Process Improvement

for the Heart Failure patient

Paul Helgerson, MD
Associate Chief of Staff, Process Improvement
VA Palo Alto Healthcare System
Learning Objectives

• Involve participants in local heart failure improvement initiatives
• Introduce the improvement framework as a tool to facilitate future efforts
• Identify means of successfully implementing change and finding new opportunity
Questions for Consideration

What are the most effective steps we can take as an organization to improve the care of the CHF patient?
Common Answers

- Improved adherence to guidelines/evidence basis
- Deliver further advanced therapies (e.g. LVAD)
- Decrease admissions/readmissions/keep more care in the home
- Improve collaborative decision making regarding goals of care
- We already do a pretty good job!
Domains of Improvement

- Evidence Basis
- Operations and Efficiency
- Patient Centered Care
VA-TAMMCS
Identifying A Framework

- Vision -> Identify Values
- Analysis -> Enumerate Priorities
- Team -> Interdisciplinary, Front Line
- Aim -> Direction, Leadership
- Map -> Understand our Work
- Measure -> Chart Progress
- Change -> Active, Rapid Cycle
- Sustain -> Plan for Lasting Effect
One Way

VA TAMMCS

Vision Analysis

“Deciding Phase”

Make Changes

“Doing Phase”

Sustain Spread

“Keep Doing Phase”
Project Selection Matrix Tool is a useful way to choose a project.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Project</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Likelihood of Success</td>
<td></td>
<td>5</td>
<td>10</td>
<td>8</td>
<td>10</td>
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<tr>
<td>$$ Impact (cost or revenue)</td>
<td></td>
<td>10</td>
<td>5</td>
<td>6</td>
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<td>Patient Satisfaction</td>
<td></td>
<td>10</td>
<td>4</td>
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<td>Employee Satisfaction</td>
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<td>Completion in 4-6 weeks</td>
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<td>10</td>
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</table>
84 steps
63 non-value steps
21 value-added steps
A Typical Healthcare Process

Start

Rework

Value Added Work

Finish
VAPAHCS Blood Culture Contamination Rate

- National Standard = 3%
- VAPAHCS Goal = 2%

- RPIW (late July)
- Competency Fair ICU & IICU (early October)
- Competency Fair 2A & 3C (early November)
- *LMS module online
- *Orders default to peripheral draw (late January 2011)
- Customized kits in use (August 2011)
Implementation of PDSA: The “How” to Change

Change

PDSA: The “How” to Change

Hunches
Theories
Ideas

Very small scale test

Follow-up tests

Wide-scale tests of change

Implementation of change

Learning from Data

What’s the Sequence?

Source: Institute for Healthcare Improvement (IHI)
Defining “Spreadable”

- Demonstrable Effectiveness
  - Implies formal recording/reporting

- Trialable

- Modular/encapsulated
  - Can I describe exactly what I did? Can I turn it into a “kit”

- Low “cost” (expense, easy)
  - Can the new innovation actually become the path of least resistance
Rules of Diffusion
(by Donald Berwick)

• Identify changes that are ready to spread
• Find innovators and support them
• Invest in early adopters and allow communication with innovators
• Make early adopters observable
• Allow re-invention of innovation
• Trust and enable innovation
Local Initiatives

• CHF Process Improvement Team
  – Initial goal of improving patient education in CHF
  – Scoped to inpatient and outpatient domains
  – Valuable output, valuable lessons of scope and “rapid cycle change” practice

• ARC Collaborative/Project RED
  – Overlapping “vision” of fewer readmission
  – Compelling blend of evidence and implementation science
Admission – Congestive Heart Failure
Your Self-Management Tool for Hospital Stay

Instructions to the Patient: Tracking weight daily is important. Use this flow sheet to work with your team to stay informed and to prepare for discharge.

Your weight at admission is ________ pounds. Not sure? Ask your nurse or doctor. We are happy to help. Daily weights are an excellent way to track control of congestive heart failure.

**Step 1: Get Informed**

Areas that I would like further education about include (check all that apply):

- Daily Weights
- Low Salt Diet
- Warning Signs/Symptoms
- Medications

**Step 2: Chart Your Progress**

Write in your weight daily. If your weight changes by more than 2-3 pounds/day or 5 pounds/week at home, call your doctor.

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<thead>
<tr>
<th>Date</th>
<th>Weight (lbs)</th>
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**Step 3: Prepare for Discharge**

Answer these questions prior to leaving:

1) What is my new target weight? ________ (lbs)

2) Do I have a VA scale at home? Yes No (circle one)
   If not, ask your doctor to order one.

3) What is my water pill and what dose should I take? ________
   Discuss this with your doctor before discharge.

Patient Name
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<tr>
<th>Sunday</th>
<th>Monday</th>
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Discharge Home – Congestive Heart Failure
Your Self-Management Tool for Home

Instructions to the Patient: Self care for congestive heart failure is important to keep you out of the hospital. This sheet will help you manage your care.

Step 1: Weigh Daily

My Discharge Weight _____ (lbs) on _____ (date)

<table>
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<th>Date</th>
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Step 2: Take Your Pills

My Water Pills:

Name

Dose

Time of Day

_______

_______

_______

Step 3: Know Your Warning Signs

If you have any of these warning signs, call the Advice Nurse at the Telephone Care Program (TCP) at 800-455-0057.

1) Weight gain of more than 2 or 3 pounds in one day, or 5 pounds in one week.
2) Increase in shortness of breath.
3) Increase in leg swelling.

Bring this sheet to your appointment.

Follow up appointment: __________________________

Patient Name: ________________________________
Project RED

• Educate the patient throughout the hospital stay
• Make appointments for follow-up prior to discharge
• Hardwire a follow-up plan for pending test results
• Organize post-discharge services
• Medication plan (reconciliation, availability)
Project RED

• Reconcile plan with guidelines and pathways
• Action plan for problems/emergencies
• Ensure a comprehensive discharge summary is available to the “right” people
• “Teachback” of the plan
• Provide a written summary of the discharge plan
• Provide telephone reinforcement of the plan

Source: http://www.ahrq.gov/qual/projectred/