Quality Assurance and Performance Improvement (QAPI) in Healthcare for Older Adults: Heart Failure

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WHY: Heart failure is a common chronic health condition and public health problem affecting an estimated 5.8 million Americans yearly. It is the most common cause of hospital admission in older adults 65 years of age or older. Hospitalizations for heart failure account for approximately 50% of all cardiovascular related hospital admissions. The evidence demonstrates that as many as half of these admissions are readmissions and are preventable (Boltz, Capezuti, Fulmer, & Zwicker, 2016). The Medicare Payment Advisory Committee (MedPAC), an independent federal body created to advise Congress on issues affecting the Medicare Program, has highlighted heart failure as one of seven conditions that account for nearly 30% of potentially preventable readmissions in the 15-day period following initial hospital discharge (National Quality Measures Clearinghouse, 2015). The Centers for Medicare and Medicaid Services (CMS) is focusing on decreasing avoidable hospitalizations across the healthcare continuum. Currently, hospitals are subject to financial penalties for patients readmitted within 30 days of hospital discharge with certain diagnoses, including heart failure.

BEST APPROACH: To ensure and evaluate the implementation of evidence-based practice standards across the healthcare delivery continuum, it is important to monitor and evaluate key indicators related to a diagnosis of heart failure. Early identification of those at risk for re-hospitalization during the hospital stay provides opportunity for interventions to decrease the readmission rate and keep patients at home. Post-acute care interventions are critical for prompt identification of decompensation. It is important to assess and involve the patient and/or caregivers in the self-management of heart failure symptoms. The interventions may be modified dependent upon the care delivery setting e.g. acute, short-term rehabilitation, long-term care, and home care. Implementation of the PDSA model will ensure recommended application of a performance improvement approach (See *Try This:*® QI Issue Quality Assurance and Performance Improvement).

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Implementing the Plan Do Study Act (PDSA) Model for Performance Improvement related to Heart Failure

Plan: To improve the implementation of Heart Failure Clinical Practice Guidelines, select the appropriate interventions and identify indicators for evaluation.

Develop a monitoring tool which looks at the nurse's assessment of the following:

- Dyspnea, Fatigue, Orthopnea (consider use of multiple pillows at night), Respiratory effort
- Chest pain or pressure or other related pain
- Abdominal distention
- Vital signs, blood pressure sitting and standing with signs of dizziness or lightheadedness
- Use of symptom and daily weight log
- Assessment of extremities for edema; pulse; color; temperature
- Functional status (See *Try This*:® Katz Index of ADL; Lawton IADL; Reducing Functional Decline in Older Adults during Hospitalization)
- Psychosocial issues (Consider what might lead to exacerbation of heart failure, such as diet, dining out, access to shopping/food, ability to afford groceries, travel)
- Signs/symptoms of depression (See *Try This*:® Geriatric Depression Scale)
- Environmental assessment
- Lifestyle changes and determination of patient's motivation for change
- Understanding of heart failure, previous education and willingness to learn and participate in self-care and/or identification and education of available caregiver
- Compliance to prescribed diet or fluid restrictions, change or decrease in appetite
- Medication adherence (medications may include an Angiotensin Converting Enzyme Inhibitor, Angiotensin II Receptor Blocker or Beta Blocker)
- Instructions on when to contact the primary care provider or emergency services
- Health care provider visit: Patient seen by primary care provider within 14 days of hospital discharge

Do: Conduct the review of implementation of clinical practice guidelines relative to heart failure. Document observations, including any problems and unexpected findings. Collect data you identified as needed during the "plan" stage.

Study: Aggregate the data, evaluate it for trends and patterns. Identify opportunities for improvement using statistical process control tools such as histograms (bar chart showing a distribution of variables; characteristics noted as columns; column height demonstrates frequency of occurrence), Pareto charts (type of histogram that ranks causes by their overall influence), and other graphs. Assemble a team of practitioners to help analyze aggregated data.

Act: Make any recommendations or modifications to ensure improvement and implementation of Clinical Practice Guideline interventions.