

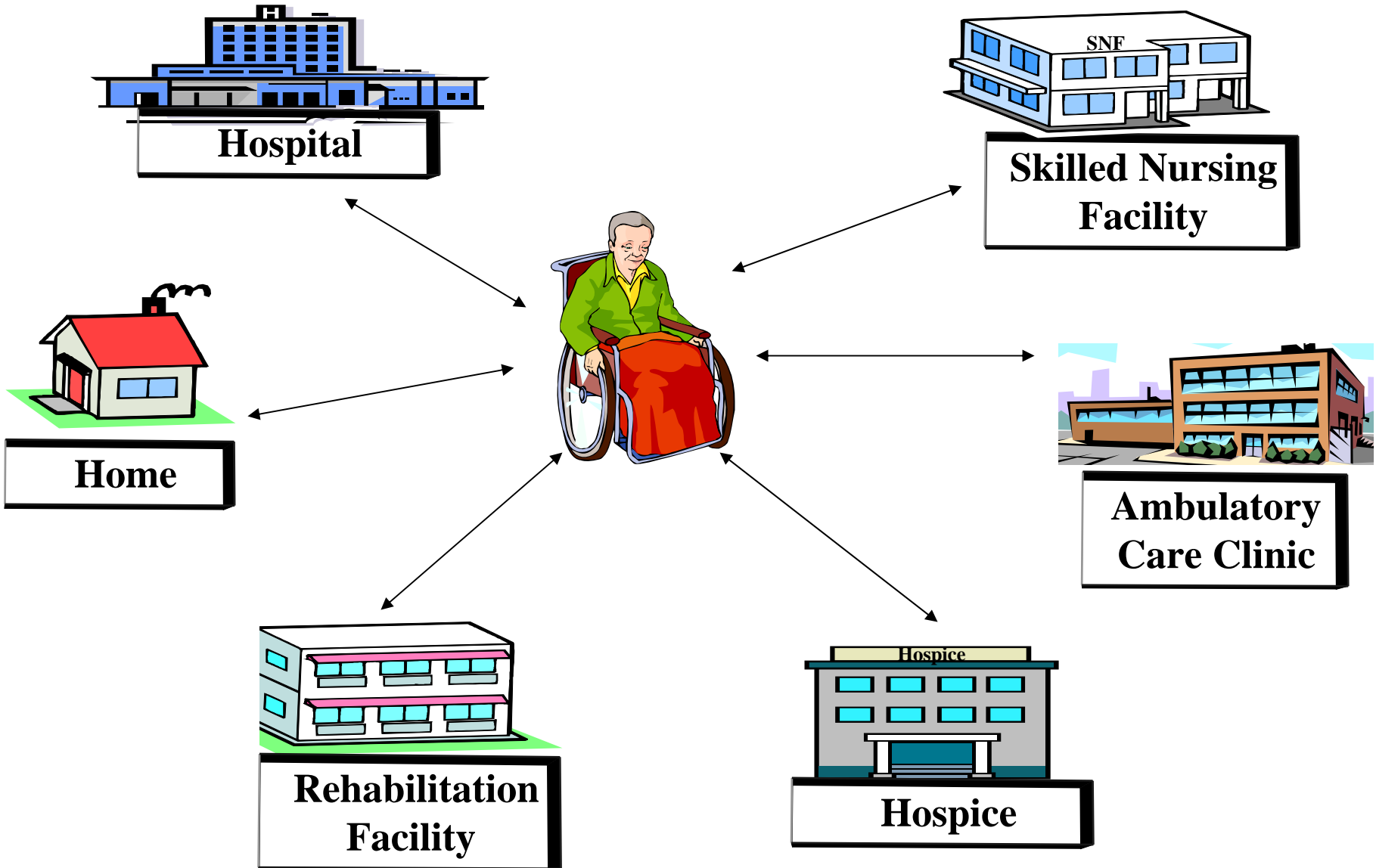


Creating an Ideal Transition Home for Patients with Heart Failure

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Fundamental Disconnect amongst Sites of Care



Courtesy of Eric Coleman, MD

Transforming Care at the Bedside

Launched in 2003, Transforming Care at the Bedside (TCAB) is a national program of the Robert Wood Johnson Foundation (RWJF) and the Institute for Healthcare Improvement (IHI) that engages leaders at all levels of the organization to:

- improve the quality and safety of patient care on medical and surgical units
- increase the vitality and retention of nurses
- engage and improve the patient's and family members' experience of care
- improve the effectiveness of the entire care team

Transforming Care at the Bedside: Premises

- Patient-centered work redesign can create value-added care processes and result in better clinical outcomes and reduced costs
- Effective care teams can have a positive impact on patient outcomes
- Management practices and organizational culture have a significant impact on the work environment and empowerment of front-line staff
- Matching staff's knowledge and capabilities with work responsibilities enhances job satisfaction
- Eliminating inefficiencies through work redesign enhances staff satisfaction and morale

IHI Model for Improvement*

What are we trying to accomplish?

