**Organization:** Johns Hopkins Bayview Medical Center

**Solution Title:** Establishing an Evidence Based Practice Patient Education Program

**Program/Project Description, including Goals:**

*What was the problem to be solved? How was it identified?*

Multiple studies reporting costly preventable readmissions prompted the Centers for Medicare and Medicaid’s (CMS) to stipulate hospitals will no longer be reimbursed for readmissions occurring within 30 days of discharge for same illness. The Johns Hopkins Healthcare System (JHHS) responded to this mandate as an opportunity to optimize patient outcomes while improving utilization of resources for patient care, instituting a system-wide Transitions of Care (TOC) initiative. Each hospital within JHHS was charged with implementing seven strategies to reduce avoidable admissions, Johns Hopkins Bayview Medical Center’s (JHBMC) Progressive Care Unit (PCU) was appointed to implement an effective patient education initiative.

*What baseline data existed? What were the goals—how would you know if you were successful?*

In preparation for the Maryland Health Services Cost Review Commission’s (HSCRC) Admission Readmission Revenue (ARR) program to implement hospital pay for performance based on readmissions on July 1, 2011, Bayview’s baseline was placed third highest Medicare readmission rate in the Maryland and above National average for CHF readmits. With 750 annual admissions for HF in fiscal year (FY) 2010, there was a 27.4% readmission rate for patients compared to the nation’s best hospitals’ rates of 17% (Parak, 2010).
The strategies model was developed by the JHHS Readmissions Task Force, led by Amy Deutschendorf, Eric Howell, and Mary Myers.

Measurements established and tracked for comparison, as presented by Lean Sigma Director, Laura Winner, 2012.
Process:

**What methodology or process was used to develop the Solution?**

With the services of the Lean Sigma consulting group Bayview launched an Armstrong Institute for Patient Safety and Quality project in the form of a CHF Collaborative. Numerous initiatives cascaded, coinciding with the PCU Team’s education initiative. The Team set off on a review of the literature to address staff-voiced concerns and questions, Evidence Based Practice (EBP), and validated tools that could be incorporated into a teaching program targeting the ten most frequent diagnoses of patient admissions. The Transitional Care Model was identified as a key component contributing to the significant reduction of avoidable readmissions, in concert with Teach Back methodology, health care literacy principles, and post-discharge elements (Vance, 2011).

Solution:

**What Solution was developed?**

In accordance with the Scope and Standards of Nursing Practice (ANA, 2010), nurses educate their clients as a routine part of care and management. Collaboration, a crucial mechanism to the process, necessitated such elements as: consistency of content, uniformity in assessment and evaluation measures, reliably efficient means of communication, and ways to eliminate barriers to workflow and time management. Training was essential to implement the Teach Back method for closing the communication loop with learners to enable their self care management and efficacy. Searches of the literature and resourcing the expertise of colleagues within Bayview, were necessary to implement changes in practice. Utilizing the open-ended Teach Back technique, the nurses provided education and followed with key questions to verify
their understanding of information taught. The key questions close the loop of understanding and assist with determining the focus of education going forward.

Implementation of the Teach Back technique has been validated as a reliable means for effectively closing the loop with the patients and families, as the learner repeats back content in a manner that can be evaluated (DeWalt, Callahan, Hawk, Broucksou, Hink, Rudd, and Brach, 2010). The Self Care Heart Failure Index (SCHFI) tool was developed to assess Congestive Heart Failure (CHF) patients’ ability to care for themselves, thus, identifying needs or risks (Reigel, 2009). For example, the SCHFI assists in identifying a patient that may benefit from a free scale and medication organizer prior to discharge. Updated heart failure TIGR video presentations were made available for patient viewing on in-room television. As a result of the Collaborative, the “Thriving with Heart Failure” booklet was published as the standardized
content included in a packet designed for take home for high risk CHF patients. Electronic tablets loaded with interactive CHF education programs were added for distribution among patients. Colorful take home CHF-Zone magnets were developed for patients to easily identify the warning signs when they should call their doctor, before a hospital visit is needed. A new Meditech heart failure teaching documentation bundle was developed for easy accessibility to detailed teaching records that are efficient and less time intensive for nursing. Transition guide nurses were introduced as a patient resource for at-home visits upon discharge.

How was it implemented?

Since CHF was identified as the most frequent readmission diagnosis for PCU, the initial CHF instruction format for the institution was used as a model to develop Teach Back guides for other disease related patient instructions. Krames and Healthy Directions patient instructions were used in accordance with existing objective-directed teaching plans. A set of topic related teaching materials were placed in ready to use packets located in files in each hallway for easy access in patient care areas. In the context of its Self Care Model, the SCHFI was used as an assessment tool to determine related risks and knowledge deficits. Easy to use preloaded electronic tablets, on-demand videos, and special literacy aids have been offered to patients in addition to distributed printed resources. This nursing process has necessitated the collaborative communication and participation of each unit staff member, as well as the expertise of the inter-disciplinary team.

