Process Improvement *for the* Heart Failure *patient*

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Learning Objectives

- Involve participants in local heart failure improvement initiatives
- Introduce the improvement framework as a tool to facilitate future efforts
- Identify means of successfully implementing change and finding new opportunity

Systems Redesign

Questions for Consideration

What are the most effective steps we can take as an organization to improve the care of the CHF patient?

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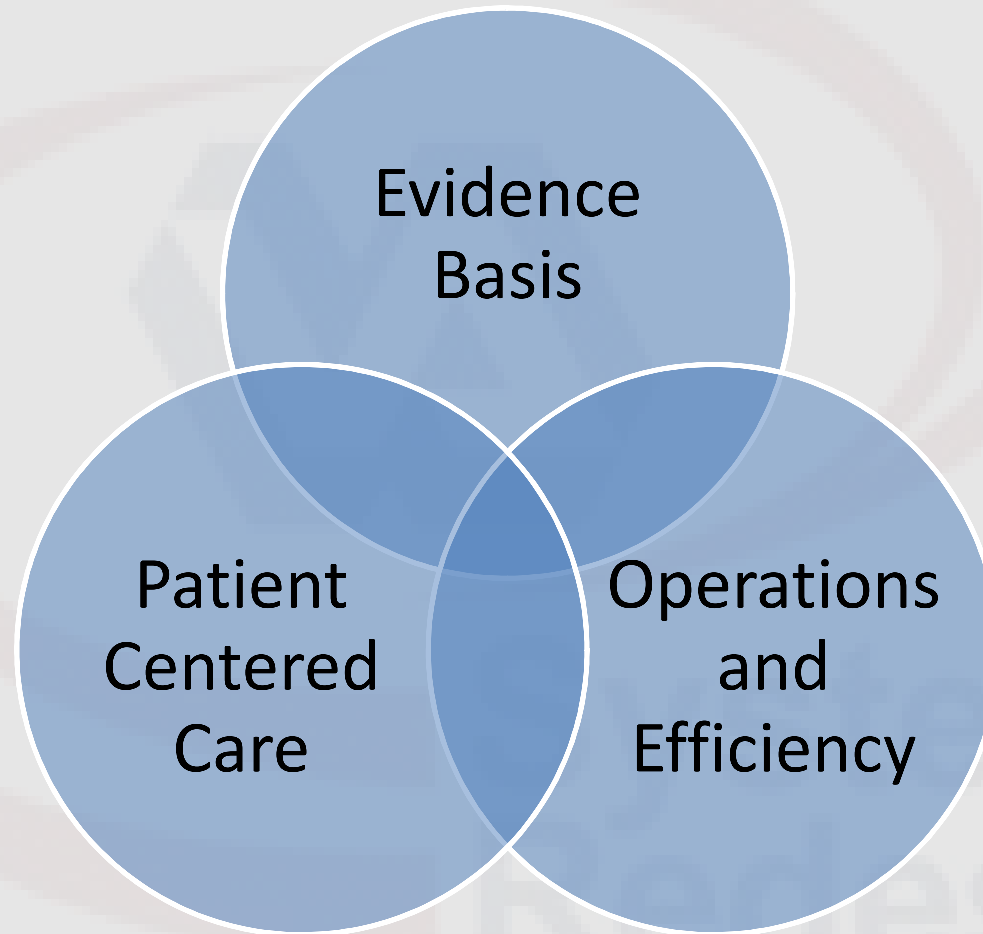
Common Answers

- Improved adherence to guidelines/evidence basis
- Deliver further advanced therapies (e.g. LVAD)
- Decrease admissions/readmissions/keep more care in the home
- Improve collaborative decision making regarding goals of care
- We already do a pretty good job!