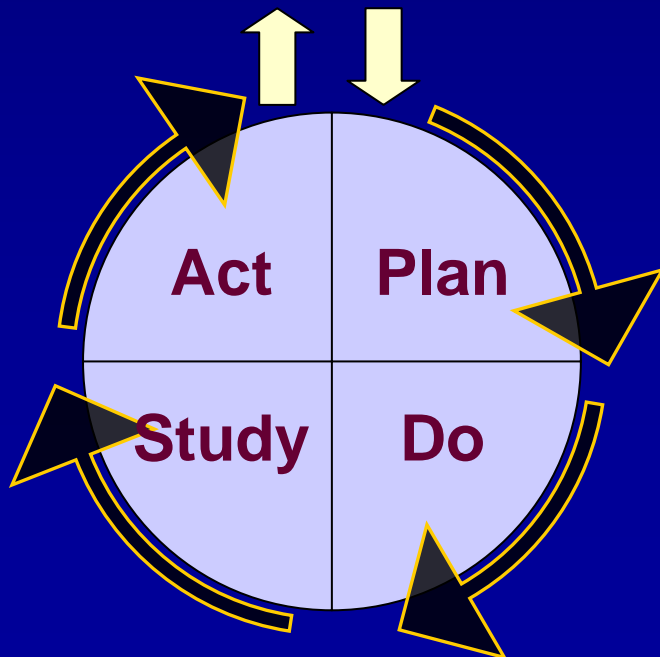
How will we know that a change is an improvement?

What changes can we make that will result in improvement?

Setting Aims

Establishing Measures

Selecting Changes



What changes can we make that will reduce readmissions?

Aim: Reduce unplanned readmissions of patients with heart failure to 5% or less

Key Changes:

1. Enhanced Assessment of Patients
2. Enhanced Teaching and Learning
3. Patient-Centered Communication Handoffs
4. Post Acute Follow-up

Creating an Ideal Transition Home

1. Enhanced Admission Assessment for Post-Discharge Needs

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

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2. Enhanced Teaching and Learning

- Identify the learner(s) on admission (i.e., the patient and family caregivers)
- Redesign the patient education process to improve patient and family caregiver understanding of self-care
- Use Teach Back daily 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

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3. Patient-Centered Handoff Communication

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

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4. Post-Acute Care Follow-Up

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

Aim Statement for St. Luke's Hospital

“By January 1, 2007, St. Luke's Hospital's Telemetry and Medical Units will reduce unplanned readmissions by 50% (from 12 to 6%) by improving the transition home process for all patients with Heart Failure.”

