

Impact of Transitional Care Interventions on Heart Failure Patients

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PURPOSE

To assess the effectiveness of transitional care interventions (TCIs) on the readmission rate of persons diagnosed with heart failure compared to the efficacy of standard discharge instructions (SDIs) provided persons diagnosed with heart failure on discharge.

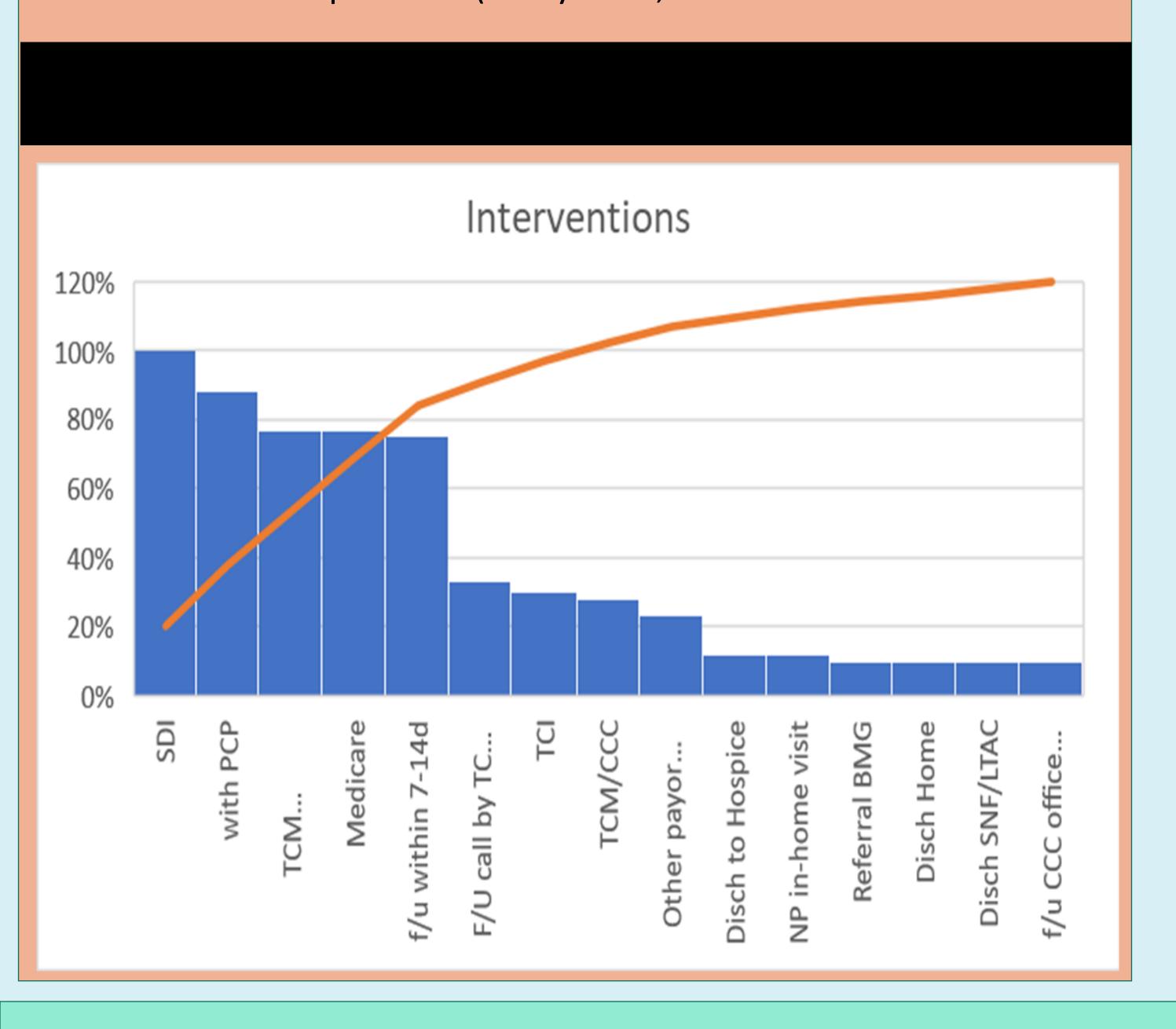
PROBLEM

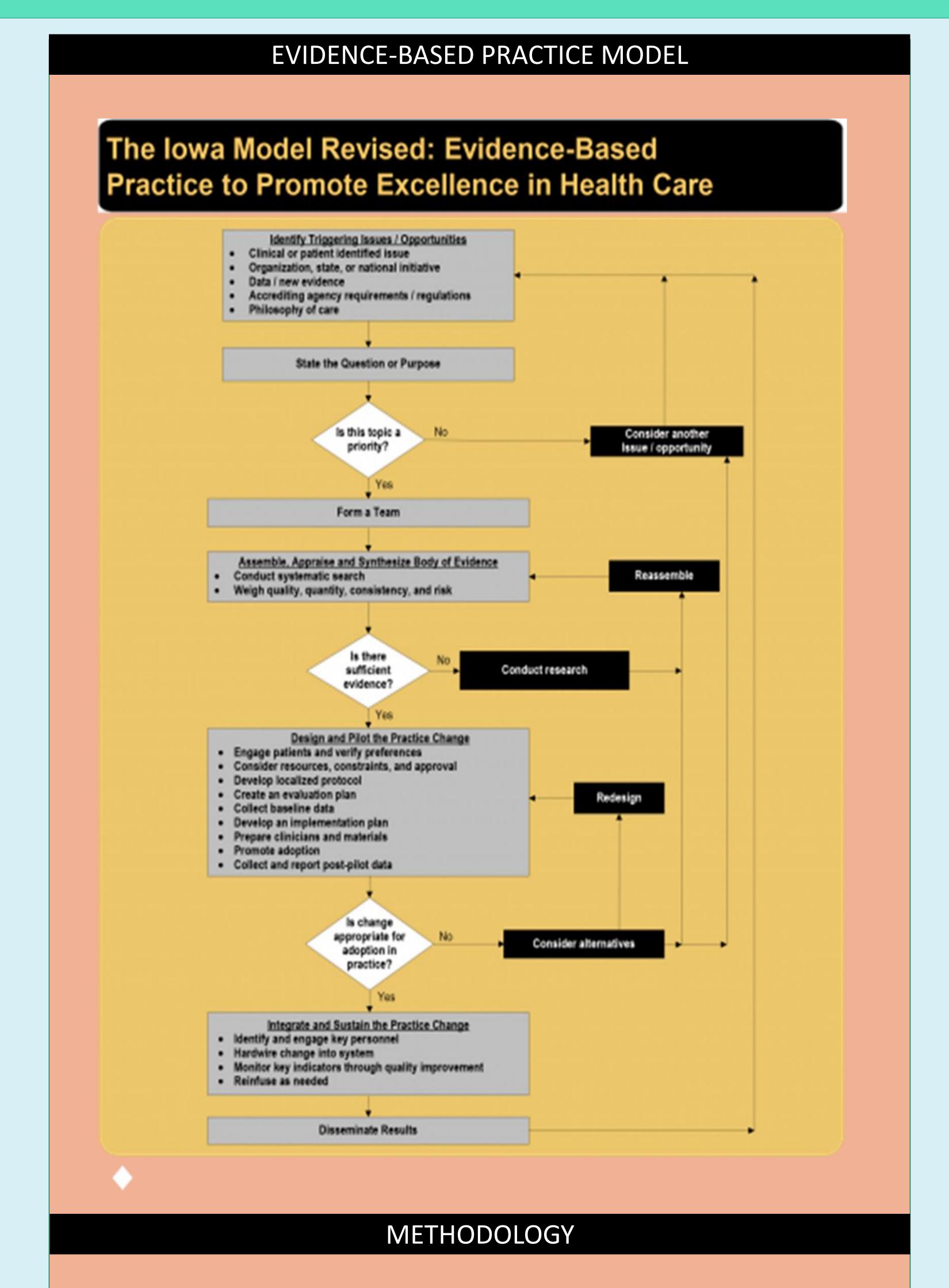
In the U. S., approximately 25% of patients hospitalized with heart failure (HF) return within 30 days of initial discharge. In southeast Mississippi, healthcare entities are experiencing the burden of increased health care costs associated with the 30-day readmission rate of persons diagnosed with heart failure.

