Heart Failure Disease Management Program At JBVAMC, Chicago

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JESSE BROWN VA MEDICAL CENTER

- 200 bed acute care facility
- 4 Community Based Out-patient Clinics (CBOCs)
- 58,000 Veterans
- IN FY 2008 : 768 HF admissions- cost over $10 Million

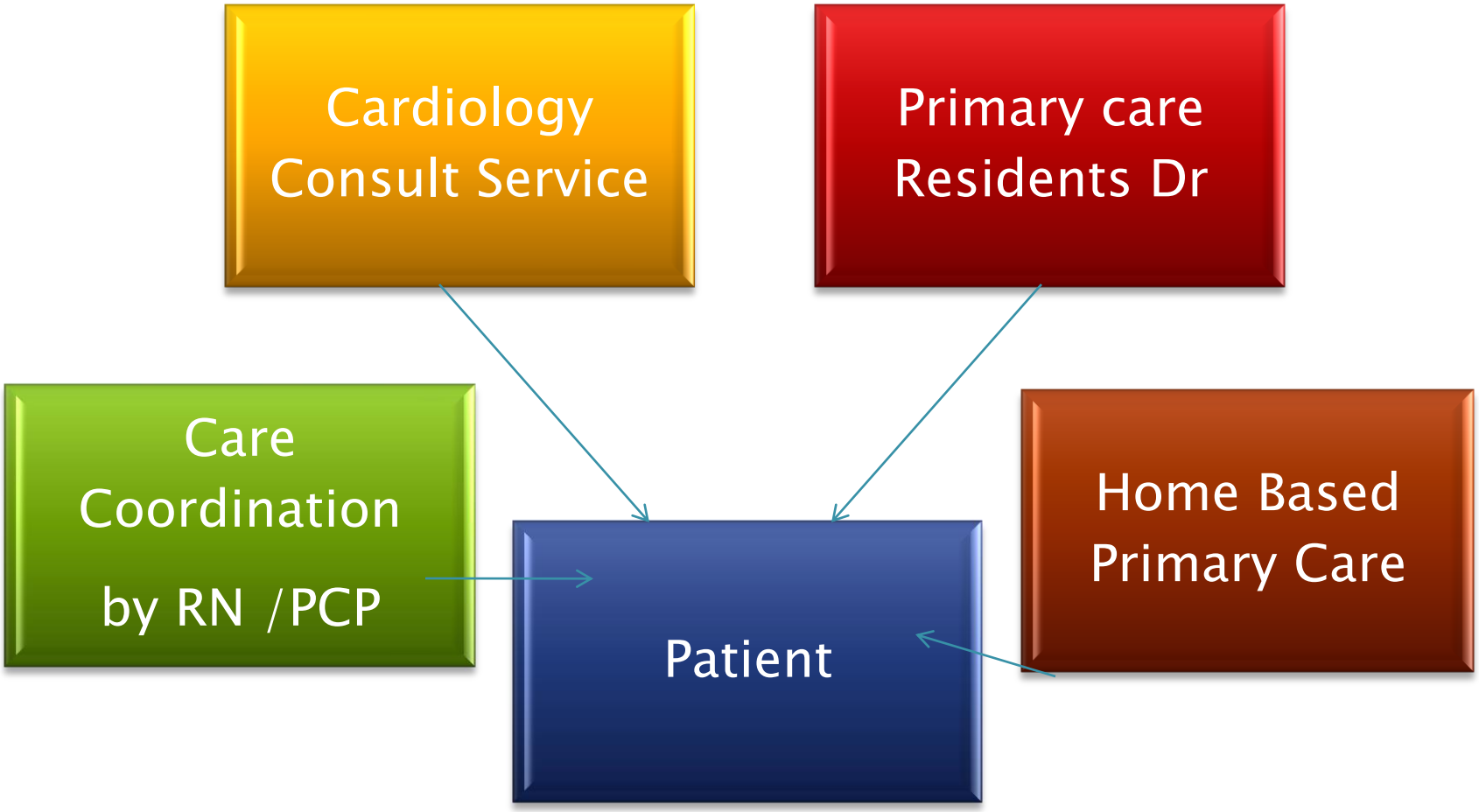
Readmissions occurrence:
- 29 within 0 to 2 days
- 121 within 30 days

Length of stay: 0-1 days /115 admissions

Problem Statement

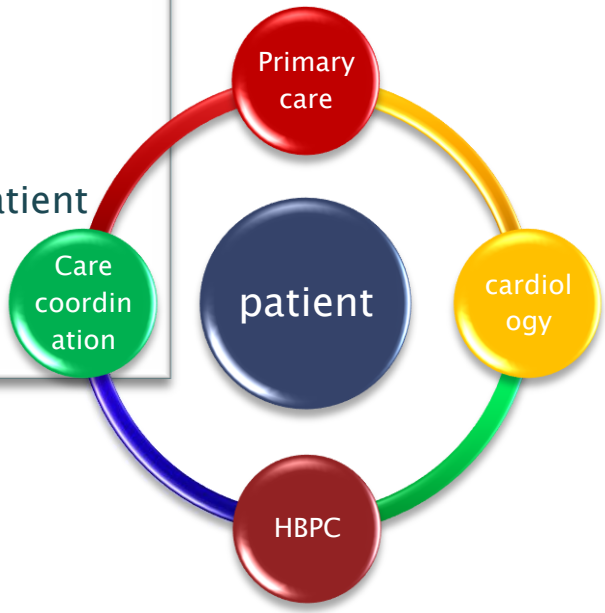
JBVAMC lacks a comprehensive heart failure disease management program (HFDMP) to meet the needs of veterans diagnosed with chronic heart failure.

