TRANSITIONS OF CARE

A Critical Component of Heart Failure Care

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Disclosure

- I have nothing to disclose

- According to The Joint Commission, one in four Medicare patients hospitalized for acute medical illness is discharged to a skilled nursing facility [1]
- 23% of these are readmitted to the hospital within 30 days [1]
- Patients admitted with HF have a 20-30% risk of death within a year [9]

2019 ACC Expert Consensus Decision Pathway on Risk Assessment, Management, and Clinical Trajectory of Patients Hospitalized with Heart Failure

- “Actionable knowledge”[9]

- Practical guidance for point of care

Focused Discharge Handoff

- Communication tool to improve continuity of care during transition phase
- Designed to travel with the patient and provide most important information for continuing care clinicians in multiple disciplines [9]

From SNF to Home

- 24.2% of patients discharged from SNF to home were readmitted to a hospital within 30 days of SNF discharge
- The risk of readmission was highest in the first two days after SNF discharge
- Readmission risk declined with longer SNF length of stay [2]

How do adults learn?

- Adults need to know why they need to learn something
- Adults need to learn experientially
- Adults approach learning as problem-solving
- Adults learn best when the topic is of immediate value.

ACCF/AHA Recommendations for Hospital Discharge

- Multidisciplinary HF disease-management programs for patients at high risk for hospital readmission are recommended (Class of Recommendation I, Level of Evidence B)
- A follow-up visit within 7-14 days and/or a telephone follow-up within 3 days of hospital discharge are reasonable (Class of Recommendation IIa Level of Evidence B)

■ 1.Britton, Meridith Campbell LMSW et al : *Care Transitions Between Hospitals and Skilled Nursing Facilities: Perspectives of Sending and Receiving Providers* https://www.jointcommissionjournal.com/article/S1553-7250(17)30048-X/pdf Accessed online 7/30/19

■2.Cheney, Christoper:*Reduce Hospital Readmissions with Effective SNF to Home Transitions* https://www.healthleadersmedia.com/clinical- care/reduce-hospital-readmissions-effective-snf-home-transitions Accessed online 7/30/19

■3.Yancy, Clyde MD et al :*2013 ACCF/AHA Guidelines for the Management of Heart Failure*

■https://www.ahajournals.org/doi/pdf/10.1161/CIR.0b013e31829e8776 Accessed online 7/30/19

■4.National Quality Forum (NQF), *Preferred Practices and Performance Measures for Measuring and Reporting Care Coordination: A Consensus Report,* Washington, DC NQF;2010

■5. 2013 Heart Failure Guideline Data Supplements https://www.ahajournals.org/action/downloadSupplement?doi=10.1161%2FCIR.0b013e31829e8776&file=online_data_supplement.pdf

■accessed online 7/30/19

■6. Skilled Nursing Facility Value-Based Purchasing Program: Frequently Asked Questions April 2019 https://www.cms.gov/Medicare/Quality- Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/Other-VBPs/SNF-VBP-FAQs-Final.PDF. Accessed online 11/1/2019

■7. Target :HF Honor Roll Measure Logic/Rationale https://www.heart.org/-/media/files/professional/quality-improvement/target-heart-failure/targethf- measure-logicrationale-ucm_496871.pdf?la=en&hash=4AEA7E05D681FE297BE5BED120FBDD9859AF3A11 accessed online 12/9/19

■8. Knowles, Malcolm: https://www.instructionaldesign.org/theories/andragogy/ accessed online 7/1/19

■9. Hollenberg, Steven MD et al *2019 ACC Expert Consensus Decision Pathway on Risk Assessment, Management, and Clinical Trajectory of Patients Hospitalized with Heart Failure* http://www.onlinejacc.org/content/accj/74/15/1966.full.pdf accessed online 1/2/20

■10. Lenert LA, Sakaguchi FH, Weir CR. *Rethinking the discharge summary: a focus on handoff communication.* Acad Med. 2014;89(3):393–398. doi:10.1097/ACM.0000000000000145 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4090779/#!po=43.7500 accessed online 1/28/20