University Hospital
Introductions

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Special Thank You to Monica Worrell, BSN, RN
Objectives

- Explain/describe what defines readmission for heart failure.
- Discuss two strategies for improving heart failure patient care.
- Distinguish two challenges and highlight two benefits of seeking accreditation for Advanced Heart Failure and improving patient care.
Penalties by CMS for Heart Failure 30 day Readmissions

• Readmission for any cause within 30 days of discharge among patients with a primary diagnosis of heart failure (HF)

• Affordable Care Act, Medicare began financially penalizing hospitals with higher-than-average 30 day readmission rates.

• Bonuses are given to hospitals with lower than average 30 day readmission rates

• According to the CMS data analysis, in 2012 an estimated
  • 8% of hospitals will receive the maximum penalty
  • 57% of hospitals will receive less than the maximum penalty
  • 34% of hospitals will receive no penalty
Estimates of Cost of Readmission

- Medicare: 18 billion spent on 30 day rehospitalizations annually
  - 1 out of every 5 Medicare patients discharged from a hospital is readmitted within 30 days (CMS)
  - HF is ranked as the #1 chronic condition for 30 day readmissions
- 30 Day All Cause HF readmission rates range 17.3%-24.7%
- Readmissions are frequent, costly and can be reduced

IHI, 2010
Hospital Value-Based Purchasing (HVBP)

- Authorized by Congress

- Encourages hospitals to improve the quality and safety of care that Medicare beneficiaries and all patients receive during acute-care inpatient stays by:
  - eliminating or reducing the occurrence of adverse events
  - adopting evidence-based care standards and protocols
  - re-engineering hospital processes that improve patients’ experience

- The HVBP program is designed to promote better clinical outcomes for hospital patients, as well as improve their experience of care during hospital stays

- How often do patients with HF get complete d/c instructions?
Greater Cincinnati Demographics

- Population: 2.13 million (12% over age 65)
- Male to Female ratio: 49% : 51%
- Race: White 85%, African American 13%, Other 2%
- Below poverty level: ranges from 33-39%
- People uninsured: 18%
- People with a bachelor's degree: 29%

(Based on 2010 census information of 15 counties)
Greater Cincinnati Demographics

- Obese or Overweight: 64.2%
- Adults who have been told they have high blood pressure: 33.6%
- Adults who have been told they have high cholesterol: 28%
- Adults who engaged in insufficient activity or no activity: 53.1%
- Current smokers: 29%

(Based on 2010 census information of 15 counties)
UCMC Patient Demographics FY12:

Inpatient Admissions: 676
Heart Failure Clinic Visits: 3387

Average LOS: 5.7 days
Average age: 60 yrs.
Female: 47%
Male: 53%
African American: 67%
Caucasian: 30.6%
Other: 2.4%
Principal Diagnoses

- 29% Acute on Chronic Systolic
- 17% Acute on Chronic Systolic/Diastolic
- 16% Acute on Chronic Diastolic
- 38% All other Heart Failure Diagnoses
5/1/2013

Program Landmarks

1985 – First Heart Transplant at University Hospital (the regions only Cardiac Transplant Center)

2005 1985 2010

1987 – First Cardiac Assist Device implanted in clinical trials

1985-1994

1997 – Inception of Comprehensive Heart Failure Treatment Center

1996 – First FDA approved LVAD implanted

2002- Heart Failure gene identified by team at UC

2005-2014

2009 – Contracted surgical group to provide cardiac surgical services

2011 – Implemented RWJ initiative & Your Heart’s Connection Team

2012 – Achieved AHA Get with the Guidelines Bronze Level

2011- First continuous flow LVAD and first CentriMag Temporary RVAD implanted at UCMC

2013- Achieved AHA Get with the Guidelines Silver Level
Program Mission

The Advanced Heart Failure Program is dedicated to serving the needs of adult patients in various stages of heart failure with compassion and a commitment to excellence.
Program Goals

Goal
The goal of the Advanced Heart Failure Treatment Center is to become the premier regional provider for patients with advanced heart failure.

