Reducing HF Readmissions: The Creighton Story Using Project RED

Creighton University Medical Center

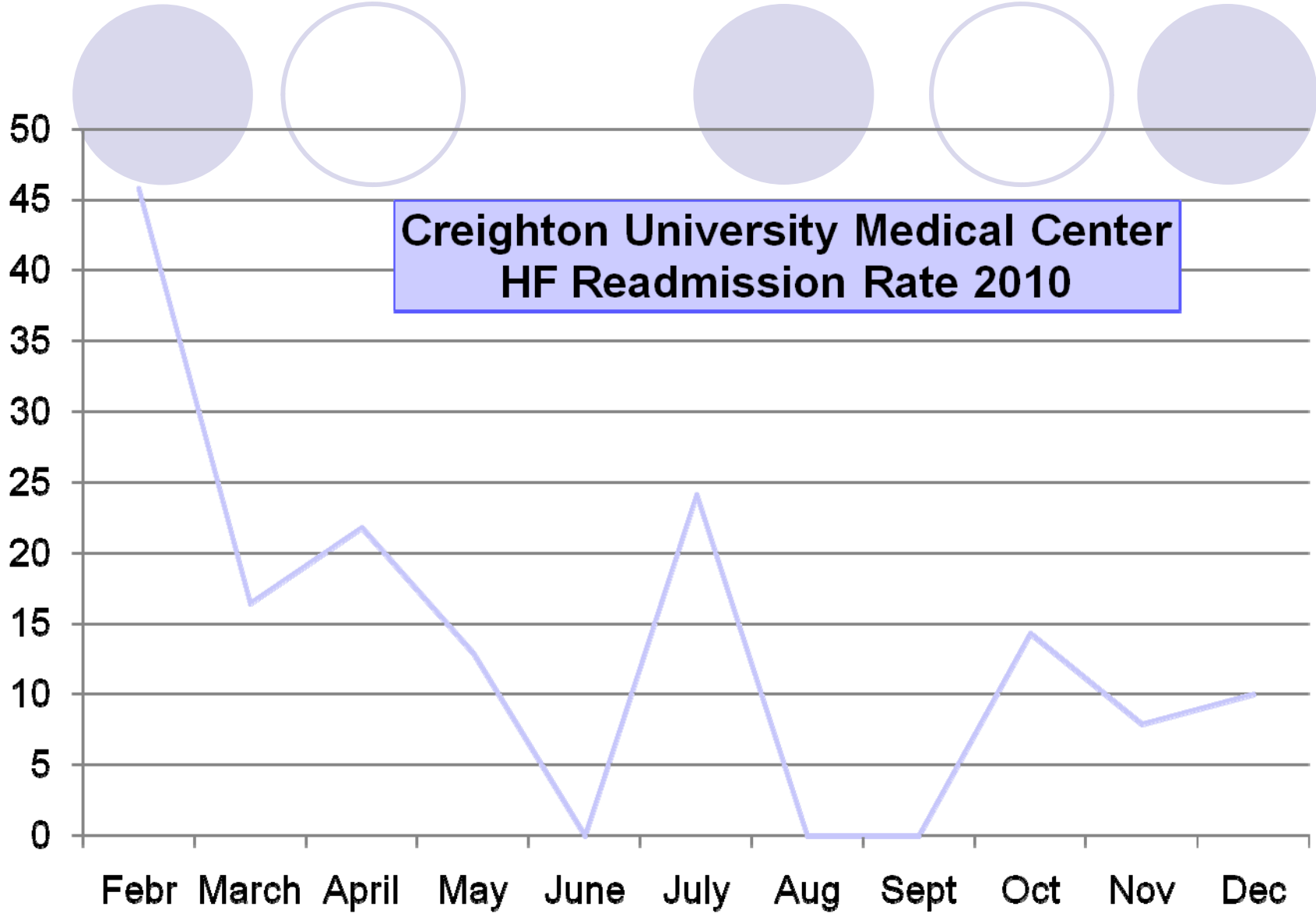
Cathy Jesus MSW CSW, Director of Clinical Quality Improvement
Dianne Hayko, RN MS, Director, Informatics, Education, PI

Objectives

- To identify the key initiative to reduce HF readmissions
- To list the components of the Project RED Model
- To describe initiatives to improve care transitions points including discharge

