Transitional Care HF Clinic: How Do We Deal with the HF Discharged Patients

Sonja D. Brune, MSN, APRN, CCNS, CHFN, AACC
Specialist
UT Medicine Department of Medicine / Division of Cardiology
Heart Failure Program

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Background

- 5.8 million Americans are living with heart failure (HF)
  - Projections estimate this to increase to 8 million by 2030
  - Total direct and indirect costs will exceed $70 billion by 2030
- In spite of medical and technological advances, approximately half of Americans die within 5 years of HF diagnosis
- Over 1 million people are hospitalized with heart failure each year
- Approximately 25% (~ 250,000) are readmitted within 30 days
- 80% of HF hospital admissions present through the emergency department (ED)

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Timeline of Hospital Readmissions Reduction Program (HRRP)

2007	2009	2010	2012	2013	2019
MedPAC advised Congress on Medicare re: HF readmissions	CMS began public reporting of readmission rates on Hospital Compare	HRRP created under ACA to decrease hospital readmissions	Penalty phase of HRRP began	Modified to include only unplanned readmissions	CMS includes risk stratification by proportion of Medicaid patients

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Is the program effective?

Readmission rates have decreased by 0.5% per year	
Raising awareness	Unfairly penalizes hospitals for issues beyond their control
Institutional investment in mechanisms to better assist patients during discharge and transitions	Incentivizes readmission avoidance over patient survival
Percent of hospital penalized has risen from 64% in 2013 to 79% in 2018	Encourages "gaming" the system
Medicare savings through penalties was $290M in 2013, $428M in 2015, and $564M in 2018	Punitive measures unlikely to produce process improvements
	Recent evaluation of outcomes in Canada revealed no change in readmission rates but decline in mortality

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Is the program equitable?

Readmission penalties >> Mortality metrics	Socioeconomic disadvantaged may be suffering more
Hospitals with higher readmission rates tend to have lower mortality	HRRP disproportionately penalized safety-net hospitals that serve greater proportions of socioeconomically disadvantaged populations
Patients presenting for potential readmission may be discharged, leading to higher rates of death	Fewer resources Lower baseline health status Greater health care use rate
GWTG-HF registry correlates increased 30-day and 1-year mortality with implementation of HRRP	Greater functional limitations Cognitive impairment Reduced health literacy
Medicare savings through penalties was $290M in 2013, $428M in 2015, and $564M in 2018	Poor medical compliance Limited transportation resources Unstable housing

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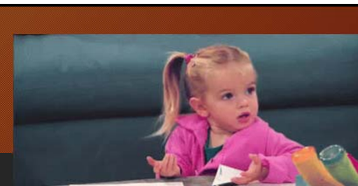

So…. Who is to blame???

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The Hospital?

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Institutional factors

- Safety-net hospitals serve greater proportions of socioeconomically disadvantage patient populations
- Many emergency departments continue to be overwhelmed by patients seeking care that should be managed in the clinic setting
- HRRP relies on administrative claims → risk adjustment algorithms may not be capable of appropriately accounting for hospital differences in sickness intensity and complexity or may be mischaracterized
- Failure to recognize worsening clinical status prior to discharge from the hospital
- Failure to identify or address comorbid conditions (underlying depression, anemia, hypothyroidism, etc.)
- Failure to optimize medication doses prospectively

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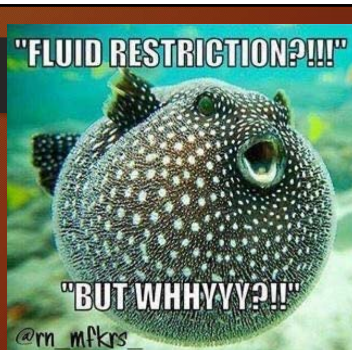
The Patient?



