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University of Cincinnati Heart, Lung & Vascular Institute

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Introduction

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OBJECTIVES

- Discuss Evidence Based Practice
- Highlight UC Health Medical Centers Heart Failure Clinical Practice Guidelines
- Share our Heart Failure Program entitled “Your Hearts Connection”
- Discuss Program Metrics
- Summarize Growth & Development Strategies

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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)

Evidence Based Practice

- AHA http://www.heart.org
- HFSA http://www.hfsa.org/hf_guidelines.asp
- ESC http://www.escardio.org/Pages/index.aspx

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Clinical Practice Guidelines

Comprehensive Guidelines developed by the Multidisciplinary Heart Failure Team

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

(Based on the ACC/AHA, HFSA, & ESC guidelines)

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Heart Failure Program Design and Development

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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.

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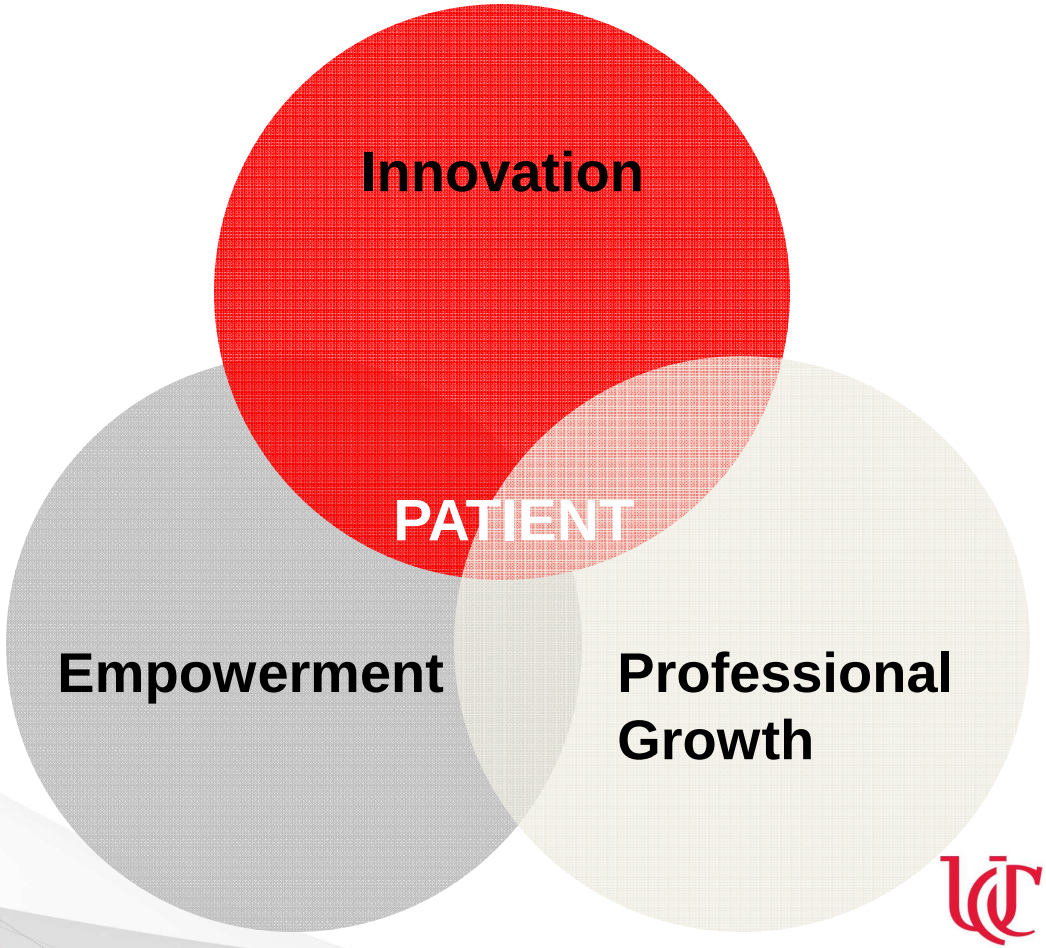
Bi-Monthly Heart Failure Meeting



