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An intensive nurse practitioner (NP) lead congestive heart failure (CHF) home-based primary care (HBPC) initiative: A cost effective method to deter rebound admissions and emergency department (ED)visits while improving symptoms and quality of life

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Heart failure is a difficult and costly medical condition to manage and rebound admissions plague hospital systems now driven to focusmanagement into the outpatient setting. This HBPCNP Lead Team in partnership with Cardiology and Geriatrics developed a twelve point twelve week intensive outcome based education, symptom management and intensive intervention program to reduce rebound and ED visits. CHF high medical use patients were identified by inpatient medicine team members and Case Managers as having had 3 or more hospital admissions for CHF in the previous year, extended inpatient stays for CHF in the previous year and/or high use of outpatient visits including emergency department visits. The program model in its first year reduced CHF ED visits by 78% and inpatient hospital stays by 71% and improved the overall quality of life for participating patients. Improvements were sustained over the following 12 months. The Nurse Practitioner lead HBPC model is a highly successful cost effective method for reducing medical costs for refractory CHF patients while improving symptom management and quality of life.

Biography

Bridget Vetere Kmetz (Vetere-Overfield), completed an MS for Family Nurse Practitioner at the University of Maryland. She Leads a Rural Mobile Medical Clinic Team at the Richmond Virginia VAMC, is the Commander of the 7218th Medical Support Unit in Louisville Kentucky as an Army Reservist and serves as an adjunct Professor at Virginia Commonwealth University. She has authored and co-authored over 15 papers and presented numerous poster presentations.She has over 31 years of combined nursing practice. Her focus presently is on rural outpatient delivery of primary care, internal medicine and tele-health.

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