### 1 | DEFINE AND MONITOR

<table>
<thead>
<tr>
<th>Improvement Category &amp; Measurement Description</th>
<th>Baseline</th>
<th>Goal</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
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<tbody>
<tr>
<td>Quality</td>
<td>Reduce 30d readmissions for Heart Failure</td>
<td>14.93%</td>
<td>8.00%</td>
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<tr>
<td>Quality</td>
<td>No increase in HF mortality</td>
<td>11.40%</td>
<td>11.40%</td>
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<tr>
<td>Service</td>
<td>No decrease in HCAPS (“Definitely Recommend”)</td>
<td>69%</td>
<td>≥69%</td>
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<tr>
<td>Cost</td>
<td>Mean LOS Days</td>
<td>5.1 days</td>
<td>≤5.1 days</td>
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#### 2 | PROBLEM AND GOAL STATEMENTS (SM-RT Problems/SMART Goals)

30 day Readmission rate for Heart Failure (DRGs per CMS definition) was 14.93% for the 24 months ending May 30, 2015.

1. Reduce HF Readmissions to 8.0% by 9/30/2016 (this is a 47% decrease)
2. No decrease in HCAPS by 6/30/2016
3. No increase in LOS by 6/30/2016

#### 3 | ANALYSIS AND INVESTIGATION

1. Database analysis: High risk areas are Discharge to SNF, after hours, and w/o Cards involvement
2. No standardized medical care pathways for nursing or physicians
3. Difficult discharge process
   1. Have difficulty anticipating discharges to allow timely discharge planning
   2. Difficult process scheduling and communicating follow-up for off-hours discharge
4. Inconsistent patient education process and content leading to poor compliance
   1. Polypharmacy challenges quality and educational objectives.
   2. Patients become confused about their meds
   3. Med Rec is a major problem. Unclear for patients, inconsistent.
5. Patients don’t perform daily HF cares, keep appointments, weigh daily, diet
   1. Need Standard Work for patients. Not everyone has a scale for daily weights.
   2. Patient’s don’t know who to call if doing poorly.
   3. Inconsistent nurse training and qualification, support materials; training content
6. No Standard Work for providers post discharge
   1. Difficulty communicating for smooth transition for inpatient to outpatient providers
   2. Those who make follow-up calls to patient don’t have a provider to report to.
   3. Loss of provider continuity if discharged to SNF
7. HF Clinic not prepared to accept short term appointments.
   1. Schedule template inadequate and inflexible.
   2. No established process to coordinate care between various providers and HFC
   3. No one designated to receive patient calls to Heart Failure Hotline

#### 4 | IMPROVEMENT DESIGN AND IMPLEMENTATION

1. Discharge Process
   1. Establish Nursing Certification and Competency for HF teaching; include HH nurses
   2. Create standardized patient education and follow-up packet
   3. Create new patient materials to facilitate understanding, involvement and compliance
   4. Pre discharge Cards consult by Cards NP for all HF discharges, CM to trigger.
   5. Provide scales for patients in need to encourage daily weights
   6. In process: bring a test patient into the process
   7. Use Pre discharge Planning Sheet
   8. Use LACE score to anticipate high risk discharges needing extra attention
2. Medical and Nursing Care
   1. Taskforce of hospitalists, cardiologists and nursing to create care pathway
   2. Create Standard Work for those doing discharge and discharge follow-up
3. Post Discharge Cares
   1. HF clinic scheduling template revised
   2. Clarification of protocols for use of Heart Failure Hotline phone during after-hours
   3. Establish relationship with preferred Home Health agencies
4. Future efforts
   1. Explore processes to utilize pharmacists in cases with polypharmacy
   2. Explore processes for improving communication in discharges to SNF
### Heart Failure Scorecard

<table>
<thead>
<tr>
<th>Name:</th>
<th>Discharge Date:</th>
<th>Discharge Weight:</th>
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**If you gain 5 pounds, are more short of breath, or have any problems or questions, call the Heart Failure Hotline (208) 234-0112**

<table>
<thead>
<tr>
<th>Month</th>
<th>Day</th>
<th>Daily Weight</th>
<th>Blood Pressure</th>
<th>Low Salt Intake</th>
<th>Take Pills Morning</th>
<th>Take Pills Evening</th>
<th>Doctor’s Appointment Name</th>
<th>Time</th>
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### Heart Failure Discharge Scheduling Worksheet

- **Admission Date**
- **Discharge Date**

**Patient Contact Information**

**Discharge Diagnosis**

**Pocatello Cardiology Followup**

- Patient already has appointment with ________ at ________ on ________
- Patient needs to have an appointment scheduled ________ days from discharge with ________

- Tests already ordered and scheduled (test/date):

**Special Instructions**

- (You may also leave a voice message for Pocatello Cardiology at 234-2278.)

**Hospital Provider(s)**

- Hospitals
- ICU
- Cardiology

**Primary Care Provider**

- Has appointment with ________ at ________ on ________

**Home Health Provider**

- Procedural during Hospitalization
  - Echo
  - TEE
  - Cath
  - NMST
  - Cardiac Surgery
  - Other
  - PCI
  - Cardiovension
  - Pacer/ICD/CRT-D

**Name of Person completing form**

*Please fax to 232-2195*

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*Please bring this Scorecard with you to your Doctor’s Appointments.*

*Portneuf Medical Center (02/08/2016)*