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| **A. General Information** |   |   |   |   |   |   |   |
| ***Project Title & Project #:*** | Heart Failure Communication Checklist & Discharge Plan  |
| ***Department/Division/Team:***  | Heart Failure Committee |
| ***Population:*** | All children hospitalized with ADHF where the patient is either admitted to the HF service or the HF service has formally consulted. HF and ADHF are defined using the ACTION clinical definitions.1 |
| ***Brief Project Description (AIM):*** | **Communication Checklist:** To standardize language usage and team communication for inpatient heart failure patients via a daily bedside checklist tool in an effort to improve outcomes in patients during acute heart failure admission.**Discharge Plan:** To standardize the internal discharge planning process for patients in an effort to reduce readmission and effectively transition to outpatient care, while also providing insight for future quality improvement efforts pertaining to children with acute heart failure.  |
| ***Measures:*** | 1. **Communication Checklist:**
	1. Adoption of checklist usage on daily team rounds (average days per week completed)
	2. Hospital length of stay for acute heart failure admission
	3. Heart failure score trend during admission while using checklist
2. **Discharge Plan:**
	1. Adoption of discharge plan
	2. Decrease percentage of patients readmitted within 30 days
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| ***Prepared By:*** | Ryan Butts, Danielle Burstein, Kristen George, Kathleen Simpson, Joseph Spinner, Brian Feingold, & Christopher Almond  |
| ***Date:***  | 1.23.21 |
| **B. Project Background:** |   |   |   |   |   |   |   |
| Heart failure in children remains a cause of significant morbidity and mortality. Although due to various mechanisms, such as cardiomyopathy and congenital heart disease, there are common heart failure treatment and management pathways across patient population. During an acute heart failure episode admission, whether for a new diagnosis or in a chronic patient, patients are at risk for progressive decompensation. Improving communication about patient status and treatment goals among care team members (including patients) may help improve patient outcomes. Additionally, the inclusion of a formalized discharge plan can aide in a seamless transition from inpatient to outpatient care for children with acute heart failure.  |
| **C. Project Scope (and exclusions)**: |
| Inclusion: 1. Meets ACTION definition for ADHF (HF leading to hospitalization) \*

\* **HF Definition:** *A clinical syndrome that results from any structural or functional impairment of ventricular filling or ejection.  Cardinal symptoms include breathing difficulty, feeding intolerance, and decreased activity.***Acute Decompensated Heart Failure (ADHF) Definition**: *HF severe enough to warrant hospitalization.* 1. Cardiac diagnoses:  see appendix for full list. Examples include:

DCM (primary and secondary), RCM (primary and secondary), HCM (primary and secondary), ARVC, LVNC, myocarditis, Failing Single Ventricle CHD regardless of function, Two-Ventricle CHD, Heart transplant graft dysfunction1. All ages provided admitted to an ACTION hospital
2. If patient receives a VAD during admission they will be eligible for the communication checklist and the discharge plan project.

Exclusions: 1. Patients with history of heart failure admitted for other reason (non-heart failure episode)
2. If a patient is transplanted during their admission they will be eligible for the communication checklist but not the discharge plan.
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| **D. High Level Timeline/Schedule:** |   |   |   |   |   |   |   |
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| October 2020   | * Invite teams to participate in project at ACTION Fall 2020 meeting
* ACTION Newsletter – Invitation Packet Details
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| November – December 2020  | * Global QI call for questions on application
* Teams commit to joining the project
* Teams select, resource, and support team members
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| January 2021  | * Project kick-off meeting
* Teams develop a project plan
* Teams adopt operational definition of measures
* Teams adopt Key Driver Diagram
* Teams assess their current system focused on discharge
* Share progress on setting teams, developing plans, and testing to increase reliability to interventions
* Teams develop PDSAs to test
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| January 2021 – September 2021   | * Teams test to increase reliability and achieve 80% (if enough patients)
* Share progress during Global QI meetings
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| October 2021 – March 2022  | * Teams test to increase reliability to future factors and share webinars and in-person meetings
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| March 2022 –  Forward  | * Sustain reliability and monitor outcomes
* Reduction goal achieved
* Intervention bundle and change package published
* Spread learning to entire network
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| **E. Communication & Expectations:** |   |  |   |   |   |   |
| All ACTION sites with a completed IRB/DUA are welcome to be involved in this project. Chloe Stegeman & Kenton Reason will send a survey to invite centers to participate, and responses will be due by **11/13/20**. We will ask each participating center to identify one point person for the project, but anyone on the project team can enter or view data in REDCap. To set up data access, we will need the following:**1.)** Name of person **2.)** Institutional affiliation **3.)** Email address, and **4.)** The level of permissions needed (i.e. entering data, viewing, etc.). Lastly, a REDCap account will need to be created prior to being able to enter data prospectively. The designated data team members will need to be added to the IRB and study staff listing. Please email Mary.Berwanger@cchmc.org to update your staff listing. Patients will also be consented for prospective data entry, so anyone consenting or interacting with the data will need to be listed on the ACTION IRB study staff listing. **Communication Checklist**1. HF rounding communication checklist will be completed and discussed daily on team rounds with goal to be inclusive of attending, support staff (PA, APP, etc.), trainees (MS, residents, fellows), bedside RN or RN representative, family member (if bedside), and patient (if age appropriate).
2. Team will identify beforehand which member (typically attending, support staff or trainee) will have primary responsibility for completing checklist daily.
3. Team will likewise identify which member will have primary responsibility for entering certain QI data (daily use, certain measures and trends as specified by study) regarding patients for whom the checklist is utilized.
4. **We are tracking frequency of use of this tool.**
* ***The recommended method*** of tracking the frequency of daily checklist use is to scan the QR code each day you use the checklist. When you use the checklist, simply scan the QR code, enter the data for the 3 fields, and submit. **Do this each day you use the checklist.**

