

**Left Ventricular Function (LVF) Assessment
for Heart Failure –
Achieving the Standard of Care
Tools and Resources for Hospital Performance Measurement
Improvement Activities**

Sixth in a series of targeted quality improvement articles

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Illinois Hospital Association

Left Ventricular Function (LVF) Assessment for Heart Failure – Achieving the Standard of Care Tools and Resources for Hospital Performance Measurement Improvement Activities

Achieving the Highest Standard of Care

Left ventricular function (LVF) assessment for Heart Failure (HF) examines whether the contractile function of the heart's left ventricle was assessed in patients with HF. Illinois hospitals in THE 4th quarter of 2003 achieved 85.9% compliance compared to 85.4% for nationally reported Joint Commission on Accreditation of Healthcare Organizations (JCAHO) measurement data for the same time period. The goal for all Illinois hospitals is 100% compliance with the standard of care.

LVF Assessment for HF Measurement Description

Heart failure is a chronic, progressive disease characterized by frequent hospital admissions that can be reduced if the patient follows the treatment plan and lifestyle changes outlined by the physician. Simply defined, heart failure is the inability of the heart to supply the body's need for oxygenated blood. LVF assessment is a critical step in the effective diagnosis and management of patients with heart failure.

Calculating the Measure's Performance. LVF assessment for HF is reported as a percent, based on:

- Numerator includes HF patients with documentation in the hospital record that LVF was assessed before arrival, during hospitalization, or is planned for after discharge.
- Denominator includes HF patients.

The *Technical Specifications* manuals are a resource for the measure description, rationale, the numerator and denominator, inclusions and exclusions, contraindications, and how data is processed including what results in *missing data* and *not in measure populations*. To view, click on the links below and follow the additional steps.

- For JCAHO, go to:

www.jcaho.org/

Click on "Performance Measurement", click on "Core Measure Information", click on "Specifications Manual....", scroll down to "Measure Information Forms", select the Core Measurement of interest.

- For the Center for Medicare and Medicaid Services (CMS), go to:

www.qnetexchange.org/

Click on "HDC", Scroll down to "Related Resources", click on "Topic-Specific Resources, Zip Files."

Successful Quality Improvement and Compliance Experiences Shared by Illinois Hospitals

The experiences and successes for achieving compliance with LVF assessment for HF are presented below from hospitals representing a variety of characteristics and locations throughout Illinois. The Illinois Hospital Association appreciates the efforts of these

hospitals in sharing their experiences with others and also the sharing of contact names at each hospital for additional follow up questions or discussions.

Some common and unique success factors or strategies include:

- Developing and implementing heart failure experts
- Incorporating quality efforts into the organization's culture
- Ongoing monitoring by utilization review with physician contact
- Concurrent chart review.

Sarah D. Culbertson Memorial Hospital

Located in Rushville, Illinois, Sarah D. Culbertson Memorial Hospital is a small and rural hospital that recently converted to critical access hospital status. Lynn Stambaugh, R.N., B.S., Director of Quality Assurance/Utilization Review attributes that their small size contributes in part to their success with the heart failure core measures. "Our numbers are small and we see and treat few patients...we have to get it right, it is the standard of care," states Stambaugh.

Being a small facility, Stambaugh performs multiple functions that aids in reaching the high compliance with the care standards. Stambaugh states, "As the director of utilization review, I am alerted to when patients with CHF (congestive heart failure) are admitted to the hospital. I routinely review the patient's medical record to determine whether left ventricular function (LVF) has been ordered and results documented in the chart." This concurrent review is most effective when done early on in their hospital stay. Stambaugh works with the Medical Records staff to determine LVF assessment history and ensure documentation of diagnostic tests. "When test results are available, I'll remind doctors to include this in their dictation. It is important to meeting the standard of care." Culbertson Memorial Hospital also has standing CHF orders that include LVF assessment.

Reporting performance measures is critical to Culbertson Memorial Hospital's successes. Stambaugh reports monthly to the medical quality assurance meetings and the medical staff meetings. "It is also a good time to review and remind our physicians of the standards of care." Core measure results are also shared with the nursing staff. "It's automatic, nurses know when a patient with CHF is admitted what to do, they know the standards of care, it benefits the patient." Contact: Lynn Stambaugh, R.N., B.S., Director Quality Assurance/Utilization Review at lynnestam@frontiernet.net.

Advocate Christ Hospital and Medical Center

Advocate Christ Hospital and Medical Center is a large tertiary teaching facility located southwest of Chicago in Oak Lawn, Illinois. Marc Silver, M.D., Director, Heart Failure Institute relates the long history of commitment to improving the clinical treatment of patients with heart failure. "Hospitals now part of the Advocate System were looking at heart failure closely in the early 1990's, before the hospitals came together as a system. We created a document for the standards of care for heart failure patients."

Today, the commitment continues, as heart failure is included in their Performance Excellence program. As part of the program, heart failure is a clinical measure regularly

and widely reported. “Heart failure is one area included in our dashboard,” relates Dr. Silver. With the dashboard, “Everyone gets to look at it, everyone is aware of how we are performing with the standard of care. Every month the quality data is reported out and discussed in the different areas of the hospital and with the primary care physicians.”

Another important intervention to come out of the Performance Excellence program has been the development and implementation of “heart failure experts.” “We have implemented at all the system hospitals heart failure experts, a nurse, someone who ‘owns’ the issue. These nurse experts work with and educate the staff and patients. The nurses work collegially with the physicians helping the MDs implement the care standards, sometimes prompting them about the use of ACEI and assessing and recording ejection fractions.”

