Initiative addresses challenges of managing heart failure

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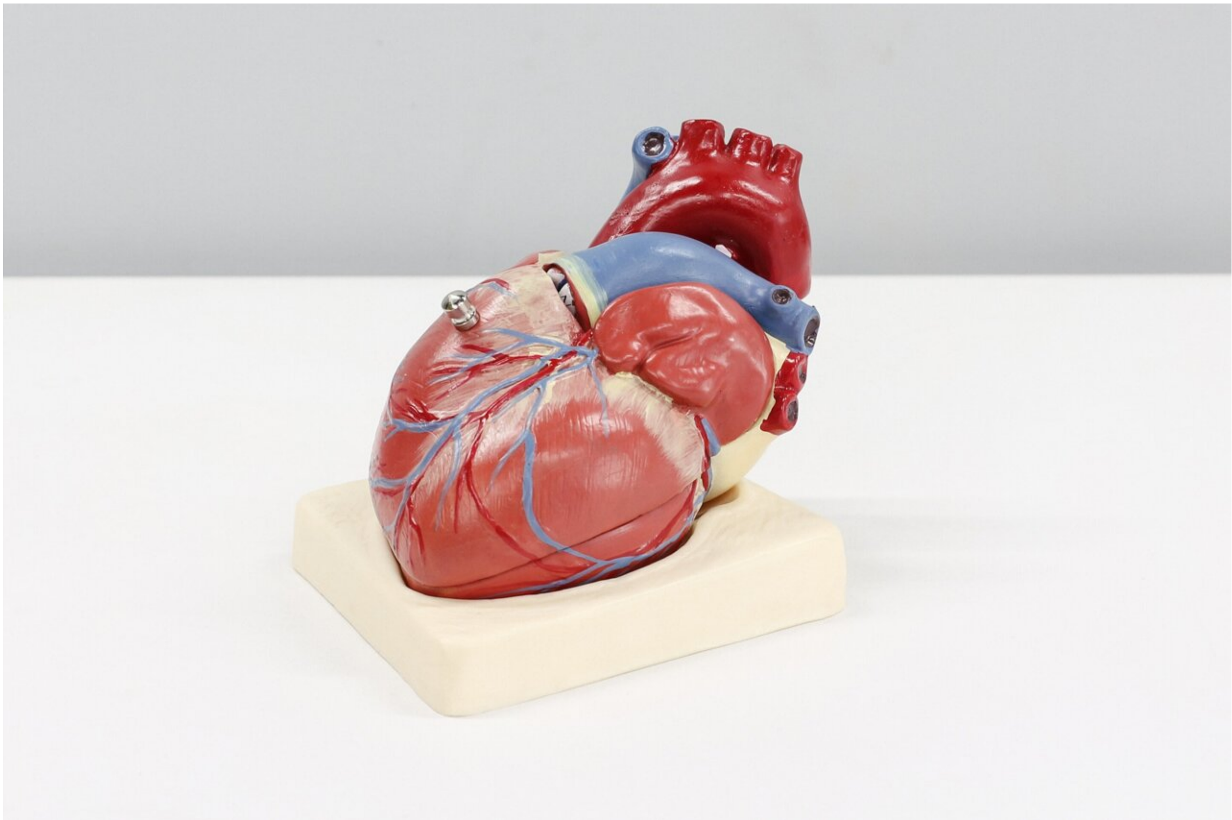

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A pilot program at a New York hospital designed to help patients manage heart failure after being discharged from the hospital quickly improved patient adherence to their medication and treatment plan, and

resulted in fewer readmissions.

"Decreasing 30-Day Readmission Rates in Patients with Heart Failure" details how a program at The Brookdale University Hospital and Medical Center, Brooklyn, New York, empowered the initial cohort of 47 patients with heart failure and their families with self-care strategies, as well as providing them with resources, education and support.

Prior to program implementation, the hospital's 30-day readmission rate for patients with heart failure was 28.6%, which exceeded both the national and New York state's mean readmission rates. For patients in the pilot study, the 30-day readmission rates fell to 12%, with only six patients needing to be readmitted to the hospital. The article is published in the August issue of *Critical Care Nurse*.

With 530 patient beds, Brookdale is one of the largest nonprofit voluntary teaching hospitals in Brooklyn. A safety-net hospital, it provides care for all patients regardless of their financial and insurance status, serving a community with one of the highest poverty and crime rates in New York City.

Co-author Nancy Rizzuto, DNP, MSN, ANP, CCRN, is an adult nurse practitioner and Brookdale's director of nursing for critical care in the cardiology division.

"Managing heart failure is challenging for the patient and the health care provider, requiring adherence to lifestyle changes, dietary restrictions and medications, and learning to recognize when symptoms are getting worse," she said. "Patients often lack resources and require ongoing support and education to help them have optimal outcomes. We focused on empowering them with tools and techniques to manage their health and helping them overcome any feelings of helplessness about their condition."

The initiative used current best practices and guidelines based on recommendations from the American College of Cardiology, American Heart Association and the Heart Failure Society of America.

The cardiology and nursing teams worked collaboratively to develop a standardized checklist/protocol/pathway with order sets to coordinate the care of heart failure patients beginning at admission, throughout their hospital stay, at discharge and during transitions of care.

The pilot program enrolled 47 patients who were admitted to the telemetry unit over the course of a month. Stage 3 systolic heart failure was the most common diagnosis, with 36 patients. Seven patients had stage 2 diastolic heart failure, and four had stage 4 biventricular heart failure.

On a daily basis throughout their hospital stay, patients received individual education on their disease process, medications, diet, exercise and early symptom recognition. They also received a needs assessment to identify potential post-discharge services, such as physical therapy, devices and a home visit with a nurse.

Patients to be discharged were given a follow-up appointment with a cardiologist to occur within seven days and a prescription for their heart failure medications. If needed, the in-house pharmacy filled the initial 30-day prescription and gave the medications to the patient prior to discharge. Case management services arranged for transportation to the cardiologist appointment for patients who needed it. Patients received a call from a nurse 48 to 72 hours after discharge to discuss any concerns and provide additional education.

Of the 39 patients who had a follow-up appointment with a cardiologist, 32 (82%) kept their appointment. None of these patients had exacerbation of symptoms or needed readmission to the hospital.

"We found that 99% of the patients who kept their follow-up appointment with a cardiologist within the first week after leaving the hospital adhered to treatment plans and medications," Rizzuto said.

The six patients who were readmitted said they were not adhering to their medications and diet plan. Additional education reinforced the importance of medication management and provided other strategies to help them. Dietary consults addressed how to modify meals to better accommodate cultural cooking styles, taste preferences and cost concerns.

The journal article also covers efforts to educate the staff about the program and practice patient teaching methods. Following the training sessions, staff adherence to the program components improved substantially, with recommendations carried out in 82% to 98% of patients.

Based on the results from the initial cohort, heart failure patients admitted to the hospital, as well as those with high-risk conditions identified by the cardiology clinic, will be enrolled in the program. The team will continue to review weekly heart failure admission reports and monthly readmission reports and track nurses' and patients' adherence to the program.

More information: Nancy Rizzuto et al, Decreasing 30-Day Readmission Rates in Patients With Heart Failure, *Critical Care Nurse* (2022). DOI: 10.4037/ccn2022417

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