REDUCING 30-DAY HEART FAILURE READMISSIONS WITH AN INTERPROFESSIONAL CLINIC FOR THE UNDERSERVED: AN INNOVATIVE PARTNERSHIP

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- This information or content and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by, HRSA, HHS, or the US Government.

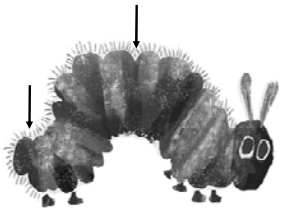
UAB Hospital: Practice

- Large academic medical center located in the medical district of Birmingham
- Two sites (the main campus hospital and Highland's campus hospital)
- 1046 bed facility on main campus
- 300 bed facility on Highlands Campus
- UAB employs approximately 2,500 registered nurses (2245 in staff nurses and 154 in leadership roles)

UAB School of Nursing: Academic

- As part of a research university and academic health center, shapes patient-centered healthcare by preparing recognized nurse leaders who excel as clinicians, researchers, and educators in Alabama, nationally and internationally.
- Offers baccalaureate, master's, and doctoral nursing education

Our Journey



Monthly Joint Meeting

Academic-Practice Partnership

- Mechanism to strengthen nursing practice and help nurses become well positioned to lead change and advance health
- Academic institutions and practice settings will formally address the recommendations of the Institute of Medicine Future of Nursing
- Create systems for nurses to achieve educational and career advancement

Heart Failure and Readmissions

- Heart failure is the leading cause of hospitalization among adults >65 years of age in the United States
- Annually, >1 million patients are hospitalized with a primary diagnosis of heart failure
- Accounts for a total Medicare expenditure exceeding $17 billion
- Admission rates following heart failure hospitalization remain high, with ≥50% patients readmitted to hospital within 6 months of discharge

Stevenson LW et al. Circulation. 2011; Cubbon RM et al. Circulation. 2011; Ross JS et al. Circulation. 2010.

Climate Leading to the Idea

- One in six Alabamians, or 18.1 percent of the population, live below the national poverty level compared to approximately 14.3 percent nationally
- Recent closure of the regional indigent hospital, Cooper Green, has created a critical access to care issue for this vulnerable population
- In 2012, UAB provided emergency department and inpatient care to almost 6,100 indigent patients

HRSA Heart Failure Clinic

- Idea—Create a nurse-led medical home for underserved patients with heart failure

Interprofessional Collaborative Practice Model

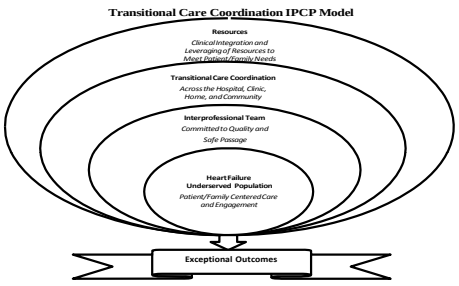
- "When multiple health workers from different professional backgrounds work together with patients, families, carers, and communities to deliver the highest quality of care"
- Interprofessional team-based care is care delivered by intentionally created, usually relatively small work groups in health care, who are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient or group of patients

(WHO, 2010)

Transitional Care

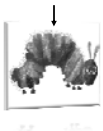
- Transitional care is the "sending" and "receiving" aspects of care
- …a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location
- Key principles include: providers communicate with each other, essential services are provided, caregivers involved in planning, clear instructions are given on how to manage their condition

(Coleman & Boult, 2003)



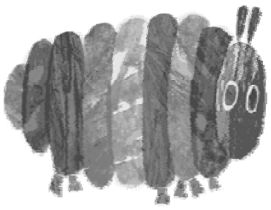
Grant Funding

- Health Resources and Services Administration: Nursing Education, Practice, Quality and Retention (NEPQR) Funding



Challenges

- Space
- Resources
- Policy and Procedures
- Processes
- Unanticipated Challenges



Clinic Space

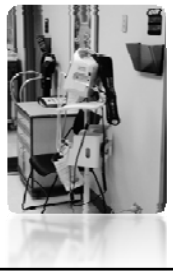
- Lost clinic space (existing clinic)
- Searched for 4 months
  - Potential space in Highlands campus
  - Potential space in Clinical Research Area
- Space located late October, but needed renovations
  - Hospital supported renovations