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How to Reduce HF Readmissions

First step is to admit that you have a problem…
(Clearly, "usual care" has it's shortcomings)

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"Usual Care" in HF Fails To

- Prescribe evidence-based, guideline-derived medications
- Discontinue medications that may exacerbate HF
- Titrate medications to target doses
- Adequately address comorbidities
- Consider device therapy
- Make referrals for advanced HF therapies
- Coordinate care with hospice/palliative care
- Provide dietary counseling
- Provide adequate discharge planning
- Provide adequate follow-up and monitoring
- Address patient and caregiver needs
- Answer patient/caregiver questions in simple, understandable terms
- Help patients seek assistance with medication costs
- Consider lowest cost evidence-based medications
- Counsel patients about activity and sex

HFDM: From Planning to Implementation 1st Ed 2014

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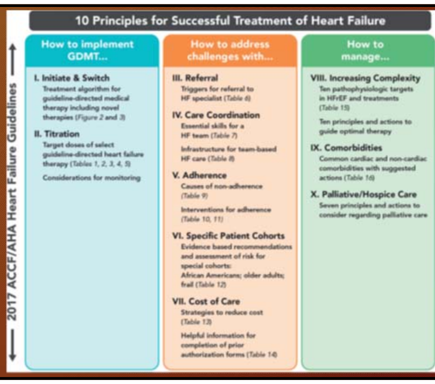

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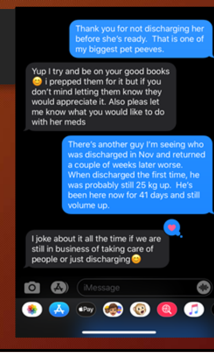
It's not all about the post-discharge follow up…

- Failure to decongest
- Failure to identify comorbid conditions
- Lack of understanding of patient's physical and cognitive status
- Polypharmacy
  - Inadequate medication reconciliation
  - Failure to optimize medication doses prospectively
  - Failure to discontinue known HF-exacerbating medication regimens
- Various socioeconomic factors
- Lack of communication resulting in primary care provider not knowing patient admitted
- Lack of advance care planning



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Getting Started

- Institutional needs assessment
  - Designate stakeholders/"champions" for core team
  - Review current metrics
  - Identify resource allocation (budget, staff, equipment, clinical space, etc)
  - Identify all providers anticipated to be involved in patient care (ED providers, hospitalists, etc)
  - Identify all cardiology providers anticipated to be involved in patient care
- Patient needs assessment
  - Extensive chart review of HF readmissions over predetermined period of time (ie: last 3 or 6 months)
    - Identify major factors contributing to readmissions for your patient population

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Program Implementation

- Business Plan
- Data Collection and Monitoring
- Operational Plan
- Program Scope
- Services Provided
- Building the Team
- Facilities
- Workflow

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Strategizing

- Prediction models
  - ADHERE Algorithm – predicts in-hospital mortality in ADHF
  - EHMRG Score – predicts mortality of emergency CHF patients
  - GWTG-HF Risk Score – predicts in-hospital HF mortality
  - LACE Score – predicts 30-day readmission or death
  - MAGGIC Risk Calculator for HF – estimates 1- and 3-year HF mortality
- Unit based interventions
  - Emergency department
  - Observation units
  - Inpatient units

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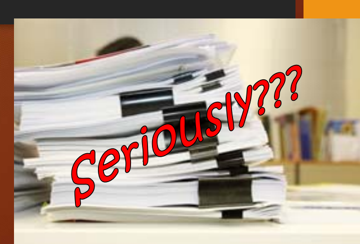
Inpatient Interventions

- Patient education
- Medication reconciliation
- Discharge planning



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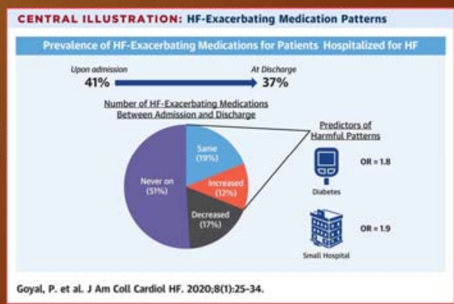

2020 American College of Cardiology Foundation

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Outpatient Interventions

- Transition of Care
  - Follow up phone call (by nurse navigator who saw patient in hospital)
  - Follow up phone call (by pharmacist who performed medication reconciliation)
  - Scheduled clinic visit in Heart Failure Disease Management Program within one week of discharge
  - Telemanagement
  - Device remote follow-up
  - Palliative and hospice care

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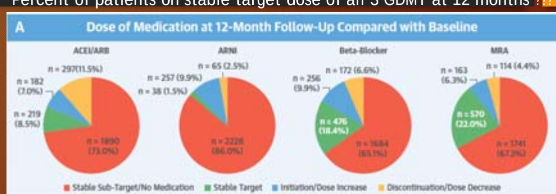
CHAMP-HF Registry

Percent of patients on stable target dose of all 3 GDMT at 12 months ???



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< 1%!!!

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Our Story

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