"A Transitional Care Model (from hospital to home to the community) for Patients with Heart Failure"

Nancy Roberts, MSN, RN

"A Transitional Care Model (from hospital to home to the community) for Patients with Heart Failure" seeks to improve quality of life, overall health status and care experience for these patients through delivery of a comprehensive transitional care model. The pilot project will evaluate the effectiveness of a comprehensive and high-touch transitional care model to be implemented across the continuum of care for patients with Congestive Heart Failure DRGs of 291, 292 and 293 who are admitted to Kent Hospital*.

Success will be measured through defined clinical outcomes, decreases in preventable readmissions, and provider and patient perception of care. These findings will be analyzed and compared to a group that does not receive comprehensive transitional care across the continuum. Secondly, ease of replicability will be examined to determine the feasibility of expanding the model to other diagnoses across the multi-hospital healthcare system, Care New England.

The Heart Failure Care Management/Transition Program Team will oversee the ongoing development and implementation of the pilot project. A multidisciplinary Specialty Care Team with clearly defined roles and responsibilities will provide all patient care and education. Furthermore, the Transition Program Team will report its findings and recommendations to the Care New England Care Management Advisory Committee. This committee, co-chaired by Nancy Roberts, has been charged with driving and developing care management guiding principles, standards and processes across care settings that promote clinical excellence, patient centered practices, and transformation from a fee-for-service to a value based system of care that targets at-risk populations while reducing preventable rehospitalizations.

* Since the application period for the Practice Change Leaders Program, Kent Hospital was chosen to participate in the CMS Bundled Payments for Care Improvement initiative (Model 2). The DRGs identified in the pilot are also included in the bundle project; however, this will not impact the pilot project goals and objectives or its ability to move forward.