A Nurse-Led Heart Failure Education Program to Improve Discharge Follow-Up Through Transitional Care: A Quasi-experimental Study

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Background

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 and is projected to increase 25% by 2030. Heart failure hospitalizations are associated with an estimated $32 billion dollars in health care costs with the highest frequency of readmissions.

Aims and Objectives

The purpose of this quality improvement project was to implement a heart failure education program focused on increasing attendance to a transitional care clinic after hospital discharge, and reduce 30-day readmissions.

Methods

We employed a quasi-experimental design, enrolling (N=22) participants. A nurse-led heart failure education program was implemented using standardized heart failure education materials focused on symptom management and transitional care.

Figure 1. Standardized Heart Failure Education Brochure

Baseline data was collected on N=146 and N=22 individuals attending the clinic over a 6-month period. We evaluated post hospital discharge attendance to a transitional care clinic, and readmission.

Results

There was a significant improvement with follow up attendance at the transitional care clinic (< p=0.05) and a decrease in 30-day hospital readmissions. Among the (N=22) participants, 64% were not readmitted into the hospital 30 days after discharge.

Figure 2. 30-Day Hospital Readmissions Post Intervention

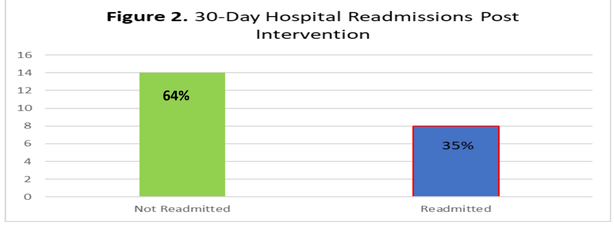

Table 1. Demographic characteristics (N=22)

	Frequency/Percentages	Means (SD)
Age		64.5 (10.1)
Sex		
Male	9 (41%)	
Female	13 (59%)	
Race		
White	10 (46%)	
Black	11 (50%)	
Latino/Hispanic	1 (4%)	

Table 2. Post-discharge attendance to transitional care clinic

Pre-intervention	Post-intervention	*P*-value
N=146	N=22	
1.27 (.456)	1.24 (.427)	< 0.05

Conclusion

Results from this study reflect the importance of using standardized education materials and positive impact of a transitional-care focused heart failure education program on hospital 30-day readmission rates. Further investigation is necessary to explore the association between increased transitional care follow-up and improved self-management of heart failure.

References

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64%

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