Call for Process Change to Improve Scheduling HF Follow Up Appointments Within 7 Days of Discharge from a Rural Inpatient Setting Leads to Readmission Reduction

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Background

Meadville Medical Center, (MMC), located in rural Pennsylvania, has 200 staffed beds and 5225 annual discharges. Of those, 261 are annual heart failure discharges. "Life expectancy gaps between rural and urban areas are increasing. Similar patterns have been seen for CVD and cardiovascular mortality, with a 40% higher prevalence of heart disease among rural residents.[1] In Pennsylvania, among 194 acute care facilities, the median 35+ heart disease/stroke age adjusted death rate is 416 per 100,000[2]. MMC enrolled in the American Heart Association's Get With The Guidelines® – Heart Failure (GWTG-HF) in February 2023 through participation in the Rural Health Care Outcomes Accelerator Program. MMC opened a new Heart Failure Clinic in July 2024. Upon opening, providers quickly identified the need to improve having outpatient follow up appointments scheduled prior to discharge for patients admitted with a primary diagnosis of heart failure and to have those appointments scheduled within 7 days of discharge.

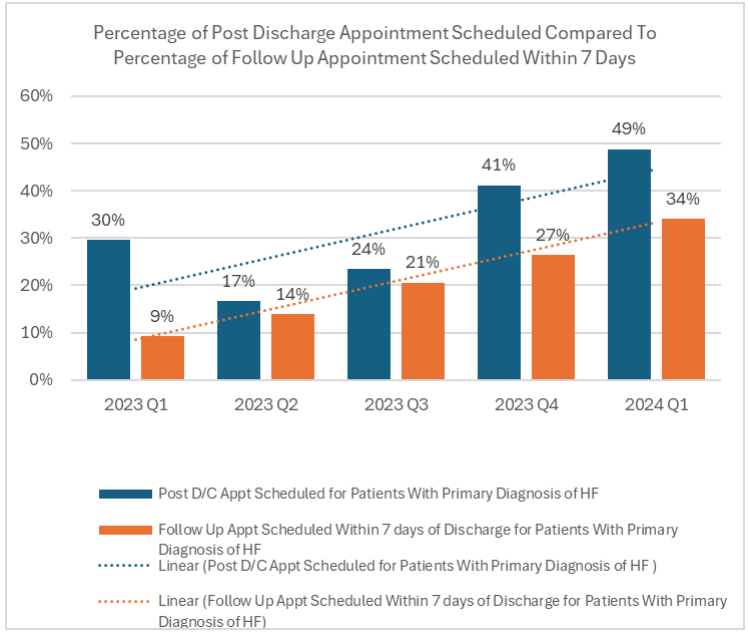
Objectives

- Collect data on all admitted patients with a primary diagnosis of heart failure using GWTG-HF.
- Monitor data specific to 2 GWTG-HF measures: 1) Post Discharge Appointment for HF Patients and 2) Follow Up Visit Within 7 Days or Less.
- Increase the percentage of patients discharged with a primary diagnosis of heart failure who have follow up appointments schedule prior to discharge and the appointment is within 7 days of the discharge date.
- Overarching long term goal is to decrease readmission rates of patients with a primary diagnosis of heart failure .

Methods

In February 2023, Meadville Medical center enrolled in GWTG-HF and began abstracting data specific to patients with a primary diagnosis of Heart Failure, starting with patients discharged January 1, 2023. A multidisciplinary team was formed and consists of an advanced practice nurse, cardiology, quality improvement team members, chief medical officer and a resident. This multidisciplinary team meets monthly, reviews GWTG-HF data and identifies

GWTG-HF Data from Q1 2023 through Q1 2024[4]



This work represents the authors' independent analysis of Meadville Medical Center's hospital data gathered using the AHA Get With The Guidelines® (GWTG) IQVIA Registry Platform but is not an analysis of the national GWTG dataset and does not represent findings from the AHA GWTG National Program

opportunities for improvement, provides education to hospitalists and other clinicians who care for heart failure patients. In addition to this multidisciplinary team, Meadville Medical center also has a population health team, providing remote monitoring, medication management and management of chronic disease education for patients. Near future plans include updating discharge order sets to improve compliance of scheduling follow up appointments within the first 7 days after discharge "to optimize care and reduce hospitalization." "Early post discharge follow up may help minimize gaps in understanding of changes to the care plan or knowledge of test results and has been associated with lower risk of subsequent rehospitalization."[3]

Results

Between Q1 2023 and Q1 2024, a concerted effort has been placed into improving scheduling follow up appointments prior to patients' discharge and then having those appointments be within 7 days of discharge and has led to an almost 400% improvement. With that improvement, 30- day heart failure readmission rates have also decreased from

Conclusions

With multidisciplinary team commitment, data sharing, provider education & implementation of new discharge order sets, MMC looks to improve rates of scheduling follow up appointment within 7 days of discharge for patients with a primary diagnosis of heart failure.

References

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