Low Numeracy Is Associated With Increased Odds of 30-Day Emergency Department or Hospital Recidivism for Patients With Acute Heart Failure

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Background—More than 25% of Medicare patients hospitalized for heart failure are readmitted within 30 days. The contributions of numeracy and health literacy to recidivism for patients with acute heart failure (AHF) are not known.

Methods and Results—A cohort of patients with acute heart failure who presented to 4 emergency departments between January 2008 and September 2011. Research assistants administered subjective measures of numeracy and health literacy; 30-day follow-up was performed by phone interview. Recidivism was defined as any unplanned return to the emergency department or hospital within 30 days of the index emergency department visit for AHF. Multivariable logistic regression adjusting for patient age, sex, race, insurance status, hospital site, days eligible for recidivism, chronic kidney disease, abnormal hemoglobin, and low ejection fraction evaluated the relation between numeracy and health literacy with 30-day recidivism. Of the 709 patients included in the analysis, 390 (55%) had low numeracy skills and 258 (37%) had low literacy skills. Low numeracy was associated with increased odds of recidivism within 30 days (adjusted odds ratio, 1.41; 95% confidence interval, 1.00–1.98; P=0.048). For low health literacy, adjusted odds ratio of recidivism was 1.17 (95% confidence interval, 0.83–1.65; P=0.37).

Conclusions—Low numeracy was associated with greater odds of 30-day recidivism. Further investigation is warranted to determine whether addressing numeracy and health literacy may reduce 30-day recidivism for patients with acute heart failure.

Key Words: emergency ■ epidemiology ■ heart failure ■ heart failure readmission ■ follow-up studies

Health literacy, or “the degree to which individuals can obtain, process, and understand basic health information and services needed to make appropriate health decisions,”1 and numeracy,2 or “the ability to use and understand numbers in daily life,”3 are key elements of disease self-management. Unfortunately, low numeracy and health literacy are common,4–7 associated with worse health outcomes,8 and costly,9 accounting for up to 5% of health care costs annually.10 Furthermore, healthcare providers are often unaware of their patients’ low literacy levels.11,12

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Heart failure is a common cause of hospital admission and is associated with frequent rehospitalizations.13–15 Estimated US costs exceeded $39 billion in 2010,16 much of it because of emergency department visits and hospitalizations.13,17 Hospitalization for acute heart failure represents an important inflection point in a patient’s clinical course. More than 25% of patients admitted for heart failure are readmitted to the hospital within 30 days and importantly, many readmissions are for nonheart failure-related causes.17 In addition, mortality increases with each subsequent rehospitalization; median survival is 2.5 years after first hospitalization and 6 months after fourth hospitalization.18,19 Identifying factors associated with recidivism, or recurrent emergency department visits and unplanned hospitalizations, is an important step toward improving outcomes for patients with acute heart failure.

Previous small and retrospective studies suggest that patients with chronic heart failure and low health literacy may be at high risk for emergency care, hospitalization, and death.20–22 However, the relation between numeracy and health literacy with recidivism after an episode of acute heart failure are not well understood. Therefore, the goal of this study was to evaluate the relation between both numeracy and health literacy with 30-day recidivism, defined as an emergency department visit or unplanned hospitalization, after an acute...
heart failure-associated emergency department visit. We hypothesized that low numeracy and health literacy would both be associated with greater odds of recidivism.

**Methods**

We conducted a multicenter, prospective cohort study of adult patients who presented to 4 hospital-based emergency departments with acute heart failure between January 2008 and September 2011. Patients with a clinical diagnosis of acute heart failure who were able to provide informed consent and who completed assessments of numeracy or health literacy were eligible for inclusion. This study was approved by each of the 4 local institutional review boards.

**Study Population**

All patients >18 years of age who presented to the emergency department were screened for dyspnea, cough, and acute pulmonary edema. Treating physicians then determined whether potentially eligible patients met additional clinical criteria for acute heart failure based on the modified Framingham criteria (Table 1).23,24 Patients who passed both screens and who could be enrolled within 3 hours of first physician contact were approached for consent. On receiving consent, research assistants administered numeracy and health literacy scales25–29; they then collected detailed sociodemographic and medical history data, which was verified by medical record review. The results of the numeracy and health literacy screen were not provided to the patient or providers. Patients clinically diagnosed of acute heart failure by treating physicians were included in the analysis. Patients meeting the following criteria were excluded: initiation of palliative care during the 30-day follow-up period; hospital admission for the entire follow-up period; and unknown date of death. Patients with an unknown date of death were excluded because it was unknown whether these patients had an opportunity to experience recidivism.