Creighton Heart Failure Readmission

- Within Nebraska
  - 2007 14th out of 18 NE PPS Hospitals
  - Latest 2nd out of 18 NE PPS Hospitals
- Within Tenet Health System Score Card
  - 2010 YTD 9 out of 47 hospitals
  - Tenet Academic Centers rank 1st of 3
  - Readmission rate of 13.5 [Goal 18% or less]


Creighton University Medical Center
HF Readmission Rate 2010
50
45
40
35
30
25
20
15
10
5
0
Febr
March
April
May
June
July
Aug
Sept
Oct
Nov
Dec

Project RED Re-engineering Discharge

- Educate the patient about Dx during stay
- Schedule appointments for follow up care
- Organize post discharge services
- Confirm medication list
- Review steps what to do if problem arises
- Expedite transmission of discharge info to next provider
- Assess degree of patient understanding of discharge information – repeat in own words
- Provide written discharge transition plan of care
- Provide telephone reinforcement of discharge plan within 2-3 days of discharge

Boston University Medical Center Research Group funded by Agency for Healthcare Research and Quality

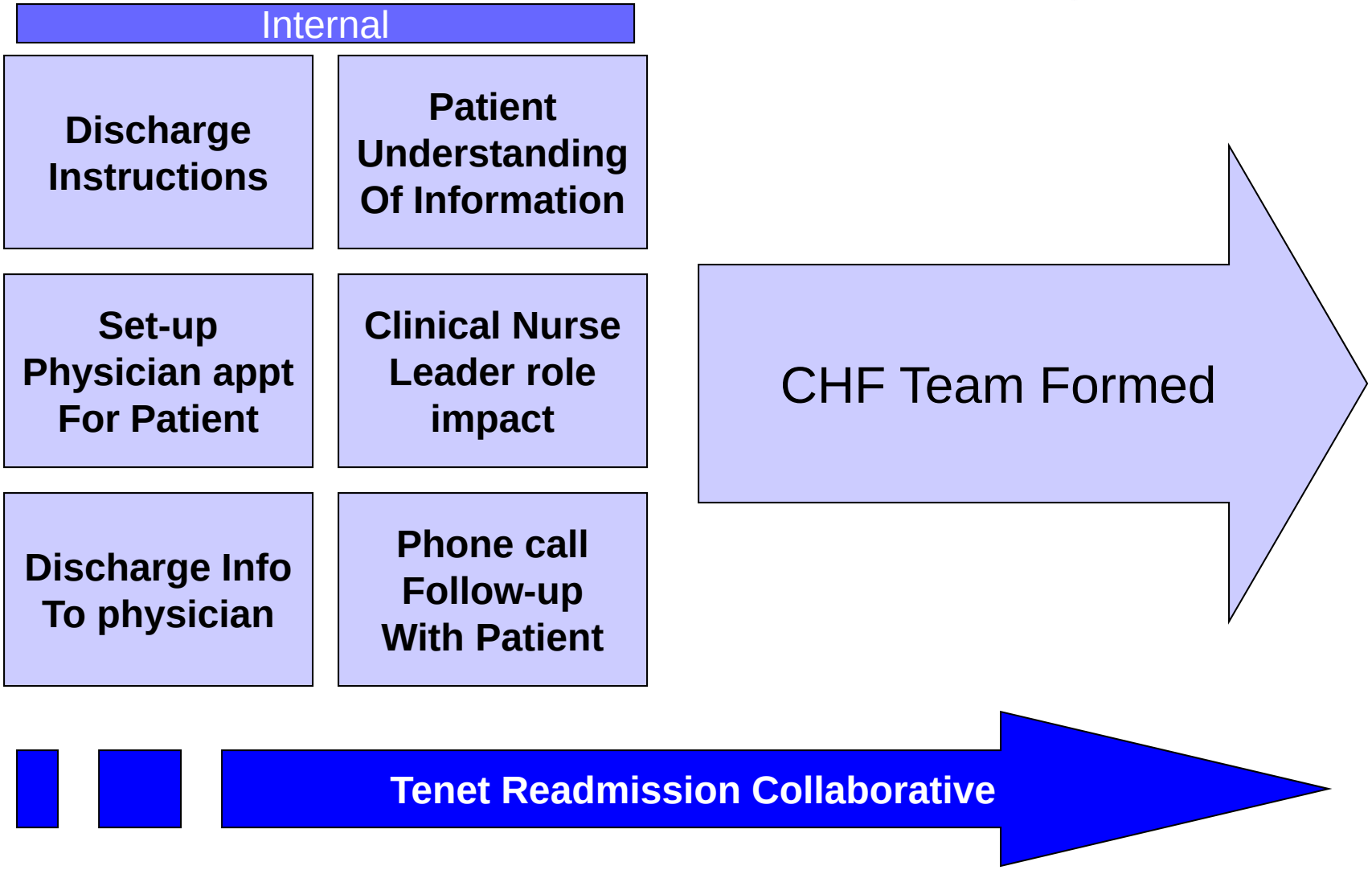
CUMC Discharge Transition to Community

External		Internal	
Meet with physician groups	BCBS discharge Follow-up	Discharge Instructions	Patient Understanding Of Information
Meet with Nursing Homes	Meet with CHF clinic	Set-up Physician appt For Patient	Clinical Nurse Leader role impact
Meet with UniNet Follow up Care	Meet with Cardiac Center	Discharge Info To physician	Phone call Follow-up With Patient

Pre-Hospital Emergency Care

Drill down on processes

CUMC Discharge Transition to Community



CHF Team

- Formed March 2010
- Multidisciplinary
  - Nursing
  - Physicians
  - Case Management
  - Social Work
  - Nutrition
  - Pharmacists
  - Cardiac Center
  - CHF clinic
  - Emergency Care

Initiatives

- Admission
  - Assess/identify factors related to readmission
  - Identify CHF admits
  - Heart on chart - room
  - Lasix list review
  - Literature review
  - Focus on reasons for return to prevent readmissions
  - Use self-care behavior tool – design discharge

Initiatives continued

- Patient education ‘Heart Failure Zone’
- Readmission case review
- Explore discharge resources ASAP
- Focus on discharge readiness
- Focus on patient understanding – AskMe3
  - What is the main problem? Able to answer
  - What do I need to do?
  - Why is this important to do this?

Heart Failure Zones

EVERY DAY:

