Heart Failure Readmission Project

Angie Leach, RN
FLEMING COUNTY HOSPITAL
A not for profit hospital with approximately 100,000 sq. ft., it serves residents of Fleming and surrounding counties. The hospital employs over 260 staff members and has 52 acute care beds, 10 of these being swing beds.
Getting Started

- Gained Administrative and Physician support for HF Readmission project
- Established Interdisciplinary Heart Failure Committee
- Identified Physician Champion
- Created Plan of Action (Handout)
- Joined Get With The Guidelines-Heart Failure program to begin tracking performance of evidence based guidelines
Science Review

- Collected all existing Heart Failure pathways, protocols, treatment algorithms and order sets
- Evaluated compliance to current published guidelines from the American Heart Association/American College of Cardiology
- Committee made recommendations for new HF Order Set
- Implemented HF Order Sets
Evaluated Current process

- How can we Identify target population?
- Who can take responsibility for assuring guidelines/measures are achieved?
- What processes are already in place?
- Review and Revision of Discharge Instructions (included Dietary and Pharmacy partners)
- Reviewed patient educational information
Implementation of Program

- In-services to nursing staff, including Case Management on treatment guidelines
- Familiarized nursing staff with new Admission Order Set, Discharge Instructions, CHF Checklist Flowchart and Educational packets
- The new CHF process is Nursing “owned”
- Instructed nursing staff to flag CHF charts with CHF Checklist on front of chart
- Give rewards to staff for documenting...names in drawing
- Discharge education given to patients on DAY 1
- Schedule of TV Educational programs given and prescribed to patient
- Nursing staff keeps Case Management informed of patient progress daily
**DISCHARGE INSTRUCTIONS FOR HEART FAILURE**

**Weight Yourself Everyday**  
In the morning after waking and before Breakfast

No Added Salt!  
Salt causes fluids to build up!  
Avoid deep fried foods.  
Avoid adding salt during or after cooking.  
Avoid processed meats.  
Avoid processed foods.  
Read food labels.  
Use pepper and salt free spice blends.  
Try flavored vinegars, lemon or lime juice, fresh or dried herbs, or garlic.

**REPORT THESE SYMPTOMS TO YOUR DOCTOR**

- Increased swelling in:
  - ankles
  - legs
  - face
  - fingers
  - stooped posture

Increased shortness of breath, especially when lying down

Extreme tiredness

Nausea or lack of appetite

When you return home, if you have ANY of these symptoms:

**CALL 911 OR GO TO THE EMERGENCY ROOM**

- Sudden, severe shortness of breath
- Restless, dizzy, or lightheaded feeling
- Very fast or irregular heart beat
- Facial droop, difficulty with speech
- Weakness in arms or legs
- Chest pain or discomfort or pain

**CHF CHECKLIST FLOWCHART**

(Not a part of permanent record/Place in discharge call box on discharge)

1. Echo order and/or documentation of ejection fraction  
   (If No, physician ordered to order and/or document ejection fraction.)  
   (Most recent echo, stress test or MUGA results may be obtained and placed on chart for ejection fraction results.)
   (ACE or ARB to be prescribed for patient with LVEF and NO CONTRAINDICATIONS)

   Yes [ ]
   No [ ]
   Initials [ ]
   Date/Time [ ]

2. Was ACE prescribed on admission? (If No, reason documented)  
   MD ordered to prescribe or document reason why not ordered.
   MD prescribed on discharge? (If No, reason documented)
   MD ordered to prescribe or document reason why not ordered
   OR

   Yes [ ]
   No [ ]
   Initials [ ]
   Date/Time [ ]

3. Was ARB prescribed on admission? (If No, reason documented)  
   MD ordered to prescribe or document reason why not ordered.
   Was ARB prescribed on discharge? (If No, reason documented)
   MD ordered to prescribe or document reason why not ordered
   OR

   Yes [ ]
   No [ ]
   Initials [ ]
   Date/Time [ ]

4. Was Beta Blocker prescribed on admission? (If No, reason documented)
   MD ordered to prescribe or document reason why not ordered.
   Was Beta Blocker prescribed on discharge? (If No, reason documented)
   MD ordered to prescribe or document reason why not ordered
   OR

   Yes [ ]
   No [ ]
   Initials [ ]
   Date/Time [ ]