Domains of Improvement



VA-TAMMCS

Identifying A Framework

- Vision > Identify Values
- Analysis > Enumerate Priorities
- Team > Interdisciplinary, Front Line
- Aim > Direction, Leadership
- Map > Understand our Work
- Measure > Chart Progress
- Change > Active, Rapid Cycle
- Sustain > Plan for Lasting Effect

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One Way

V A T A M M C S

Vision Analysis

Make Changes

Sustain Spread

“Deciding Phase”

“Doing Phase”

“Keep Doing Phase”

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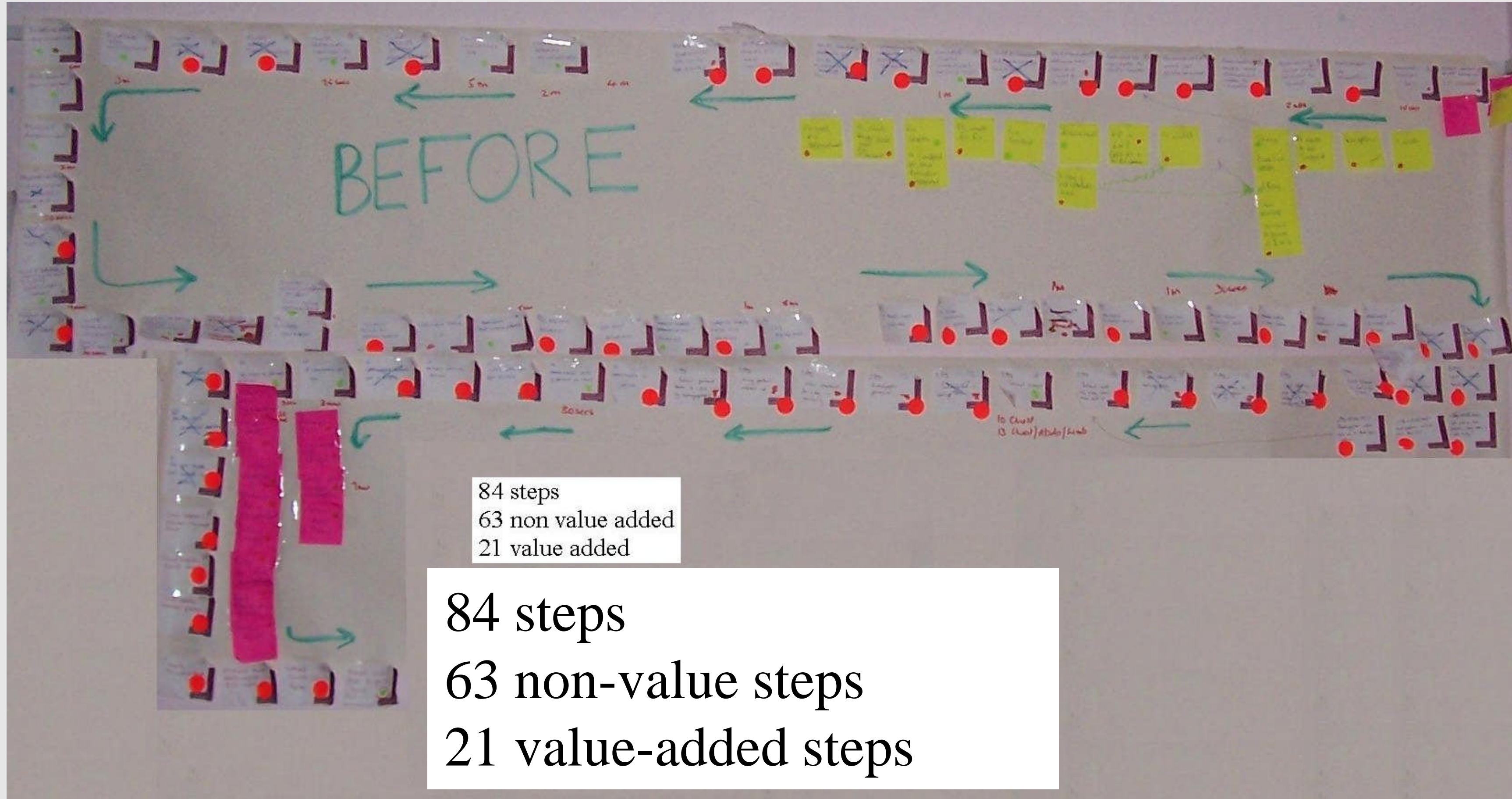
Improvement Framework