**Data Collection**

Patients were enrolled as convenience samples at 4 hospitals: 2 tertiary care hospitals with ≈55,000 and 90,000 annual adult emergency department visits (hospital 1 and 2, respectively), and 2 community hospitals with ≈33,000 and 47,000 annual adult emergency department visits (hospital 3 and 4, respectively). Hospital 1, 3, and 4 enrolled patients 16 hours a day; 7 days a week; hospital 2 enrolled patients 24 hours a day, 7 days a week. Study data were collected and managed using Research Electronic Data Capture (REDCap) tools.30

**Numeracy and Health Literacy**

We used 2 validated instruments to measure numeracy and health literacy. The subjective numeracy scale26–29; the subjective health literacy scale26 assess numeracy and health literacy, respectively.

**Table 1. Cohort Inclusion Criteria: Modified Framingham Criteria**

<table>
<thead>
<tr>
<th>Major Criteria</th>
<th>Minor Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of heart failure</td>
<td>Extremity edema</td>
</tr>
<tr>
<td>Paroxysmal nocturnal dyspnea</td>
<td>Night cough</td>
</tr>
<tr>
<td>Pulmonary interstitial edema on CXR</td>
<td>Dyspnea on exertion</td>
</tr>
<tr>
<td>Rales</td>
<td>Hepatomegaly</td>
</tr>
<tr>
<td>Cardiomegaly</td>
<td>Pleural effusion</td>
</tr>
<tr>
<td>S3 gallop</td>
<td>Tachycardia &gt;130 bpm</td>
</tr>
<tr>
<td>Jugular venous distension</td>
<td></td>
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<tr>
<td>Positive hepatojugular reflex</td>
<td></td>
</tr>
</tbody>
</table>

2 Major or 1 Major and 2 Minor Criteria are required to establish a preliminary diagnosis of heart failure by the Framingham criteria. bpm indicates beats per minute; and CXR, chest x-ray.

Subjects are asked about their perceived abilities and attitudes related to numeracy and health literacy. These scales have been validated against objective measures of literacy and numeracy, including the Short Test of Functional Health Literacy in Adults (S-TOFHLA) and the Rapid Estimate of Adult Literacy in Medicine (REALM).25,26 and the Wide Range Achievement Test Mathematical subtest (WRAT-4),25,26 respectively. Additionally, the numeracy scale and the health literacy scale were validated in a general adult emergency department population and were shown to add information above and beyond patient demographics and level of education.29

The numeracy scale comprises 8 written items on a 6-point Likert-like scale, 4 regarding perceived skills using numbers and 4 addressing preferences regarding the use of numbers (Table 2).27,28 On a scale from 8 to 48, higher scores indicated higher subjective numeracy skills. In a previous study of a general adult emergency department patient population, this numeracy scale had a Cronbach α of 0.82.23 The health literacy scale includes 3 oral items on a 5-point Likert-like scale addressing patient perceptions regarding their health literacy (Table 2).26 On a scale from 3 to 15, higher scores indicated higher subjective health literacy skills. This health literacy scale demonstrated a Cronbach α of 0.74 in a general emergency department population.29

**Measures of Recidivism**

Patients were contacted by phone 30 days after the initial emergency department visit for acute heart failure. Outcomes were obtained from patient or caregiver report, with confirmation by review of medical records and the Social Security Death Index. The primary outcome was 30-day recidivism, defined as ≥1 emergency department visit or unplanned hospitalization for any cause within 30 days of the index emergency department visit.

