3-20-2020

Follow Up Care For Heart Failure Patients And Association With Hospital Readmission

Supraja Thunuguntla
The University of Texas Rio Grande Valley, supraja.thunuguntla@utrgv.edu

Michael Machiorlatti
The University of Texas Rio Grande Valley

Mohammad Rizwan
The University of Texas Rio Grande Valley

Sonya Rivera
The University of Texas Rio Grande Valley

Juan Cortinas Galvan
The University of Texas Rio Grande Valley

See next page for additional authors

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

Supraja Thunuguntla1, Michael Machiorlatti2, Mohammed Rizwan, Sonya Rivera2, Juan Cortinas Galvan1, Jose Campo Maldonado 1,2

1 UTRGV-SOM Department of Internal Medicine

2 UTRGV-SOM Department of Population Health and Biostatistics

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.