Objectives
1. Increase access to advanced therapies for patients with advanced heart failure
2. Raise awareness of current treatment options through social networking and education of the community and their healthcare providers
3. Optimize patient outcomes utilizing standardized performance measures
Multidisciplinary Program Development Team

- Stephanie H. Dunlap, DO. Medical Director Advanced Heart Failure Program
- Director, Cardiovascular Services
- 2 CNS, Heart Failure Coordinators
- Mechanical Circulatory Device Coordinator
- Transplant Coordinator
- Intermacs Coordinator
- Advanced Practice Nurses from the Advanced Heart Failure Treatment Center

- Managers from Cardiology Division
- Clinical Program Developers
- Pharm D
- Social Workers
- Physical Therapy
- Nutrition Services
- Quality Improvement, Compliance and Safety
- Coordinator of Accreditation, Compliance and Safety
- Performance Improvement and Informatics
Joining a National Effort to Improve the Quality of Heart Failure Healthcare

- In October 2010, UCMC, joined more than 100 other forward-thinking hospitals through the Robert Woods Johnson Initiative. Together, 16 communities identified ways to improve the quality of patient care provided to heart failure patients.

- Nationally, 98% of hospital teams participating in (RWJ) Aligning Forces for Quality improved the quality of care for their patients in measurable ways.
Robert Woods Johnson Initiative

Goal
Lift the overall quality of health care while reducing racial and ethnic disparities and provide models for real reform.

*University Hospital was selected by RWJF to lead the local Aligning Forces for Quality effort. In all, 16 regions of the country have been designated as part of Aligning Forces. In each region, a range of efforts to help doctors, nurses and hospitals improve quality – as well as engage consumers to be better patients – was tested.*
The graph displays baseline readmissions data (Oct-09 to Mar-10) prior to joining a National Effort to Improve the Quality of Heart Failure Healthcare and subsequent readmissions data throughout the initiative. The trend lines reflect the general direction of improvement during each period of time.
Your Heart’s Connection Program

Mission
To offer patients the education and resources to properly manage and treat congestive heart failure.

Goal
To implement a disease management program to provide a comprehensive education and resource liaison to support and empower CHF patients. The program will be designed with a primary focus of reducing hospital re-admissions.
Your Heart’s Connection Program

• After admission, the care team places a referral to Your Heart’s Connection.

• The nurse and/or heart failure coordinator initiates the education process and gives the patient an education packet.
  • Education packet focuses on diet, fluid restriction, daily weights, activity, and worsening heart failure symptoms
  • All in-patients are encouraged to attend a 60 minute heart failure education class
  • The patient is screened for barriers and consults are ordered as needed: social work and financial counseling for all patients

• If needed, patients are provided a scale, medication organizer, measuring cup and calendar for daily weights
Your Heart’s Connection

The data collected from February 2011 to November 2011 demonstrated a 28% reduction of patients re-admitted for all causes of heart failure, demonstrating that the interventions used have been beneficial in empowering the patients to best take care of themselves as well as keep them comfortable in their own environment.
Advanced Heart Failure Program

Readmission Rates

• Prior to Robert Woods Johnson & Your Heart’s Connection: 26.7% (FY10)
• After Robert Woods Johnson & Your Heart’s Connection: 22.4% (FY12)
UCMC: Road to Accreditation

- Get with the Guidelines- Heart Failure
- 2 APN HF coordinator positions created and qualified personnel hired
- Established clinical practice guidelines
Clinical Practice Guidelines

Comprehensive Guidelines developed by the Multidisciplinary Heart Failure Team based on current national guidelines

- Diagnostic Testing
- Assessment
- Nursing Care
- Medical Management
- Treatments & Interventions
- Recognition of Barriers
- Consults

(Based on the ACC/AHA, HFSA, & ESC guidelines)
UCMC Road to Accreditation (con’t)

- HF pathway & discharge checklist updated
- After-hospital care plan developed & implemented
- *Your Hearts Connection* education folder given to patient when able to participate in education process.
  - Calendar, mediset, measuring cup, scale
- Discharge weights documented on transition of care form.
  
  Forms faxed at discharge to the next level of care: personal provider, nursing home, Home Care etc.
Discharge Planning

- Follow-up appointments arranged within 7 days of discharge
- Advocate for discharge home with home health or to nursing home
- Free two week supply of discharge medications given to indigent patients
- Patient evaluated prior to discharge using teach back method on knowledge of HF self-care
- Patients contacted within 72 hours of discharge and encouraged to use the *Your Hearts Connection* phone line for questions
- Patients questioned regarding education, preparedness, & overall satisfaction with hospital experience.
Your Heart's Connection Patient/Caregiver Satisfaction Survey

Completing this survey will help us improve the hospital experience we provide to heart failure patients.

