



Welcome!

We will get started promptly at 12 noon.



Heart Failure – Patient self-management supports better outcomes

Nickie Piermont, MS, APRN, GCNS-BC

Clinical Nurse Specialist/Health Advocate
Lifespan Healthcare System

Mary Biello, RN

Transition of Care Specialist
Visiting Nurse Home and Hospice

Date: April 21st & April 27th



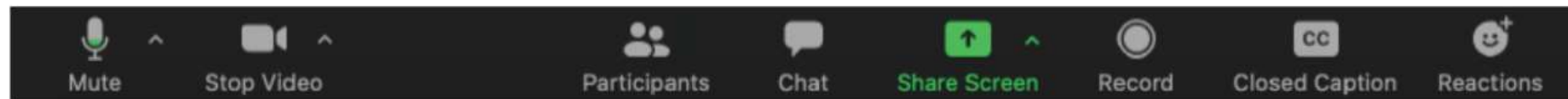
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Use Chat to introduce yourself & ask questions

How to use Zoom

At the bottom of your screen, you will see a black bar with icons:



Chat **Everyone** for general comments or questions

Welcome!

- Today's session is being recorded
- Although we want active participation, we ask that you please keep yourself on 'mute' during the presentation
- Please introduce yourself (name, organization & role, location) using the Chat feature

The IPRO QIN-QIO

The IPRO QIN-QIO

- A federally-funded Medicare Quality Innovation Network – Quality Improvement Organization (QIN-QIO) in contract with the Centers for Medicare & Medicaid Services (CMS)
- 12 regional CMS QIN-QIOs nationally

IPRO:

New York, New Jersey, and Ohio

Healthcentric Advisors:

Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont

Qlarant:

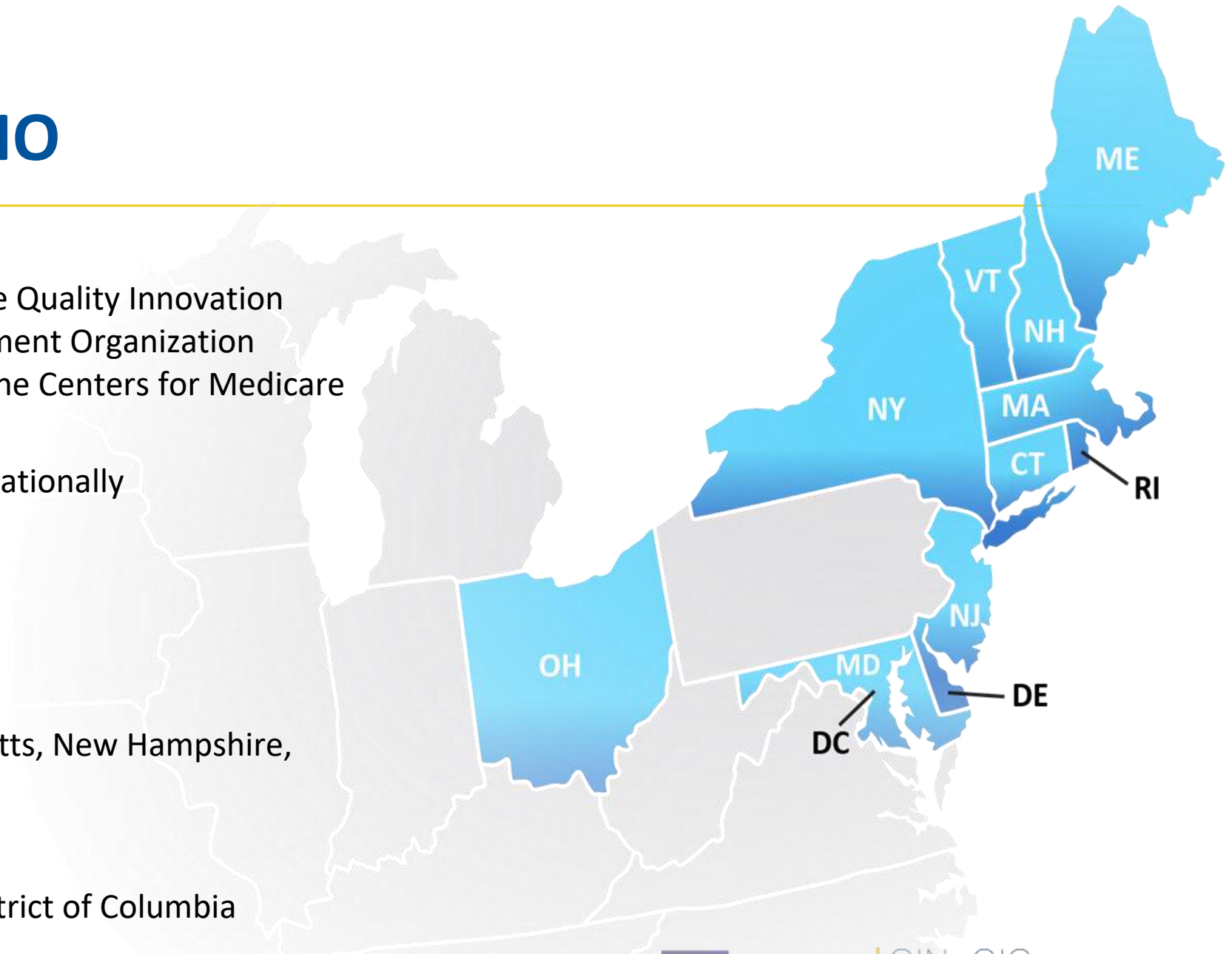
Maryland, Delaware, and the District of Columbia

