2017 Updates to Target: Heart Failure

July 20, 2017

Presenter: Gregg C. Fonarow, MD, FACC, FAHA

TARGET:HF

Our Presenter

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Disclosures

- Research NIH
- Consultant Amgen
- Janssen
- Medtronic
- Novartis
- St. Jude Medical

Target:HF Overview

What Is Target: HF?

- Launched in 2011, A national initiative of the American Heart Association within GWTG HF that focuses on targeted area that provides healthcare professionals with content-rich resources and materials designed to help advance heart failure awareness, prevention, and treatment.

Target: Heart Failure Mission**:**

Increase 3 key patient-centered care domains with very well established or emerging evidence-base:

- *Medication optimization*
- *Early follow-up and care coordination*
- *Enhanced patient education*

Get With The Guidelines® - Heart Failure Overview

- Get With The Guidelines®- Heart Failure launched in 2005
- 4 Achievement Measures and 10 Quality Measures
- Hospitals enrolled have several opportunities to be recognized for their efforts and are recognized at National events
- As of June 2017, there are greater than 87 Get With The Guidelines manuscripts focused on Heart Failure.
  - Publications are viewable at www.heart.org
- 684 Hospitals enrolled in the program
- Over 1,500,000 patients entered into the PMT

Most Comprehensive Measure Set Available

Achievement Measures	Quality Measures	Reporting Measures
• ACEI/ARBs or ARNi at Discharge* • Evidence-Based Specific Beta Blockers* • Measure LV Function • Post-Discharge Appointment for Heart Failure Patients	• ARNi at Discharge • Aldosterone Antagonist at Discharge* • Anticoagulation for Atrial Fibrillation and Atrial Flutter • Hydralazine Nitrate at Discharge • DVT Prophylaxis • CRT-D or CRT-P Placed or Prescribed at Discharge • ICD Counseling Provided or Prescribed or Placed at Discharge • Influenza Vaccination During Flu Season • Pneumococcal Vaccination • Follow-Up Visit Scheduled Within 7 Days or Less	• Blood Pressure Control at Discharge • Beta Blocker at Discharge • Beta Blocker Medication at Discharge • Lipid-Lowering Medications at Discharge • Omega-3 Fatty Acid Supplement Use at Discharge • Diabetes Treatment • Diabetes Teaching • Smoking Cessation • Discharge Instructions • ICD Placed or Prescribed at Discharge • Advanced Care Plan • QRS Duration Documented • Heart Failure Disease Management Program Referral • Follow-Up Visit or Contact Within 48 Hours of Discharge Scheduled

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Most Comprehensive Measure Set Available

Reporting Measures *(Continued)*

- Follow Up Visit or Contact Within 72 Hours of Discharge Scheduled
- 60 Minutes of Heart Failure Education
- Referral to AHA Heart Failure Interactive Workbook
- Referral to HF Disease Management, 60 Minutes Patient Education, Or HF Interactive Workbook*
- Heart Failure Activity Level
- Heart Failure Diet
- Heart Failure Follow-Up
- Heart Failure Weight
- Heart Failure Symptoms Worsen
- Length of Stay
- Care Transition Record Transmitted
- Advance Directive Executed
- Discharge Disposition
- Ivabradine Prescribed

Descriptive Measures

- Age
- Diagnosis
- Gender
- Race
- HF Composite Measure
- HF Defect-Free Measure
- JC/CMS HF Defect Free Measure
- Target: HF Defect Free Measure

Mortality & Readmission Measures

- In-Hospital Mortality
- Risk Adjusted Mortality Ratio

- Readmission Frequency & Rate
- 30, 60 & 90 Day Readmissions & Rate
  - *Not equivalent to the CMS 30-Day Risk-Standardized Readmission Measure. It is not risk-adjusted, does not represent all cause readmission, and does not capture readmissions from other hospitals.*

Target: HF Award Recognition Measures

- Discharge use of ACEI/ARB or ARNi
- Evidence-based beta blocker
- Aldosterone antagonist (In all eligible heart failure patients with reduced LVEF, in absence of documented contraindications, intolerance, or patient/system reasons)
- Early post-discharge follow-up with visit or phone call scheduled to occur within 7 days of hospital discharge
- UPDATED: Enhanced patient education as evidenced by referral to heart failure disease management program, provision of at least 60 minutes of heart failure education by a qualified heart failure educator, or provision of AHA heart failure interactive workbook OR were referred to an outpatient cardiac rehabilitation program

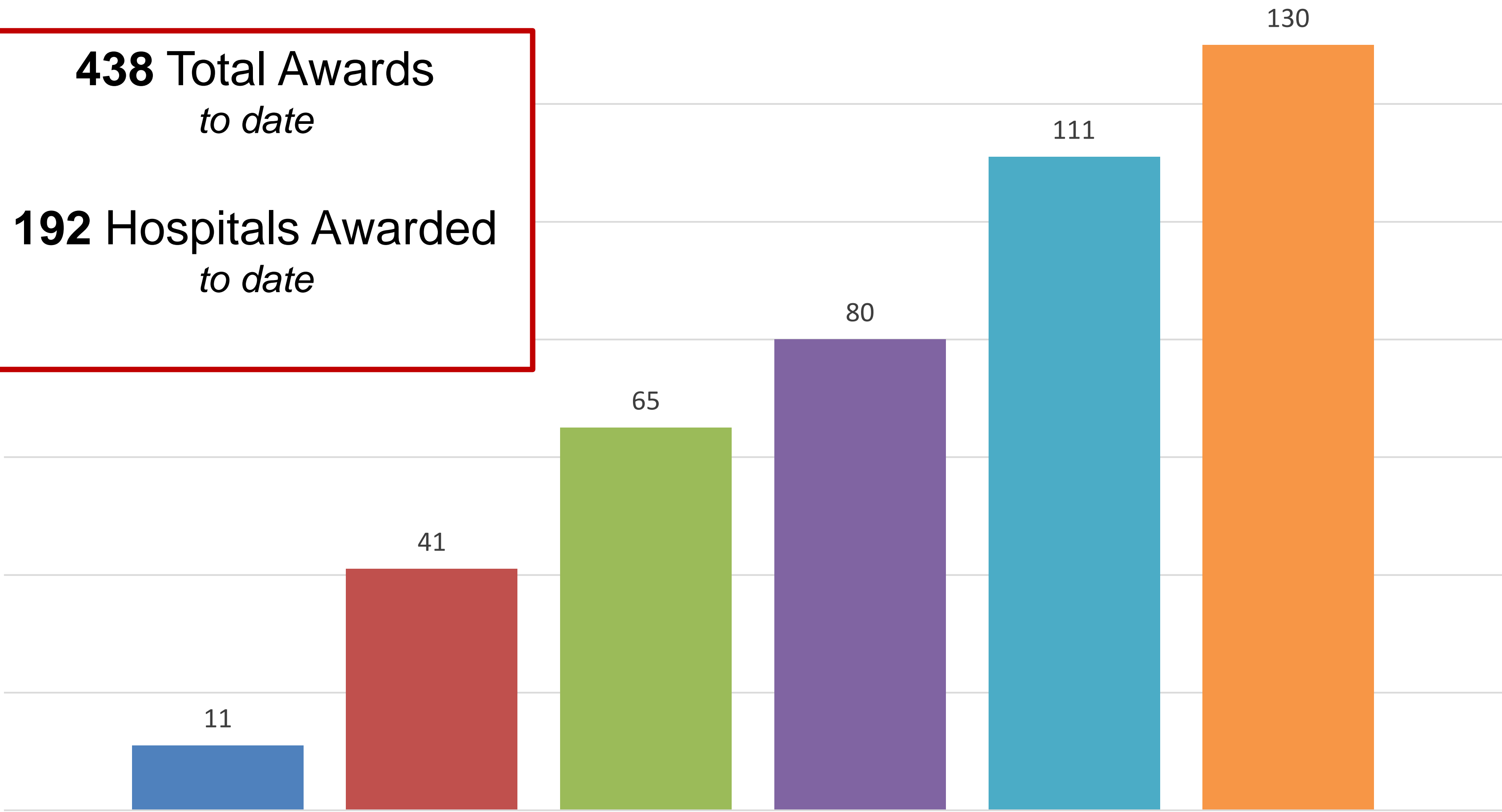
Updated recognition measure available in the PMT Spring 2018

Target: Heart Failure Honor Roll Recognition

Requirements: Documentation of all three care components for **50% or greater of compliance** for eligible patients with heart failure.

