H2H Initiative/HAMVAMC

Goal: To reduce 30 day readmission rates for patients with heart failure (HF)

HAMVAMC enrolled *H2H/VAH CHF Queri* on February 16, 2010

Team members: CCHT, pharmacy, hospitalists, CM, prosthetics, primary care.

Team leader: Gloria Engelberger NP HF clinic

Identifying patients who would benefit from HF Clinic

* Evaluation of current process at   discharge for patient with HF diagnosis

• Identifying key team members

•Hospitalists did not routinely consult to HF clinic.
•Case management did not alert HF Clinic of discharge phone call.
•HF Clinic staff did not routinely check T Drive for patients admitted with primary diagnosis of HF.
• No scales stocked in prosthetics for daily weights.

Identifying patients who would benefit from HF Clinic

- Enlisting key players (HF Clinic NP)
- Changing processes

Goal:
HF clinic NP checks T Drive daily for patients admitted with HF diagnosis and schedules follow up in HF clinic within 10 days of discharge

Barrier:
One person HF clinic. No ancillary staff. T Drive not checked on all days due to patient load.

Plan for Improvement:
Vital to have improved participation from CM and care providers to alert HF clinic of discharged HF patients. Intensify efforts to remind team members of their key role.

Identifying patients who would benefit from HF Clinic

- Enlisting key players (Hospitalist)
- Changing processes

Goal: Hospitalists/EVMS students to alert HF clinic at discharge.
Barriers:
-Rather hit and miss. Surprisingly the ER has been proactive at alerting HF clinic with patients treated for HF.
Plan for improvement:
-Re education of care providers perhaps providing prompts at work areas on inpatient units.
-Regular reminders at medical service meetings
- Actively recruit ER providers to alert HF clinic.

Identifying patients who would benefit from HF Clinic

- Enlisting key players (Case managers)
- Changing processes

Goal:
Case managers to alert HF Clinic NP per their discharge follow up call to the patient discharged with HF.
Barrier:
50% participation by CM, missed opportunity to identify patient s that need follow up in HF within 10 days.
Department in transition.
Plan for improvement:
Change in care delivery in primary care to pod concept. Gain knowledge on new system and educate as needed.

Reducing 30 day readmission rates for HF Medications

Goal: Assure that prescribed medications are appropriate.

Reconciliation of medications at discharge.

Reconciliation of medications post discharge phone call.

Reconciliation of medications HF clinic follow up appointment.

Barrier:

Patients inability to understand medication regimen. Failure to pick up medications at discharge and to take as directed. Failure to refill.

 Follow up phone call does not require patient to identify present medications.

Failure of patient to bring medications for review to HF clinic

Plan for improvement:

Post discharge phone call should identify medications per patient.

Schedulers to remind patients to bring medications to appointments

Urge adherence to plan of care and importance of refills.

Reducing 30 day readmission rates for patients hospitalized with primary diagnosis of HF
Symptom management

Goal:

- Improve resource allocation for HF patients (scales for home use and logs for weight and medications)
- Improve identification of high risk HF patients who would benefit from CCHT
- Improve identification of high risk patients who would benefit from HBPC.

Barriers:

- Scales are not routinely provided to veterans at discharge though they are now stocked in prosthetics.

Plan for improvement:

- Work with discharge team to identify patients who have a need for scales for daily weights.

Reducing 30 day readmission rates for HF
Closing remarks

Barriers related to socioeconomic factors (what makes the VAH patient population unique)

Homelessness

Polysubstance abuse

Diminished cognitive ability

Plan for improvement

Determine percentage of admitted HF patients who have socioeconomic comorbidity to better determine the scope of perceived problem.

Evaluate present system of referral for MH services.

Questions/discussion