Working to ensure high-quality, safe healthcare for
20% of the nation's Medicare FFS beneficiaries



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IPRO QIN-QIO *small Talk* series

Our *small Talks* are short, impactful presentations designed to meet your needs during this uniquely challenging time.

Two different topics will be presented on a monthly basis and each *small Talk* will:



Consider a ***challenge***

Identify ***interventions***

Guide you to a specific ***result*** or outcome

Quick Overview



1

Challenge: *Patients with heart failure who are discharged to the community are at high risk for readmission*

2

Intervention: *Providing standardized patient and family education across the continuum reinforces knowledge and can enable self-management*

3

Result: *Engaged patients and families who are managing their conditions and aware of “red flags” are less likely to be readmitted to the hospital*

Challenge

- Rates of re-hospitalization (30 day and 60 day)
 - CMS penalties
 - Patient outcomes
 - Costs of hospitalization
- Multiple chronic conditions and risk factors for re-hospitalization

Challenge – The data agrees

Time Period: Oct-2020 to Sep-2021

Index Admission: Principal Diagnosis Category (Top 10)	Number of Readmissions for Specified Diagnosis	Total Readmissions in State	Percent of Total Readmissions
Heart failure	328	3,950	8.3%
Septicemia	233	3,950	5.9%

Time Period: Oct-2020 to Sep-2021

Readmission: Principal Diagnosis Category (Top 10)	Number of Readmissions for Specified Diagnosis	Total Readmissions in State	Percent of Total Readmissions
Heart failure	339	3,950	8.6%
Septicemia	297	3,950	7.5%



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Intervention – Applying 5 Principles

1. **Learning is enhanced with positive reinforcement**
2. **Learning is enhanced by integration and connection**
3. **Learning must be relevant**
4. **Adults learn best by solving problems**
5. **Learning is enhanced when memory is not overloaded**

Source: Sutter Center for Integrated Care



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**For most patients, system demands exceed their skill level.
Most health materials are written at a level that exceed the reading skill of
the average high school graduate.**



Source: Rudd, R. 2010. "Literacy and Health." Harvard School of Public Health



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Best practice - Improve retention & evaluate learning

- **Teach-Back Method**

- Everyone learns at their own pace
- Cements retention by saying instead of passive learning

- **When to Use Teach-Back**

- When a return demonstration is not possible or appropriate
- Whenever you want to evaluate learning and retention

Integrated Model of Care for Chronic Disease

- **Patient Centered Care**
 - Goal setting
 - Patient Self Management
 - Zone tools
 - Assess health literacy
 - Motivational interviewing
 - Teach Back
 - Scenario based learning

Clear information increases patient engagement and empowerment

Information about one's health leads to greater patient empowerment and engagement; these, in turn, predict a desire for more health-related information.

- Source: Empowerment and engagement among low-income Californians: Enhancing patient-centered care. 2012 Blue Shield of California Foundation Survey. September 2012



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Share....

Please share – Unmute or add a response to Chat.



Are you currently using any patient education tool for heart failure or other chronic disease, that supports self monitoring?

What tool are you using?

Care Transitions Intervention



Key Elements – “The Four Pillars”

Medication Self-Management

- Patient is knowledgeable about medications
- Patient has a medication management system

Dynamic Patient-Centered Record

- Patient understand and utilizes the personal health record (PHR) to facilitation communication and ensure continuity of care plan across providers and settings
- Patient or informal caregiver manages the PHR

Follow-up

- Patient schedules and completes follow-up visit with the PCP or specialist
- Patient is empowered to be an active participant in these interactions

Red Flags


- Patient is knowledgeable about indications that their condition is worsening and how to respond

My Health Plan – Taking Care of My Heart Health


“What is my main problem?”