**Discharge Plan** 1. Discharge plan is created prior to discharge and reviewed by multi-disciplinary care team (including parents) on day of (or before) discharge.
2. Team will identify beforehand which member (typically nurse coordinator or bedside nurse) will have primary responsibility for completing discharge plan.
3. **The tool can be completed by hand on paper,** [**electronically filled out and exported to PDF**](https://redcap.research.cchmc.org/surveys/?s=PYEJFW7MCD)**, or built into the Epic EMR** (if sites have this option). The expectation is that providers share a copy of the discharge plan with other providers, the patient, and family members to improve discharge planning and communication.
* ***The recommended method*** of completing/populating the discharge plan is to click the link above or scan the QR code and electronically complete the plan. After filling in the form, **you must download the PDF** or enter your email address to receive a copy of the PDF. Then you can share the PDF plan with others.

**Prospective Data**Prospective data for HF patients, as well as data for our process measures, will be collected via REDCap: <https://redcap.research.cchmc.org/index.php?action=myprojects>*.* The expectation is for patient data to be entered into REDCap once the patient has been discharged from the heart failure hospital admission (and consented for ACTION!). You must have a login to the CCHMC REDCap in order to enter data for this project (per the emails that have been sent out). Please contact the operations/data team if you are having trouble accessing this REDCap.The REDCap survey asks for an “ACTION ID.” You will notice a new method for creating a patient’s ACTION ID. This process has been standardized for this project (and will be rolled out to other QI projects soon!). This will allow better tracking of patients between ACTION projects and will be more clear for data analytics on back end. The ACTION ID will be populated each time you enter data. The ID is comprised of the hospital number, the patient’s full name initials (First, Middle, Last - *\*use “x” if patient does not have middle initial*), and the patient’s DOB. This creates an ACTION ID with a mathematical equation that de-identifies the ID. For example, if the CCHMC site number was 10, using Lauren Elise Smyth, and DOB: 05/02/1988, the ID would be auto-generated as: **010-LES-5022010**. FYI – If you have completed the Discharge Plan via the electronic fillable form, you do not need to upload your Discharge Plan to this REDCap. However, if you completed the Discharge Plan by hand on paper, or some other method, please upload a PDF copy of your Discharge Plan to this patient-level REDCap.**Retrospective Baseline Data**Teams joining this project are also encouraged (not required) to enter baseline Heart Failure patient data into the retrospective HF REDcap: <https://redcap.research.cchmc.org/surveys/?s=8PJKL4M8JM>. Ideally, we are asking teams to submit retrospective data back to October 1, 2019. Please use the same inclusion/exclusion criteria as stated above for entering this retrospective baseline data. The REDCap survey asks for an “ACTION ID.” This process will be the same as outlined above in the prospective data section.  |
| **F. Project Risks & Mitigation**: |
| **Risk** | **Level (high/med/low)** | **Mitigation and Escalation Strategy** |
| Workload burden for staff |  low |  Simplify data collection on tool and minimize required data entry |
| Patient confidentiality |  low |  No identifying data (PHI) will be included on the rounding sheet |
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| **G. Roles and Responsibilities** |   |   |   |   |   |   |
| **Sponsor/Champion:** Provides overall direction on the project. |
| **Name** | **Title/Role** |
| Angela Lorts | MD/ ACTION leader |
| David Rosenthal | MD/ ACTION Leader |
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| **Team Leader:** Leads the team and provides guidance on scope of the project. |
| **Name** | **Title/Role** |
| Danielle Burstein | MD/ Heart Failure Committee – QI Lead |
| Ryan Butts | MD/ Heart Failure Committee – QI Lead |
| Christopher Almond | MD/ Heart Failure Committee - PHIS Lead |
| Brian Feingold | MD/ Discharge Plan Lead |
| Joseph Spinner | MD/ Discharge Plan Lead  |
| Kristin George | NP/ Heart Failure Checklist Lead |
| Kathleen Simpson | MD/ Heart Failure Checklist Lead |
| **Project Support** (**QIC/QOM/Data Analytics/Project Manager Support):** Leads in the planning & development of the project; manages the project to scope and/or provides data analysis and reporting expertise for the project. |
| **Name** | **Title/Role** |
| Chloe Connelly | MA/ Data Quality Analyst |
| Clifford Gammon | Sr. Data Quality Analyst |
| Paige Krack | MBA, MS/ Quality Improvement Consultant |
| Kenton Reason  | MHA/ Project Manager Support |
| Lauren Smyth | MHA/ Program Manager |
| Chloe Stegeman | MBA/ Project Manager Support |
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| **Team Members:** Works toward the deliverables of the project. |
| **Communication Checklist** | **Discharge Plan** |
| Neha Bansal, MD | Kurt Schumacher, MD |
| Beth Hawkins, NP | Julie Schmidt, NP |
| Jillien Lochridge, NP | Colleen Surmay, MSRN/ CPNP |
| Lindsay May, MD | Lindsay May, MD |
| Jenna Murray, PN | Neha Bansal, MD |
| Julie Schmidt, NP | Christopher Almond, MD |
| Colleen Surmay, MSRN/ CPNP |  |
| Christopher Almond, MD |  |
| **Family/Patient Representative:** |
| **Name** | **Title/Role** |
|  n/a  |    |
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