VA

Project Selection Matrix Tool is a useful way to choose a project

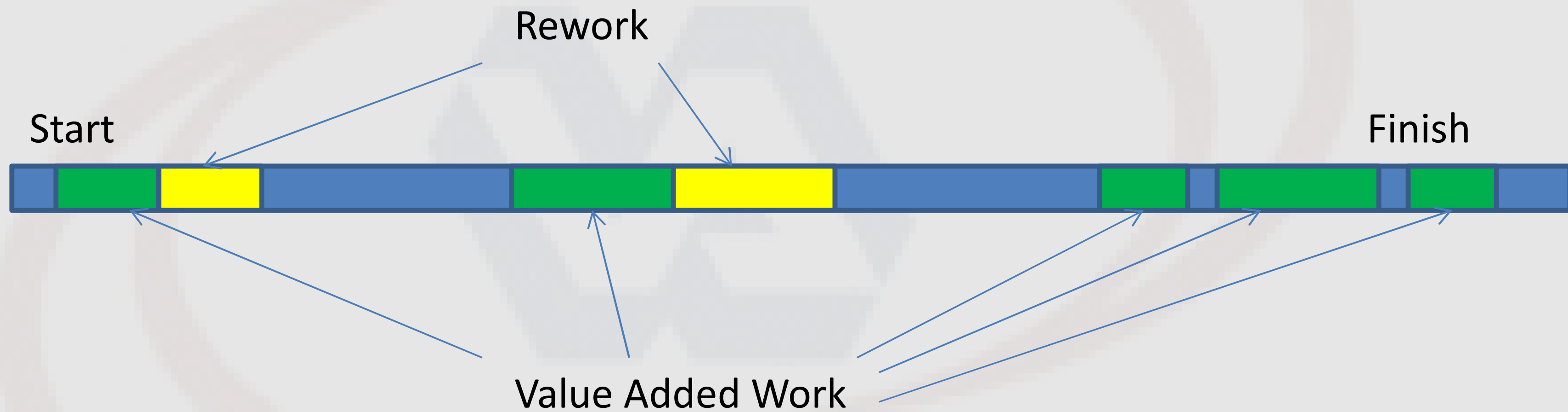
Criteria	Project 1	Project 2	Project 3	Project 4
Likelihood of Success	5	10	8	10
$$ Impact (cost or revenue)	10	5	6	1
Patient Satisfaction	10	4	5	10
Employee Satisfaction	10	2	5	10
Completion in 4-6 weeks	1	10	10	10

