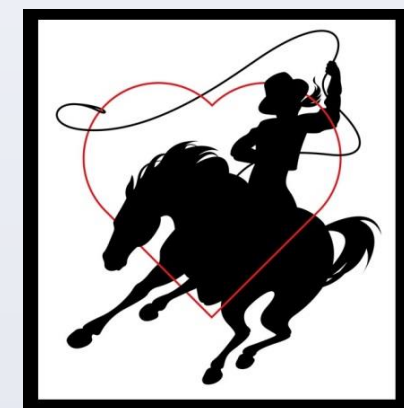


BACKGROUND

- ♥ Heart failure is a major health problem in the United States, affecting approximately 5.7 million Americans; taking a tremendous toll on the quality and longevity of lives as well as United States healthcare expenditures
- ♥ The purpose of this poster is to summarize our successful round-up of decreasing CHF readmissions



OBJECTIVES

- ♥ To describe the development of a multidisciplinary approach for reducing heart failure readmissions
- ♥ To define and evaluate the data that demonstrates reduction in readmissions

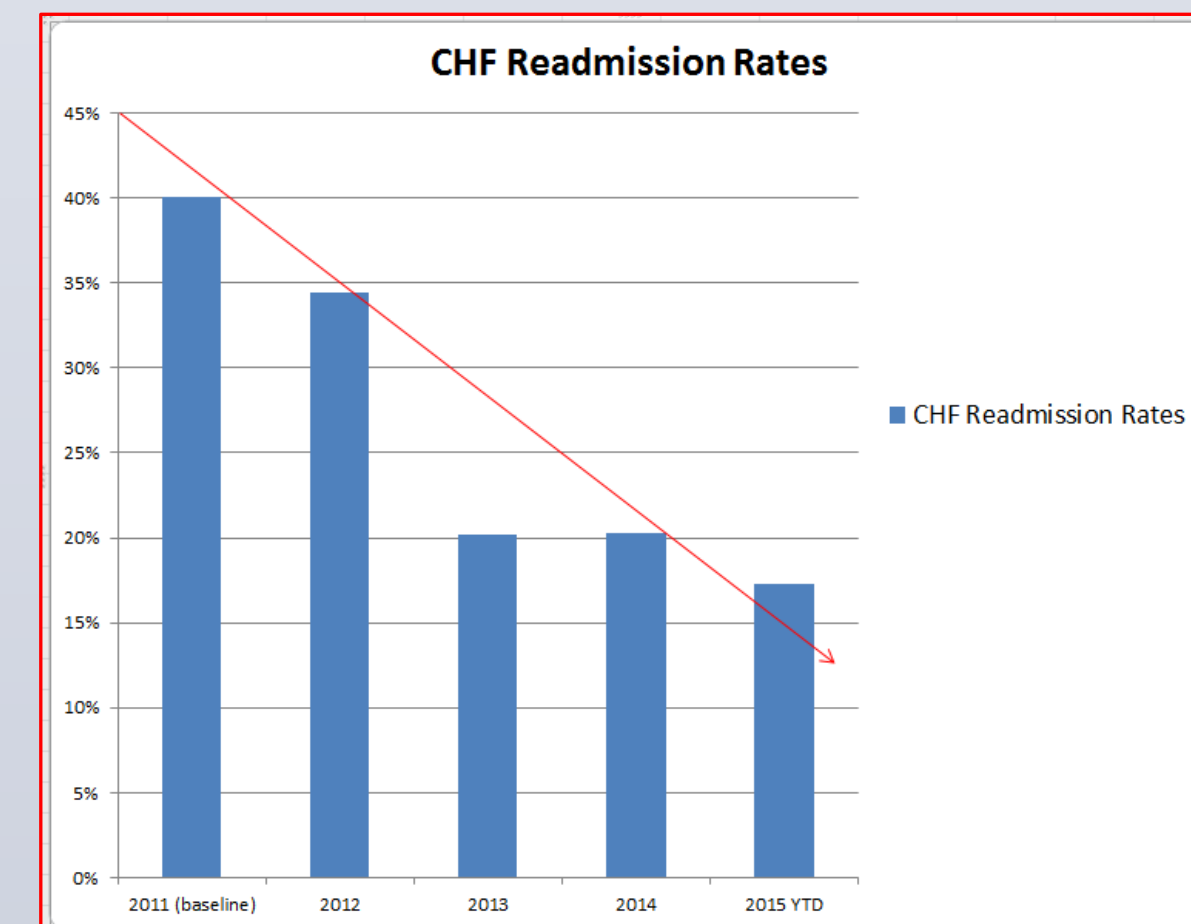
INTERVENTIONS

- ♥ Delgado-Passler et al (2006), determined that post discharge management by nurse practitioners could improve the quality of care given to heart failure patients.^[1]
- ♥ A multidisciplinary team approach for strategic planning and guidance of heart failure patients
- ♥ Development of a nurse practitioner led collaborative team
- ♥ A dedicated inpatient nursing unit staffed with certified heart failure nurses
- ♥ Provide extensive inpatient education that begins at admission and is evaluated with teach back
- ♥ Medication reconciliation and bedside prescription delivery at discharge

- ♥ Discharge plan that includes personalized follow-up phone calls and a follow-up appointment with the nurse practitioner
- ♥ Implementation of an outpatient diuresis clinic
- ♥ Remote impedance monitoring of patients
- ♥ Developed outpatient Cardiac Lifestyle Enhancement Program free to patients and used as a bridge to Medicare/Medicaid's Cardiac Rehab

DATA COLLECTION AND EVALUATION

- ♥ The outcome data for the primary diagnosis of heart failure collected using an equal six months with and without the nurse practitioner and collaborative team was collected in 2012
- ♥ Readmission rates for the first six months without an NP and team was 34.41% and the last six months utilizing the team dramatically reduced the rate to 18.50%. Our year-to-date is 17.26%
- ♥ Guidelines set forth by QualityBLUE^[2] by High Mark Blue Cross/Blue Shield and Get With the Guidelines^[3] (GWTG) by the American Heart Association were utilized to provide optimal care
