WELCOME

Best Practices in Heart Failure Care

*A breakfast presentation brought to you by the American Heart Association & The Joint Commission*

2015 Scientific Sessions
Heart Failure Quality Improvement Programs

Hosts

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Presenters

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- **Wendi Roberts, RN, MS, CLNC, TNS** Executive Director, Disease Specific Certification, The Joint Commission

- **Laura Kingsbury, RN, BSN, TNS, CEN, SANE-A** Cardiology Program Coordinator, Mercy Health System, Janesville, WI

Best Practices

[heart.org/getwiththeguidelines](heart.org/getwiththeguidelines)
IOM 6 Domains of Quality

- Experience of Care
- Health of a Population
- Per Capita Cost

IHI Triple Aim

Quality Care

- Safe
- Effective
- Efficient
- Timely
- Equitable
- Patient Centered
The TOOLKIT of Quality

<table>
<thead>
<tr>
<th>Tool</th>
<th>Definition / Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence</td>
<td>Data on associations between actions and outcomes; derived from a hierarchy of scientific research</td>
</tr>
<tr>
<td>Data Standards</td>
<td>Agreed upon definitions, nomenclature, and data elements; facilitate communication and comparison</td>
</tr>
<tr>
<td>Clinical Practice</td>
<td>Detailed summary of the body of evidence for a given disease process or content area; includes specific recommendations for standards of care; graded on level (I, IIa, IIb, III) and type of evidence (A, B, C)</td>
</tr>
<tr>
<td>Guidelines</td>
<td></td>
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<tr>
<td>Quality Metrics</td>
<td>A broad range of measures that support self-assessment and quality improvement at the provider, hospital, and/or healthcare system level.</td>
</tr>
<tr>
<td>Process Performance</td>
<td>Discrete care elements that are the standard. Must allow for practical identification of those patients for whom a specific action should be taken [a clear denominator], easy determination of whether or not the measure has been performed [a clear numerator], and opportunities for timely feedback</td>
</tr>
<tr>
<td>Measures</td>
<td></td>
</tr>
<tr>
<td>Outcomes Performance</td>
<td>Measures of health that are important to patients and are through to be affected by processes of care; generally require risk-standardization to account for case mix</td>
</tr>
<tr>
<td>Criteria</td>
<td>Identify common, prototypical patient subgroups for which expert clinicians assess the benefits and risks of a test or procedure (score 1-9); primary goals are to reduce overuse and minimize underuse</td>
</tr>
</tbody>
</table>

CLASS (STRENGTH) OF RECOMMENDATION

CLASS I (STRONG) Benefit ± Risk

Suggested criteria for writing recommendations:
- Is recommended
- Carries a clear-cut benefit
- Treatment strategy A is clearly superior, indicated in preference to treatment B
- Treatment A should be chosen over treatment B

CLASS II (MODERATE) Benefit ± Risk

Suggested criteria for writing recommendations:
- May be reasonable
- May be considered reasonable
- Equivalence, effectiveness is unknown/undetermined/unresolved

CLASS III (WEAK) Benefit ± Risk

Suggested criteria for writing recommendations:
- May not be reasonable
- May not be considered reasonable
- Treatment strategy B is clearly superior, indicated in preference to treatment A
- Treatment B should be chosen over treatment A

LEVEL (QUALITY) OF EVIDENCE

LEVEL A
- High-quality evidence from more than 1 RCTs
- Meta-analysis of high-quality RCTs
- Visc or more RCTs contributed to high-quality registry studies

LEVEL B
- Moderate-quality evidence from 1 or more RCTs
- Meta-analysis of moderate-quality RCTs

LEVEL C
- Moderate-quality evidence from 1 or more well-designed, well-executed randomized trials, observational studies, or registry studies
- Meta-analysis of such studies

LEVEL D
- Expert opinion or practice guidelines or registry studies with no information on design or execution
- Meta-analysis of such studies

LEVEL E
- Consensus of expert opinion based on clinical experience where evidence is insufficient, vague, or conflicting

CIR and DCR are determined independently. A CIR may be coupled with any DCR. A recommendation with CIR 1-2-3 does not mean that the recommendation is weak. More important clinical questions addressed in guidelines are not ranked in the same hierarchy. Although RCTs are credible, there may be other clinical research that provide better evidence. This may be helpful in situations where a particular test is not adequately studied.

For the purpose of specifying evidence, there are no upper limits, and the strength of recommendations may be modified based on the evidence.

