

RHQN Quality Newsletter, January 2007

RHQN Heart Failure Initiative:

Final Q2 2006 data reflects that we have been unable to sustain gains in three areas.

	<u>Discharge Instructions</u>	<u>LVF assessment</u>	<u>ACEI/ARB</u>	<u>Smoking Cessation</u>
Q1 (2006)	69%	63%	85%	71%
Q2	68%	69%	81%	49%

The data may continue to reflect issues with documentation and we encourage nursing leaders to work with front-line staff to address what barriers may still exist and develop possible intervention strategies to test. Including quality measures as routine part of discharge planning will also allow the opportunity to make sure all the measures that your hospital is reporting will be addressed prior to the patient being discharged. Remember, documentation is the key to success!

The intervention materials previously sent to you by the RHQN, examples of pre-printed discharge instruction sheets, chart prompts/stickers, are designed to help you achieve 100% compliance every time. Using a preprinted discharge sheet, such as the example that the RHQN sent out in 2005, helps to address specific components of discharge instructions, including smoking cessation counseling, and also becomes “instant” documentation that education has taken place. Chart prompts/stickers can serve as reminders to busy clinicians and at the same time provide an easy way to document. Nursing staff are key to assisting busy providers remember to document. Providing staff education and having these or similar materials available to busy front-line staff at all times will ensure that patients are getting evidence-based care, appropriate instruction, and will ensure that the documentation supports your efforts. If you would like more examples or assistance with this, please contact Jackie Huck at jackieh@awphd.org

Why a continued focus on heart failure? A recent article in JAMA addressed the fact that “heart failure continues to be a serious public health concern in the United States: the overall prevalence of heart failure was 5 million individuals in 2003, with 550,000 new cases being reported each year. Heart failure is the leading cause of hospitalization in persons older than 65m with almost 3.6 million hospitalizations attributed to heart failure as the primary or a secondary discharge diagnosis each year. Because heart failure is a significant cause of morbidity, mortality, and health care expenditures, it is especially important to utilize evidence-based therapies that have been demonstrated to improve

clinical outcomes”¹ As baby boomers reach retirement, the number of heart failure cases is expected to rise significantly. To review current guidelines developed by the American College of Cardiology (ACC) and the American Heart Association go to the respective websites, links to those websites can be found on the RHQN website at <http://www.rhqn.org/>.

It is important to remember the significance of education, follow-up and coordination of care for this population as well as patients living with other chronic illness, in order to decrease hospital admission, readmission and mortality rates and to increase the quality of life for patients living with chronic illness. Nursing staff can make a significant impact in this area. We would encourage you to continue your efforts to improve care and apply intervention strategies to all patients admitted with HF, whether it is a primary or secondary diagnosis.

Contact Jackie Huck at jackieh@awphd.org if you have any questions or would like to discuss further. Jackie Huck is available to assist if needed.

It is time for the final request for Q3 2006 HF data, due by Feb 28th, and if you have it available, Q4 2006 data.

If you have submitted HF data into the clinical QIO warehouse for Q3, you can access your HF measure report by going to www.qualitynet.org, login, reports, clinical warehouse feedback reports, click on Heart Failure, your name will display, put in discharge date of 07/01/2006 through 09/30/2006 and hit the submit button, click on report viewer, click on magnifying glass, your report will open, save it to where you want and then attach it in an email and send to Jackie Huck. If you are experiencing difficulty with this, contact Karen Atherton at Qualis Health (1.888.288.4817), and she will assist you. The deadline for data submission into the clinical QIO warehouse is February 15th.

There has been some confusion about the ICD-9 codes included for the HF abstractions, please see the inclusion list below.

Include:

Principle diagnosis ICD-9-CM code (from acute inpatient care) of:

- 402.01 Malignant hypertensive heart disease with heart failure
- 402.11 Benign hypertensive heart disease with heart failure
- 402.91 Hypertensive heart disease with heart failure, unspecified
- 404.01 Malignant hypertensive heart disease and renal disease with heart failure
- 404.03 Malignant hypertensive heart and renal disease with heart failure and renal failure
- 404.11 Benign hypertensive heart and renal disease with heart failure
- 404.13 Benign hypertensive heart and renal disease with heart failure and renal failure

¹ Source: “Association Between Performance Measures and Clinical Outcomes for Patients Hospitalized with Heart Failure” JAMA January 3, 2007 – Vol 297. No 1

- 404.91 Hypertensive heart and renal disease with heart failure, unspecified
- 404.93 Hypertensive heart and renal disease with heart failure and renal failure, unspecified
- 428 Congestive heart failure, unspecified
- 428.1 Left heart failure
- 428.20 Systolic heart failure, unspecified
- 428.21 Acute systolic heart failure
- 428.22 Chronic systolic heart failure
- 428.23 Acute on chronic systolic heart failure
- 428.23 Acute on chronic systolic heart failure
- 428.30 Diastolic heart failure, unspecified
- 428.31 Acute diastolic heart failure
- 428.32 Chronic diastolic heart failure
- 428.33 Acute on chronic diastolic heart failure
- 428.40 Combined systolic and diastolic heart failure, unspecified
- 428.41 Acute combined systolic and diastolic heart failure
- 428.42 Chronic combined systolic and diastolic heart failure
- 428.43 Acute on chronic combined systolic and diastolic heart failure
- 428.9 Heart failure, unspecified

Preparation for Survey:

Everyone should have received an email from Dr. Myron Bloom regarding preparing your Annual CAH Report. Dr Bloom also sent out good examples that could be adapted/modified for your own facility if desired. Employing a team approach to preparing this report and including it as a standard agenda item at each quality team meeting will help reduce the stress that can be associated with preparing the report for the Department of Health. Remember that each department should be asked about their accomplishments as well as their immediate and long term needs for tactical and strategic planning. Using the last survey report as a “working” document going forward will also help ensure that all recommendations have been addressed by the time of your next survey. Since the Department of Health has now gone to announced surveys for CAHs, always being ready is key to success. Thinking, and acting like a JCAHO hospital, even if you are not, is a sure way to help you go through a successful survey. If you did not receive the recent email with examples, contact Brad Vollegraaf at bradv@awphd.org.

Upcoming Events

February 28th, Noon-1pm: RHQN QI Call