DISCLOSURES

• NONE
OBJECTIVES

• DEFINE TRANSITIONS OF CARE (TOC)
• DESCRIBE IMPACT OF TOC ON HEART FAILURE PATIENTS/COMMUNITY
• DESCRIBE RAPID FOLLOW UP (AND COMPONENTS) AS PART OF TOC
HEART FAILURE BACKGROUND - BRIEF REVIEW

• HEART FAILURE IS EXPENSIVE CARE
  5.7 MILLION LIVING WITH HEART FAILURE (AHA)
  ADDITIONAL 670,000 PEOPLE DIAGNOSED EACH YEAR (AHA)
  #1 DIAGNOSIS FOR HOSPITAL READMISSIONS (AHRQ)
  HOSPITALS INCUR HUGE PENALTIES FOR NOT REACHING GOALS (MILLIONS $)
  APPROXIMATELY 22-25% OF PATIENTS WITH HF ARE READMITTED WITHIN 30 DAYS

INEFFICIENT TOC CAN CONTRIBUTE TO HUGE (BILLIONS $$$) COSTS (HOSPITALS NOW ENDURING
COSTS/PENALTIES FOR UNPLANNED AND UNNECESSARY READMISSIONS FOR HF) (3.3M=41B)
BURDEN OF HEART FAILURE- IT’S HUGE

• WHO- PATIENTS, FAMILY, CARE PARTNERS, HEALTH CARE PROVIDERS
• WHERE- ACUTE CARE SETTINGS, HOME, NURSING HOMES, REHAB FACILITIES & HOSPICE
• WHAT- EMOTIONAL, FINANCIAL, RESOURCES, TIME
• WHY- LACK OF :
  • RESOURCES
  • UNDERSTANDING OF DISEASE AND PROGNOSIS- CHRONIC AND PROGRESSIVE! NO CURE
  • COMMUNICATION (NO PCP, VNS, REFERRING PHYSICIANS)
* ALL IMPACTED BY INEFFICIENT TOC PROCESSES
TRANSITION OF CARE

• **THE JOINT COMMISSION DEFINES AS:**
  • THE MOVEMENT OF PATIENTS BETWEEN HEALTH CARE PRACTITIONERS, SETTINGS AND HOME AS THEIR CONDITION AND CARE NEEDS CHANGE

• **ROOT CAUSES OF INEFFECTIVE TOC**
  • BREAKDOWN IN COMMUNICATION
  • BREAKDOWN IN PATIENT EDUCATION
  • BREAKDOWN IN ACCOUNTABILITY

• **SOURCE: JOINT COMMISSION**
TOC MODELS

• SEVERAL EVIDENCE BASED MODELS EXIST
  • CARE TRANSITIONS INTERVENTION (CTI), TRANSITIONAL CARE MODEL (TCM), BETTER OUTCOMES FOR OLDER ADULTS THROUGH SAFE TRANSITIONS (BOOST), THE BRIDGE MODEL, GUIDED CARE, GERIATRIC RESOURCES FOR ASSESSMENT AND CARE OF ELDERS (GRACE) AND PROJECT RED (RE-ENGINEERED DISCHARGE) *CHF *MI *PNA

• COMMON COMPONENTS
  • MULTIDISCIPLINARY, COMMUNICATION, COLLABORATION, COORDINATION, COMPREHENSIVE, RISK ASSESSMENT, SHARED ACCOUNTABILITY, STANDARDIZATION (PLANS/FORMS/PROCEDURES/TRAINING), TIMELY FOLLOW UP, ANALYSIS-WHY READMIT?, AND PROGRAM EVALUATION

