Abstract 5

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Title: Replicating a Successful Heart Failure Unit

Background:
825,000 new cases of Heart Failure (HF) are diagnosed each year, with an expected cost of $69.8 billion dollars in 2030. HealthPark Medical Center (HPMC) utilizes a HF unit to cohort patients in order to initiate best practices and ensure guideline directed care. This has significantly decreased readmission rates and increased core measure compliance. Due to increasing census demands and based on the prior model used at HPMC, more HF units were created in order to achieve similar success rates.

Methods:
Participants for this aggregate data review were patients who were seeking treatment for HF at HPMC and Gulf Coast Medical Center (GCMC). Units were selected at HPMC and GCMC to cohort the HF patients. Multidisciplinary team members were selected at each location. Participants include: a HF coordinator (team leader), nursing unit staff, case management, pharmacist, dietician, care transition nurse, cardiac rehab, and physical therapist. An attending cardiologist, hospitalist, and advanced providers also participate periodically. An education program was created and implemented for the team members. The team members met Mondays, Wednesdays, and Fridays. Each HF patient's care was reviewed and discussed focusing on: proper diagnosis, disposition, discharge planning, medical therapy regime and proper use of guideline directed care. Patient education was standardized and a communication tool was created to track patient's learning progress. The education communication tool was initiated with inpatients and forwarded across the continuum of care. Standardized depression screenings (PHQ-9) were conducted on all HF patients; results were communicated within the electronic medical record for use by the outpatient setting. An action plan was created for implementation based on the PHQ-9 score. Discharged patients were followed-up on with a phone call and a visit by care transition coaches: to assess the patients understanding of the education, re-assess for depression, and ensure compliance. The primary endpoint was a decrease in HF readmission rates.

Results:
A total of 218 patients between October 2013 and September 2014 (Fiscal Year (FY) 2014) were treated on the HF unit at HPMC. Pre-HF unit the 30 day readmission rate was 20%. After initiation of the HF unit readmission rates dropped to 10%. Cohorting the HF patients on a unit where staff had specialized training and a multidisciplinary team approach was used showed a 10% decrease in readmission rates. Of the 255 HF patients treated at HPMC and GCMC, 45 patients (17.6%) were readmitted within 30 days of discharge. Additionally, cohorting the HF patients increased the consults to the supportive care disciplines: palliative care, care

transitions, home health, parish nurses, cardiac rehab, hospice, skilled nursing facilities, rehab facilities, telehealth, tertiary care facilities, and the Mended Hearts support group.

Conclusion:

This aggregate data review provides preliminary evidence regarding cohorting HF patients and utilizing a multidisciplinary team approach with standardized use of guideline directed treatment. With this approach, significant reductions in readmission rates were achieved. According to our results it is very useful to create a HF unit for reducing readmissions, optimizing patient care, and improving quality of care. It is our opinion; this is achieved in large part by increasing disease process awareness, improving communication across the continuum of care, education, and the standardization of care.