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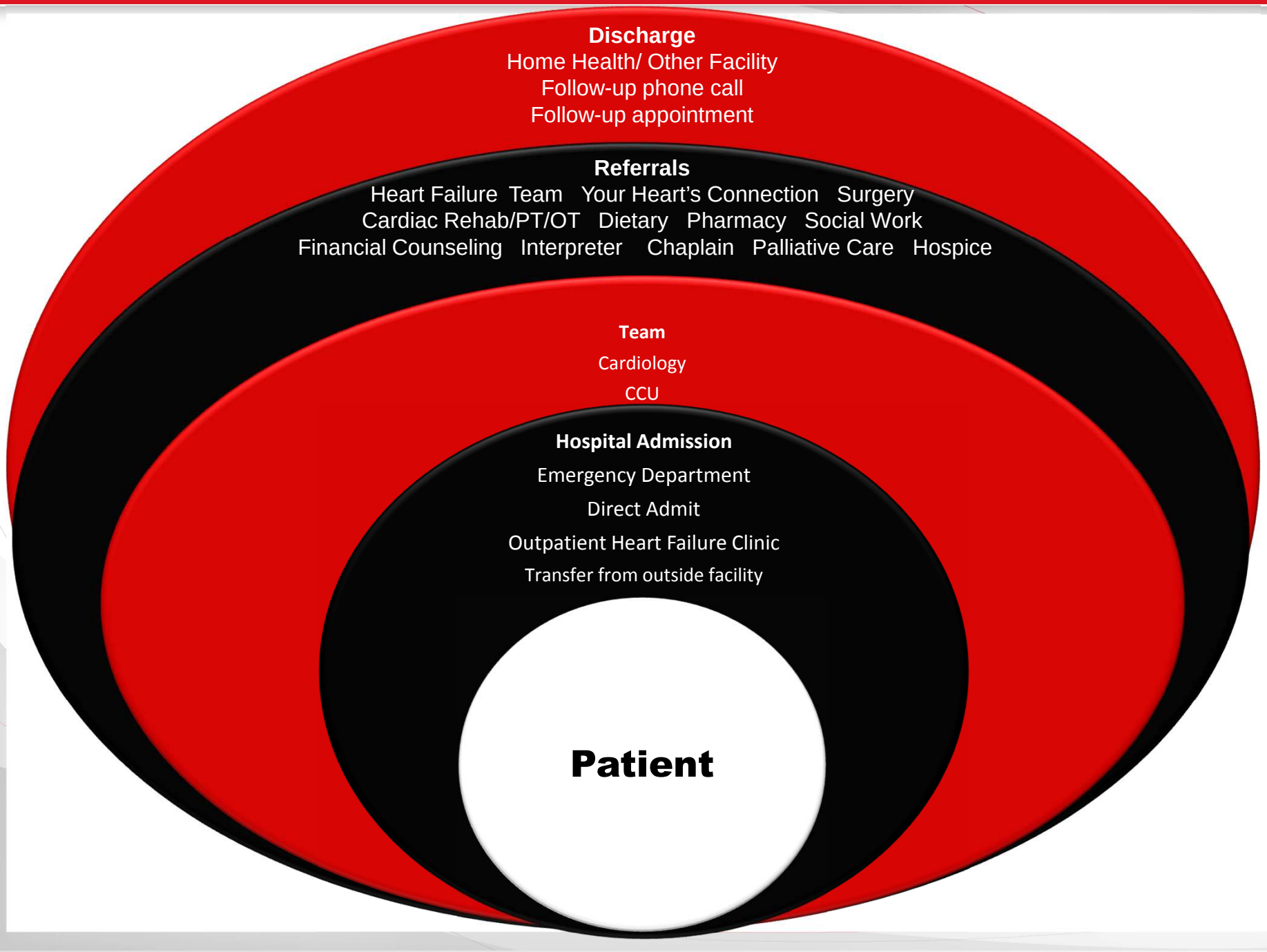
Multidisciplinary Program Development Team

