# The Patient Movement: A Doctorate of Nursing Practice Led Quality Improvement Project on Care Transitions for Patients with Heart Failure

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## Purpose

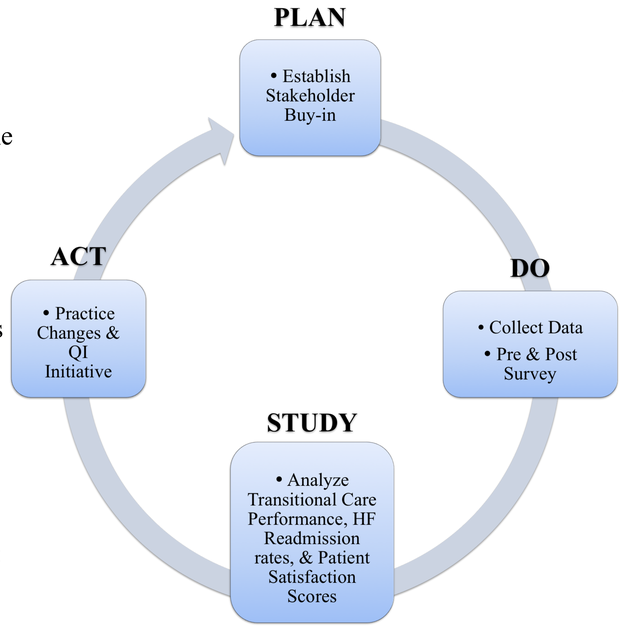
- **Objective:** The aims of this evidence-based quality improvement (QI) projected is to investigate the use of a Healthy Community Plan Framework (HCPF) to decrease 30-day rehospitalizations in older adults (≥ 65 y/o) who are diagnosed with heart failure (HF) by 20% through the implementation and dissemination of comprehensive discharge interventions by the transitional care team within 6 months at Mease Countryside Hospital (MCH) in Pinellas County, Florida.

## Background

- Heart Failure (HF) is the most prevalent complex condition that affects 5.7 million Americans.
- There have been adverse effects on quality of care and healthcare costs associated with HF readmissions.
- Hospital Readmission Reduction Program (HRRP) has imposed financial penalties on hospitals with excessive readmissions ratios that occur within 30-days of initial discharge for patients with specific conditions, like heart failure.
- Innovative strategies, such as safe transfers were designed to provide time limited services during the handoff of chronically ill patients between the hospital and home.
- Safe transfers for HF patients include five key-operating interventions:
  - ➢ Admission Assessment with Geriatric Principles & Values.
  - ➢ Timely Notification to the Primary Care Physician with a scheduled follow-up appointment.
  - ➢ Multidisciplinary Team Coordination with ongoing communication. Physician-Pharmacist
  - ➢ Collaborative Medication Reconciliation.
  - ➢ Arranging a Discharge Meeting with Transitional Care Coach.

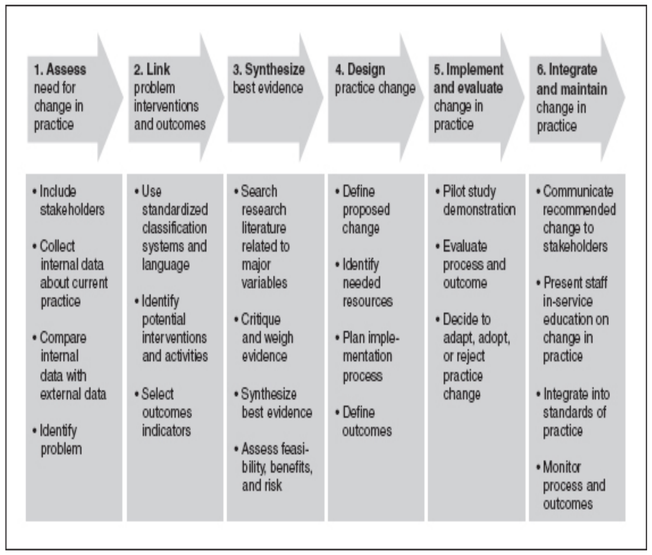
## Methods

- **Design**: The innovation of this practice improvement project utilized a quasi-experimental pre-test post-test design that targets modifying interventions that fill gaps at Baycare Health Systems through the implementation and dissemination of process improvement objectives within their transitional care program.
- **Sample:** 26 members of the Transitional Care Team.
- **Setting:** The current transitional care program, Enterprise Care Management Operations, at Mease Countryside Hospital (MCH) located in Safety Harbor, Florida, a hospital within the Baycare Health System: a non-for-profit healthcare organization in the Tampa Bay area whose value is to achieve healthcare excellence for the community.
- **Theoretical Framework: PDSA Cycle**

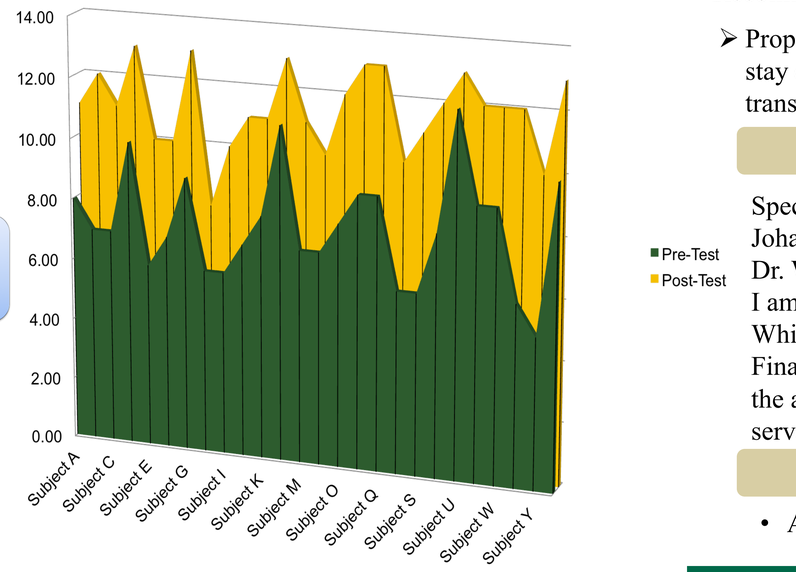



## Instruments

- **Conceptual Model: IOWA was used to guide this practice change**




## Results




## Discussion

- **Implications for Practice:**
  - ➢ A knowledge-focused trigger was identified at MCH with regards to current transitional care practices.
  - ➢ Implementation of an educational in-service illustrated an increase in the staff's knowledge and confidence level on the transitioning of heart failure patients.
- **Limitations:**
  - ➢ A limited sample size of $N = 26$ members of the transitional care team posed a challenge.
  - ➢ Limitations were offset by many strengths structured within the IOWA model, which can be used to effectively implement practice change at the unit or organizational level.
- **Project Feasibility:**
  - ➢ The implementation of interventions has a cost associated with the careful regard for disseminating a comprehensive plan.
  - ➢ This intervention, however can effectively be integrated into the workflow of the transitional care team which allows it to be put into practice without added clinical resources or hiring.
- **Recommendations:**
  - ➢ Proposals for future studies include the exact length of stay expense, transitional care fees, and savings for transitioning HF patient's home.

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## References

- Available on Request

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