HEART FAILURE DISEASE MANAGEMENT PROGRAM

A patient with heart failure is being discharged from the hospital. Heart failure is a condition in which the heart struggles to supply the body with oxygenated blood. Will the patient be readmitted to the hospital?

If that hospital is within the OSF Healthcare System, the answer might surprise you. An innovative and aggressive intervention effort, the Heart Failure Disease Management Program is working to reduce readmissions — to break the admit-readmit cycle for our patients with heart failure. The OSF Cardiovascular Service Line initiated this program in 2010 and made significant progress in 2011. In order to accomplish its goals, the program is focusing on improving the coordination between all health care providers across the entire OSF continuum of care, spanning both the inpatient and outpatient settings.

The positive impact of this program on patient care is anticipated to be the result of sharing quality and outcome data with physicians and other providers, as well as administrators. A disease registry is being developed and will allow health care providers to evaluate outcomes of the program and then make any necessary changes.

The Epic electronic medical record system will likewise play a key role in providing the data needed as evidence-based standards of care are developed. In addition, the data collected will allow OSF to benchmark with other health care systems across the United States.

And, of course, **OSF** *my*Health, the computer connection designed for patients (profiled elsewhere in this report), will permit patients with heart failure to monitor their own progress and connect with their physicians.

The future of the Heart Failure Program will involve more connections between patients and health care providers, including home health, rehabilitation specialists, skilled nursing facilities, urgent care, ambulatory procedure centers and hospice.

Heart failure clinics will also be an important future link between patients and their physicians.

Progress in Treating Heart Failure

Heart failure cannot be cured, but with treatment, patients can live longer and have a better quality of life. There is a growing number of patients with heart failure because people are living longer.

The initial results over this past year are very promising. Using the prior year's readmissions for heart failure as a baseline, early data for 2011 showed a decrease of 5.1 percent across the entire OSF Healthcare System — an encouraging start.

Details of OSF Response

The initial steps in the Heart Failure Program's "Hospital to Home" project are taken at the hospital before discharge and include ensuring an appointment is made before the patients leave the hospital to see their physician within five office days after hospital discharge. Patients receive interactive education, called teach-back, to ensure they understand what they were taught on critical components such as diet, medications, and when to call their doctor.

The Future ... Connections Are Extensive

According to Cardiologist Dr. Parker McRae, the systemwide physician champion for the Heart Failure Program, this effort will serve as a template for other chronic diseases. "The connections designed into this program focus on continuity of care," says Dr. McRae. "This will, of course, prove to be of great help for our cardiac patients, but will also become a valuable prototype for a variety of other chronic conditions."

Will the heart failure patient be readmitted? We hope not. Improving the coordination of care and connecting patients with heart failure to other health care providers across the OSF continuum of care should further reduce the need for patients to be readmitted to the hospital. Ultimately the connections being implemented in the OSF Heart Failure Disease Management Program will help patients with heart failure live longer and improve their quality of life.

SUCCESS AT THE REGIONAL LEVEL

The geography of OSF HealthCare is extensive, covering much of central and northern Illinois and the Upper Peninsula of Michigan. Recognizing the needs and resources are unique to each area, a regional system was developed in 2008. But commonalities were likewise recognized, leading to connections on important medical issues. The CV Service Line, and specifically the Heart Failure Management Program, illustrate that connection.

OSF St. Joseph in Bloomington has been a program leader as they established a process to review the monthly metrics and project components, such as five-day follow-up appointments and patient education. When targets are not met, action plans are developed and monitored.

Consistency has been a feature of efforts by OSF Saint James and OSF Saint Anthony, where an advance practice nurse (APN) sees all patients prior to discharge. OSF St. Francis in Escanaba has done very well on both outcome (readmissions) and process measures.

Our partners in improving care for heart failure patients may be separated by many miles, but hospitals and caregivers in the four OSF HealthCare regions have come together in a common commitment to learn and share.