- Stephanie H. Dunlap, DO. Medical Director Advanced Heart Failure Program
- Lynn Weishaupt, RN, MSN Director, Cardiovascular Services
- Kim Arthur, CNS, Heart Failure Coordinator
- Cheryl Hernandez, CNS, Heart Failure Coordinator
- Ginny Beckenhaupt RN, BSN, MCS Coordinator
- Mary Collier, RN, MSN, Transplant Coordinator
- Nancy McGuire RN, BSN, CCTC Intermacs Coordinator
- Russell Hoffman, ACNP, Advanced Heart Failure Treatment Center
- Anita Whitton, CNP, Advanced Heart Failure Treatment Center
- Linda Baas, ACNP, Advanced Heart Failure Treatment Center
- Sandy Greer RN, Manager CVICU/CSD
- Justin Foreman, ACNP, Advanced Heart Failure Treatment Center
- Monica Worrell, Clinical Program Developer
- Lindsey Clark, PharmD
- Nicole Wyse MSW, LSW
- Kristen Jordan, MSW, LSW
- Andrew Braisted, MHSA, Business Manager Cardiology
- Vickie Norton RN, JD, MBA, Director Quality Improvement, Compliance and Safety
- Todd Osborne RN, LNC, Coordinator of Accreditation, Compliance and Safety
- Jane Davis, PT Manager of Rehabilitation Services
- Melissa Doherty, RD LD, Nutrition Services
- Diane Dieckman, R.N., BBA, CPHQ Director, Performance Improvement and Informatics
- Judy Witt RN, Performance Improvement


Discharge
Home Health/ Other Facility
Follow-up phone call
Follow-up appointment
Referrals
Heart Failure Team Your Heart's Connection Surgery
Cardiac Rehab/PT/OT Dietary Pharmacy Social Work
Financial Counseling Interpreter Chaplain Palliative Care Hospice
Team
Cardiology
CCU
Hospital Admission
Emergency Department
Direct Admit
Outpatient Heart Failure Clinic
Transfer from outside facility
Patient

Your Heart's Connection

This is a multidiscipline team that provides a disease management program, comprehensive education, and resource liaisons to support and empower HF patients. The program was designed with the primary focus of reducing hospital re-admissions.

- Dietary and Social Work consults
- Financial Consult (Two week supply of discharge medications free of charge)
- HF Education and a resource packet utilizing a teach back method of understanding
- Dedicated portable phone line with messaging system
- Medication organizer, measuring cup and scale for daily weights
- Nurse driven follow up phone calls within 72 hours of hospital discharge

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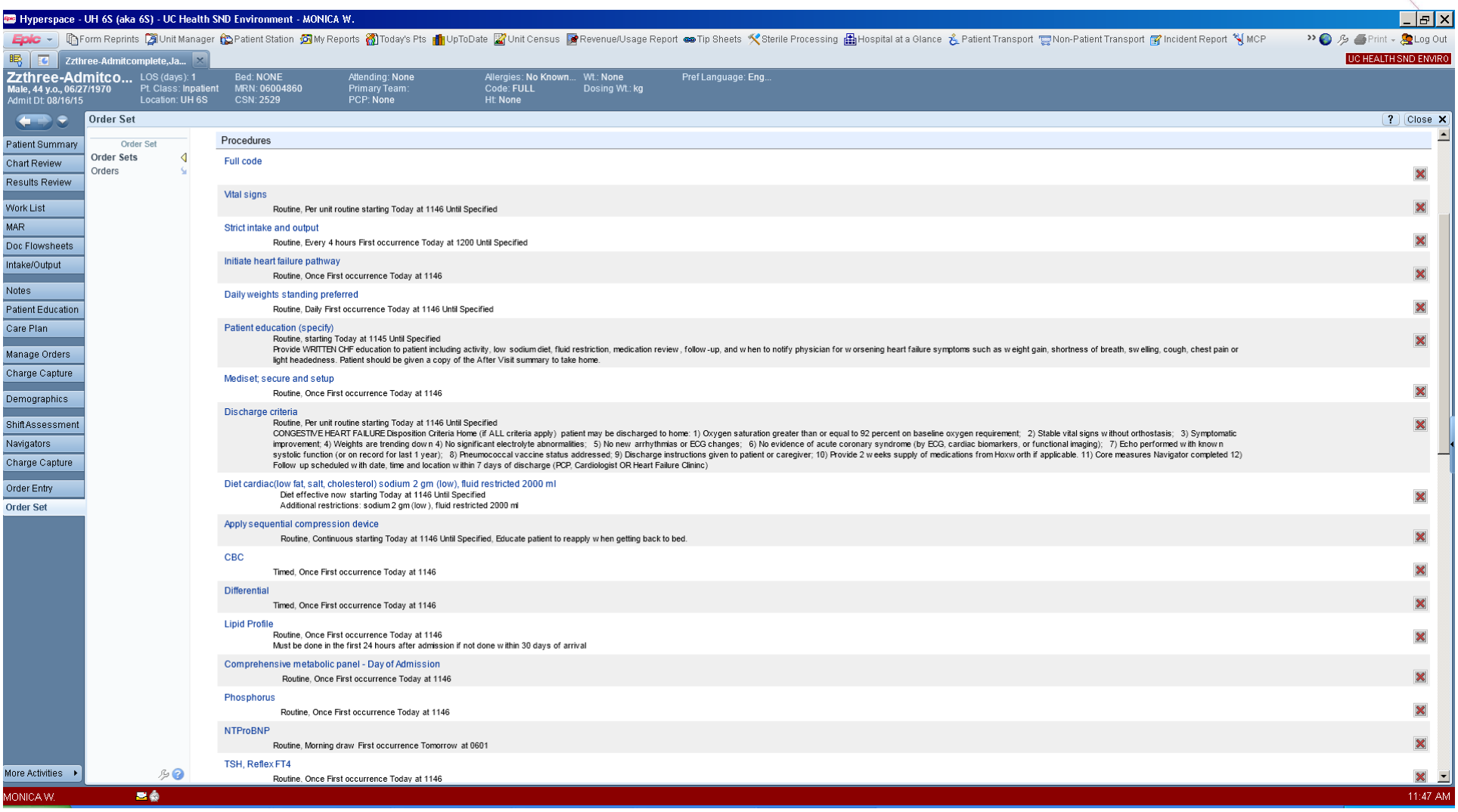
Heart Failure Order Sets