**Statistical Analysis**

Descriptive statistics are presented as medians and interquartile ranges or frequency and percentages. Demographics were compared using the χ2 test, Fisher exact test, or Wilcoxon rank sum test, as appropriate. Unadjusted and adjusted logistic regression with 95% confidence intervals (CIs) was used to evaluate the associations between numeracy and health literacy with 30-day recidivism. Thirty-day recidivism was examined as a dichotomous outcome; 1 or more recidivism events within the 30-day follow-up period were categorized as positive, whereas no recidivism in the follow-up period was categorized as negative. For patients with any missing component of the recidivism outcome, the missing components were conservatively coded as negative if the status of recidivism was unclear. Numeracy and health literacy are related but unique skills, with only moderate correlation; therefore, numeracy and health literacy were evaluated in separate regression models. Planned secondary analysis evaluated these scales dichotomized to indicate low numeracy and health literacy with 30-day recidivism. Covariates thought to reflect healthcare access, disease severity, and resource utilization in patients with heart failure were determined a priori based on review of existing literature and clinical judgment, including age, gender, race, insurance status, history of chronic kidney disease, abnormal...
hemoglobin on presentation (<13 g/dL or ≥17 g/dL), and ejection fraction <30%. Hospital site was also included in the model. The maximum number of days patients were eligible for recidivism was also included as a covariate and was defined as the number of days within the 30-day follow-up period that patients were alive and not admitted to the hospital and, therefore, were at risk for recidivism. Local polynomial smoothed lines with 95% CI were used to generate figures illustrating the relation between numeracy and health literacy with predicted probability of 30-day recidivism, based on the adjusted multiple logistic regression models. In these figures, higher numeracy and health literacy scores indicate higher numeracy and health literacy skills. Previously, a small subset of this data were analyzed to evaluate whether numeracy or health literacy were associated with a composite outcome of prolonged hospitalization, death, and recidivism within 30 days; because of the exploratory nature of our analysis, no adjustment for Type I error was made for this analysis. A \( P \) value <0.05 was considered statistically significant. All analyses were performed using Stata/IC 11.2 (Copyright 2009, College Station, TX).

Results

Among the 4 study hospitals, 737 patients were enrolled (Figure 1); of these, 28 patients were excluded, including 5 who were admitted to the hospital for the duration of the follow-up period, 16 who were placed on palliative care, and 7 who died but the date of death was missing, leaving 709 patients in the analysis. Enrollment at each participating hospital included 303 subjects at hospital 1, 108 subjects at hospital 2, 10 at hospital 3, and 288 at hospital 4. The follow-up rate at 30 days was 98%; 2 subjects had incomplete data for the primary composite outcome and were included in the analysis as not having experienced recidivism. Clinical characteristics of subjects, comparing those who experienced recidivism within 30 days against those who did not, are found in Table 3. Details regarding clinical outcomes are found in Table 4.

Overall, 668 subjects took both the numeracy and literacy scales, 35 took only the health literacy scale, and 6 took only the numeracy scale. Twenty-five subjects left 1 item blank on either the numeracy or health literacy scale and the missing values were imputed as the mean score of the completed items. Three hundred ninety (55%) of patients had low numeracy skills, or a numeracy score <34, and 258 (38%) had low health literacy skills, or a health literacy score <12. Two hundred twenty-seven (32%) patients experienced at least 1 recidivism event; of these 62 (9%) returned to the emergency department for acute heart failure and 59 (8%) were admitted for acute heart failure. The remaining 155 patients experienced recidivism for conditions other than acute heart failure, including dyspnea not caused by acute heart failure (23%), chest pain (13%), other cardiovascular complaints (15%), infection (11%), complications related to other comorbid conditions (19%), and fall or trauma (6%).

Results of the regression analyses are depicted in Table 5. For patients with low numeracy, the adjusted odds ratio of recidivism within 30 days was 1.41 (95% CI, 1.00–1.98; \( P \)=0.048); for patients with low health literacy, the adjusted odds ratio of recidivism within 30 days was 1.17 (95% CI, 0.83–1.65; \( P \)=0.37). Per point decrease on the 41-point health numeracy scale, the adjusted odds ratio of 30-day recidivism was 1.02 (95% CI, 1.00–1.04; \( P \)=0.04). Per point decrease on the 13-point health literacy scale, the adjusted odds ratio of 30-day recidivism was 1.05 (95% CI, 1.00–1.10; \( P \)=0.05). Figures 2 and 3 illustrate the relation between predicted 30-day recidivism and numeracy and health literacy, respectively.
Discussion

To our knowledge, this is the first large, multicenter, prospective study of a diverse patient population to show that numeracy is associated with 30-day recidivism for patients with acute heart failure.