5. Does patient have a history of smoking in the past year?
   Yes [ ]
   No [ ]
   Initials [ ]
   Date/Time [ ]

6. Smoking Cessation Advice/Counseling Given
   Notes:  

7. Activity Level Instructions Given
   Level Recommended on Discharge
   Notes:  

8. Diet/Tuid Intake Instructions Given
   Diet Prescribed on Discharge
   Notes:  

9. Instructions on Follow-up with MD/ANEPA
   Appointment Date/Time:  

10. Medication Instructions Given
    | Medication | Date | Frequency |
    |-----------|------|-----------|
    | Beta Blocker: |      |           |
    | ACEI: | | |
    | ARB: | | |
    | Diuretics: | | |
    | Notes: | | |

11. Worsening of Symptoms Instructions Given
    Notes: | | |
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<th>TIME</th>
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<th>TUESDAY</th>
<th>WEDNESDAY</th>
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<th>FRIDAY</th>
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<td>Living with Prostate Cancer</td>
<td>Lung Cancer: Improving Survival</td>
<td>Nasal Congestion and Controlling Your Allergies</td>
<td>Alzheimer's Disease: Hope and Help</td>
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<td>Emphysema &amp; Chronic Bronchitis: Coming Up For Air</td>
<td>Preventing Flu And Pneumonia</td>
<td>COPD: Take Control</td>
<td>Asthma: One Breath at a Time</td>
<td>Emphysema &amp; Chronic Bronchitis: Coming Up For Air</td>
<td>Preventing Flu And Pneumonia</td>
<td>COPD: Take Control</td>
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<td>Irregular Heartbeats: Beating the Odds</td>
<td>Heart Failure: Women at Risk</td>
<td>Irregular Heartbeats: Restoring the Rhythm</td>
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Transitions of Care-Case Management

- Case management coordinates with Home Health Agency
- Perform LACE Tool prior to discharge (prediction of readmission)
- Hospital auxiliary provides funding for scales and pill boxes for CHF patients
- Discharge instructions include daily weights with calendar for documenting at home
- Case Management now performs all patient call backs within 48h of discharge (This is tricky sometimes because the patients who are at high risk are scheduled f/u apt within 48h)
- Intense script to walk through interventions: daily weight, medication adherence and recognition, ride to f/u apt, home health visit conducted
Physician Support

- Physician championing the program at Medical Staff meetings
- Made visits to local physician offices to introduce new CHF Order Sets to MD’s (took cookies as incentive!)
- Continuous MD Education: At MD Dictation Stations provided information on Mortality Predictor, Articles, Best Practice information
- Presented progress and improvement at Med Exec Committee meetings
Evaluation and Quality Improvement

- Real time data input and management using the Get With The Guidelines Patient Management Tool helped identify areas for improvement.
- Helps improve guideline adherence before patients discharged and before data submitted to CMS.
- Stayed engaged with American Heart Association educational events to learn from webinars for best practices and ideas for quality improvement.

Let’s review our results!
ACEI/ARB at Discharge

![Bar Chart](chart.png)
Evidence-Based Specific Beta Blockers
Post Discharge Appointment for Heart Failure Patients

Percent of eligible heart failure patients for whom a follow-up appointment was scheduled and documented including location, date, and time for follow up visits, or home health visit.
Discharge Instructions
Follow-up Visit Within 7 Days or Less
Benchmarking Fleming County - Comparison to over 945 hospitals in Get With The Guidelines

ACE/ARB at Discharge

Fleming County Hospital Performing better than the nation

Chart: Percent of Patients

- 2012
- 2013
- 2014

Time Period

Legend:
- My Hospital
- All Hospitals
Benchmarking Fleming County - Comparison to over 945 hospitals in Get With The Guidelines

Evidence Based Beta Blockers

Fleming County Hospital Performing better than the nation
Benchmarking Fleming County - Comparison to over 945 hospitals in Get With The Guidelines

Post Discharge Appointment for Heart Failure Patients

Fleming County Hospital Performing better than the nation
Proud of our recognition from the American Heart Association

2 Consecutive years of 85% or higher in Four Heart Failure Achievement Measures and 75% or higher in 4 Quality Measures

The American Heart Association and American Stroke Association recognize this hospital for achieving 85% or higher adherence to all Get With The Guidelines® Heart Failure Performance Achievement indicators for consecutive 12 month intervals and 75% or higher compliance on at least 4 of the Get With The Guidelines Heart Failure Quality Measures to improve quality of patient care and outcomes.