Hospitals must be GWTG-HF performance achievement award hospitals.

Target:HF Honor Roll
2011 to 2017



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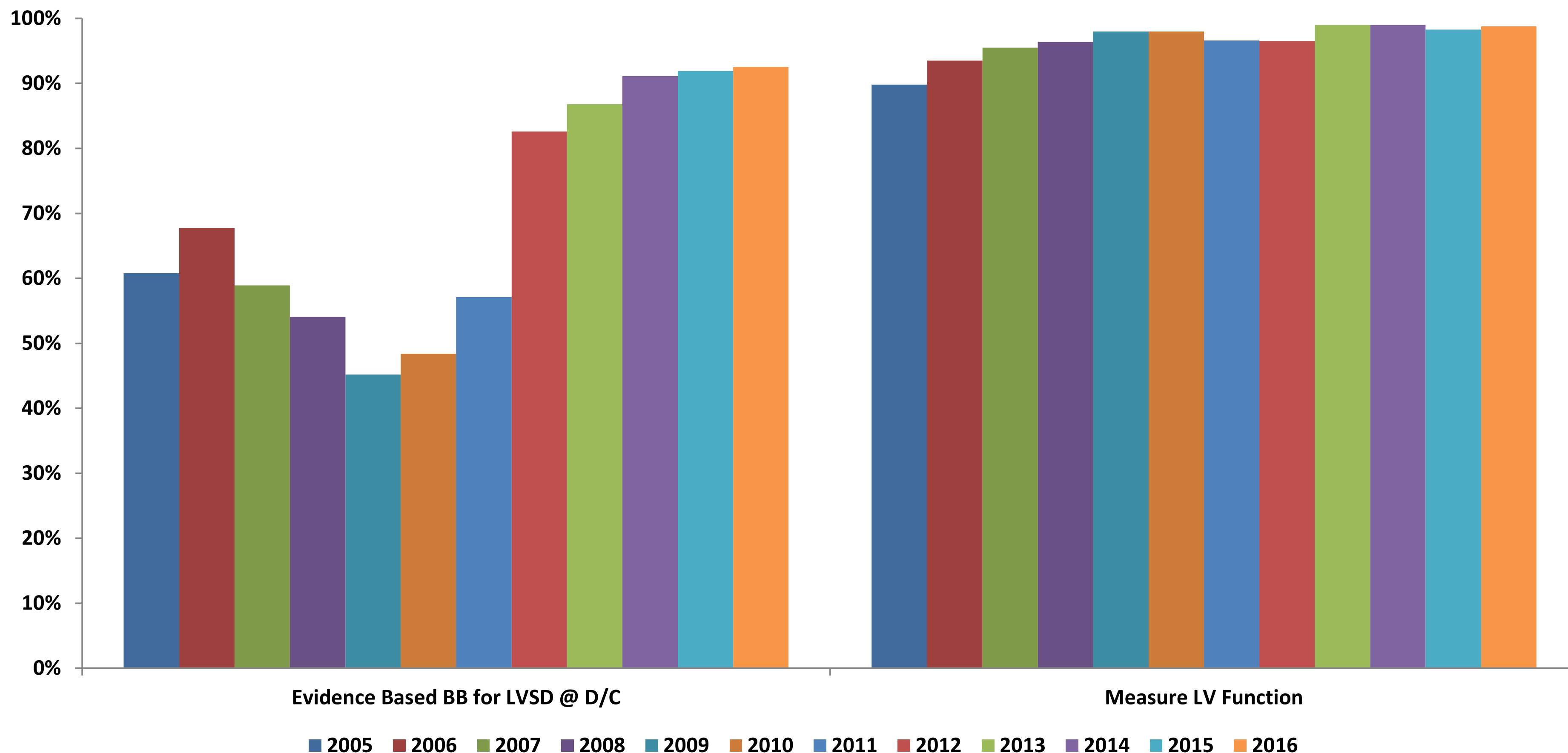
GWTG-HF: Achievement Measures (1)



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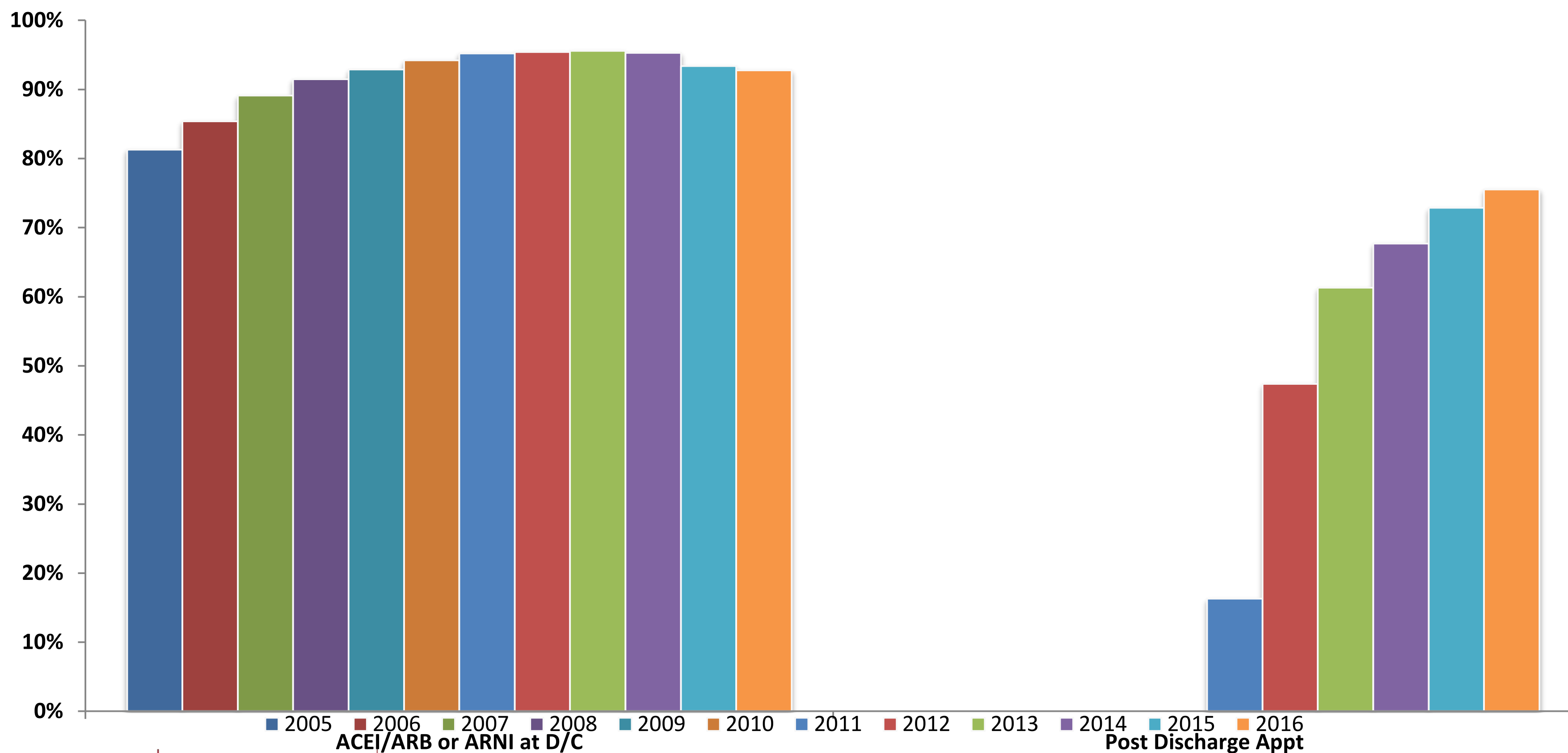
April 2017