Map



Map

A Typical Healthcare Process



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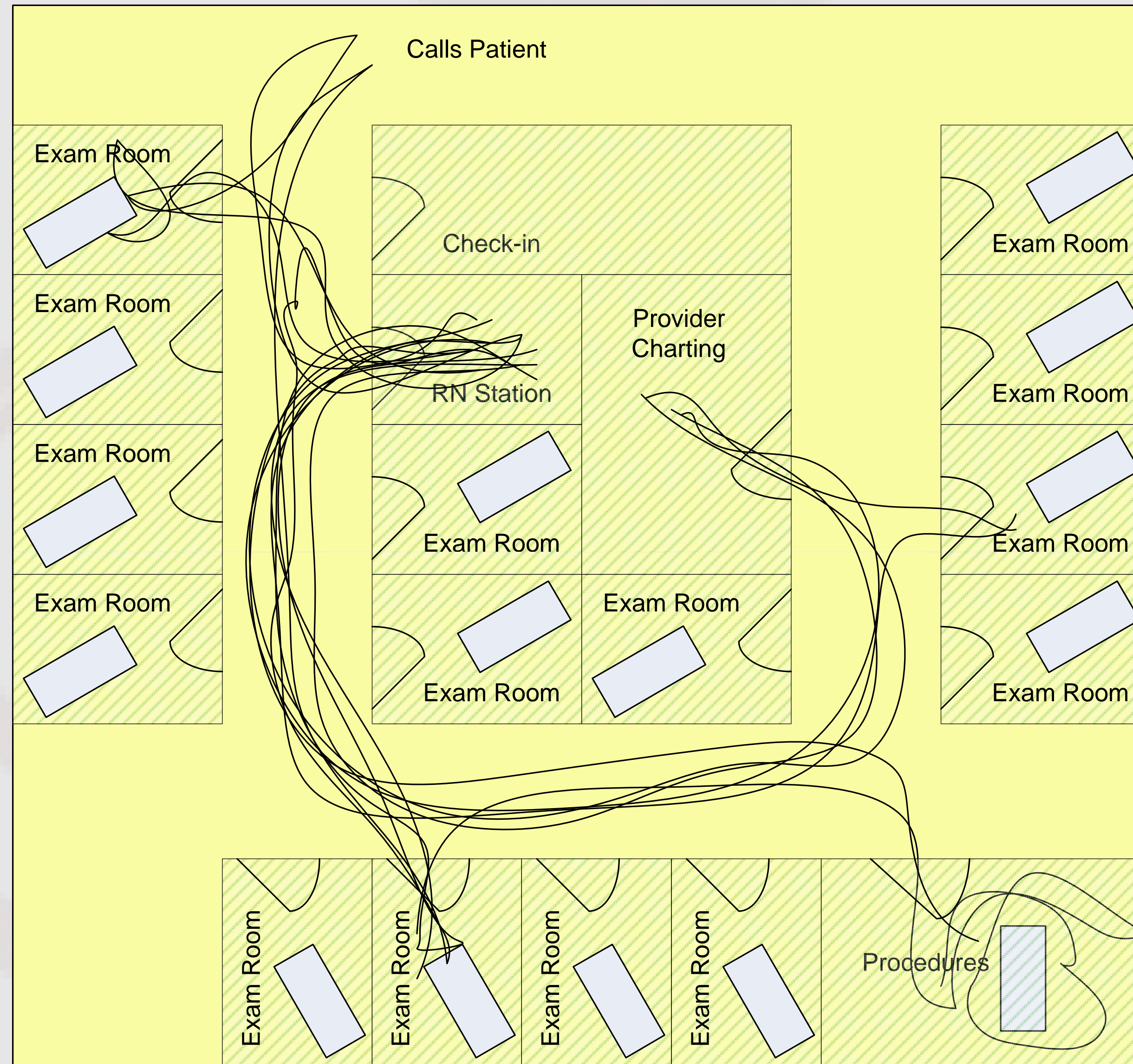
Calls Patient
Exam Room
Exam Room
Exam Room
Exam Room
Check-in
Provider
Charting
RN Station
Exam Room
Exam Room
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Exam Room
Procedures

