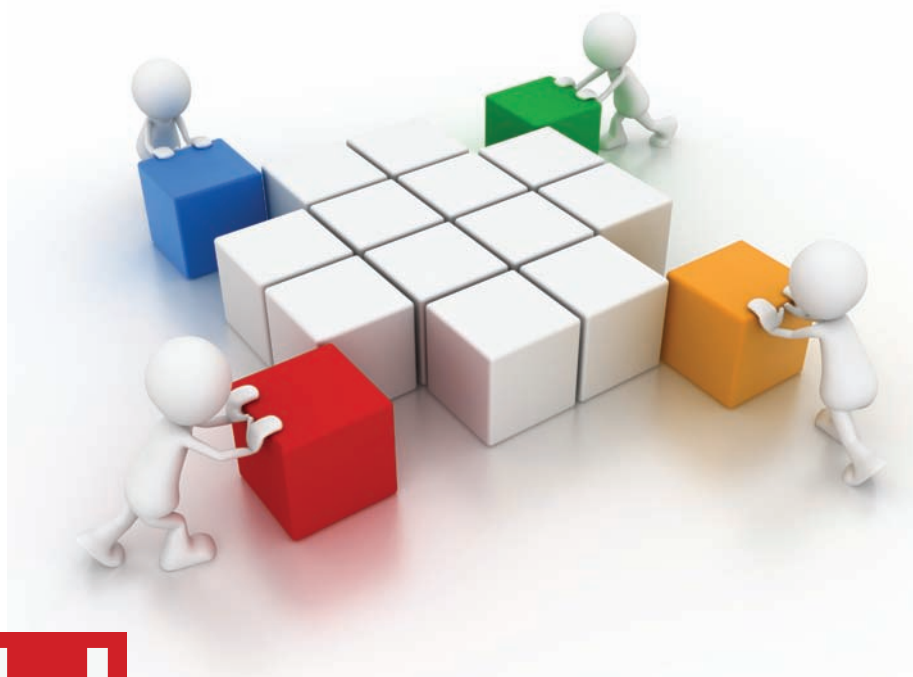


Standardizing The Hospital Discharge Process For Patients With Heart Failure To Improve The Transition And Lower 30 Day Readmissions

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readmissions may be preventable and that as many as 1 in 8 HF patients are readmitted within 15 days of hospital discharge (MedPAC, 2007). Other research shows that one quarter to one third of these patients return to the hospital after suffering a preventable complication, two thirds report that no one at the hospital talked to them about managing their care at home, and four out of five patients requiring assistance with basic functional needs failed to have a home health referral (Clark, 2006). The Centers for Medicare & Medicaid Services (CMS) funded Georgia Medical Care Foundation (GMCF), the Medicare Quality Improvement Organization (QIO) for Georgia, as part of the Care Transitions Project in 14 states to improve care transitions and lower 30-day hospital readmission rates for Medicare beneficiaries. GMCF worked with hospitals in a targeted three-county region of Georgia. This report describes the successful efforts of one of the participating hospitals to reduce unnecessary readmissions for HF patients by standardizing the discharge process.

Getting Started

At the beginning of the project, providers from the targeted community attended a kickoff session to review project goals and expectations. In order to generate a sense of urgency, the kickoff was followed by a series of individual provider meetings facilitated by the QIO that reviewed national and regional data on the prevalence of unnecessary rehospitalizations.
(more on page 26)



Heart failure (HF) is a significant clinical and economic burden with nearly 6 million Americans estimated to be living with the disease (Lloyd-Jones, 2010). As one of the top 10 causes for hospital admissions in the United States, the burden of heart failure (HF) falls disproportionately on older Americans with Medicare billed for two-thirds of HF-related hospital charges (Russo, 2007; Mazaffarian, 2010). Among Medicare enrollees, HF hospitalization rates are higher in African-Americans, Hispanics and American Indians/Alaska Natives than among whites and, geographically, hospitalizations for HF are

highest in the southeastern United States (Mensah, 2005). In addition, more than a quarter of Medicare beneficiaries diagnosed with HF are readmitted to the hospital within 30 days of discharge (Jencks, 2009). Recent Medicare data from Georgia confirm those estimates finding that 25% of Georgians hospitalized between March 2010 and February 2011 were rehospitalized within 30 days.

