Ralph H Johnson VAMC Charleston SC H2H Working Group

Working group comprised of volunteers committed to our Heart Failure Patients. Members include Cardiology NP, EBP Nurse, Care Coordination Home Telehealth Nurse, Internist, Research PHD, Patient Care Manager, Geriatric MD, Cardiac Research Nurse, Education Nurse and Cardiologist

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Where to begin?

- We conducted a preliminary needs assessment on
  - How staff handle education related to medication and disease self-management
  - How providers perceive medication management
  - Discharge instructions and re-admission data that conflict depending on source
- It became apparent
  - That patient education was inconsistent and many times happened immediately prior to discharge and without confirmation of Patient understanding
  - Patient follow up many times did not take place as planned by the in –hospital team, within a critical time period, or addressing HF specific needs
  - We needed to identify administrative and clinical staff to support potential interventions in a systematic manner
  - Appointment making was complicated by varying staff interpretations of policy
  - More systematic data collection needs to be in place

Convening a Broader Team

- H2H working team
- Bedside Care Collaborative – systems design
- Patient Education Committee
- Patient Centered Medical Home Team
- VA Nurse Academy Students

Plan

- Obtain baseline data regarding knowledge and communication practices of patients and staff and assess what type of education and follow-up is being provided now
- Develop NP HF clinic, coordinated with Primary Care
- Implement proactive approach in engaging in – patients diagnosed with HF with a learning activation approach vital to self-management
- Draft proposal to support the development of an effective, Patient- centered intervention for HF team management

Goals and Desired Outcomes

- Provide opportunity to engage and activate patient in HF self- management
- Provide staff with a teaching plan that includes assessment, plan, intervention and teach back.
- Contribute to medical center redesign of discharge process and care transitions
- HF clinic to assist with timely follow up and interventions post discharge
- Eventually use what we learn to change process for other chronic disease management