The Implications of Adherence to the Heart Failure (HF) Clinic on Readmission Rates to the Hospital

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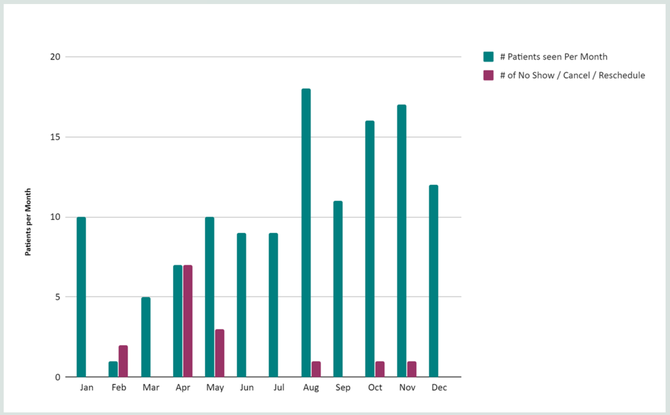
Background

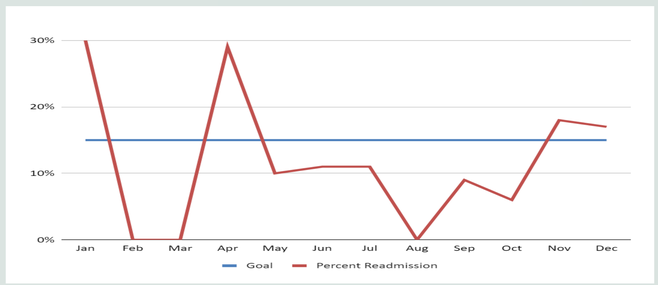
- Heart failure (HF) is a complex clinical syndrome characterized by the reduced ability of the heart to pump and/or fill with blood.
- HF is a global pandemic and is responsible for costs of more than $39 billion annually in the USA alone.
- Follow-up at HF Clinic is recommended to all HF patients at discharge to promote optimal medical and lifestyle management and decrease subsequent readmissions. However, attendance at these visits in the past year was low (14.9%).

Figure 1. HF Outpatient Clinic Visits in 2019



- HF readmission rate (18.8%) at Ascension Providence Rochester Hospital in 2019 exceeded the target of 15.10%.

Figure 2. HF 30-Day Readmission Rates in 2019



Quality Improvement Objective

Use Plan-Do-Study-Act methodology to reduce 30 day readmission rates by >5% by increasing patient attendance at HF clinic post discharge visits.

Plan

- Intervention: HF patients called 1-2 days after discharge to ensure follow-up appointment was scheduled and explore attendance barriers.
- Evaluation: documentation of attendance barriers and chart review to determine readmission rates.

Do

- Team: five residents + Ascension Heart Failure Clinic Nurse Practitioners (HFC NP) + IT
- Intervention implemented by residents over 2-months
  - 8 HF patients discharged/contacted

Study

Figure 3. Comparison of Pre- and Post-Intervention HF Clinic Attendance

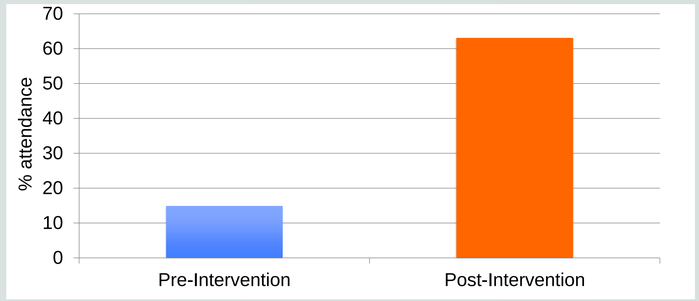
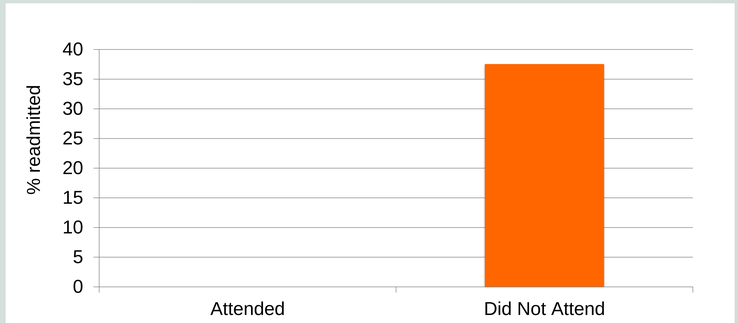


Table 1. Common Barriers to Attending HF Post-Discharge Clinic Visit

Patient-Reported Barriers
• Frustration with too many appointments
• Confusion of why to attend because already has access to and satisfied with home healthcare nurse
• Lack of transportation
• Living in a nursing home

Study

Figure 3. Post-Intervention 30-Day Readmissions by HF Clinic Attendance



Act

- Calling patients immediately following hospital discharge appears effective in improving their HF clinic attendance and subsequently decreasing readmissions..
- Additional work is needed to improve intervention feasibility including:
  - Utilization of hospital HF team spread sheet to track follow-up calls
  - Creating a shared calendar for scheduling and confirming HF clinic appointments
  - Documenting calls in the EMR to improve interdisciplinary communication

PUBLIC HEALTH IMPLICATIONS

Heart failure is the most frequent cause of hospitalization in persons age > 65. Simple protocols like phone calls may promote the continuity of care necessary to minimize readmissions and subsequently improve patient quality of life.