Role of the Heart Failure Coordinator

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Disclosures

- None
Objectives

- Understand the incidence of Heart Failure in the United States
- Understand the cost of Heart Failure in the United States
- Describe the structure of a heart failure clinic and importance of referrals
Objectives

- Describe the role of the heart failure coordinator
- Explain the Transitional Care Management (TCM) process and its importance
Heart Failure in the United States

- About 5.7 million adults in the United States have heart failure.¹

- One in 9 deaths in 2009 included heart failure as contributing cause.¹

- About half of people who develop heart failure die within 5 years of diagnosis.¹


Heart Failure in the United States

- Heart failure costs the nation an estimated $30.7 billion each year.\(^3\)
  - This total includes the cost of health care services, medications to treat heart failure, and missed days of work.


Heart Failure in the United States

[Map showing incidence of heart failure across the United States]

Rates are spatially smoothed to enhance the stability of rates in counties with small populations.

ICD-10 codes for heart failure: 150, deaths with heart failure mentioned in any of the 20 listed causes of death on the death certificate.

Data Source: National Vital Statistics System and the U.S. Census Bureau

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## Heart Failure Costs

<table>
<thead>
<tr>
<th>Year</th>
<th>Prevalence of HF (%)</th>
<th>Direct costs of HF ($ billions)</th>
<th>Indirect costs of HF ($ billions)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>2.8</td>
<td>24.7</td>
<td>9.7</td>
</tr>
<tr>
<td>2015</td>
<td>3.0</td>
<td>32.4</td>
<td>11.3</td>
</tr>
<tr>
<td>2020</td>
<td>3.1</td>
<td>42.9</td>
<td>13.0</td>
</tr>
<tr>
<td>2025</td>
<td>3.3</td>
<td>57.5</td>
<td>15.1</td>
</tr>
<tr>
<td>2030</td>
<td>3.5</td>
<td>77.7</td>
<td>17.4</td>
</tr>
<tr>
<td>Overall change (%)</td>
<td>25.0</td>
<td>215</td>
<td>80</td>
</tr>
</tbody>
</table>

Heart Failure Costs

## Financial Impact: Readmission Costs

<table>
<thead>
<tr>
<th>Condition</th>
<th>Cost Per Readmission</th>
<th>Readmission Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Congestive Heart Failure (CHF)</td>
<td>$13,000</td>
<td>25.1%</td>
</tr>
<tr>
<td>All-Cause Readmission</td>
<td>$11,200</td>
<td>21.2%</td>
</tr>
<tr>
<td>Heart Attack</td>
<td>$13,200</td>
<td>17.1%</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>$13,000</td>
<td>15.3%</td>
</tr>
<tr>
<td>COPD</td>
<td>$8,400</td>
<td>7.1%</td>
</tr>
<tr>
<td>Joint Replacement: Total Hip</td>
<td>$12,300</td>
<td>8.2%</td>
</tr>
<tr>
<td>Joint Replacement: Total Knee</td>
<td>$10,200</td>
<td>5.1%</td>
</tr>
</tbody>
</table>

Source: Healthcare Cost Utilization Project

Rate Measures

Performance Achievement Goal: 85%

Percent of Patients

0 10 20 30 40 50 60 70 80 90 100

Aldosterone Antagonist at discharge*: My Hospital
Anticoagulation for Atrial Fibrillation or Atrial Flutter: My Hospital
Hydralazine Nitrate at Discharge*: My Hospital
DVT Prophylaxis: My Hospital
CRT-D or CRT-P Placed or Prescribed at Discharge: My Hospital
ICD Counseling or ICD placed or prescribed at discharge: My Hospital
Influenza Vaccination During Flu Season: My Hospital
Pneumococcal Vaccination: My Hospital
Follow-up Visit Within 7 Days or Less: My Hospital

Time Period

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- Aldosterone Antagonist: 84.2%
- Anticoagulation AF: 95.5%
- Hydralazine/Nitrate: 50%
- DVT Prophylaxis: 100%
- CRT–D/CRT–P: 94.7%
- ICD: 95.1%
- Influenza Vaccine: 96.53%
- Pneumococcal Vaccine: 95.8%
- Follow–Up in 7 Days: 73.4%
30 Day Readmission Rate at St. Luke’s Medical Center

18.2% Readmission rate June 2015–May 2016

- Below expected based on our patient’s sickness O/E Ratio of 0.91.
  - This means that we end up readmitted 9% fewer patients than expected
Strategies to Reduce Heart Failure Readmissions

Reform and Payment Changes in Relation to Heart Failure Readmissions

- Greater Transparency
- Recovery Audit Contractor Program
- Changes in Readmission Payment Policy
- Bundled Payment
- Changing Care Delivery Models

