

Decreasing 30 Day Readmission Rates in Patients with Heart Failure

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INTRODUCTION

- Heart failure (HF) is a global health priority affecting ~36 million people. ¹
- There are some 5.7 million adults in the United States with Heart Failure. ¹
- Heart failure costs the nation an estimated \$30.7 billion each year.²
- Heart Failure is a chronic disease with serious health consequences.
- Readmission after discharge is a health care utilization problem.
- The 30 – day average National readmission rate is 21%, at this institution it was 28.9%.

OBJECTIVES

To reduce 30-day hospital readmissions for HF by implementing a comprehensive self-care program for patients and families :

- Develop an Evidence–based HF Program and an infrastructure to support implementation.
- Pilot the HF Program on a Telemetry Unit
- Evaluate the 30-day Readmission Rate for HF after Implementation of the Pilot Program

METHODS

Setting

A non-profit, Level One Trauma , Stroke, & STEMI center that serves economically challenged communities in NYC.

Conceptual Model

Transitional Care Model ³

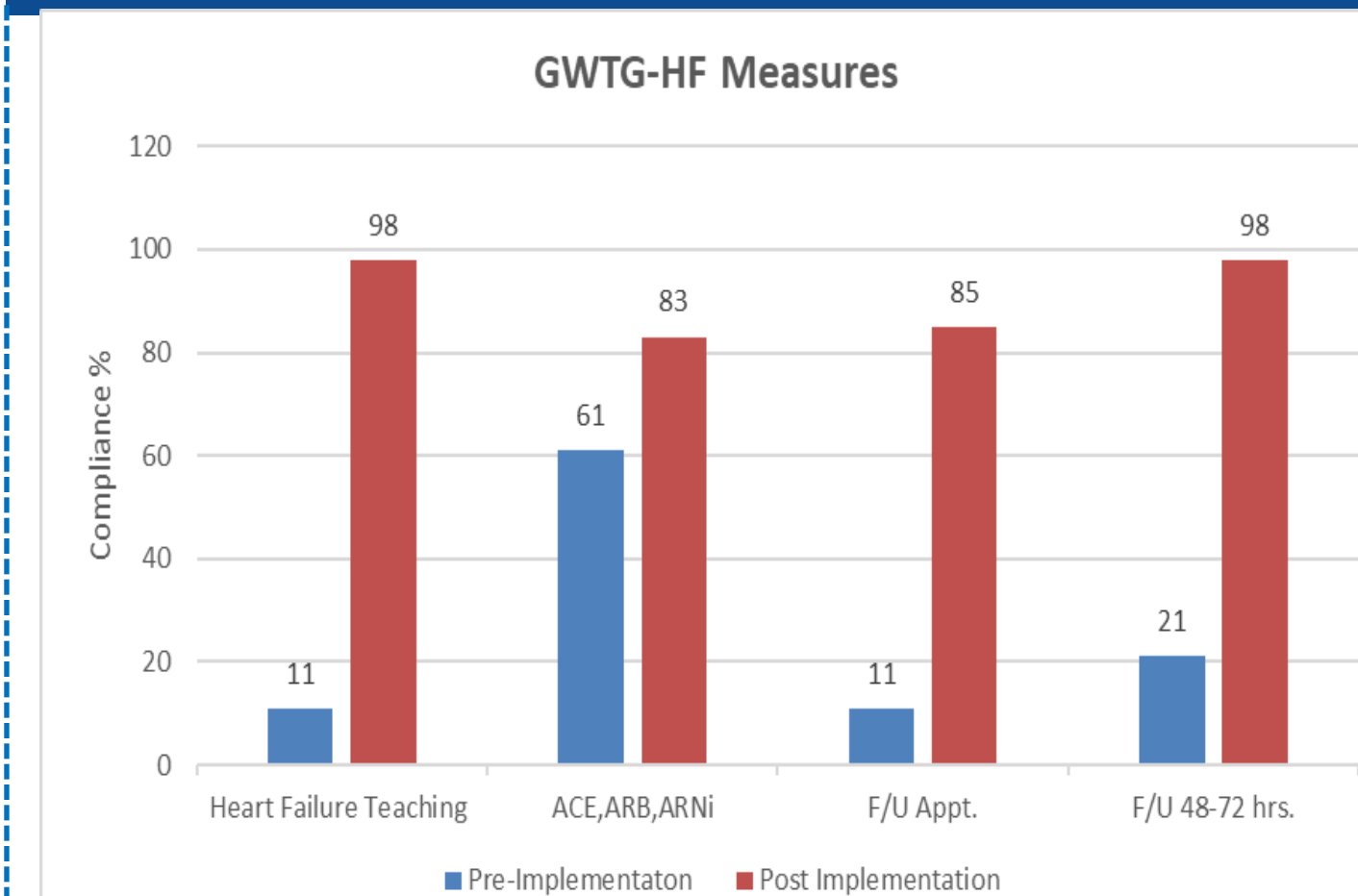
Development of Pilot Program

- A Multidisciplinary Team led by Nursing developed a HF Education plan utilizing best practices and guidelines from the ACC (American College of Cardiology), AHA (American Heart Association) HFSA (Heart Failure Society of America).
- Standardized HF checklist/protocol/pathway with order sets were created to coordinate care of HF patients from admission, hospital stay, discharge, and transition home.

