Managing Congestive Heart Failure Through Standardized Symptom Assessment

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Managing Congestive Heart Failure Through Standardized Symptom Assessment

Shanda Joy

University of San Francisco - School of Nursing and Health Professions

Nursing 660: Quality Improvement and Outcomes Management

Dr. Cathy Coleman, DNP, RN, MSN, CNL, CPHQ

July 26, 2022
Abstract

**Problem:** Transitional care programs have increased in popularity to focus on optimizing transitions of care from acute hospitalization to home based settings to reduce hospital readmissions. The transitional care model utilized at this urban, integrated health facility is mostly 100% telephonic, short term (30 days) case management. Approximately 30% of the patients referred to the program have a diagnosis of congestive heart failure.

**Context:** Hospital reimbursement has decreased due to high readmissions rates, especially among congestive heart failure (CHF) patients. This process improvement project was aimed at decreasing CHF related readmissions through educating patient/families on CHF watch symptoms and increasing their confidence in managing their chronic conditions.

**Intervention:** The intervention utilized was a smart phrase addition that standardized case management assessment of heart failure and assigned a patient activation score regarding self-management of the chronic condition. Creation of and utilization of a smart phrase addition to the regional assessment dot phrase that standardizes management of heart failure highlighted evidence-based areas that could lead to readmission.

**Measures:** Primary measure was the reduction of the all-cause CHF readmission rate.

Process measures: I. Increase average patient readiness score by 3 points and II. 85% utilization of smart phrase by RN case manager for appropriate CHF patients.

**Results:** Primary measures cannot be analyzed as no readmission data is currently unavailable at time of submission. Regardless, the low number of patients who received the disease specific assessment is too low to correlate with any changes in readmission rate.

Process measures: I. Patient activation score increased by average of 1.88 points which is below goal of 3.0 points. II. Smart phrase utilization was 70.83% of qualified referrals (N=24).
Conclusions: The data obtained, and feedback received showed disease specific assessments can be beneficial in case management especially when coupled with motivational interviewing. The addition of standardized scripts and smart phrases to HER documentation is encouraged.

Keywords: transitional care, post discharge follow up, motivational interviewing
Managing Congestive Heart Failure Through Standardized Symptom Assessment

The phase of discharge from hospital to home is a critical time for all parties involved. Treating physicians are using a variety of clinical indicators to determine if the patient is stable for discharge, the nursing staff is readying the patient with an array of information including warning signs to watch for and medication management, and the patient is often not 100% well and overloaded with information. The uncertainty of this scenario makes post discharge follow-up even more important. It is imperative for the patient to have the information needed to best care for themselves and their chronic conditions and thus post discharge programs fill this care gap. Post discharge programs vary greatly in how they outreach, enroll, and provide services to discharged adult patients which poses a problem when evaluating effectiveness and determining if the program’s efficacy outweighs the associated operational costs.

Problem Description

The past decade has brought renewed focus on reducing hospital readmissions. In 2012, The Centers for Medicare & Medicaid Services (CMS) announced a reduced reimbursement structure correlated to disease processes with high readmission rates (Hospital Readmissions Reduction Program, 2020). As part of this framework, CMS emphasized the importance of increased care coordination throughout the continuum of care. This resulted in the creation of many, mostly telephonic, transitional care programs with the goal of health stabilization and reduction of 30-day readmissions. The transitional care program being evaluated during this quality improvement (QI) project is located at a large, urban Northern California integrated care hospital system. When compared to the national average, this facility has a readmission rate greater than the national average and according to the CMS public website is consistently penalized for congestive heart failure (CHF) readmissions. The excessive number of CHF
readmissions contributes significantly to the all-cause readmission rates. The transitional care program at this facility is tasked with reducing readmission through short-term, often 30-day, case management focused on eliminating barriers to care, medication and treatment adherence, and symptom recognition. As part of this, an initial assessment is conducted with the goal of identifying barriers to condition stabilization including discharge instructions, warning signs and durable medical equipment follow-up. However, the initial assessment lacks any disease specific questions to guide home management. Thus, the process improvement project will focus on this quality gap by adding and testing a smart phrase with disease specific and motivational interviewing questions within the initial assessment to guide management for congestive heart failure, the facility’s highest readmission category (Appendix A).

