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Health care providers come together to fight heart disease
By Scott Whipple

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FARMINGTON — Every year, nearly 5 million people experience heart failure. Hospital readmission for these patients has become a pervasive, costly issue that needlessly impacts patients' quality of life.

Qualidigm, a "Communities of Care" initiative, helps reduce preventable heart failure readmissions in Connecticut.

The endeavor is an offshoot of the Heart Failure Readmission Collaborative launched last year by the Connecticut Hospital Association and Qualidigm. Together with Connecticut hospitals, these organizations review processes and the transitions of care to ensure that patients, their caregivers, and their clinicians have the critical information they need and that care delivery is efficient. One goal of the Collaborative is measurably reducing unnecessary readmissions for heart failure patients.

On Monday, Qualidigm hosted a one-year milestone meeting for the Communities of Care at Ashlar Village at Masonicare in Wallingford. Close to 150 statewide health care providers from the physician community, hospitals, home health care agencies, nursing homes, other specialty-care practitioners and insurers gathered to discuss Palliative and Hospice Care relative to heart disease. The meeting also included an interactive presentation on "Teach-Back," an effective way to talk with patients about their disease and how to care for themselves to maintain their health.

Qualidigm's education committee, chaired by cardiologist Dr. Jason Ryan of the Farmington-based UConn Health Center, is creating educational videos for health care providers, patients and their caretakers. The videos will be distributed statewide to ensure continuity and uniformity in the important information all health care settings receive.

The idea for the videos started with talks Ryan gave to various groups about problems and challenges facing heart patients. The series is expected to be completed in four to six months.

Ryan said one in every five patients admitted to a hospital with heart failure goes home, only to return 30 days later. However, many of these trips back can be prevented if care in the community is coordinated and high quality.

"This frustrates families who see their loved ones going in and out of the hospital," Ryan said. "They often think that it's part of the disease process when it's not."

The real problem, he stressed, is how the community takes care of these people.

”If done the right way, patients can stay home a lot more,” Ryan said.

He added that a goal of the initiative is to reduce the readmission rate by 20 percent.

“We’re trying to educate both staff and patients on how to take care of themselves,” he said.

This includes patients taking their medication every day, avoiding salt, weighing themselves to make sure they aren’t retaining fluids. This behavior takes place not only in hospitals and in nursing and rehabilitation homes.

Ryan ‘s videos will provide a standard of teaching in this area; whether it’s Bristol Hospital or John Dempsey Hospital every caregiver will be “on the same page” in terms of what nurses are telling their patients.

The educational videos for patients and nurses will teach both groups what heart patients need to know so nurses can become better educators on managing the disease.

Ryan, who has a background in public health, said he has always had an interest in taking care of patients, not simply administering medicine, but managing a community and keeping it healthy.

“When heart patients repeatedly go home and come back they aren’t getting the kind of care they need,” he said.