GWTG-HF: Achievement Measures (2)



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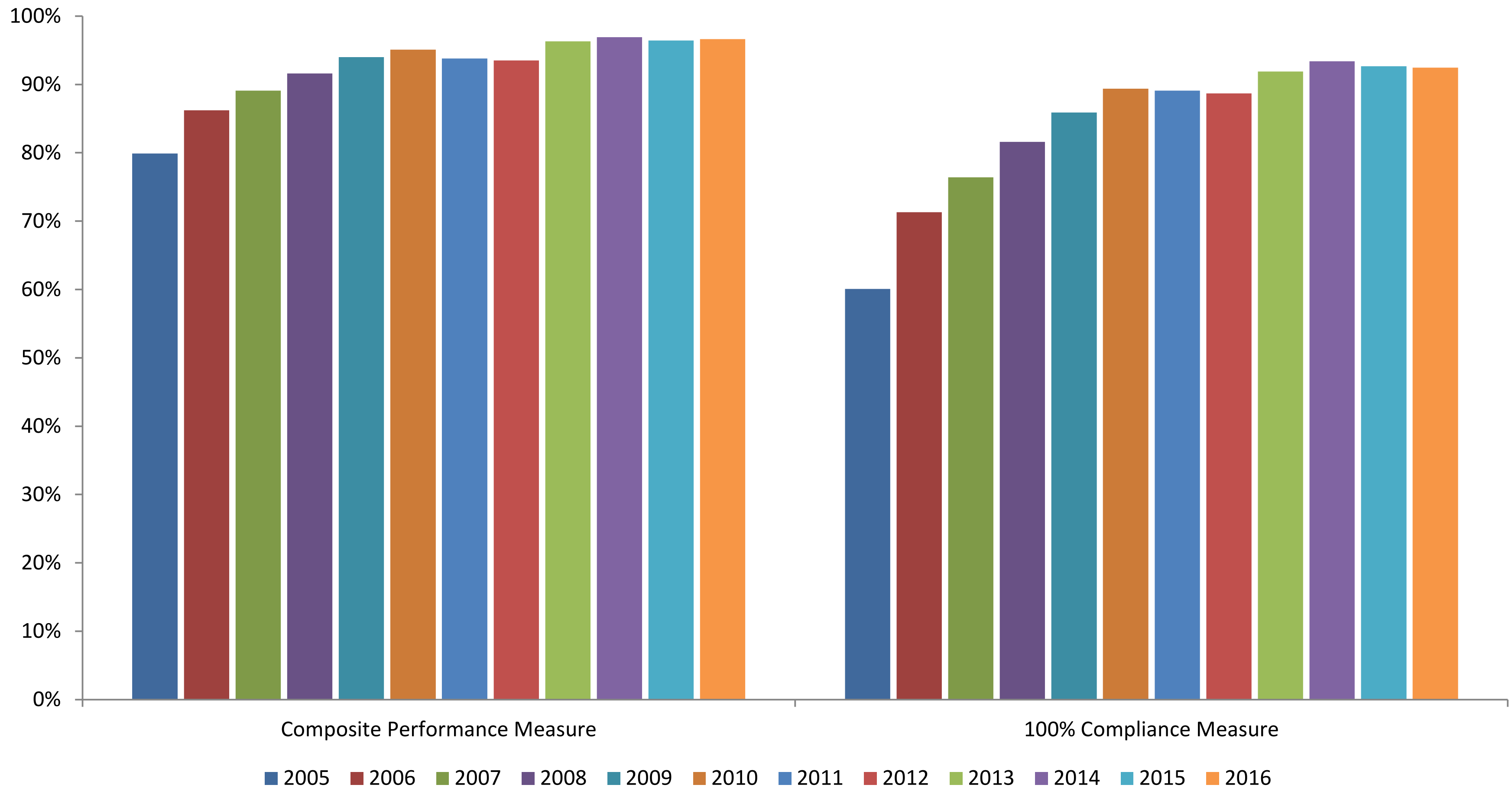
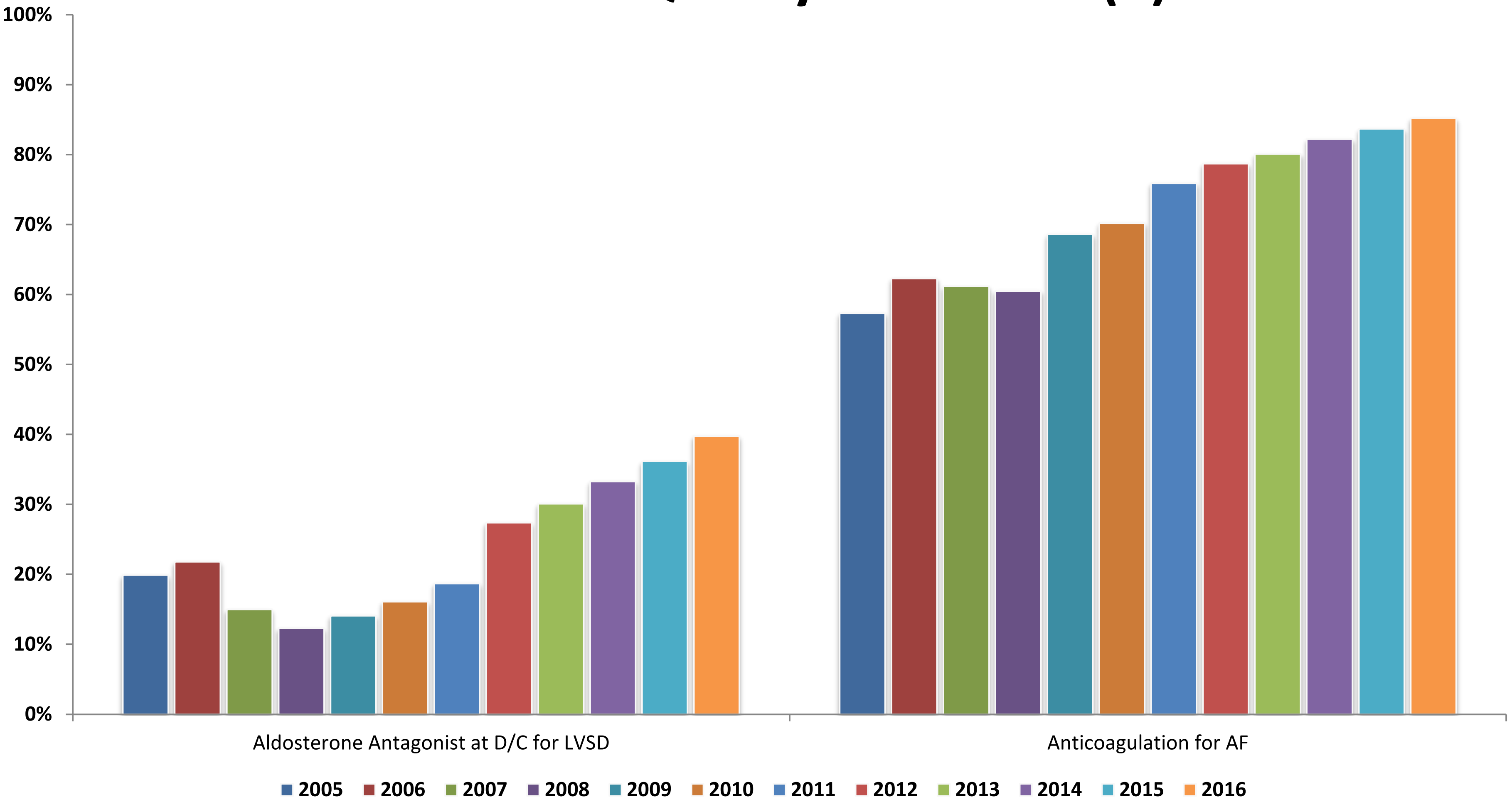
GWTG-HF: Achievement Measures (3)