**Available Knowledge**

**PICOT Question**

When initiating quality improvement projects, it is imperative to formulate a question to ensure the clinical problem being addressed has clear parameters to create change. In many academic settings, the use of a PICOT question, P(Population) I(Intervention) C(Comparison) O(Outcome) T(Timeframe), is used to further define the problem, review literature, and identify best practices. Thus, the PICOT question developed to address the concerns wherein this project is as follows: Can adding congestive heart failure specific questions in the initial assessment (I) for adult patients (P) decrease all cause congestive heart failure readmission rates (O) compared to current practice (C) by June 30th, 2022 (T)?

**Search Strategy**

A literature search was conducted on the CINAHL, Cochrane Library, Johanna Briggs and PubMed databases limiting the timeframe from 2014-2022. A variety of keywords and
phrases were used including heart failure (HF), readmission, disease management, post discharge, telehealth, telephonic case management, aftercare, and transitional care. The searches returned over 300 articles, and this number was reduced by combining search terms to narrow the specificity. Articles were eliminated that included discharges from specialty groups such as maternity, pediatrics, and mental health. To be included in this review, articles had to address telephonic follow up within 5 days of discharge and its related effectiveness and/or congestive heart failure management. This narrowed down the literature search to less than 15 studies in which 7 were chosen due to information regarding chronic disease management and/or telephonic case management (Appendix B).

**Synthesis of Evidence**

Arcilla et al., (2019) discussed the importance of motivational interviewing when managing chronic conditions. Motivational Interviewing (MI) assesses patients’ readiness to better self-manage and understand a medical condition. MI utilizes the nurse or other facilitator to ask questions in an open-ended manner to solicit specific feedback and information from the patient and/or patient family regarding priorities for change behavior.

Although Goldgrab et al (2018), largely discusses the medications needed to manage CHF they acknowledge that medication alone cannot prevent readmission. Many patients cannot tolerate the medications and discontinue use without informing the care team which leads to readmission. Whether the medication adherence is due to intolerance or other factors, it is a hugely important component of stabilization and interventions that focus on adherence tend to have more success (Goldgrab et al., 2018).

Transitional care programs multiplied greatly around 2010 when CMS began decreased reimbursements for chronic conditions. Hines et al. (2010) discusses the importance of
transitional care models to focus on teaching and reinforcing self-management by educating on medications, helping set up primary care appointments and adverse symptom awareness.

In 2019, Poudel et al., conducted a systematic review that found motivational interviewing was successful in decreasing readmissions and improving overall quality of life, which suffers greatly for patients diagnosed with CHF. Due to the person-centered and open-ended language used in motivational interviewing, the use of these techniques could be beneficial in making long last change with CHF patients.

Hospital discharge is an area in which quality gaps readily occur and could result in huge safety failures. Radhakrishnan et al., (2018) discussed the necessity to bridge communication from acute care to outpatient settings to make sure patients are well cared for and understand discharge instruction and monitor for any complications.

Both Takeda et al, (2019) and Taklalsingh et al, (2020) found care transitions program to be beneficial for both patients and hospital readmissions especially when medication adherence and adverse symptom monitoring are components.

Rationale

CHF is continually the highest readmission category which points to the need for further patient education and focus on identifying symptoms when they are still subacute and can be managed by primary care in the outpatient setting. Recurrent use of disease specific questions help patient to focus on which symptoms are most likely to lead to decompensated symptoms and reinforce accessing care through primary care. Including the patient activation rating allows patients and case managers to analyze the effectiveness of the education. Additionally, having case managers use standardized assessment tools ensures a certain level of quality all patients receive. A Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis was conducted
to determine if this process improvement project was worth implementing (Appendix C). After which, it was determined the strengths outweighed the threats and this project could produce many benefits to the patients, department, and facility. Standardization allows for more quality improvement initiatives to occur and is always focused on evidence-based interventions.