ACC and AHA RECOMMENDED TRANSITIONAL CARE MANAGEMENT INTERVENTIONS

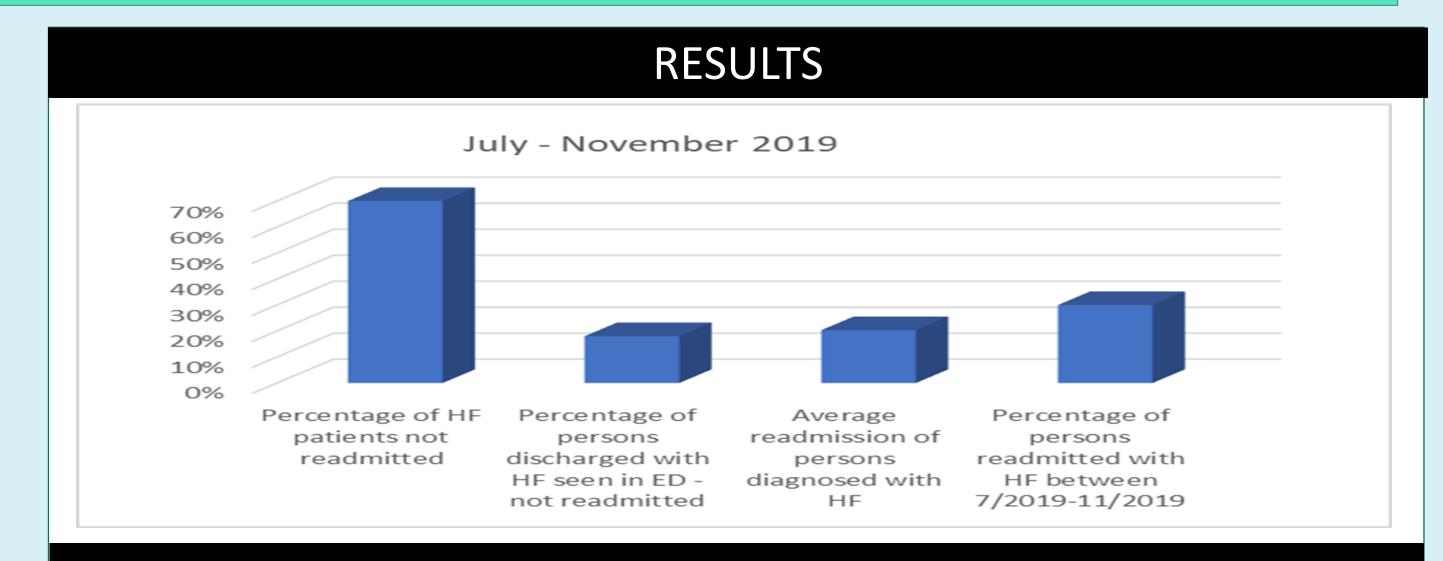
Multidisciplinary HF disease-management programs