Implementation

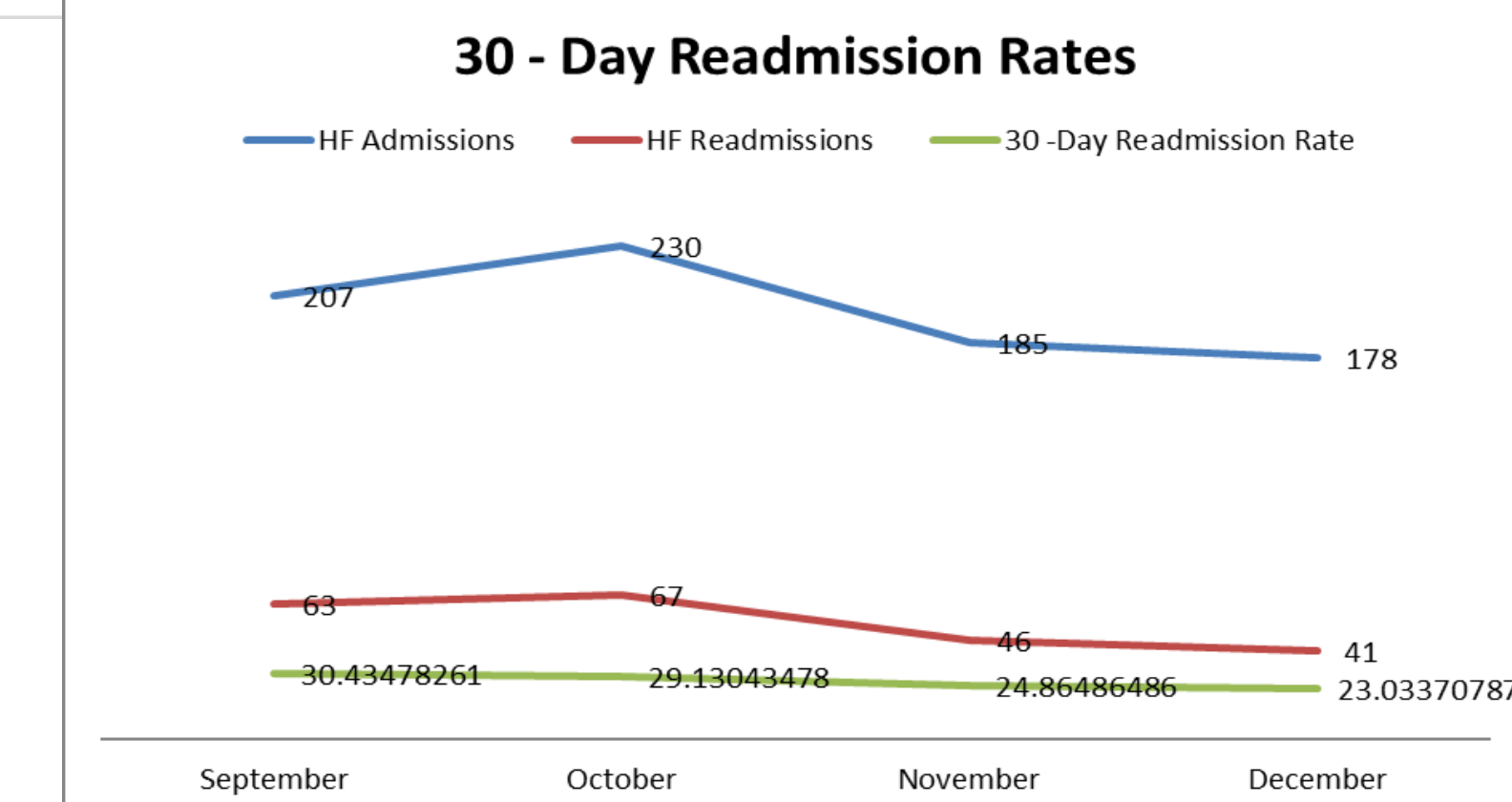
- The Department of Nursing education trained the nursing staff on the telemetry unit. Using the “teach back” method, patients were taught at bedside about their disease process, early symptom recognition, self- care strategies, medication management, nutrition, life- style modification and were given a follow-up plan.
- Patient teaching was provided daily from admission until discharge.
- A weekly list of patients admitted for HF was distributed to the Cardiology team via email by EPIC.
- Nurses were monitored for adherence to the program by reviewing documentation in the EMR , and the call - back checklist.

RESULTS



A total of 47 patients were in the pilot. Ages ranged from 48-90; 37 Black, 9 Hispanic, 1 White. There was improvement in all aspects of the HF program by the nurses after implementation.

The 30-day readmission rate dropped by 16.6% after the pilot program.



Conclusion: Implementation of an Evidence Based HF program was feasible and demonstrated improvement in HF teaching, patient centered education and referral to providers and resources. The program reduced gaps in care, provided better coordination and transition of care. The goal of reducing the 30-day readmission rate was achieved. Worse patient outcomes were related to socioeconomic factors, which included unaffordability of healthy food choices, lack of education about their disease process, and access to care. Ongoing implementation will include the Med/Surg units and identify patients at higher risk for poorer outcomes to better tailor teaching and individualize care plans.

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