

# Hospital Story

# Heart Failure

# Readmissions

Linda Flemmer, RN BSN  
Director of Quality, Risk,  
Compliance

Preston Memorial Hospital  
Kingwood, West Virginia

# Objectives

- Describe Preston Memorial's approach to decreasing readmissions for heart failure
- Review the challenges and approaches to appropriate follow-up post-acute care

# About Us

- Multidisciplinary team addressing issue –  
Physicians, Quality, Nursing, Case  
Management
- Critical Access Hospital –
  - 25 beds, ED with approximately 10,000 annual  
visits
  - Rural setting in Northern West Virginia
  - Low income, primarily Medicare/Medicaid.
  - Aging population with cardiac disease, diabetes

# About Us

- In 2012, the 30 day heart failure readmission rate was 22.6%
- AHA's HEN national benchmark rate was 18%
- We recognized that this was our largest readmission “headache” that needed to be addressed!

# Tests & What we Learned

- Our heart failure patients were coming back through the ED in respiratory distress with fluid overload
- These patients were admitted for 2-3 days of diuresis, labs, education, then discharged
- **They were loyal customers – they kept coming back!**
- **What could we do?**

# Tests & What we Learned

## 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

**Considered use of a survey to identify HF patients at risk for readmission**

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

# Tests & What we Learned

## 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

Discharge teaching with “teach back”, follow up appointments made before discharge, electronic medication reconciliation, written instructions. (Projects RED & BOOST)

- Can you name one medicine you are taking to manage heart failure?  
\_\_\_\_\_
- When weighing yourself daily, at what weight gain should you call your doctor? \_\_\_\_\_
- Can you explain why it is important to avoid foods high in salt?  
\_\_\_\_\_
- Can you tell me three symptoms of heart failure?  
\_\_\_\_\_

• **Pre-Teach Back**

- Can you name one medicine you are taking to manage heart failure?  
\_\_\_\_\_
- When weighing yourself daily, at what weight gain should you call your doctor? \_\_\_\_\_
- Can you explain why it is important to avoid foods high in salt?  
\_\_\_\_\_
- Can you explain why it is important to avoid foods high in salt?  
\_\_\_\_\_
- Can you tell me three symptoms of heart failure?  
\_\_\_\_\_

• **Post-Teach Back**

# Tests & What we Learned

Despite teaching patients about activity level, diet, discharge medications, scheduling follow-up appointments, and weight monitoring ...

Some patients still presented with large, unrecognized weight gain and distress.

Why?

# BARRIERS & RESOLUTION

- Recognition of a **Healthcare Literacy issue**
- This was NOT “patient non-compliance”
- Patients 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, reading skills, cognitive decline)

# PLAN

- We interviewed patients
- We brainstormed
- 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 at Medical Staff Meetings
  - Passed information to the office staff at the phones

# PLAN

- Physicians were able to advise patients on diuretic dosing at home or see them in the office the same day.

# PLAN

- Sunday Shoes education written at a 6<sup>th</sup> grade reading level in large font
- Included pictures of appropriate shoes – no slippers or tennis shoes
- Included reminders about Sunday Shoes on the discharge phone calls for heart failure patients
- Added a question about Sunday Shoes education to heart failure teach back

## 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.



# RESULTS

- 2014 – ZERO 30 day readmissions for heart failure
- 2015 – ZERO 30 day readmissions for heart failure
- 2016 – ZERO 30 day readmissions for heart failure through June

# Advice for Others

- 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
- Use teach back and reinforce education in the patient's own language
- Post discharge phone calls work

# Next Steps

- Develop new teach back tools.
- Pre-education questions completed **by the patient** in their own words and writing.
- Post-education questions are completed **by the patient** throughout the stay in their own words.
- The tool is reviewed and amended by nursing prior to discharge.
- Reinforces teaching in language best understood by the patient – **THEIR OWN**.
- Testing for our high volume diagnoses – COPD and Pneumonia

# Contact Information

Linda Flemmer, RN BSN

Director of Quality, Risk, Compliance

Preston Memorial Hospital

150 Memorial Drive

Kingwood, WV 26537

[lflemmer@prestonmemorial.org](mailto:lflemmer@prestonmemorial.org)

304-329-4711