Measurable Outcomes:

What are the results of implementing the Solution? Provide qualitative and/or quantitative results to data. (Please include graphs, charts, or tools).
As a result of our efforts PCU has a significant increase in service excellence scores for two quarters after implementation of the patient education program. The PCU was in the green for two quarters after implementation and received the traveling trophy award from service excellence. The patient satisfaction scores for Instructions and Care at home increased significantly. The baseline Press Ganey score was 80.3 in April 2011. The score continued to trend up monthly to the highest mean score of 92.7 in the following November. PCU patient satisfaction scores have remained above 85, with a measurable decline in readmissions. While other strategies have contributed to the success, patient education has been an integral part of the initiative.

Sustainability:

*What measures are being taken to ensure that results can be sustained and spread?*

At this writing, PCU been recognized with the greatest reduction in readmissions for all of JHBMC and JHH, crediting patient education initiatives as a major element to this success of discharge readiness. Multiple educational strategies have continued to evolve on the PCU. The development of a COPD self care tool, motivational interviewing skills, and expansion of core-
measure driven education are a few of the refinements added to this continuum of daily patient education. Random audits of the Meditech teaching bundle reveal usage and compliance.

![Johns Hopkins Bayview 30-Day All Cause Readmissions by Fiscal Year](image1.png)

Readmissions are tracked hospital-wide. The electronic tablets are refurbished devices can now be populated with patient identification for accurate tracking and measurements. Press

![PCU 30-Day All Cause Readmissions by Fiscal Year](image2.png)
Ganey surveys continue provides valuable feedback including patient satisfaction as it relates to the education they received during their admission, once they leave the hospital.

**Role of Collaboration and Leadership:**

*What role did teamwork and collaboration play in the Solution? What partners and participants were involved?*

There have been many partnerships that contributed to the success of the educational segment of the transitions of care initiative, and continue to create new and exciting approaches to education in our unit. The Heart Failure clinic collaborated with the education committee to develop the heart failure booklet, and the take home magnets. Our Librarian at the Harrison Medical Library has guided the education committee well in our literary searches. Each person on the unit has a role to play in facilitating educational opportunities for our patients. In addition to the CHF Collaborative, the PCU has modeled the consistent implementation of daily rounds of an interdisciplinary team that is highly involved in facilitating effective patient communication. It is this team that orchestrates the various facets of risk stratification, safe discharges, and linkage with Transition Guides or outpatient services.

*Was the organization’s leadership engaged and did they share the vision for success?*

Our Patient Care Manager, Elaine Gittings, has been supportive and interactive in the education committee’s endeavors, often attending meetings. She has proved to be a resource suggesting avenues that might otherwise have been overlooked. A Hopkins nursing magazine published patient’s own stories of the benefits the received from our education initiatives. Elaine assisted with the set up and photo session on our unit allowing for a realistic interview with one of our patients on the PCU. Carol Sylvester has facilitated inter-department support at every level, with the involvement of Directors of Nursing and Executive Administrators.
**How was leadership support demonstrated?**

Our unit and its educator leadership have been recognized with multiple awards. Administrative and managerial leaders have been present and engaged from the beginning. More recent safety initiatives and quality measures bring our leaders and staff together, in a partnership sustain the increasing scope of patient centered improvements.

**Innovation:**

*What makes this Solution innovative? What are its unique attributes?*

The Moments of Excellence in Nursing was published featuring the accomplishments and benefits of the TOC Pilot. Members of our Team have presented at Nursing Grand Rounds; participated in training nursing orientees, preceptors, and charge nurses; Professional Practice Council. Bayview nursing has networked through Magnet Council and other work groups to break through learning barriers, equip patients or caregivers, and provide services to support patients’ growing efficacy with the tasks of self care management. Patient safety is at the core of this patient education strategy as every measure is directed at identifying and reducing risks associated with knowledge deficits or barriers to implementing self care measures. The design and intent is aimed toward replication. A poster presentation representing these initiatives was awarded with a financial grant at Bayview’s 2013 National Patient Safety event.

**Contact Person: Cynthia Lotz**

**Title:** RN  
**Email:** clotz2@jhmi.edu  
**Phone:** 410-550-0882

*Cited references available upon request.*
The Solutions selected to receive the Minogue Award for Patient Safety Innovation will reflect the following Award criteria:

- Be innovative
- Demonstrate measurable change
- Exhibit strong collaboration
- Exhibit strong leadership
- Advance the culture of patient safety
- Constitute a best practice with the ability to spread

Maryland Patient Safety Center’s 2014

SUBMISSION AND APPLICATION FORMS ARE DUE BY FRIDAY, NOVEMBER 8, 2013. Faxed or Mailed Solutions will not be considered. All Solutions must be received electronically.