**NOVEL HEART FAILURE PROTOCOL DRAMATICALLY REDUCES HOSPITAL READMISSIONS FROM SKILLED NURSING FACILITIES**

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**Introduction**: Congestive heart failure (CHF) is the leading cause of hospitalization and readmission among patients 65 and older, accounting for 24% of all US Medicare inpatient expenditures. Time and cost-effective interventions for reducing CHF readmissions are limited, and lengthy cardiac rehabilitation programs, post-discharge clinic appointments, and home nursing visits are not practical for many patients residing at skilled nursing facilities (SNF). Therefore, we developed a CHF management protocol that allows remote monitoring and synthesis of clinical data to rapidly identify and treat those at risk for cardiac decompensation.

**Methods**: SNF residents satisfying inclusion criteria met with a multidisciplinary on-boarding team that included a cardiologist, physical therapist, and nurse. SNF staff members were given an iPad with protocols for monitoring patient weight, renal function, and brain natriuretic peptide (BNP). This data was entered into an iPad application developed by our team. Pathologic constellations of data, (e.g., a 3 lb weight gain with 20% rise in BNP) would automatically generate alerts to the on-call cardiologist. Weekly phone conferences allowed for review of each enrolled patient by the care team and optimize heart failure therapy regimens.

**Results**: During a three-month period prior to protocol initiation, 11 of 36 (31%) SNF residents with heart failure were readmitted to the hospital for cardiac causes. After protocol initiation, only 3 (8%) of 40 enrollees with heart failure were readmitted for cardiac causes. This readmission rate has remained stable between 5-10% throughout program expansion. Most recently between 9/2017 and 11/2017, among 57 enrollees, only 4 (7%) were readmitted to the hospital for a cardiac cause, and among these - only one patient was diagnosed with decompensated heart failure. The protocol did not increase time spent on patient care.

**Conclusion:** An app-based heart failure protocol that could identify and communicate concerning data trends significantly reduced CHF readmissions. This cost-effective intervention requires no increased time commitment, making it an attractive option amidst burgeoning healthcare costs and workload.