



# Heart Failure Readmissions

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# Objectives

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- Describe Preston Memorial's approach to decreasing 30 day readmissions for Heart Failure by 20%.
- Review the challenges and approaches to appropriate follow-up post-acute care



# About Us

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- Multidisciplinary team – Physicians, Quality, Nursing, Case Management
- Critical Access Hospital –
  - 25 beds, ED with 9,840 annual visits in 2011
  - Rural setting in West Virginia
  - Low income, primarily Medicare/Medicaid.
  - Aging population with cardiac disease, diabetes





# Tests & What we Learned

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## Outpatient infusion program for patients requiring intravenous diuresis.

Planned to use existing outpatient infusion center for service.

- Barriers
  - Low volume – 1-3 patients monthly
  - Transportation difficulties for patients
  - Physicians preferred doing this in their offices – no support for a hospital program
- Abandoned outpatient infusion



# Tests & What we Learned

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## Use of an assessment tool to identify HF patients at risk for readmission

- We know our patients – they are our neighbors
- Surveys may be more valuable for hospitals in larger settings
- Redundant process - abandoned



# Tests & What we Learned

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## Post discharge phone calls (Project RED)

- 100% of our patients are called post discharge, 81% successfully reached by a nurse from Acute Care
- Discuss Clinical Outcomes
  1. Pain
  2. Medications
  3. Follow Up Appointment
  4. Discharge Instruction Clarity
- Improved satisfaction, improved compliance with discharge plan



# Tests & What we Learned

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- Discharge teaching with “teach back”, follow up appointments made before discharge, electronic medication reconciliation, written instructions. (Projects RED & BOOST)
- Despite teaching patients about activity level, diet, discharge medications , follow-up appointment, and weight monitoring ...
- Some patients still presented with large, unrecognized weight gain and distress.

## Why?



# Barriers & How we Resolved

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- Told to weigh themselves daily, but
  - Can't see the scale
  - Don't own a scale
  - Can't interpret change in weight (poor math skills, cognitive decline)



# Barriers & How we Resolved

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- Decided to use structured, formal shoes (“Sunday Shoes”) to assess pedal edema
- Did not want Physicians receiving puzzling calls – “My shoes don’t fit.”
  - Reviewed with Medical Staff over two months
  - Passed information to the office staff at the phones

# Sunday Shoes Program for Heart Failure

- Your doctor has said that you have heart failure. Patients with heart failure may come back to the hospital again and again. If you follow your discharge instructions, you may be able to stay home longer.
- One reason people come back to the hospital is too much water weight. Gaining water weight puts a strain on your heart. If you see yourself gaining water weight, you need to call your doctor for treatment.
- If you do not have a scale to weigh yourself, you can join the “Sunday Shoes” program.
- When you go home, find your best Sunday shoes. Put them on. See how they fit. If you gain water weight, your feet and legs swell. Your Sunday shoes will not fit as well.
- Put these shoes on every morning. If your Sunday shoes do not fit like when you first got home, call your doctor. Tell your doctor you have gained too much water weight. Ask to be seen immediately.

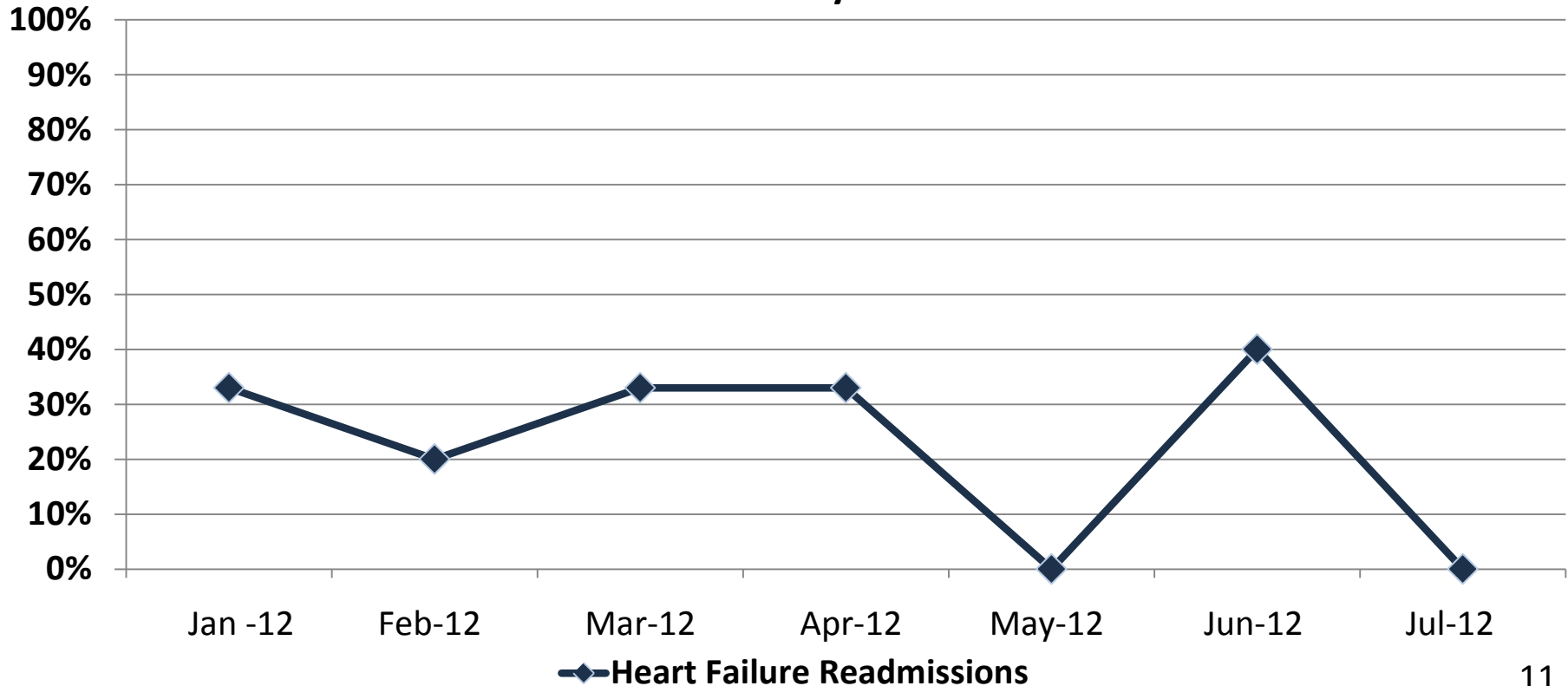




# Measures – What & How

- Low volumes (3-6 heart failure patients monthly)
- 30 day HF readmission rate Q4-2011 = 30%
- June 2012 = 2 readmissions, both of whom missed discharge education

**Heart Failure 30 Day Readmissions**





# Advice for others

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- Know your patients and their barriers
- Don't over analyze the situation – consider your size and population
- Gain physician support
- Use simple solutions that are easily understood by patients with low health literacy
- Consider the Sunday Shoes Program to assess pedal edema in heart failure patients
- Post discharge phone calls work



# Contact Information

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