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A unique educational model in transitional care of congestive heart failure patients

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Health-related quality of life (HRQOL) in individuals with congestive heart failure (CHF) is frequently compromised and associated with increased readmissions to the hospital and use of healthcare resources. Evidence supports use of various transitional care programs has been to effectively reduce effectively reduce hospital readmission rates explored. This project's uses a unique approach that has not to our knowledge been implemented elsewhere. This novel approach to providing transitional care is comprised of nursing, social work, exercise physiology and nutrition students serving as a vehicle to transcend and bridging e the gap between hospital, home and clinic. It is consistent with the IOMs Future of Nursing: Leading Change, Advancing Health (2011) recommendation to prepare competent and skilled nurses to practice in the future healthcare system. This project demonstrates an innovative academic and practice collaboration model providing students with learning experiences in a patient-centered environment spanning the care continuum. Leveraging students and faculty with the expertise and resources in both academic and practice settings focus on overcoming individual, environmental and structural barriers to help the CHF patient achieve effective self-care management. This project is also evaluating the impact of this educational model on improved patient care outcomes. This project is a collaboration between an urban hospital, clinic based CHF clinic, and the University and the CHF patient and family. Students provide telephone and home visits to NYHA Class II and III CHF patients recently discharged from the hospital. Weekly transitional care team meetings are held to review patients and discuss appropriate plans of care. Formative and summative evaluations from students demonstrated a high degree of satisfaction. Moreover, the project was deemed successful by the hospital, CHF clinic and school of nursing in terms of student learning and patient outcomes with a decreased rate of emergency department visits and re hospitalizations.

Biography

Nan Smith-Blair completed her PhD from the University of Kansas in 2000. She is an Associate Professor in Nursing at the University of Arkansas whose primary duties include working with Honors students and conducting research. She has previously worked in the healthcare system at all levels of management including hospital administration. She has published more than 20 papers. She was elected as a Distinguished Fellow in the National Academies of Practice in 2014. She currently serves as President of the Southern Nurses Research Society and on the Leadership Council of the Council for the Advancement of Nursing Science.

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