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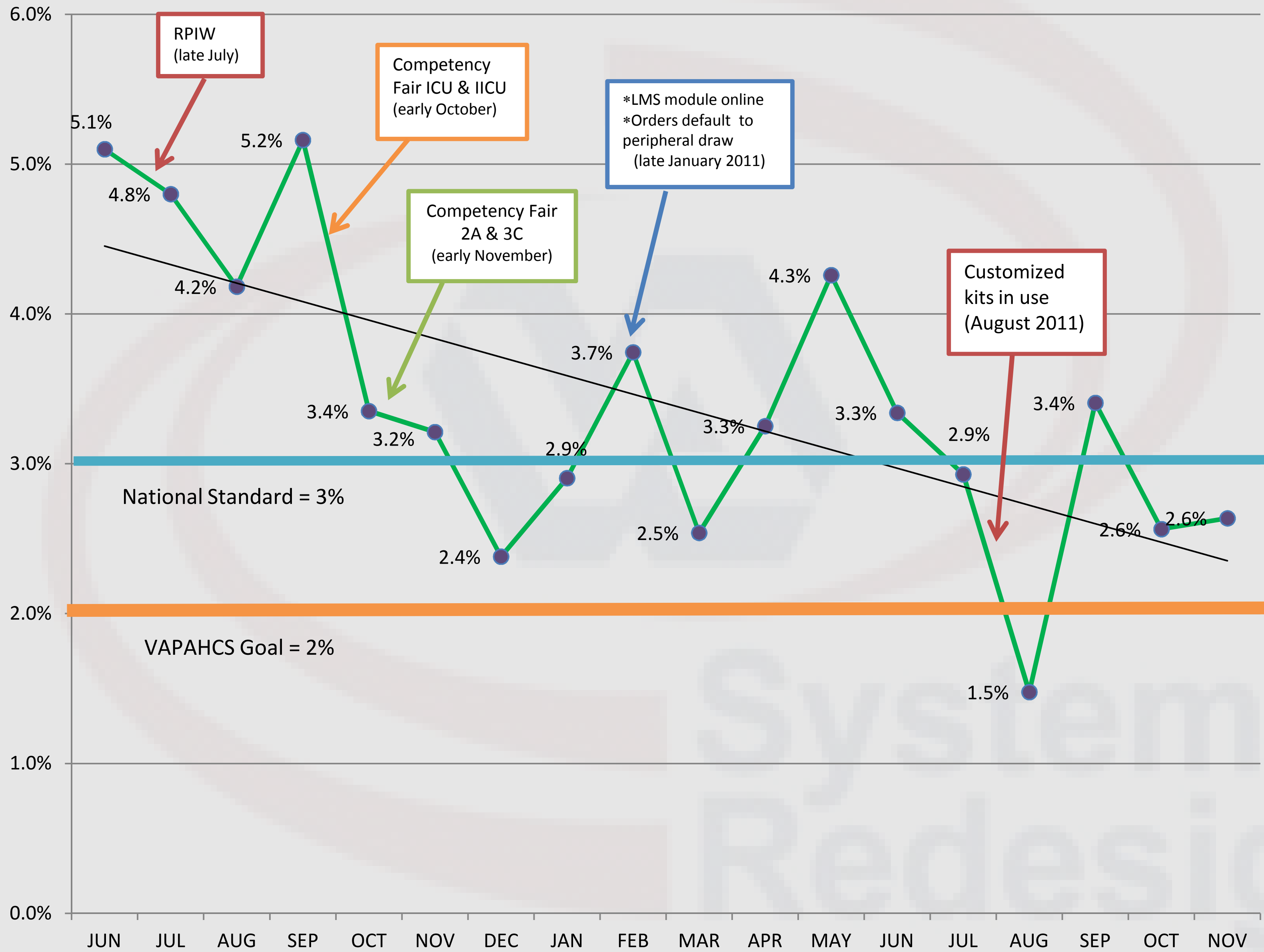
Redesign