Conceptual Framework

Lewin’s Theory of Change and The Institute for Healthcare Improvement (IHI) Model for Improvement (MFI) will be used simultaneously to implement changes. Lewin’s theory includes three phrases: unfreezing, moving, and refreezing (King et al., 2019). During phase one of unfreezing, internal readmission number were reviewed and showed CHF readmissions were the highest readmission category for many years. Additionally, analysis of the current case management process for patients with congestive heart failure was conducted. The variance in questions and symptoms discussed by case managers clarified the need for standardized assessments.

The transitional care program team members are familiar with the three fundamental questions posed by the IHI: 1. What are we trying to accomplish? 2. How will we know that a change is an improvement? 3. What change can we make that will result in improvement? (Langley et al., 2009) (Appendix D). In this improvement project, the answers to the above questions were 1. We are trying to help patients better manage their CHF diagnosis and symptoms. 2. If patients and clinicians’ partner to better manage CHF symptoms, it will lead to reduced hospital stays and readmissions. 3. To do this, a disease specific tool to reinforce education around treatment and medication adherence and symptoms recognition while coupled with tracking of patient readiness. Most team members are master’s degree prepared and familiar with process improvement and they are motivated to help (see microsystem assessment
Appendix B). There is good feedback and active team engagement that fosters a culture of continuous quality improvement.

**Project Aim**

**Specific Aim**

By June 30, 2022, the all-cause congestive heart failure readmission rate for adult patients treated at this integrated medical center will be reduced by 2% from baseline readmission data by utilizing a CHF disease specific smart phrase added into the regional approved initial assessment documentation beginning April 1, 2022.

**Global Aim**

Global aim for the use of the smart phrase would be a tiered process if found to empower patients to manage disease and reduce readmission. First, in 6-12 months regional approval and validation of the CHF smart phrase will occur so it can be rolled out and utilized by other service areas. Second, over 12-36 months, creation of smart phrases to address quality and care gaps in the next two highest disease categories sepsis and chronic obstructive pulmonary disease will occur and become regional best practice. Moreover, this process improvement project would lead to continuous training in motivational interviewing and utilization of techniques to better connect to patients and families.

**Context**

The Transitional Care Program is a regional program of this integrated healthcare system. The microsystem for this assessment is a small outpatient case management department which provides services for two local facilities. This program is by referral only. Referrals occur through two processes, (1) automatic referrals based on escalated low, medium, and high-risk scores for patients being discharged home and (2) referrals entered into the system by transitions
employees, the majority of these are for CHF patients (see Appendix E). The purpose of this program is to reduce 30-day all cause readmissions by enrolling members into an optional 30-day case management program focused on care transitions between acute inpatient and skilled nursing facility discharges to home with or without home health services. To achieve the program aims a project charter was put together to focus the team and highlight the outcome measures (Appendix F). The transitions clinicians focus on disease management education, warning signs and symptoms of a worsening condition, care coordination, addressing social factors and involving the family/caregivers in management.

**Patients**

The average daily case load of the Transitions team is 200 members split among the team. Members are contacted by phone 2-3 times during the first week post discharge, 2 times the second week and 1 time during weeks 3 and 4. Members with unstable health issues receive additional calls based on nurse assessment. Patients are limited to adults (aged 18+) who are discharged to home, board & care, and assisted living facilities. Most patients, around 70%, are aged 46-79. The top 3 disease categories are heart failure, chronic obstructive pulmonary disease, and sepsis. We work with patients and their families/caregivers to ensure patients receive continuity of care and any issues are addressed in a timely manner. Although no official survey has been conducted, many patients and their families send notes of thanks and appreciation to the department supervisor.