An 8-point decrease on the numeracy scale, or a 1-point change on each of the 8 questions, would be expected to confer 16% higher odds of experiencing recidivism. Thus, although the magnitude of association between numeracy and recidivism may seem small per point on the scale, the differences between individuals are significant, as are the disparities on a population level. Annually, >$17 billion is spent on heart failure in the United States, much of it because of costs associated with rehospitalizations. An intervention addressing numeracy may reduce rehospitalizations and should be tested to evaluate its impact on costs associated with heart failure.

Approximately 55% of patients in this study had low numeracy skills, and 37% had low health literacy skills. This is similar to prior research, in which 36% of the general population had basic or below-basic health literacy skills, and after pooling multiple studies, 26% of patients had low health literacy. The ability to determine which of 2 quantities is larger is considered a basic numeracy skill, and finding values on a table is considered an intermediate numeracy skill. Patients with heart failure are expected to weigh themselves daily, monitor sodium intake, and in some cases titrate diuretics to adjust for water weight gain. These patients often have multiple comorbidities and take multiple medications requiring titration. The ability to use and understand numbers is a necessary component of effective disease self-management, and it may outweigh the importance of general health literacy for diseases that require relatively complex mathematical skills for disease self-management.

It is noteworthy that many of the return emergency department visits and unscheduled hospitalizations were not directly related to acute heart failure. These findings are similar to prior research in which acute heart failure was the cause of readmission for 16% of patients with heart failure, where 22% of readmissions were related to other cardiovascular complaints.

Table 3. Clinical Characteristics

<table>
<thead>
<tr>
<th></th>
<th>Experienced Recidivism (n=227)</th>
<th>Did Not Experience Recidivism (n=482)</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Demographic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age, median years (IQR)</td>
<td>60 (52–71)</td>
<td>62 (52–72)</td>
<td>0.50</td>
</tr>
<tr>
<td>Men, No. (%)</td>
<td>136 (60)</td>
<td>262 (54)</td>
<td>0.17</td>
</tr>
<tr>
<td>White, No. (%)</td>
<td>113 (50)</td>
<td>262 (54)</td>
<td>0.26</td>
</tr>
<tr>
<td>Insurance status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Private/Group, No. (%)</td>
<td>54 (24)</td>
<td>128 (27)</td>
<td>0.10</td>
</tr>
<tr>
<td>Federal or State Insurance, No. (%)</td>
<td>151 (66)</td>
<td>293 (61)</td>
<td></td>
</tr>
<tr>
<td>Self-pay, No. (%)</td>
<td>22 (10)</td>
<td>60 (12)</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;High school, No. (%)</td>
<td>165 (74)</td>
<td>296 (62)</td>
<td>0.02</td>
</tr>
<tr>
<td>College, No. (%)</td>
<td>48 (21)</td>
<td>134 (28)</td>
<td></td>
</tr>
<tr>
<td>Postgraduate, No.(%)</td>
<td>12 (5)</td>
<td>49 (10)</td>
<td></td>
</tr>
<tr>
<td>Clinical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chronic kidney disease, No. (%)</td>
<td>73 (32)</td>
<td>83 (17)</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Hgb &lt;13 or &gt;17, No. (%)</td>
<td>154 (68)</td>
<td>268 (56)</td>
<td>0.002</td>
</tr>
<tr>
<td>EF&lt;30%, No. (%)</td>
<td>52 (23)</td>
<td>129 (27)</td>
<td>0.49</td>
</tr>
<tr>
<td>Numeracy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjective numeracy, median (IQR)</td>
<td>30 (22–36)</td>
<td>32 (24–39)</td>
<td>0.02</td>
</tr>
<tr>
<td>Low subjective numeracy, No. (%)</td>
<td>138 (61)</td>
<td>252 (52)</td>
<td>0.04</td>
</tr>
<tr>
<td>Literacy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Subjective literacy, median (IQR)</td>
<td>13 (9–15)</td>
<td>13 (10–15)</td>
<td>0.06</td>
</tr>
<tr>
<td>Low subjective literacy, No. (%)</td>
<td>92 (41)</td>
<td>166 (35)</td>
<td>0.13</td>
</tr>
<tr>
<td>Disposition</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Discharged from the ED, No. (%)</td>
<td>17 (8)</td>
<td>30 (6)</td>
<td>0.52</td>
</tr>
<tr>
<td>Days admitted, median (IQR)</td>
<td>3 (1–5)</td>
<td>3 (2–5)</td>
<td>0.44</td>
</tr>
</tbody>
</table>

ED indicates emergency department; EF, ejection fraction; Hgb, hemoglobin; and IQR interquartile range.