GWTG-HF: Quality Measures (1)



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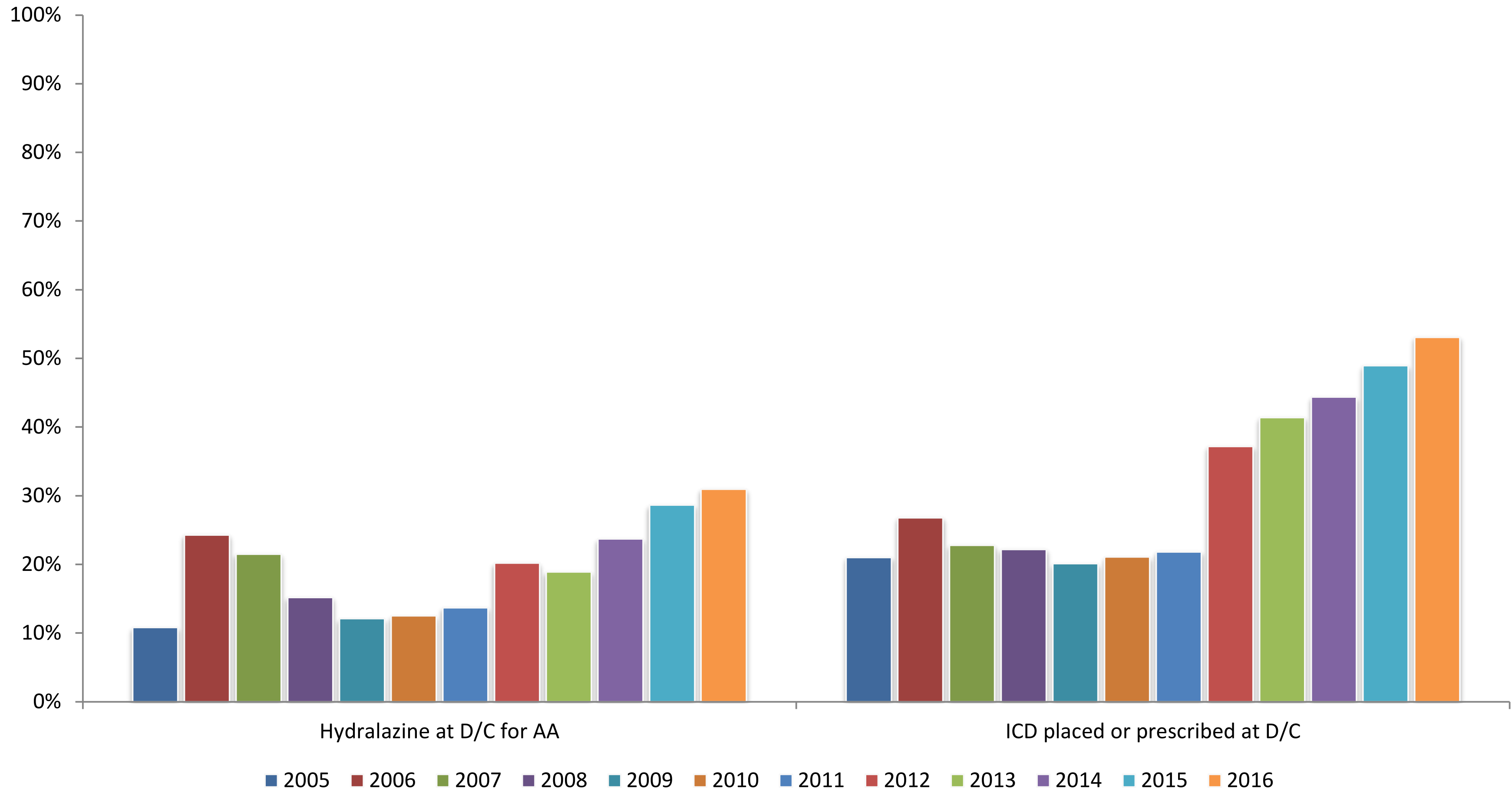
GWTG-HF: Quality Measures (2)



