Improving Hospitalization and Outcomes of Care in Heart Failure Patients

Sue Blockberger-Miller RN, MSN
Strategic Advisor
National Research Corporation
July 24, 2013

“This is a remarkable time for those of us intent on improving health care.”

- Institute for Healthcare Improvement

www.nationalresearch.com
Objectives

- Describe the impact heart failure patients have on outcomes of care
- Understand how to maximize the use of your data to determine priorities for improvement
- Identify your agency next steps in improving outcomes for heart failure patients

Healthcare Improvement

IHI Triple Aim - the driver behind healthcare evolution (not just reform)

- Improve Patient Experience
- Improve Healthcare
- Lower Cost of Care
Heart Failure Stats

• Heart Failure as a Primary Diagnosis
  – Hospitalization Rate: 41%

• Heart Failure as a Secondary Diagnosis
  – 39%

• Heart Failure (Traditional Medicare)
  – 30-DAY Readmission rate
    26.6%

Source: National Research Corporation

Hospitalization

Home Health Compare July 2013
Hospitalization

Home Health Compare July 2013

30-Day Readmit Rates
(by payor)
30-Day Readmits
(by diagnosis)

30-Day Readmission Rates, Traditional Medicare Patients

Patient Outcomes

Source: National Research Corporation Q3 2012- Q2 2013
Heart Failure Costs

Source: National Research Corporation Q3 2012- Q2 2013

Figure 5. Distribution of aggregate hospital costs by diagnostic category,* 2010

* Based on principal discharge diagnosis by Major Diagnostic Category (MDC)

Source: AHFRC, Center for Delphi, Organization, and Markets, Healthcare Cost and Utilization Project, Nationwide Inpatient Sample, 2010
What Matters Most to Mr. Brown?

Patients are *More* Satisfied with Home Health Agencies Than Hospitals

Overall satisfaction of 9 or 10  
Would "definitely" recommend

Data Source – Hospital Compare and Home Health Compare, October 2012
Patient Communication is Key to Outcomes...

And Home Health Agencies Outshine Hospitals in Communication Measures

<table>
<thead>
<tr>
<th></th>
<th>Nurses “always” communicated well</th>
<th>Doctors “always” communicated well</th>
<th>Staff “always” explained meds</th>
<th>Home health team communicated with patients</th>
<th>Discussed medicine, pain, and home safety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>77%</td>
<td>81%</td>
<td>62%</td>
<td>85%</td>
<td>83%</td>
</tr>
</tbody>
</table>

Data Source — Hospital Compare and Home Health Compare, October 2012

What current practices do you have to keep your patients at home?
### Example: Current HF Practices

**Patient Level**
- Front loading
- Phone calls to patients
- Improved internal communication
- HF Programs
- Education on heart failure

**Agency Level**
- Telehealth
- Cross Continuum Practices
- Nothing??

### Considerations.....
Heart Failure Patients & the *TripleAim*

- **Improved Health/Outcomes**
- **Patient Satisfaction**
- **Cost**

**The one BEST solution?**

- A wealth of resources, ideas, and best practices
- No single answer that will work for everyone
- Depends on your patients, your staff, your strengths, your priorities, your community

IHI.org | A resource from the Institute for Healthcare Improvement

www.nationalresearch.com
Person Centered Care

National organizations increasingly recognize person centered care as a standard for care and service.

– Comprehensive
– On-going process
– Nurturing and empowering practices
– Promotion of purpose and meaning to life
Improving the Patient Experience

SHIFT

Patient Involvement
Patient Engagement
Improved Self-Care

Understanding key to patient engagement

- **Key words:** Patient feels *informed* about their health and *confident* about their role in care decisions=predicts engagement

- **Much more so than:** education, income, gender, race/ethnicity; primary language, where they are receiving care
HHCAHPS: Top Five Drivers of Willingness to Recommend

1. Care providers listened carefully to you
2. Care providers seemed informed and up-to-date
3. Explained things in a way easy to understand
4. Care providers treated you with courtesy and respect
5. Informed you about when care providers would arrive

National Research Corporation 2013 HHCAHPS

Health Literacy

The Ability To:
“Obtain, Process and Understand Basic Health Information & Services Needed to Make Appropriate Health Decisions & Follow Instructions for Treatment.”

(Institute of Medicine 2004)

Health Literacy includes:
Listening, analytical and decision-making skills, prose literacy (reading text), document literacy (navigating an appointment slip), and quantitative literacy (figuring calories in multiple servings)
Impact of Health Illiteracy

90 Million Americans Lack Health Literacy to Effectively Execute Care

- Economic Cost Estimates: $50-73 Billion
- Medication Errors
- Increased Hospitalizations
- Increased Emergency Department Visits
- Increased Severity of Illness


Understanding impacts outcomes

- Those with low health literacy are more likely to:
  - Skip necessary medical tests
  - Use ER more
  - Have difficulty managing chronic diseases
Schillinger (2003)

Patient Centric Care: How Well Are We Doing?

MD Assessed Comprehension
Yes
No
0
10
20
30
40
50
60
70
80
90
100
Pt Responded Correctly

Wolf et al., Center for Healthcare Strategies (2006)

Patient Centric Care: How Well Are We Doing?

