

### **Heart Failure Resource Center (HFRC): Enhancing Quality of Life for Heart Failure Patients**

#### **The Challenge:**

**Congestive heart failure is the number one diagnosis-related group for hospitalization and consumes significant health care resources. Heart failure patients often demonstrate poor compliance with their care plans and recommended behaviors, leading to repeat hospital admissions.**

#### **The Goal:**

**Improve heart failure patients' quality of life by improving their self-management skills and reducing hospitalizations through nursing assessment and evidence-based practice.**

#### **An Innovative Solution:**

**The Heart Failure Resource Center at the Fuqua Heart Center of Piedmont Hospital in Atlanta.**

#### *Where To Learn More*

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#### **What It Is**

- A nurse-led system for developing outpatient care protocols and using them to improve patient care and outcomes. Two Advanced Practice Nurses assessed earlier outpatient programs at their hospital for heart failure patients and found them inherently limited in the numbers of patients that could be managed. A hospital-based outpatient clinic was developed to serve this large patient population and wide geographical area.

#### **What It Does**

- Led by Nurse Practitioners, physicians assist in development of patient care protocols; they are not present in the clinic but are readily available to consult.
- NPs assess and evaluate the patient's needs and response to care. NPs adjust and optimize medications to improve patients' status and relieve heart failure symptoms. If patients are mild to moderately decompensated at time of an HFRC visit, NPs intervene with IV diuretic therapy in order to avoid emergency room visits or hospitalizations.
- The team provides ongoing education for the patient, family and significant others, as well as early intervention and management of the patient's health status.
- The majority of HFRC patients are referred by their physician as part of their hospital discharge plan. Basic heart failure education and self care information is delivered before discharge; patients are sent home with comprehensive assessment tools to complete and bring to their initial HFRC visit 5-10 days after discharge.
- Patient progress towards being optimized on their medications and clinical protocols determines how often they come to the clinic for evaluation and follow up care. Care is based on evidence-based protocols developed by the multidisciplinary team and approved by the medical directors.

## Edge Runners



- For the most difficult cases, the HFRC can manage care using telemonitoring systems.
- Functions as an outpatient hospital service; considered a cost-neutral benefit for patients as the hospital has chosen to accept payment from payers and not pursue balances.
- A heart failure patient education booklet was developed by the nurses.
- Piedmont Hospital obtained Disease Specific Care certification in Heart Failure by The Joint Commission originally in 2004 and recertified in 2006.

### How It Stands Out

- Nurses work to the full extent of licensure and spend quality “face-time” with patients – enabling the clinic staff to build strong relationships and trust with patients and families.
- Hospital readmission 30 days after discharge for heart failure patients (DRG 127) treated by HFRC was 1.6% for fiscal year 2007, which was 75% lower than for patients not in the program. The national average for readmission 30 days after discharge for DRG 127 patients is 20%.
- Hospital readmission 90 days after discharge for heart failure patients treated by HFRC was 2.9%, vs. 10.4% for those not in the program.
- In fiscal year 2007, 85% of HFRC patients were on ace-inhibitor or angiotensin receptor antagonist therapy. Of those, 65% had their therapy optimized (i.e. the best possible dose for that patient). Research has shown that these medications help people live longer and decrease hospitalizations by blocking the effects of harmful stress hormones that make heart failure worse. They lower blood pressure and decrease fluid retention.
- Ninety-six percent of HFRC patients were on Beta-blocker therapy. Of those, 56% had their therapy optimized (i.e. the best possible dose for that patient). Of patients not on Beta-blocker medication, 3% were determined to be intolerant to the medication therapy.
- Anecdotally, nurses in the program are very satisfied with their ability to work to the full capacity of their licensure and to develop and deploy their expertise with heart failure.
- A newly established Heart Failure specialty unit was developed in the hospital, on the premise that standardization and increased clinical focus will drive evidence based care, improve patient compliance and outcomes and decrease length of stay.