

**Improving Access to Shared Care for Rural Dwelling Advanced Heart Failure Patients:**

**A Quality Improvement Project**

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NURS 703A: DNP Project Planning

Spring Term, 2022

Dr. Jonathan Soffer – Chair

This paper is submitted in partial fulfillment of the requirements for  
the Doctor of Nursing Practice degree.

## Abstract

Heart failure (HF) is a leading cause of morbidity and mortality in the United States. In recent decades there have been few advancements in disease management. Advanced heart failure treatment (AHFT) centers provide state of the art care for patients with HF including use of left-ventricular assist devices (LVAD), heart transplants, and integrated palliative care. Rural dwelling HF patients have worse health outcomes and have difficulty accessing AHFT centers which tend to be located in urban areas. Shared care treatment models have been shown to improve access to specialty care, but have not been widely studied in advanced HF patients. This quality improvement project assessed the experience of patients participating in a new AHFT shared care program. Participant interviews revealed multiple themes including financial benefits of the shared care program related to reduced travel distance and increased access to LVAD monitoring. Participants desired more opportunities to engage with the shared care clinic and recommended integration of electronic health records across systems. Stakeholder interviews revealed an opportunity to develop a shared patient appointment database and explore opportunities to create partnerships with additional AHFT centers. Through multiple PDSA cycles a shared appointment database was developed, refined and implemented into the shared care clinic. Post-intervention surveys described increased communication between sites and schedulers, reducing redundancy.

*Keywords: shared care, advanced heart failure therapy, quality improvement, quality improvement project, heart failure, rural health*

## **Improving Access to Care for Rural Dwelling Advanced Heart Failure Patients:**

### **A Quality Improvement Project**

#### **Problem Description**

Heart failure (HF) is a leading cause of morbidity and mortality among older adults in the United States (Tsao et al., 2022; Virani et al., 2020). Over the past decade, morbidity and mortality rates have remained unchanged without significant advancements in disease management (Roger, 2021). Health outcomes for rural Americans living with HF are worse than their urban counterparts, with an increased 30-day and 90-day mortality after hospitalization (Loccoh et al., 2022). Access to care centers that provide advanced heart failure therapies (AHFT), including heart transplants and left-ventricular assistive devices (LVAD), contribute to this disparity. Lack of access to advanced care centers who provide advanced heart failure therapies including heart transplant and LVADs are thought to contribute to higher rates of emergency department visits and hospitalization for rural HF patients (Alonso et al., 2020).

To improve outcomes for rural HF patients, a geographically isolated (>250 miles to nearest academic health center providing AHFT) outpatient HF clinic initiated a shared care program to reduce disparities in access to AHFT. The Advanced Practice Registered Nurse (APRN)-led clinic, which is located within a larger cardiology practice, utilizes a multi-disciplinary model to provide comprehensive cardiology services to advanced HF patients. In an effort to improve AHFT patient access to care, the HF clinic has collaborated with the two nearest advanced care centers (aprox. 250 miles away) to provide shared patient care. This project assessed the quality of the HF program for its first cohort of patients, explored opportunities for improvement, and options to expand the shared care model with other advanced care centers.

#### **Available Knowledge**

HF is a progressive chronic disease affecting millions of Americans (Tsao et al., 2022). The disease primarily affects older adults, with a lifetime risk of 20-45% for those over the age of 45 (Tsao et al., 2022). HF is noted as a contributing cause of death on one of every eight death certificates in the United States (Tsao et al., 2022). The disease is challenging to prognosticate due to its characteristic cycles of acute exacerbations and plateaus. The American Heart Association (AHA) has developed criteria for categorizing HF disease progression into four stages: A, B, C, or D, with advanced HF correlated with stage D (Tsao et al., 2022). Patients with advanced HF are frequently hospitalized for treatment, as their symptoms are not adequately managed by guideline-directed medication management and lifestyle interventions (Heidenreich et al., 2022). Current treatment guidelines recommend treating advanced HF patients with palliative care, palliative inotropes, and AHFT (Heidenreich et al., 2022).