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

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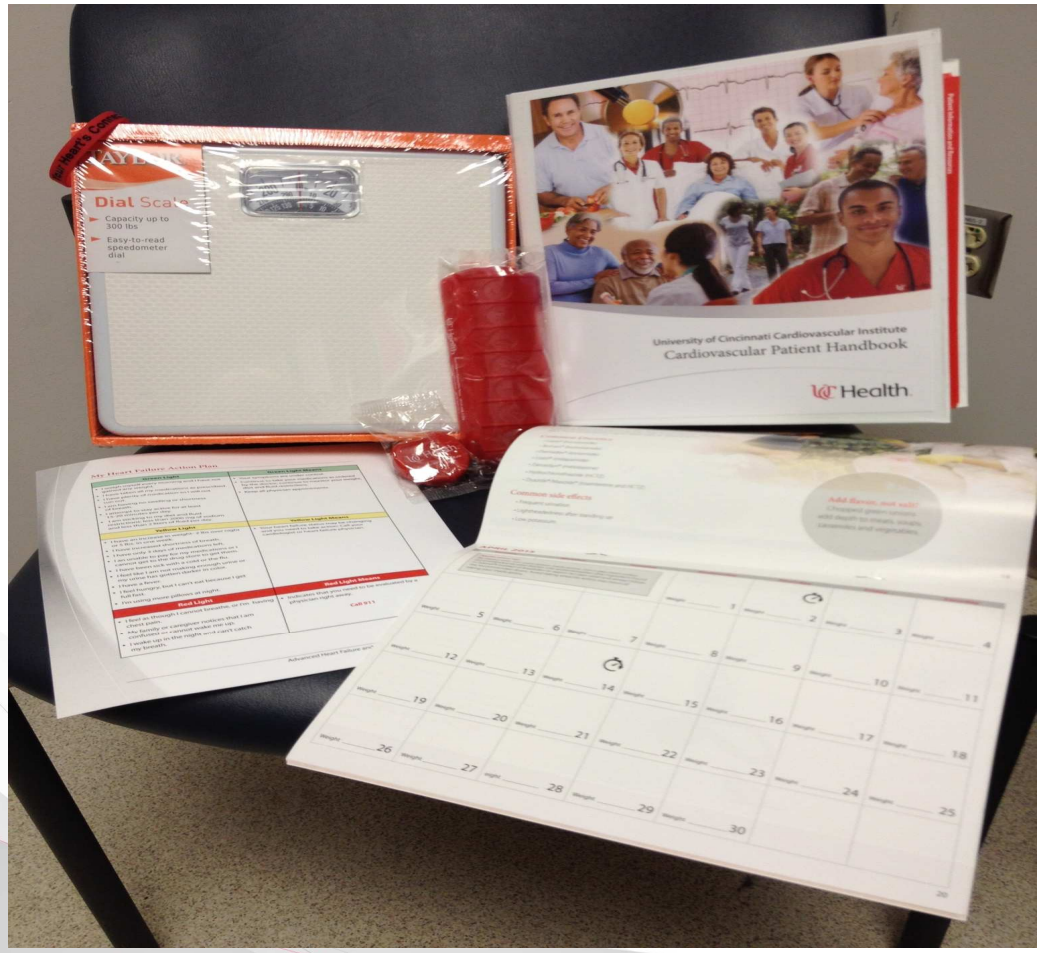
Patient Education Materials



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Two Full Time Heart Failure Coordinators

1. Admission Coordinator: Scans hospital wide to determine patients with heart failure (pulling reports), audits chart to ensure advanced directives are complete, audits chart to ensure heart failure education is being performed, performs assessment & teaching on each patient, participates in heart failure rounds, and communicates with multidisciplinary team members as needed.