Changes Implemented at St. Luke's Hospital

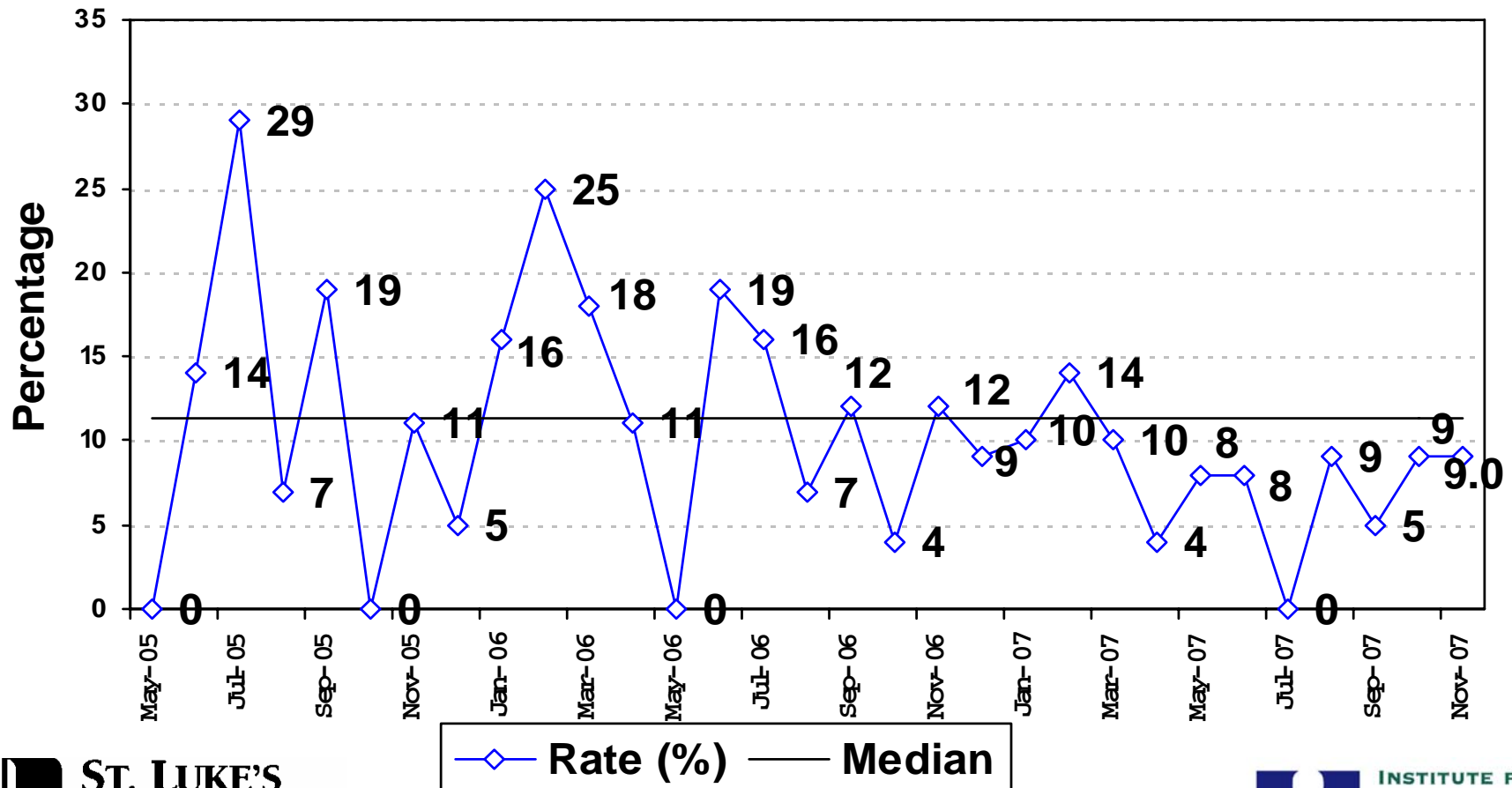
- Home care nurse (VNA) makes complementary visits within 24 to 48 hours after discharge
- Physician office follow-up visit scheduled within 3 to 5 days (particularly for high-risk readmission patients)
- Advanced Practice Nurse makes follow-up phone calls on seventh day after patient discharge
- Patient education processes and materials were revised to incorporate health literacy concepts for written materials
- Improved satisfaction of patients with discharge instructions based on patient response about unanswered questions

Changes Implemented at St. Luke's Hospital

- Improved medication reconciliation
- Partnered with home care agency and two long-term care facilities to standardize and enhance the quality of the handoff communication process
- Hospital recently appointed a medical director for heart failure who will work closely with the APN and HF team to review care processes
- A reminder to use Teach Back was added to standard HF admission and discharge order sets
- Referral to Palliative Care for patients with advanced stages of HF is being tested
- Monitoring to look for opportunities for ongoing improvement

