

Development and Implementation of an Interprofessional Collaborative Practice Team at a Heart Failure Clinic

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PURPOSE

The Heart Failure Clinic described herein utilizes an innovative, interprofessional collaborative practice (IPCP) model around transitional care coordination to reduce 30-day hospital readmissions in heart failure patients. Additionally, it reviews the initial six months challenges and rewards associated with an IPCP model and caring for a complex heart failure population.

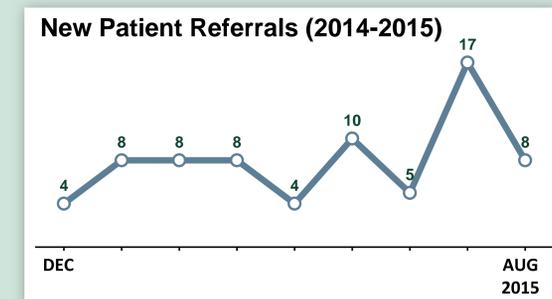


OBJECTIVES

1. Establish nurse-managed heart failure center for underinsured and/or medically underserved population
2. Implement IPCP model around transitional care coordination to reduce 30-day hospital readmissions in heart failure patients
3. Integrate nursing and other health professions students into IPCP model to gain experience with team-based care and the healthcare needs of vulnerable populations
4. Implement a model in which health professionals become competent at IPCP
5. Achieve the Triple Aim to:
 - Improve the patient experience
 - Improve the health of population
 - Reduce per capita cost of health care

CHALLENGES

1. Finding resources to meet the needs of the patients
2. Balancing patient's needs for support and empowerment vs overstepping/acting for the patient
3. Referral consistency
4. New model of health care
5. Staffing the clinic with the right personnel



TEAM DEVELOPMENT

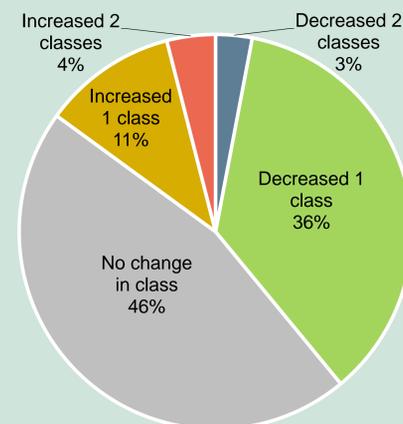
Monthly and annual surveys are administered to the IPCP team to assess the progress of team development and the implementation of the IPCP model. Preliminary results indicate that successes are beginning to emerge as the team matures, resulting in more efficient team communications inherent in the IPCP approach.

One of the most important ways our clinic assesses and improves its quality of care is asking patients what they think. Clinic patients fill out a satisfaction survey at each visit. The results indicate that our patients are highly satisfied with the care they receive.



PATIENT OUTCOMES

Over 6 months, 39% of patients* saw a decrease of 1-2 classes[^] of heart failure.



*N=29 patients

[^]New York Heart Association Classification System, Class I-IV

Transitional Care Coordination IPCP Model