**Professionals**

The East Bay Transitions team consists of 1 advanced practice registered nurse (RN) supervisor, 7 RNs, 1 licensed clinical social worker (LCSW), and 1 senior operations specialist. Of the 7 RNs, 5 have master’s in nursing degrees, 1 has a bachelor’s in nursing degree and
currently enrolled in a master’s program, and 1 has an associate in nursing degree and is currently enrolled in a master’s program. The LCSW typically works in tandem with the RN, however, does manage some psychosocial cases individually. For the purposes of this improvement process, the LCSW will be excluded. The senior operations specialist assists with data collection and daily team operations. The East Bay Transitions department is open 6 days a week (Monday-Saturday) from 8am-5pm. Saturdays are not fully staffed with only 2 RNs working. The department staff verbalizes their contentment with their job.

**Intervention**

The intervention for this process improvement project centers around the use of a smart phrase that can be added into the generic initial assessment used by transitional care case managers. The smart phrase was created in HealthConnect and access without the ability to edit was given to all RNs on the team. The information contained in the smart phrase uses the symptoms most likely to lead to CHF related readmission according to Takeda et al. and heart failure chronic condition case managers. These symptoms to watch for include weight gain of 2lbs or greater in one day and/or 5 lbs. in 5 days, adherence to sodium and fluid restrictions, edema, activity intolerance, shortness of breath, development of cough, and chest pain. This information was combined in a series of question with the ability to select what the patient confirms and denies (Appendix B). In the generic initial assessment, there is a question to specify if a patient has CHF; if the answer is yes, this smart phrase is added under the question. According to Poudel et al. (2019), a large component of successful case management is patient’s readiness and ability to make and engage in change. The final question of the smart phrase utilizes motivational interviewing to assess for patient readiness by documenting a score between 1-10 that indicates their level of confidence in making meaningful change.
**The Team**

The RN case managers on the transitional care program team will be using the invention tool and they are a core part of the team. Other team members include an employee from the HealthConnect educational training team who helped with the technical creation of the smart phrase and the transitions program senior operations specialist, who provided data specific to CHF numbers for the service areas and adherence to regional guidelines. Additionally, the operations specialist will be helping to present the data findings in graphs (see Appendix G).

**Study of the Intervention**

The intervention tool was used for a total of 30 days. There are no other interventions related to CHF at the facility at this time. The operations specialist helped with determining how many patients were admitted to the facilities during the intervention timeframe to ensure the number of patients admitted with CHF was around the average of 35 per week. A chart review was conducted on all referrals to the transitions program during the 30-day intervention to determine the % of time the smart phrase was used versus missed for patients referred with CHF. During the intervention, a massive change to the transitional care program occurred under regional guidance. This program was advised to no longer enter any additional referrals into the system as region was looking to valid the proprietary software used for the risk score. Although the number of CHF patients admitted to the included facilities still averaged around 35 patients per week, there was only an average of 5 referrals received by the Transitions program. Due to this drastic change, limited data was attained and no conclusion regarding effect on readmission rate could be determined. Focus turned to analyzing the process and balancing measures as described below.
Measures

The primary outcome for this process improvement intervention was a 2% reduction in CHF readmission from the previous year’s baseline. Due to CMS reductions in repayments due to high CHF readmissions, a reduction in all cause CHF readmission will save the hospital significant revenue. Additionally, helping patients to better manage their CHF diagnosis and facilitating access at the right time and in the right place (outpatient) is a major part of this integrated delivery systems mission to improve the health of communities. Process measures that will be analyzed include % of time smart phrase was used on patients with CHF diagnoses and increases in patient readiness activation score. Balancing measures include are staff satisfaction and relative ease of use related to the smart phrase integration. Open feedback was provided to this researcher after invention to determine staff satisfaction.