Shared care is a collaboration between a primary care provider and a specialist provider to provide care to patients with chronic health conditions (Smith et al., 2017). While the model has been demonstrated to be effective in management of chronic mental health conditions, (the application of shared care has not been well studied in HF (Smith et al., 2017).

Much of the research examining the effect of location on HF outcomes has focused on the impact of rurality and distance from advanced care centers on mortality and adverse events (stroke, clotting, driveline failure, etc.). Across studies, those living more than 90 miles from the advanced care centers had worse outcomes than those who lived closer than 90 miles or in urban areas (Ravichandran et al., 2018, Alonso et al., 2019). While rural patients had higher quality of life prior to AHFT, they experience more comorbidities than their urban peers (Alonso et al., 2021). Patients living with HF often have frequent healthcare interactions. Specifically, for patients who receive LVADs the time spent interacting in the medical setting is extensive, with more than 1 of every 5 days spent engaging in the health care system (Chuzi et al., 2022).

Three studies have assessed differences in outcomes between patients who receive care at implanting centers and those who receive care at shared care sites (Gajanan et al., 2020; Shah et al., 2021; Yin et al., 2022). Results indicate no reduction in quality metrics such as mortality, stroke, and infections between the AHFT-implanting centers and their shared care clinic sites (Gajanan et al., 2020; Shah et al., 2021; Yin et al., 2022). None of these studies assessed the personal impact of participating in a shared care AHFT program, described the impact on access to care, or specifically discussed how the care was distributed and shared between the sites.

### **Rationale**

It is well established that shared-care AHFT programs provide equivalent care compared to AHFT programs at advanced care centers. However, what is unknown is how shared-care partnerships impact the patients' lived experience. Our geographically-isolated HF clinic assessed the quality of the AHFT shared-care program after its first year and a half treating AHFT patients. Access to timely and consistent AHFT care can improve health outcomes for patients; we explored this topic and assessed impact on access to care.

Collaborative relationships can improve patient access to care. The clinic identified an opportunity to create a standardized patient appointment database for shared care visits with the AHFT center. This intervention reduced redundancy, increase transparency in patient visits, and increased ease of use for staff and providers at both sites. This quality improvement project utilized the Institute for Healthcare Improvement (IHI) model for the core framework (IHI, 2022). The IHI model utilizes small measurable tests of change to improve quality and focuses on the Institute of Medicine's goals of person and family centered care (IHI, 2022).

### **Specific Aims**

This project had three aims, which were completed in December 2022 (see timeline in appendix B). The first was to describe the patient population accessing the AHFT shared-care in the first year of

program implementation, including demographics and perspectives on participation in clinic. Specifically, this project analyzed quality measures, assessing if the clinic increased patient access to AHFT, the financial benefit of access, and recommendations on timing of visits between the two sites. The second aim was to reduce waste in the system and increase transparency by creating and implementing a standardized patient tracking and appointment database which could be shared across the two health systems. The final goal was to identify potential AHFT centers to expand the shared-care clinic model for rural & remote patients.

## **Methods**

### **Context**

This quality improvement project took place in an outpatient HF clinic located within a larger cardiology practice. The clinic is affiliated with a regional health system comprised of three hospitals and multiple specialty and primary care practices. The clinic is partnered with several large academic health centers to support HF patients. The clinic is in the Pacific Northwest in an urban county, surrounded by rural and remote counties. The multidisciplinary HF clinic consists of one APRN and a rotating cardiologist who see's new patients only, one registered nurse, one medical assistant, one part-time social worker, one part-time nurse navigator, and one part-time pharmacist.

### **Interventions**

Assessment of the patient's experience and participation in the AHFT shared-care program was conducted through patient and caregiver interviews. The interviewer used a questionnaire (see appendix C) to assess barriers in accessing AHFT care, financial impact of care in their home communities, frequency of visits, and opportunities for improvement. The first interview tested the success of questionnaire and revisions were then made based on patient feedback and ease of use. The second intervention aimed to increase communication between the AHFT center and regional shared care HF clinic using a patient appointment database via multiple PDSA cycles. The third intervention was

the creation of a resource guide on all the transplant centers within 500 miles of the HF clinic. The guide contained past heart transplant rates, distance from the regional HF clinic, and contact information.