- ♥ We continue a dashboard delineating the rates/cause on all cause readmission at our monthly multidisciplinary team meetings and that information is used to provide education and guide our future endeavors



RESULTS

- ♥ During a three year time frame our CHF readmission rates went from a baseline of 40% in 2011 to an average of 17.26% year-to-date.
- ♥ We have observed better patient compliance and improved communication between patient and providers.
- ♥ Having dedicated phone access with a provider for weekends and afterhours has provided patients with immediate advice and a sense of security.
- ♥ IV diuresis clinic, remote monitoring and home inotrope therapy has allowed for more patient options and has decreased readmission.

IV DIURESIS CLINIC: COST AVOIDANCE

- 1 required inpatient admission
- 23 did not require admission
- 8 had admission within 30 days prior; 8 HF readmissions avoided
- AHRQ average HR readmission: \$13,000 x 8 = \$104,000 cost avoidance
- 15 without an admission 30 days prior: 15 HF index admissions avoided
- AHRQ average HF admission: \$11,000 x 15 = \$165,000 cost avoidance

\$269,000 in cost avoidance

OUR TEAM



CONCLUSION

- ♥ Education and the use of a multidisciplinary team approach fosters the bond between the providers and the heart failure patient, improving not only their care, understanding of the disease process and self management but also their trust in receiving quality care
- ♥ It is paramount that patients understand heart failure is not a transient disease but a disease that requires constant attention
- ♥ Outcome data demonstrate a positive reduction in readmissions; therefore, the use of a multidisciplinary team and multiple treatment modalities has a causal relationship to the patient adhering to recommendations and having less exacerbations requiring hospitalizations
- ♥ With the focus on readmission rates and reimbursement, having a dedicated heart failure team is essential for decreasing readmissions

REFERENCES

1. Delgado-Passler, P., & McCaffrey, R., The influence of post-discharge management by nurse practitioners on hospital readmission for heart failure. *Journal of American Academy of Nurse Practitioners*, 2006. 154-160. Retrieved January 31, 2014, from <http://www.ncbi.nlm.nih.gov/pubmed/16573728>
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