VAPAHCS Blood Culture Contamination Rate
6.0%
5.0%
4.0%
3.0%
2.0%
1.0%
0.0%
RPIW
(late July)
Competency
Fair ICU & IICU
(early October)
*LMS module online
*Orders default to
peripheral draw
(late January 2011)
Competency Fair
2A & 3C
(early November)
Customized
kits in use
(August 2011)
5.1%
4.8%
4.2%
5.2%
3.4%
3.2%
2.4%
2.9%
3.7%
2.5%
3.3%
4.3%
3.3%
2.9%
1.5%
3.4%
2.6%
2.6%
National Standard = 3%
VAPAHCS Goal = 2%
JUN
JUL
AUG
SEP
OCT
NOV
DEC
JAN
FEB
MAR
APR
MAY
JUN
JUL
AUG
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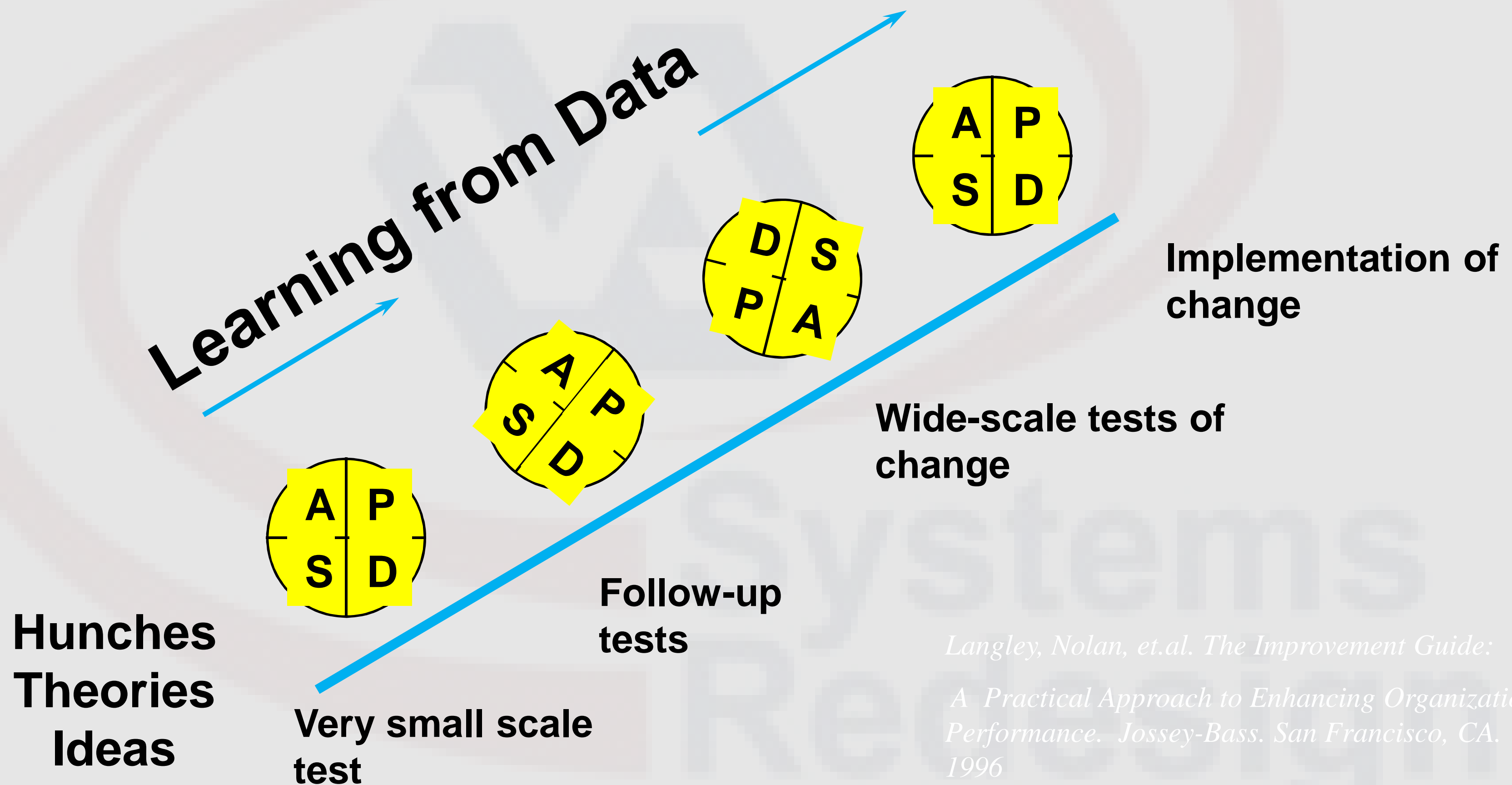
Improvement Framework

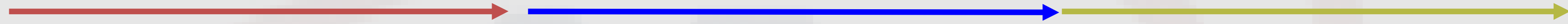
Change

PDSA: The “How” to Change



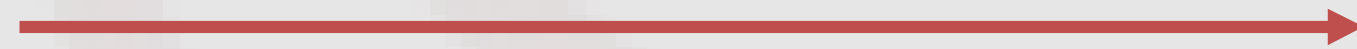
What's the Sequence?