• SUCCESS RELIES ON SOME ASSUMPTIONS
  • INSTITUTIONS HAVE ENOUGH STAFF, MONEY, SPACE AND BUY IN*

• SOURCE- THE JOINT COMMISSION
Figure. Prominent factors impeding transition of care in chronic heart failure care. GDMC indicates guideline-directed medical care; HCP, healthcare provider; and Pt, patient.
*AHA, TARGET HF RECOMMENDS ALL PATIENTS ADMITTED WITH HF HAVE FOLLOW UP CLINIC VISIT WITHIN 7 DAYS (*24-72 HR) OF HOSPITAL DISCHARGE AND IT IS DOCUMENTED (WHERE, WHEN AND WITH WHOM)- PATIENTS CAN DECOMPENSATE VERY QUICKLY POST HOSPITAL DISCHARGE, ESPECIALLY IN THE “LAND OF CONVENIENCE”

- META ANALYSIS SUGGESTED ONLY 12-34% OF D/C SUMMARIES HAD REACHED THE OUTPATIENT CARE TEAMS BY THE TIME THE PATIENT SAW THE PROVIDER (P&T OCTOBER 2015 VOL 40 NO. 10)

- MEDICATION RECONCILIATION REMAINS A SIGNIFICANT PROBLEM (P&T OCTOBER 2015 VOL 40 NO. 10)

- EVERY SINGLE PERSON PLAYS A ROLE- AN IMPORTANT ONE!
THE AHA ON HF TOC- 10 POINTS
10 IMPORTANT IDEAS/KEY POINTS TO KEEP IN MIND

TRANSITIONS OF CARE IN HEART FAILURE: A SCIENTIFIC STATEMENT FROM THE AMERICAN HEART ASSOCIATION. CIRC HEART FAIL 2015; JAN20

1. TOC SHOULD BE INDIVIDUALIZED
2. 3 HOSPITAL BASED FACTORS ARE PREDICTORS OF 30 DAY READMISSIONS- LV FUNCTION, SMOKING CESSATION AND HF ADMISSIONS/YEAR
3. 8 PARTS- EDUCATION, SELF CARE MANAGEMENT, WEIGHT MONITORING, SODIUM RESTRICTION, EXERCISE RECS, MEDICATION REVIEW, SOCIAL/PSYCHOLOGICAL SUPPORT & FOLLOW UP PHONE CALL
4. 3 CATEGORIES- CLINIC CARE, MULTIDISCIPLINARY PROGRAMS W/MULTIPLE PROVIDERS & CASE MANAGEMENT MODELS
5. *CASE MANAGEMENT AND MULTIDISCIPLINARY CARE PROGRAMS IMPROVED BOTH EARLY AND LATER HF RE-HOSPITALIZATIONS (AND ALL CAUSE) WHEN COMPARED TO USUAL CARE
6. NURSE IS THE CENTER!
7. WHEN F/U PHONE CALLS MADE (48-72HR)- ONE REPORT SUGGESTED 46% HAD PROBLEMS UNDERSTANDING AND COMPLYING WITH DIET AND SELF CARE NEEDS
8. EFFICIENT “HANDOFF” COMMUNICATIONS TO OUTPATIENT HCP NEED TO IMPROVE IN ORDER TO IMPROVE MED REC AND FOLLOW UP
9. OPTIMAL TOC CAN DECREASE READMISSION/HOSP RATES, RISK FOR ADVERSE EVENTS AND PROMOTE PATIENT SATISFACTION
10. HF PROGRAMS SHOULD BE CONSIDERING IMPLEMENTING THESE PRINCIPLES IN HIGH RISK PATIENTS*
**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 understands 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 or 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

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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.
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): ___________________

