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.

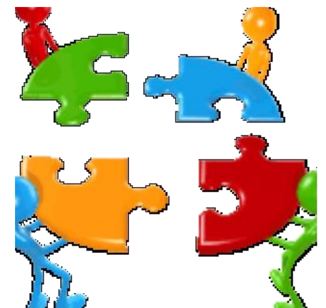
#3. List three strategies for building effective multidisciplinary teams to enhance successful hand-offs and improve transitions of care.

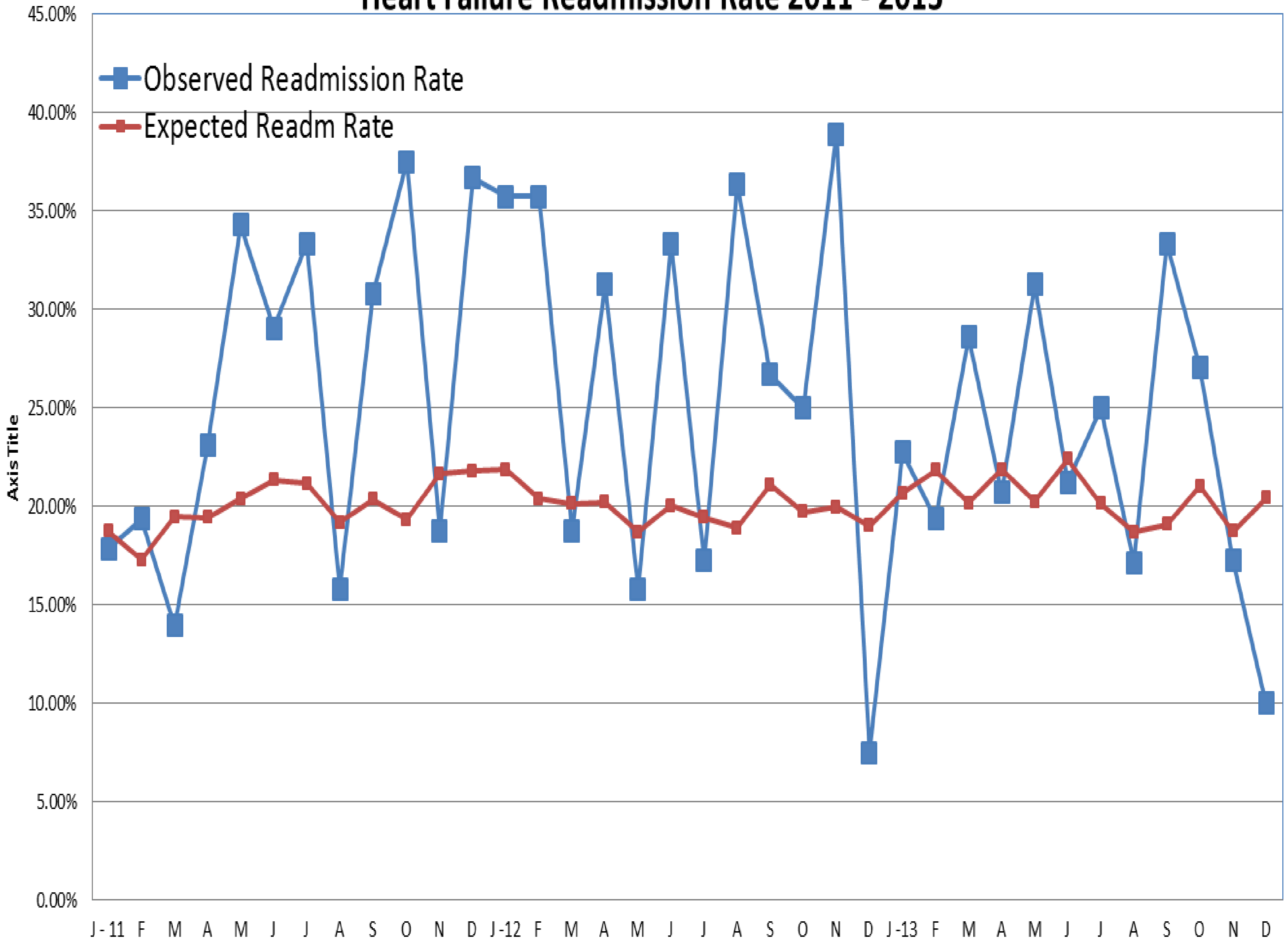
Our Lady of Lourdes Memorial Hospital, Inc.