Table 4. Outcomes, by Recidivism Type (n=709)

<table>
<thead>
<tr>
<th></th>
<th>Any outcome, No. (%)</th>
<th>ED visit, for AHF, No. (%)</th>
<th>ED visit, not for AHF, No. (%)</th>
<th>Unscheduled hospitalization, for AHF, No. (%)</th>
<th>Unscheduled hospitalization, not for AHF, No. (%)</th>
<th>Subjects with any unverified outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>227 (32)</td>
<td>62 (9)</td>
<td>163 (23)</td>
<td>59 (3)</td>
<td>121 (17)</td>
<td>4 (0.6)</td>
</tr>
</tbody>
</table>

AHF, acute heart failure; and ED, emergency department.
and the remaining 62% of admissions were for various other complaints. This is likely a reflection of the multiple comorbid conditions associated with acute heart failure, further reinforcing the importance of clear health communication for vulnerable patients with complex medical conditions. The potentially important role of numeracy in predicting readmissions for conditions other than heart failure, which constitute a significant portion of readmissions after hospitalization for acute heart failure, warrants further investigation.

Prior research has shown that patients with low numeracy and health literacy skills have worse clinical outcomes, are less likely to use preventive services, and lack the skills necessary for disease self-management. These patients are also more likely to be hospitalized, have high mortality, and report low quality of life. In addition, specifically for patients with heart failure, low health literacy has been linked to worse clinical outcomes and more frequent emergency department visits. Low medication adherence and low health literacy may have contributed to emergency department visits for 192 patients with chronic heart failure. During the evaluation of a pharmacy intervention for 61 patients with chronic heart failure, low medication adherence and low health literacy were associated with emergency department visits for cardiovascular complaints. In addition, a recent retrospective cohort study of 1492 patients with chronic heart failure in the Kaiser Permanente Colorado health system found that low subjective health literacy was associated with increased all-cause mortality but not with hospitalizations.

Strengths and Limitations

The strengths of this study include the size of the cohort and the unique focus on patients with acute heart failure and who are, therefore, most at risk for poor clinical outcomes and most likely to benefit from interventions aimed at improving chronic disease self-management.

Although our study suggests that low numeracy is associated with increased 30-day recidivism, the results should be interpreted in the context of several limitations. We used subjective measures of numeracy and health literacy rather than objective measures, such as, the S-TOFHLA, REALM, or the WRAT. Objective measures are time consuming, must be administered by research assistants, are often not well received by patients, and are difficult to use in a clinical setting. The subjective measures of numeracy and health literacy used in this study were both validated in a general emergency department patient population. Education level is thought to be in the causal pathway leading to low numeracy and health literacy skills and was, therefore, not included as a covariate in the models; the potential independent contribution of

<table>
<thead>
<tr>
<th>Numeracy (n=674)</th>
<th>Unadjusted OR (95% CI)</th>
<th>P Value</th>
<th>Adjusted OR (95% CI)†</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1.02 (1.00–1.04)</td>
<td>0.013</td>
<td>1.02 (1.01–1.04)</td>
<td>0.037</td>
</tr>
<tr>
<td>Low numeracy (n=674)</td>
<td>1.42 (1.03–1.95)</td>
<td>0.034</td>
<td>1.41 (1.00–1.98)</td>
<td>0.048</td>
</tr>
<tr>
<td>Health literacy (n=702)</td>
<td>1.06 (1.01–1.11)</td>
<td>0.011</td>
<td>1.05 (1.00–1.10)</td>
<td>0.052</td>
</tr>
<tr>
<td>Low health literacy (n=702)</td>
<td>1.29 (0.93–1.78)</td>
<td>0.129</td>
<td>1.17 (0.83–1.65)</td>
<td>0.371</td>
</tr>
</tbody>
</table>

CI, indicates confidence interval; and OR, odds ratio.