## **Study of the Interventions**

### **Measures**

The primary outcome measure for this project was completed interviews with all of the patients (N=6) who have participated in the AHFT shared-care program. The interviews assessed patient perceptions of program quality and patient experience. The second measure was a process measure, as the shared patient appointment database was implemented and utilized by both partners. A brief questionnaire before and after the intervention assessed the needs of the database tool and then evaluated use of the tool. The third measure was the creation of a resource guide to the AHFT treatment centers within 500 miles of the HF clinic.

## **Results**

### **Analysis**

Collected data was secured in a confidential digital file system. Patient interviews were transcribed into excel. The data was secured via OHSU encryption, password protection, and two-factor authentication (Duo). Data was de-identified and handwritten interview notes were transcribed into Microsoft Word, then destroyed. Themes were then identified and organized. Specific quotes that illustrate concepts were utilized to describe the clinic outcomes. Pre-and-post intervention provider surveys were de-identified and handwritten survey notes were transcribed into Microsoft Excel and then destroyed. All results were entered into Microsoft Excel and data was graphed by responses.

### **Ethical Considerations**

Ethical considerations included the safe handling of data and maintaining anonymity of survey respondents. All clinic staff and partner organizations were informed of this quality improvement project. Patients involved in the shared-care program at the HF clinic were asked if they would like to

provide feedback on their experience in the clinic in a short interview. They were informed that the participation was voluntary, and their responses would be grouped, and de-identified from the clinic team (see appendix C). The interviewer was honest and transparent with patients about the role of the interviews in increasing the clinic's understanding of the patient experience, and how this information would be used to increase quality of and access to care for other advanced HF patients. Participants were notified that the questionnaire explored their access to healthcare, specifically living in a remote region of Oregon, and the impact the clinic has had on their expenses and time seeking care. These are sensitive topics related to finances and end-of-life; the clinic social worker was available to consult as needed. This quality improvement project was submitted to the IRB board and deemed not research (see appendix D).

### **Patient Demographics and Survey Results**

Our primary outcome was met with interviews with all active participants in the shared care program (N=6). The participants were primarily male (66.6%), with an average age of 42, with a range of 38-78 years-old. Sixty-six of the participants lived rurally, while 33% lived within urban boundaries. The average travel time to the shared care clinic was 56 minutes (range 10-90), compared to 305 minutes (range 219-330) to get to the nearest academic health center (see Table 1). Sixty-six percent of patients reported a delay in accessing medical care due to distance. The main barriers identified were transportation and illness, one participant utilized the RV sites as a way to mitigate barriers to care (see Table 2).

When assessing communication between the shared care regional clinic and the academic health center 33% said communication was excellent, 50% of patients stated the communication was good, and one participant discussed the improvement in technology (see Table 3). All participants stated that regional site and academic health center were knowledgeable about what happened at past visits at the other agency. Recommendations for improving the care between the sites included connecting



inter-agency data through MyChart, transitioning the regional center EMR to EPIC, and increasing the speediness of technology during visits. Additionally, more frequent visits at the regional site was requested by 33% of participants. Participants identified the unique opportunity that the shared-care clinic provided: “the partnership has really helped this [LVAD] work for us. If we were having to go to [advanced heart failure center], we wouldn’t be able to do it”. Travel was consistently identified as the biggest barrier to accessing advanced heart failure care.

### **Provider Database Implementation Results**

Pre and post intervention data was collected on the need for increased communication related to patient appointment scheduling through a shared agency database. During the project, it was identified that a database had already been created, but was not being utilized. A brief training intervention took place with the clinic provider and scheduler. Monthly patient scheduling meetings were organized and scheduled out as recurring meetings to increase use of the tool. After two months of consecutive meetings, the APRN was surveyed on the impact of this intervention in increasing scheduling communication. Strengths identified in the post-provider survey included increased communication related to scheduling of patients between the two agencies which helped prevent patients “from falling through the cracks”. A remaining barrier was identified, when patients are admitted to a hospital outside of the two local health systems.