Inadequate discharge planning, lack of self-management training and poor follow-up leave many people with HF in a revolving door of hospitalizations (Nelson, 2008). The Medicare Payment Advisory Commission found that 75% of

talizations and their negative impact on patients and families. Impending payment reform, coupled with the launch of multi-stakeholder groups addressing readmissions both statewide and nationally, motivated hospital leadership at the subject hospital to convene a readmissions action team in January 2009. The Quality Resources Director, with senior leadership support, gathered and led an interdisciplinary team to review current processes and implement interventions to reduce 30-day readmissions. The HF team was composed of champions from several departments: case management, nursing, cardiology, patient education, palliative care and quality improvement, as well as representatives from two area home health (HH) agencies. This group was empowered by hospital leadership to initiate change, and they were ready for the challenge.

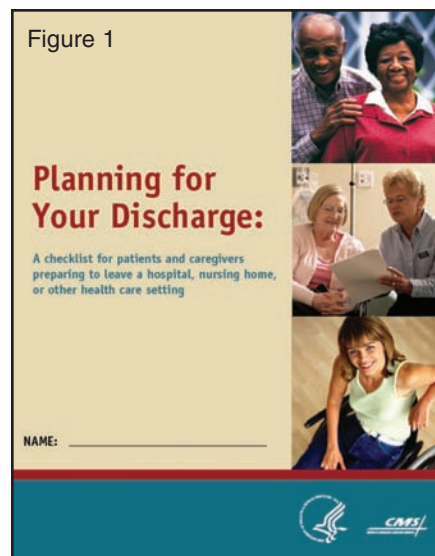
The readmissions team first did a root cause analysis to identify readmission drivers. This was accomplished through a retrospective review of patients with HF diagnosis codes discharged between August 1, 2007 and August 31, 2008, and found that most patients were discharged home (52.4%), followed by discharges to skilled nursing facilities (SNFs) (20.2%), or HH (17.6%). A retrospective chart review of 23 patients discharged with HF and readmitted for any cause from April 1 to July 31, 2008, found that:

- Just over half (n=12) were discharged home with no post-acute support,
 - patient teaching, although documented by staff, was inconsistent, with no acknowledgement that patients understood the instructions,
 - 66% (n=15) did not have adequate advance care planning, and
 - 25% (n=7) were readmitted from a SNF.

The team concluded that the lack of a standard process for appropriate transition support for HF patients was a driving factor for readmissions and identified a tool kit developed by the Institute for Healthcare Improvement (IHI) as part of the 5 Million Lives Campaign (IHI, 2008). Recognizing the significant impact that HF plays in hospital readmissions, IHI developed the “Getting Started Kit: Improved Care for Patients with

Congestive Heart Failure How-to Guide.” The tool kit guides teams to improve outcomes for patients with HF by providing intervention strategies that enhance the admission assessment, promoting teaching and learning, and supporting patient-centered handoff communication and timely post-acute care follow-up.

The “How-to Guide” provided evidence-based components to help the HF team get started. They met monthly with agendas, minutes and action steps. Small work groups focused on patient education, discharge planning, advance care planning and post-hospital follow-up. Home health liaisons worked with the hospital case managers and each other to support standard orders and align educational materials.



An “intervention bundle” was developed by the team for all HF patients discharged home. These interventions were piloted on Medicare patients admitted to the Telemetry Unit with a primary or secondary diagnosis of HF. Case managers and the HF Core Measures Coordinator identified the HF patients using designated DRG codes. Patients were flagged in the hospital’s electronic medical record system and targeted for the “intervention bundle.” As case managers and staff nurses completed interventions, they were checked off in the system, allowing for further tracking. The “intervention bundle” included:

- pre-printed orders for home health referral to ensure that eligible patients re-

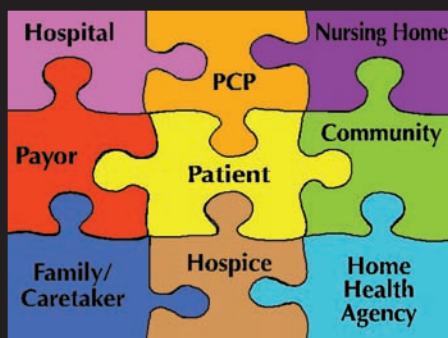
ceived post-hospital support;

- the CMS “Planning for Your Discharge” booklet (Figure 1) to help patients and families assess their post discharge needs;
- a patient/caregiver teaching protocol using the Teach Back method that organized teaching components and outlined patient expectations;
- a life planning/palliative care screening, using a screening tool developed by the palliative care team to identify patients needing a consult to review advanced directives, chronic disease management, pain management or the need for hospice/palliative care; and
- a post-discharge phone call by nursing staff to answer questions about medications and remind patients to make a follow-up appointment with their physician.

