Background
The global burden of heart failure is growing with an estimated distribution of 26 million adults living with heart failure worldwide. Heart failure is a burdensome condition, affecting more than 6 million Americans and is projected to increase 25% by 2030. Heart failure hospitalizations are associated with an estimated $32 billion dollars in healthcare costs with the highest frequency of readmissions.

Aims and Objectives
The purpose of this quality improvement project was to implement a heart failure education program focused on increasing attendance to a transitional care clinic after hospital discharge, and reduce 30-day readmissions.

Methods
We employed a quasi-experimental design, enrolling (N=22) participants. A nurse-led heart failure education program was implemented using standardized heart failure education materials focused on symptom management and transitional care.

Baseline data was collected on N=146 and N=22 individuals attending the clinic over a 6-month period. We evaluated post hospital discharge attendance to a transitional care clinic, and readmission.

Results
There was a significant improvement with follow up attendance at the transitional care clinic (<p=0.05) and a decrease in 30-day hospital readmissions. Among the (N=22) participants, 64% were not readmitted into the hospital 30 days after discharge.

Table 1. Demographic characteristics (N=22)

<table>
<thead>
<tr>
<th>Race</th>
<th>Frequency/Percentages</th>
<th>Means (SD)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>10 (46%)</td>
<td>64.5 (10.1)</td>
</tr>
<tr>
<td>Black</td>
<td>11 (50%)</td>
<td></td>
</tr>
<tr>
<td>Latino/Hispanic</td>
<td>1 (4%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 2. Post-discharge attendance to transitional care clinic

<table>
<thead>
<tr>
<th></th>
<th>Pre-intervention</th>
<th>Post-intervention</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=146</td>
<td>1.27 (1.456)</td>
<td>1.24 (1.427)</td>
<td>&lt;0.05</td>
</tr>
</tbody>
</table>

Conclusion
Results from this study reflect the importance of using standardized education materials and positive impact of a transitional-care focused heart failure education program on hospital 30-day readmission rates. Further investigation is necessary to explore the association between increased transitional care follow-up and improved self-management of heart failure.

References
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