A NURSE BASED BRIDGE TRANSITIONAL CARE MODEL REDUCES READMISSIONS AND ED VISITS

ACC Poster Contributions
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Background: Cardiovascular readmission (readmit) and emergency department (ED) visits following hospitalization are common, costly, and a burden to patients(pt). Most transitional models emphasize discharge education, telemangement, or home-based interventions. In a pilot study of a nurse practitioner out-pt model, pt attendance in a BRIDGE clinic reduced readmit/ED visits. We assessed 30-day readmits/ED visits between cardiac pts who attended the BRIDGE clinic(BRIDGE+) and those who did not (BRIDGE-)

Methods: We retrospectively collected data on pts referred to BRIDGE from June 2008 to Feb 2009, comparing BRIDGE+ to BRIDGE- in terms of age, diagnoses, comorbidities, time to follow-up visit with cardiologist, readmits, ED visits.

Results: Of 342 pts referred to BRIDGE, 230 (67%) attended; mean age 63.1; 55.6% male. Pts with > 2 comorbidities were more likely to attend BRIDGE (≤ 2, 10.9% vs. > 2, 19.6%, p = .027). BRIDGE+ pts were less likely to be readmitted or seen in ED than BRIDGE- (readmit odds ratio 0.34, 95% CI 0.18-0.68; ED 0.42, 95% CI 0.21-0.82). Except atrial fibrillation pts, attending BRIDGE clinic was associated with a significant decrease in readmits/ED visits (figure).

Conclusions: The BRIDGE clinic is an effective model for improving care across the hospital-to-home transition for a variety of cardiac conditions. Despite more comorbidities, pts with CHF, ACS, and other acute cardiac diagnoses who attended BRIDGE were less likely to be readmitted in 30 days or be seen in the ED.