Program shows success in implementing patient transition care processes

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Hospitals participating in the American College of Cardiology's Patient Navigator Program, showed significant improvement in implementing performance measures that help heart attack and heart failure patients transition from the hospital to home and keep them out of the hospital longer, according to research to be presented at the ACC's 67th Annual Scientific Session.

In the U.S., a high percentage of patients with heart failure and myocardial infarction (heart attack) are readmitted to the hospital after they have been treated. However, when patient transition care processes are implemented, the number of heart failure readmissions may decrease and in-hospital death after a heart attack may decrease, according to the research.

"Hospital readmissions are devastating to patients and their families, and patients who are readmitted have a greater chance of mortality. Additionally, readmissions take a heavy toll on our entire health care system," said lead study author Nancy M. Albert, PhD, associate chief nursing officer, Office of Nursing Research and Innovation at Cleveland Clinic Health System in Cleveland. "We were encouraged to see a trend toward decreased heart failure readmissions when process improvements were implemented. However, improvements won't happen automatically; strong support is needed by hospital leadership, staff, patients and all stakeholders."

When heart patients leave the hospital, they suddenly must manage their

own care. For some, there are no issues, but for many this transition can be overwhelming. For example, a typical heart patient may be required to take five to nine medications each day, at different times and in different doses. If patients don't fully understand or follow dosage guidelines, they are at risk for returning to the hospital. Additionally, many heart patients have other health issues, such as diabetes, high blood pressure and chronic lung disease, which can make managing their own care even more difficult.

Researchers evaluated what happened one year after implementation of the American College of Cardiology Patient Navigator Program—a transition-care improvement initiative at 35 acute care hospitals in the U.S. The study focused on 17 of the 36 program processes and researchers analyzed over 14,000 patients at baseline and 3,860 patients at one year who were hospitalized for heart failure or myocardial infarction.

Transition-care improvements included six processes of care and one outcome performance measure. After one year improvement was seen across all processes. Providers were:

- 2.2 percent more likely to prescribe a life-saving heart failure medicine, called a beta-blocker
- 7.4 percent more likely to schedule a follow-up appointment before hospital discharge to occur within seven days of discharge
- 4.4 percent more likely to review home medications at admission with their patients
- 0.2 percent more likely to review medications ordered at discharge with their patients
- 4.8 percent more likely to review medications at admission and discharge with their patients
- 8.8 percent more likely to educate patients about self-care and when to contact a provider

Regarding the one outcome performance measure, the study showed that after myocardial infraction, in-hospital mortality decreased from 4 percent to 3.7 percent.

Researchers will continue to study the transition care measures to learn the measures that works best, such as assessing two-year program outcomes to better understand how a hospital's commitment to quality efforts affects patient outcomes. In addition, other measures that were not included in the first report will be studied.

Due to the success of the first phase of the Patient Navigator Program, the ACC recently announced the launch of Patient Navigator Program: Focus MI. In the expanded program hospitals participating in the ACC's ACTION Registry have the opportunity to transform care by sharing successful strategies, mentorship and specialized tools and resources. In addition, 15 of the original 35 hospitals from the first phase of the Patient Navigator Program will focus on identifying best practices for improving patient care and readmissions, including 30 and 90 days follow up post hospital discharge - an increasing area of focus for proposed payment and reimbursement models.

Provided by American College of Cardiology