Transitions of Care in Heart Failure

Facilitating Safe, Smooth, and Efficient Quality Shifts or Transitions from one setting to the next.

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FINANCIAL DISCLOSURE: None

UNLABELED/UNAPPROVED USES DISCLOSURE: None
Objectives

- Define Transitions
- Explain the importance of a transition program for patient with heart failure
- Discuss Readmission risks for patient discharged with heart failure diagnosis.
- Discuss components of successful transition programs
- Explain transition practices in different settings
Definition of Chronic Care

- Chronic conditions are defined as health problems that last 12 months or longer and restrict an individual’s self care, independent living, and social interactions and require ongoing medical interventions and services. (Agency for Healthcare Research and Quality)

Defining Heart Failure

*Decompensated* heart failure is the inability of the heart to supply adequate blood flow and oxygen delivery to peripheral tissues and organs.

Under perfusion of organs leads to:
- Reduced exercise capacity
- Fatigue
- Shortness of breath
- Organ dysfunction
- Confusion

Heart failure is a chronic, progressive medical condition characterized by recurrent exacerbations requiring ongoing disease management.
Heart Failure Epidemiology

- Heart Failure affects over 5 million Americans.
- Annual cost in 2012 $30.7 billion; anticipated to increase to $69.7 billion in 2030
- Approximately 870,000 new cases each year
- In 2010, 1 in every 9 deaths was attributed to heart failure
- “Heart Failure Paradox”
- Incidence and prevalence increase with age.
- HF- most common reason to hospitalize individuals older than age 65.
- Acute decompensated heart failure was responsible for over one million hospital discharges in 2010.
- 21% of hospitalized HF patients over the age of 65 were discharged to LTC facilities in 2010; a significant increase from 2000.

Heart Failure Management in Skilled Nursing Facilities; A scientific statement from the American Heart Association and the Heart Failure Society of America. J Card Fail. 2015; 21:263-299
As You Know

- Almost one-fifth of the Medicare Beneficiaries who had been discharged from an acute care facility were readmitted within 30 days (Jencks, Coleman 2009)

- Nearly 90% of readmissions are unplanned and potentially preventable which translates into $17 Billion or nearly 20% of Medicare hospital payments (Hernandez et al, 2010)
Patient Protection and Affordable Care Act

- Value Based Purchasing (VBP); a pay for performance system.

- VBP links Medicare prospective payment to quality performance and pays a bonus for good performance and reduces payment for poor performance.

- Hospitals with higher than expected 30-day readmission rates receive reduced Medicare payment.

The discharge problem

The hospital discharge is **poorly standardized** and is characterized by **discontinuity** and **fragmentation** of care; lack of **coordination** in the handoff from the hospital to community care, and poor delineation of discharge responsibilities among hospital staff. This process places patients at high risk of postdischarge adverse events and rehospitalization.

Preparing the Patient for Discharge

- Why did the patient require hospitalization, what caused the decompensation?
  - Was it related to progression of disease?
  - Discuss Goals of Care
- Are symptoms improved? Is patient as baseline functional status?
  
  For Medicare patients discharged from hospital with new disability in ADL, only 30% returned to prior level of functioning.

- What are the patient's short and long term goals?

- What resources are needed?
  - Medications
  - Meal preparation
  - Visiting nurses
  - SNF
  - Rehab
  - Scale
  - Mobility issues
  - Transition team
  - Advanced Heart Failure Services
  - Transportation

- Does the patient or care provider understand disease self-management?

- Is there a follow up appointment?

- Was a discharge summary sent to receiving provider?

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Why are patients re-hospitalized

- Don’t understand medications

- Can’t recognize red flags

- Unable to manage health care
**Why are Patients’ Re-Hospitalized**

- Lack of Primary Care communication
- No follow-up care
- Call 911 to ED

**AHA and IHI Best Practice Interventions**

- Improving *Transition* processes between care settings
- Redesigning Primary Care - Medical Home
- Patient education and self management training during hospitalization and after discharge
- Timely referral to Home Care
AHA Best Practice Interventions

- Management and communication of changes in medication regime
- Timely communication (handoffs), between care settings
- Early post acute care follow-up (by HF health care provider, home care nurse or care coordinator)
- Proactive discussions of advance care planning and or end of life preferences and communication of those preferences among providers
What is Transitions

• A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care.

(Coleman and Berenson 2004)

Transitions = Handovers in Care
Care Transitions

- Include transfer of patient information as well as professional responsibility to both deliver the information and assure it is understood

- Significant Patient Safety Issue

Transitions = Paradigm Shift

- Clinician does to the patient and controls the agenda
  - Patient receive information and advice on medications, diseases

- Patient tells the transition nurse their goals and what prevents them from meeting their goals

- Patient tells the nurse what they know about their health and meds
In Patient Transition Nurse Care Model

- Intense discharge planning starting within 48 hours of admission
- Medication reconciliation and education
- Education on disease specific Red Flags
- Scheduling of Physician follow-up appointment
Post- Acute Transition Nurse

- Communication with physician office, SNF, home care, and HF Center
- Accurate discharge instructions
- Post discharge phone call to verify that post acute services are in place
- Ensure GDMT
- Assist patient to remove barriers that prevent them from achieving goals.

