Coordinated Outreach Achieving Community Health (COACH) for Heart Failure

Session C205
March 11, 2016

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Learning Objectives

#1: Discuss challenge of heart failure readmissions and effect on quality and cost of care.

#2: Describe process for concurrent screening and timely provision of care.

#3. List three strategies for building effective multidisciplinary teams to enhance successful hand-offs and improve transitions of care.
Our Lady of Lourdes Memorial Hospital, Inc.

- Ascension Health Ministry
- Binghamton, NY
- Acute Care Community Hospital
- 242 licensed beds; average daily census ~ 130-150
- Primary Care Network
- Home Health/Hospice - 4 counties
Opportunity for Improvement

- Heart failure (HF) team for years- focused on inpatient care
- Inconsistent care across the continuum
- Many barriers unrecognized
- Lack of consistency in HF education - hospital, primary care & homecare
- CMS focus on readmissions
2014, the COACH Program!
Actions Taken

- HF committee revised - key players
- Weekly meetings
- Goal Tree
- HF readmission reports reviewed
- Plan to deliver care initiated
- Dissemination of information
  - Presentations for providers, Network
  - Information flyers
COACH Inpatient Services

- Concurrent identification of HF patients:
  - B-naturetic peptide results
  - Referrals to CVD Manager
  - Length of stay
  - Chart review

- CVD Manager individualized education

- Referrals:
  - Palliative Medicine
  - Cardiology
  - Physical Therapy
  - Dietician
  - Cardiac Rehabilitation
Cardiovascular Disease Manager’s Role

- Review HF medications & clinical care
- Ensure echocardiogram assessed; ACE-I & ARB
- Schedule follow-up appointment with PCP and/or Cardiology in 3-5 days
- Complete discharge checklist
- Homecare or CVD home visits
- Follow-up phone calls
Resources

Education:

- HF Folder
  - “The Stronger Pump”
  - HF Zone Card
  - Informational brochures
  - T-Time
- Scales
- BP cuffs
- Transportation
A casual and comfortable environment to promote better quality of life for patients with Congestive Heart Failure.

You and a Guest Are Invited to Attend

T-Time
A casual time for conversation regarding Congestive Heart Failure.

DATE: November 12, 2015
TIME: 5:00-6:00pm
PLACE: Lourdes Hospital, Lecture Hall, Main Floor
TOPIC: Heart Healthy Nutrition
PRESENTED BY: Chef Gregory Borosky & Kirtan Singh, MS, RD, CDN

THE EVENING WILL INCLUDE:
• Guest Speakers
• Question & Answer Forum
• Educational Information
• Light Refreshments

To Register Call 1-877-9LOURDES
COACH Outpatient Services
Home Care

- Lourdes At Home Intake
  - Staff attempt to see patient within 24 hours
- Mandatory HF training for all field clinicians
- Home Care Connect call button
- Front load visits
- Dietary and PT (energy conservation)
- Tele-health
  - Landline
  - Wireless (Ascension Health Grant)
  - Tele-triage
COACH Outpatient Services
Primary Care

- Patient identified with EHR alert
  - RN provides HF education each visit
  - Success through teamwork

- Transitional Care Calls:
  - Template developed by RNs
  - Comprehensive assessment ensured
  - Documentation directly into the EHR
  - Connect patient with other services if needed
## Transitional Care Call Template

**Order Details**

**For:**

**Status:**

- **Active**
- **Debate**

**To Be Done:**

- 28Jul2015

**Overdue:** 02Aug2015 12:00AM

### Record web ordering

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**Chart Update:** 7/28/2015
Challenges Addressed

- MEDICATIONS!
- Auto-refill
- Misunderstanding of discharge medications
- Difficulty obtaining medications
- Lack of transportation
- Lack of coordination of care plan between providers
- Inability to access provider when needed
Results after COACH for HF

- Standardized care for HF patients
- Community meeting with local pharmacists
- Patients reported increased satisfaction
- Greater utilization of palliative medicine
Heart Failure Readmission Rates 2011 - 2014

- 2011: 25.22%
- 2012: 25.55%
- 2013: 23.08%
- 2014: 18.93%

25% reduction from 2011 - 2014

COACH For HF initiated 2014
Plans for the Future

- Nursing home engagement
- Spread COACH program to other chronic diseases
- ID cards to identify patients as HF COACH patient
- Increase ED referrals & interventions
- HF clinic
Executive Summary

- System wide goal to reduce readmissions
- COACH program developed
- Interdisciplinary approach
- Significant reduction in HF readmissions
- Consistency across the continuum of care
Questions?