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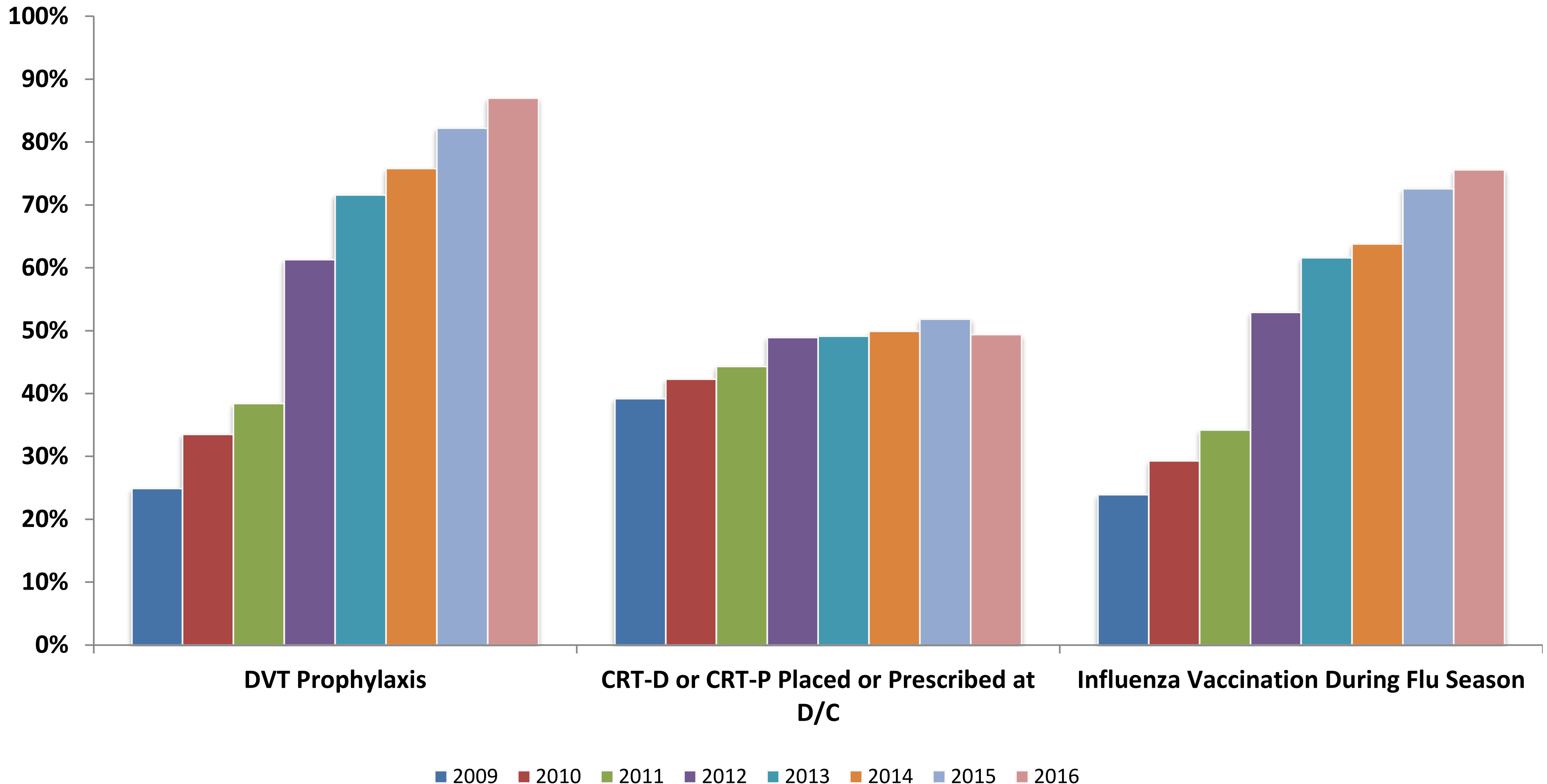
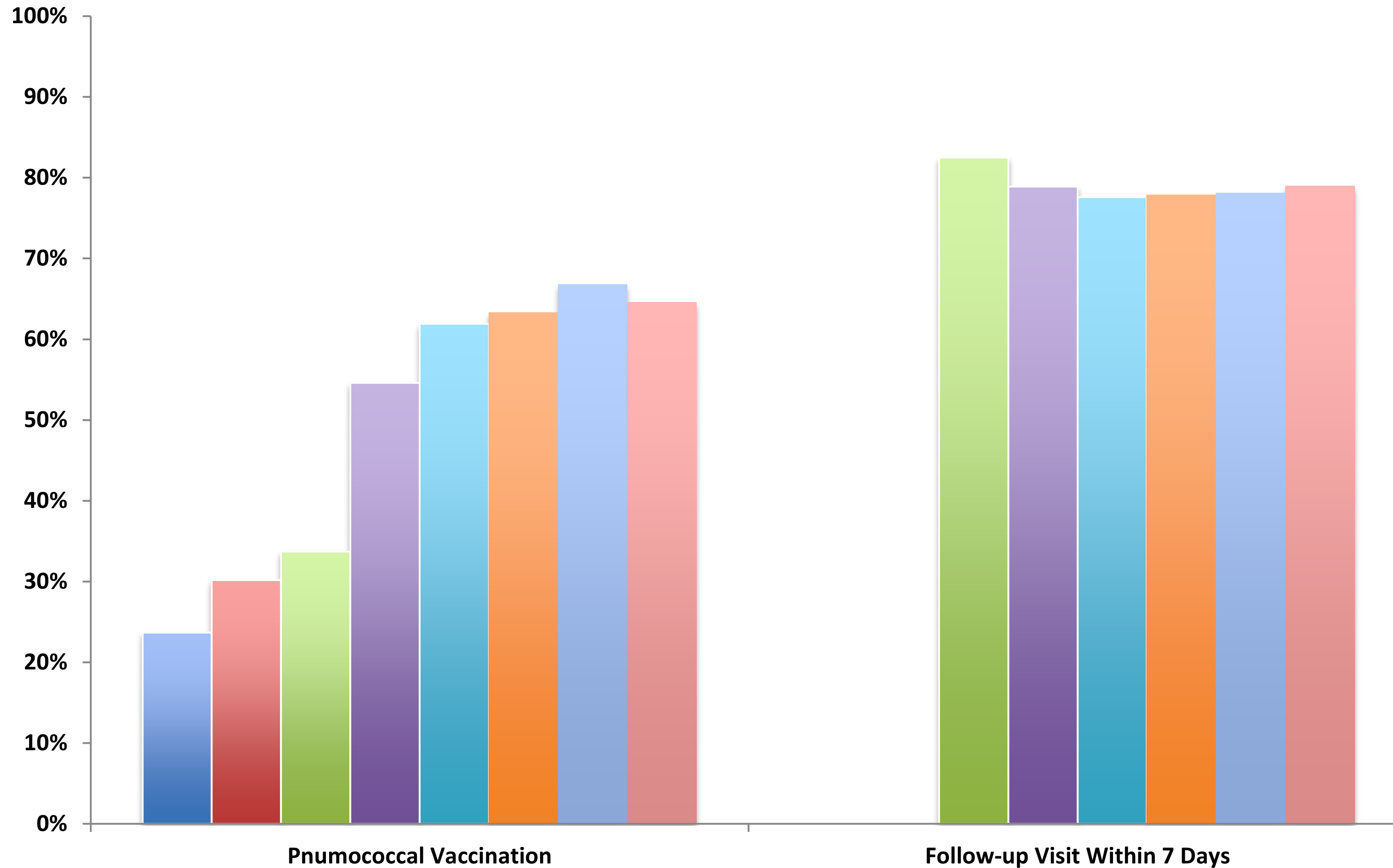
GWTG-HF: Quality Measures (3)



GWTG-HF: Quality Measures (4)



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TARGET: HF

Program Updates

Objectives of the Update

- Re-brand Get With The Guidelines Target: Heart Failure
- Enhance clinical tools to be reflective of the 2013 HF Guidelines, and updates in 2016 and 2017
- Launch *OnTarget*, a monthly newsletter featuring clinical resources and on key program elements
- Update the main website heart.org/targethf with updated branding
- Launch the Target:HF App to bring key clinical resources to your mobile device

Taking Action

- National Heart Failure Clinical Work Group members met to review and assess the program
- Conducted a review of all existing materials and provided updates to the clinical tools
- Materials were updated and went through a thorough AHA science review
- Updates made are reflective of the *2013 ACCF/AHA Guideline for the Management of Heart Failure* and the updates released in 2016 and 2017

Taking Action

- Enhancements to clinical tools include:
  - Medication updates including ARNi and Ivabradine
  - Inclusion of the LACE+ risk score as an additional clinical tool
  - Updated Target:HF Composite measure to include Cardiac Rehab
  - Updated patient readmission risk factor, medication adherence and cardiac rehab
  - Updated list of factors of readmission to include patient factors such as: frailty, cognition/memory, social support and language barriers, etc.