The diagnosis that brought you to the hospital is called **Heart Failure**.


This means your heart is weaker or stiffer than it should be and has trouble pumping enough blood to all the parts of your body that need it. Heart failure can be managed but it cannot be cured.




Symptoms of Heart Failure




Sudden weight gain




Shortness of breath




Swelling of your feet, ankles, legs, and belly




Having a hard time breathing while lying down




Cough



Fast heart rate




Feeling very tired



Feeling sick to your

My Health Plan Taking Care of Heart Health




My Name: _____

My Doctor: _____

Phone #: (_____) _____

Bring this book with you to your appointments.



**HealthyPeople
2020**

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Quality Improvement Organization

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My weight has not changed.
I need to follow my routine and weigh myself tomorrow morning.



My weight is up three pounds from yesterday or five pounds in the past week.
I need to be extra careful about high-salt foods and what I drink. I need to call my doctor for instructions.



I am struggling to breathe, have chest pain, or feeling uneasy.
I need to call 911.

HEART FAILURE ZONES

EVERY DAY...

- Weigh yourself in the morning before breakfast, write it on your chart and compare to yesterday's weight.
- Take your medicine as prescribed.
- Check for swelling in your feet, ankles, legs and stomach.
- Eat low-salt food.
- Balance activity and rest periods.

Which Heart Failure Zone are you today... GREEN, YELLOW, OR RED?

GREEN ZONE

ALL CLEAR – This zone is your goal

- Your symptoms are under control. Your symptom-free weight is _____ lbs.
- You have no shortness of breath.
- You have not gained more than two pounds. (It may change one or two pounds some days).
- There is no swelling of your feet, ankles, legs or stomach.
- You have no chest pain.

YELLOW ZONE...

CAUTION—This zone is a warning.

Call your doctor's office if you are experiencing any one of these:

- You have a weight gain of three pounds in one day or a weight gain of five pounds or more in one week.
- More shortness of breath.
- More swelling of your feet, ankles, legs or stomach.
- Feeling more tired. No energy.
- Dry, hacky cough.
- Dizziness.
- Feeling uneasy; you know something is not right.
- It is harder for you to breathe when lying down. You can only sleep sitting up in a chair.

RED ZONE!




EMERGENCY. Go to the emergency room or call 911 if you are experiencing any of the following:

- Struggling to breathe. Unrelieved shortness of breath while sitting still.
- Chest pain.
- Confusion or trouble thinking clearly.

Other Elements

- Medication Record
- Diet, foods with salt, reading labels
- Exercise

My Health Plan
Taking Care of Heart Health







My Name: _____

My Doctor: _____

Phone #: (____) _____

Bring this book with you to your appointments.

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Having a Good Tool in One Facility isn't Enough

- Introduce at hospital
continue with post-acute
and then into community
 - Same tool
 - Same approach
 - Same instructions
 - Same language
- Reinforce and support across
the continuum



Cross Continuum Collaboration



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A Success Story



Hospital



Nursing
Home



Home
Health



Physician
Office



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Chat In

Please unmute yourself or use the chat feature to share questions, ideas, success strategies, and/or lessons learned



**Improvement is a Team
Support**



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Share.....

Please share – Unmute or add a response to Chat.



Are you currently sharing any patient education tools that support self monitoring, across settings? Could you?

Leaving in Action

- Now post pandemic, is it time to reconnect with colleagues in nursing homes, home care, practices?
- Evaluate what education may be needed for staff as well in terms of heart failure management, and how to teach patient self management.
- Access the resource, My Health Plan - Taking Care of My Heart Health, in the IPRO Resource Library:

<https://qi-library.ipro.org/2022/03/08/my-health-plan-taking-care-of-heart-health/>

Additional Resources

➤ **Rise Above Heart Failure**

American Heart Association Go-To-Guide, an easy-to-use, interactive tool designed to empower doctors and nurses to engage **heart failure** patients.

