

**REDUCING THE PERCENTAGE OF HEART
FAILURE PATIENTS READMITTED TO THE
HOSPITAL WITHIN 30 DAYS OF DISCHARGE: A
SYSTEM REDESIGN PROJECT
CINCINNATI VAMC**

Sandy Jo Brown, RN, BSN, CPHQ

Dr. Sandra Dickens

Dr. Philip Schmitt

Kate Meyer, RN, BSN

Ross Puterbaugh, MSN, RN, CNL

Kristine Wilson, MSN, RN, CNL

Kimberly Wise, RN

Steve Zimmerman, RN, BSN

HF AT THE VA

- The VA provides care for approximately 240,000 veterans with heart failure. In 2005, over 42,000 of these veterans were hospitalized with a primary diagnosis of heart failure.
- Approximately 30% of veterans hospitalized for heart failure are readmitted to the hospital within 30 days of discharge. This readmission rate was identified by Cincinnati as an area for improvement.
- A System Redesign Team was formed to help reduce hospital readmissions for HF patients.



EVIDENCE BASED ORDER SETS

- The CHF order set provides “one-stop shopping” order entry to make it easier for physicians to prescribe a treatment plan for patients admitted with HF. The order sets are evidence-based and were developed by Cardiology, Internal Medicine, Pulmonology and Pharmacy.
- Each order set is packaged with menus for activity, diet, fluid management, general patient care, medications, GI and VTE prophylaxis, laboratory, radiology, consults, oxygen therapy and discharge planning.



PROVIDER EDUCATION

- For all care providers, seminars about heart failure were presented by Dr. Steinberg, Chief of Staff.
- For nursing staff providing direct care to HF patients, three weeks of multidisciplinary mini-educational sessions were offered on the units.
 - Ensured they were up-to-date on current evidence-based HF care
 - These 15 minute sessions were presented by Dietitians, Care Coordinators, Pharmacists, Nurse Educators, and CNL's.
 - Topics covered:
 - Dietary education/Sodium and fluid restrictions
 - HBPC & Care Coordination
 - HF medications
 - Nursing assessment and daily management for HF patients
 - In-house education for HF patients, and post-discharge follow up plans.



PATIENT EDUCATION

- All HF patients will also be provided with an educational booklet and education by a Clinical Nurse Leader during their inpatient stay.
- **Key points for all HF patients include:**
 - **Daily weight monitoring**
 - **Medication compliance**
 - **Low-sodium diet**
 - **Fluid restrictions**
 - **Activity**
- All HF patients receive a refrigerator magnet about heart failure. This magnet is a reminder for patients to call their physician if they begin to experience symptoms of worsening HF. Early action may prevent hospitalization for an HF exacerbation.

Signs of Heart Failure

If you have one or more of these symptoms:

- Weight gain of 3 pounds in 1 day or
- Weight gain of 5 pounds or more in 1 week
- More shortness of breath
- More swelling of your feet, ankles, legs or stomach
- Feeling more tired - *no energy*
- Dry, hacking cough
- Harder to breathe when lying down
- Chest pain

Call doctor _____
at _____



Cincinnati VA Medical Center



POST-DISCHARGE FOLLOW-UP

Early follow-up after discharge is key to preventing re-admissions.

There are three methods available to ensure a HF patient has early follow-up after a hospitalization.

1. Heart Failure SIGMA Clinic

- Starting April 2010, all HF patients discharged to home are encouraged to attend the **Heart Failure SIGMA Clinic**. Pts are be followed for four weeks after a HF exacerbation.
- At clinic appointments, Pt's:
 - Have labs drawn
 - See a physician to review symptoms and medications
 - Receive further multi-disciplinary education on daily weight monitoring, medications, diet and activity.



2. Follow-up in the home

- When appropriate, patients will be referred to **Home Based Primary Care (HBPC)** and/or Care Coordination/Home Telehealth for follow-up and closer monitoring.

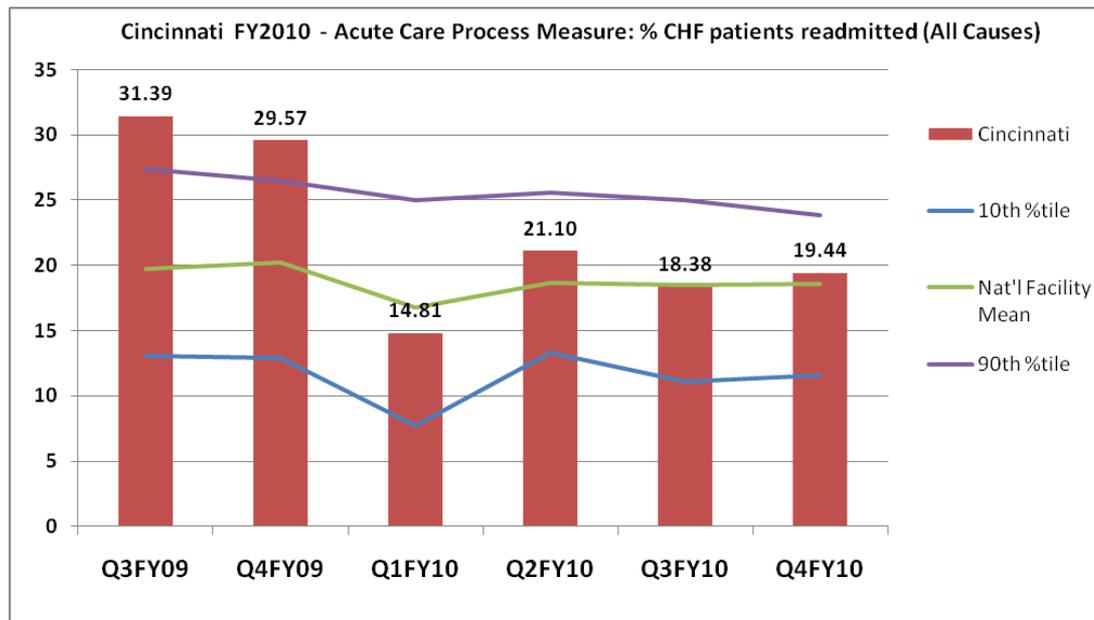
3. Primary Care Appointments

- If a patient is not able to attend the SIGMA and is not appropriate for HBPC, the patient is scheduled to see a **Primary Care Nurse (PCRM)** within 5 days of discharge and their **Primary Care Physician (PCP)** within 30 days of discharge.



RESULTS

- Implementation of the early follow-up protocol began in 2009. Q4FY09 showed a slight decrease in the HF readmission rate, and the Q1FY10 HF readmission rate dropped significantly. Although there was a slight increase in Q2FY10, a significantly lower readmission rate has been sustained throughout FY10.



QUESTIONS???