Ethical Considerations

This process improvement project is not considered research per University of San Francisco and hospital organizational guidelines and has not undergone evaluation by the Institutional Review Board at either institution (see Appendix H). No services, support or information has been withheld from any member since the goal of intervention is to improve standard of care those living with CHF. There is no potential harm to any patients. Furthermore, the intervention upholds autonomy, specifically the right to receive all medical information and education to be able to make informed decisions regarding care and beneficence, acting in the goodness and compassion for others, as stated in the American Nurses Association code of ethics (Gaines, 2021).
Outcome Measures Results

Primary Outcome

The goal of this project was to decrease the all-cause readmission rate by decreasing the CHF readmission rate. CHF is the largest category that affect readmissions at this urban facility. The percentage of referrals this department receives for patient with CHF is typically around 30%. However, due to a change in the regional programming, CHF referrals dropped drastically and only a total of 17 patients had completed the program as intended. As of July 2022, the all-cause readmission and CHF readmission data is unavailable. Nevertheless, even if the data was available and showed a decrease in readmissions, it could not be attributed to the process improvement project as the number of patients enrolled was not substantial enough to affect the outcome measure.

Process Measures

During this project, there were two process measures to analyze. The first, was patient activation, or readiness and the second, utilization of a smart phrase for appropriate patients. While conducting the literature search, it became clear using motivational interviewing to increase patient activation or readiness was a major component of successful case management programs. As part of the smart phrase, patients were asked to rate their confidence in following the disease specific guidelines on a scale of 1-10 with 1 not being ready and 10 being extremely ready. The goal was to see a 3-point increase in patient activation. Of the 17 patients whose case manager utilized the smart phrase, there was an average increase in activation score of 1.88 with only one patient reporting the same score at the beginning and end of the 4-week cycle (Appendix G). During chart audits, 9 of 17 patients were known to case managers as frequently
admitted for CHF related illnesses. The frequent interaction between the case manager and patient could possibly affect the readiness score as the patient is familiar with management recommendations and personalization suggestions.

The case managers utilized the smart phrase 17 out of 24 opportunities with patients who meet CHF related criteria. This resulted in a 70.83% utilization rate whereas 85% was the goal. There are multiple factors that could have possibly affected this number. Primarily, the person conducting this process improvement project was not readily available during implementation to coach, remind, and champion the use of the smart phrase. Additionally, a regional operational change caused focus to shift as case managers were learning and engaging in a new process.

Balancing Measures

An open request was sent to the case managers involved in implementation to discuss their satisfaction with the process improvement project and relative ease of using the smart phrase. Three of six case managers who participated in the implementation provided feedback. In summary, there were three main takeaways:

1. The smart phrase was not difficult to use but it was different than their normal process, so they did not always remember to use it.
2. The standardized symptom assessment was a helpful reminder to address all the components as sometimes one category could be missed when relying on memory.
3. Motivational interviewing can be uncomfortable, and more training is needed.

Summary

Although none of the outcome measures were achieved during the implementation of the process improvement project, there were many insights gained. Case management is a niche where foundational training is necessary and can be applied to all areas of nursing practice. For
example, motivational interviewing (MI) techniques and practices help case managers better connect to and engage with the patients. The use of motivational interviewing can greatly increase patient activation and readiness to manage self-care, which is the goal for all programs.

Additionally, MI builds trust and allows the patients and their families to gain confidence with managing chronic conditions. In this author’s opinion, motivational interviewing should be a requirement in case management jobs and yearly training a condition of employment. Additionally, consistent coaching of staff when beginning a new process is extremely important to increase adherence. Although this case manager’s absence during implementation could not be avoided, it appears to have negatively impacted utilization of the smart phrase.

**Conclusions**

The creation of standardized symptom assessments can be beneficial for every disease managed through chronic conditions and population health departments. It is important to validate the information all patients are receiving to ensure the highest quality of evidence-based care and understanding. In combination with motivational interviewing techniques, case management of chronic conditions is highly encouraged to maximize self-care and improve outcomes for patients, families, and health care systems.
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Appendix A

Disease Specific Smart Phrase

This Transitional Care Case Manager discussed the following with (member options: 322705):

Current weight *** lbs - taken upon waking, after voiding and before eating. Patient is aware any weight gain of 2lb/1 day or 5 lbs /5 days warrants a call to the PCP and/or nurse advice line for possible medication adjustment.