- 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





Heart Failure Readmission Rate 2011 - 2013
Observed Readmission Rate
Expected Readm Rate
Axis Title
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
J - 11 F M A M J J A S O N D J -12 F M A M J J A S O N D J -13 F M A M J J A S O N D

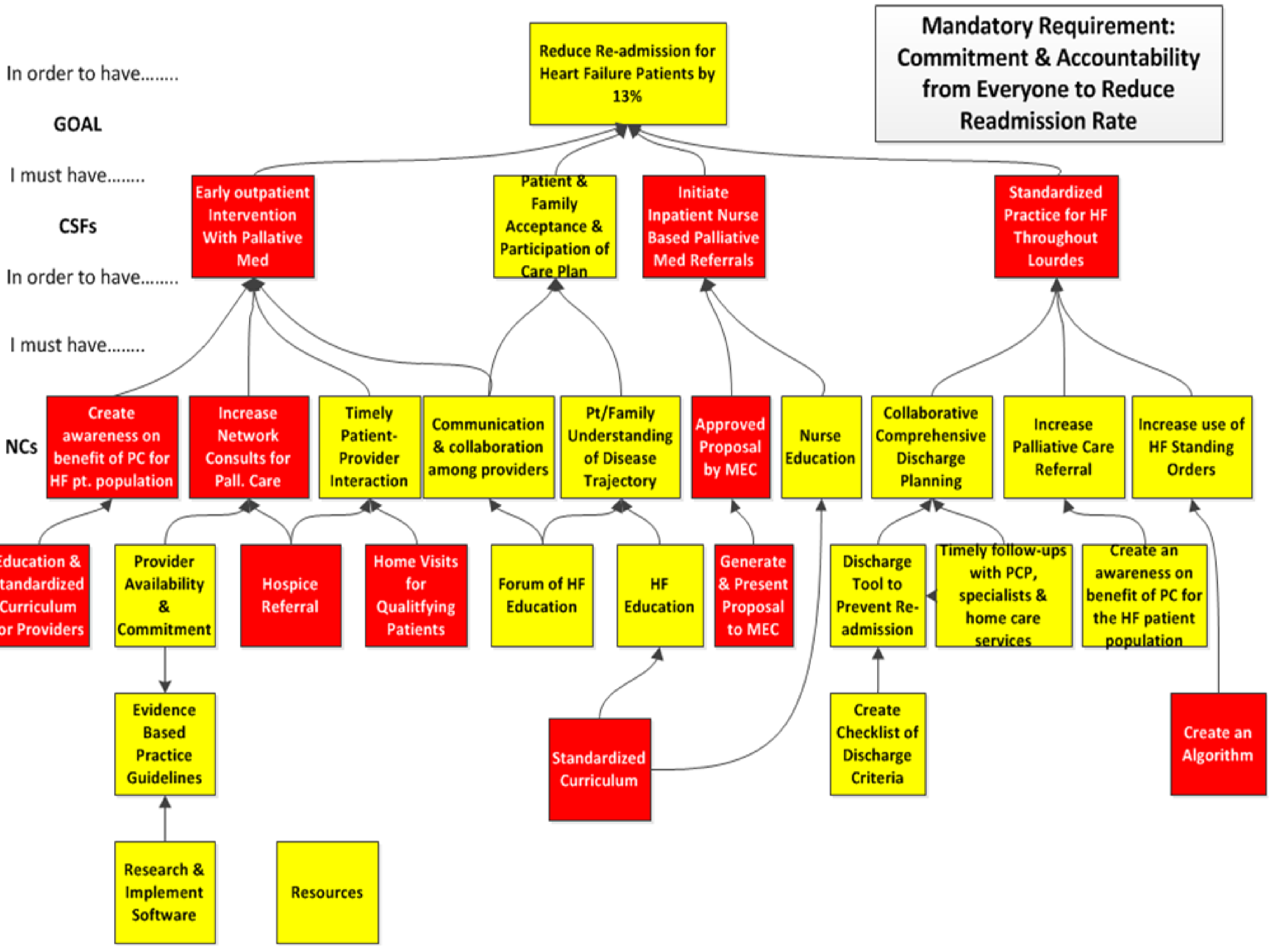
2014, the COACH Program!

