes worked!

Month	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Percent Readmits	23.214 %	22.642%	31.667%	12.963%	14.754%	9.375%
Total Patients	56	53	60	54	61	32
Number of Readmits	13	12	19	7	9	3