Update to Target:HF Composite Measure

Referral to HF Disease Management, 60 Minutes Patient Education, HF Interactive Workbook or Referral to Outpatient Cardiac Rehabilitation Program

Percent of heart failure patients who were referred to heart failure disease management, received 60 minutes of patient education by a qualified educator, received an AHA heart failure interactive workbook, or were referred to an outpatient cardiac rehabilitation program

Exclusions: (Always remove from denominator)

- Comfort Measures only documented
- Patients transferred to another acute care hospital; patients discharged/transferred to a Designated Cancer Center or Children's Hospital; patients who expired; patients who expired in medical facility; patients who left against medical advice; patients discharged to hospice; patients discharged to a federal hospital; patients discharged/transferred to a critical access hospital (CAH)
- Patients for whom disease management is not applicable
- Patients for whom 60 minutes of HF education is not applicable
- Patients for whom referral to AHA heart failure interactive workbook is not applicable
- Patients for whom referral to Outpatient Cardiac Rehabilitation Program is not applicable

Numerator

Heart failure patients who were referred a disease management program OR received 60 minutes of patient educator by a qualified educator, OR received an AHA heart failure interactive workbook OR were referred to an outpatient cardiac rehabilitation program

Taking Action

Updated Collateral

TARGET:HF

THE FACTS ABOUT HEART FAILURE

THE PROBLEM

1 IN 8 DEATHS HAS HEART FAILURE MENTIONED ON THE DEATH CERTIFICATE

THE LIFETIME RISK OF HF OCCURING FOR PEOPLE WITH A BP GREATHER THAN 160/90 IS 1.6 TIMES THAT OF THOSE WITH BLOOD PRESSURE LESS THAN 120/90 MM HG

50 PERCENT OF PEOPLE DIAGNOSED WITH HEART FAILURE WILL DIE WITHIN FIVE YEARS

IN THE GWTG-HF REGISTRY, ONLY ONE TENTH OF ELIGIBLE HF PATIENTS RECEIVED CARDIAC REHABILITATION REFERRAL AT DISCHARGE AFTER HOSPITALIZATION FOR HF

AMONG MEDICARE PART D

TARGET:HF

REDUCING 30-DAY READMISSIONS THROUGH ENCOURAGEMENT, EDUCATION AND EXPERIENCE.

ENCOURAGEMENT

EDUCATION

EXPERIENCE

REDUCE READMISSIONS

JOIN THE FIGHT

HEART FAILURE QUALITY MEASURE SET

ACHIEVEMENT MEASURES | QUALITY MEASURES | REPORTING MEASURES

TARGET:HF

GENERAL INFORMATION

Discharge date: (mm/dd/yyyy)

Patient name:

Date of birth: (mm/dd/yyyy)

Primary care physician:

Cardiologist:

Homecare? YES NO | Assisted Care? YES NO

Labs ordered/done prior to first follow-up call or appointment? YES NO | Date: (mm/dd/yyyy)

PATIENT EDUCATION

Weight monitoring

Do you have a scale at home that you can use to weigh yourself? YES NO

Can you see the numbers on the scale? YES NO

Have you been weighing yourself daily? YES NO

Dry weight (at home, 1st day after discharge)

Did you take your dry weight 1 day after discharge? YES NO

Do you have a weight diary? YES NO

Do you understand how and when to check your weight? YES NO

TARGET:HF

HEART FAILURE DISCHARGE CHECKLIST

Please complete all boxes for each HF indicator:

Admit Date: ______ Admit Unit: ______ Discharge Date: ______ Discharge Unit: ______

Attending Physician: ______ HF Etiology: ______

Follow-up appointment (date/time/location): ______

Complete All Boxes for Each HF Indicator	YES	NO	Reason Not Done/Contraindications
Angiotensin-converting enzyme inhibitor (if LVSD)			NA CI
Angiotensin receptor blocker (if LVSD and ACEI not tolerated)			NA CI
Angiotensin receptor/neprilysin inhibitor (if LVSD, and in place of an ACEI or ARB)			NA CI
β-Blocker (if LVSD, use only carvedilol, metoprolol succinate, or bisoprolol)			NA CI
Aldosterone antagonist (if LVSD, Cr ≤2.5 mg/dl in men, ≤2.0 mg/dl women,potassium <5 mg/dl, and patient's potassium and renal function will be closely monitored)			NA CI
Hydralazine/nitrate (if self-identified African American and LVSD)			NA CI
Most recent left ventricular ejection fraction (___%) Date of most recent LVEF (___) Method of assessment: Echocardiogram, Cardiac catheterization, MUGA scan			
Anticoagulation for atrial fibrillation or flutter (permanent or paroxysmal) or other indications			NA CI
Precipitating factors for HF decompensation identified and addressed			NA CI
Blood pressure controlled (<140/90 mm Hg)			NA CI
Pneumococcal vaccination administered			NA CI
Influenza vaccination administered (during flu season)			NA CI
EP consult if sudden death risk or potential candidate for device therapy			NA CI

Patient Sticker Here

TARGET:HF

Heart Failure 30-day Readmission Risk Calculator

Adults with heart failure are at high risk for early rehospitalization. This risk may vary by patient, heart failure and provider characteristics. Clinical risk tools may help to stratify risk.

The Yale risk calculator can help predict heart failure 30-day readmission:

The Center for Outcome Research and Evaluation (CORE) released an online readmission risk calculator for heart failure.

You can view the CORE risk calculator at http://readmissionscore.org/heart_failure.php

The online readmission risk calculator can help predict a patient's likelihood of hospital readmission for heart failure within 30 days of discharge. Despite the benefits of the heart failure readmission calculation, there are some limitations worth noting:

- **This tool provides only an estimate of risk for readmission.**
- **The tool assumes that the performance of the treating hospital is average in terms they did not seek to limit the number of variables (as the calculation does) or to include information about in-hospital.**
- **When CORE developed the risk adjustment model, adverse events.**
- **The calculator does not provide guidance on how to use the estimates.**

Despite these limitations, the risk calculator can provide hospitals with valuable insights regarding possible readmission.

Hospitals should consider what transition care/care coordination strategies they should deploy to decrease 30-day readmission. Target: Heart Failure offers many tools and resources to hospitals.

Find out what's available at heart.org/targethf

TAKING THE FAILURE OUT OF HEART FAILURE

TARGET:HF

TARGET:HF

Discharge Criteria for Patients Hospitalized with Heart Failure

Recommended for all adult patients with heart failure:

- Precipitating and exacerbating factors addressed
- Transition from intravenous to oral diuretic successfully
- Near optimal/ optimal volume status achieved
- Near optimal/ optimal pharmacologic therapy for heart failure
- Stable renal function and electrolytes within normal range/ near normal range based on patient's baseline
- No symptomatic supine or standing hypotension or dizziness
- Patient and family education completed
- Details regarding medications and medication reconciliation
- Need for medication adherence understood by patient/family
- Dietary sodium restriction and understands rationale for adherence
- Need for daily activity and exercise, and under stands rationale for both
- Need for monitoring of daily weights and when to contact provider
- Plan to reassess volume status early after discharge is documented (when/where)
- Plan to monitor electrolytes and renal function early after discharge is documented (what/when)
- Plan to titrate heart failure medications to target dose, if needed, is documented (what/when)
- Plan to reinforce patient and family education post-discharge is documented (when/where/themes)
- Follow-up clinic visit scheduled within 7 days of hospital discharge is documented (where/when/with whom)
- Follow-up phone call scheduled in addition to clinic visit is documented (when)
- Referral to outpatient cardiac rehab program

- Oral medication regimen, stable for at least 24 hours
- No intravenous vasodilator or inotropic agent for at least 24 hours
- Ambulation before discharge to assess functional capacity
- Careful observation before and after discharge for worsening, or development of, renal dysfunction, electrolyte abnormalities and symptomatic hypotension
- Plans for more intensive post-discharge management (scale present in home, visiting nurse, or telephone follow-up no longer than 3 days after discharge)
- Referral for formal heart failure disease management

This is a general algorithm to assist in the management of patients. This clinical tool is not intended to replace individual medical judgement or individual patient needs.