Planning And Implementing The Intervention

Transition Coaches: Care Transitions Intervention (CTI)^{SM1} coach training with Dr. Eric Coleman’s team was scheduled by the QIO in April 2009. Representatives from the participating HH agencies attended. One agency designated its social worker, who attended the training, to be the transition coach for all referred HF patients. The other HH agency used materials from the training and from the QIO to train all staff at eight other HH agencies in the hospital referral region on the principles of patient self-management in order to incorporate these principles into their nursing visits. The HH agencies worked with patients and families to complete a personal health record, schedule a follow-up appointment with the patient’s physician and ensure that the patient attended the appointment, clarify medication regimens, and reinforce disease-specific red flags discussed during the hospitalization.

Transition Planning: Home health liaisons and agency supervisors worked to align their patient teaching materials with the hospital-provided patient education materials. Home health nurses incorporated an HF Zone Tool into their teaching protocol and agreed to do Teach Back using an HF red flags magnet, designed
(more on page 28)



GMCF Care Transitions Initiative

Creating an Ideal Transition Home

1. Enhanced Admission Assessment for Post-Discharge Needs

- a. Include family caregivers and community providers (e.g., home health nurses, primary care physicians, nursing home staff, clinic nurses) as full partners in standardized assessment, discharge planning, and predicting home-going needs
- b. Reconcile medications upon admission
- c. Initiate a standard plan of care based on the results of the assessment

2. Enhanced Teaching and Learning

- a. Identify the learner(s) on admission (i.e., the patient and family caregivers)
- b. Redesign the patient education process to improve patient and family understanding of self care
- c. Use Teach Back in the hospital and during follow-up calls to assess the patient's and family caregivers' understanding of discharge instructions and ability to do self care

3. Patient and Family-Centered Handoff Communication

- a. Reconcile medications for discharge
- b. Provide customized, real-time critical information to the next care provider(s) that; (1) accompanies the patient to the next institution; and/or (2) is transmitted to the receiving physician and/or home health agency or other care provider at time of discharge

4. Post-Acute Care Follow-Up

- a. High-risk patients: prior to discharge, schedule a face to face follow-up visit (home care, care coordination visit or physician office visit) to occur within 48 hours after discharge
- b. Moderate risk patients: Prior to discharge, schedule a follow-up phone call within 48 hours and schedule a physician office visit within 5 days

**Taken from IHI Transforming Care at the Bedside, How-to Guide:
Creating an Ideal Transition Home for Patients with Heart Failure 2007**

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by the education work group, at the home visit. They also committed to contact the patient within the first 24 hours post-discharge to schedule the first home visit. A home health referral for all HF patients was added to the discharge protocol. This prevented calls back and forth to the prescribing physician. An educational flyer about HH referral criteria was provided to both hospitalist physicians and case managers.

Hospital case managers agreed to distribute and review the CMS “Planning for Your Discharge” booklet with patients and families to get them more involved in early discharge planning. As the project progressed, the hospital patient and family education coordinator created a one-page hospital specific discharge planning check list, which included many elements of the CMS version. This check list was later implemented hospital-wide and included for all patients in their admission packet.

The palliative care coordinator led a team to develop a palliative care screening tool to identify patients who might benefit from a palliative care consult. The consults could address advance care planning or chronic disease education as well as referral for palliative care and hospice. A protocol for using the tool, named the “Life Planning Screening Tool,” (p. 29) was developed and pilot-tested on the Telemetry unit. Pilot data were tracked from April 1, 2009, to April 30, 2010. The language of the tool was changed several times for clarity, and a process for screening, scoring and notifying the primary physician about the need for an order was developed. The palliative care coordinator provided education about the tool and referral process to nursing staff and hospitalist physicians.

Finally, nurses made follow-up phone calls to HF patients within 48 hours of discharge to ask about medications and any other concerns. They also reminded patients to schedule a follow-up appointment with their primary physician.

Patient Education: The hospital’s Telemetry Unit Educator, HF Core Measures Coordinator and Patient and Family Education Coordinator met with nursing staff to review current patient education practices to improve content as well as

promote continuity and patient and family involvement. Together they created an education protocol that included: a Journey Board or patient care path, a red flags magnet and an education record with a teaching timeline and Teach Back component. They incorporated the HF Zone Tools, (p. 31) the “Tracking Your Weight” tip sheet, and an HF booklet and video into the protocol. Patients were asked if they had a scale at home. The participating HH agencies donated funds to provide scales for patients who could not afford one. A Scales Team explored scale prices, purchased several and set up a process for identifying patient needs and a distribution plan. Scales became available on the Telemetry unit and in the gift shop. HF classes were offered once a week for hospital inpatients, patients and family members able to attend. Each class had a didactic educational component to review diet, medications and red flags and an unstructured component where patients were encouraged to ask questions, learn about community resources and share stories.

