Heart Failure: Reducing 30 Day Readmission Rates and Transition of care

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Objectives

• 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
• Discuss advanced therapies available to the heart failure population
• Discuss transition of care and follow up
• How the heart failure coordinator impact a SYSTEM
University of Cincinnati Medical Center

Awards & Recognition
Our practice and people are recognized locally and nationally

- **American Heart Association** Get with the Guidelines Heart Failure Gold Plus Award and Honor Roll Recipient 2017
- **American Heart Association** Mission: Lifeline STEMI Receiving Center Silver Performance Award
- **US News and World Report** “High-Performing” recognition for cardiology, cardiac surgery and pulmonology
- **American College of Cardiology/American Heart Association** National Cardiovascular Data Registry ACTION Registry/Get with the Guidelines Platinum Performance Award
- **The Joint Commission** Certification in Left Ventricular Assist Device (LVAD)
- **The Joint Commission** Advanced Certification in Heart Failure Treatment
Special Missions

- Academic Medical Center & Teaching Hospital
- Tertiary and Quaternary Referral Hospital
- Safety Net Hospital: we serve 90 percent of the region’s patients that are below poverty level
- We serve greater than 25% of all heart failure patients in the Greater Cincinnati area

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).
Most Costly Medical Conditions

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.
- Responsible in the transition of care of the patient upon discharge
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
- Transition of care for many patients with multiple providers can be very difficult

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 We Impact the Hospital SYSTEM?

- **Community**: Improve knowledge in the medical community (HFSA)
- **Patient Education**: Improve recognition prior to acute exacerbation
- **Treatment**: Improve management of exacerbation (disease specific unit)
- **Discharge**: Improve management of transition of care
- **Follow up**: Improve or create dialogue between hospital, home, and clinic

Transition of Care
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
Precipitating Factors Associated with Readmissions

- Approximately 60% of readmissions are due to poor adherence to dietary and pharmacologic regimens
- Worsening cardiac function
- Cardiac toxins (e.g., Alcohol, cocaine)
- Right ventricular pacing
- Inappropriate medications
- Progression of ventricular dysfunction
- Adverse medication effects
- Problems with patient management leading to readmissions
- Under treatment of excess volume status

Causes of Readmission to address during hospitalization

- Lack of optimized evidence-based care (medications and devices)
- Inaccurate and incomplete medication reconciliation
- Deficiencies in patient self-care and educational need
- Studies show that most HF patients lack an understanding of their diagnosis and the role they have in self care
- Teach back should be used to ensure patient understands the information taught
- Standardized education materials in multiple delivery methods (written, video, verbal)
Care of the Heart Failure Patient

- Enhanced admission assessment including in-depth assessment of reason for readmission if appropriate
- Individualized goals - of - care plan and education
  - Individualized patient and family centered education at bedside
  - Individualized patient assessment and needs
- Bedside nurses should Participate in physician rounds with patient
- Ensure patients receive appropriate inpatient consults (Nutrition, Social Work, Physical Therapy, etc.)
- Ensure patients with financial barriers/medication gaps receive a discharge medications prior to leaving the hospital
- Staff Education on Heart Failure & on use of the teach Back Method
  - Patient & family Heart Failure education classes offered weekly are helpful

Medication Management Strategies

- Ask about over the counter medications
- Tailor medications to patients daily schedule
- Use once-daily dosing when possible
- Pill bottles should be labeled in large print with drug name and dosing
- Ask patient how they are tolerating their medications
- Consider pre-prepared pill dispensers
- Provide updated list and written instructions for medication changes at every visit
**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**

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

**Care of Heart Failure Patient**

- Arranges follow-up appointments within 7 days of discharge
- Assessment and facilitation of the transition of care
- Contacts patients within 72 hours of discharge and encourages patients to call for questions
  - Ensure patient has medications
  - Is patient aware of post discharge appointments
  - Assist in developing an emergency plan and contact numbers
Medication Programs

- Heart Failure Patients are eligible to receive 2 weeks of medications free at discharge
- Medication synchronization program
- Medication transition program
- Medication concierge program

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

**Successful Transition of Care**

- Communication between the sending and receiving physician including the plan of care, goals and preferences, updated list of problems and contact information.
- Plan for follow up including necessary tests, healthcare appointments and Medication reconciliation.
- Preparation of the patient and caregiver for what to expect at the next site of care
Transition of Care
What can we really do?

• Started an Outpatient IV furosemide program. Patients identified in the hospital as extremely high risk were sent home with a vial of IV furosemide to be administered by the homecare nurse under the supervision of the outpatient providers at the Advanced Heart Failure Treatment Center.