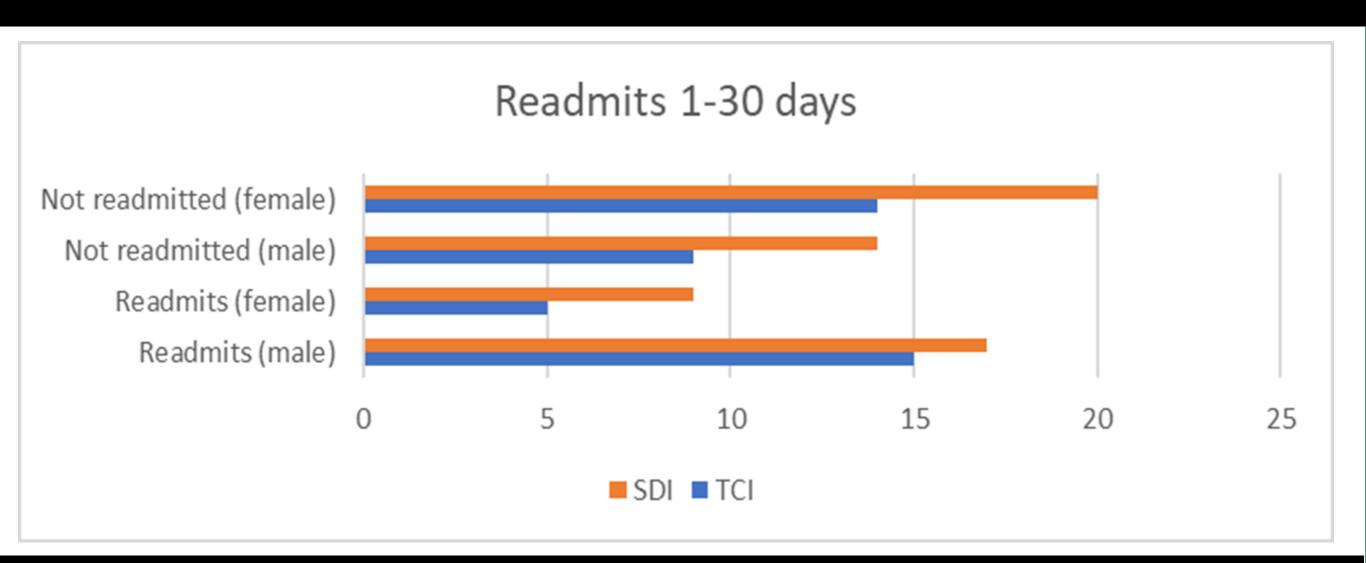
- Follow-up (face-to-face) within 7-14 days post-discharge
- Telephone follow-up within three days
- Guideline-directed medical therapy (GDMT)
- Use of clinical risk-prediction tools and
- Palliative or hospice care (Yancy et al., 2017