Improvement Hold Gains Spread



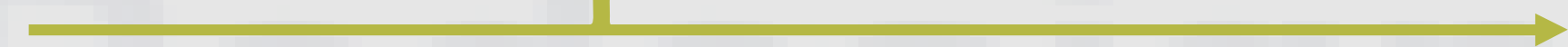
??? more like …

Improvement



Hold Gains

Spread



Source: Institute for Healthcare Improvement (IHI)

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Defining “Spreadable”

- Demonstrable Effectiveness
  - Implies formal recording/reporting
- Trialable
- Modular/encapsulated
  - Can I describe exactly what I did? Can I turn it into a “kit”
- Low “cost” (expense, easy)
  - Can the new innovation actually become the path of least resistance

Rules of Diffusion (by Donald Berwick)

- Identify changes that are ready to spread
- Find innovators and support them
- Invest in early adopters and allow communication with innovators
- Make early adopters observable
- Allow re-invention of innovation
- Trust and enable innovation

Local Initiatives

- CHF Process Improvement Team
  - Initial goal of improving patient education in CHF
  - Scoped to inpatient and outpatient domains
  - Valuable output, valuable lessons of scope and "rapid cycle change" practice
- ARC Collaborative/Project RED
  - Overlapping "vision" of fewer readmission
  - Compelling blend of evidence and implementation science

Admission – Congestive Heart Failure

Your Self-Management Tool for Hospital Stay

Instructions to the Patient: Tracking weight daily is important. Use this flow sheet to work with your team to stay informed and to prepare for discharge.

Your weight at admission is _________ pounds. *Not sure? Ask your nurse or doctor. We are happy to help.*
Daily weights are an excellent way to track control of congestive heart failure.

Step 1: *Get Informed*

Areas that I would like further education about include *(check all that apply)*:

- ☐ **Daily Weights**
- ☐ **Low Salt Diet**
- ☐ **Warning Signs/Symptoms**
- ☐ **Medications**

Step 2: *Chart Your Progress*

Write in your weight daily. If your weight changes by more than 2-3 pounds/day or 5 pounds/week at home, call your doctor.

Date	*Date*	*Date*	*Date*	*Date*	*Date*	*Date*
Weight (lbs)	*Weight (lbs)*	*Weight (lbs)*	*Weight (lbs)*	*Weight (lbs)*	*Weight (lbs)*	*Weight (lbs)*

Step 3: *Prepare for Discharge*

Answer these questions prior to leaving:

1) What is my new **target weight?** ______ *(lbs)*
2) Do I have a **VA scale** at home? **Yes No** *(circle one)*
   If not, ask your doctor to order one.
3) What is my **water pill** and what dose should I take? ________
   Discuss this with your doctor before discharge.

____
Patient Name

Weight

Record Your Weight Each Day in the Squares

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)
Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)
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Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)	Date Weight (lbs)

VA PAHCS
Veterans Affairs Palo Alto Health Care System

Discharge Home – Congestive Heart Failure

Your Self-Management Tool for Home

Instructions to the Patient: Self care for congestive heart failure is important to keep you out of the hospital. This sheet will help you manage your care.

Step 1: *Weigh Daily*

My Discharge Weight ______ *(lbs)* on ______ *(date)*

Date	*Date*	*Date*	*Date*	*Date*	*Date*	*Date*
Weight (lbs)	*Weight (lbs)*	*Weight (lbs)*	*Weight (lbs)*	*Weight (lbs)*	*Weight (lbs)*	*Weight (lbs)*

Step 2: *Take Your Pills*

My Water Pills:

Name	*Dose*	*Time of Day*

Step 3: *Know Your Warning Signs*

If you have any of these warning signs, call the Advice Nurse at the Telephone Care Program (TCP) at 800-455-0057.

1) Weight gain of more than 2 or 3 pounds in one day, or 5 pounds in one week.
2) Increase in shortness of breath.
3) Increase in leg swelling.

Bring this sheet to your appointment.

Follow up appointment: ________________ **Patient Name:** ________________________________

Project RED

- Educate the patient throughout the hospital stay
- Make appointments for follow-up prior to discharge
- Hardwire a follow-up plan for pending test results
- Organize post-discharge services
- Medication plan (reconciliation, availability)

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Project RED

- Reconcile plan with guidelines and pathways
- Action plan for problems/emergencies
- Ensure a comprehensive discharge summary is available to the “right” people
- “Teachback” of the plan
- Provide a written summary of the discharge plan
- Provide telephone reinforcement of the plan

Source: http://www.ahrq.gov/qual/projectred/

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