## **Discussion**

### **Summary**

This project aimed to describe the patient experience of participating in an advanced HF shared-care program. In exploring the shared-care model and implementation, a need for improved communication between sites was identified. A shared database to track patient scheduling across two different EHRs and health systems was created. In reviewing use of the database, it was identified that a consistent review/meeting cycle was needed to ensure use. The IHI Model for Improvement was used to

improve communication and modify current communication systems (IHI, 2022). Finally, a handout was created with the AHFT centers in the pacific northwest. Since the start of this project, a second academic health center has already established a new partnership to share care with their advanced heart failure patients with LVADs.

### **Interpretation**

Surprisingly the patient population was younger than the general HF population with an average age of 42. One possible explanation could be the criteria for AHFT. Frailty which is typically associated with advancing age is a contraindication to LVAD and/or heart transplant, additionally some advanced care centers limit age to 70 and under.

There are limited studies or quality improvement projects that assess the patients experience in sharing AHFT across organizations and/or sites. During project implementation a study was published by Graham and colleagues which explored the health care providers experiences in providing care through a palliative and cardiology home based shared care program (2022). They explored the shared care model with palliative and cardiology care for home dwelling HF patients (Graham et al., 2022). Findings from their study found an increase of communication and referrals to palliative care with the use of the collaborative shared care model (Graham et al., 2022).

The findings of this quality improvement project suggest that the shared care model is a value added to patients living remotely from their ADHF center. Communication between health centers met the patient's needs and helped reduce the financial burden of travel. There continue to be opportunities to improve communication between sites by aligning electronic health systems.

### **Limitations**

This project is limited in its generalizability due to the unique relationship across health systems, the specialty nature of both clinics and the small population of advanced heart failure therapy patients. This quality improvement project met the goal of interviewing six patients. It is a relative low number

representing only 20% of current advanced heart failure patients at the partner academic health center, and 100% of the shared care clinic patients.

### **Conclusion**

Shared care programs for rural advanced heart failure patients improve access to highly specialized care. This is achieved through reduction of barriers such as travel costs and time for the patients, as well as coordinated access to healthcare providers and LVAD monitoring. When working across multiple health systems with separate and unique EHRs there is value in the use of shared appointment tracking databases to facilitate improved communication. There are opportunities to expand shared care programs for HF patients and help serve rural and remote patients better through this collaborative practice.

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**Table 1**

Survey Results: Travel Time

	Mean	Range
Travel to regional Heart Failure Clinic	56 minutes	10-90 minutes
Travel time to Advanced Heart Failure Center	305 minutes	219-330 minutes

Note. Travel time to the regional heart failure clinic was on average an hour, indicating rural dwelling patients.

**Table 2**

## Survey Results: Financial Impact of Clinic

	Quotes
Financial Impact	“Our main cost is transportation. And staying overnight and stuff. It has to reduce our cost, we have to stay overnight, sometimes two nights”
	“Yes, it reduced the cost of travel significantly. I can go there (Regional HF Clinic) then to (Academic Health Center) every other month.”
	“Yes, it helps a lot not having to go to (Academic Health Center) for every appointment. It's \$20 to (Regional Health Center), and \$120 to (Academic Health Center) just gas. I used to stay the night, insurance will only cover \$40”
	“The travel has been the biggest problem we've had so far. Physically and emotionally.”
	“It saves us a lot of money, probably thousands of dollars. You know if we were more challenged we would think about it, we just do what we are told to do and we are okay.”



**Table 3**

Survey Results: Technical &amp; Frequency of Visit Themes

Technical Recommendations	<ul style="list-style-type: none"><li>• Connecting health center data through MyChart</li><li>• Increase speediness of technology connections during visits</li><li>• Transition to EPIC for charting</li></ul>
Frequency of visit recommendations	<ul style="list-style-type: none"><li>• More frequent visits at regional site</li><li>• No improvement recommendations</li></ul>

