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Research Paper

Improving quality of life and decreasing readmissions in heart failure patients in a multidisciplinary transition-to-care clinic

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ABSTRACT

Objectives: The purpose was to pilot the feasibility and impact of a 4-week transition-to-care program on quality of life for heart failure patients.

Background: The transition from the acute care to the outpatient setting has been shown to be a critical time with heart failure patients.

Methods: A pre- and post-test design was used. Quality of Life, measured by the Minnesota Living with Heart Failure Questionnaire, and hospital readmissions were the outcomes. A convenience sample of 50 persons was recruited into a multidisciplinary transition-to-care program for heart failure patients following hospitalization. Thirty-six (72%) completed the study.

Results: There was a significant improvement in quality of life. Men reported greater improvement in physical symptoms and less emotional distress when compared to women. Only 2 participants were readmitted within 30 days.

Conclusions: Study findings support improved quality of life and decreased readmission rates following a multidisciplinary transition-to care program for heart failure patients.

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Introduction

The incidence and prevalence of heart failure (HF) has increased dramatically in the past three decades. HF now affects approximately 5.7 million people in the United States and is the cause of more than 55,000 deaths a year; one in five people die within one year of diagnosis from HF syndrome.^{1–3} It has been estimated that HF affects 10 per 1000 individuals after 65 years of age, and 1 in 5 will develop it after 40 years of age.^{4–6} The most common risk factor of HF is coronary heart disease which is also considered the most costly medical condition in the United States.^{1,2,7} Common symptoms of HF are: shortness of breath during daily activities; trouble breathing when lying down; weight gain with swelling in the legs, ankles, or lower back; and general fatigue and weakness.^{1,2,8} The Heart Failure Society of America defines HF as a

syndrome characterized by high mortality, frequent hospitalization, reduced quality of life (QOL), and a complex therapeutic regimen.^{1,2,8,9}

Approximately, 20% of patients hospitalized nationally with HF are readmitted within 30 days.^{10–13} All hospital readmissions are expensive with HF considered one of the most expensive diagnosis costing approximately \$32 billion annually.^{6,10,11,14,15} Further it is the leading cause of hospital admissions and readmissions in persons older than 65 years.^{6,16,17} More than 2.5 million Medicare beneficiaries were hospitalized for HF from 2001 to 2005, and 1 in 10 died within 30 days of hospitalization.^{6,7} Since HF is one of the most costly diagnosis for Medicare, the Centers for Medicare and Medicaid Services (CMS) began tracking 30-day readmission rates in 2009 as part of the Hospital Readmission Reduction Program of the Affordable Care Act.^{6,18,19} The data for readmissions has been utilized to assess penalties to underperforming hospitals through the reduction of Medicare-based reimbursements by 1% in 2013, 2% in 2014 and up to 3% in 2015.^{6,19}

Previous literature has shown that HF patients often lack support from healthcare teams especially when transitioning from hospital to home.^{6,20} The transition from the acute care to the

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outpatient setting has been shown to be a critical time; patients are at high risk during this phase and are prone to exacerbations. Patients with chronic diseases such as HF and multiple comorbidities are particularly at risk for readmission.^{20–22} To address this problem for patients with HF, a variety of outpatient HF management and transitional care programs of varying lengths have been implemented nationally.^{1–3,6,9,11–13,17–31} The American Geriatrics Society²³ identifies transitional care as the “actions designed to ensure coordination and continuity of healthcare as patients transfer between different locations.” CMS has addressed this vital area of care management by adding Transition Care Management Codes (TCMs). These TCMs CPT 99495 and 99496 are intended to both reimburse for, and assist in, tracking follow-up care provided for patients following discharge from an acute care facility to their community setting.³²

It is recommended that transitional care begin during admission and continued through discharge. Transitional care programs have been designed to ensure continuity of care, contribute to clinical stability, improve patient outcomes, and reduce rates of hospital readmissions and related health care costs.^{20,23} Most transitional programs include the nurses' role in coordinating multidisciplinary referrals based on patients' needs, communication among the inpatient team, communication with homecare providers and developing and implementing care plans to include patient and family education, medication management/titration, and increasing patient's physical activity levels and functional capacity.^{20,24,33}