HRSA Heart Failure Clinic

- Clinic opened December 1, 2014

Resources

- Budget
- Furniture
- Equipment
- Medications
- Clinic Flow
- Laboratory Process



Budget

- Grant covers salary budget
- No budget

- Worked to create budget supported by the hospital for supplies and high risk medications

Furniture and Equipment

- Every Piece of Furniture
- All Equipment

- A brand new Physio-Control LP20e Defibrillator was approved for 2016 capital budget to replace the loaner.


Clinic Flow

- Since we were not part of an existing clinic, we had to create new processes for the clinic and we continue to refine them
  - Free Parking for Patients
  - Clinic Marketing


Laboratory Process

- No mechanism for obtaining labs
- Worked with Laboratory Department
  - Labwork resolved
- Continue to work on charge issues
  - Continuing to work with billing


Personnel-The Right Fit

- Nurse Practitioner
- Patient Care Technician

Current Staff

- Two Nurse Practitioners
- Clinical Nurse Leader
- Social Worker
- Collaborating Physician
- Patient Care Technician (August 2015)

- Integrating Students into the clinic (Clinical Nurse Leader and Nurse Practitioner)

Preliminary Program Results

- Overall Clinic Metrics
- Interprofessional Collaborative Practice Survey
- Patient Satisfaction Survey

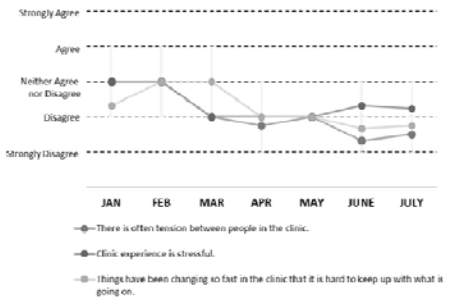
Preliminary Program Results

Metric (#)	June 2015	July 2015
Scheduled Patients – new and return	37	58
Patients Seen	29	34
No Shows	8	24
New Patients seen	4	10
Return Patients Seen	25	24
Established Patients	25	31
New Referral Received	5	17
Patients Denied	1	1

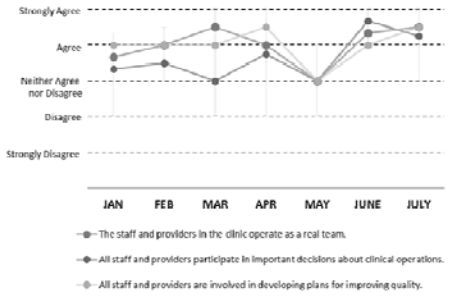
Preliminary Program Results

Metric (#)	Dec	Jan	Feb	Mar	Apr	May	Jun	July
New Referral App. Scheduled within 7 days of discharge	0	4	6	0	1	5	4	15
Clinic Patients Readmitted to UABH or ED	3	1	5	1	3	2	2	4

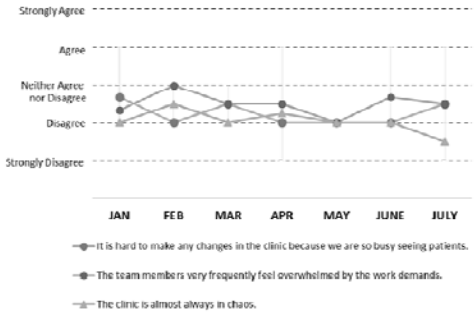
Preliminary Program Results Stress



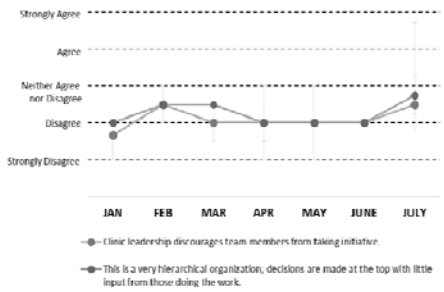
Preliminary Program Results Teamwork



Preliminary Program Results Workload



Preliminary Program Results Leadership



Preliminary Program Results Satisfaction

11. How satisfied were you with your visit?

Very Dissatisfied	0%
Dissatisfied	0%
Neutral	4%
Satisfied	26%
Very Satisfied	69%

There were a total of 118 responses to this question.