Signs/symptoms - Patient reports (SMJHFSYMPTOMS:321627 Patient denies (SMJHFSYMPTOMS: 321627)

Nutrition - Patient reports {SMJHFNUTRITION:321628} sodium restriction. We discussed staying away from already prepared foods, including canned soups and frozen entrees, especially those that have a sauce packet included.

Fluid restriction - Patient reports {SMJHFFLUIDRESTRICTION:321629} mL fluid restriction. Patient is {SMJHFNUTRITION:321628} to fluid restriction.

Physical exercise - Patient reports ***

Patient encouraged to be active daily and to balance activity with rest.

Medication adherence - Patient reports taking medications [SMJHFMEDS:321630].

Patient readiness - On a scale of 1-10 with 1 not being ready and 10 being extremely ready, how would you rate your confidence in following these guidelines {SMJHFHlist:321631}?
# Appendix B

## Evidence Evaluation Table

<table>
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<th>Design</th>
<th>Sample</th>
<th>Outcome/Feasibility</th>
<th>Evidence Rating</th>
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Appendix C

SWOT Analysis

**Strengths**
- Increase quality of case management
- Standardization of practice
- Increase patient ability to self-manage care
- Research based symptom assessment

**Weaknesses**
- Short term project
- Increased workload
- Lack of staff comfort with MI
- Limited to patients with CHF

**Threats**
- Regional program changes
- Possible duplication with CHF RN CM
- Lack of Patient/family engagement

**Opportunities**
- Financial incentives related to decreased readmissions
- Increased patient/family understanding and engagement
- MI practices can be transferred to all areas
Appendix D

Institute for Healthcare Improvement Model for Improvement

Langley et al., 2009
Appendix E

Driver Diagram

Transitional Care Program Referrals

- Escalated low, medium, and high-risk automatic referrals
- CHF referrals manually entered by team
- New referrals dispersed between RN case managers

- Patient agrees to enrollment
  - Initial assessment and biweekly/weekly calls for ~30 days
  - Patient not readmitted within 30 days; referral successfully closed

- Patient declines enrollment
  - Patient readmitted
  - Referral closed
Appendix F

Project Charter

Reducing Congestive Heart Failure Readmissions Through Disease-Specific Assessment

**Project Charter**: Reducing Congestive Heart Failure Readmissions Through Disease-Specific Assessment.

**Global Aim**: Global aim for the use of the smart phrase would be a tiered process if found to empower patients to manage disease and reduce readmission. First, in 6-12 months regional approval and validation of the CHF smart phrase will occur so it can be rolled out and utilized by other service areas. Second, over 12-36 months, creation of smart phrases to address quality and care gaps in the next two highest disease categories sepsis and chronic obstructive pulmonary disease will occur and become regional best practice.

**Specific Aim**: By June 30, 2022, the all-cause congestive heart failure readmission rate for adult patients treated at Oakland and Richmond Medical Centers will be reduced by 2% from baseline readmission data by utilizing a CHF disease specific smart phrase added into the regional approved initial assessment documentation beginning April 1, 2022.

**Background**: The transitional care program at this facility is tasked with reducing readmission through short-term, often 30-day, case management focused on eliminating barriers to care, medication and treatment adherence, and symptom recognition. As part of this, an initial assessment is conducted with the goal of identifying barriers to condition stabilization including discharge instructions, warning signs and durable medical equipment follow-up. However, the initial assessment lacks any disease specific questions to guide home management. Thus, the process improvement project will focus on this quality gap by adding and testing a smart phrase with disease specific and motivational interviewing questions within the initial assessment to guide management for congestive heart failure, the facilities highest readmission category in order to reduce Medicare penalties (U.S. Centers for Medicare & Medicaid Services, 2020).

