Background

Global Impact
- 195 countries suggested that the global burden of heart failure (HF) was high, and that the occurrence of HF nearly doubled from 33.5 million in 1990 to 64.3 million in 2017.1

National Impact
- Heart failure diagnosis was estimated to increase by 46% between 2012 and 2030 and was listed as a cause of death on 379,800 death certificates out of 2,839,205 deaths in 2018.2

Local Impact
- Fifteen out of fifty patients at a busy NY upstate clinic had HF-associated hospital readmission in six months and therefore a failure mode and effects analysis completed (Diagram 1).

Purpose
To explore and synthesize evidence that supports the implementation of the American Heart Association/AHA (Transitions of Care: TOC) Scientific Guidelines to decrease heart failure affiliated hospital readmissions.

Methods
Review Protocol
- Key search terms: heart failure associated readmissions, heart failure transition of care, reduced thirty-day readmission, American Heart Association recommendations, multidisciplinary.
- Search yielded 231 initial articles further limited to 54 articles then 15 articles for integrative review (Figure 1).

Inclusion/Exclusion Criteria

Data Analysis
- Effectiveness of AHA transition of care program examined.
- Themes identified through literature search and review.
- Fifteen articles reviewed independently focusing on outcomes of intervention applied to decrease HF-associated readmissions.
- Articles summarized and organized alphabetically utilizing the Johns Hopkins Nursing Evidence-Based Practice Summary Tool.

Results
- Multidisciplinary Follow-up
Multidisciplinary follow-up improved HF outcomes by utilizing a team-based approach to care.
- Early Follow-up
Early discharge follow-up positively influenced HF prognosis.
- Improved Quality of Life
Patients with HF have episodes of extreme fatigue and it is suggested that HF transitions of care programs can improve overall quality of life (QOL) but more studies to be conducted.
- Improved Medication Adherence
Patients attending a HF TOC program received education about HF and were therefore more compliant with taking guideline directed medical treatment (GDMT).
- Nurse-Led Transitions of Care
Nurse led HF transition of care (TOC) programs can improve the overall health outcomes for patients diagnosed with HF.

Conclusion:
- Recommendations for:
  - More cohesive and effective collaboration of HF TOC.
  - More research and education to support teaching.
  - Advocacy for HF TOC to be offered as the standard of care.

Implications
- Findings serve as a source for improved clinical outcomes including decreased healthcare spending.
- Quality of life improvement for patients with HF.
- Improved interprofessional collaboration for nursing staff and nursing leadership.
- Blueprint for implementing HF transition of care programs in other affiliated practice sites.
- Improved care coordination.

Limitations
- Lack of minority population.
- Some studies reported accessibility and distance as barriers for patients living in remote areas.
- Most studies done in high-income countries with most done in the US, insufficient data from middle-income countries with different healthcare systems.

Next Steps
- Implement HF TOC programs in under-represented populations to afford these populations access to high-quality, collaborative, patient-centered care.

References

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