Evaluating The Intervention

Evaluation Measures And Data Sources: The hospital coding department ran 30-day readmission data monthly from its internal decision support database. They counted readmissions that occurred within 30 days following a discharge with a principle diagnosis of HF defined by 28 DRG codes. This real-time information (numbers and patients) was reviewed at monthly team meetings. Scores on patient satisfaction with medication and discharge planning from the Hospital Consumer Assessment of Health Care Providers and Systems (HCAHPS) survey questions were monitored. The education coordinator on the Telemetry Unit was responsible for tracking HF Education Logs, training nursing staff and monitoring their Teach Back sessions. Home health agency supervisors reported making home visits with agency nurses to complete competency check lists related to the CTI. The palliative care team collected data on screening tools and referrals.

The QIO monitored monthly 30-day

rehospitalization rates using hospital-specific Internal Standard Analytic Table (ISAT) data and Medicare claims data that were received quarterly. Home health rates were also tracked through claims data.

Evaluation Results: Process measures captured the number of beneficiaries who received the intervention.

From January 1, 2009, to January 31, 2010, case managers tracked that 320 out of 414 (77%) eligible Medicare beneficiaries discharged to home received the “intervention bundle.” The 94 who did not receive the bundle were missing an education record or had not been entered into the database. An education record template with Teach Back component was finalized in September 2009, and 69 out of 96 (66%) eligible patients completed it in the first three months. The CMS “Planning for Your Discharge” booklet was revised by the hospital into a one-page document and implemented hospital-wide in November 2009. A palliative care screening tool pilot was initiated in April 2009 on the Telemetry Unit. All patients on the unit were screened and data were tracked through March 31, 2010. A total of 1,283 patients were screened.

The HF team met monthly from January 2009 to January 2010 including representatives from nursing, case management, cardiology, utilization review, home health and quality resources. The hospital Quality Resources Director conducted the meetings and distributed agendas and minutes with action steps.

Proximal measures were used to assess the level of implementation of new processes as well as patient involvement and satisfaction. The percentage of patients referred to home health increased from 26.4% in January 2009 to 32.4% in January 2010. Hospital HCAHPS scores for discharge information questions and communication about medication questions improved from 73.5% in July 2007 to 80% in January 2010 and from 68.6% to 74.3% respectively. Of the patients screened for palliative care, 175 met the criteria for palliative care referral and 96 (54.8 %) referrals were completed. The number of referrals increased from 4
(more on page 30)

Life Planning Screening Tool

(This is NOT a permanent part of the medical record)

TOTAL SCORE FOR ALL 3 SECTIONS:

For a patient with a **score > 4**, a consult for life-planning and disease education is strongly recommended.

Date: _____ Nurse Signature: _____ Name of Physician Contacted: _____

Order Received Order Declined

1. Disease Processes: **1 point each for Total of Section 1:** _____

- Cardiac disease (i.e. CHF, CAD, CM w/EF<25%) Stroke w/Decreased Function Liver disease
- End Stage Renal Disease Metastatic or Recurrent Cancer Advanced Dementia
- COPD, emphysema, pulm fibrosis, pulm HTN, lung disease Severe PVD with or without amputation

2. Use the Palliative Performance Scale below to assess the functional status of the patient.

Ambulation	Full	0
	Reduced	0
	Mainly sit/lie	1
	Mainly in bed	1
	Bed Bound	1
Activity Level and Evidence of Disease		0
Normal activity; No evidence of disease		0
Normal activity; Some evidence of disease		0
Normal activity with effort; Some evidence of disease		0
Unable to do work; Some evidence of disease		1
Unable to do any work; Significant evidence of disease		1
Unable to do any work; disease Extensive		1
Self – Care		0
	Full	0
	Infrequent assistance	0
	Consistent assistance	1
	Almost total care	1
	Total care	1
Intake		0
	Normal	0
	Normal to slightly reduces	0
	Reduced sips /bites	1
	Minimal/sips	1
	None	1
Level of Consciousness		0
	Full	0
	Confused at times	0
	Varies from full to drowsy or confused	1
	Lethargic and confused	1
	Varies from lethargic to comatose/unresponsive	1
Add Points for Total of Section 2: _____		

3. Other criteria to consider in screening

- Frequent visits to the Emergency Department (>1 x mo for same diagnosis)
- More than one hospital admission for the same diagnosis in last 30 days
- Prolonged length of stay without evidence of progress
- Greater than one ICU admission during this stay
- Documented poor or futile prognosis
- Life-limiting illness and has chosen not to have life prolonging therapy
- Unacceptable pain or other debilitating symptoms (i.e. dyspnea, vomiting) > 24 hours

1 point each for Total of Section 3: _____

Additional Comments regarding consult (i.e. need for symptom management, difficult family dynamics, education barriers, placement concerns, etc.)

