[illegible] women. Pre-program health data (blood pressure, cholesterol, blood glucose levels, body mass index, and health behaviors) were collected to calculate My Life Check scores. A 6-month heart healthy program was developed and delivered using Life's Simple 7 CVD health information. Motivational interviewing was used to address readiness, confidence, behavior change barriers to , goal setting and progress. Post-program health data were obtained on participants with the lowest My Life Check Scores who completed the program. Demographics were tabulated using descriptive statistics and My Life Check scores presented as % change.

RUSH UNIVERSITY MEDICAL CENTER

Improvements in Self-Efficacy Among Heart Failure Patients: A Post-Discharge Telephonic Outpatient Program

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Background

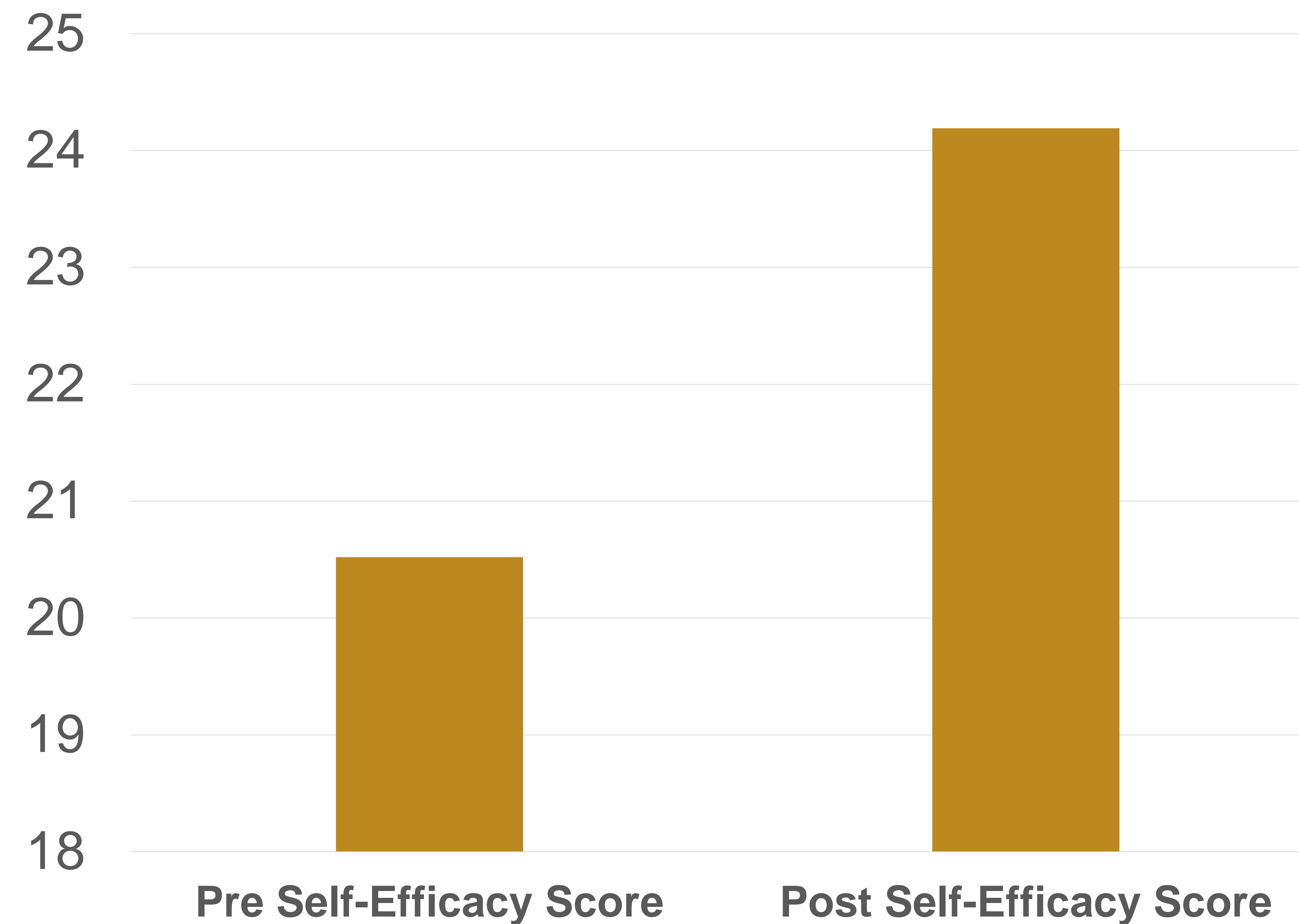
- Heart failure (HF) is the leading cause of hospitalization in patients older than 65 years with many hospitalizations preventable
- Prevalence and cost of HF are high and increasing
- 30 day readmission rate for HF at the clinic is 23.7% versus national average of 22.6%
- Lack of:
  - beneficial health behaviors in a local HF population
  - inadequate hospital discharge follow-up
  - readmission rate higher than the national average

Project Purpose and Focus

- Purpose - Improve HF-related self-efficacy and decrease hospital readmissions for HF patients
- Project impact - Strengthen the clinic tradition of patient-centered care by improving follow-up for HF patients and decreasing HF readmissions

Objectives

- Successful implementation of HF discharge program as evidenced by:
  - 60% patient improvement in HF-related self-efficacy and positive perception of the program as measured by The Self Efficacy Questionnaire (Baker et al., 2005) and satisfaction score
  - decrease the 30-day HF readmission rate to 20% or less among those in the program
  - implementation of HF clinic within two years (long term)



Methods

- Program implementation from September 2015 to May 2016
- Three-part telephone program that included HF-related education, handouts, and a self-efficacy questionnaire
- Participant eligibility: established clinic patient, ejection fraction 40% or less, and recently in the hospital
- *First phone call*: within one week of hospital discharge, collected pre-implementation data, explained project, reviewed basic HF education, mailed handouts after phone call
- *Second phone call*: one week later, used Teach-Back method to review HF medications and lifestyle modifications, asked about new symptoms, set up RN visit if needed
- *Third phone call*: three weeks after first call, collected post-implementation data, assured they had follow up visit and all questions answered

Results

- 21 HF patients recently discharged from a suburban hospital
- Age range: 47-92 years, average 68.4 years, mostly male (66.7%)
- Ejection fraction ranged from 11- 40%, average of 27.9%
- Most (90.5%) reported an adequate support system and 47.6% had college degrees
- Satisfaction scores were unanimously 100% positive for all three questions
- Self-efficacy scores improved an average of 3.52 points of a possible 30 points (p=.001)
- Participants with a higher readmission rates:
  - were 80 years of age and older
  - had lower ejection fractions/sicker
  - had post-implementation self efficacy scores of 22 or less
- 30-day HF readmission rate for participants in the program was 4.8%, all-cause readmission rate was 19%

Implications for APRN Practice

- Telephone program focused on self-management, education, and follow-up can improve HF self-efficacy
- Need to identify at-risk populations (80 years of age or older, self-efficacy score of 22 and less, lower ejection fraction/sicker patients), as they may require closer follow up
  - in-person visit or 'booster session'
  - more phone calls, extra support
  - extra information and reinforcement
- Social worker to help with financial issues