IHI Expedition:
Effective Implementation of Heart Failure Core Processes

Peg Bradke, RN, MA, Faculty
Christine McMullan, MPA, Director
December 15, 2011

These presenters have nothing to disclose

WebEx Quick Reference

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Today’s Agenda

• Homework Discussion
  — Peg Bradke
• Care of the Heart Failure Patient
  — Andrea Andrews, RN; Hazelton General Hospital
• Questions and Answers
• Increasing Reliability
  — Peg Bradke
• Homework for next session
  — Peg Bradke
Chris McMullan, MPA, is the Director of Continuous Quality Improvement at Stony Brook University Medical Center. She served as an adjunct faculty member at the Harriman Business School and School of Professional Development at Stony Brook University. She was Lead Faculty on the IHI Early Warning Systems: The Next Level of Rapid Response Expedition and a Faculty member on the IHI Sepsis Detection and Initial Management Expedition. She was a co-faculty member of the Hospital Association of New York State’s 2007 learning collaborative to prevent ventilator associated pneumonia. Ms. McMullan has held a variety of managerial positions in quality improvement and human resources.

Peg M. Bradke, RN, MA, Director of Heart Care Services, St. Luke's Hospital, coordinates services for two intensive care units, two step-down telemetry units, the Cardiac Catheter Lab, Electrophysiology Lab, Diagnostic Cardiology, Interventional/Vascular Lab, and Cardiopulmonary Rehabilitation. In her 25-year career, she has had various administrative roles in critical care areas. Ms. Bradke works with the Institute for Healthcare Improvement on the Transforming Care at the Bedside initiative and Transitions Home work. She is President-Elect of the Iowa Organization of Nurse Leaders.
Follow Up discussion after Stony Brook

On the last call Stony Brook shared their bedside rounding tool. Feel free to chat in your work:

- What trigger tools have you used to assure compliance to core measures?
- How are you educating staff on the core measures patients?

Homework from Dec. 1 call

Have a discussion with coding.
- What has been your experience with your identification of HF patients as it relates to the final diagnosis code assigned?
- What action have you taken to assure findings are similar?
- Check 10 charts to see if final codes from coders line up with the concurrent diagnosis
We began our journey in the care of our heart failure patients in January 2007, when we were invited to be a part of the—Accelerating Best Care (ABC) in Pennsylvania Program funded by our state legislature.

Representatives from The Baylor Health Care System, who developed the ABC at Baylor program, showed us the results of their quality improvement program.

They explained the cultural changes needed to improve quality and the practical tools needed to accomplish their goals.

The basis of the ABC Program is to break a problem down into small pieces, like a puzzle, quickly analyze the problem through data collection, implement interventions and analyze results adding additional interventions if needed, all in a short period of time.
• Prior to learning the methodology of the ABC Program, departments would identify problems and tackle the whole problem.
  • Team work with other affected departments was sometimes present, but not always;
  • Months and months of data would be collected;
  • Interventions were delayed; quality targets were not always met and
  • Improvements were not noted in a timely fashion.

• A core group of 14 individuals, from different disciplines within our organization, began rigorous training on the ABC process in January, 2007.

• Training, conducted by coaches from Baylor and Thomas Jefferson, focused on the structure, process, and outcomes of improving quality using the ABC methodology and laid the groundwork for projects the core group were to complete.

• Five quality initiatives were selected to go through the ABC methodology of quality improvement during the training period.

• One of these projects involved our HF core measures, first focusing on HF discharge instructions.

**WHY HEART FAILURE?**

• Top Admission Diagnosis
• Most Common Reason for Readmission
• Core Measure
• Financial Impact

• Our HF Team was formed and the assessment of all patients on the telemetry unit was our focus.

• The baseline for our heart failure discharge instruction core measure compliance for January, 2007 was 79%
• Our team identified the need for standing order sets for CHF admissions. These were implemented and made mandatory for use by the Medical Staff, with support from the Medical Executive Committee leadership.