This is voluntary and will be kept confidential.

You received education about heart failure. We understand that it may have seemed overwhelming at the time, now that you have been home, was the amount of information...

Too much? Just the right amount? Not enough?

Please indicate your agreement to the following statements. Please select "N/A" if the statement does not apply.

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>The physician provided me with information about my condition.</td>
<td></td>
<td></td>
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<tr>
<td>The doctors and nurses involved me and my family in my care.</td>
<td></td>
<td></td>
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<tr>
<td>I was satisfied with the nursing care I received in the hospital.</td>
<td></td>
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<tr>
<td>Did the nurses give you a printout of your medications each day?</td>
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<tr>
<td>Was this helpful? Attending the Your Heart's Connection class was helpful.</td>
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<td></td>
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<tr>
<td>The written material I received about heart failure was helpful.</td>
<td></td>
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<tr>
<td>I felt prepared to go home.</td>
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Is there anyone you would like to recognize for their contributions? If so, who?

Is there anything we could have done or can still do to make you feel more comfortable and prepared at home?
Benefits of Accreditation

- Highlight to the community & payers the use of evidence based practices
- Quality of patient care is improved through a systematic approach
- Demonstrates a commitment to higher standards of service
- Provides a framework for organizational structure and management
- Provides a competitive edge in the marketplace
- Enhances staff recruitment and development
Phase II Initiatives: Focusing on Quality

- Implementation of EPIC system wide
  - Ordersets: admission & discharge
  - Core measure navigator
  - Education documentation
  - Follow-up appointments
- Collaboration with ancillary staff
  - Social work, dietary, PT/OT, cardiac rehab
Phase II Initiatives: Focusing on Quality

- New education materials for patients
  - Cardiology handbooks
  - Patient driven, daily medication information sheet
  - Your Hearts Connection bracelets
- Continuous education to staff
  - Nursing
  - Physicians & residents
  - ED observation unit
  - Coders
Education: Healthcare Providers

- RN Orientation Skills Checklist
- Initial Training and Competence
- Critical Care Internship Program
- Bi-Annual Competency (Spring/Fall)
- Yearly Staff Skills Checklist
- Demonstration Skills Lab
- Individualized Teaching
- Resource Manuals
- Morbidity and Mortality Panel
- Patient Safety Crucial Conversation Meetings

- Interim updates provided by Heart Failure Coordinator and/or staff educator
- Grand Rounds/Nursing Grand Rounds
- Access to Internet, computer based training, device manuals, training CDs, and reference cards
- Dinner for Spotlight on Heart Failure
- Monthly in-services for residents
Phase II Initiatives: Focusing on Quality

- IMPACT Committee
- Transition of Care meetings
- Focus group for literacy & health literacy
- Continued growth of mechanical circulatory support and cardiac transplant programs
- Ultrafiltration program for in and outpatients
Phase II Initiatives: Focusing on Quality

• Partnerships with outside agencies
  – Education to skilled nursing facilities
  – Homecare Agencies & Rehab Facilities
    • Invitations to nursing competencies
    • Lecture provided by HF nurse practitioners
    • Individualized training in HF clinic
  – Palliative Care & Hospice
    • Early introduction and education
    • More family meetings
    • Home inotrope therapy
Community Outreach

- Heart Failure classes for inpatients and monthly classes for outpatients
- Greater Cincinnati Urban League Health Fair
- American Heart Association Mini-Marathon
- American Heart Association's Go Red For Women Event
- Annual Center for Closing the Health Gap Conference & Health Expo
- Deaf and Hard of Hearing Community Health Fair
- Heart Month & HF Clinic Open House

- Meeting with congressman to discuss healthcare legislation
- Su Casa Health Fair
- UC Campus Wellness Health Fair
- Women 4 Women
- Breathe Heart Failure and Cardiovascular Symposium
- Cardiovascular Disease for Primary Care and Specialist
- EMS Midwest Conference
- Greater Cincinnati Health Council
- Advanced Heart Failure & LVAD Case Study Presentation
Barriers

- Transportation Issues
  - To physician visits, dialysis, pharmacies, rehabilitation sessions & out-patient testing
- Lack of primary care providers
- Literacy Issues: health literacy and illiteracy
- Monetary issues regarding healthy foods and lack of inner city grocery stores
- High sodium American diet (3-4 gram)
Thank You!