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Implementation of a heart failure clinic: strategy for reduction in 30-day readmissions

Laurinda Karpel
Binghamton University--SUNY

Implementation of a Heart Failure Clinic: Strategy for Reduction in 30-day Readmissions

Laurinda M. Karpel, RN-BC, FNP, DNP Student

BINGHAMTON UNIVERSITY
STATE UNIVERSITY OF NEW YORK

Background

Approximately 6.5 million adults are living with Heart Failure (HF) in the United States. Heart failure is one of the leading causes of hospitalizations and readmissions.

Preventing 30-day readmissions or Emergency Department (ED) visits is a priority for clinicians, hospital administrators, as well as other stakeholders. Early follow up after discharge with reinforcement of HF education, continuation or escalation of guideline directed medical therapy, and follow up phone calls have been promoted as methods of reducing 30-day readmission rates.

Purpose

The aim of the project was to start a multi-disciplinary HF clinic to reduce 30-day readmissions or ED visits within a large multi-specialty clinic.

Methods

In a community hospital in Northeastern Pennsylvania, a team of providers developed a HF clinic to evaluate patients who had recently been discharged from the hospital with a principal admission diagnosis of heart failure.

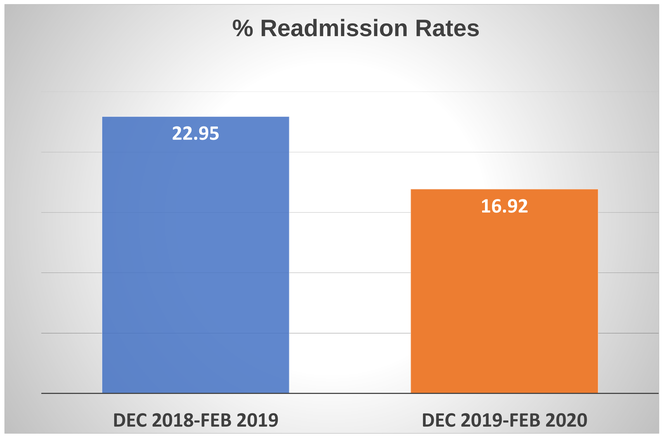
Referrals were initiated primarily by the hospital team, including hospitalists and consulting cardiologists. The clinic would also see acutely decompensating HF patients who were previously established in the outpatient cardiology clinic.

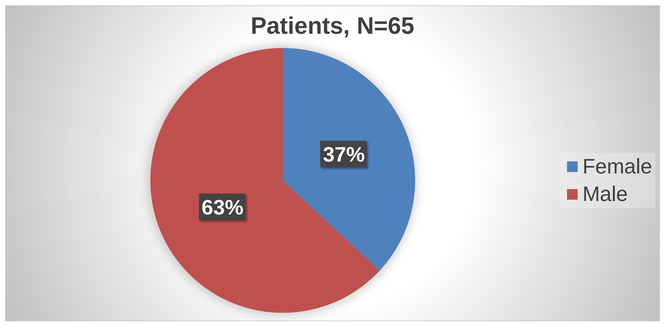
The visit was primarily conducted by one of two heart failure nurse practitioners, in collaboration with a HF registered nurse (RN), and a pharmacist all supervised by a dedicated HF physician.

Theoretical Framework of this project was guided by the Logic Model:

- Utilized by planners, funders, managers, and evaluators of programs and interventions.
- This model includes process and outcome components as well as indicating when to expect certain change.
- Will provide direction and clarity by presenting the big picture of change as well as other important details throughout the project.

Results





- Sixty-five patients met the criteria for evaluation during the three-month study period (N=65).
- Readmission for heart failure within 30 days of hospital discharge occurred in 16.92% of patients during the first three months of the study period, in the sample group.
- In the comparison group, readmission for heart failure had occurred in 23.62% of patients.
- Thus, during this period of the study, we achieved an absolute risk reduction of 6.03% and a relative risk reduction of 0.26% in 30-day HF readmissions.
- Number of IV diuretics administered in the clinic was 29 in sample group compared to 13 in comparative group.

Conclusion

- Our study demonstrates the feasibility of starting a nurse practitioner led HF clinic, in collaboration with a RN and pharmacist, with the specific intent to reduce 30-day readmissions and ED visits.
- Further, despite the small sample size, we documented substantial reductions in HF readmissions within 30-days.
- As team members, Advanced Practice Registered Nurses (APRN), RN's, and pharmacists should continue to advocate for close HF follow up.
- Close follow up, patient access to care, availability of intravenous (IV) diuretic therapy, and HF education are all components of a comprehensive HF clinic and part of the Logic Model devised for this project.

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