• To increase compliance with our core measures—more importantly—to provide quality care to each of our CHF patients every time—all the time, we placed a yellow CHF form on the front of the charts for all CHF patients with the words “STOP—CHF” on them.

• A CHF discharge instruction form was developed and implemented to be utilized for all CHF discharges. This form addressed all the required elements by CMS which include the following:
  • Diet
  • Activity
  • Medications
  • Weight
  • Symptoms
  • Follow-up

• After implementation of these interventions, our compliance for heart failure discharge instructions went to 100% in May, 2007.

• For a better understanding of where HGH began its journey with HF core measures, and where it journeyed to, please note the following:

<table>
<thead>
<tr>
<th>Evaluation</th>
<th>Baseline Data in 2004</th>
</tr>
</thead>
<tbody>
<tr>
<td>LVS Function</td>
<td>67%</td>
</tr>
<tr>
<td>ACE or ARB for LVSD</td>
<td>48%</td>
</tr>
<tr>
<td>Adult Smoking Cessation</td>
<td>19%</td>
</tr>
<tr>
<td>Discharge Instructions</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>First Quarter 2007</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>LVS Function</td>
<td>100%</td>
</tr>
<tr>
<td>ACE or ARB for LVSD</td>
<td>100%</td>
</tr>
<tr>
<td>Adult Smoking Cessation</td>
<td>100%</td>
</tr>
<tr>
<td>Discharge Instructions</td>
<td>84%</td>
</tr>
</tbody>
</table>

- Our readmission rate of heart failure patients within 31 days for the first four months of 2007 was reduced to 7.7%. Statewide data showed a 14.7% readmit rate within 31 days for HF patients.

- The financial gains realized by a decrease in our HF readmit rate to 7.7% was $31,046. (based on a LOS of 3.6 days and 22 fewer admits with variable costs of $392 per day—realizing our readmits stayed a day less than an actual admission with HF).

- With this ABC methodology of looking at our PI processes, team building was evident; departments learned how the actions of one department affect others; team participants became excited about quality improvement because of its immediate results and interventions that were possible; and it no longer took months and months to identify problems, analyze, and implement resolutions.

- There are more successes in “fixing” smaller parts of a problem than trying to “fix” the whole problem at one time.
• HGH received The Most Improved Care Award in May, 2008 from Quality Insights of Pennsylvania for improvement in our appropriate care measures.

• At the start of our participation in this project (in 2005) we were ranked # 35 our of 36 hospitals for HF ACMs. At the end of this project, we were ranked # 1 out of 36 in HF ACMs

• We have received the HF Gold Award from GWTG AHA in 2009 for two year’s worth of HF data being at 85% compliance or better.

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**HF CORE MEASURE COMPLIANCE**

<table>
<thead>
<tr>
<th>Measure</th>
<th>4th Quarter 2009</th>
<th>4th Quarter 2010</th>
<th>3rd Quarter 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge Instructions</td>
<td>96%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Evaluation of LVS Function</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>ACEI or ARB for LVSD</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Adult Smoking Cessation Advice/Counseling</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>HF—Patient Appropriateness of Care Compliance</td>
<td>97%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
To sustain our HF compliance, as evidenced by the previous slide, we have implemented the following through our ABC process:

- Placed a clinical quality data RN specialist on the clinical units--monitoring the care our HF patients receive in “real-time”
- Have revised our HF discharge instructions to include a follow-up call to the patient within 72 hours of discharge
- Collaborated with our home health agency in utilizing home telehealth monitors for our HF patients who request our agency and who meet criteria for these monitors.
- These monitors assess weight, blood pressure, O2 saturations, and pulse, along with a set of questions individually selected for each patient regarding edema, shortness of breath, meds, etc.
- These monitors are set up to be checked daily and the information is then sent to a secure website, which our home health nurses check on a daily basis (Monday—Friday) and identify any real or potential problems. If a problem is identified, the home health nurse calls the patient for more information and then either calls the physician or sends a nurse out to evaluate.