**Sponsors**

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<tr>
<td>Continuum Service Director</td>
<td>Roland Gigon</td>
</tr>
<tr>
<td>Transitional Care Program Manager</td>
<td>Maria-Lani Malicdem</td>
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</table>

**Goals**

To develop a standardized assessment tool that focuses on congestive heart failure management and symptom recognition that includes an element of motivational interviewing:

1. Decrease in all cause hospital readmission rate
2. Increase in patient activation score in managing chronic condition
3. Standardize CHF management and documentation

**Measures**

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<td>Outcome</td>
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<td>2% all cause CHF readmission reduction</td>
<td>Clarity reports, KP tableaus</td>
<td>90%</td>
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<tr>
<td>Process</td>
<td></td>
<td></td>
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<tr>
<td>% Case managers using smart phrase for appropriate patients</td>
<td>Chart review-Health connect</td>
<td>85%</td>
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<tr>
<td>Increase patient activation score</td>
<td>Chart Review-Health connect</td>
<td>Increase of 3 points on 10-point scale</td>
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<td>Balancing</td>
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<tr>
<td>No increase in readmission rate for other disease categories</td>
<td>KP tableaus</td>
<td>No increase in base readmission rate of 14%</td>
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**Team**

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<td>Maria-Lani Malicdem, RN</td>
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<td>Data Specialist</td>
<td>Wade Hess</td>
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<td>HealthConnect Educator</td>
<td>Joshua Campbell</td>
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<td>Case Management nurse champions</td>
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<td>Jennifer Manio</td>
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<td>William (Bill) Mertz</td>
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<td>Linh Chau</td>
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**References**


**Measurement Strategy**

**Background (Global Aim):** To standardize implementation of disease specific smart phrases when conducting initial assessments for chronic conditions.

**Population Criteria:** Adult patients diagnosed with congestive heart failure.

**Data Collection Method:** Data will be obtained from institution tableaus for data review and chart review of all patients referred to transitional care program.

**Data Definitions**

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<th>Data Element</th>
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<tr>
<td>Smart Phrase</td>
<td>A dot phrase add on to generic initial assessment containing disease specific information.</td>
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<td>Patient activation score</td>
<td>1-10 scale of how ready patient feels in addressing care needs.</td>
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<td>Chart Review</td>
<td>Manual review of cases referred to Transitions program to determine if smart phrase was used.</td>
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**Measure Description**

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<tbody>
<tr>
<td>2% all cause CHF readmission reduction</td>
<td>N=# patients readmitted with heart failure in 30 days D=# patients readmitted in 30 days</td>
<td>Institutional tableau, infview/clarity reports</td>
<td>&lt;14%</td>
</tr>
<tr>
<td>% case managers use smart phrase for CHF patients</td>
<td>N= # of CHF with smart phrase usage D=# of CHF patients</td>
<td>Chart review</td>
<td>&gt;=85%</td>
</tr>
<tr>
<td>Increase patient activation score</td>
<td>N= # patients with &gt;= 3 pts D=# patients where scale used</td>
<td>Chart Review</td>
<td>+3 pts on 1-10 scale</td>
</tr>
</tbody>
</table>
Appendix G

![Patient Activation Score](image)

- **Change in Score**
- **Individual Patient**
- **Patient Activation Score**
- **Average Change in Activation**
- **Target Change**
Appendix H