HF Readmissions within 30 days

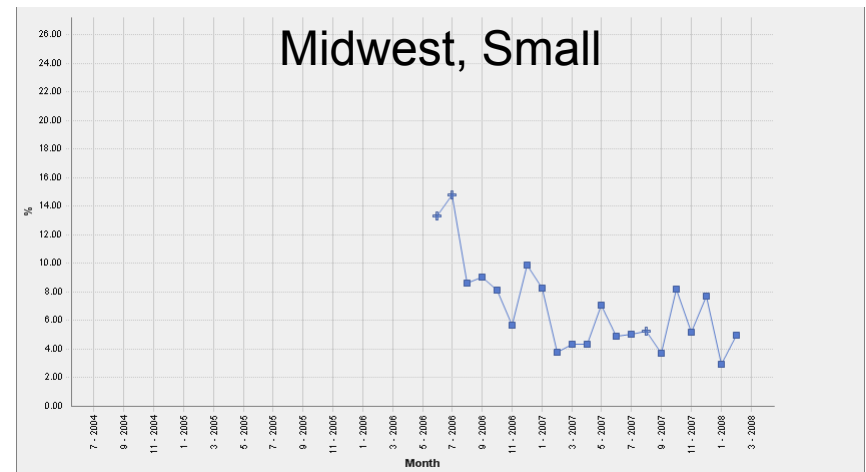
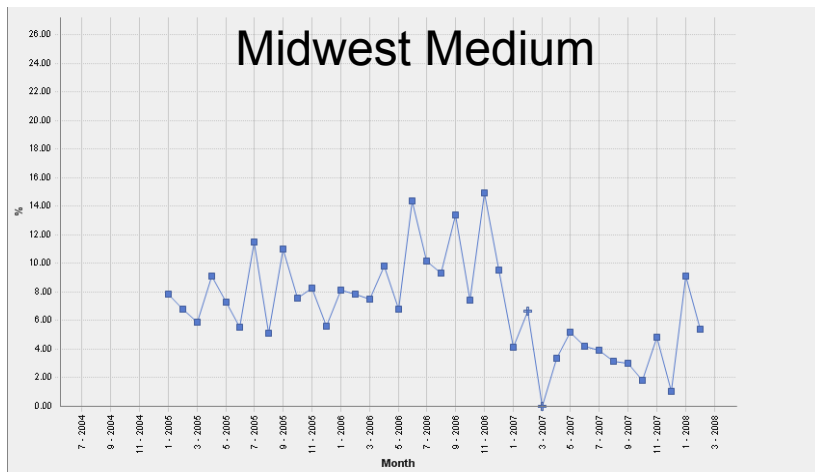
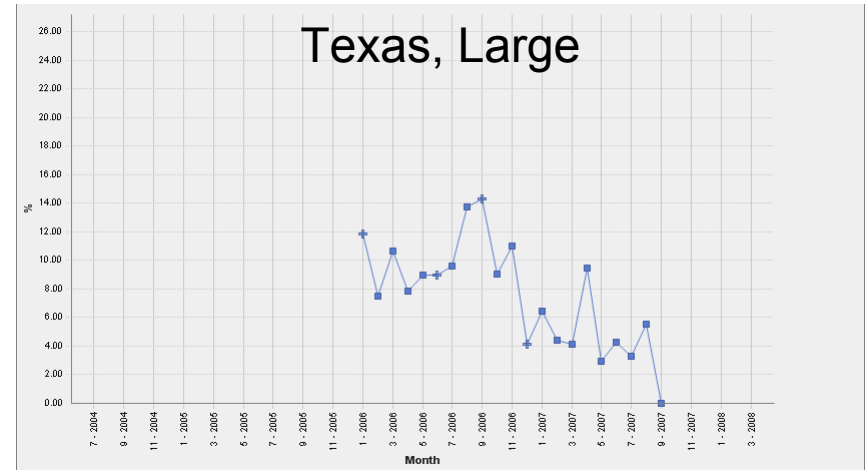
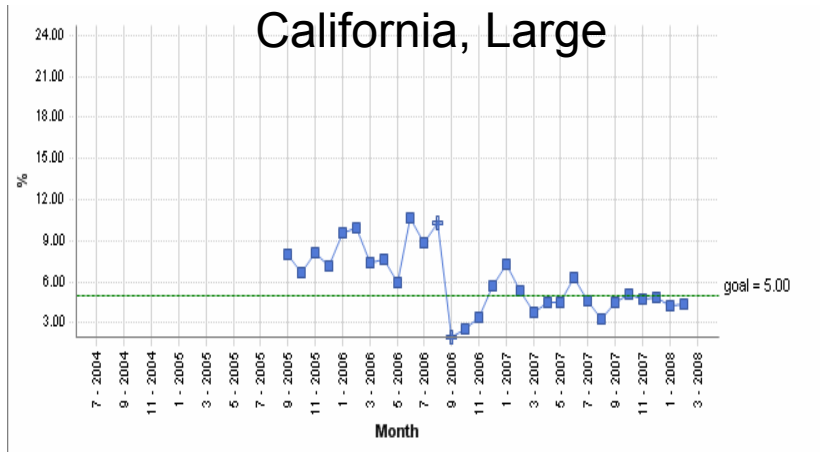
St Luke's Hospital Iowa Health System