<table>
<thead>
<tr>
<th>Complete All Boxes for Each HF Indicator</th>
<th>YES</th>
<th>NO</th>
<th>Reason Not Done/Contraindications</th>
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</thead>
<tbody>
<tr>
<td>Angiotensin-converting enzyme inhibitor (if LVSD)</td>
<td></td>
<td></td>
<td>NA</td>
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<tr>
<td>Angiotensin receptor blocker (if LVSD and ACEI not tolerated)</td>
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<td>CI</td>
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<tr>
<td>Angiotensin receptor/neprilysin inhibitor (if LVSD, and in place of an ACEI or ARB)</td>
<td></td>
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<td>NA</td>
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<tr>
<td>β-Blocker (if LVSD, use only carvedilol, metoprolol succinate, or bisoprolol)</td>
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<tr>
<td>Aldosterone antagonist (if LVSD, Cr ≤2.5 mg/dl in men, ≤2.0 mg/dl in women, potassium ≤5 mg/dl, and patient’s potassium and renal function will be closely monitored)</td>
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<td>NA</td>
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<td>Hydralazine/nitrate (if self-identified African American and LVSD)</td>
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<td>CI</td>
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<tr>
<td>Most recent left ventricular ejection fraction (<strong><strong>%); Date of most recent LVEF (</strong></strong>)</td>
<td></td>
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<td>NA</td>
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<tr>
<td>Method of assessment: □ Echocardiogram  □ Cardiac catheterization □ MUGA scan</td>
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<td>CI</td>
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<tr>
<td>Anticoagulation for atrial fibrillation or flutter (permanent or paroxysmal) or other indications</td>
<td></td>
<td></td>
<td>NA</td>
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<tr>
<td>Precipitating factors for HF decompensation identified and addressed</td>
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<td>CI</td>
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<tr>
<td>Blood pressure controlled (&lt;140/90 mm Hg)</td>
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<td></td>
<td>NA</td>
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<tr>
<td>Pneumococcal vaccination administered</td>
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<td>CI</td>
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<tr>
<td>Influenza vaccination administered (during flu season)</td>
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<td>NA</td>
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<tr>
<td>EP consult if sudden death risk or potential candidate for decide therapy</td>
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<td>CI</td>
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</tbody>
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Patient Sticker Here
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<tr>
<th>Counseling</th>
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<tbody>
<tr>
<td>Sodium restricted diet – provide patient with an individualized sodium limitation in &quot;mg&quot;/day</td>
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<tr>
<td>Fluid restriction (if indicated)</td>
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<tr>
<td>Monitor weight daily</td>
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<tr>
<td>What to do if HF symptoms worsen</td>
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<tr>
<td>Physical activity level and exercise plan</td>
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<tr>
<td>HF related medications</td>
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<tr>
<td>Enhanced HF education (at least 60 minutes by trained HF educator)</td>
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<tr>
<td>Smoking cessation counseling for current or recent smokers (have quit within the last year)</td>
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<tr>
<td>ICD/sudden death risk counseling (if indicated)</td>
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<tr>
<td>Dietitian/nutritionist interview</td>
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<tr>
<td>Weight reduction counseling (if indicated)</td>
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<tr>
<td>Cardiac rehabilitation interview and enrollment (if indicated)</td>
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<tr>
<td>Need to keep follow-up appointments</td>
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<tr>
<td>Review of medications (potential side effects, why indicated, need for adherence)</td>
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<tr>
<td>HF Patient education handout/zones sheet/booklet</td>
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<tr>
<td>HF patient discharge contract</td>
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<tr>
<td>Referral to heart failure disease management program</td>
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Patient Sticker Here
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<tr>
<th>Follow-up Services Scheduled</th>
<th>Yes</th>
<th>No</th>
<th>Not Applicable</th>
<th>Date Scheduled</th>
<th>Comments</th>
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<tbody>
<tr>
<td>Cardiologist follow-up</td>
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<tr>
<td>Primary care follow-up</td>
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<tr>
<td>HF Disease Management Program</td>
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<tr>
<td>Cardiac Rehabilitation</td>
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<td>Stress testing</td>
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<tr>
<td>Echocardiogram follow-up, EF determination</td>
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<td>Electrophysiology referral or follow-up (assess need for ICD or CRT)</td>
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<tr>
<td>Lipid profile follow-up</td>
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<td>Anticoagulation service follow-up</td>
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<tr>
<td>Electrolyte profile/serum lab work follow-up</td>
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<tr>
<td>Clinical summary and patient education record faxed to appropriate physicians</td>
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</table>

NA = Not applicable or not indicated,
CI = Contraindication documented either by physician or by RN per verbal discussion with physician.