Statement of Determination

CNL Project: Statement of Non-Research Determination Form

Student Name: Shanda Joy

<table>
<thead>
<tr>
<th>Title of Project:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managing Congestive Heart Failure Through Standardized Symptom Assessment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Brief Description of Project:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Creation of a CHF disease specific smart phrase to pair with nonspecific initial assessment form for transitions program.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>A) Aim Statement:</th>
</tr>
</thead>
<tbody>
<tr>
<td>By June 30, 2022, all cause congestive heart failure readmission rate for adult patients treated at Oakland and Richmond Medical Centers will be reduced by 2% by utilizing a disease specific assessment add-on.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B) Description of Intervention:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intervention is the use of standardized disease specific questions for patients with CHF case managed by the Transitions team.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>C) How will this intervention change practice?</th>
</tr>
</thead>
<tbody>
<tr>
<td>This intervention standardizes the care provided to patients with chronic conditions. Additionally, standardization allows for a minimum standard of care to be given. Also, it reinforces education for patients managing the chronic condition.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>D) Outcome measurements:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduction in all cause CHF readmission rate</td>
</tr>
<tr>
<td>Staff case and satisfaction with smart phrase addition</td>
</tr>
<tr>
<td>Increase in motivational interviewing question related to readiness</td>
</tr>
</tbody>
</table>
To qualify as an Evidence-based Change in Practice Project, rather than a Research Project, the criteria outlined in federal guidelines will be used:
(http://answers.hhs.gov/ohrp/categories/1569)

**X** This project meets the guidelines for an Evidence-based Change in Practice Project as outlined in the Project Checklist (attached). Student may proceed with implementation.

☐ This project involves research with human subjects and must be submitted for IRB approval before project activity can commence.

Comments:

**EVIDENCE-BASED CHANGE OF PRACTICE PROJECT CHECKLIST** *

**Instructions:** Answer YES or NO to each of the following statements:

<table>
<thead>
<tr>
<th>Project Title: Managing Congestive Heart Failure Through Standardized Symptom Assessment</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>The aim of the project is to improve the process or delivery of care with established/accepted standards, or to implement evidence-based change. There is no intention of using the data for research purposes.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The specific aim is to improve performance on a specific service or program and is a part of usual care. ALL participants will receive standard of care.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The project is <strong>NOT</strong> designed to follow a research design, e.g., hypothesis testing or group comparison, randomization, control groups, prospective comparison groups, cross-sectional, case control). The project does <strong>NOT</strong> follow a protocol that overrides clinical decision-making.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The project involves implementation of established and tested quality standards and/or systematic monitoring, assessment or evaluation of the organization to ensure that existing quality standards are being met. The project does <strong>NOT</strong> develop paradigms or untested methods or new untested standards.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The project involves implementation of care practices and interventions that are consensus-based or evidence-based. The project does <strong>NOT</strong> seek to test an intervention that is beyond current science and experience.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The project is conducted by staff where the project will take place and involves staff who are working at an agency that has an agreement with USF SONHP.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The project has <strong>NO</strong> funding from federal agencies or research-focused organizations and is not receiving funding for implementation research.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>The agency or clinical practice unit agrees that this is a project that will be implemented to improve the process or delivery of care, i.e., <strong>not</strong> a personal research project that is dependent upon the voluntary participation of colleagues, students and/or patients.</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>If there is an intent to, or possibility of publishing your work, you and supervising faculty and the agency oversight committee are comfortable with the following statement in your methods section: &quot;This project was undertaken as an Evidence-based change of practice project at Kaiser Oakland hospital or agency and as such was not formally supervised by the Institutional Review Board.&quot;</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
ANSWER KEY: If the answer to ALL of these items is yes, the project can be considered an Evidence-based activity that does NOT meet the definition of research. IRB review is not required. Keep a copy of this checklist in your files. If the answer to ANY of these questions is NO, you must submit for IRB approval.

*Adapted with permission of Elizabeth L. Hohmann, MD, Director and Chair, Partners Human Research Committee, Partners Health System, Boston, MA.

STUDENT NAME (Please print):

Shanda Joy

Signature of Student:

Shanda Joy DATE 4/30/22

SUPERVISING FACULTY MEMBER NAME (Please print):

Signature of Supervising Faculty Member

Catherine Coleman, DNP, MSN, CRNP DATE 5/3/22