The Clinical Nurse Leader: Establishing Relationships That Result in Decreased Heart Failure Readmissions
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Background: Heart Failure (HF) readmissions have adverse consequences for patients who often suffer poor outcomes, as well as healthcare networks that incur financial penalties. Our six hospital health network’s inpatient HF program failed to decrease the readmission rate, which remained at 24%. We focused on improving care transitions with a new outpatient effort utilizing a clinical nurse leader (CNL), a master’s prepared nurse generalist who brings evidence-based practice and patient-centered care to healthcare microsystems. Purpose: The aim of this project was to decrease hospital readmissions for HF patients utilizing a new nursing role.

Methods: The target population was patients discharged from the hospital with a primary diagnosis of acute HF. The decision to utilize the CNL came after our network’s administrative task force reviewed a variety of programs that had achieved positive outcomes. It was decided to remodel the existing inpatient program and to bring the focus to the outpatient domain. A team of two CNLs and two mid-level providers was formed and positioned in the network-owned cardiology office. Tele-monitoring was the key in assessing each patient’s risk for readmission. This was done by calling patients within 72 hours after discharge. Patients often left the hospital environment with little means to self-manage their condition. By establishing relationships and utilizing the teach-back method, the CNL was able to assess the patient or caregiver for an understanding of self-care strategies and adequately guide the patient or caregiver. Early follow-up office visits with the patient’s healthcare care provider (HCP) or one of the mid-level practitioners was done. The CNL led the team to make decisions on medication adjustments or more frequent office visits, and, as the care coordinator, had the means to assist the patient with a referral to a home health agency or other community resource. This process of extensive and intensive follow-up proved rewarding with positive outcomes; however, gaps in care still existed. The CNL then fostered a collaborative relationships with skilled nursing facilities and a palliative care transition with a new outpatient effort utilizing a clinical nurse leader (CNL), a master’s prepared nurse generalist who brings evidence-based practice and patient-centered care to healthcare microsystems.

Results: The CNL significantly impacted the readmission rate of HF patients. Enhanced network-wide. The network readmission rate for fiscal year 2013 was 15%.

Conclusions: This was the key in assessing each patient’s risk for readmission. This was done by calling patients within 72 hours after discharge. Patients often left the hospital environment with little means to self-manage their condition. By establishing relationships and utilizing the teach-back method, the CNL was able to assess the patient or caregiver for an understanding of self-care strategies and adequately guide the patient or caregiver. Early follow-up office visits with the patient’s healthcare care provider (HCP) or one of the mid-level practitioners was done. The CNL led the team to make decisions on medication adjustments or more frequent office visits, and, as the care coordinator, had the means to assist the patient with a referral to a home health agency or other community resource. This process of extensive and intensive follow-up proved rewarding with positive outcomes; however, gaps in care still existed. The CNL then fostered a collaborative relationships with skilled nursing facilities and a palliative care transition with a new outpatient effort utilizing a clinical nurse leader (CNL), a master’s prepared nurse generalist who brings evidence-based practice and patient-centered care to healthcare microsystems.