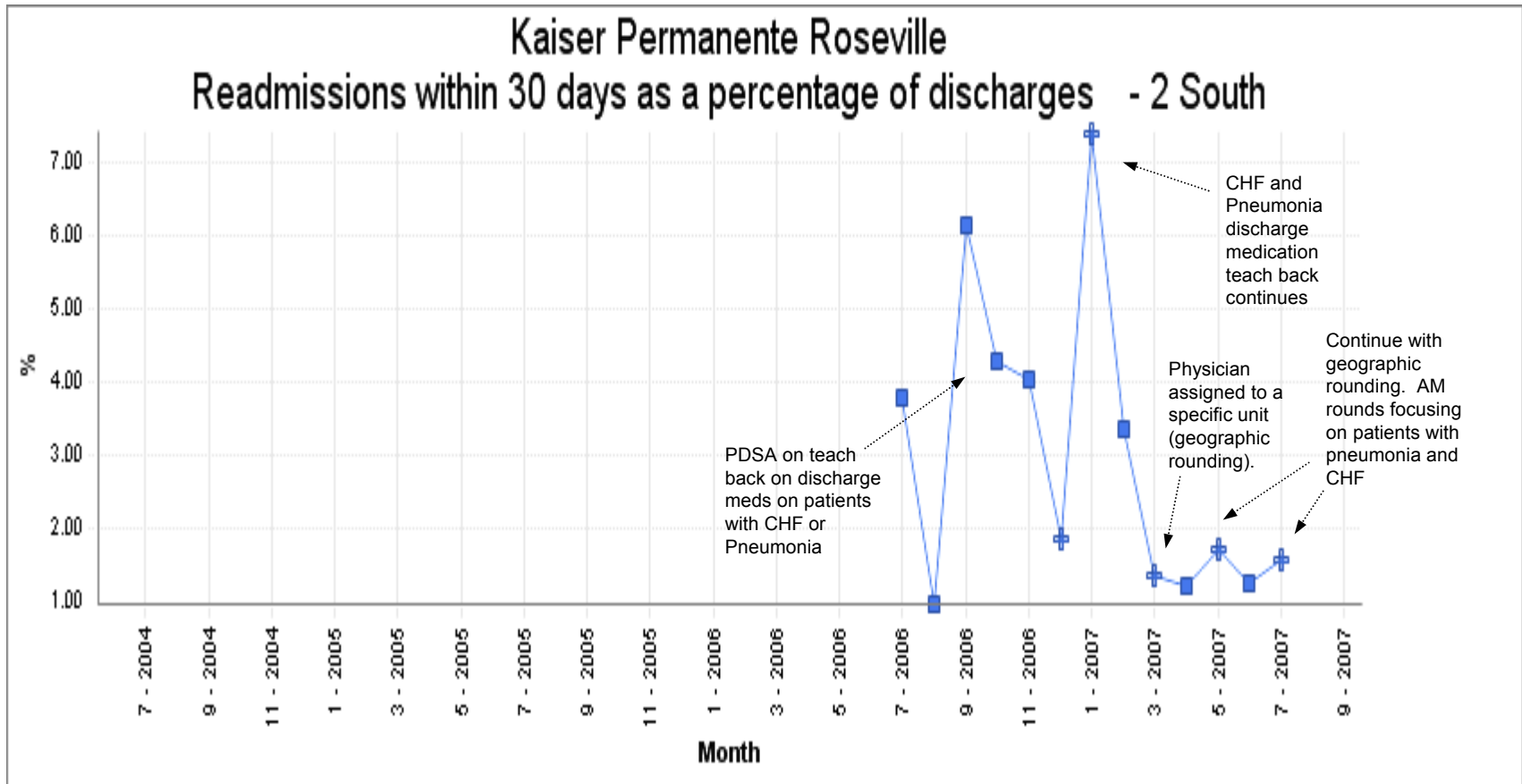
**ST. LUKE'S
HOSPITAL**
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Reducing Readmissions



Readmissions Within 30 Days



Summary: Creating an Ideal Transition Home

Key Changes:

1. Enhanced Assessment of Patients
2. Enhanced Teaching and Learning
3. Patient-Centered Communication Handoffs
4. Post Acute Follow-up

Learn More about TCAB & Download the Transitions Home Toolkit

- IHI's website

<http://www.ihl.org/IHI/Programs/StrategicInitiatives/TransformingCareAtTheBedside.htm>

<http://www.ihl.org/IHI/Programs/InnovationCommunities/TakingActiontoTransformCareattheBedside.htm>

- Toolkit

<http://www.ihl.org/NR/rdonlyres/CA987222-F6CE-4956-9BBC-F666482B2986/5863/TCABTransitionsHomeHowtoGuideOct07.doc>