Medical care following hospitalization for a first acute heart failure episode in Paris and its suburbs

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Background

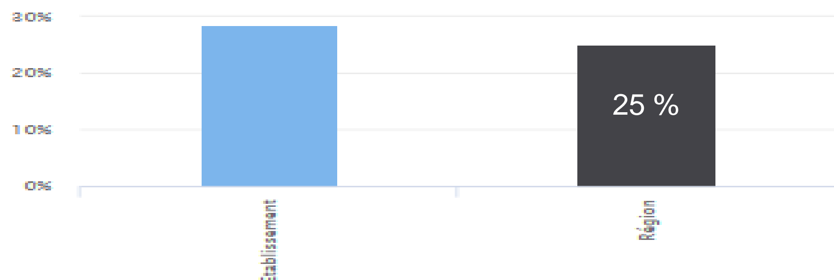
- **Chronic Heart failure** (CHF) is a **highly prevalent disease**
- In 2017, 1 million people out of 67,2 million (1,8%) had CHF in France
- Its treatment requires close collaboration between multiple health professionnals
- **Guidelines** were published in France in **2014**
- **The aim of our study was to describe medical care during the 6 months following hospitalization**
- No conflict of interest

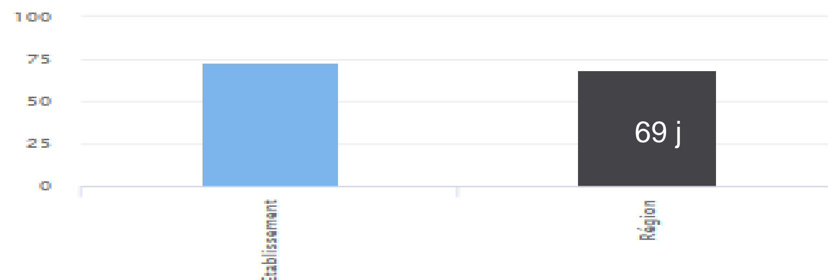
Methods

- Since 2015 we have built a tool with the **main indicators of clinical follow up**
- Indicators : hospital readmission, admission in emergency unit, mortality, ambulatory clinical follow up and medication regimens
- Those indicators were evaluated at each hospital level (145) and at a geographic level (175 “cantons”)
- Limitation of the analysis+++ The results should be interpreted with caution
- No adjustement on patient characteristics

Prise en charge dans les 6 mois suivant le séjour

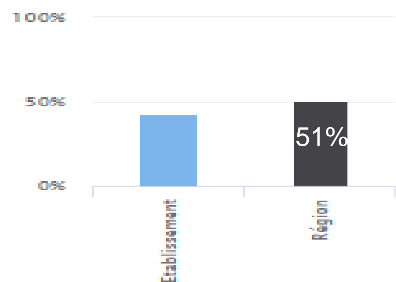
Réhospitalisation pour insuffisance cardiaque aigüe

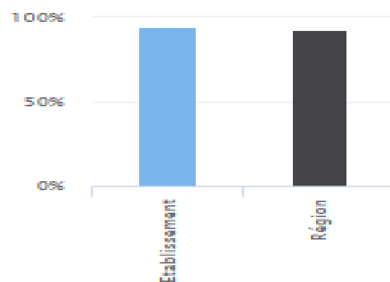




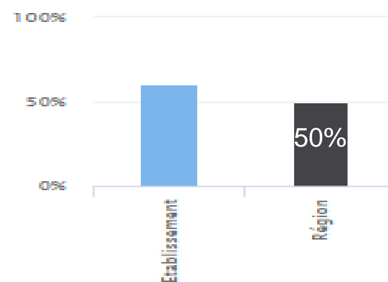
Prise en charge médicale

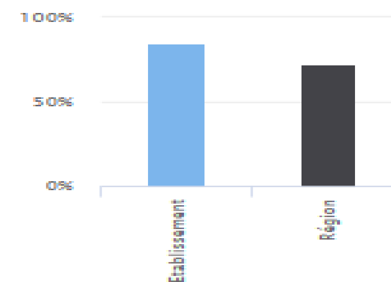
Prise en charge par un médecin généraliste





Prise en charge par un cardiologue





Prise en charge médicamenteuse

	IEC (ou ARA II)	Bétabloquant	Diurétique	Digoxine	Amiodarone	Ivabradine
Etablissement	65.7%	76.5%	90.5%	7.0%	29.3%	1.7%
Région	65.9%	71.9%	82.2%	6.4%	27.5%	2.2%

Conformité aux recommandations

Prise en charge par un médecin généraliste dans les 14 jours et par un cardiologue dans les 2 mois

Etablissement	Région
24.8%	26.2%

Traitement Bétabloquant + IEC (ou ARA II)

Etablissement	Région
52.5%	50.5%

Results

- Our analysis (2016 data) found out a **poor rate of compliance to guidelines**
- Only 26% on average for follow up composite indicator
- **Great variations** between hospitals, and geographic levels (canton)
- Hospital rehospitalization rate varied from 2.8% to 46.4%
- Canton Follow up Composite indicator varied from 9.1% to 54.2%
- This emphasizes the fact that **improvement of processes is required**