- Weigh yourself in the morning before breakfast, write it down and compare to yesterday's weight.
- Take your medicine as prescribed.
- Check for swelling in your feet, ankles, legs and stomach.
- Eat low salt food.
- Balance activity and rest periods.

Which Heart Failure Zone are you today? GREEN, YELLOW or RED?

GREEN ZONE

ALL CLEAR – This zone is your goal

Your symptoms are under control. You have:

- No shortness of breath.
- No weight gain more than 2 pounds (it may change 1 or 2 pounds some days).
- No swelling of your feet, ankles, legs or stomach.
- No chest pain.

Heart Zone

YELLOW ZONE

CAUTION - This one is a warning

Call your doctor's office if:

- You have a weight gain of 2-3 pounds in 1 day or a weight gain of 5 pounds or more in 1 week.
- More shortness of breath.
- More swelling of your feet, ankles, legs, or stomach.
- Feeling more tired. No energy.
- Dry hacky cough.
- Dizziness.
- Feeling uneasy, you know something is not right.
- It is harder for you to breathe when lying down. You are needing to sleep sitting up in a chair.

RED ZONE

EMERGENCY

Go to the emergency room or call 911 if you have any of the following:

- Struggling to breathe. Unrelieved shortness of breath while sitting still.
- Have chest pain.
- Have confusion or can't think clearly.

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Initiatives continued

- Follow up appt set for patient all discharges
  - Appointment made for patient 65%
  - Follow up on weekend discharges

Appointment within a week best practice

- Working with each physician individually if need

Initiative continued

- CHF class post hospitalization launched Fall 2010 with the Cardiac Center
  - Class held once a month
  - Taught by multidisciplinary team: Nurse Practitioner , Dietitian, and pharmacist
  - Referred upon discharge/scheduled
  - No cost to the patient

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THE CARDIAC CENTER of CREIGHTON UNIVERSITY MEDICAL CENTER
Quality Patient Care Through Education and Research

Heart Improvement Therapy: **DO MORE** with Heart Failure

If you have been diagnosed with or are at risk for heart failure, or know someone who is, this program is for you. Participating in your own care, or that of your loved one, is the key to living successfully with heart failure. Join experts from the Creighton Cardiac Center to learn more about the steps you can take to combat the signs and symptoms of heart failure.

