Introduction
Volume overload is a major contributing factor of initial admission and subsequent readmissions for decompensated heart failure (HF). Other contributors include dehydration and acute kidney injury. HF readmissions create a financial burden on the health care system and readmissions are related to increased mortality for patients. Causation of hypervolemia may be related to 1) sodium indiscretion, 2) medication non-adherence, or 3) suboptimal diuretic dosing. Timely assessment and intervention can circumvent treatment in the Emergency Department (ED) where admission often becomes inevitable.

Methods
A HF Transitional Care (TC) program is offered to all discharged HF patients in a 500 bed academic medical center. In this program, 3 nurse practitioners (NP) staff a NP run Urgent Clinic supported by nurses where concerns of weight changes and HF symptoms can be assessed and treated.

Results
- Of the 39 patients seen in the HF urgent clinic from July 2014 to December 2014, 25 received oral medication adjustments, 14 received IV diuretics and 0 received IV fluids.
- Of the 39 patients seen in the HF urgent clinic 9 had a HF admission in the previous thirty days. Only 2 in this subset were readmitted after their clinic visit. An additional 2 were admitted for a first admission after being evaluated in urgent clinic. Therefore 35 potential admissions/readmissions were averted.

Conclusions
The availability of an urgent clinic for HF patients can successfully decrease hospitalizations and readmissions. HF patients who previously would seek treatment in the ED now have alternative treatment. They voice satisfaction at circumventing ED waits and a hospital admission. Preventing the initial admission then avoids the start of a costly admission-readmission cycle. Of the 39 patients seen in clinic only 4 had admissions/readmissions therefore preventing 35 potential admissions. At an average hospital cost of $10,000-$12,000 per average HF admission, this represents a fiscal savings of $350,000-$420,000. When reducing readmission rates below institutional benchmarks, this can prevent disincentive penalties by the Center of Medicare Services (CMS) and thereby maximizing Medicare reimbursements.

References