Integrating Residents – Organizational Quality Metric of reducing 30-day readmission of patients with acute decompensated heart failure (Interdisciplinary QI project)

Fahimeh Talaei, MD[1]; Mahmoud Ibrahim, MD[1]; Elizabeth Mikhail, MD[1]; Dheeraj Alexander, MD[1]; Khaled Almorsy, MD[1]; Varsha Moudgal, MD[2]; Kavitha Kesari, MD[1]
[1]Department of Internal Medicine, McLaren Health System and Michigan State University, Flint, Michigan; [2]Department of Infectious Disease, McLaren Health System and Michigan State University, Flint, Michigan

Introduction: Hospital readmissions post-discharge for congestive heart failure (CHF) pose a significant burden on patients and healthcare systems, indicating potential gaps in care quality. The 2022 heart failure guidelines advocate for structured workflows to address this issue. Despite this, McLaren Flint Hospital witnessed a rise in 30-day readmissions for CHF exacerbation, highlighting the need for intervention. To tackle this challenge, our resident-faculty Quality Improvement (QI) team has partnered with institutional QI/Patient Safety (PS) initiatives. Our goal is to establish a coordinated approach involving various healthcare professionals to optimize the discharge process and transition of care for CHF patients at McLaren Flint Hospital.

Methods and Materials: Our intervention comprises two crucial tools: a CHF workflow sheet and a CHF medication sheet. The workflow begins with patient identification through daily census reports. Upon discharge, nurses implement the CHF medication sheet, with medications prescribed by medical floor doctors. Pharmacists and dietitians review and educate patients about medications and dietary considerations, respectively. Additionally, case managers organize post-discharge phone calls and appointments with primary care physicians within 48 to 72 hours and 7 days, respectively. Weekly reports on patients requiring cardiac rehabilitation are also dispatched. Plan-Do-Study-Act (PDSA) Toolkit guides our implementation, allowing for continuous improvement and adaptation.

Results: The initial implementation phase commenced on March 6th, 2024. Nursing staff are well-versed in the workflow, and CHF medication forms are readily accessible in patient charts. However, challenges in timely medication reconciliation and orders pose operational hurdles, necessitating resolution. Ongoing evaluation will provide more comprehensive results approximately two months post-completion of the first PDSA cycle.

Conclusion: Our initiative aims to address areas for improvement in reducing 30-day readmission rates post-CHF exacerbation at McLaren Flint Hospital. Utilizing the PDSA cycle toolkit, we will monitor outcomes and refine our process accordingly.