H2H Initiative: Update

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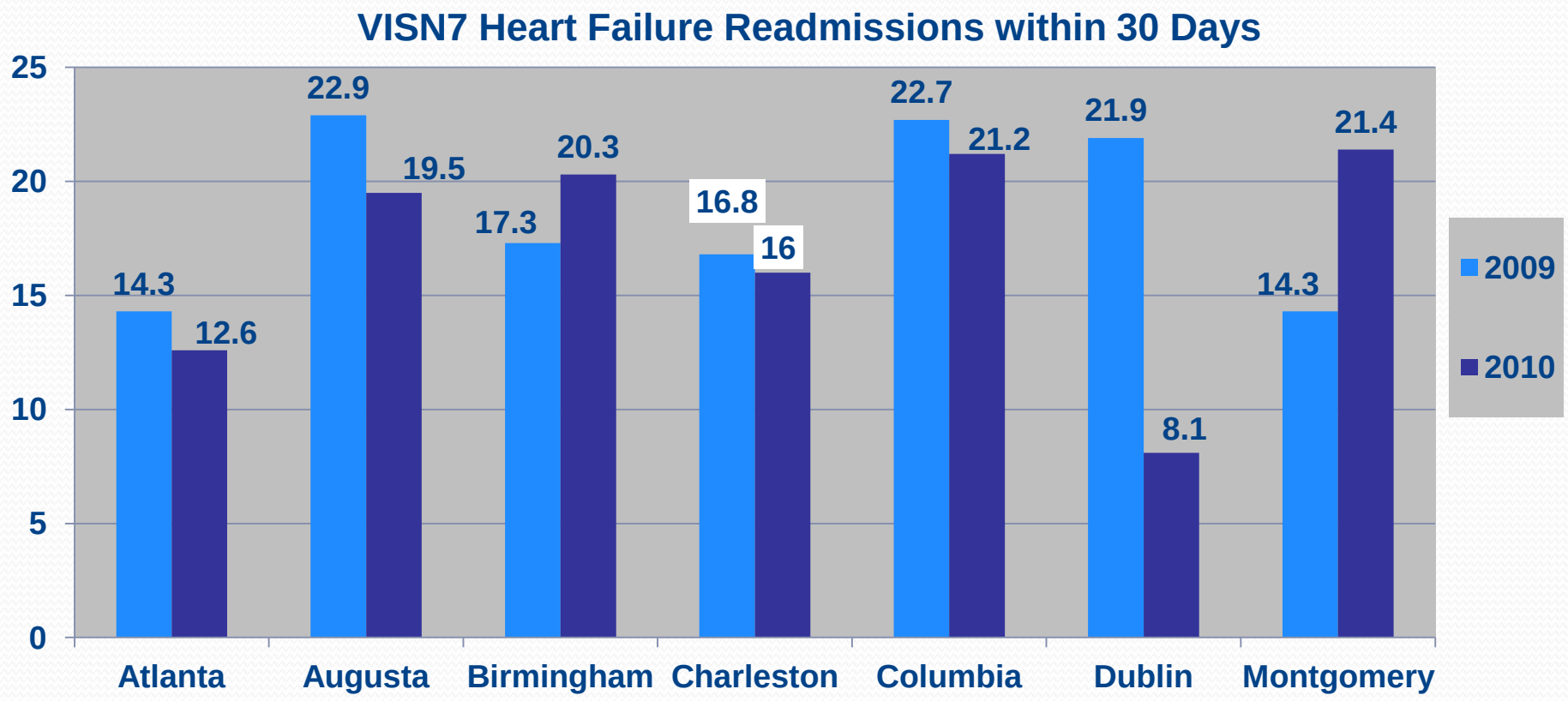
Update includes

- Charleston Heart Failure Readmissions ‘report card’
- Assessment of Discharge and Teaching Process
- Interventions to date
- Share Lessons Learned
- Current Plan: Grant Submission

VISN 7 Heart Failure Readmissions within 30 Days



US Non-VA = 22.5%

30 Day Re-Admissions

- **Hospital readmissions may indicate**
  - **poor in-hospital care**
  - **insufficient discharge planning**
  - **uncoordinated transition care back to community and primary care**
  - **inadequate post-discharge/follow-up care**

