Core Measures: Improving Outcomes in Cardiac Patient

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Hospital discharges for heart failure by gender
(United States: 1979-2004). Source: NHDS, NCHS and NHLBI.
Note: Hospital discharges include people discharged alive, dead and status unknown.
Prevalence of heart failure by age and gender
(NHANES: 1999-2004). Source: NCHS and NHLBI.

Source: NHLBI.
* HF based on physicians review of medical records and strict diagnostic criteria.
Heart Failure

• Is a major and growing public health problem, affecting 5.3 million people, mostly elderly, with 660,000 new cases diagnosed each year in the US.

• Is the underlying cause for 12 to 15 million office visits and 6.5 million hospital days each year.

• As the elderly population grows in coming decades, the prevalence of HF is expected to increase substantially.

• Many patients with HF are caught in a “revolving door” process that ultimately culminates in deterioration and re-hospitalization.

• 36% of all the patients that were readmitted within 30 days had a diagnosis of Heart Failure CMS study based solely on Medicare data
Core Measures: What are they?

- They are standardized evidence-based performance measures
- They are PROCESS measures (how recommended care is provided)
- The core measure results are reported to the Centers for Medicare and Medicaid Services (CMS), The Joint Commission (TJC) and other insurance payers
- Results can be tied to reimbursement
- Results are reported to the public
Core Measures are done for the following reasons:

- It is a requirement of the Centers for Medicare and Medicaid Services (CMS) and The Joint Commission. All hospitals in the United States are required to send scores on the Core Measures every month.

- It is the right thing to do for the clinical care for the patient.

- Research has shown that the activities associated with Core Measures will provide the best outcome for the patient.

- It is a reflection of the ability of our organization to provide high quality care not just to one patient, but across a population of patients.
We all have a vital role to play in Core Measures

MD

Community

Nurse

Manager

Data Abstractor

Quality Improvement Coordinator

Heart Failure Core Measures

At a glance…

HF-1: Discharge Instructions

HF-2: Evaluation of LVS Function

HF-3: ACEI or ARB for LVSD

HF-4: Adult Smoking Cessation Advice or Counseling
Heart Failure-1 Discharge Instructions

Description: Heart failure patients discharged home with written instructions or educational material given to patient or caregiver at discharge or during the hospital stay addressing all of the following activity, diet, discharge medications, follow up appointment, weight monitoring, and worsening symptoms.

Rationale:
- Patient non-compliance with diet and medications is an important reason for changes in clinical status.
- Health care professionals should ensure that patients and their families understand their dietary restrictions, activity recommendations, prescribed medication regimen, and the signs and symptoms of worsening heart failure.
- Despite National Guideline Support (Hunt 2005), comprehensive discharge instructions are rarely provided to eligible older patients hospitalized with heart failure (CMS National Heart Failure Project baseline data).
Heart Failure-1 Discharge Instructions

Data abstraction requirements:

- The data elements for each of the six discharge instruction elements provide the opportunity to assess each component individually.
- However, completion of all six instruction categories is required for this composite measure.
- The medications listed in the Discharge Summary MUST include all the medications listed in the Discharge Instructions.

Heart Failure-2 Evaluation of LVS Function

Description:
Heart failure patients with documentation in the hospital record that left ventricular systolic (LVS) function was evaluated before arrival, during hospitalization, or is planned for after discharge.

Rationale:
- Appropriate selection of medications to reduce morbidity and mortality requires the identification of impaired left ventricular systolic function.

- National guidelines advocate evaluation of LVS function as the single most important diagnostic test in the management of all patients with heart failure (Hunt 2005).

- Despite recommendations, LVS function is not evaluated in a substantial proportion of eligible older patients hospitalized with heart failure (Jencks, 2000).
Heart Failure-2 Evaluation of LVS Function

Data abstraction requirements:

• The patient’s LVS function must be documented in the medical record for each admission.

• It is acceptable to include documentation from the physician’s office that documents the patient’s LVS function.

Heart Failure-3 ACE/ARB for LVSD

Measure description:
Heart failure patients with left ventricular systolic dysfunction (LSVD) who are prescribed an ACEI or ARB at hospital discharge. LVSD is defined as chart documentation of LVEF <40% or narrative description of LVS function consistent with moderate or severe systolic dysfunction.

Of note: Documented EF of 35-40% would be considered 37.5%

Science-based rationale:
• ACEI therapy reduces mortality and morbidity in HF patients and LVSD and is effective in a wide range of patients.

• Recent clinical trials have established ARB therapy as an acceptable alternative.

• National guidelines strongly recommend ACEIs for patients hospitalized with heart failure and have also supported the inclusion of ARBs in performance measures for heart failure.

• ACEIs and ARBs remain underutilized in eligible older patients hospitalized for heart failure.
Data Abstraction Requirements:

• Contraindication for use of ACEI or ARB medications MUST be documented if not prescribed to the patient at discharge.

Common contraindications for ACE/ARB Inhibitors: hyperkalemia, renal insufficiency, renal artery stenosis, previous reaction/allergy to similar drug (angioedema, rash, anaphylaxis), hypotension BP <100, moderate to severe aortic stenosis

Tip:
• Documentation for each patient encounter must stand alone. Clinical reviewers may not access prior admissions to identify contraindications.

Heart Failure-4 Adult Smoking Cessation Advice/Counseling

Description:
Heart failure patients with a history of smoking cigarettes, who are given smoking cessation advice or counseling during hospital stay. For purposes of this measure, a smoker is defined as someone who has smoked cigarettes anytime during the year prior to hospital arrival.

