Home Health Transitional Care Interventions (TCI) to Reduce Rehospitalization in Geriatric Patients with Heart Failure

Rose Munuve'-Akinnola, BSN, RN
Sonya Wade, DNSc, APRN, RN, FNP-BC, Shainy Varghese, PhD, APRN, RN, CPNP

UNIVERSITY of HOUSTON
COLLEGE of NURSING

Practice Concern

- 5.7 million Americans aged 20 years or older living with Heart Failure (HF). [4,5]
- Prevalence of HF is still increasing; more than 8 million Americans will be living with HF by 2030. [4]
- Approximately 70% of these will be 65 years of age or older. [4]
- Costs of HF care will increase almost 3-fold for those over 65 years of age by 2030. [3,5]

Needs Assessment

Increase in Medicare Penalties

- Center for Medicare and Medicaid Services (CMS) fiscal year 2018, approximately $564 million withheld in HF rehospitalization penalties, higher than $528 million withheld for FY 2017. [6]

Cost of illness

- HF is the most common cause of index hospitalization (1 in 4) in Americans aged 65 and older. [2]
- Medicare population has highest unplanned HF rehospitalization rates accounting for $2.7 billion in Medicare spending in 2013.[1,6]
- Total costs of HF, including indirect costs will increase from $31 billion in 2012 to $70 billion in 2030. [3,6]

Human burden of rehospitalization

- Poor health outcomes in terms of quality of life and mortality. [1]

PICOT Question

In patients aged 65 and older with HF, how does high-intensity transitional care compare to regular transitional care in reducing unplanned rehospitalization within six months of hospital discharge?

Literature Review

- **Databases**: CINHAL, Cochrane , EMBASE, PubMed
- **Keywords**: Heart failure, rehospitalization, geriatrics, transitional care interventions

Inclusion Criteria	• English or Spanish language studies • Full text available • Rehospitalization for HF within six months of index HF admission • Utilizing TCI and a control group receiving usual care
Exclusion Criteria	• Telephone or clinic visit follow up only • Discharged to elsewhere (not home)
Levels of Evidence	• 6 Level 1 • 8 Level 2

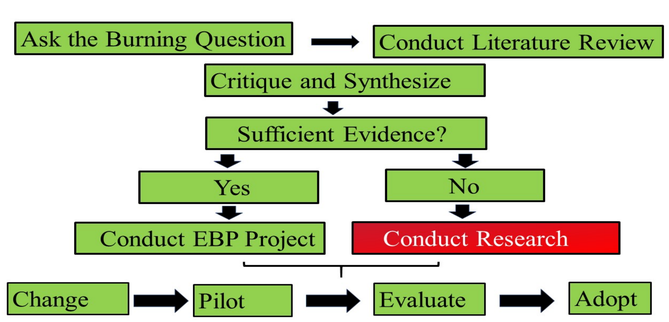
- **Summary of Literature:** High intensity TCI at home reduces rehospitalization in patients with heart failure. [7]

EBP Guidelines

- All patients with HF should be assessed for risk of rehospitalization using the Hospitalization risk assessment screening tool.
  - Factors in prior patterns, existing chronic conditions, risk factors
    - Based on scoring of 5 or greater factors assessed
      - Coordinate multidisciplinary home visits
      - More visits first few weeks of episode
- Utilize an evidence-based HF Disease Management program including teaching tools, to assure consistency in care and patient teaching.
- Focus should be on helping patients to understand and retain information using the Teach Back Method of education.
  - Patients or family members explain in their own words what they need to do or know.

Theoretical Framework

IOWA Model of Evidence-Based Practice and Research



Titler, M. (1994) [5]

Implementation

Pilot the change

- Provider Education
  - Face to Face interdisciplinary team of Nurses, Physical Therapists and Speech Therapists.
- Tools
  - Hospitalization risk assessment screening tool and use Teach-Back method consistently.
- Stakeholders
  - Governing Body - Legal oversight of agency management and operation.
  - Administrator - Responsible for day-to-day operations.
  - Staff nurses and Patients.
- Cost
  - Agency absorbs $850 in training hours and materials. Cost offset by savings of $3,650 per quarter in HF home health resumption of care assessments cost.

Evaluation

CMS-CASPER system reports for Pre and post comparison of HF rehospitalizations 6 months after implementation of practice change.

- Is there a decrease in HF rehospitalization within 6 months?

Adopt and institute change in practice.

References

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