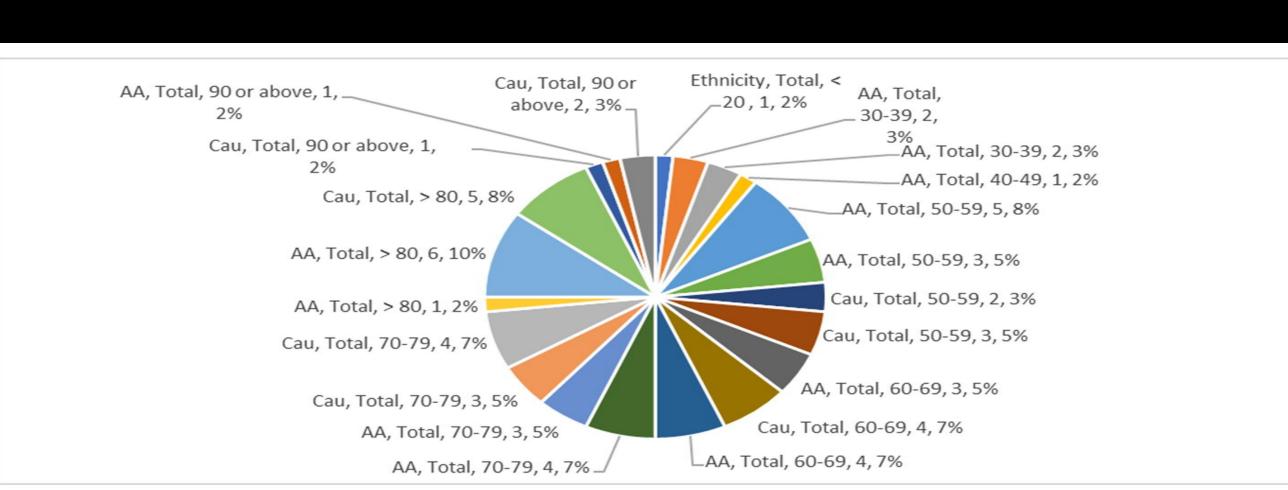


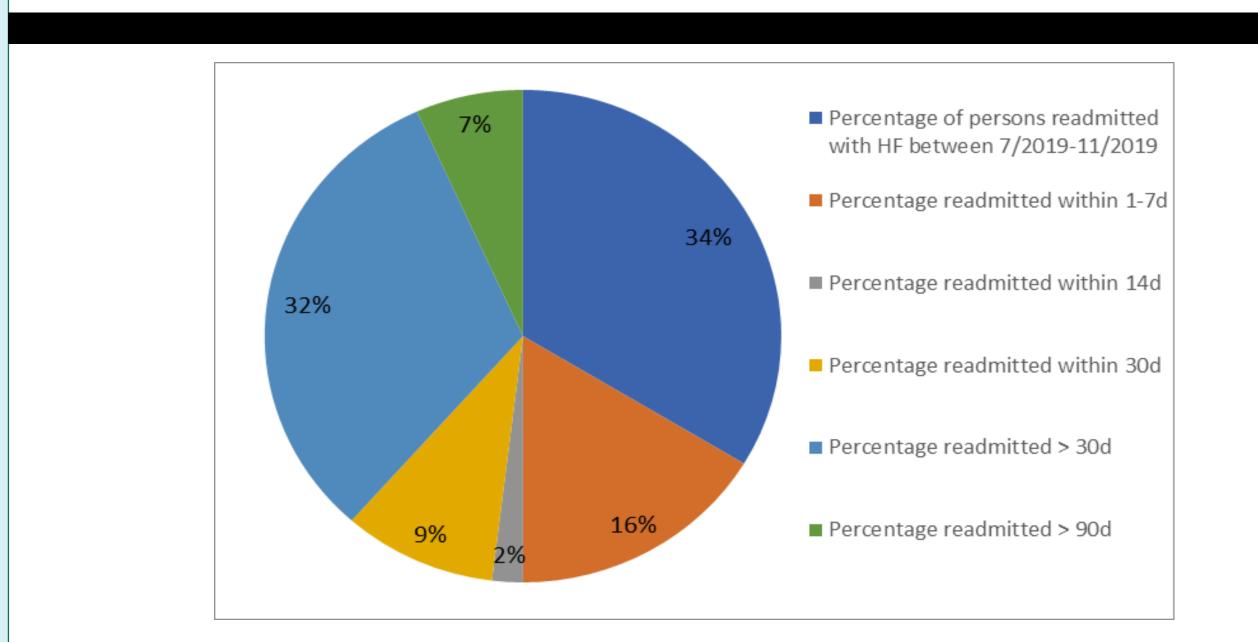


The Iowa Model for EBP was valuable in the conduction of the systematic chart reviews, performance of a gap analysis compared to the recommendation of the American College of Cardiology (ACC) and American Heart Association (AHA), the weighing of the quality of interventions, quantity, and the consistency of care provided to a person(s) diagnosed with heart failure.









RESULTS

Of the 111 electronic health records (EHR) reviewed, 60 were selected for inclusion in the statistical analysis (n=60). The number of persons readmitted in < 30 days of initial discharge with a diagnosis of HF was 18 (30%), with the reception of SDIs or TCIs. The number of persons diagnosed with HF that received TCIs at discharge was 43 (72%), and 100% (n=60) of the population received SDIs.