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Two Full Time Heart Failure Coordinators

2. Discharge Coordinator: Audits patients chart to ensure the patient is on optimal medication regimen, has had recent LV function testing, and an Intra-conduction device conversation is noted. Ensures patient is scheduled for post admission follow up appointment and performs post discharge phone call within 72 hours of hospitalization.

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Your Heart's Connection Program: Discharge Planning

- Follow-up appointments arranged within 7 days of discharge
- 35% discharged with home health or to nursing home
- Two week supply of discharge medications given free of charge
- Before discharge, patient is evaluated with an assessment test or teach back method on their knowledge in HF self-care
- Patients contacted within 72 hours of discharge and encouraged to use the *Your Hearts Connection* phone line for questions

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Discharge Planning

- Medical
  - Confirm Follow-up Care
  - After hospital care plan
  - Medication Reconciliation
- Supplies
  - Scale
  - Pill Organizer
  - Measuring cup
- Education
  - Your Heart's Connection
  - Classes
  - Teach Back Method Used from Institute for Health Initiatives
- Community Resources
  - Home health
  - Heart Failure Clinic
  - Follow-up phone call
  - Your Heart's Connection phone line

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Your Heart's Connection Patient/Caregiver Satisfaction Survey

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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 feel the statement does not apply.

	Yes	No	NA
The physician provided me with information about my condition.			
The doctors and nurses involved me and my family in my care.			
I was satisfied with the nursing care I received In the hospital.			
The education I received about my medications was helpful.			
Attending the Your Heart's Connection class was helpful.			
The written material I received about heart failure was helpful.			
I felt prepared to go home.			

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?

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Education: Healthcare Providers

- Initial Training and Competence,
- RN Orientation Skills Checklist
- BI-Annual Competency (Spring/Fall)
- Critical Care Internship Program
- Demonstration Skills Lab
- Yearly Staff Skills Checklist
- Unit Educator
- Individualized Teaching (upon request or need)
- Resource Manuals on units
- Available Intranet Policies & Procedures
- Delmar Nursing EBook (Intranet)
- Krames On-Demand Education (Intranet)
- 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
- “Spotlight on Heart Failure” Dinner
- Monthly in-services for house staff
- Up-to-Date
- Partnership with Visiting Nurses’ Association to educate home health nurses
- Follow-up phone calls to nursing homes/rehab facilities & home health

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
- Cincy Cinco
- Deaf and Hard of Hearing Community Health Fair
- Heart Month & Clinic Open House
- Group Master's and Women's Open
- Meeting with congressman to discuss healthcare legislation
- Su Casa Health Fair
- UC Campus Wellness Health Fair
- Western & Southern Financial
- 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
- Nursing Homes

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Data Collection

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Continual Growth and Development

- Advanced Directives
- Palliative Care
- Indications for Medication Use
- Motivational Interviewing
- Heart failure coordinator home visits

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Advanced Directives

Advanced Directives: The Joint Commission Advanced Certification for Heart Failure Performance Improvement #4 requires patients to have documentation in the medical record of a one-time discussion of advance directives/advance care planning with a healthcare provider.

Intervention: A heart failure coordinator performs an audit of the admission nursing assessment that provides each patient with a detailed evaluation on advanced directives. In the event the patient would like additional information on advanced directives the heart failure coordinator then reaches out to Chaplin services to ensure a consult has been received.

