**Sigma's 30th International Nursing Research Congress**

## A Nurse-Led Heart Failure Education Program to Improve Discharge Follow-Up Through Transitional Care

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**Purpose:** The global burden of heart failure is growing with an estimated distribution of 26 million adults living with heart failure worldwide. Heart failure is a burdensome condition, affecting more than 6 million Americans, contributing to nearly 300, 000 deaths each year. The prevalence of heart failure projected to increase 25% by 2030, with 50% of patients having a 5-year mortality rate from the time of initial diagnosis. Thirty day readmission contributes to more than $15 billion dollars in health care expenditures in the U.S. underscoring a need for the development and implementation of programs that reduce readmission and improve outcomes for individuals with heart failure. The purpose of this feasibility study was to implement a nurse-led heart failure education program focused in promoting follow-up care for patients with a goal of improving patient attendance to a transitional care clinic and reducing 30-day readmission.

**Methods:** A convenience sample of (N=22) patients admitted to the hospital with a diagnosis of heart failure or fluid volume excess were invited to participate. Heart failure education sessions were provided prior to hospital discharge. Descriptive statistics, attendance to transitional care clinic, and 30-day hospital readmission were evaluated.

**Results:** Descriptive statistics were analyzed using SPSS® version 24. The mean age was 64 years old with 59% were female and 41% male. There was some improvement but, no statistical significance in attendance to the transitional care clinic in the post intervention period. There was statistical significance for a reduction in 30-day hospital readmission (p=< 0.05) in the post intervention period.

**Conclusion:** A well designed plan for transitional care remains a critical component of patient care necessary to improve post-discharge follow-up and reduce 30-day readmission. Future implications may reveal new material to present to patients upon hospital discharge. Nurses are uniquely qualified to implement evidence-based patient education to promote the improvement of follow-up transitional care and reduce 30-day readmission.

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**Title:**
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**Keywords:**
Heart failure, Readmission and Transitional Care

**References:**
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**Abstract Summary:**
Readmission for patients with heart failure are an on-going concern for hospitals, healthcare policymakers, patients and families. In this presentation, we will discuss a nurse-led evidence-based education program used to improve post discharge follow up through transitional care and reduce 30-day readmission for patients with heart failure.

**Content Outline:**
Introduction:

1. The global burden of heart failure is growing with an estimated distribution of 26 million adults living with heart failure worldwide

2. The prevalence of heart failure projected to increase 25% by 2030, with 50% of patients having a 5-year mortality rate from the time of initial diagnosis. T

3. Thirty day readmission contributes to more than $15 billion dollars in health care expenditures in the U.S. underscoring a need for the development and implementation of programs that reduce readmission and improve outcomes for individuals with heart failure.

Body of presentation:

By the end of this session, the learner will be recognize 3 concepts of transitional care:

1. Previous studies show that transitional care programs improve health outcomes for individuals with heart failure
2. Including education about transitional care services at discharge can increase likelihood of patients using this resource
3. Transitional care interventions and services can be used to successfully reduce 30 day readmission for patients with heart failure

By the end of this session, the leaner will be able to recognize 2-3 concepts of care addressed in heart failure education:

1. Adequate knowledge about heart failure is an important factor for patients to recognize symptoms, understand disease process, and seek appropriate advice.
2. Nurse-led transitional care clinics can be used to facilitate follow-up appointments, care, and heart failure education
3. Patients who receive education focused on transitional care are more likely to attend transitional care clinic appointments.

By the end of this session the learner will identify 3 factors that contribute to readmission:

1. Various reasons contribute to hospital readmission in heart failure patients. Research shows that patient's lack of understanding about disease process, inadequate level of symptom recognition, inability to make appropriate decision to alleviate symptoms
2. The absence of timely follow-up once patient has transitioned from hospital to home contribute to the increased readmission rate for heart failure patients.
3. It is important to provide adequate and efficient patient education by nurses during inpatient hospitalization, incorporated with a scheduled follow-up visit within seven days post discharge is essential to promote transitional care appointments reduce 30-day readmission.

Conclusion:

1. A well designed plan for transitional care remains a critical component of patient care necessary to improve post-discharge follow-up and reduce 30-day readmission.

2. Nurses are uniquely qualified to implement evidence-based patient education to promote the improvement of follow-up transitional care and reduce 30-day readmission.

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**Author Summary:** Dr. Baptiste has had a 18-year nursing career devoted to caring for adults, specializing in cardiovascular prevention and health care. She has recently joined the Johns Hopkins Hospital Emergency Medicine Leadership Team, assisting nurse leaders working on various quality improvement projects. Dr. Baptiste has published in areas of heart failure and cultural humility. She has presented nationally and internationally in areas of nursing education with a promoting nurse competencies in acute-care clinical settings.

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