TAKING THE FAILURE OUT OF HEART FAILURE

TARGET:HF

Identifying Avenues for Growth

- Conducted in-depth telephone interviews with active Target: HF customers
- A qualitative discussion guide was used focusing on:
  - Challenges associated with caring for heart failure patients
  - Target HF program awareness and benefits
  - HF resources currently used
  - Website feedback
  - Communication preferences
- Assessed hospital needs for resources to support their efforts to treat heart failure and lower readmission rates.
- Determined availability of resources for hospitals, and identify how Target: HF fills the gap.
- Assessed current program look and feel, programmatic, marketing, and communications elements

Identifying Avenues for Growth

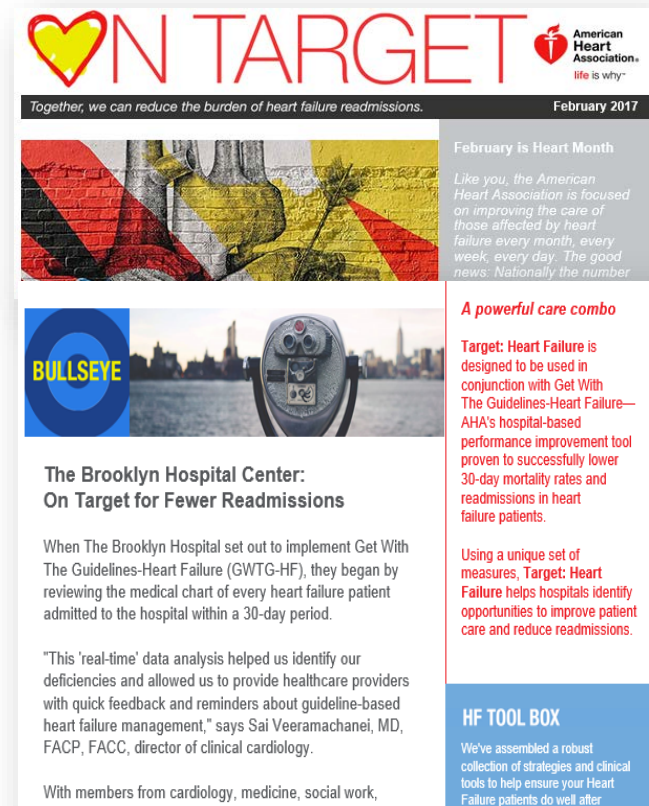
Target: HF Customer Survey - Insight on Metrics

- General consensus is the right metrics are in place, and that they are helpful in keeping the focus on the patient (rather than hospital process)
- Most frequently discussed metrics were evidence-based beta blockers, in-hospital education, and scheduling follow-up appointments
- Those within the Quality area spoke to the need for more powerful data mining software to allow for more detailed/customized extractions and aggregations
- Ability for EHR information to automatically flow into Get With The Guidelines so less time is spent on chart extractions

Connecting with a Wider Audience

***On Target* Newsletter Series**

- Emailed monthly
- Highlights key-topics in improving 30-day rehospitalization rates
- Special 3 month focus on medication adherence including: ACE/ARB or ARNI, Evidence-based beta blockers, Aldosterone Antagonist
- Featured Clinical Tools and Resources



ON TARGET

American Heart Association. life is why

Together, we can reduce the burden of heart failure readmissions. February 2017

February is Heart Month

Like you, the American Heart Association is focused on improving the care of those affected by heart failure every month, every week, every day. The good news: Nationally the number

BULLSEYE

The Brooklyn Hospital Center:
On Target for Fewer Readmissions

When The Brooklyn Hospital set out to implement Get With The Guidelines-Heart Failure (GWTG-HF), they began by reviewing the medical chart of every heart failure patient admitted to the hospital within a 30-day period.

"This 'real-time' data analysis helped us identify our deficiencies and allowed us to provide healthcare providers with quick feedback and reminders about guideline-based heart failure management," says Sai Veeramachanei, MD, FACP, FACC, director of clinical cardiology.

With members from cardiology, medicine, social work,

A powerful care combo

Target: Heart Failure is designed to be used in conjunction with Get With The Guidelines-Heart Failure—AHA's hospital-based performance improvement tool proven to successfully lower 30-day mortality rates and readmissions in heart failure patients.

Using a unique set of measures, **Target: Heart Failure** helps hospitals identify opportunities to improve patient care and reduce readmissions.

HF TOOL BOX

We've assembled a robust collection of strategies and clinical tools to help ensure your Heart Failure patients do well after

To receive OnTarget, email, liz.olson@heart.org

Website Updates

- Heart.org/targethf
- New look launching in the coming month
- Refreshed look and feel.
- Revised navigation
- Easier to access key program materials, research and patient education resources

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INTRODUCING! Target: HF App

- Progressive Web App
- Interactive mobile site – designed for mobile use
- Dedicated link targethf.heart.org (COMING SOON)
- Ability to save to home screen
- Adaptability for phone, tablet users
- Accessible from computer
- Includes the Yale Risk Calculator and LACE+ Calculator; input data right from your phone, tablet
- Key clinical topics in heart failure featured in our media area
- Editable PDF clinical tools
- Clinical Tools editable in-app with CSV email