Our home health agency tracks all home health patients readmitted to the hospital during a home health episode, along with the number of patients on monitors readmitted to the hospital. Of 27 placements of monitors from 02/2009—10/2009, we had only two readmissions to the hospital, and neither were for a CHF diagnosis.

- In 2010, 25 monitors were placed on HF discharges, and 4 were readmitted within 60 days after the monitor was placed. Two of these four had CHF, but one of these two also had diagnoses of lung cancer and COPD.
- So far in 2011, we have had 18 monitors placed on HF discharges with 3 readmits to the hospital, and one of these three readmits was for CHF.
Our patient and family centered initiative utilizing telehealth monitors provides a sense of security for CHF patients and families in their transitioning from the acute care setting to the outpatient setting. They are more comfortable in their home environment with these monitors, knowing they have a mechanism in place to address issues and problems at the time they arise—with the interaction of the home health nurse and patient/family member.

This process allows the CHF patient to be followed safely in the outpatient setting/home environment.

ACCOMPLISMENTS AT HGH with OUR HF CORE MEASURE PROCESS

- Have submitted our CHF order sets and medication forms to the AHA, and were chosen to have our CHF tools posted in the GWTG Tool Library.
- Remain a HF mentor hospital for the IHI 5,000,000 Lives Campaign
- Had an article, showcasing our Heart Failure Tools, appear in the December, 2009 issue of “Critical Pathways in Cardiology” journal.
- Received the Gold Plus Heart Failure Award in 2011 (3 years in a row).
- Have received the five star rating for treatment of our HF patients from Healthgrades.

When providing optimal HF care, we benefit in many ways:
- LOS is decreased
- Utilization of resources is decreased and
- most importantly, patient satisfaction is increased.
* I hope my presentation regarding our ABC process, care of the HF patient, and HF core measure compliance helped you better understand our journey in providing the best care for our patients, every time—all the time—though our teamwork and collaboration.

**QUESTIONS ??**

For more information contact:

Andrea Andrew  
Director of Quality / Case Management  
Hazleton General Hospital  
570-501-4744  
aandrews@ggha.org
Building Reliability

- Need Reliability of the Evidenced Based Core measures to build on the continuum of care after discharge
- Core Measures work in tandem with Readmission Effort
- First step identifying the Core Measure Patients
Make your process sustainable over time

- Continually manage the process using the PDSA cycle
- Keep your eye focused on enhancing the process rather than blaming someone or some group for failure
- Key to work: culture change, communication and teamwork

Adult Smoking Cessation Advice/Counseling

- Numerator: Heart failure patients (cigarette smokers) who receive smoking cessation advice or counseling during the hospital stay
- Denominator: Heart failure patients with a history of smoking cigarettes any time during the year prior to hospital arrival
SMOKING

**ALL PATIENTS** regardless of diagnosis, need documentation of smoking education (cessation education, stay quit or second hand smoke exposure).

♥ If unable to give this to the patient, it can be given to the family.
♥ If unable to give education at the time the initial nursing history/assessment is completed and documented, smoking education cessation should be documented when the patient is able to receive the information.

Providing adult smoking cessation advice and counseling

- Establish a standardized process to ask all patients their smoking status and create a standardized, stepped education response for all patients who smoke.
Homework for January 5, 2012 call

Andrea shared the importance of team participation. Be prepared to discuss or share through the chat:

- What is the composition of your core measure team?
- How do you operate?
- Do you use the same process for all core measure patients, MI, HF and Pneumonia?

Expedition Communications

- If you would like additional people to receive session notifications please send their email addresses to improvementmap@ihi.org.
- We have set up a listserv for the Expedition to enable you to share your progress. To use the listserv, address an email to HFExpedition@ls.ihi.org.
Next Session

January 5, 2012, 12 – 1 PM ET
Reliably providing ACE inhibitor or angiotensin receptor blockers (ARB) at discharge for heart failure patients.