144 Identification of Heart Failure Patients Requiring Palliative Care Utilizing a High Risk Phenotype
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Introduction: PC of End Stage HF (ESHF) patients uncommon due to lack of known high risk predictors of HF mortality. Purpose: Examine referral frequency HF patients to PC. Identify high risk indicators hospitalized ESHF patients in tertiary and community setting. Identify specific high risk phenotype of ESHF patients requiring PC. Subjects/Methods: Medical records of 1st 200 HF admissions in suburan tertiary center and 1st 100 HF admissions in community hospital with primary DCHF discharge diagnosis retrospectively reviewed in 2008 & 2010. ADHERE criteria (SBP < 115 mmHg, blood urea nitrogen > 43 mg/dl, creatinine > 2.75 mg/dl) used to predict in-hospital mortality. Framingham CHF criteria used confirm HF diagnosis. Seattle HF Model (SHFM) calculator used to assess discharge to predict one-year mortality. 1 year follow-up from hospitalization and HF related lab values/clinical data. Cut Chart developed to define low/mod/high dose diuretics listed in SHFMC. Referrals to PC/Hospice, patient expirations noted. Results: Purposive sample (n=300) Patients separated into 2 groups based upon SHFM mortality calculated at DC (H &gt; 10% and &lt; 10%), chi square analysis, independent t test performed. All three cohorts statistically analyzed. Cohort 1 comprised initial 200 patients from Tertiary Care Medical Center. Cohort 2 comprised 100 patients in Community Hospital. Cohort 3 combined Cohort 1 and 2 (n=300). Framingham criteria for diagnosis HF met in 252 patients. Framingham group (n=252): (n=85) had a &gt; 10% mortality, and (n=167) had &lt; 10% mortality calculated by SHFM. Statistically significant findings &gt; 10% (n=85) group in all 3 cohorts: combined Cohort 3 (n=252) comprised of 62.4% male, 91.8% non-hispanic white, mean age 75 (SD=151). Identical statistically significant findings replicated in each cohort, and both cohorts combined. Combined cohort most functionally compromised (NYHA Class III 69.4%, IV 29.4%, 37.6% had HCPs. Life expectancy 5.6 years, PC referrals 4.7%. Phenotype of High Risk Indicators (PHRI) identified as DCHF patients at discharge with: Low discharge SBP/cholesterol/EF &lt; 31%, BUN &gt; 35 mg/dl, ischemic etiology, higher diuretic dose (defined in Diuretic Cut Chart), patients on no statin identified as being at higher risk of mortality. Conclusions: PHRI will provide objective method of determining high risk HF patients upon discharge, and increase referrals to PC. Implications: Timely referral HF patients to PC not offered in most cases in both settings. Familiarizing health care providers with objective criteria for evaluation of the potential need for PC referrals is needed. Keywords: BUN=Blood Urea Nitrogen, EOL=end of life, DC=di- charge, HF=Heart Failure, DCHF=decompensated Heart Failure, SBP=systolic blood pressure, PC=palliative care, ESHF=end stage heart failure, SHFM=Seattle Heart Failure Model, HCP=health care proxy, PHRI=Phenotype High Risk Indicators

145 A Novel Palliative Care Program for Patients with Chronic Heart Failure That Decreased Readmission Rates
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Background: Heart failure (HF) diagnoses continue to rise. As patients live longer and with more comorbidities they struggle with profound symptom burden that often will limit their ability to participate in even minimal life activities. The unpredictability of the HF prognosis leaves patients, caregivers and healthcare providers (HCP) perplexed regarding what to expect and how to care for this patient population. New guidelines have brought to light the reality that palliative care (PC) needs to be integrated into the continuum of care for HF patients. The aim of this initiative was to decrease readmissions by offering a palliative care program to patients with HF. Methods: The clinical nurse leader (CNL)/Heart Failure Care Coordinator (HFCC) working in an outpatient HF program within a six-hospital health network in northeastern Pennsylvania led an interdisciplinary team to find an evidence-based palliative care program (PC) for HF patients within the HHC network. The team consisted of a PC physician, the CNL/HFCC, two mid-level providers and the network home health care (HHC) department, which included nurses, therapists and social workers. Referrals were made to the team, not the PC physician. Criteria for enrollment were established and a care path for the HHC nurse was introduced. This program was started in tandem with usual medical care. Patient-centered care was the primary goal for this program, operationalized as identifying and fostering patient decision-making. The tenets of the program were introduced to HCPs within the network. The team met to assess and discuss patient progress every two weeks and made recommendations for interventions as appropriate. Of note, opioid use, as indicated to relieve dyspnea, was introduced to some patients from this population in small doses. Those patients who opted to receive opioids reported improvement in symptoms. The patients initially were covered under their insurance for the HHC team visits but as they progressed to a less acute state the insurance would no longer cover them. The network decided to then cover the cost of the HHC team; including nurses and social workers. Results: The network readmission rate fell from 24% to 15% and this program was seen as one of the reasons for this reduction. As of this writing the PALS HF program has enrolled 80 patients, with a 16% readmission rate, a proven win-win for the patients and the health care network. Conclusions: The PALS HF program has realized a reduction in readmissions of enrolled patients. This happened because there was a fundamental change in the process of care delivery. Furthermore, network administration was willing to financially back this novel process of care delivery, reaping additional revenue over the long term. Most importantly, patient outcomes improved as a result of this program.

146 Prognostic Value of Body Fat Mass in Acutely Decompensated Heart Failure
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Introduction: The protective role in acutely decompensated heart failure (ADHF) patients has been reported. In previous studies, higher fat mass was associated with lower level of N-terminal pro-brain natriuretic peptide