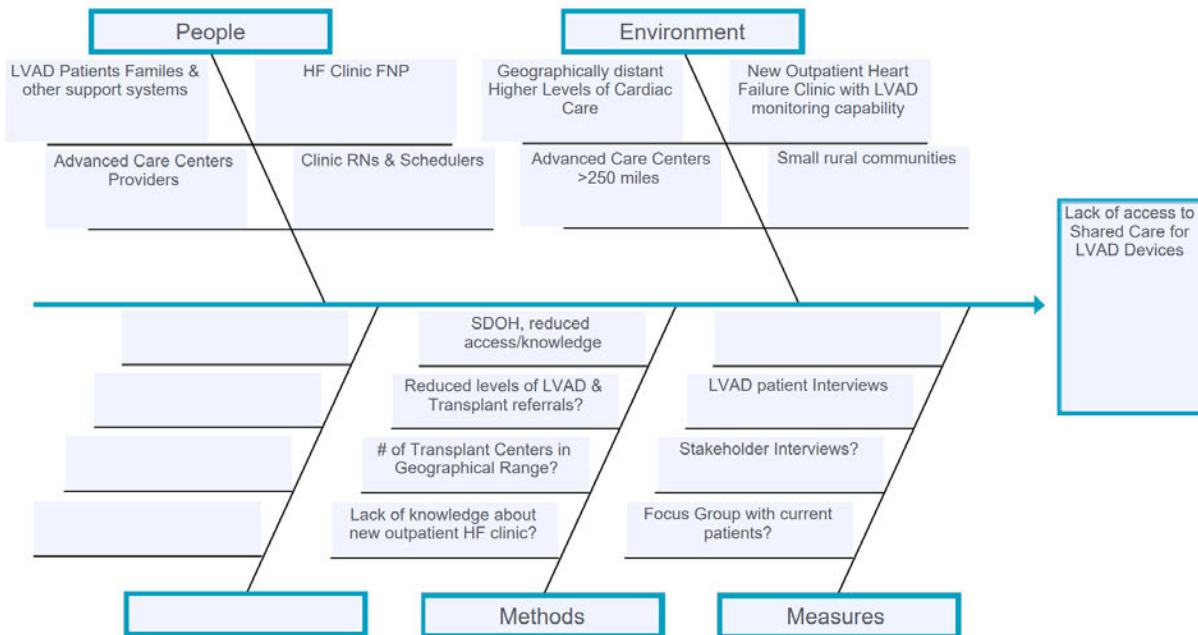
Appendix A.

### Template: Cause and Effect Diagram

**Team:** DNP Project

**Project:** LVAD Shared Care Expansion

- 1) Input the effect you'd like to influence.
- 2) Input categories of causes for the effect (or keep the classic five).
- 3) Input causes within each category.





## **Appendix C.**

### **Interview Questions**

Thank you for taking the time to talk with me today. We are looking to improve the quality of care at the heart failure clinic. We would like to ask you some questions about the care you have gotten here, and if expanding this service has improved your access to care. We are also looking to see what we can do better and are open to your suggestions. This survey/interview is completely anonymous. I won't record any specific names or locations. If you feel like you need to stop or take a break, that is fine, please let me know. You also, don't need to complete the survey/interview, and are welcome to go at anytime. Your answers will not impact your care at the clinic and the results will only be shared as a group.

### **Access to Care**

1. How long have you been coming to the heart failure clinic?
2. How long does it take to you to travel to the Heart Failure (HF) Clinic?
3. How long does it take to get to the transplant center?
4. If you need to see a provider urgently, can you normally get seen on the same day or next day at the HF clinic?
5. Have you delayed getting needed medical care due to transportation issues in the past year?
6. Have you delayed getting needed medical care because you live in a rural area and the distance to travel is too far?
7. What are other reasons or barriers you have had in getting to the HF clinic or the AHC?

### **Continuity of Care**

1. How do you feel about the communication with and between the transplant center & the HF Clinic?

2. After going to the transplant, did your HF clinic provider talk with you about what happened at that visit?
3. What could we do to help improve the continuity of care for you between the two clinics?

**Financial Impact**

1. Has participation in the HF clinic shared care program helped reduce your costs of healthcare?
  - a. If yes, how? Why?
  - b. If no, why not?

**Closing**

- Is there anything else that you would like to share with us about your care at the heart failure clinic?
- Is there a question that we didn't ask you, but you think we should have asked?

Thank you for your time!

