

Heart Failure "Transition of Care" Model

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BACKGROUND

Heart failure (HF) is a major public health problem affecting over five million patients in the United States. It is the leading cause of hospitalization for people aged 65 and older, and hospital readmission rates are 25% within 30 days. Over the past three years, our HF readmission rates have equaled and even exceeded that of the nation. To address this, we opened an outpatient HF Clinic in 2009. Our initial results were significant; we achieved a 23% reduction in our HF readmission rates. That, however, was not enough to reach our readmission goal; therefore, we established a *Transition of Care* taskforce in 2010 to examine additional opportunities to reduce our readmission rate.

SETTING

This is a 437-bed tertiary care community hospital providing care to 700 to 800 HF patients annually. Over the past two years, our average 30-day HF readmission rate has been 26%. We have a multi-disciplinary HF Disease Management Program with a dedicated HF Unit, Outpatient HF Clinic, Health Link Telephonic Program, and hospital-based home health agency.

PURPOSE

The purpose of this project was to develop a multi-disciplinary continuum of care model to bridge the gap between the inpatient and outpatient setting, with the goal of reducing our 30-day HF readmission rate.

DESIGN/METHODS

We convened a rapid-cycle process improvement team consisting of members of our HF Team. Using the PDCA approach, we performed a GAP analysis of our HF continuum of care to identify opportunities for improvement. A protocol was mapped out on a flowchart and implemented in stages over the course of 2010.

The entire continuum of care was addressed from the emergency department (ED) through discharge to outpatient care:

Standardization of HF care and the transition process

- Developed HF Protocol for ED to include orders, baseline weight, response to treatment, patient education, and a documentation system that provided transfer of information from the ED to inpatient units.
- Developed a "transition of care" discharge plan to include an automatic care management consult, HF-specific discharge instructions, automatic HF Clinic follow-up appointments, and referral for post-discharge phone calls.

Improved patient education

- Developed patient-friendly education materials to include *Living with Heart Failure* book and *Take Control of Heart Failure* flyer.
- Incorporated "Teachback" into patient education process
- Initiated automatic dietary consult for HF diet education
- Provide an HF DVD resource as adjunct to patient education
- Implemented an HF Navigator position for patient education and review of barriers to self-management

Identified reasons for readmissions

- Implemented electronic process for identification and concurrent review of HF readmissions

Improved follow-up care and community resources

- Obtained funding for scales
- Revised Health Link Nurse telephonic protocol to a "transition coach" model
- Collaborated with local skilled nursing facilities and rehab
- Developed a free cardiopulmonary REACH program (**R**each, **E**ducation, **A**ssessment, **C**are for **H**eart Failure)
- Partnered with community primary care physicians to ensure adequate follow-up

RESULTS

The 30-day HF readmission rate was reduced by 45%, from an average of 26.9% to 15.7%. Results have been sustained for 5 consecutive months. This project also impacted both the medical care of and quality of life for patients with newly diagnosed or chronically suffering from Heart Failure. It:

- Provided a "bridge" to foster a successful transition from an inpatient setting to the successful management of HF in an outpatient setting within the community.
- Provided the tools, support, and guidance necessary to close the gap between acute and chronic care, while encouraging participation and self-care.
- Provided a necessary and invaluable resource to physicians and other providers within the community.
- Provided patients with the ability to actively take part in their healthcare, which is the very foundation of disease management programs.