LEVEL A: Evidence-direct recommendations (CIR 1 and DCR 1-2-3) do not offer specific recommendations, but rather reflect the use of uncontrolled, expert opinion or practice guidelines. This level of evidence indicates that the recommendation is based on a systematic review of the literature, meta-analysis or consensus of experts.
The Importance of Data in QI

- System changes
  - EMR
  - Standing orders
  - Critical pathways
  - Integrated care

- Clinician leaders
- Administrative support
- Data
- Benchmarking

Get With The Guidelines®-Heart Failure &
Target: Heart Failure℠

- GWTG-HF
  - Launched in 2005
  - Program aims to improve care by promoting consistent adherence to the latest scientific treatment guidelines
  - 536 Participating U.S. hospitals
  - 867,362 enrolled patients
  - Focuses on the acute heart failure patient from ED admission through discharge

- Target: Heart Failure (launched in 2011) focuses on the transition time from hospital discharge to outpatient setting
Measures Can Improve

Heart Failure Readmission Solutions / Best Practices
### 10 Key Practices in HF QI

**Quality Improvement resources and performance monitoring**
1. Having ≥ 1 quality improvement team for reducing readmission for HF and MI
2. Monitoring proportions of discharged patients with 7-day f/u appointment
3. Monitoring 30-day readmission rates

**Medication Management**
4. Providing information to all patients about medications (including purpose of each med, which were new, which had changed in dose/frequency, which had stopped)
5. Pharmacist responsible for conducting medication reconciliation at discharge
6. Having pharmacy technician primarily responsible for obtaining medication history as part of medication reconciliation process

**Discharge and follow-up**
7. Providing patients or their caregivers direct contact info for a specific clinician in case of emergency and/or other type of emergency plan
8. Arranging an outpatient follow-up appointment before patients leave the hospital
9. Ensuring the outpatient MDs are alerted to a patient’s discharge within 48h
10. Calling patients regularly after discharge to either follow-up on post-discharge needs or to provide education


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### Survey of H2H Hospitals for Strategies to Reduce HF/AMI Readmissions

Percentage of Hospitals Implementing 10 Key Practices Summary scores indicating the frequency with which hospitals implemented key practices in quality improvement and performance monitoring, medication management, and discharge and follow-up

All solutions are local: Colorado

- Joint Commission Accredited
- Joint Commission Certified in for Disease Specific Care
  - TJC/AHA Advanced Heart Failure (2013 and 2015)
  - Mechanical Circulatory Support
  - Palliative Care
  - Comprehensive Stroke Center
- AHA “Get with the Guidelines” Gold Recognition
- ACC Patient Navigator Program Participant
- CCM1 Bundled Payment Model 4 Pilot Site
Taking the next step . . .
Advanced Certification in Heart Failure

Wendi Roberts
The Joint Commission

The Joint Commission’s Advanced Certification in Heart Failure program was developed in collaboration with the American Heart Association.
Benefits of Certification

• Builds the structure required for a systematic approach to clinical care
• Reduces variability and improves the quality of patient care
• Pushes you to look at yourself more closely
• Creates a loyal, cohesive clinical team
• Provides an objective assessment of clinical excellence
• Differentiates clinical care in the marketplace
• Promotes achievement to referral sources

Accreditation vs. Certification

• Accreditation Surveys
  Organization-wide evaluation of care processes and functions
• Certification Reviews
  Product or service-specific evaluation of care and outcomes
Who is eligible for Advanced Certification in Heart Failure?

- Accredited hospitals with an established inpatient heart failure clinical treatment program
- Provide ambulatory care services through a hospital-based and hospital-owned heart failure clinic OR a collaborative relationship with one or more cardiology practices
- At least a Bronze performance award from Get With The Guidelines-HF

Advanced Certification in Heart Failure
56 Certified Programs

As of 10/27/15
Advanced Certification in Heart Failure

**Structure**
Standards + program specific requirements

**Quality & Safety of Care for Patients**

**Process**
Get With the Guidelines – Heart Failure

**Outcome**
Standardized Performance Measures
(required inpatient measures plus optional outpatient measures)

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**Disease-Specific Care Standards**

- **Program Management**
  7 standards
- **Delivering or Facilitating Clinical Care**
  6 standards
- **Supporting Self-Management**
  3 standards
- **Clinical Information Management**
  5 standards
- **Performance Improvement and Measurement**
  6 standards
Standard Highlights (1 of 2)

