Hearts at Home:

Care in the Community

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Background

Renown Health had already established a heart failure program including:

- standardized in-patient teaching module
- standardized evidence based care plan
- published information guide
- yearly calendar to track and trend daily weight
- stoplight status for self-assessment
- four point teaching
- return demonstration plan
- refrigerator magnet reminder

An out-patient heart failure clinic and nurse navigator support the program from the acute hospital and outpatient settings.

This project reflects sixteen months of implementation of the heart failure teaching program into the continuum of care.

Project Aim

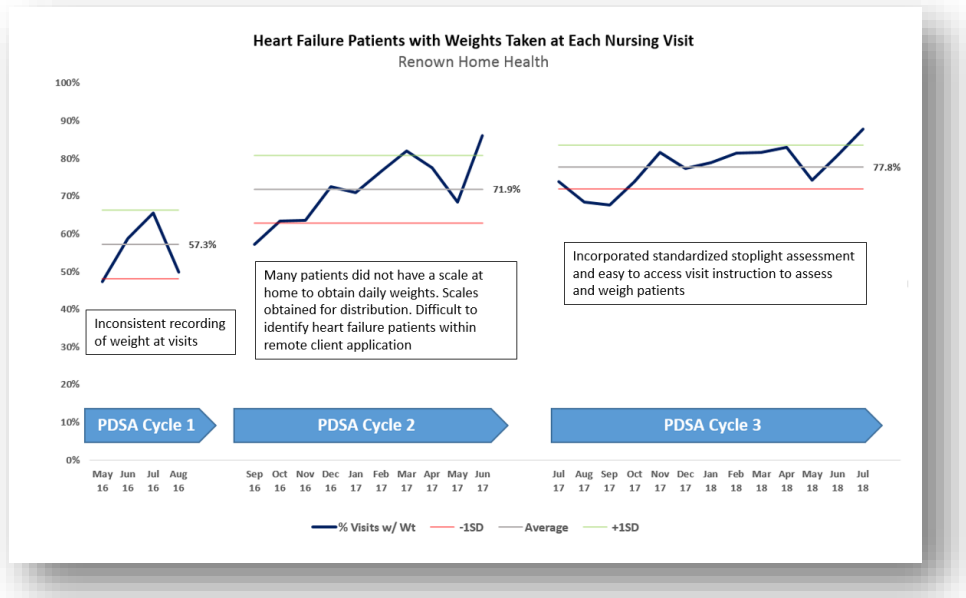
Our agency goal was to improve the health and well-being of our heart failure patients by integrating the established heart failure program into the home setting. Quality care for patients discharging to home health services with heart failure is supported across the continuum. We created a safety net of assessment, care planning, and interventions.

Barrier: For people who transitioned home with Home Health care, there was no structural framework for managing heart failure.

There was no reliable way to identify Home Health patients with a heart failure diagnosis. Patients with heart failure lacked consistent documentation of weight. Clinicians were not managing heart failure in a consistent manner.

Changes Made

- We developed a method to **identify heart failure patients** with home health- even if it was not their primary diagnosis.
- We provided **scales** to patients with heart failure.
- We **changed the electronic medical record** to document a heart failure stoplight assessment.
- We **created a community – wide treatment order set** for escalating diuretics, additional laboratory monitoring, front loading nursing visits, additional PRN visits as indicated, and paramedic support for in home intravenous diuretic therapy.
- We **measured progress**. We monitored staff compliance with obtaining weight with nursing visits, accurate stoplight assessment documentation, and escalation for patients when yellow or red status assessment was reported.



Outcomes

Home Health successfully integrated an established heart failure program into clinical operations. By creating standardized Home Health clinical pathways there has been an improvement in clinical documentation, clinical outcomes, patient participation in their care, and crisis intervention.

As a result:

↑ **75%**
Improved stoplight documentation

↑ **36%**
Improvement in documented weight with each nursing visit

↑ **33%**
More patient visits reported green stoplight status

At the end of PDSA Cycle 3, implementation of the heart failure care plan improved to 90%. This included scheduling PRN visits, flagging red stoplight status, and documenting weight with every visit.

Next Steps

Extend this approach to other disease states with similar parameters such as COPD.

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