Transition Nurse

- Heart Failure trained RNs provide:
  - Identification of population
  - Teach back
  - Medication Review and reconciliation
  - Coordination of care
  - Facilitate transitions of care across the continuum of care
  - Population management through post discharge follow up for 30-90 days

HF Navigators demonstrate continued education and competency in heart failure care
Your Goal Weight:

- Green Zone: All Clear
  - No shortness of breath
  - No swelling
  - No weight gain
  - No chest pain
  - No decrease in your ability to maintain your activity level

Green Zone Means:
- Your symptoms are under control
- Continue taking your medications as ordered
- Continue daily weights
- Follow low-salt diet
- Keep all physician appointments

- Yellow Zone: Caution
  - Weight gain of 3 or more pounds
  - Increased cough
  - Increased swelling
  - Increase in shortness of breath with activity
  - Increase in the number of pillows needed
  - Anything else unusual that bothers you

If you have any of the following signs and symptoms:
- Call your home health nurse if you are going into the YELLOW zone

Yellow Zone Means:
- Your symptoms may indicate that you need an adjustment of your medications
- Call your home health nurse.

Name: ____________________
Number: ___________________
Instructions: ____________________

- Red Zone: Medical Alert
  - Unrelieved shortness of breath: shortness of breath at rest
  - Unrelieved chest pain
  - Wheezing or chest tightness at rest
  - Need to sit in chair to sleep
  - Weight gain or loss of more than 5 pounds
  - Confusion

If you have any of the following signs and symptoms:
- Call your physician immediately if you are going into the RED zone

Red Zone Means:
- This indicates that you need to be evaluated by a physician right away
- Call your physician right away

Name: ____________________
Number: ____________________

Heart Failure Red Flags

Mortality Reduction with Optimal Pharmacological Therapy (OPT)

- β-blockers Mean
- ACE inhibitors Mean
- Spironolactone RALES
- Eplerenone EPHEBUS

Reduction in mortality (%)

35%  30%  30%  21%

Courtesy of D. Agnoletti, MD

2. Mean mortality reduction from initial ACE inhibitor trials

Heart Failure Red Flags
Telehealth

Device derived HF Diagnostics

Carelink / Carelink HF
Transmission

Cardiosight
Reader

Device Interrogation
CardioMEMs System

CardioMEMS™ HF System

- Care Managers imbedded in select physician practices
- Intermittent skilled home care
- Inpatient transition nurse for those patients that do not meet homebound criteria and for patients living in skilled nursing facilities
Physician Practice Care Manager

- Accepts handoff from inpatient transition nurse and home care nurse
- Tracks patient to ensure compliance with NCQA Medical Home standards

Physician Practice Care Manager

- Ensures compliance with health screening interventions
- Conducts telephonic monitoring and education
- Refers and coordinates with outpatient services
- Meets data collection and documentation requirements
Practice Care Management
Outcome Measures

- 30 day re-hospitalization
- Patient Satisfaction
- Physician practices: NCQA outcome measures such as LDL, A1C for diabetics, blood pressure, weight loss.

Skilled Facility Project

- **Goal**: Continued provision of HF expertise
  - >30% of Heart Failure readmissions from SNFs
- Partnership with 4 skilled nursing facilities
  - SNF commits to bed availability, dietary department changes, daily weights, patient appointments at HF center
- Education provided to all levels of staff at the facility
- Provides continuity of HF medical management and education for our patients
- Follow up post SNF discharge by Transition Coach
- Team meeting with hospital and SNF teams to discuss outcomes
- HF NP’s visit patients weekly
Home Health Care Manager

- Intermittent skilled care
- Disease specific care management
  - Continued heart failure education and annual competencies for nursing team
- Telehealth
- Palliative Care Service
- Heart Failure Hospice Team
- Monthly interdisciplinary team meetings

Heart Failure Hospice Care

- Patient Qualifications: advanced heart failure patient with no available or no desirable restorative medical interventions.
- Provides expert, comprehensive management at end of life.
- Resources include physicians, nurse practitioners, nurse case manager, nurse’s aides, social worker, chaplain, bereavement specialist.
- Focus on symptom management and avoidance of hospitalization.
- Neither prolongs life nor hastens death.
- It’s not just about morphine! Continuation of most cardiac medications to avoid decompensation.
Home Health Outcome Measures

• Home Health Compare Data
  • Re-Hospitalization rates
  • Emergent care without re-hospitalization
  • Patient Satisfaction
  • Potentially Avoidable Event Report
    • Emergent Care for fall injury
    • Emergent care for wound infection
    • Emergent care for medication side effects

Components to a successful transition for a patient with chronic heart failure

• Medication reconciliation - admission and discharge
• Very early postdischarge contact and communication with patient and/or care provider
• Early office follow up within first week of discharge
• Patient education including skills for recognizing early warning signs
• Communication of patients health record with patient and postdischarge health care providers
• Continued post discharge education and evaluation of learning
Successful transitions

Routinely assess patients for high risk characteristics that are associated with poor outcome

Ensure transition services are provided by qualified and trained HF nurses and health care providers.

Allow adequate time in the hospital and postacute setting to deliver complex chronic HF intervention and assess patient and caregiver response.

Rehospitalization Risk Factors

- Renal insufficiency
- Low cardiac output states
- Diabetes
- COPD
- NYHA class III or IV
- Persistent symptoms
- Frequent hospitalizations for any cause
- Multiple active comorbidities
- Depression
- Impaired cognition
- Inadequate social support
- Poor health literacy
- Non adherence to therapy

Challenges Ahead

Resources - Post acute care management is not funded

Real time data collection and analysis

Challenges Ahead

Risk assessment for readmission thus triggering intensity of care transitions

Post acute care management system
In Conclusion

• There is “No Silver Bullet”

• An organization must adopt a suite of interventions that suit their unique characteristics

• Acceptance of the need for palliative and end of life care is essential for success

• It Takes a Village” to implement these needed changes
  • Communication
  • Communication
  • Communication
There is No Place Like Home