In November 2017, the O/E performance for HF the Plan, Do, Study, Act (PDSA) methodology for small tests of network video
In 2019, the plan is to spread
Other members of the
Increasing CAT utilization from 44% in 2017 to 59% in 2018,
Utilization from 66% in 2017 to 81%
Balancing Metric
Atrium Health PCU achieved Tier One (rolling year)
O/E from 1.20 (Nov 2017) to a target of 0.86 O/E by December 2018
reduction best practice measures was developed.
For patients whose hospitalization included an HF diagnosis from 51% in 2017 to 43% in 2018 (Graph 1).
In addition to the reduction noted in the percentage of patients readmitted with a heart failure diagnosis from 51% in 2017 to 43% in 2018 (Graph 2).
Process Metrics
• Increasing HF Powerplan Utilization from 66% in 2017 to 81% in 2018, exceeding stretch goal
• Increasing Palliative Care Consultations from 1% in 2017 to 53% in 2018, exceeding stretch goal
• Increasing CAT utilization from 44% in 2017 to 59% in 2018, exceeding stretch goal
• Increasing HF Post-Discharge Appointment Scheduled within 5 Business Days of Discharge from 45% in 2017 to 48% in 2018, exceeding baseline performance of 45%
• Balancing Metric – Atrium Health PCU achieved Tier One status with the 2018 Teammate Engagement Survey
With volumes and resource allocation to the HF population,
Atrium Health Cleveland utilized a recently budgeted full-time position from PCU and transitioned it to a HF program coordinator for the entire facility. In 2019, the plan is to spread the HF readmission work to all units at the organization with a even greater impact on patient outcomes.
• Atrium Health Cleveland is dedicated to serving the patients within the community. Heart Failure is a prominent diagnosis in the community requiring focused and dedicated services to prevent readmissions and improve care across the continuum. Implementing the HF readmission work has allowed patients to receive high quality, evidence-based care improving health, understanding disease processes, increasing medication education, and identify available resources through the engaged multidisciplinary work at Atrium Health-Cleveland and extending outside the walls of the facility.

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Results

Graph 1 - Atrium Health Cleveland All-Payer Heart Failure 30-Day Same-Facility Readmission O/E

Graph 2 Atrium Health Cleveland Patients Readmitted with HF in 2018

Improvement Process

During our monthly meetings, we identified a gap in educating patients in a standard manner to focus on HF education to assist in their disease process. Needed improvements involved thorough education about HF, early identification of HF symptoms, and medication education. We formalized an education plan where each day identified HF patients would receive one-on-one education with the PCU CS and unit-based pharmacist. The addition of the pharmacist to the education plan allowed the team to tailor patient’s knowledge deficits around their plan of care to improve their understanding of medication purposes and side effects beyond just taking the medication. During education, teach back methods were used, as well as a dietary visual aid guide developed by a staff nurse participating in Clinical Advancement Program as a project to improve education

The huddle process began in August 2018 to identify HF patients and examine incorporation of key components defined within the process metrics as well as discharge needs related to their continuum care. The huddles consist of the multidisciplinary team with outline roles and responsibilities during huddles. The PCU CS’s role and responsibilities are comprised of identifying patients daily from the generated list, reviewing consultation needs (palliative/cardiology) with the CHG Nurse and Palliative Care representative, recognizing patients that need HF specific education with the CS and pharmacist. Other members of the huddle were given designated responsibilities such as the Guest Relation Specialist completing ordered GWN HF “Managing Your Treatment Plan” video and PCU clinical care managers reviewing anticipated discharge date, discharge disposition of patient and barriers to discharge.

To balance the effect of implementing daily huddles on PCU, the team used teammate engagement survey results as a balancing measure to determine the impact teammate satisfaction and engagement. Implementing daily huddles on PCU did not reflect a negative impact on teammates

Knowing the impact readmissions have on patients, caregivers, and the organization, Atrium Health-Cleveland recognized the need for focused improvement work around patients with HF. A multidisciplinary team was formed to take action and structure work around this complex diagnosis under facilitation by the Performance Improvement (PI) Coordinator during the fourth quarter of 2017. With the volume of HF patients, the leadership team was able to identify resources for driving change by designating a Clinical Supervisor (CS) on PCU to serve as the catalyst for change in the HF improvement work. In addition to the CS, the Clinical Care Management Coordinator assumed the leadership role for the PI Team. Monthly meetings were held to identify barriers and refine care related to the HF diagnosis and focus on techniques to prevent readmissions. Data analysis showed that majority of the HF patients were admitted to the Progressive Care Unit (PCU) at Atrium Health-Cleveland. With many of the HF patients being primarily admitted to PCU at Cleveland, the forward implementation of reducing HF readmissions became a primary focus for the leadership team and nursing staff.

The Model for Improvement provided a framework for this project using the Plan, Do, Study, Act (PDSA) methodology for small tests of change. Identification of the patient population was key to develop focused work in the beginning stages of the project. A business objects report was created by partnering with Information & Analytics Services (IAS) identifying the HF patients with the organization. The report was automatically distributed to the multidisciplinary team daily. With the support of the SHVI service line, the team determined to focus on key process metrics to impact the readmission rate. Tactics included:
• Utilization of the HF Powerplan order set.
• Palliative care consult
• Utilization of the Care Alignment Tool.
• Scheduling follow-up appointments within five business days.
• – GetWell network video utilization.

Atrium Health strives to provide the best care for all patients. One performance metric that helps us measure the quality of care we provide our patients is 30-Day Unplanned Readmissions. Not only are readmissions burdensome to the patient, costly to both the patient and organization but also may indicate we have an opportunity for improvement in the care we provide. Additionally, 30-day Unplanned Readmissions are a measure in the Centers for Medicare and Medicaid Services (CMS) Hospital Readmission Reduction Program (HRRP).

Based upon the rolling year performance in 2017, Atrium Health Cleveland established a structured team to address Heart Failure (HF) readmissions. In November 2017, the O/E performance for HF Readmissions was at its highest peak of 1.20 according to the Sanger Heart & Vascular Institute Rose Dashboard. Understanding that the patient population was complex and widespread, the facility created a workgroup to identify opportunities for improvement and allocate resources to the processes that would impact HF readmissions.

With our ongoing efforts to prevent HF readmissions within this patient population, having access to this publicly reported data allowed us to compare our outcomes to that of other hospitals, as well as, understanding the financial impact to the facility. Based on this information, and the identified impact to our patients, the decision to formally establish a team to research and implement HF readmission reduction best practice measures was developed.

•Reduce All-Payer Heart Failure 30-Day Same-Facility Readmission O/E from 1.20 (Nov 2017) to a target of 0.86 O/E by December 2018 (rolling year)
•Process Metrics for 2018
  •Maintain HF Powerplan Utilization ≥ 66% (2017 baseline performance). Atrium Health Cleveland is currently exceeding SHVI stretch goal however wanted to ensure the facility maintains performance.
  •Increase Palliative Care Consults from 1% (2017 baseline performance) to 10% (SHVI stretch goal).
  •Maintain Care Alignment Tool (CAT) utilization ≥ 44% (2017 baseline performance)
  •Increase HF Post-Discharge Appointment Scheduled within 5 Business Days of Discharge from 45% (2017 baseline performance) to 59.4% (SHVI target goal)
•Balancing Metric – Maintain Teammate Engagement Results of Tier One on the Progressive Care Unit (PCU) at Atrium Health Cleveland

Introduction
Goals

Atrium Health