Using a Patient Contract in Heart Failure:

Engaging the Patient & Nurse

The Heart Failure Program
Pinnacle Health Cardiovascular Institute
Christina M. Ring, MSN, RN-BC, CRNP
Who They Are

Living with Heart Failure
Who We Are

- Located in Harrisburg, Pennsylvania
- Only regional heart failure program
  - Two hospitals
  - Two distinct demographic regions
  - Two large cardiology practices

...ONE PROGRAM!
Harrisburg City

- 83% Ethnic & cultural minorities
- 32% Living below poverty line
- 23% Less than a high school diploma
- Average Household Income - $31,000
  (PA state = $50,000).
Our Population Served

717 individuals
Primary Diagnosis, CY 2011

- 359 Females, 358 Males
- 77% White, 20% Black, 2% Hispanic, 1% Asian, Middle Eastern or Unknown
- 46% Reside within a Harrisburg Zip Code
- Ages range from 30 to 90
Heart Failure & Low Income

+ + =

+ + + =

PinnacleHealth
Identified Issues in Care

- Care Transitions
- Communication
- Adherence
- Readmissions

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<thead>
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<tbody>
<tr>
<td></td>
<td>25.2%</td>
<td>25.0%</td>
<td>24.8%</td>
<td>24.7%</td>
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Blue Card: Step One

- Aim to standardize education
- Scaffold education day to day
- Expect a Gold Standard every time

Driving Goal:

Improve overall care provided, improve quality of life for the patient, reduce inpatient admissions.
The Original “Blue Card”

### Heart Failure Discharge ~ Patient Education

<table>
<thead>
<tr>
<th>Heart Failure Packet Given:</th>
<th>Date/Initials</th>
<th>Date/Initials</th>
<th>Date/Initials</th>
<th>Date/Initials</th>
<th>Date/Initials</th>
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<tbody>
<tr>
<td>o &quot;Managing Signs and Symptoms of HF&quot; handout</td>
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<tr>
<td>o Daily Weights</td>
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<td>o Medications and potential side effects</td>
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<tr>
<td>o Sodium restriction</td>
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<td></td>
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<tr>
<td>o Fluid restriction</td>
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<tr>
<td>Follow-up appointment scheduled</td>
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<tr>
<td>Pharmacy name and fax number</td>
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<tr>
<td>Prescriptions faxed to pharmacy</td>
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<tr>
<td>Outpatient follow-up</td>
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<tr>
<td>o Outpatient clinic</td>
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<tr>
<td>o Home care</td>
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<tr>
<td>o Refused services</td>
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<tr>
<td>Daily hospital weight</td>
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<td></td>
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<tr>
<td>Phone number to reach patient at home for follow-up phone call</td>
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</tbody>
</table>

- Please remember to document your teaching in Soarian!

**Patient Label:**

Weight upon D/C
Blue Card: Step Two

- Initiate on one unit…
  - Initiate on two units…
    » Initiate on 22 units……

Remember…

*Measure, Measure, Measure!*
Auditing Results

2011
Averaging 50% compliance with giving standardized education to HF patients.

2012
Gold Standard Education, by %

>80%!
Blue Card: Step Three

• Celebrate Success!
  – Get With the Guidelines GOLD
  – Joint Commission Accreditation
  – Magnet Survey Exemplar 2011
Blue Card: Step Back

Getting good feedback…

…even if it hurts!
Nurse Driven
Patient Engaged

My doctor has diagnosed me with heart failure. I know I must make adjustments to my daily routine.

I promise to take __________ (my water pill) every day. If I cannot take my pill for any reason, I will call my doctor.

I promise to eat a heart healthy diet. For me, this means that I will eat
MORE ___________________________ and
LESS ___________________________.

I know my heart failure is worse if
I will call my doctor if my weight equals __________. My normal body weight is __________.

It’s important to me to work with my doctor to manage this disease. I want to succeed and be symptom-free as much as possible. For me, I know I’m having a good day when

_________________________.

In the next few weeks, I want to
_________________________.

In the future, I’d like to talk more about
_________________________.

_________________________ with my doctor and my heart failure team.

I know I have people to help me. I can call 231-8445 (The Heart Failure Clinic @ Pinnacle Health) when I feel I need help.
If I’m having a medical emergency, I will call 911.

