Abstract 17

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Title: Enhancing Heart Failure Care; Collaborating Strategies for Improved Outcomes

Background:
Heart failure (HF) affects millions of Americans and costs the U.S. healthcare system tens of billions of dollars annually. The condition requires strategic management of care through a multidisciplinary approach. Closed-loop management system that allows for performance-driven planning with the end result in mind creates successful strategic plans that are in line with the organization's mission and vision.

Methods:
In late 2012, a large community health care system with multiple campus locations established a HF pilot program to explore, develop, and implement best practices. By late 2014 the pilot program was a success and spread to all campus locations. HF Coordinators were selected for each campus location to guide the new initiatives. Through the leadership and backing of the Vice President of Patient Care Services, a two year strategic plan was established by the HF coordinators to support the process of HF accreditation, ensure standardized evidence based care, and promote patient and employee education activities that improve patient outcomes. Monthly team meetings were conducted to review action plans, measurements, and status of each initiative on the strategic plan.

Results:
A total of 18 action initiatives were established and implemented across the campus locations. Through this process each campus has been able to identify and share their strengths and weaknesses while working collaboratively as a cohesive team. Utilizing the shared knowledge has allowed for improved compliance with patient daily weights, HF documentation, staff and patient education. Six new innovative ideas have been recognized and put into practice, which include improved electronic data collection through flow row development, a trigger for palliative care referrals, cost per case analysis, hotline phone number for patient questions, cause for ICU transfer analysis, and a four county regional HF symposium with nationally recognized speakers. A system and nursing policy on HF standard of care was established and implemented. These initiatives have led to improved quality of patient care demonstrated through improved; readmission rates, order set usage, daily weight (DW) compliance, and care transitions' enrollment. From the initiation of the HF team meetings in late fiscal year (FY) 2015 thru the second quarter of FY 2016, readmission rates have decreased on average by 5%, order set usage has improved by an additional 12 order sets on average per month, daily weight compliance has improved on average 19%, and care transitions' enrollment has increased on average 4%.

Conclusion:

Developing a multi-campus strategic plan for the care of HF patients has allowed for optimized therapeutic outcomes. This strategic planning process review provides preliminary evidence regarding how to direct long term high quality patient care through a team based approach. Ensuring quality care is a strategic weapon in a competitive battle for reimbursements. Multidisciplinary team based care has been well established as a standard for quality care and this analysis suggests similar results for the strategic planning process.