Reducing HF Readmissions: The Creighton Story Using Project RED

Creighton University Medical Center

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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]
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

Meet with physician groups
Meet with Nursing Homes
Meet with UniNet Follow up Care

BCBS discharge Follow-up
Meet with CHF clinic
Meet with Cardiac Center

Discharge Instructions
Set-up Physician appt For Patient
Discharge Info To physician

Internal

Patient Understanding Of Information
Clinical Nurse Leader role impact
Phone call Follow-up With Patient

Pre-Hospital Emergency Care

Drill down on processes
CUMC Discharge Transition to Community

**Internal**
- Discharge Instructions
- Set-up Physician appt For Patient
- Discharge Info To physician
- Patient Understanding Of Information
- Clinical Nurse Leader role impact
- Phone call Follow-up With Patient

CHF Team Formed

Tenet Readmission Collaborative
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

**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.

**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.
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
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:

- Daily weight monitoring
- Observing symptoms that may signal worsening heart failure
- Medications
- Overcoming fears about living with heart failure
- Restricting salt and fluids
- Enjoying 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
**Home Instruction**

<table>
<thead>
<tr>
<th>Discharge</th>
<th>Instructions</th>
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| 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 | 6 weeks 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

Win – Win – Win !!!!
Receiving Facility/HHC – Physician – Nurse – Patient
Design Complete – Education Completed

Four Reports Designed
System generated

• Last 24 hr snap shot
• Today’s Assessment
• Discharge plan
  • Appointment
  • Follow up
  • Calls
• Medication List
  • Ready to fill
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.

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