Process for Executing Heart Failure Readmission Reduction Strategies

- Program Self-Assessment
- Opportunity and Strategy Identification
- Creation of a Comprehensive Business Plan
- Implementation and Continued Support

Proper Transitions Home
- Multidisciplinary Follow-Up
- Home Health
- Transitional Care Model
- Care Transitions Interventions Model
- Remote Monitoring
- Heart Failure Clinics
- Palliative Care Programs

Source: Nurs Econ © 2010 Jannetti Publications, Inc.
Many different models

Model at ASLMC:
- OUTPATIENT CLINIC: 1000+ Heart Failure Patients
  - Administrative level:
  - Managerial Level: Manager of Business Operations (MBA)
Structure of a Heart Failure Program

- Medical Director of Advanced Heart Failure Therapies: Board certified Cardiologist, board certified in Heart Failure
  - Team of 5 board certified cardiologists, board certified in heart failure as well
    - 1 APNP
    - 1 APNP for cardio-oncology

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Structure of a Heart Failure Program

- RN Supervisor (BSN, RN)
  - RN Coordinators: 7 FTEs trained in heart failure, heart transplant, and MCSD (Mechanical Circulatory Support Device)
- Palliative Care Nurse Practitioner
- Social Worker
- Pharmacist
- Dietician
- Financial Coordinator
Inpatient Team
- Outpatient cardiologists rotate call and round on all inpatients
- 5 APNPs
- Pharmacist: participates in daily rounds
- Dietary: Inpatient dietary education
- Palliative Care: consults on patients
- Social Work and Case Management: discharge planning
Referral Base

- Cardiologists within Aurora
  - Develop relationships for referral
- Cardiologists outside the organization
  - Community Outreach
  - Communication pre visit
  - Communication post visit
- Primary Care
- Second Opinions
- Self Referrals
- Events and Grand Rounds
Roles of the Heart Failure Coordinator

- Work with Multidisciplinary Team
- Coordination of Care
- Participation in Research
- Transitional Care
- Patient Education
Multidisciplinary Approach

- Role of Palliative Care
  - Care plan
    - Goals of Care
    - Advanced Care planning (Directives)
    - Family, Social, Spiritual Support
    - Definition of Quality of Life

- Role of Dietician
  - Low Salt diet
  - Fluid restrictions
Multidisciplinary Approach

- Role of Social Worker/Case Management
  - Home inotropes
  - Discharge Planning
  - Accessing community resources—telemedicine, VNA services, transportation,
  - Community based case managers

- Role of Pharmacist
  - Education about dosing, timing, side effects, purpose of the therapy
Referrals to other disciplines
  ◦ Nephrology: Cardio–renal syndrome
  ◦ Pulmonary
  ◦ Cardiac Rehab
Coordination of Care to Reduce Readmissions

- Frequent appointments in clinic as needed
- CBCM referrals to ensure compliance
- Frequent lab monitoring
- Medication titration per protocols by physicians/NP’s/RN’s
- 24 hour RN call
- Continued Collaboration with physicians, NP’s and RN’s
Follow-up testing
- Labs
- MVO2
- Echo
- Right Heart Catheterization
Participation in Research

- Education from research coordinators/study leads
- Review possible research studies with MD at clinic visits
- Conversation between MD and patient regarding research—another treatment option for patients
- Patients screened for studies
Participation in Research

- Current Studies at ASLMC
  - Parachute IV–LV
  - Paragon HF
  - DREAM HF
  - Interpret
  - Replace
  - CardioMems
Collaboration and communication between inpatient and outpatient teams is critical.

Inpatient MD or NP provides discharge information, plan of care, and follow-up needed to outpatient heart failure coordinator.
Transitional Care

- Patient is discharged from the hospital:
  - Transitional Care Management (TCM) call is completed by heart failure coordinator within 48 hours (2 business days) of discharge
  - Patient scheduled for follow-up, labs, testing within 3–7 days after discharge
Able to track:
- Readmissions prior to 1 week follow-up
- Readmissions within 30 days
- Patient’s who are not called
- Patient’s who do not follow-up
- Impact on patient follow-up and management of care
Patient Education

- Heart Failure Education Folder/Low Literacy Heart Failure Folder
- Created specifically for heart failure patients at ASLMC
Patient Education
Living with Heart Failure booklet

Contents:
- Daily weights and how to take a correct weight
- Sodium Restriction, high salt foods
- Review of food labels
- Fluid restriction
- Staying active with heart failure
- Heart Failure Definitions
Questions?