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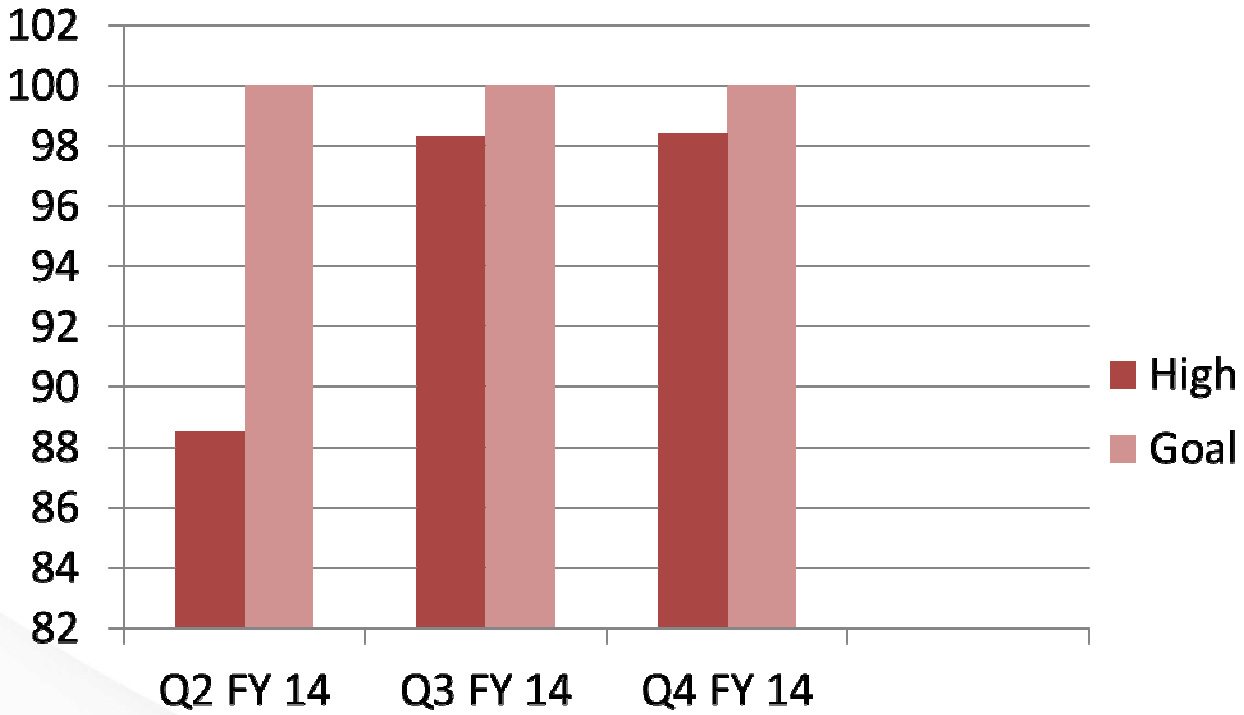
ACHF4: Fiscal Year 2014



Palliative Care

Palliative care is not just a service for patients with malignant diseases but an holistic approach that should be utilized for a wider range of life-limiting conditions such as heart failure.

Palliative services have progressed from being a community hospice movement for cancer patients, to improving quality of life through holistic assessments before reaching the terminal phase for patients with chronic illnesses with an uncertain prognosis, such as heart failure (WHO, 2002; Adler et al, 2009).

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Indications for Medication Use

ACHF Measure 3 Defines: a care transition record is transmitted to a next level of care provider within 7 days of discharge containing ALL of the following:

- Reason for hospitalization
- Procedures performed during the hospitalization
- Treatment(s)/Service(s) provided during the hospitalization
- Discharge medications, including dosage and indication for use
- Follow-up treatment and services needed

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Our institution transitioned from paper charting to electronic medical record in the fall of 2012.

EpicCare spans hospital departments and roles to connect each member of the care team to a single record and embedded clinical intelligence. It ensures that clinical decisions are based on the most up-to-date information and promotes care that is safe and well-coordinated. (www.epic.com/software-inpatient.php)

We have found that the Epic system can be cumbersome to use at certain points of interest. Our provider's have (and continue to) struggled with properly linking the patients medications with indications for use.

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Motivational Interviewing

Objective: To determine the impact of utilizing motivational interviewing and personal coaching, as a behavioral approach, to empower patients with chronic heart failure to gain confidence in their abilities to best manage their heart failure.

Needs: Professional staff training, 1 full-time FTE & coverage/support for that FTE, institutional buy in (to cover travel expenses & professional liability insurance)

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Heart Failure Coordinator Home Nursing Visits

1) improving outcomes by promoting healthy behaviors while offering continuity of provider care
2) improving health by promoting confidence in self management strategies
3) improving parents' life course through education, resources, and empowerment.

Benefits of Accreditation and GWTG Recognition

- 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

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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.