COACH *for* HEART FAILURE

Coordinated Outreach Achieving Community Health

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



In order to have........
GOAL
I must have........
CSFs
In order to have........
I must have........
NCs
Reduce Re-admission for Heart Failure Patients by 13%
Mandatory Requirement: Commitment & Accountability from Everyone to Reduce Readmission Rate
Early outpatient Intervention With Pallative Med
Patient & Family Acceptance & Participation of Care Plan
Initiate Inpatient Nurse Based Palliative Med Referrals
Standardized Practice for HF Throughout Lourdes
Create awareness on benefit of PC for HF pt. population
Increase Network Consults for Pall. Care
Timely Patient-Provider Interaction
Communication & collaboration among providers
Pt/Family Understanding of Disease Trajectory
Approved Proposal by MEC
Nurse Education
Collaborative Comprehensive Discharge Planning
Increase Palliative Care Referral
Increase use of HF Standing Orders
Education & Standardized Curriculum for Providers
Provider Availability & Commitment
Hospice Referral
Home Visits for Qualitfying Patients
Forum of HF Education
HF Education
Generate & Present Proposal to MEC
Discharge Tool to Prevent Re-admission
Timely follow-ups with PCP, specialists & home care services
Create an awareness on benefit of PC for the HF patient population
Evidence Based Practice Guidelines
Standardized Curriculum
Create Checklist of Discharge Criteria
Create an Algorithm
Research & Implement Software
Resources

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 **C**ongestive **H**eart **F**ailure.

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*
- *Educational Information*
- *Question & Answer Forum*
- *Light Refreshments*

LOURDES
www.LOURDES.com

Sponsored by Lourdes Hospital

Make friends & find support from others.

Just as in Golf, Follow Through is Key to Your Health!

If you or someone you know is affected by congestive heart failure, you might feel alone or overwhelmed at times. Luckily, you don't have to cope with heart failure on your own. Join us and connect with others whose lives are impacted by heart failure.

LOURDES

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

Chart Update 7/28/2015

For: [0]

Status: Active | Details

To Be Done: 28Jul2015

Overdue: 02Aug2015 12:00AM

Order | Results | Goals

☑ Record w/o Ordering

Follow Up Appt?:
- N/A
- No
- Yes

Follow Up Appt Detail:

Transportation to Appt?:

Transportation Detail:

Compliance with Med List Reviewed?:

Compliance w/Med Detail:

Barriers to obtaining meds?:

Barriers to obtaining med detail:

Homecare needs?:

Homecare Needs Detail:

Shortness of breath?:

Shortness of Breath Detail:

