The Role of the Heart Failure Coordinator

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Objectives

• What is the role of the heart failure coordinator
• Discuss challenges and barriers in reducing readmissions of heart failure patients
• Provide strategies to decrease heart failure readmissions and how that translates to increased revenue
• How the heart failure coordinator impact a SYSTEM
Why develop a HF program?

• Due to its high prevalence and associated high medical resource consumption, heart failure (HF) is now the single most costly cardiovascular illness in the United States. The incidence and prevalence of HF continues to increase, largely due to the aging of the population. As a result, the costs of caring for patients with HF are expected to escalate well into the 21st century (American Heart Association, 2013).

What are the costs of HF?

• Direct costs: the actual costs of services rendered (hospitalization, diagnostic tests, procedures, medications, office visits, and rehabilitation costs)
• Indirect costs: loss of income as a result of illness, travel expenses, and costs for specialized services (home care, meals on wheels)
• Intangible costs: Non-quantifiable cost to the patient and family (disruption of family dynamics, emotional and stress related suffering)
Issues to Consider in the Chronic Heart Failure Patient

- Disease of aging
- Multiple co-morbidities
- Typical patient on 15-20 drugs daily
- Common things are contraindicated: NSAIDs
- Energy levels, de-conditioning and exercise
- Dietary compliance and socioeconomics
- Health literacy etc…..

What is a Heart Failure Coordinator?

- The Heart Failure Coordinator is responsible for developing, implementing, and analyzing system-wide, interdepartmental, multi-disciplinary care and processes for the heart failure patient.
- Assess, plan, coordinate, implement, and evaluate the patient care system for the heart failure patient.
- Committed to improving patient care processes and performance outcomes.
Why do you need a HF coordinator?

- Patients are **SICK**
- Treating heart failure is complicated
- Patients are under-recognized and under-treated
- Education goes a long way in preventing readmission and improving quality of life
What will a Heart Failure Program Coordinator do for my Facility?

★ Promote higher-quality outcomes for all patients
★ Provide more efficient, coordinated care
★ Enhance Care and decrease readmissions which translates to…. **savings**

How Can the HF Coordinator Impact the Hospital SYSTEM?

• Improve knowledge in the medical community (HFSA)
• Improve recognition prior to acute exacerbation
• Improve management of exacerbation (disease specific unit)
• Improve management of transition of care
• Improve or create dialogue between hospital, home, and clinic
Heart Failure Coordinator Defined

- Enhanced admission assessment
- Individualized goals - of - care plan and education
  - Individualized patient and family centered education at bedside
  - Individualized patient assessment and needs takes time. Time the bedside nurse often doesn’t have
- Staff Education on Heart Failure & on use of the teach Back Method
  - Patient & family Heart Failure education classes onsite offered weekly
- Participation in physician rounds
- Ensure patients receive appropriate inpatient consults (Nutrition, Social Work, Physical Therapy, etc.)
- Ensures patients with financial barriers/medication gaps receive a discharge medications prior to leaving the hospital
- Contacts patients within 72 hours of discharge and encourages patients to call for questions
- Assist in developing an emergency plan and contact numbers
- Ensures patient is aware of appointments and phone numbers
- Provides staff education
- Facilitates community outreach
- Arranges follow-up appointments within 7 days of discharge
- Assessment and facilitation of the transition of care
- Manage quality indicators for certifications
Heart Failure Readmissions

- Retrospective analyses have shown an increased risk of death in the first month following discharge; the absolute increase in risk was clearly related to the number of previous admissions.
  - Failure to identify precipitant for HF decompensation
  - Under-treatment of excess volume prior to previous discharge
  - Under-utilization of evidence-based guidelines for drug and device therapy
  - Lack of cardiac specialist consultations

How can we prevent Readmissions?
Transition of Care

- Admission
- Hospitalization and Treatment
- Hospital Discharge
- Follow Up
- Discharge Planning

Admission

- Assessment to prepare for discharge
- Reason for admission addressed
- Medication reconciliation
Hospitalization and Treatment

- Adequate diuresis
- Evidence based therapy
- Assessment for need for Advanced Therapies for Devices

Discharge Planning

- Home Health Care
- Social Support
- Durable medical equipment for home care
Hospital Discharge

