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The Effect of an Empowerment Program on Geriatric Patients with Heart Failure

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Background and Significance of the Problem

Heart Failure statistics

- 20 million people worldwide
- 5.7 million people in the United States

Approximately 50% of the people who develop heart failure die within five years of diagnosis

Aging population and numerous hospital readmissions of patients with heart failure creates pressure on health facilities

Heart failure causes more hospitalizations than all forms of cancer combined

The Hospital Readmissions Reduction Program lowers reimbursements for heart failure readmissions

(Brennan, 2018; Deniger, Troller, & Kennelty, 2015; Long, Babbitt, & Cohn, 2017; Vedel & Khanassov, 2015)

Purpose and Intervention

The purpose of this project was to examine the effect of the Patient Empowerment Program (PEP) on hospital readmission rates and other clinical outcomes of geriatric patients with a primary diagnosis of heart failure in a home health setting.

Patient Empowerment Program (PEP)

- Transitional care interventions
 - Skilled Nurse: assess and educate
- *Heart Failure: Patient Guide to Managing Your Disease and Reaching Your Goals.*
- Equipment

Data Collection Tool

- A researcher-generated Data Collection Sheet

Reliability & Validity

- Based on outcomes found in literature
- Direct reflection of patient outcomes for 30 days

Socio-demographic Data	Age
	Gender
	Race
	Highest level of education
	Living arrangements
	Clinical comorbidities
	Insurance
Transitional care	Discharge date
	Date Care Manager RN contacted patient
	Number of nursing visits
	Number of physical therapy visits
Plan of care	Prescribed HF drugs
	Diuretics added to care plan
	Educated on signs and symptoms of HF
30-Day Impact	Number of ER visits
	30-day readmission date (if applicable)
	Number of hospital readmissions (if applicable)

Sample and Setting

- Pre-intervention ($N = 18$) EMRs and post-intervention ($N = 34$) EMRs
 - Patients 65 years and older
 - Homebound
 - Primary dx of heart failure
 - Known status of patient 30 days after admission into the program
- Home health agency's administrative office
- Access to electronic medical records
- Providers
 - skilled nursing, physical therapy, speech therapy, occupational therapy, social worker services, home health aides

The background of the slide is a dark orange-red gradient. On the left side, there are two vertical panels. The top panel is a dark blue/black rectangle containing the title 'Inferential Statistics' in white. The bottom panel is a larger area showing a stylized data visualization with a grid of dashed lines in blue and green, and vertical bars of varying heights in green and yellow, resembling a candlestick or bar chart.

Inferential Statistics

- Pearson correlation revealed significant, moderate relationship
 - between number of PT visits and age ($r = .453, p < .01$), suggesting that as age increases, the number of PT visits also increased
- Chi square differences were found between
 - pre- and post-intervention samples and whether education was provided ($\chi^2_{(1)} = 7.415, p < .01$)
 - number of ER visits and whether the patient was on HF medication ($\chi^2_{(1)} = 4.455, p < .05$)
 - number of hospital readmissions and whether the patient was on HF medication ($\chi^2_{(1)} = 4.455, p < .05$)

Impact for Nursing Practice, Organization and System

Findings have implications for home health providers and policymakers in guiding practice changes for managing HF patients in the community.

Findings provided evidence for the home health company that the PEP intervention improves clinical outcomes and should thus be sustained.

Conclusion

Previous studies focused on 6-12 month duration; this study found 30-day results

Findings added to the body of literature that suggests transitional care models reduce readmission rates among the elderly

PEP was effective in improving patient outcomes

References

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Questions