<https://www.heart.org/en/health-topics/heart-failure/heart-failure-tools-resources/rise-above-heart-failure-toolkit>

➤ **Guidelines for the Diagnosis and Treatment of Acute and Chronic Heart Failure (HF)**

American College of Cardiology, 2021 European Society of Cardiology (ESC)

<https://www.acc.org/latest-in-cardiology/ten-points-to-remember/2021/08/29/18/05/2021-esc-guidelines-for-hf-esc-2021>

➤ **American Heart Association Support Network**

<https://supportnetwork.heart.org/s/>



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Contact Information

Nickie Piermont, MS, APRN, GCNS-BC
Clinical Nurse Specialist/Health Advocate
Lifespan Healthcare System
npiermont@lifespan.org

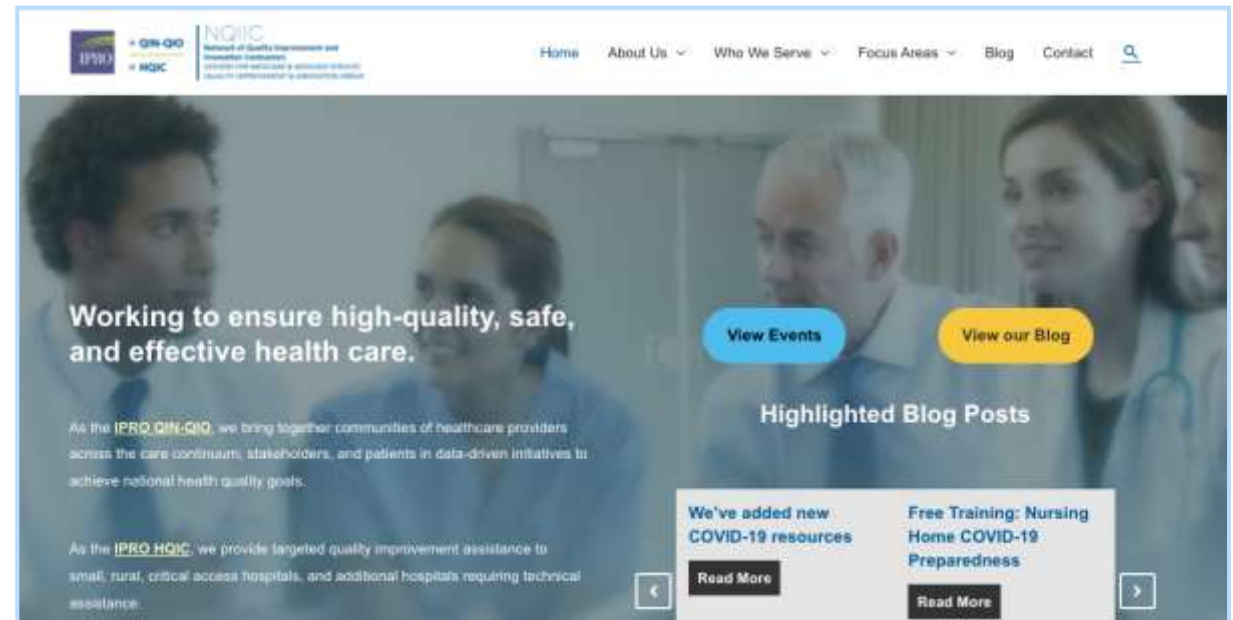
Mary Biello, RN
Transition of Care Specialist
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mbiello@visitingnursehh.org



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Benefits of Boosters

Recent evidence shows that among healthcare and other frontline workers, COVID 19 vaccine effectiveness has decreased over time, especially in those 65 and older, at preventing infection or milder illness with symptoms.

- Boosters shots increase immune response
- Boosters shots provide improved protection against becoming infected with COVID-19
- Booster shots help prevent COVID-19 with symptoms

<https://www.cdc.gov/coronavirus/2019-ncov/vaccines/booster-shot.html>

Let Us Know More...



Your feedback is critically important and will help guide us as we prepare future Small Talks and other educational events.

Please take just a few minutes to complete our session evaluation (link is in chat).

Mark your calendar for upcoming sessions



Access our calendar of events to view upcoming sessions:

<https://qi.ipro.org/upcoming-events/>

Upcoming Sessions

- 5/5 & 5/11: *Opioid Use Disorder & Related Behaviors: Supporting Patients & Each Other*
- 5/19 & 5/25: *Health Equity Organization Assessment*
- 6/2 & 6/8: *Caring for Residents with Chronic Kidney Disease – A session for Nursing Homes*

Check in with the QIO - Office Hours

- Share how it's going with your new intervention(s)
- Ask questions
- Learn from your peers

Next session: 5/26 @ 12pm

- <https://healthcentricadvisors.zoom.us/j/85491530818?pwd=SUIId3QyZllvQURJTVBFdzJndnRqdz09>



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Thank You

Thank you for your continued partnership and commitment to quality improvement.