- TJC Core Measures
- AHA GWTG Measures
- Patient/caregiver education
- Follow up appointment within 7 days
- Able to fill prescriptions/Meds given
- Follow up within 7-10 days

Follow up

- Follow up within 7-10 days
- Telephone follow up within 24 hours
- Disease Management referral
- Home Health Care/Telehealth
Key Discharge points

- Ensure scale, written education and medications in hand prior to discharge
- Involve physicians in discharge plan
- Have discharge note sent to all post care providers

Transition Program

- Promote a seamless continuum of care for HF patients
- Establish an information sharing relationship between all care providers and post discharge facilities
- Develop community based partnerships with HHC and rehab facilities to improve education and transition of care.
- Use Transition Coordinator to “bridge the gap” between hospital and home
- Monitor outcomes and explore opportunities to improve performance
What worked…. Create Sustainable Links

• Establishing relationships/trust across the continuum
• Breaking down silos to provide information sharing
• Efficient coordination of care as patient transitions from one level of care to another
• Homecare services
• Transition Coordinator – support/education provided to patient/family

How to Keep it Running Smoothly

• TEAMWORK
• Strong Leadership and approachable Medical Director
• Monthly meetings to drill down to cause of re-admissions – Root cause analysis
• Monthly process improvement meetings to look for OFI
• Avoid the BLAME GAME
Sounds Expensive….
But Does it Work?

UCMC Readmission Rates per Fiscal Year

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% HF Readmits within 30 Days
Our current CMS readmission rate is 14%

University of Cincinnati Awards & Recognition

- The Joint Commission Advanced Certification in Heart Failure Treatment (Completed September 2015 review and 2016 intracycle call with no findings)
- American Heart Association Get with the Guidelines Heart Failure Gold Plus Award and Honor Roll
**Gold Award**

- We must obtain all 4 measures at 85% or greater
  - ACE/ARB at Discharge (99.2%)
  - Evidence-Based Specific Beta Blockers (97.2%)
  - Measure LV Function (100%)
  - Post Discharge appointment for HF appointment- no time frame (97.4%)

**Gold Plus Award**

- We must obtain 4 out of 9 additional measures at 75% or greater
  - DVT Prophylaxis (97.9%)
  - Pneumococcal Vaccination (69.6%)
  - Influenza Vaccination During Flu Season (95.6%)
  - Follow up Visit Within 7 Days or Less (77.6%)
  - Anticoagulation for Atrial Fibrillation or Atrial Flutter (90.1%)
  - CRT-D or CRT-P Placed or Prescribed at Discharge (75.0%)
  - ICD Counseling or Placed or Prescribed at Discharge (77.6%)
  - Aldosterone Antagonist at Discharge (64.5%)
  - Hydralazine Nitrate at Discharge (50%)
Honor Roll

• Must demonstrate 50% or greater compliance on the following measures:
  • Evidence Based Specific Beta Blockers (97.2%)
  • ACE/ARBs at discharge (99.2%)
  • Aldosterone Antagonist at discharge (64.5%)
  • Follow-up visit or Contact within 7 days or less of discharge scheduled (77.6%)
  • Referral to HF disease management, 60 minutes of patient education, or HF interactive workbook (93%)

Comparisons Guide

AHA GWTG Gold (over 85%)
1. ACE/ARB at discharge
2. Evidence Based Beta Blocker
3. Measure of LV function
4. Post Discharge Appt for HF patient

GWTG Plus Award (4 over 75%)
1. Aldosterone Antagonist at DC
2. Anticoagulation for Afib/Aflutter
3. Hydralazine Nitrate at DC
4. DVT Prophylaxis
5. CRT-D or CRT-P Placed or Prescribed at DC
6. Influenza Vaccine During Flu Season
7. Pneumococcal Vaccination
8. Follow up within 7 days or less

Honor Roll Award (50% on all)
1. Evidence Based Beta Blocker
2. ACE/ARBs at Discharge
3. Aldosterone Antagonist at DC
4. F/u in 7 days or less
5. 60 minutes of HF education

TJC Required
1. BB therapy for LVSD prescribed at DC
2. Post DC Appt. for HF patients
3. Care Transition Record Transmitted
4. Discussion of Advance Directives
5. Advance Directives Executed
6. Post Discharge Eval for HF patients (3 attempts to contact patient within 72 hours of DC)
Thank you and have a great day!