Casting a Wide Net to Decrease Heart Failure Readmissions: The Impact of a Nurse Practitioner Run Heart Failure Transitional Care Program.

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Introduction

Preventing avoidable re-admissions for patients with heart failure (HF) is a national focus for quality outcomes, that are both fiscally and patient centered. The use of a Nurse Practitioner (NP) Transitional Model can impact readmission rates and quality measures through 1) early identification of heart failure patients, 2) evaluation through inpatient consults, and 3) transitioning to outpatient management. This certified disease management program is managed by two NPs at this academic medical center

Method

Screening done by electronic algorithms looking at:

- Admission diagnosis of heart failure
- Elevated pro-BNP levels noted in ED
- Patients with a discharge diagnosis of HF in the last 6 months and readmitted (all cause)

Program Process

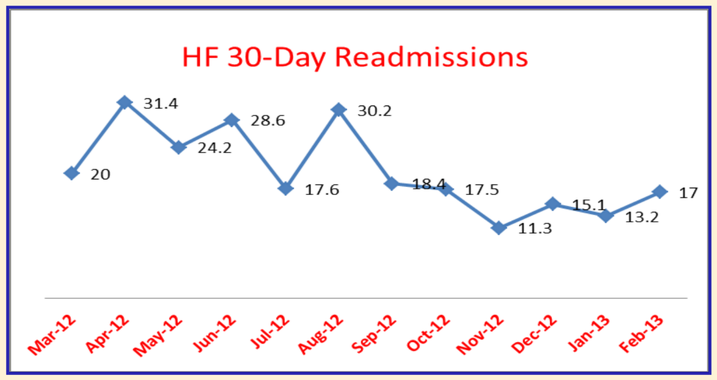
- Screening results in a list that triages the patients with the highest risk for the NP consult. The consult focuses on successful self-care management, evidence based medical therapy, and incorporates one-on-one didactic HF education.
- Patients transition to outpatient care which includes early discharge phone call follow-up, face to face seven day follow up, and tele-monitoring for six weeks.
- Patients have access to the NP urgent care clinic for evaluation and treatment of heart failure.

Program Benefits

- Use of Teach Back
- Decreased 30-day readmissions
- Affirmative patient feedback; 95% of patients would re-commend this program.

Outcomes

Average readmission rate for our hospital 2011-2012 was 21.5 % compared to **national average of 24%.** The last quarter of 2012 achieved a 14.5% readmission rate. When factoring in the academic center is an advance heart failure center offering transplantation and mechanical support, this reduction is below the national average



Conclusion

The nurse practitioner transitional model is a feasible resource to reduce readmissions for patients with heart failure and improve quality measures. Teaching self-care management, aggressive outpatient management and utilizing homecare and community resources optimizes positive patient outcomes.

References

1. Chen J, Normand SL, Wang Y, et al. **National and regional trends in heart failure hospitalization and mortality rates for Medicare beneficiaries**, 1998–2008. *JAMA*. 2011 Oct 19; 306(15):1669-78
2. Hansen LO, Young RS, Hinami K, et al**. Interventions to reduce 30-day re-hospitalization: a systematic review.** Ann Intern Med. 2011, Oct 18; 155(8):520-8
3. Stauffer BD, Fullerton C, Fleming N, et al**. Effectiveness and cost of a transitional care program for heart failure: A prospective study with concurrent controls**. *Arch Intern Med*. 2011 Jul 25; 171(14):1238-43.