Dr. Silver believes that real improvement results from “building it into the organization’s culture. You don’t want to put the burden on just 1 or 2 people responsible for quality measurements; you have to make it everybody’s business. We accomplish this in many ways, for example through educational symposia, by talking to different areas, by meeting with individual physicians.” Dr. Silver shared it is important to “bring physicians into the loop, make them part of the process. We need to communicate what we are doing, so everyone recognizes the treatment standards for heart failure, that it benefits the patients, it is the right thing to do!”

Dr. Silver fills the crucial role of “physician champion” in the heart failure improvement efforts. Dr. Silver states, “As the physician champion, I am part of the team, one of the team members, I am there to support the team.” Dr. Silver gives an example, supporting the nurse experts. “We want the nurse experts to interact with the treating physicians, sometimes assertively. As champion, the nurses need to know I’ll stand behind them and support them when they take action.”

Dr. Silver identified several barriers to improvement that are probably common to all hospital environments. Dr. Silver’s first concern was with the nurse experts informing and educating the patients about their heart failure and some physician’s reluctance to this practice. “We have come a long way in telling the patients about their disease. They are better informed now and better able to participate in their care. We need to get across to some of our physician colleagues this is the right thing to do... that this is going to be the future practice... and they could be part of it and help us in the efforts.”

Another barrier relates to emergency admissions. “About 80-90 percent of the heart failure patients are admitted through the emergency area,” relates Dr. Silver. “We need to reduce the variability in how we treat heart failure in the emergency area.”

A final barrier discussed related to change in practice of medicine and physician independence. “Care standards and guidelines have reduced the variability in care from what we saw 5 to 10 years ago and that is good,” states Dr. Silver. “However, some physicians see these order sets and guidelines as taking away their independence and creativity. The guidelines are meant for the average patient case, but not all patients will

be the same and there is still opportunity for physicians to be creative when meeting the needs for special patient cases.” Dr. Silver concludes with an interesting observation and concern, “Order sets describe what to do clinically for the patient...do these things, these are the right things to do for the patient. What order sets don’t do is tell you what not to do! We need to know what do *and we need to know what not to do.*” Contact: Marc Silver, M.D. Director Heart Institute, Advocate Christ Hospital and Medical Center at marc.silver@advocatehealth.com.

LVF Assessment for HF Web Based Resources

See Appendix I. for additional resources for LVF assessment for HF. For a comprehensive list of web based resources for HF, see [Heart Failure Web Based Resources](#) 8/13/04 on the IHA web site.

Future Series

September 03	ACEI Prescribed at Discharge (HF-3)
September 24	Pneumococcal Screening and/or Vaccination (CAP-2)
October 15	Antibiotic Timing (CAP-5)
November 05	Oxygenation Assessment at Arrival (CAP-1)

For additional information about LVF assessment for HF, the Ten National or Starter Measurements, or to comment on this series, please contact Tim Philipp, Director, Quality Improvement at tphilipp@ihastaff.org.

APPENDIX I. Heart Failure (HF) Resources

Frequently Asked Questions – (FAQs)

FAQs often reflect the insights and concerns of hospital staff involved in clinical care and data collection. Use *FAQs* as your first source to answer clinical and data related questions. *FAQs* are also an important educational tool for novice & expert. A search of:

- *LVF and HF* returns 62 results addressing clinical situations about different diagnostic tests, time of timing, and documentation concerns.

To review *FAQs* or to ask a new question, go to: www.medqic.org, locate on top and click on “Heart Failure”, click on “*FAQs*”.

American Health Quality Association – (AHQA)

The AHQA web site lists three hospital projects related to LVF assessment for HF. Contact names are provided. Locate these projects under the states of Iowa, Maryland, and Minnesota. To view these project descriptions, go to: www.ahqa.org, locate “Quality Improvement in Action”, click on “state” then locate by state.

The Minnesota project examines a collaborative of critical access hospitals to improve heart care. The contact name listed provided the final report in a second collaborative just completed June 2004. Some of the system changes listed in the report include:

- Use of standing orders
- Increased use of care planning
- Including a broader array of healthcare groups not previously involved.

The report describes additional system changes, challenges/barriers, and lessons learned.

Illinois Foundation for Quality Health Care (IFQHC)

The IFQHC is the Medicare Quality Improvement Organization (QIO) for the State of Illinois. The IFQHC recently conducted a Rural Initiative to Promote Quality Improvement with Heart Failure. The initiative, focusing on the unique factors inherent in small and rural hospitals, sought to increase compliance with core measures by changing “organizational systems and process.” Key strategies used to affect positive change and improvement included:

- Identifying opportunities through:
 - Conducting root cause analysis to examine care processes
 - Mapping entire care process including filing and obtaining test reports (echo’s and LVF assessments)
 - Increasing participation of direct care staff in identifying barriers and recommending and implementing process changes
- Promoting multidisciplinary coordination case managers and echo staff in retrieving tests reports, placing in the current patient record and communicating with physicians
- Implementing “mini grand rounds” to facilitate necessary patient care communications.

A primary goal in the initiative was to implement sustained change by focusing on systems and process that automatically “triggered” positive and desired responses in care activities. For additional information, contact Darren Barnes, R.N., Provider Liaison or Diane Land, Provider Liaison, IFQHC at (800) 386-6431.