• Developed a program where patients could come to the clinic everyday between 1-3 without an appointment “See a Nurse Now” To avoid emergency room visits and potential readmissions.

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

Get with The Guidelines 7 Day Follow Up Appointment Exclusions

• Less than 18 years old
• Transferred to Acute Care Hospital
• Transferred to Skilled Nursing Facility
• Transferred Designated Cancer Center
• Transferred to a Children’s Hospital
• Death
• Discharged/Transferred to Federal Health Care Facility
• Expired in medical facility
• Left AMA
• Discharged to Hospice
• Discharged to Medicare certified long term care hospital
• Discharged to a Psychiatric Hospital
• Discharged to a federal hospital
• Transferred to a Critical Access Hospital(CAH)
Get with The Guidelines 7 Day Follow Up Appointment Exclusions

• OTHER…..
  • Records originally created in Patient Management Tool-CAD prior to May 2006
  • Blank Discharge Date
  • Patients with a Documented Medical Reason for no Follow-Up Appointment Scheduled

Medical Reason for No Follow-Up Appointment Scheduled

• This rarely occurs but must be documented in medical record
  • Patient refusal
  • Patient left AMA or discontinued care
  • Referral to Palliative care or Hospice
  • Discharged to Correctional facility
  • International patient leaving the United States
Unacceptable Reason for No Follow Up Appointment

- Lack of availability with patients regular physician or provider
- Inability to reach the patients physician or provider
- Patients discharged when outpatient physician office or practice is closed

Where Do We Send Patients for a 7 Day Follow up?

- Primary Care Practitioner (PCP)
- Pulmonologists
- Cardiologists
  - General Cardiology, CNP, Resident and Fellow Clinic
- Nephrologists
- The Advanced Heart Failure Treatment Center
- Visiting Physicians and Home Health Care
How Do We Get Appointments?

• Collaborate closely with physician support staff
• Utilize “in basket” communication (EPIC)
• Maintain collegial relationships with outside providers
• One time appointments are always available at the Advanced Heart Failure Treatment Center if unable to obtain appointments with patients providers or if patient is uninsured.

What if we can’t get an Appointment within 7 days?

• Use of home health care - skilled nursing
  • Must have date of scheduled visit documented on patient discharge paperwork
• One time visits at the Advanced Heart Failure Treatment Center
Night, Weekend or Unexpected Discharge

- Discharge appointment scheduled within the first 2 days of hospitalization.
- All patients have 7 day appointment scheduled on Friday prior to the weekend.
- Calendar kept on the cardiology unit for unanticipated discharges
  - 2 appointment slots held in the AHFTC every Friday

Sounds Expensive…. But Does it Work?
Our current CMS readmission rate is 14%
Telehealth and Heart Failure Decreasing Readmissions?

TeleHealth Pathway

Care Innovations Device → Data transmitted to AHFTC

ICD → Data uploaded to Web or Interrogated at Office Visit

Cardiomems® Device → Patient uploads data to web
RN/MD reviews web data or Notified via e-mail

Physiologic → Data are outside parameters
CardioMEMS device

Care Innovations External Monitor
The Future of HF at UCMC Includes Telehealth!

- Home patient monitoring via tablet
- Daily monitoring via E-tablet and recording of weight, BP, pulse, oxygen saturation levels, dyspnea scale and medication compliance
- Information sent electronically to providers daily
- E-tablets equipped with videos to enhance education opportunities for patients
- Daily electronic information allows providers to make real time decision based on recorded electronic data.

Care Innovations
Program Goals

- Up-titration of medications in newly diagnosed or decompensated patients
- Reduction in readmissions and/or Emergency room visits
- Decrease in NT-ProBNP
- Improvement in self-care and health literacy
- Improved education regarding heart failure condition, medications and low sodium diet
- Improvement in Quality of Life

Surveillance

- Weight- 5 Lbs. over or under dry weight
- 1st weight at patients home
- Symptomatic bradycardia
- Symptomatic hypotension
- Hypertension
- Arrhythmia monitoring
CardioMEMS®

- Implanted device in the Pulmonary Artery transmits information daily to manufacturer
- Telehealth will allow provider to query automatically uploaded information daily and transmit fluid volume status prior to 3 weeks of symptom onset

Why Telehealth?

- Reduce unnecessary admissions or readmissions through remote monitoring or remote consultations with clinicians
- Ability to better manage their health situations while at home
- Improving the lives and care of patients
Thank you and have a great day!

AHA Certification!

You can do it!
Gold Award

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

Gold Plus Award

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

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

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 AFlb/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)