DO MORE with Heart Failure is a ONE session class for people with a diagnosis of heart failure. During each two-hour session, you will learn more about:

- **D**aily weight monitoring
- **O**bserving symptoms that may signal worsening heart failure
- **M**edications
- **O**vercoming fears about living with heart failure
- **R**estricting salt and fluids
- **E**njoying life and exercise

The classes are open to anyone, especially Creighton University Medical Center and Creighton Cardiac Center patients and their loved ones. These classes are offered twice a month at the Creighton Cardiac Center,

To learn more about the program and to sign up, call 402.280.4929.

The Cardiac Center
3006 Webster Street
Omaha, Nebraska
(northwest of Creighton University Medical Center)

Plenty of free parking is available

Initiatives continued

- Medication list accuracy with RN & clinical pharmacist, review list with patient/family
- Provide scale for home use
  - Need based
  - Order through our Staples national contract
- Phone Call follow-up within 2-3 days of discharge
  - Focus on keeping appointment – reinforcement
  - Medication – prescription – answer & reinforce schedule
  - Clinical Nurse Leader target HF population
  - Expanding, hard wiring process, data collection
  - Expanding support information for the patient need/helps
  - Post card follow up if unable to reach patient after 3 calls

Transition to Community

- Self management, HHC…..
- Student Nurse visit ongoing
- Skilled nursing facility with like CHF management goals
  - Transition of information
  - Weight oversight critical
  - Staff education
  - Use HF zone education tool

New Discharge Instruction Patient Specific Information..

Plan of Care Transition

12/04/2009 15:58 Discharge Instruction Creighton University Medical Center

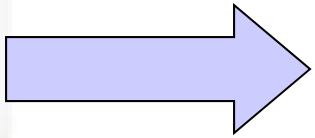
	Discharge	Instructions
Home Instruction	Activity	no pushing, no pulling Comment: as tolerated; no arm movement on left side above shoulder level for six weeks; no lifting > 10lbs, weigh daily (if wt increases > 2lbs overnight or 5lb in 1 wk take lasix 40mg orally)
	No lifting	6weeks 10 pound or more
	Diet:	Low fat, Low Sodium
	Notify MD if:	short of breath, Chest pain, lightheadedness, palpitations, Dizziness Comment: ICD shock; redness, swelling, or drainage at incision site
	Appointment #1	
	Doctor	Comment: Dr. Jill Kierscht
	Appt Date/Time	Comment: 1 week
	Appt status	Call for appoint
	Appointment #2	
	Cardiology	Dr. T. Hee
	Location	Cardiac Center
	Appt is for:	Lab Tests, follow up
	Appt Date/Time	Comment: 12/10/2009 @ 10:15a.m.
	Appt status	Appointment made
	Instruction	Comment: Check INR at this visit with Dr. Hee
	Appointment #3	
	Cardiology	Dr. W. Biddle
	Location	Comment: Denison
	Phone number	7122631608
	Appt is for:	follow up
	Appt Date/Time	Comment: 12/29/09 @ 1:30p.m.
	Appointment #4	
	Doctor	Comment: ICD Clinic
	Appt status	Will call you

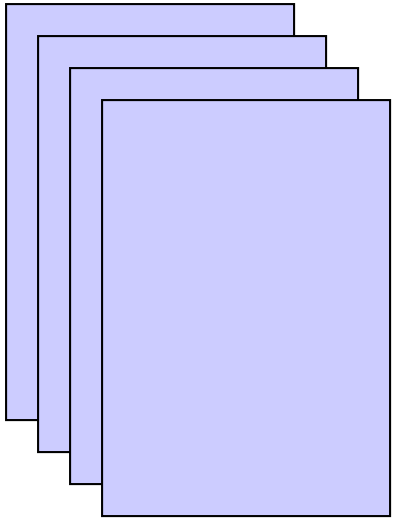
Transition to Skilled Care

- Met with skilled facility partners
  - Three meetings with SNF and QIO representatives
  - Identify information needed/wanted
  - Refined list, determined if data system generated
- Skilled facility wish list of information
- Goal minimal work by nurses at CUMC and provide clear information for receiving facility to also include HHC going forward

Transition to Community….