Rationale:
• Smoking cessation reduces mortality and morbidity in all populations.

• Even brief smoking cessation advice from care providers increase the probability to quit.

• National guidelines strongly recommend smoking cessation counseling for smokers with cardiovascular disease, including heart failure (Fiore, 2000; and Hunt, 2005).

• Smoking cessation counseling is rarely provided to eligible older patients hospitalized with heart failure (CMS National Heart Failure Project baseline data).
**Heart Failure-4 Adult Smoking Cessation Advice/Counseling**

Ask “*Have you smoked any cigarettes in the last year?*”

Document patient is smoker & smoking cessation counseling/advice has been given.

Data abstraction for this measure may be derived from these medical record sources:

- Consultation notes
- Discharge instruction sheet
- Discharge summary
- Emergency department record
- History and physical
- Medication administration record
- Nursing notes
- Progress notes
- Respiratory therapy notes
- Teaching sheet

Patient is clinically ready for discharge but may need assistance with HF management

Next Steps for the Heart Failure Patient
Hospitals Role in Transition to the Community

Cardiovascular Unit is working on better transitions into the community that include…

- **Teach back education for the patient and family/caregiver**
- **Coaching referral when indicated**
- **Making patient follow up appointments before the patient leaves the hospital…best scenario is a follow up appointment within 3-5 days of discharge**
- **Follow up phone call from a CVU nurse to check on patient’s progress and reiteration of discharge instructions**
- **Follow up phone call from cardiac rehab when indicated to discuss weight monitoring, diet and activity**
Outpatient Clinics…
Continuing the Use of Core Measure Guidelines

Physician Office HF Algorithm’s for Improved Outcomes

HF Screens in the Clinics

Help guide the clinician on how to treat their patient based on algorithms defined by their respective disease management counterparts and best practice guidelines.

Screens for Disease Management Care
Disease Management Care

- Takes 16-21 times of repetition to make something a habit.
- Teach back method tells us to only teach a patient 1-2 things at a time...at hospital discharge we have limited time to teach 6 discharge instructions when patients are still “sick”.

Continued education on self care management are important in the outpatient setting

Self Management Responsibilities
Your True Weight: __________________

- No unusual shortness of breath
- No new or increased swelling in ankles or lower legs
- Weight gain less than 5 pounds in 7 days
- No increased fatigue
- No decrease in your ability to maintain normal activity level

Green Zone Means:
- You are doing a great job with self-care!
- Continue taking your medications
- Weigh yourself daily and record your weight
- Follow a low-salt diet
- Follow your exercise plan
- Keep doctor appointments

If you have any of the following signs or symptoms:
- Increased weight of 5 pounds or more in 7 days
- Increased cough
- New or increased swelling in ankles or lower legs
- Increased shortness of breath with activity or at rest
- Increased number of pillows needed to sleep, or need to sleep in a chair
- You lose 5 or more pounds in a week and haven’t increased your diuretic in the past few days
- You are vomiting and/or have diarrhea and are getting dehydrated
- Anything else unusual that bothers you

Yellow Zone Means:
- Call if you are in the YELLOW ZONE
- Call your doctor to report your symptoms. You may need an adjustment in your medications or need to be seen.

Red Zone Means:
- This indicates that you need to be evaluated by a doctor right away.
- CALL 911.

Example of Patient/Caregiver Guidelines
Be Active

Benefits
- Increased energy
- Better sleep at night
- Strong muscles – making everyday tasks easier
- Improved cardiovascular health
- Help in maintaining or losing weight
- Improved mood and sense of well being

For Your Safety
- Start slow
- Follow your recommended exercise plan
- Stop and talk to your Doctor if you have the following...
  - unusual tiredness
  - fast or slow heartbeat
  - dizziness or lightheadedness
  - irregular heartbeat
- Stick to your exercise plan

Even though you have heart failure, you can, and should, be active. The best exercise plan is one that is developed for you and includes activities that interest you. Be sure to speak to your health care professional about setting up a fitness plan and exercise level prior to starting.
Patient/Caregiver Guidelines

What will make me better?
Much can be done to improve the heart’s pumping and to treat the symptoms, but heart failure can’t be completely cured. There are many things you can do to feel better! A few changes can lessen the symptoms of heart failure and improve your overall health and quality of life. An important part of treatment is taking care of any underlying problems, such as high blood pressure.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Medicine can help make it easier for your heart to pump, strengthen your heartbeat and remove excess fluid from your body. It is important to take your medications everyday.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>Keeping active is important. Even though you have heart failure, you can enjoy physical activity and exercise. A little exercise can make a big difference in your health. Your health care provider can help you develop an exercise plan based on your level of fitness.</td>
</tr>
<tr>
<td>Weight</td>
<td>Weighing yourself daily and keeping a record will help you and your health care providers know if your heart failure is under control. Rapid changes in your weight can mean you are gaining or losing fluid.</td>
</tr>
<tr>
<td>Diet</td>
<td>Three important dietary adjustments are to: limit the amount of salt you eat (less than 2,000 mg/day); limit your intake of fluids (less than 8 cups/day), and limit alcohol consumption (one drink or less/day). Other changes in what you eat may be advised depending on your various health issues.</td>
</tr>
<tr>
<td>Symptoms</td>
<td>It is your job to monitor your symptoms and communicate with your health care providers about any changes.</td>
</tr>
</tbody>
</table>

*Dr. Appt
*Weigh Yourself
*Watch your Diet
*Be Active
*Know your symptoms
*Take your Medicine
Questions?