The hallmark of transitional care is that it is a time limited patient-oriented service. It helps to ensure continuity of care, reduces the risk of poor outcomes, and facilitates safety when transferring between healthcare settings.^{25,31} The transitional care goal is to complement, not to replace primary care, disease management, discharge planning or case management, by educating patients with chronic disease and their caregivers.^{25,31} Much research on transition-to-care programs focus on reducing medication errors, decreasing re-hospitalizations and length of stay, cutting overall costs, and lowering mortality.^{22,24,26–28,33}

In addition to hospital readmissions, quality of life and symptom management are important outcomes associated with transitional care programs.^{6,20,25,29,31} Despite optimal medical management, patients with HF experience a myriad of physical symptoms, emotional concerns, and may still have major impairment of functioning upon discharge.^{6,34–37} Transitional care programs have generally focused exclusively on hospital readmission. However, little research has examined the impact of these programs on managing the physical and emotional symptoms of patients with HF or on their quality of life.

There is some evidence to support the value of transitional care programs on quality of life in HF patients.^{6,20,25,29,31} Moreover, those who participated in transitional care had a better understanding of their illness, increased knowledge of medications^{20,29,33} and a reduction in the number of readmissions.^{6,20,25,27,29,31} Conversely, several studies of transitional care programs failed to document a significant impact on quality of life.³⁰ Seto and colleagues³⁷ identified from their research that some persons needed more time to master the complexities of HF self-management than was offered in the transitional care program, that is, patients, as with all people, learn at their own pace and at times need additional follow-up to understand what is needed for self-care.

Learning from these studies, and guided by the Stetler Model of research utilization to facilitate evidence-base practice,³⁸ we anticipate that an intensive, individualized, time-limited intervention has the potential to improve the quality of life in patients with HF. Stetler posits that linking research use and research-related actions forms a foundation for evidence-informed

practice. The purpose of this study was to examine the feasibility and effects of a 4-week transition-to-care program on quality of life in patients with HF.

Material and methods

Design

A prospective one group pre- and post-test design was used to address the study purposes. In this study participants completed the pre-test prior to beginning the 4-week transition-to-care intervention. The post-test was administered at the end of the transition program.

Sample

A convenience sample of 50 participants was recruited from a major Southern Healthcare System which had initiated a 4-week pilot transition-to-care program for HF patients following inpatient hospitalization. Inclusion criteria were 45 years of age and older, male or female, not pregnant, and with a primary diagnosis of HF. Exclusion criteria were 44 years of age and younger, pregnant, and a primary diagnosis other than HF.

Intervention

This 4-week, multidisciplinary, transitional program was specifically designed to provide weekly education and support to HF patients (see Fig. 1). The HF inpatient coordinator/navigator initiated the discharge protocol and collected data relevant to the appropriate HF measures. The patient was discharged to the outpatient transition clinic within 1–3 days where they began receiving comprehensive and individualized HF management. This program included weekly clinic visits with a multidisciplinary team consisting of a nurse practitioner or physician assistant, nurse navigator, pharmacist, social worker and dietician. At the first visit, the transition clinic personnel initiated a risk assessment, confirmed guideline management, determined if the patient was compensated or decompensated (managed this according to guidelines), and contacted the primary care doctor with a patient update.

The patient attended weekly sessions for 4 weeks. Each visit consisted of a physical assessment and evaluation which included vital signs, weight, assessment of volume overload by checking for lower leg edema, abdominal distention, and jugular venous distention, and assessment of heart and lung sounds by a nurse practitioner. Additionally, medication reconciliation was performed collaboratively between the nurse practitioner, pharmacist, and clinic nurse. The nurse practitioner had the patient provide a 24–48 h recall of their oral intake including food and liquids and reviewed logs of daily weights and blood pressure. The initial visit was 1 h and follow-up visits were 30 min. The clinic provider also initiated the following referrals as needed: rehabilitation, home care, hospice and/or palliative care.

All visits were grounded in evidence-based interventions aimed at HF management and focused on patient education, medication management (e.g. titration of beta blockers and diuretics), and assistance with coordination and delivery of care as needed per living arrangements. Patients also had access to phone triage Monday through Friday during office hours. The telehealth connection consisted of ongoing phone call follow-up for 3 weeks post transition clinic. After attending 4 weeks in the transition clinic the patient's care was coordinated and they were scheduled for follow-up with their primary care provider and or referred to cardiology or the HF Clinic for longitudinal care. This study was

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