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FOLLOW UP CARE FOR HEART FAILURE PATIENTS AND ASSOCIATION WITH HOSPITAL READMISSION

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Background: CDC reports 6.5 million adults in the US have Heart failure (HF) with yearly costs topping 30 billion. HF patients admitted to Valley Baptist (VB) are readmitted 26% of the time, which is close to the national average of 23%. Standard of care for HF patients is follow up care (FU) for 30 days from discharge. Hospitalization for any reason within 30 days is considered a “readmission”. On 10-1-2019 at VB, remote nursing care changed from weekly house visits to weekly phone calls. Aim is to evaluate the effectiveness of this policy change on readmission rates.

Methods: Retrospective chart review using 170 patients admitted with HF from 8-1-2019 to 1-31-2020 at VB. Variables considered: readmission, age, length of stay (LOS), in-hospital education and FU. Descriptive statistics [mean (SD) and n (%)] were created overall and stratified by readmission. Binary logistic regression assessed the association with readmission and time to admission.

Results: The average age of patients was 68.8 years with the mean LOS 5.5 days. During hospital stay, 54.1% (92/170) of patients received education; 29.3 % (27/92) of them received it through a skilled nurse in the Progressive Coronary Care Unit while 70.7% received it from the primary nurse. Readmission rates were 31.7 % before nursing care changed from weekly house visits to weekly phone calls and 19.3% afterwards ($p = 0.0633$). There was no evidence in-home visits vs phone calls produces a disparity in readmission rates after adjustment OR = 1.75 (95% CI 0.84-3.66, $p = 0.1363$).

Conclusions:

The FU change produced no disparity in readmission rates, which may result in lower costs to FU with new policy. In-home visits were more prevalent with re-admissions than phone calls. CHF severity likely determined who received in-hospital education from skilled nursing staff which could have introduced selection bias.