HEART FAILURE DISEASE MANAGEMENT PROGRAM (HFDMP)

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Presented by:
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Heart Failure (HF) is associated with:
- Increased hospital readmission rates
- Decreased quality of life
- Decreased functional status

Dedicated Nurse Practitioner (NP)/ Advanced Practice Nurse-led HF Disease Management Programs (HFDMP) in collaboration with HF Cardiologists - focused on self-care have shown to be cost-effective and improve outcomes in HF patients.

Recently a NP/ HF Cardiologist-led HFDMP was implemented at a VA Medical Center to meet the needs of the veterans diagnosed with HF.
Need for dedicated evidence based low cost HF program to reduce hospital readmission rates without compromising quality of care is identified in November 2009.

Based on Literature search, NP-led HFDMP with focus on improving self care among veterans with HF was planned by February 2010.

Collaborating Physician, Nurse Practitioner, nursing staff, clinic space, and equipment are secured by August 2010.

Heart Failure Booklet written and printed by July 2010, and the CHF video copyrights are secured by August 2010.

Nursing Staff in specialty care and telemetry trained for program by September 2010.

The physicians and nursing staff are educated about the program, and electronic consult initiated.

By September 27th HFDMP is initiated and is currently runs 2 full days a week.

The plan for starting a HFDMP was approved in December 2009.

The HFDMP clinic was started on September 27th 2010 and fully operational in October 2010.

To date, the HF program has expanded from one-half day to 2 full clinic days and one-half NP run telephone consultation clinic day.

The HF booklet has become a great success among the veterans and staff.

CHF video placed on CCTV by September 2010 and runs at 9am and 6pm every day.

Nurses role in educating patient using the HF booklet and the HF video, and doing the 6 minute walk test have been clearly established.

Patients are being referred to the HFDMP by physicians and nurses via electronic consults and word of mouth, respectively.

There are 42 patients enrolled in the program.
HFDMP

- It is a 90-day intense program focused on self-care
- It is an acute HF Program to see patients within 7-days of discharge
- Patients are recruited during in-patient rounds and via electronic consults
- Team: Cardiologist + NP
- Clinic Days: Mondays + Wednesdays
Outcomes

Primary Outcomes
- Decrease HF related re-hospitalizations
- Improve self care activities and quality of life

Secondary Outcomes
- Increase HF knowledge
- Increase functional status
Methods

1. Initial clinic visit includes:
   - Obtaining baseline measures
   - Six Minute Walk test
   - Viewing a 12-minute HF video
   - One-on-one HF self care education from the nurse using a “HF Management Guide”

*Hand-held ECHO by MD
II. After initial session, patients come every two weeks or prn to the clinic for a 30-minute clinical follow-up and education sessions and receive:

- Review of their HF self-care log
- HF management by the NP
- Medication reconciliation
- One-on-one in-clinic education sessions by NP

III. Patients also receive weekly telephone consultations
Results

- Clinic has expanded from ½ day to 2 days
- We now have +50 acute consults
- Only 5 patients have been discharged

Data on 42 patients
- very complex HF patients
- 10 completed the program
- 4 hospitalizations- 2 sec to other causes
- 1 death: non-cardiac causes
Limitations

- Space
- Staff- nurses are covering too many clinics so not always available to do teaching or help with 6 MWT
- Pharm-D promised- not yet delivered
- NP and HF MD have other obligations
- Budget cuts/ hiring freeze
- High acuity and high patient volume - not always able to discharge patients after 90-days
Conclusions

- Low Cost
- Successful in meeting outcomes
- Sustainable
- Can be replicated at other VAs