OK | Cancel

Start

Desktop

5:29 PM
7/28/2015

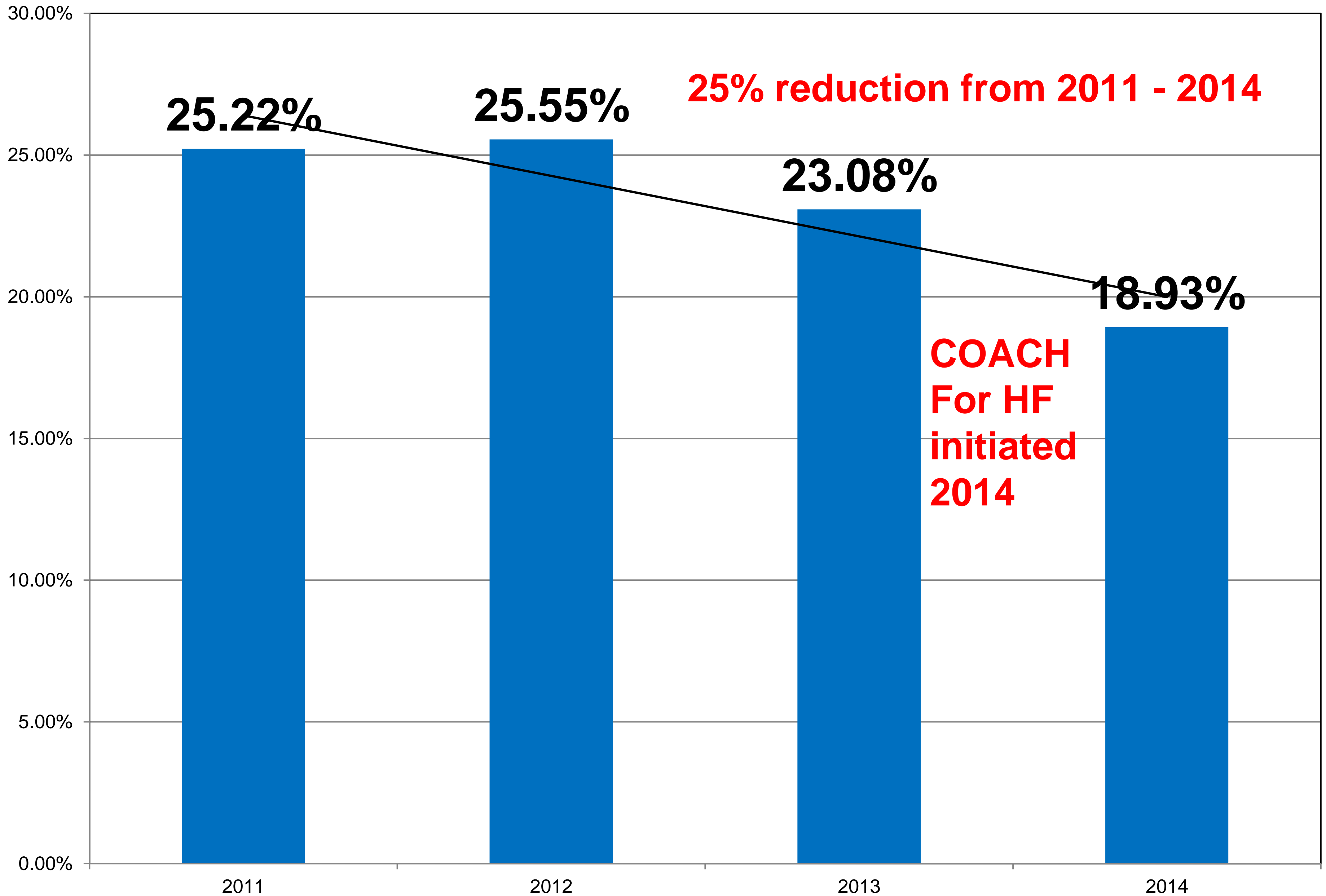
Challenges Addressed

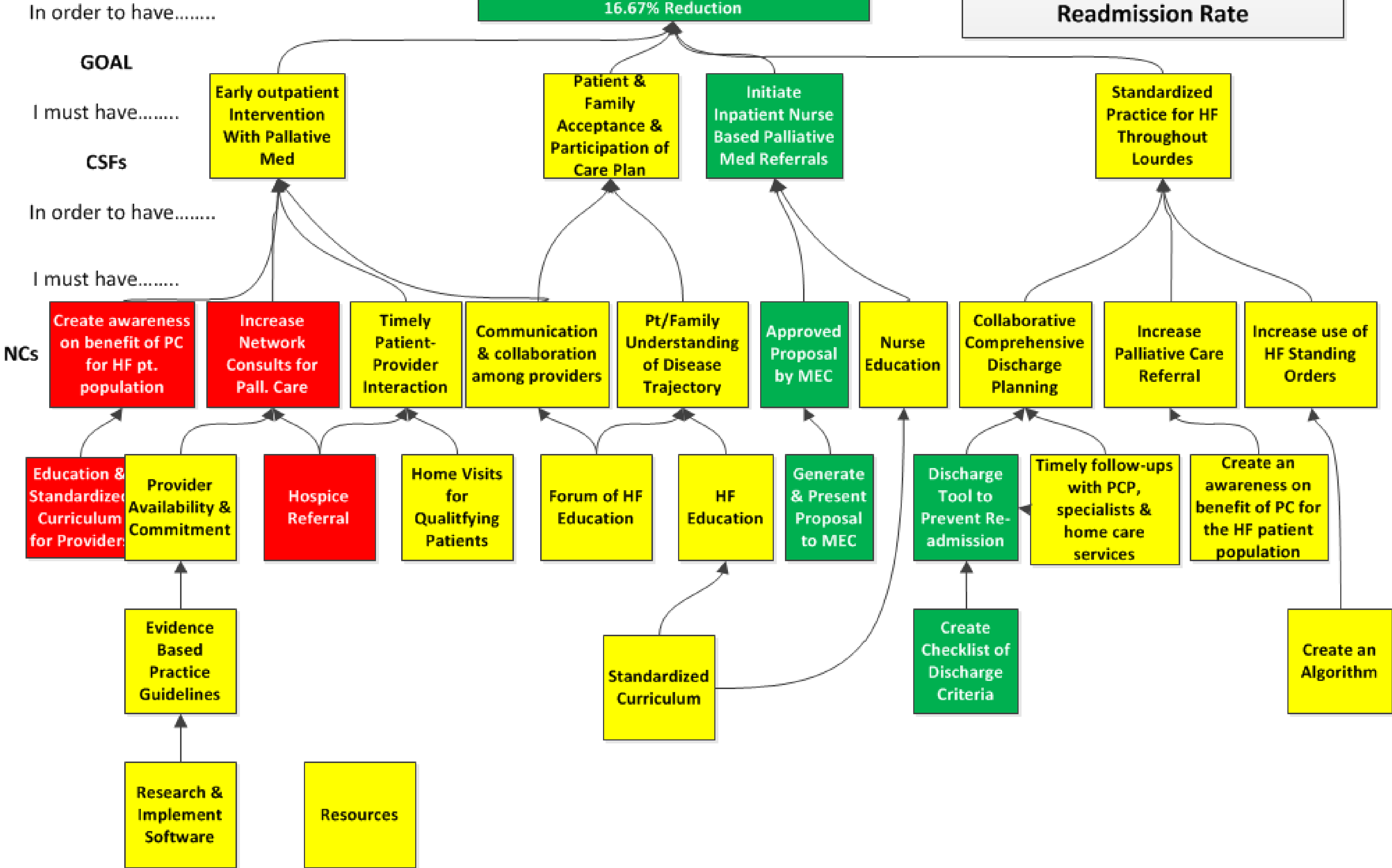
- MEDICATIONS!
- Auto-refill
- Misunderstanding of discharge medications
- Difficulty obtaining medications
- Lack of transportation
- Lack of coordination of care plan between providers
- Inability to access provider when needed

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





Reduce Re-admission for Heart Failure Patients by 13%
Baseline: Jul 2010-Mar 2011: 23.84%
Measurement: July 2013-June 2014
Starting Readmission Rate: 24.00%
Cumulative Readmission Rate: 20.00%
16.67% Reduction
Mandatory Requirement: Commitment & Accountability from Everyone to Reduce Readmission Rate
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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?