Challenges: Heart Failure Resource Utilization



Purpose: Patient-centered care

- Overall goal : Implement comprehensive patient-centered Heart Failure Disease Management Program
- Standardize HF education through the hospital
- Implement a cardiology HFDM clinic (half a day due to limited resources) to see patients within 7 days of discharge
- Improve self-efficacy to reduce readmissions, improving quality of life, & functional status
- Ultimate goal is to develop a HFDM model that can be replicated at other VAs with similar resources and patient population.



Why HFDM program ?

HFDM programs

- reduced readmissions and hospital LOS
- improved health outcomes
- Improved self-efficacy, better quality of life, and function,
- greater patient satisfaction
- reduced healthcare costs (Krumholtz, et.al., 2006, McAlister, et.al. 2001, Watts, et.al, 2009 , Sochalski, 2009).

HFDM Out-patient clinic

- critical to success of HFDMP (Philips, Singa, et,al., 2005).
- In clinic person communication program achieved better results than tele-management program alone (Sochalski, 2009)
- Successful HFDM programs included : clinic follow-ups, telephonic program, and in-house follow-up by nurse practitioner (Kwok, et.al., 2008, McAlister, et.al, 2001, Naylor, et.al., 1999;).
- Reduced readmissions by 2.5%, and length of stay by 5.7% (Kwok, et al, 2008, Watts, et.al 2009)

Strengths

- Executive Leadership Support
- Chief of Cardiology and Chief of Medicine Support
- Electronic medical records
- Patient Administrative Services data base for QA/QI
- HF patients want it
- Providers want it

Opportunities

- Upcoming National QA/QI incentives / rewards to reduce HF readmission rates
- VA QUERI support
- National wave- health care reform
- JBVAMC signed for "H2H" initiative
- JBVAMC on magnet journey

Weaknesses

- Limited resources both personnel and financial
  - In-patient recruitment
  - Data tracking
  - In-patient/ out-patient education
  - Telephone follow-ups
  - Weekend coverage
- Patients may go to ED
- Lack of infrastructure to launch full HFDM program

Threats

- Cross over of patient enrollment between various programs
- Patient compliance may not improve due to socio-economic issue
- Complexity of HF disease and co-morbidities
- Poor patient support system

Process Objectives #1: Obtain input and support from key stakeholders in organization – Completed

- Assess need for HFDMP: June 2009
- Review of Literature : June 2009 – March 2010
- Approval for program obtained: December 2009
- Chief of Medicine, Cardiology & Chief of nursing meetings : January –Feb 2010
  - Developed Power Point presentation January –2010
- Multidisciplinary HF Committee formed

  – Chief of Cardiology, Chief of Medicine, Associate Chief of Medicine, Chief of nursing, Associate chief of nursing, Tele-health team, Home health nurse manager, Pharmacist, Cardiology nurse manager, Performance measures team, magnet coordinator, clinical nurse leaders, Hospitalist, CPRS team, Patient educator, psychologist, dietitian.
- VA Quality Enhancement Research Institute (VA QUERI) meetings : Once every 2 months

Process Objectives #2: Laying the ground work for clinic (DNP project)

- Collaborative Cardiologist Commitment obtained & Collaborative agreement signed: December 2009
- Space & equipment commitment obtained :March 2010
- Educational materials for the HF program being developed: May 2010
- Clinic protocol developed and signed: May 2010
- Electronic Consult set up – done– but will implement June 30th
- Tools: –decided

  Seattle risk stratification Tool ,
  Riegel's self efficacy tool ,
  Quality of Life Questionnaire, &
  6– minute walk test

- In–patient Staff training for patient Education – June 2010

Process Objective #3: Clinic Implementation – Start July 1, 2010

- Start Clinic: July 1, 2010
- Activate Consult: June 30, 2010
- Recruit in-patients with HF diagnosis : June 30, 2010
- Start discharge education (by RN) at time of hospital admission: June 30, 2010
- Flag HF charts and patient rooms to alert providers: June, 2010
- Start data collection using electronic medical records: July 1, 2010
- Stakeholder meeting every month for program input
- Revisions to program based on team input and quarterly data analysis.

Proposed Outcome Measures:

for the HFDMP clinic (DNP project)

- Improved self-efficacy
- Improved quality of life
- Increased functional capacity
- Reduction in 30 day readmission rates
- Decreased hospital Length of stay
- Decreased overall cost of care

Questions ?

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