# Reducing Heart Failure Readmissions: An Evidence-Based Approach

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## Background
- Heart Failure (HF) is associated with high morbidity, mortality, and healthcare expenditures.  
- HF is a leading cause of rehospitalization in the United States.  
- HF readmissions lead to poor patient outcomes, decreased patient satisfaction, and increased healthcare costs.

## Problem
There is a considerable need for effective heart failure care that is evidence-based.

## Methods
- A review of literature was conducted using EBSCO Host and CINAHL databases using the search period of 2004-2014.  
- Literature identified the use of Transitional Care Programs (TCPs) and thorough patient education to be greatly effective in reducing HF readmissions.

## Article | Methods | Results
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- Conducted over a four year period.  
- Subjects enrolled (N=239), control group (n=121), intervention group (n=118).  
- Control group received the standard of care.  
- Intervention group received care from Advanced Practice Nurses (APNs). | Statistically significant difference in the rate of readmissions between the intervention and control groups (p=.01).  
- 30-50% reduction in readmissions in intervention group.  
- Patients who received transition care services were significantly less likely to be readmitted to the hospital than patients who received usual homecare services (p = .01).  
- The 30-day readmission rate at BMCG was 48% lower after the intervention.  
- The reduction in readmissions was greater than reductions seen at other facilities within the Baylor Health Care System where the TCP was not in place.  
- Pharmacists involvement was associated with increased adherence to the Joint Commission's core measures related to discharge instructions.  
- Significant reduction in 30-day all-cause readmissions (p = 0.02).  
- Reduction of 30-day HF readmissions did not reach statistical significance.  
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## Conclusion
- Hospitals that go beyond a basic discharge plan and focus on improving patients' transitions from hospital to home will have a greater impact on reducing readmissions.  
- TCPs typically include:  
  - A comprehensive patient assessment  
  - Mechanisms to gather and share information across disciplines  
  - Engagement of patients and family  
  - Services during and after hospitalization coordinated by a master's-prepare nurse.  
  - Multidisciplinary teams and impersonal communication in patients' homes are factors that predict program success.

## Implications for Nursing
- TCPs are nurse-led, multidisciplinary programs that span from the time of hospital admission through the transition from hospital to home.  
- The bedside RN has the important role of providing crucial education to HF patients.