



Maximizing Limited Resources in Reducing Readmission Rates in a Heart Failure Transitional Model

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Introduction

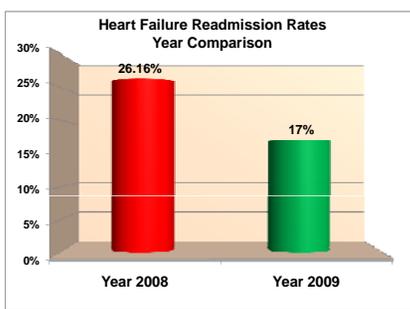
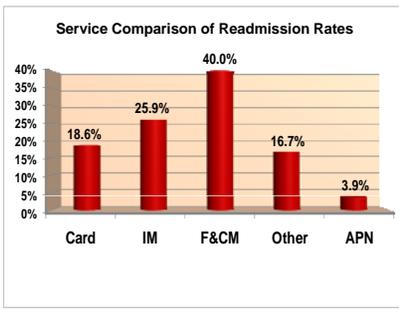
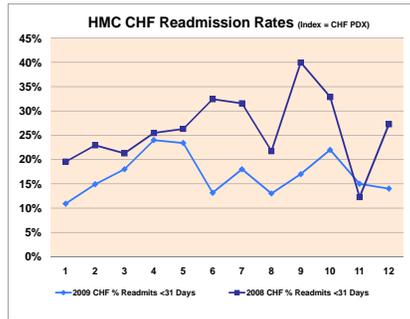
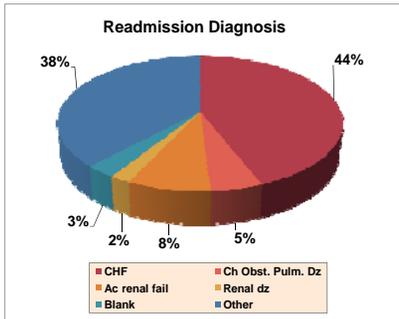
Reducing heart failure 30-day readmissions can be daunting in current economic conditions. This presentation shows the impact of an advance practice nurse consult system on readmission of patients with heart failure.

Methods

Patients at risk were identified daily using the electronic process of the hospital census. Criteria were one hospitalization for any cause and one hospitalization for heart failure. ICD9 codes for all heart failure cases were utilized. Each at risk patient was screened by the nurse practitioner to determine eligibility for a potential consult. An alert was placed on the chart to the primary service providers as a recommendation for a consult for heart failure transitional management. Consult included extensive inpatient education, identification and recommendations of treatment of comorbidities. Detailed, discharge planning and education of the patient and caregivers initiated in the hospital. The consult included follow up care for six weeks, either telephone management and/or clinic visits.

Results

After **six months**, 30-day readmissions for heart failure patients decreased from 23.9% to 18.9%. The nurse practitioner rate for 30-day readmission had the lowest service line readmission rate at 3.9%.



Discussion

Identification of at risk patients is a critical aspect of appropriate use of the nurse practitioner consult. Using the ACC/AHA guidelines of patient selection for heart failure disease management, patients at highest risk should receive the intervention of the nurse practitioner. However only 31% of the patients identified at risk received a consult for heart failure transitional care. Despite this modest number of consults, the impact on readmissions was decreased by 8.16% for the year overall.

Conclusions

Establishing a relationship with a heart failure advanced practice nurse during hospitalization with six weeks of follow-up care demonstrated success in reducing 30-day readmission rates. These results also show that the program is economically feasible in times of limited resources.



References

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