Understand "Take Medication on Empty Stomach"
Yes
No
0
10
20
30
40
50
60
70
80
90

Misinterpret Rx Label Warning
Yes
No
0
10
20
30
40
50
60
Patients with Low Literacy Nearly Twice As Likely To Be Hospitalized

Baker et al. (1999)

Patient Centered Care: Can They Understand Prescription Labels?
Patients with Literacy Level Less than 6th Grade are **three times (3x)** more likely to misinterpret warning labels

Davis et al. (2006)

Correct Understanding vs. Instruction Demonstration
“Take Two Tablets by Mouth Twice Daily”

Heart Failure & Health Literacy Studies

- Relationship between literacy, knowledge, self-care behaviors

- Patients with inadequate health literacy are at increased risk for poor self-care and negative outcomes ie; hospital readmission

Medications & Patient Experience

<table>
<thead>
<tr>
<th>Improvement in Management of Oral Meds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gave care in a prof. way</td>
</tr>
<tr>
<td>-------------------------</td>
</tr>
<tr>
<td>1st Quartile</td>
</tr>
<tr>
<td>2nd Quartile</td>
</tr>
<tr>
<td>3rd Quartile</td>
</tr>
<tr>
<td>4th Quartile</td>
</tr>
</tbody>
</table>

Average Measure Rates
Health Literacy Interventions

Assessing Patient Skills: Behavioral Indicators of Low Health Literacy

- Identify red flags from the patient
  - I’d like to discuss this with my family
  - I can’t discuss this, I lost my glasses
- Medication review
- Looking at the medications (pills) and not the prescription label
  - Not able to name the medication
  - Unaware of why they are taking medication
  - Does not know when to take medication

Health Literacy & Communication

- Adult learning principles
- How we communicate is essential to success of patient understanding

*Visual materials + oral interaction = most effective results*
Communication Strategies With Patients
Active Listening & Teachback

Changing the Heart Failure Trend.....
Telehealth Studies

- Telehealth studies resulted in significant improvement of HF **self-care** behaviors.
  - daily weighing
  - medication management
  - exercise adherence
  - fluid and alcohol restriction
  - salt restriction
  - stress reduction
- **Consistency** of monitoring is key

Heart Failure Study

- Form partnerships with community doctors to address readmission issues.
- Collaborating with other hospitals to develop consistent strategies for reducing readmission.
- Having nurses supervise the coordination of medication plans.
- Scheduling follow-up appointments before patients leave the hospital.
- Developing systems to forward discharge information to the patient’s primary care doctor.
- Contacting patients on all test results received after they are discharged.
Health Literacy

Are you a health literate organization?
• Leadership promotes
• Easy to use patient materials
• Communicates effectively
• Ensures easy patient access
• Targets high risk patients

Own Your Data!

• Drill down and understand your patient population
  – What are their characteristics?
  – age, gender, ethnicity
  – Risk factors?
  – Length of stay?
  – Patient volume by diagnosis
• Know where you stand compared to others
• Make appropriate decisions for clinical research and intervention
Make an appointment with your data!

<table>
<thead>
<tr>
<th>Report</th>
<th>Who</th>
<th>When</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospitalization, 30-Day Readmit</td>
<td>DON, Branch Mgr.</td>
<td>Monthly-Quarterly</td>
</tr>
<tr>
<td>Pot. Avoidable Events, Outcomes, Process Measures</td>
<td>Performance Improvement</td>
<td>Weekly-Quarterly</td>
</tr>
<tr>
<td>Admissions, Discharge, Patient/Clinician Level Reports</td>
<td>RN Supervisor</td>
<td>Daily-weekly</td>
</tr>
</tbody>
</table>

Data Roadmap

Pathways to Monitor ACH

- Home Health Compare → -What data points are available when? -What time frames? -Risk Adjusted?
- CMS Casper Reports →
- HHQI → -Monthly Tracking and Trending
- Data Source Partner → -Proprietary Benchmarks and Insights
- Internal Reporting → -Custom Analysis
In general, human beings do not do "big" things. We do little things.
We get up, we go to work. We hug our loved ones and make phone calls. We check email, exercise and fix dinner. We do little things!

Highly successful people simply do the right little things, at the right time, in the right way, and they do lots of them.

If you would achieve great things, do little things and pile them one on top of another, until you reach the stars.

Philip E. Humbert, www.philiphumbert.com
HHQI: Home Health Quality Initiative

- [http://www.homehealthquality.org/](http://www.homehealthquality.org/)

- **Dedicated to improving the quality of care provided to America’s home health patients.**

- **Fundamentals of Reducing Acute Care Hospitalizations BPIP.**
  - [http://www.homehealthquality.org/Education/BPIPS.aspx](http://www.homehealthquality.org/Education/BPIPS.aspx)

---

**Resources**


- J Cardiovasc Nurs. Adequate health literacy is associated with higher heart failure..2012 Jan-Feb; 27(1):33-43. 10.1097/JCN.0b013e318216a6e9

Faculty Contact Info

Sue Blockberger-Miller, RN, MSN
Strategic Advisor
sueb@ocsys.com

National Research Corporation
402.475.2525
www.ocshomecare.com
www.nationalresearch.com