- Program scope includes inpatient and outpatient, transitions and care coordination
- Care coordination is provided across inpatient and outpatient settings
- Patients re-evaluated within 72 hours after discharge (via phone call, home visit or scheduled office visit)
- Prior to discharge, a follow up appt. is scheduled to occur within 7 days

Standard Highlights (2 of 2)

- Functional capacity is assessed
- Comprehensive plan of care developed
- Heart Failure team implements interventions (addressing assistance with self-management activities, fluid management, symptom management, nutrition, medications, exercise, stress and risk reduction, coping, immunizations, palliative care)
- Data collection includes functional capacity, symptom stability, and 30-day readmissions for heart failure symptoms
ACC/AHA Guidelines Required

- The program must follow the current American College of Cardiology/American Heart Association heart failure guidelines, *2009 Focused Update Incorporated Into the ACC/AHA 2005 Guidelines for the Diagnosis and Management of Heart Failure in Adults*.

Standards Update Project in Process

- Work is underway to match standards with 2013 AHA/ACC Guidelines
- Anticipate revised standards in mid-2016
Heart Failure Performance Measure Sets

<table>
<thead>
<tr>
<th>Mandatory as of January 1, 2015</th>
<th>Encouraged but not Required</th>
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<tbody>
<tr>
<td>ACHF Measures</td>
<td>ACHFOP Measures</td>
</tr>
<tr>
<td>ACHF–01: Beta-Blocker Therapy Prescribed at Discharge</td>
<td>ACHFOP–01: Hospital Outpatient Beta-Blocker Therapy Prescribed for LVSD</td>
</tr>
<tr>
<td>ACHF–02: Post-Discharge Appointment for Heart Failure Patients</td>
<td>ACHFOP–02: Hospital Outpatient ACEI or ARB Prescribed for LVSD</td>
</tr>
<tr>
<td>ACHF–03: Care Transition Record Transmitted</td>
<td>ACHFOP–03: Hospital Outpatient Aldosterone Receptor Antagonist for LVSD</td>
</tr>
<tr>
<td>ACHF–04: Discussion of Advance Directives/Advanced Care Planning</td>
<td>ACHFOP–04: Hospital Outpatient NYHA Classification Assessment</td>
</tr>
<tr>
<td>ACHF–05: Advance Directive Executed</td>
<td>ACHFOP–05: Hospital Outpatient Activity Recommendations</td>
</tr>
<tr>
<td>ACHF–06: Post Discharge Evaluation for Heart Failure Patients</td>
<td>ACHFOP–06: Discussion of Advance Directives/Advanced Care Planning</td>
</tr>
<tr>
<td></td>
<td>ACHFOP–07: Advance Directive Executed</td>
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</table>

Measure Specifications Manuals

http://www.jointcommission.org/certification/heart_failure.aspx
Contact Information

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Journey to Advanced Heart Failure Accreditation

2015 AHA Scientific Sessions®
Heart Failure Breakfast
Tuesday, November 10, 2015
Laura Kingsbury, BSN, RN, CEN, TNS, SANE-A
Mercy Health System, Janesville Wisconsin
Mercy Health System

- Mercy is a comprehensive vertically integrated health care system consisting of 70 facilities in 24 communities throughout Wisconsin, and Illinois.

- Mercy Hospital and Trauma Center, Janesville, Wisconsin, is a 240-bed acute care facility

- Mercy Harvard Hospital, Harvard, Illinois, is a 15 bed Critical Access Hospital combined with a 45 bed skilled nursing facility

- Mercy Walworth Hospital and Medical Center, Lake Geneva, Wisconsin, is a 25-bed critical access hospital

- 43 Outpatient Clinics

- Four core service areas: hospital-based services, clinic-based services, post-acute care and retail services, and insurance products.
Mercy Health System
Recognized for Excellence

- Magnet® Recognition (2014)
- Awarded bronze recognition through the Workplace Partnership for Life Hospital Campaign for organ donation enrollment efforts (2014)
- Received the Get With The Guidelines Stroke Gold-Plus Quality Achievement Award from the American Heart Association/American Stroke Association (2014)
- Malcolm Baldrige National Quality Award (2007)
- The Joint Commission’s Top Performer for Key Quality Measures for Mercy Harvard Hospital (2014)
- US Department of Health and Human Service’s Silver Medal of Honor for providing exemplary commitment to organ donation (2009, 2014)
- Named to Hospitals & Health Networks magazine’s 25 Most Wired/Most Improved for enhancements made between 2012-2013
- US News and World Report’s 2016 Best Hospital