I promise to take good care of myself, so I can live life to the fullest.

Patient ___________________________ (signature)
_________________________ (printed)
_________________________ (date)
_________________________ (time)

ADULT HEART FAILURE PASSPORT: CLINICAL PLAN

PinnacleHealth Hospitals
Blue Card: Moving Forward!

- Continually re-evaluating
- Using Teach-Back, the best way
- Communicate between settings
- Transition to an electronic workflow
Teach-Back for HF

Quality care is all about patient involvement and quality communication.

Teach-Back Image obtained from AHRO.gov
Preliminary E-Screens

<table>
<thead>
<tr>
<th>Answered Correctly:</th>
<th>Individualized Patient Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the name of your water pill?</td>
<td>Short Term:</td>
</tr>
<tr>
<td>Yes</td>
<td>be symptoms-free as much as possible</td>
</tr>
<tr>
<td>No</td>
<td>stay out of hospital</td>
</tr>
<tr>
<td>Education Reinforced</td>
<td>recognize symptoms of worsening heart failure</td>
</tr>
<tr>
<td></td>
<td>learn more about heart Failure</td>
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<tr>
<td></td>
<td>learn more about my medications</td>
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<td></td>
<td>learn more about community resources</td>
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<tr>
<td></td>
<td>learn more about my diet</td>
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<tr>
<td></td>
<td>learn more about increasing activity</td>
</tr>
<tr>
<td>Name at least 3 foods you should avoid</td>
<td>Other Short Term Goal:</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Education Reinforced</td>
<td></td>
</tr>
<tr>
<td>How much fluid should you drink?</td>
<td>Long Term: in the future I hope to</td>
</tr>
<tr>
<td>Yes</td>
<td>eat a heart healthy diet</td>
</tr>
<tr>
<td>No</td>
<td>lose weight</td>
</tr>
<tr>
<td>Education Reinforced</td>
<td>establish caregiver support</td>
</tr>
<tr>
<td></td>
<td>medical planning, chronic illness management, palliative care</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>What amount of weight gain should you report?</td>
<td>Other Long Term Goal:</td>
</tr>
<tr>
<td>Yes</td>
<td></td>
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<tr>
<td>No</td>
<td></td>
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<tr>
<td>Education Reinforced</td>
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<tr>
<td>Name your yellow zone symptoms</td>
<td></td>
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</table>
Screens Continued

- What is your stop light zone today?
  - Red
  - Yellow
  - Green

- Admit Weight
  - kg

- Daily Weight
  - kg

- Discharge Weight
  - kg

- Activity Level:
  - Bedrest
  - Chair
  - Ambulate to BR
  - Ambulate in Room
  - Ambulate 1/2 hall
  - Ambulate hall

- Scale at home
  - Yes
  - No

- Scale Obtained

- Transition of Care
  - PCP's Name
  - Follow Up Appt scheduled: / / 
  - (goal, 5-7 days post discharge)

- Patient phone number for follow up call:

- Pharmacy Name

- Pharmacy Fax Number
  - Yes
  - No

- Prescriptions Faxed:
  - Yes
  - No

- Outpatient Follow up:
  - Heart Failure Center
  - Home Care
  - Refused Services
Bumps in the Road

- Turnover of inpatient nurses
- Introduction of the EMR
- Identifying the HF patient as an inpatient
- Tracking them all down!
Allies For the Trip

- Outpatient Heart Failure Center
  - Nurse Navigators for the most complex
  - Appointments for monitoring and education
  - Reduced readmission rates
  - Audits care & education
    for both the
    Inpatient & Outpatient
Fast tracks to Care

- A clear view…
- Data analysis and application
- Making the case
- A quality, dedicated, engaged team
On the journey…

Quality is never an accident; it is always the result of high intention, sincere effort, intelligent direction and skillful execution; it represents the wise choice of many alternatives”

William A. Foster
References

• Images

• Descriptive Data
  – Census.gov: Harrisburg City

• Low Income statistics

Special thanks to our Heart Failure Program Team- both Inpatient & Out; our amazing nurses, physicians, Case management and Performance Improvement Teams, our Medical Librarians, and our willing Editors!