## Appendix D.



## IRB MEMO

Research Integrity Office

3181 SW Sam Jackson Park Road - L106RI  
Portland, OR 97239-3098  
(503)494-7887 irb@ohsu.edu

### NOT HUMAN RESEARCH

June 3, 2022

Dear Investigator:

On 6/3/2022, the IRB reviewed the following submission:

Title of Study:	Improving Access to Shared Care for Rural Dwelling Advanced Heart Failure Patients: A Quality Improvement Project
Investigator:	<a href="#">Jonathan Soffer</a>
IRB ID:	STUDY00024525
Funding:	None

The IRB determined that the proposed activity is not research involving human subjects. IRB review and approval is not required.

Certain changes to the research plan may affect this determination. Contact the IRB Office if your project changes and you have questions regarding the need for IRB oversight.

If this project involves the collection, use, or disclosure of Protected Health Information (PHI), you must comply with all applicable requirements under HIPAA. See the [HIPAA and Research website](#) and the [Information Privacy and Security website](#) for more information.

Sincerely,

The OHSU IRB Office

## Appendix E.

Letter of Support from Clinical Agency

Date: 05/26/2022

Dear *Tiffany Allen*,

This letter confirms that I, allow *Tiffany Allen* (OHSU Doctor of Nursing Practice Student) access to complete his/her DNP Final Project at our clinical site. The project will take place from approximately *June 27<sup>th</sup> 2022 to December 10<sup>th</sup> 2022*

This letter summarizes the core elements of the project proposal, already reviewed by the DNP Project Preceptor and clinical liaison (if applicable):

- **Project Site(s):** *Southern Oregon Cardiology, Medford Oregon 520 Medical Center Dr Ste 200, Medford, OR 97504*
- **Project Plan: Use the following guidance to describe your project in a brief paragraph.**
  - **Identified Clinical Problem:** *Assess the quality of patient experience in participating in a shared care AHFT program. Identify if the program increased access, reduced financial burdens for participants and increased quality of life? Look for continued opportunities to improve.*
  - **Rationale:** *The evidence is clear that shared care AHFT programs are capable of providing equivalent care across locations, but what is unknown is how shared care partnerships impact the patient's quality of life or share the patients lived experience. Our geographically isolated APRN led heart failure clinic will assess the quality of the program after its first year and a half treating shared care patients. The patients' perceptions will be collected on the impact of participation in shared care for their AHFT. Access to timely and consistent AHFT care can improve health outcomes for patients, so we will ask patients if the clinic filled this need for timely care.*
  - **Collaborative relationships can improve patient access to care.** *The clinic has identified an opportunity to create a standardized patient appointment database for shared care visits with the AHFT center. This intervention has the potential to reduce redundancy, increase transparency and ease of use for staff and providers at both sites.*
  - **Specific Aims:** *This project has three aims. First to describe the patient population accessing the AHFT shared care in the first year of program implementation including demographics and perspectives on participation in clinic. Specifically assessing if the clinic helped increase their access to AHFT, the financial benefit of local access to advanced heart care and recommendations on timing of visits between the regional and academic health center. The second aim is to reduce waste in the system and increase transparency by creating and implementing a standardized patient tracking and appointment spreadsheet which can be shared across the two health systems by staff. The final goal is to identify potential AHFT centers to expand the shared care clinic model for rural dwelling patients.*
  - **Methods/Interventions/Measures:** *Semi-Structured interview guide to elicit patient perspective on participation in shared care advanced heart failure therapies. Pre & Post survey via Qualtrics for providers on shared patient database.*
  - **Data Management:** *Data will be collected and stored in a secure manner, interview data will be de-identified and stored on password protected and dual authentication drives.*
  - **Site(s) Support:** *Site will provide space to conduct activities, interview patients, distribute questionnaires, retrieve patient data from electronic health record.*

During the project implementation and evaluation, *Tiffany Allen* will provide regular updates and communicate any necessary changes to the DNP Project Preceptor.

Our organization looks forward to working with this student to complete their DNP project. If we have any concerns related to this project, we will contact *Tiffany Allen* and *Jon Soffer* (student's DNP Project Chairperson).

Regards,

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DNP Project Preceptor: Linda Pierson FNP-C, [piersonl@socardiology.com](mailto:piersonl@socardiology.com) 541) 930-7222

*5-26-22*  
Date Signed