VA Office of Rural Health, 2010:
http://ruralhealth.und.edu/presentations/pdf/011910chf_readmissions.pdf

Our VAMC Assessment

- Interdisciplinary team- worked together on “visual pipeline” to see opportunities to connect with veteran; Identified
  - Missed opportunities during hospitalization for teaching
  - System issues r/t to follow-up appointments & access to educational handouts
  - Failure to assess learning needs of patients
  - Potential need for a NP led HF clinic to triage and stabilize Veterans with decompensation

Assessment

- Utilized VALOR students/MUSC Nursing students to observe discharge teaching and to collect data on what patients understood about HF
- Lessons Learned included
- Some patients do not 'own' their disease for example:

  Of 50 patients interviewed, few said:

  "*I have congestive or chronic heart failure*"

  Most said: *"My heart* ***condition****…"*

  *"****They say*** *I have congestive heart failure"*

  "What do you mean I have heart failure…."

  " My doctor says I'm congested…."

Interventions

- H2H Taskforce Partnered with Bedside Collaborative Committee to decrease readmissions
- Improved access to teaching materials (Krames added to nursing teaching template)
- Included reporting of patient educational needs during shift handoffs
- Post-discharge Follow-up phone call: added 5 questions to discharge data collected specific to Heart Failure

Interventions

- New York Heart Failure classification stages I-IV added to discharge note enabling specific data collection (now mandatory)
- Alert developed to be sent to the Care Coordination Home Telehealth (CCHT) staff from the Admission History and Physical in the electronic medical record (EMR) in order to begin patient education upon admission (pilot)
- Identified appropriate personnel responsible for f/u appointments within 7 days; instruction provided to clerks on how to access system for scheduling during off hours
- Patient & Staff Education: During HF week, held seminar on the "State of Heart Failure at Charleston VAMC" (CEUs provided) and visited local CBOCs providing HF information

Research

Care Coordination Home Telehealth received funding for our research project titled "Communication in CHF Care Coordination in Home Telehealth Implementation" (QUERI funded)

- Involved: recording conversations with patients; conversations initiated by an alert on our telehealth data
- Recordings completed in January & now performing discourse analysis and identifying best practices including
  - Ask for the Veteran's agenda
  - Speak more slowly, listen for cues and respond, avoid interruptions
  - Use pauses giving Veteran time to think and express needs and understanding of discussion
  - Practice the "*Teach Back*" to validate understanding and variations in health literacy
  - Encourage conversation through the use of open-ended questions
  - Seek unresolved issues (esp. from social contexts) at closings: "*What other questions do you have?*"

Lessons Learned

- Staffing needed: CCHT current staffing could not meet demands for in-patient teaching of self-management; determined need time-committed staff (position)
- Takes time to make system changes: CCHT alert discontinued – must go through additional approvals to become an ongoing change to system alerts
- Sustainability difficult: 5 questions r/t HF not collected consistently due to variety of people in this position; need committed personnel for additional patient instruction/support

Implications for Practice

- We have to provide effective dialogue on heart failure and self management between staff, patients and caregivers
- Improve medication management through knowledge exchange, Teach Back, shared problem-solving, and improved access
- Provide improved access to prompt follow up care upon transition to home
- Increase effective communication between staff, patients and caregivers

Implications for Practice

Effective communication is needed to provide our staff , patients and caregivers with the means to combat Chronic Heart Failure

- ASK some variation of : *What does CHF/HF (Congestive, Chronic, Failure) mean to you…What are you doing to manage your HF*
- Be prepared to hold a dialog on the basic physical and mental effects of HF- change in lifestyle, co morbidities, mental health issues such as depression, end of life issues
- Verify patient understands: *Teach Back*
- Avoid yes/no questions
- It's true, Silence can be Golden, coupled with active listening
- Encourage the patients to discuss how HF affects their daily lives

Plan

Submitted QUERI: 1 year Rapid Response Proposal

- Involves HF Nurse Navigator to assist/educate/improve communication between all disciplines and Veterans with HF
- Implement an evidence-based approach to care transitions across the spectrum of care (Project RED)
- Build support through ongoing analysis with interdisciplinary team (cardiologists, pharmacy, nutrition, nursing, primary care) of effects on readmissions

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Thank you!