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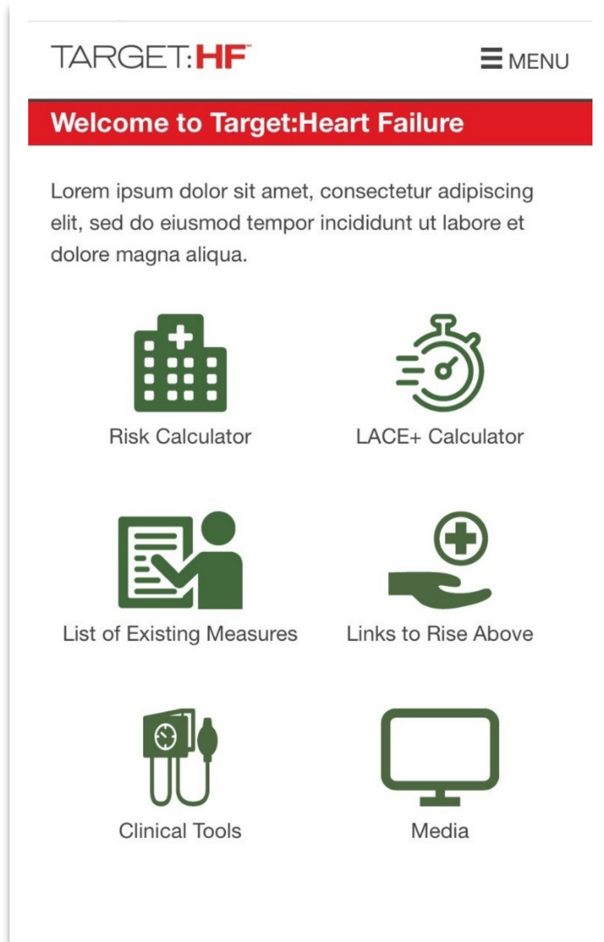
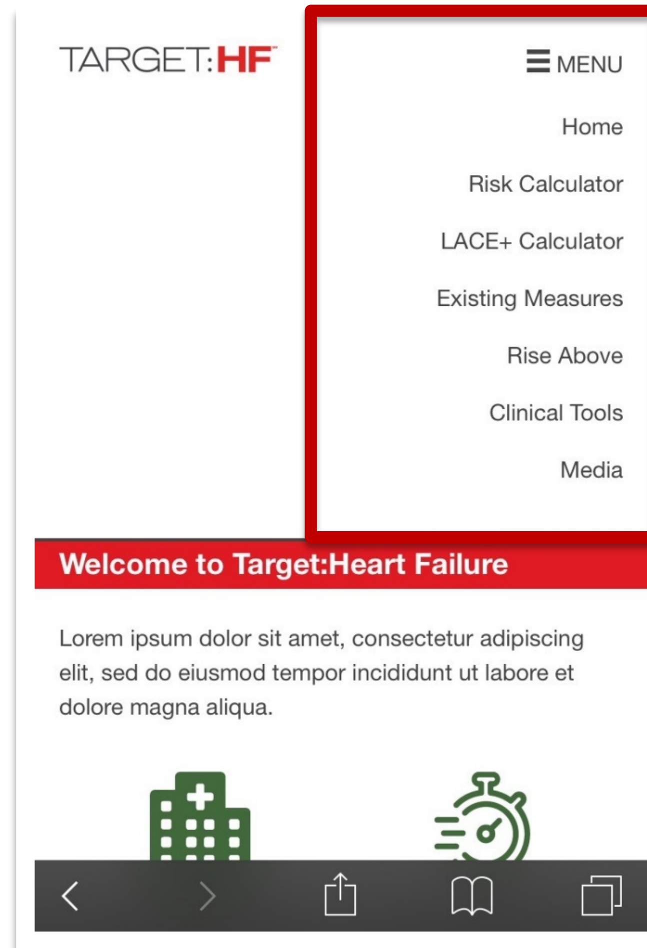
Target: HF App

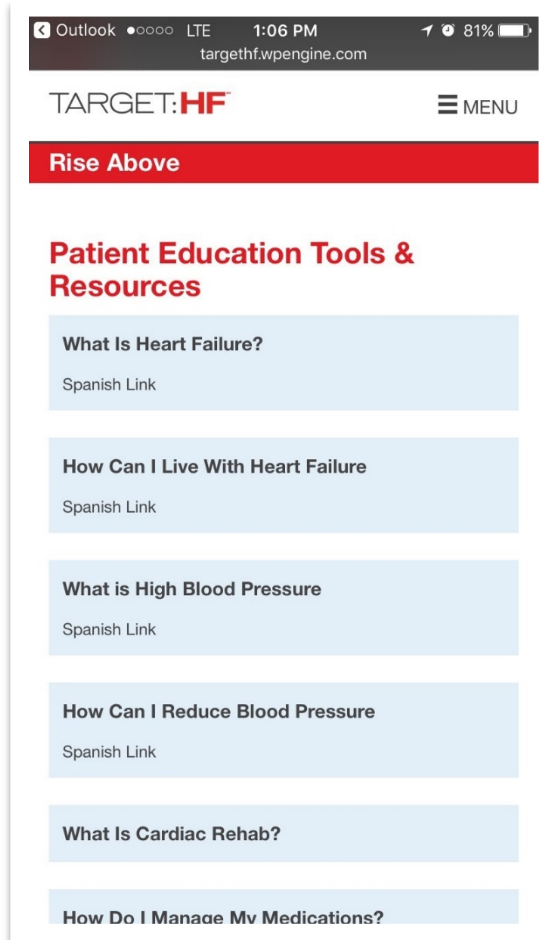
Home Screen and Menu





Target: HF App

Clinical Tools



- All clinical tools updated with the latest science.
- Fast, easy access to our most valuable clinical Tools
- Documents available in English and Spanish
- New resources for patient education in cardiac rehab, medication adherence and more
- Links to *Rise Above HF* initiative
- Updated Interactive Workbook “MY HF GUIDE” accessible from the app on your phone or tablet

Target: HF App

Webinar Recordings

Outlook ●○○○○ LTE 1:07 PM 80%

targethf.wpengine.com

WARNING SIGNS

TARGET:HF ☰ MENU

Media

Transitions of Care

Clinical Predictors of 30-Day Rehospitalization

Factors	GWTG-HF; N=33,349[1]	Medicaid Pts; N-4548[2]	Elders N=2176[3]	Alberta CA N=18,590[4]
Abnormal troponin	1.15 (1.1-1.2)			
Black race (vs. white)	1.11 (1.0-1.2)			
↑ creatinine-Kid. Dis.	1.12 (1.1-1.2)	1.45 (1.1-1.9)	1.72 (1.3-2.2)	1.43 (1.2-1.7)
Medicaid (vs. comm.)		1.68 (1.3-2.2)		
Prior adm. < 1 yr.			1.25 (1.1-1.5)	
Diabetes			1.17 (0.9-1.4)	
Atrial Fibrillation				1.14 (1.0-1.3)
Age ≥ 75 yrs				1.43 (1.0-2.0)

Cleveland Clinic

58:20

- Featuring important topics in the management of Heart Failure
- Archive of past national AHA GWTG-HF and Target:HF webinars
- Viewable in app on your mobile phone or tablet
- Future updates will include bonus video and audio content not available on heart.org

Target: HF App

LACE+ Calculator

●●○○○ AT&T LTE 4:45 PM 60%
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GENDER

☐ MALE

ACUITY OF ADMISSION

☐ URGENT (OR EMERGENCY) ADMISSION

TEACHING STATUS of the hospital

Teaching hospital

LENGTH OF STAY

Time between when the patient is first marked with a base class of inpatient and Discharge.
i.e. Does not include time spent in ED prior to inpatient admission.

< 1

ALC (Alternative Level of Care) days during admission

Patient is admitted but not receiving active medical care

◯ ALC DAYS = 0 ◯ ALC DAYS > 0

ED VISITS in Previous 6 Months

Does not include ED visits that later become an admission because the patient class of Emergency would no longer apply

◯ ED VISITS = 0 ◯ ED VISITS = 1 ◯ ED VISITS > 1

LACE+ Calculator

Your LACE+ Index

72

LACE+ Risk Stratification	LACE+Score
Highest Risk (Hot Pink)	**79 - 90**
High Risk (Red)	**59 - 78**
Moderate Risk (Yellow)	**29 - 58**
Minimal Risk (Green)	**0 - 28**

The LACE index (score 0-19) uses 4 variables to predict the risk of death or urgent readmission within 30 days after hospital discharge: LOS **(L)**, acuity of admission **(A)**, comorbidity **(C)** and ED visits in previous 6 months **(E)**.

The LACE+ Index (score 0- 90) is a modified version of the LACE Index in which each patient receives a score based on all the same parameters used by LACE, as well as the following: age; gender; teaching status of the hospital; number of days on alternative level of care during admission; number of elective admissions in previous year; number of urgent admissions in previous year.

Special thanks to our Target:HF sponsor Novartis Pharmaceuticals

Novartis Pharmaceuticals Corporation is a national sponsor of American Heart Association's Target: Heart Failure.

Contact Us to Learn More

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Stay informed on the latest updates from Get With The Guidelines

Sign Up for Focus on Quality e-Communications

THANK YOU
for your active participation and contributions to GWTG-HF

TARGET:HF