Coordinated Outreach Achieving Community Health (COACH) for Heart Failure

Session C917
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Learning Objectives

#1: Discuss challenge of heart failure readmissions and effect on quality and cost of care.

#2: Describe process for concurrent screening and timely provision of care.

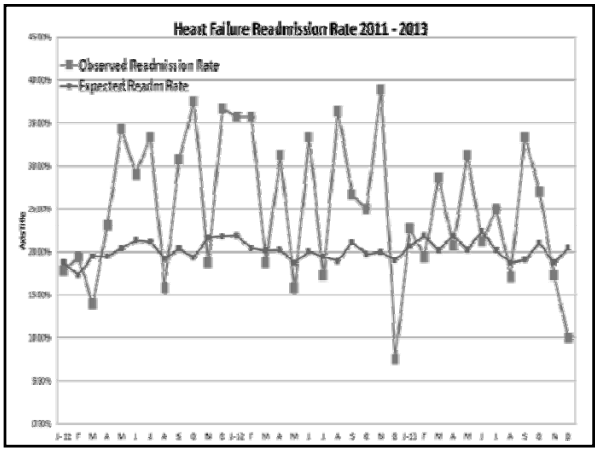
#3. List three strategies for building effective multidisciplinary teams to enhance successful hand-offs and improve transitions of care.

Lourdes Continuum of Care

- **Upstate New York-across PA border**
- **Ascension Health Ministry**
- **Acute Care Community Hospital**
- **242 licensed beds; average daily census ~ 130**
- **Primary Care Network - 26 sites**
- **Home Health/Hospice - 4 counties**

Opportunity for Improvement

- HF Team for years!
- Inconsistent care across the continuum
- Lack of consistency in HF education - hospital, primary care & homecare
- Work done in silos
- HF Core Measures & CMS focus on Readmissions
- Coding of HF patients sometimes questionable
- Spinning our wheels and not improving….



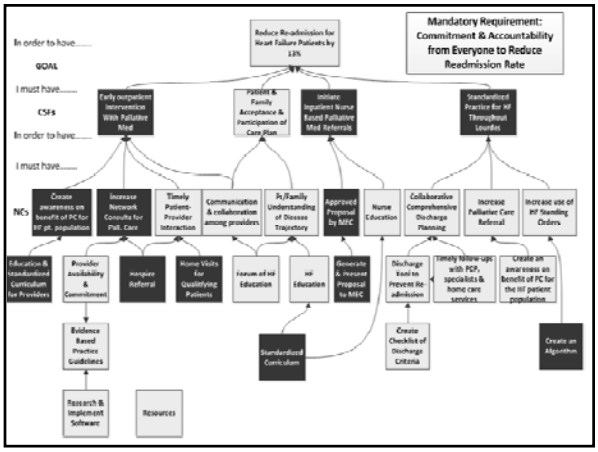
2014, the COACH Program!

COACH for HEART FAILURE

Coordinated Outreach Achieving Community Health

Actions Taken

- HF committee revised - key players
- Weekly meetings
- Goal Tree
- HF readmission reports reviewed
- Plan to deliver care initiated
- Collaboration with HIMS on coding
- Dissemination of information
  - Providers: Nurse Practitioners, Network
  - Information flyers



COACH – Inpatient Services

- Concurrent identification of HF patients:
  - B-naturetic peptide results
  - Referrals to CVD Manager
  - Length of stay
  - Chart review
- CVD Manager individualized education
- Referrals:
  - Palliative Medicine
  - Cardiology
  - Physical Therapy
  - Dietician
  - Cardiac Rehabilitation

Cardiovascular Disease Manager's Role

- Review HF medications & clinical care
- Ensure echocardiogram assessed; ACE-I & ARB
- Arrange follow-up appointment with PCP and/or Cardiology in 3-5 days
- Complete discharge checklist
- Identify patients appropriate for home

Resources

Education:

- HF Folder
  - "The Stronger Pump"
  - HF Zone Card
  - Informational brochures
  - T-Time
- Scales
- BP cuffs
- Transportation

COACH Outpatient Services – Home Care

- Lourdes At Home Intake
  - Staff attempt to see patient within 24 hours; CVD manager may make interim visit.
- Chart FLAGGED as "COACH patient" in EMR & on paper chart: Specify HF or COPD
- Mandatory HF training for all field clinicians
- Focus – promote & improve self-management
- CST button offered as "call button" service
- Heart Failure Care Plan

COACH Outpatient Services - Home Care

- Front Loaded Visits
- Medication Reconciliation & Management
- Referrals for:
  - PT (energy conservation)
  - RD (energy conservation, dietary management & guidance)
  - RT (if needed)
- Care Plan - indicator to contact CVD manager when patient discharged
- Consider Palliative Care – Medicare M & E

COACH Outpatient Services - Home Care

- Telehealth is standard of care

Fun data: In the last 30 days, 874 set of vital signs came through Telehealth; 477 needed to be addressed by nurse!