***Please return these forms to Nursing Administration when chart is torn down.**

Initiated 04/2009
Last Revised 06/2009

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during the baseline quarter January-April 2009 to an average of 8 (range 3-15) per month during the tracking period March 2009-April 2010. The screening tool was disseminated to other units of the hospital in March 2010.

Utilization or outcome measures were also used to track improvement. From Medicare claims data, the 30-day readmission rate for HF patients decreased from a baseline in January 2008 of 27.0% to a rate of 23.9% in January 2010. Also from Medicare claims data, the hospital readmission rates for patients discharged to home health decreased from 20.1% to 16.9%.

Summary

The main outcome of standardizing the discharge process and reducing all-cause readmissions of HF patients was achieved, in that 77% of HF patients received the intervention bundle with the proportion increasing over time. The IHI “Transforming Care at the Bedside for HF Patients” tool kit provided evidence-based components to focus the efforts of this team. Key components of the IHI model were implemented to proactively address post-discharge needs and enhance patient teaching. Focusing on one hospital unit and targeting a defined population made the initiative manageable. Positive working relationships between HH liaisons and hospital case managers facilitated the development of standard orders for HH referral and alignment of educational materials. The Coleman CTI training funded by CMS was an incentive for HH agencies to participate. They had heard about the intervention and were anxious to develop processes to integrate aspects of the model into their skilled visits.

Referral to HH increased throughout the project. This can be attributed to an increased awareness of appropriate referral criteria by case managers and hospitalist physicians, the willingness of agencies to align their HF education materials with the hospital, and HH nurses’ commitment to coaching principles and timely follow-up.

Tools were developed by the team to increase patient and family involvement in the discharge process and to standard-

ize the education process. Team members recognized the need to start educating patients earlier and to test them on their knowledge. The improved patient education focused on patient self-management and was associated with an increase in HCAHPS satisfaction scores. While initial use of the tools was not consistently tracked, the development of the Education Log with Teach Back documentation improved tracking efforts. Some HF patients were not entered into the case management database and thus missed the enhanced intervention. In retrospect, designating one person to complete regular process checks may have ensured that more eligible patients received the intervention.

Teach Back education is being integrated into new staff orientation and competency skill checks for nurses. The discharge check list and Life Planning Screening tools have been standardized and implemented on admission across more patient units. There remains a perception by floor nurses that many patients who would benefit from palliative care consults are not being referred. As a result, there is ongoing nurse and physician discussion and education about advance care planning.

Our experience shows that a multidisciplinary, cross-setting team with support from leadership can work together to standardize inpatient heart failure education utilizing the Teach Back method, revise heart failure protocols to include home health referral, and implement patient self-management interventions to improve outcomes for patients with HF. This was demonstrated by decreased readmissions and an increase in patient satisfaction. Building on the successes of this team, the hospital board and leadership have directed the Chief Medical Officer and Quality Resource Director to convene a larger team to expand the effort to reduce all-cause 30-day readmissions for all Medicare patients. The HF team is sharing the strategies and interventions they implemented and is providing leadership for the expanded team.

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Heart Failure Zones

Every Day:

- Weigh yourself in the morning before breakfast and write it down.
- Take your medicine the way you should take it.
- Check for swelling in your feet, ankles, legs and stomach.
- Eat low salt / sodium foods.
- Balance activity and rest periods.

Which Heart Failure Zone are you today? **Green** **Yellow** **Red**

Green Zone

All Clear: *This is your Zone*

Your symptoms are under control and 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.

Yellow Zone

Caution: *This Zone is a warning*

Call your doctor if you have:

- Weight gain of 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.
- No energy or feeling more tired.
- Dry hacking cough.
- Dizziness.
- Feeling uneasy, you know something is not right.
- Difficulty breathing when lying down. Feeling the need to sleep sitting up in a chair.

Red Zone

*** 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.
- Chest pain.
- Confusion or can't think clearly.

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