Mercy Hospital and Trauma Center
Centers of Excellence

• Advanced Certification in Heart Failure by The Joint Commission and the American Heart Association
• AHA Get With The Guidelines Silver Plus Target: HF Award
• Level II Trauma Center by the American College of Surgeons
• Advanced Certification for Primary Stroke Centers by The Joint Commission and the American Heart/American Stroke Assoc.
• Chest Pain Center with Primary PCI Accreditation from the Society of Cardiovascular Patient Care
• Total Hip Replacement Certification by The Joint Commission
• Total Knee Replacement Certification by The Joint Commission

Need for Change

• Mercy Health System was becoming an Accountable Care Organization
• Heart Failure Readmissions exceeded the national average
• Medicare’s penalty laws
• HCAHPS scores for Heart Failure patients were below goal
• Identified that Heart Failure patients needed better coordination of care
Initial Steps

- Cardiologist in collaboration with hospitalists identified need
- Worked with Quality Data Management about identifying guidelines and certification options
- Administration support
- Began GWTG data collection in 2012
- Joint Commission application submitted in 2013
- Continued preparation
- Site Visit May, 2014
Goals for Program

• Create a Heart Failure Coordinator position
• Develop a Heart Failure Clinic within our Cardiology Clinic
• Provide In-Patient patient education process
• Provide discharge Heart Failure Kits
• Improve follow up process for Heart Failure patients
• Improve coordination of care for Heart Failure patients
• Identify and following evidence-based guidelines for Heart Failure patients

Obstacles

• Hula Hoop
Obstacles

• Planning out the logistics of how the HF Clinic was going to look and work
• Getting “buy in” from the hospitalists and PCPs
• Policy and process change throughout the hospital to meet latest EBP and guidelines
• Education and practice changes for nursing staff

Best Practices
Follow Up Contact within 72 Hours

• Customer service representatives were doing discharge follow up phone calls
• Added Heart Failure Questions
• Moved this program to Nursing Services Office with Shift Coordinators
• Hired on trained RNs and changed hours to include evenings and weekends

Follow-Up Visit or Contact Within 72 Hours of Discharge

*Percent of heart failure patients who had a follow-up visit or phone call scheduled to take place within 72 hours or less of hospital discharge. Time Period: Q1 2013 - Q4 2015; Site: Mercy Health System (31267)
Case Scenarios

• Mr. James, who was d/c’d with medication changes
• Mr. Smith, who was experiencing vague symptoms within 2 days of d/c

Follow Up Appointment within 7 Days

• Nurses trained on Cadence
• Risk Stratification
• Goal to F/U in HF Clinic or with Cardiology
• Challenged with appt availability
Follow Up Visit Within 7 Days

Advanced Care Planning

• Started in-patient
• “People don’t want to talk about dying while they’re in the process of it.” — Kris Phillips, MSN, RN, Director ICU/SCU
• Discovered Respecting Choices®
• Partnered with Honoring Choices Wisconsin®
• Moved the conversation to the clinic setting
Advanced Care Plans Documented

Percent of heart failure patients who have an advanced care plan or surrogate decision maker document in the medical record. Time Period: Q2 2012 - Q4 2015; Site: Mercy Health System (31267)

Patient Navigator Role

- Meet and assess every patient admitted to hospital.
- Promotes customer satisfaction and intervenes at critical moments of service
- Identifies and intervenes in situations that pose financial risk to the patient and the organization.
- Monitors patient length of stay and facilitates efficient completion of hospital services.
Other Improvement Activities

- Increased community partnership with skilled nursing facilities
  - Lack of appropriate beds available in area
- Reaching out to county services
  - ADRC, County Case Managers, Mental Health
- Executive level complex discharge committee meets biweekly
  - (CNO, Vice Presidents, Finance and Legal, Home Health and Hospice, SNF Administrator)

Measuring the Program’s Success
Outcome Measures

• Discharge and Transition of Care outcomes on PG and HCAHPS
• Readmission rates
• Core measure outcomes

During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.

![Graph showing data trends]

- MHTC
- All Press Ganey Data Base
When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.

During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
Where do we go from here?

- Further define, develop, and grow our Heart Failure Clinic
- Grow and strengthen our Care Transition Coordinator Team
- Innovative care and treatment including:
  - device placement
  - Telemonitoring
- Continued Best Practice for all of our Heart Failure patients
Laura Kingsbury, BSN, RN, CEN, TNS, SANE-A  
Heart Failure Program Coordinator  
Chest Pain Program Coordinator  
lkingsbury@mhsjvl.org

Questions…?
Thank you for Attending!

accreditation@heart.org