Preliminary Program Results Missed Appointments

2. Have you ever missed an appointment with this clinic?

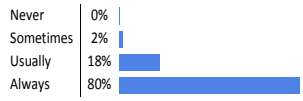
Yes	14%
No	86%

There were a total of 124 responses to this question.

If yes, why?
No transportation
transportation
no transportation
mixed up the day of appointment
Family problems
Family problems
Mixed up the day
car trouble
no way of getting here
Out of town and working
I was in the hospital.
Forgot which day my appointment was on.
Forgot
flat tire
no means of transportation
Tight schedule

Preliminary Program Results
Delivery of Information

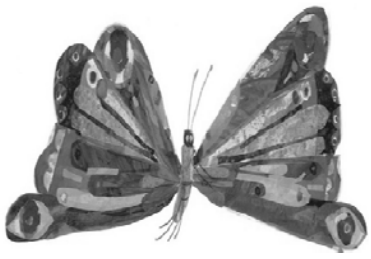
9. When you asked questions, did you get answers you could understand?



There were a total of 122 responses to this question.

Preliminary Program Results
Like Best about Clinic

Learning about my health condition more.
I was given all the information needed. I was also treated with the most respect. I feel the staff really cared about me and my health.
Very friendly and kind.
Everything
Friendly staff
Everyone was nice
They really try to help you.
Very friendly and caring
The care providers
Friendly and seem eager to help. Really care about my health and other issues
They were very helpful and respectful
Smiles
The quality of care
The appointment started on time Staff



Our Stories

- 39 year old male with a history of hypertension and DM Type 2 who was admitted December 2014 and diagnosed with HFrEF. His echo at that time showed LV EF 15%.
- Since his discharge 1/1/2015, we have followed him closely. Carvedilol and Lisinopril have been titrated to goal therapy. His currently NYHA Class I heart failure. Patient exercises daily doing a walk/run for 3 miles per day at local track and is working as barber. Repeat echo in June 2015 was essentially normal = Left ventricular ejection fraction = >55%. He was approved for Charity Care in May.

Our Stories

- 45 year old female admitted with respiratory failure, s/p trach with glottis and supraglottic stenosis
  - Discharged with HFpEF, HTN,DM, morbid obesity (>400 lbs.)
  - Discharged on 5 antihypertensives with no ENT follow up
- Seen in our clinic---set up with pulmonary and ENT
- Heart Failure and Weight Management Education completed, close follow-up
- Compliance with diet, lost > 150 lbs., Compliance with meds, only taking Lisinopril and Aldactone with BP well controlled, NYHA Class I, Hgb AIC 5.4 off all diabetes medications and now undergoing staged ENT procedures to reverse her trach.
- She just got her Medicaid approval so will be scheduling a repeat echo soon.

Our Stories

- Hispanic male with HFrEF secondary to ETOH
- Had no follow-up scheduled
- Family called and found our clinic.
- No ETOH currently, Tries to be compliant with medications, has difficulty with understanding, enlisted his son to help him ensure he gets correct medications and is now helping with pill box.

Lessons Learned-Partnership

- An academic-practice partnership is an effective framework for collaboration.
- Utilizing the talents of those in the partnership to the best of their abilities is key.

Lessons Learned-New Clinic

- Starting an Interprofessional Collaborative Clinic is hard work.
- Required skill set
  - Tenacity
  - Resilience
  - Adaptability
- Speak with the right people

Lessons Learned-Team

- A dedicated team with heart failure knowledge is important for success.
- To be successful, a team must learn to work together.
- It is difficult to overcome the many social determinants in this underserved population.
- Many volunteers have donated supplies, food, and funds for bus tickets and we thank them for their generosity.

Lessons Learned-Rewards

- Making a difference in the lives of these patients is our greatest reward.

Our Story Continues…….

Presenters

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