*Numeracy and health literacy scores were reverse scored, thus OR is per unit decrease in numeracy and health literacy skills.
†Adjusted for age, gender, race, insurance, presence of diabetes mellitus, chronic kidney disease, abnormal hemoglobin, low ejection fraction, study site, and maximum number of days known to be eligible for recidivism.

Figure 2. Numeracy and predicted 30-day emergency department and hospital recidivism*, n=673. Adjusted for age, gender, race, insurance, presence of diabetes mellitus, chronic kidney disease, abnormal hemoglobin, low ejection fraction, study site, and maximum number of days known to be eligible for recidivism; higher Numeracy Scores indicate higher numeracy skills. CI indicates confidence interval.

Figure 3. Literacy and predicted 30-day emergency department and hospital recidivism*, n=702. Adjusted for age, gender, race, insurance, presence of diabetes mellitus, chronic kidney disease, abnormal hemoglobin, low ejection fraction, study site, and maximum number of days known to be eligible for recidivism; higher Literacy Scores indicate higher health literacy skills. CI indicates confidence interval.
education to the relation between numeracy and health literacy with 30-day recidivism are not addressed in this analysis. Employment status was not included as a covariate in an effort to avoid overfitting the model. The exact relationship between numeracy and health literacy is unclear. The 2 are related, but it is thought that many patients with high health literacy may have low numeracy skills. We used a dichotomous composite outcome to indicate the burden of 30-day recidivism. Because patients who experienced multiple unplanned hospital admissions for acute heart failure were categorized the same as patients who returned to the emergency department once, our findings may underestimate the burden and severity of 30-day recidivism. Patients were screened for inclusion based on the chief complaints of dyspnea, cough, and acute pulmonary edema, which may not identify all patients with acute heart failure, such as those who with orthopnea, atrial fibrillation, or edema. Thus, it is possible that a small number of patients with acute heart failure may not have been screened for inclusion in this study. The diagnosis of acute heart failure was made by treating physicians, either in the emergency department or after admission to the hospital. Diagnoses were extracted by chart review and were left entirely to treating clinicians, who were not aware of study goals. Although diagnostic error is possible, using clinical diagnoses makes the results of the study more generalizable to real-world circumstances.

Conclusions

For patients with acute heart failure, low subjective numeracy is associated with increased odds of recidivism to the emergency department or hospital within 30 days. Subjective health literacy may also play a role, but there was no evident association between health literacy and 30-day recidivism for patients with acute heart failure in this cohort of patients. The United States has made improving health literacy a top priority, and the Centers for Medicare and Medicaid Services has emphasized reducing readmissions. As part of the effort to improve patient-centered outcomes and break the cascade of events that leads to suboptimal clinical outcomes, numeracy’s potential role in the high-cost, high-risk events of emergency department and hospital recidivism should be evaluated in future interventions aimed at improving the quality of care for patients with heart failure.

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Disclosures

The views expressed in this article are those of the authors and do not necessarily reflect the views of the Department of Veterans Affairs.

References


**CLINICAL PERSPECTIVE**

Using a prospective cohort study of 709 patients who presented to the 4 hospital-based emergency departments (EDs) with signs and symptoms of acute heart failure, we investigated the relationship between subjective numeracy and health literacy with 30-day recidivism to the ED or hospital. Low numeracy was common (55% of patients), as was low health literacy (38% of patients); ≈32% of patients returned to the ED or hospital within 30 days of the index ED visit. After adjusting for demographics and disease severity, low numeracy was associated with increased odds of returning to the ED or hospital within 30 days (adjusted odds ratio, 1.41; 95% confidence interval, 1.00–1.98; P=0.0048). Subjective health literacy may also play a role, but we did not detect a relation in this cohort of patients with acute heart failure. Although this study did not investigate how numeracy may be associated with recidivism, we hypothesize that patients with low numeracy may have a difficulty understanding medical instructions, adhering to medication recommendations, and performing disease self-management tasks. For the many patients with heart failure who are at high risk for hospitalization and rehospitalization, addressing numeracy may be a key component of future efforts to improve patient-centered outcomes and break the cascade of events that leads to suboptimal clinical outcomes.
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