Consequences

- In order to improve the compliance to guidelines, we implemented **three actions** :
  - feed-back to providers on their own results **(2015)**
  - support patient and field health professionals after hospital discharge **(2016)**
  - commitment of several hospitals to organize meetings with field professionals **(2018)**
- These actions are adapted to data limitations

Feed back

- Since 2015, every year, we have presented to about **50 hospitals** their results for exchange

- Since 2018 we have sent territory data to health professionnals

- We hope that transparency on unknown data give effects

- We think that professionnals can decide actions to improve the situation

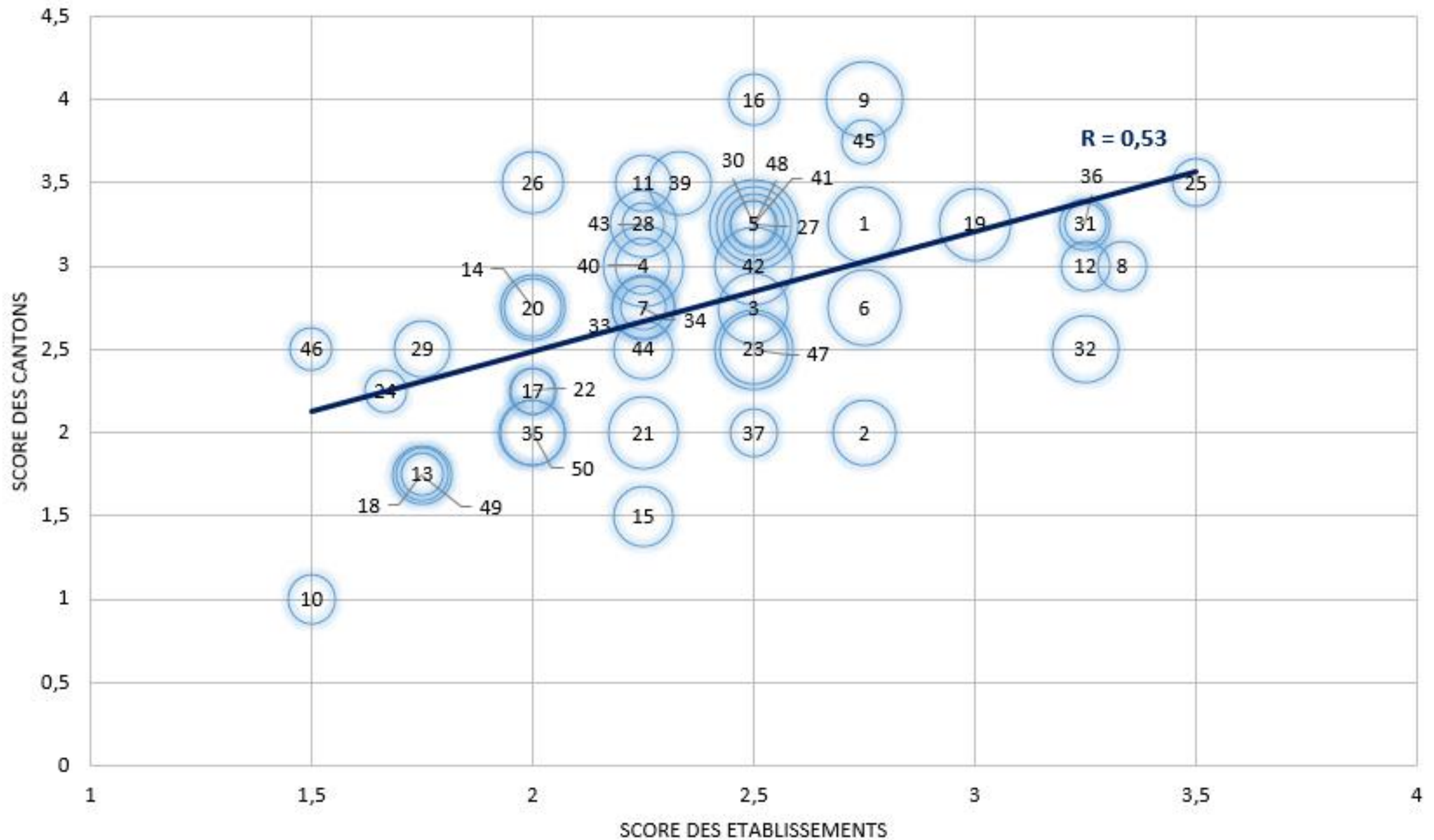
Support patient after hospital discharge

- National Hospital to home intervention program named Prado
- Its field : Delivery, surgery, 2 chronic diseases (CHF, COPD since **2016**)
- Concerns hospitals, professionnals and volunteer patients
- **80 hospitals** for CHF in IDF
- Meeting of eligible patients to organize return home
- First outcomes are satisfactory but not yet significant

Contractualization with hospitals

- This contractualization has been defined by law (2016)
- A chapter on care relevance is provided
- In Ile de France we choose CHF for this chapter.
- Primary objective : organization of a meeting with territory health professionals
- **15 hospitals** were selected in IDF (2017)
- The **first meetings (2018)** were very positive

Hospital and territory score relation



Conclusion

- The impact of actions should be assessed
- **Evaluation** in 2019/2020 on the hospital, territory and regionaly **indicator's evolution**,
- It will be difficult to conclude because of interaction
- In case of improvement, everyone can claim the good results