Information Requested





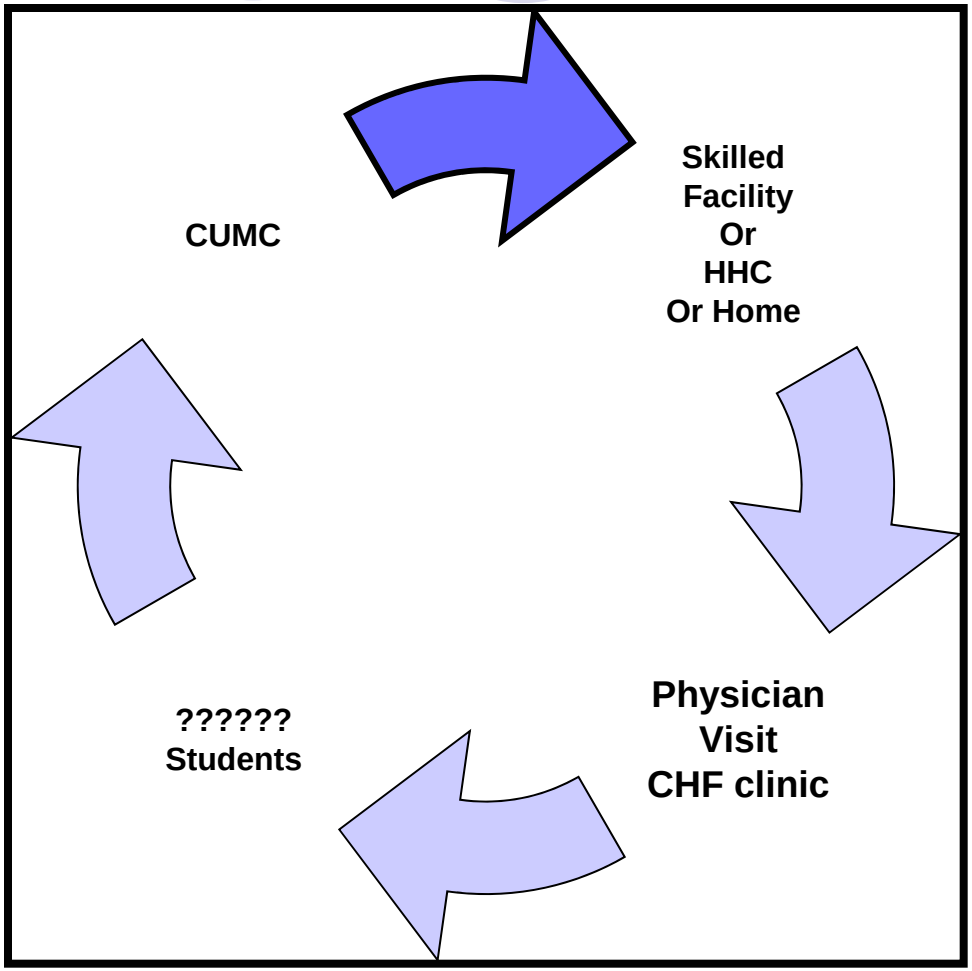
Four Reports Designed
System generated

- Last 24 hr snap shot
- Today's Assessment
- Discharge plan
  - Appointment
  - Follow up
  - Calls
- Medication List
  - Ready to fill

Win – Win – Win !!!!
Receiving Facility/HHC – Physician – Nurse – Patient

Design Complete – Education Completed

Next Steps - Community transitions points

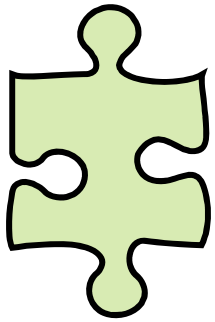


1. Work with HHC Agencies
2. Establish program with Creighton SON
3. Focus on readmitting factors – DNP project
4. Expand phone call follow-up
5. Info to PCP evaluate
6. Improve/refine processes focus on:

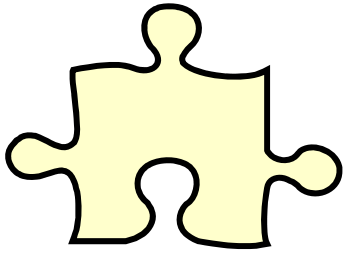
- Medication management
- Symptom management
- Follow-up appointment

Exceed set readmission benchmark

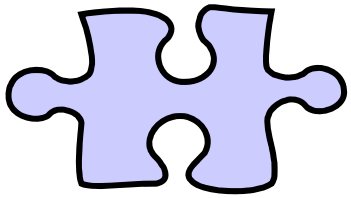
Any Questions? Thank you.



Cathy Jesus
Cathy.jesus@tenethealth.com



Dianne Hayko
Dianne.hayko@tenethealth.com



Recognize our team we are privileged
to work with everyday
Thank You