HEART FAILURE DISEASE MANAGEMENT PROGRAM (HFDMP)

AT JESSE BROWN VAMC

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Background

- Heart Failure (HF) is associated with:
  - Increased hospital readmission rates
  - Decreased quality of life
  - Decreased functional status

- Dedicated Nurse Practitioner (NP)/ Advanced Practice Nurse-led HF Disease Management Programs (HFDMP) *in collaboration with HF Cardiologists* -focused on self-care have shown to be cost-effective and improve outcomes in HF patients.

- Recently a NP/ HF Cardiologist-led HFDMP was implemented at a VA Medical Center to meet the needs of the veterans diagnosed with HF.

HFDMP Development Processes and results

- Need for dedicated evidence based low cost HF program to reduce hospital readmission rates without compromising quality of care is identified in November 2009.
- Based on Literature search, NP-led HFDMP with focus on improving self care among veterans with HF was planned by February 2010.
- Collaborating Physician, Nurse Practitioner, nursing staff, clinic space, and equipment are secured by August 2010
- Heart Failure Booklet written and printed by July 2010, and the CHF video copyrights are secured by August 2010.
- Nursing Staff in specialty care and telemetry trained for program by September 2010
- The physicians and nursing staff are educated about the program, and electronic consult initiated
- By September 27th HFDMP is initiated and is currently runs 2 full days a week
- The plan for starting a HFDMP was approved in December 2009.
- The HFDMP clinic was started on September 27th 2010 and fully operational in October 2010.
- To date, the HF program has expanded from one-half day to 2 full clinic days and one-half NP run telephone consultation clinic day.
- The HF booklet has become a great success among the veterans and staff.
- CHF video placed on CCTV by September 2010 and runs at 9am and 6pm every day.
- Nurses role in educating patient using the HF booklet and the HF video, and doing the 6 minute walk test have been clearly established.
- Patients are being referred to the HFDMP by physicians and nurses via electronic consults and word of mouth, respectively.
- There are 42 patients enrolled in the program

HFDMP

- It is a 90-day intense program focused on self-care
- It is an acute HF Program to see patients within 7-days of discharge
- Patients are recruited during in-patient rounds and via electronic consults
- Team: Cardiologist + NP
- Clinic Days: Mondays + Wednesdays

Outcomes

- Primary Outcomes
  - Decrease HF related re-hospitalizations
  - Improve self care activities and quality of life

- Secondary Outcomes
  - Increase HF knowledge
  - Increase functional status

Methods

I. **Initial clinic visit includes**:

- Obtaining baseline measures
- Six Minute Walk test
- Viewing a 12-minute HF video
- One-on-one HF self care education from the nurse using a "*HF Management Guide*"

*__Hand-held ECHO by MD__

Methods

- II. After initial session, patients come every two weeks or prn to the clinic for a 30-minute clinical follow-up and education sessions and receive:
  - Review of their HF self-care log
  - HF management by the NP
  - Medication reconciliation
  - One-on-one in-clinic education sessions by NP

- III. Patients also receive weekly telephone consultations

Results

- Clinic has expanded from ½ day to 2 days
- We now have +50 acute consults
- Only 5 patients have been discharged

Data on 42 patients

- very complex HF patients
- 10 completed the program
- 4 hospitalizations- 2 sec to other causes
- 1 death: non-cardiac causes

Limitations

- Space
- Staff- nurses are covering too many clinics so not always available to do teaching or help with 6 MWT
- Pharm-D promised- not yet delivered
- NP and HF MD have other obligations
- Budget cuts/ hiring freeze
- High acuity and high patient volume - not always able to discharge patients after 90-days

Conclusions

- Low Cost
- Successful in meeting outcomes
- Sustainable
- Can be replicated at other VAs