# Cost-effective Methods of Increasing Heart Failure Clinic Follow-up to Decrease Hospital Readmission within 30 days of Discharge

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# Background

Independent heart failure clinics effectively reduces readmissions

- HF readmission rate = 18.8% in 2019
  - APRH hospital target of 15.10%

- PDSA Cycle 1: phone calls → increased HF clinic attendance-->decreased readmission
  - Not sustainable



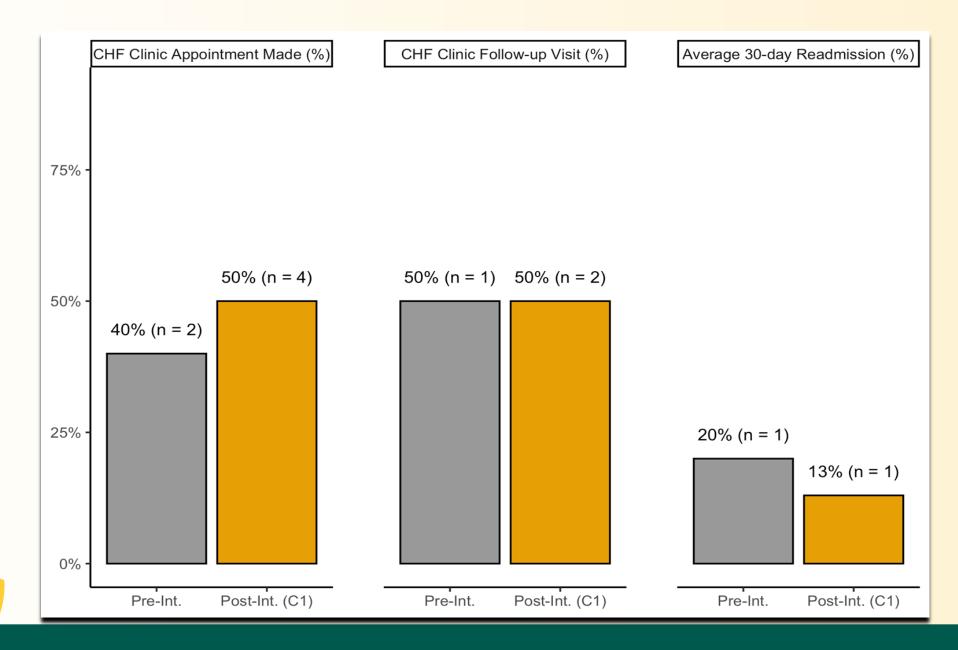
### Plan

 Visual aids and encrypted messaging scheduling reminders

### Do

- 1 month
- Visual aids attached to computer monitors in resident lounge
- Encrypted Whatsapp group created







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### Study

- Patients scheduled at CHF clinic increased from 40%(n=2) to 50%(n=4)
- CHF attendance remained stable at 50%
- Decrease readmission from 20% (n=1) to 13%(n=1)

### Act

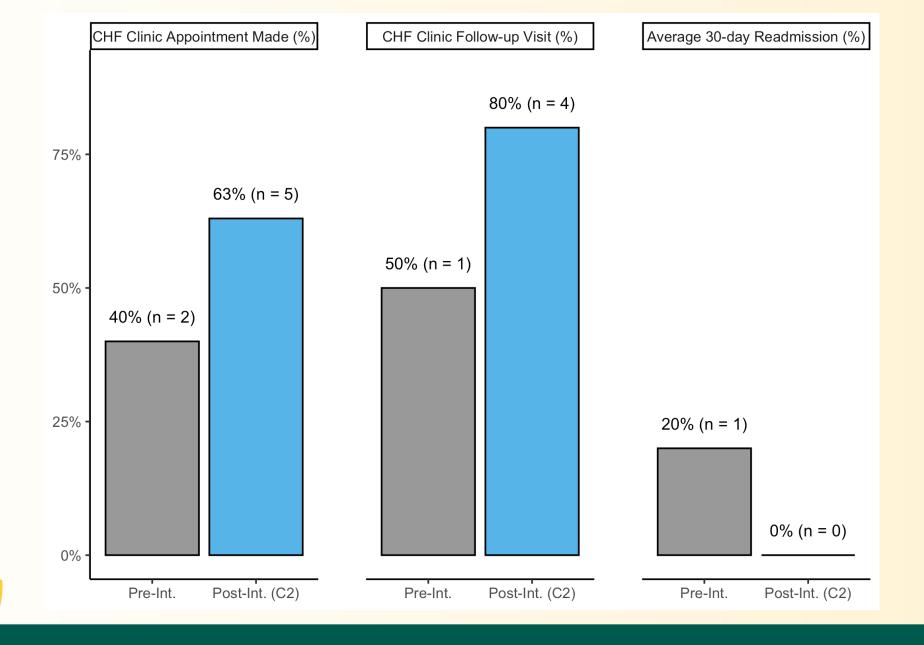
- Visual aids yield slight improvement
- Adapt to further increase attendance



Plan: resident on family inpatient service schedules follow-ups

Do: 1 Intern from the family medicine service was assigned to schedule appointments for all CHF patients in the service







### Plan

A resident on the family inpatient service schedules follow-ups

### Do

1 Intern from the family medicine service was assigned to schedule appointments for all CHF patients in the service

### Study

- 63% of patients were scheduled prior to discharge
- 83% clinic attendance
- 0% readmission

### Act

A resident is assigned monthly to schedule HF clinic follow-up visits. A formal policy is currently being developed and implemented.



## Discussion

Scheduling patients prior to discharge increased attendance and decreased readmission

Best approach: resident on inpatient team leads scheduling effort

2<sup>nd</sup> best: visual aids and messaging

