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

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


Questions