What is Telehealth?

- Daily monitoring of vital signs with series of questions; reviewed by nurse daily & intervention as indicated

Why Telehealth?

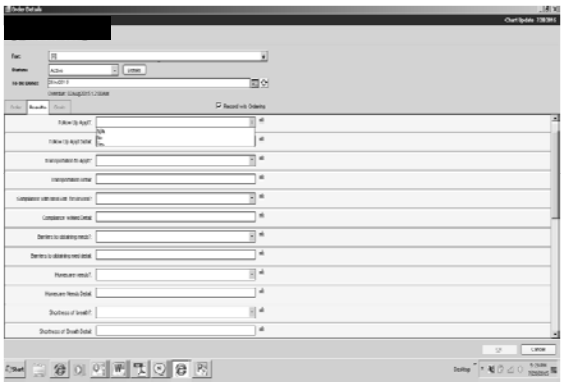
- Allows client to be home & feel safe; **proven to decrease re-hospitalizations**
- Tool that helps clients to build a habit and continue to self monitor once discharged.

COACH in Primary Care

Transitional Care Calls:

- Identify heart failure patient upon discharge
  - Information pulled from hospital EHR
- Transitional Care Phone assessment
  - Template developed by RNs
  - Comprehensive assessment ensured
  - Documentation directly into the EHR

Transitional Care Call Template



COACH in Primary Care

- Education
  - Same education resources as inpatient unit & homecare
  - Used during transitional care calls & at office appointments
- Visits with RN
  - Alert placed in EHR by staff (LPN, MOA)
  - Education for both discharged patients & those seen for routine follow up

COACH in Primary Care

- Change = progress and growth
- Success through teamwork
  - Direct care RNs from primary care offices are integral part of COACH team
  - COACH team went to primary care offices for meetings
- Share what works
  - Tools & processes slowly spread through all primary care offices

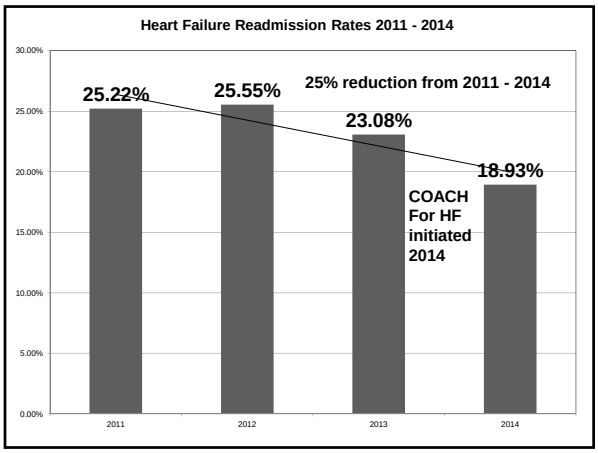
Challenges Addressed

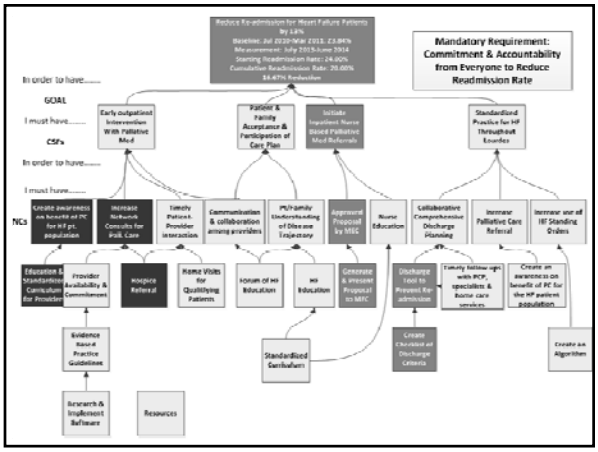
- MEDICATIONS!
- Auto-refill
- Misunderstanding of discharge medications
- Difficulty obtaining medications
- Lack of transportation
- Lack of coordination of care plan between providers
- Inability to access provider when needed

Results after COACH for HF

- Standardized care for HF patients
- Community meeting with local pharmacists

- Patients reported increased satisfaction
- Greater utilization of palliative medicine





Plans for the future

- Nursing home engagement
- Spread COACH program to other chronic diseases
- ID cards to identify patients as HF COACH patient
- Increase ED referrals & interventions
- HF clinic
- Integrated EHR
- Patient engagement & self management

Executive Summary

- System wide goal to reduce readmissions
- COACH program developed
- Interdisciplinary approach
- Significant reduction in HF readmissions
- Consistency across the continuum of care

Questions?