

PURPOSE

To demonstrate key role NPs have in HF management initiating new chronic care models to lower 30-day readmissions and increase HF clinic referrals in Accountable Care Organizations

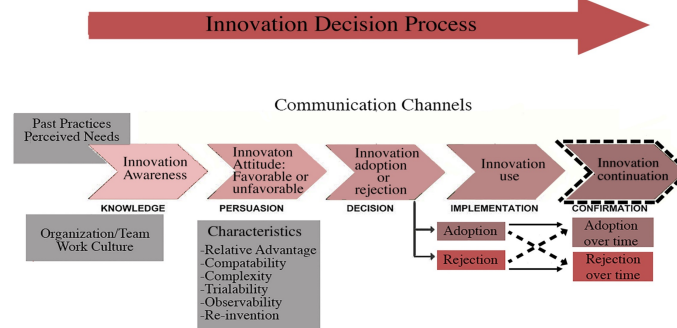
BACKGROUND

- Heart Failure (HF) is a chronic syndrome with high 30-day readmissions in Medicare patients
- Fee-for-service episodic HF care has poor patient outcomes and drains financial resources
- Hospitals seek initiatives to improve 30-day HF readmissions and transform health care systems
 - Accountable care organization models focus on quality, affordable care across settings

METHODS

- Retrospective electronic data chart review design from April 2013 to April 2014
- Sample: patients admitted to hospital with HF (n= 120)
- Nurse Practitioners: PPP outlining new HF clinic initiative**
- ACO (intervention group, n= 60)/Non-ACO (control, n= 60)
- 30-Day readmits/HF clinic referrals tracked post hospital d/c
- χ^2 analyses measured outcomes in ACO/Non-ACO groups

DIFFUSION OF INNOVATIONS IN HEALTH CARE



TERMS

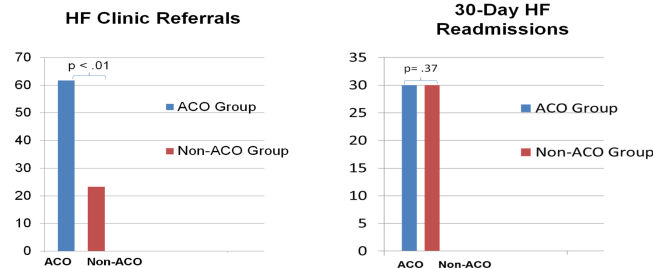
ACOs = Accountable Care Organizations
Non-ACOs = Non-accountable care organizations

30-DAY HF READMISSIONS = National rates ~20-25%
HF CLINIC REFERRALS = HF clinic patient referrals post hospital d/c

Descriptive Analysis Baseline Demographics (N = 120)

Variables	n	%
Age		
≥75	85	70.8%
Gender		
Female	63	52.5%
Race		
Caucasian	110	91.7%
Lives Alone		
No	95	79.2%
≤ 10 Miles to Clinic		
Yes	97	80.8%
NYHA Class		
I-II	83	69.2%
LV Ejection Fraction		
40% & higher	72	60%
Heart Failure Type		
Chronic	101	84.2%

FINDINGS



IMPLICATIONS

- 30-day HF readmissions between ACO/Non-ACO groups not statistically significant
- HF clinic referrals between ACO/Non-ACO groups statistically significant
- ACO group over 5x more likely to refer to HF clinic than non-ACO group
- Results suggest an innovative model can be adopted in existing health care systems using nurse practitioners