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.
RAPID FOLLOW UP
HOSPITAL TO HOME @ MSH

• CONSIDERED AN EXTENSION OF THE HOSPITALIZATION
• GOAL IS TO REDUCE AND ELIMINATE BURDEN ACROSS THE SPECTRUM
• 30 MINUTE APPOINTMENT SLOT
• COMPREHENSIVE FOLLOW UP FOR TRANSITION TO NEXT STEP
  • PT RECEIVES FOCUSED/INDIVIDUALIZED HF PATIENT EDUCATION AT THE BEDSIDE
  • SINAI SWAG (SCALE, PITCHER, PILL BOX, AND MANAGING YOUR HEART HEALTH PATIENT GUIDE)
  • APPOINTMENT MADE FOR RFU ALONG WITH PATIENT AND CARE PARTNERS/FAMILY
  • PHYSICAL EXAM INCLUDING REDS & LABS, PATIENT EDUCATION, MEDICATION OPTIMIZATION, APPROPRIATE REFERRALS-(PCP, SPECIALIST, CARDIOLOGY, VNS & PALL CARE), FOLLOW UP COMMUNICATION WITH TEAM AND PATIENT
RFU- SOME FYI’S

- CLINIC STARTED IN 2014; NURSE PRACTITIONER RUN CLINIC
- 10-20 PATIENTS ON AVERAGE A WEEK
- SIGNIFICANT POSITIVE IMPACT OF READMISSION RATE (<20%)
- PROGRAM NOW OPERATIONALIZED ACROSS SYSTEM
- MANY PATIENTS HAVE BEEN PLUGGED INTO HF TEAM/ APPROPRIATE CARE FROM THIS CLINIC
RFU/ TOC - LESSONS LEARNED

• DESPITE OUR SUCCESS, WE HAVE MORE WORK TO DO…
• CONTINUED AND IMPROVED COMMUNICATION WITH MEDICAL TEAMS, VNS, SW AND SARS
• IMPROVE REFERRALS FOR PRIMARY CARE (*WE NEED THESE GATEKEEPERS)
• SUPPORTING OUR COLLEAGUES (PCP, GERIATRICS, VNS, SARS & GENERAL CARDIOLOGISTS) TO “PUSH THE ENVELOPE” WHEN IT COMES TO INCREASING MEDICATIONS, ESPECIALLY DIURETICS (IV), FREQUENT FOLLOW UP IS NEEDED AND COMMUNICATION- BEING AVAILABLE
• CONTINUING TO EDUCATE OUR OWN TEAMS ABOUT BENEFITS OF RFU
TAKE AWAYS

• PATIENT EDUCATION & COMMUNICATION ARE AT THE CENTER OF TRANSITION OF CARE

• COMMUNICATION IS PARAMOUNT AND LACK OF LEADS TO POOR PATIENT CARE, OUTCOMES AND SATISFACTION

• HELP TO MAKE SURE PATIENT HAS RIGHT MEDICATIONS AND UNDERSTANDS DISCHARGE PLAN AND SELF CARE - BEFORE THEY ARE DISCHARGED

• DOUBLE CHECK TO MAKE SURE THE PATIENT IS DECONGESTED AND EUVOLEMIC!!!

• DOUBLE CHECK TO MAKE SURE THE PATIENT HAS A RFU APPOINTMENT - BEFORE THEY ARE DISCHARGED

• RFU IS IMPORTANT PIECE IN TRANSITION OF CARE

• IT REALLY TAKES A VILLAGE
THANK YOU!!!

• QUESTIONS ???

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  • JENNIFER.ULLMAN@MOUNTSINAI.ORG

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