RI ACC 12th Annual Symposium Cardiology Update for Primary Care Providers

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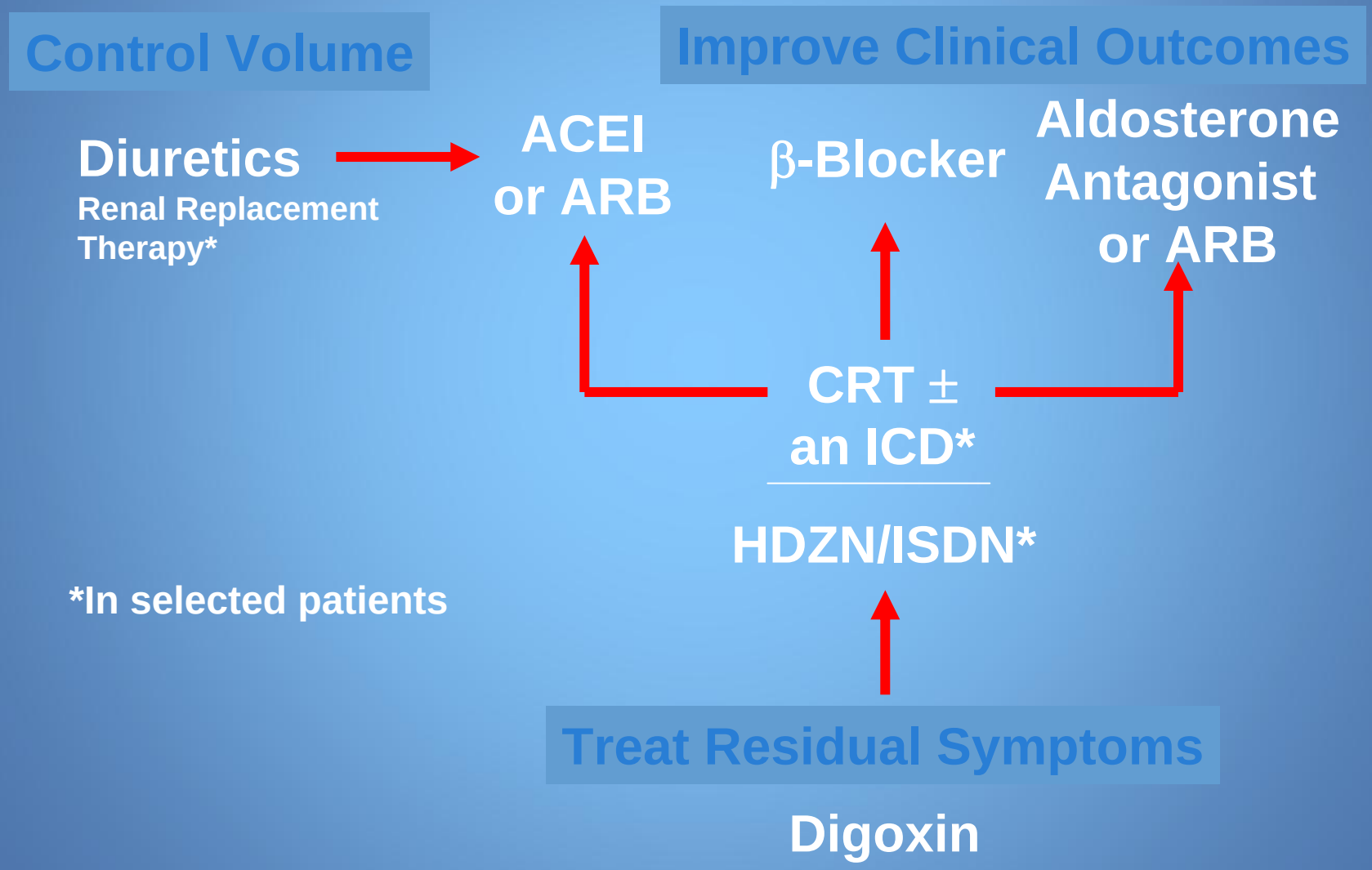
Heart Failure Readmissions

Can we prevent the inevitable?

Disclosures

None

Evidence-Based Treatment Across the Continuum of Systolic LVD and HF



Predictors of Mortality Based on Analysis of ADHERE Database

- Classification and Regression Tree (CART) analysis of ADHERE data shows:
- Three variables are the strongest predictors of mortality in hospitalized ADHF patients:

BUN > 43 mg/dL

Systolic blood pressure < 115 mmHg

Serum creatinine > 2.75 mg/dL

Fonarow G et al. JAMA 2005;293:572-80

HFSA 2010 Practice Guideline (12.25, Table 12.7)
Discharge Criteria for Hospitalized ADHF Patients

•Recommended prior to discharge for all patients with HF:

- **Exacerbating factors addressed**
- **Near optimum fluid status and pharmacologic therapy achieved**
- **Transition from IV to oral diuretic completed**
- **Patient education completed with clear discharge instructions**
- **Follow-up clinic visit scheduled, usually 7-10 days**

•Should be considered prior to discharge for patients with advanced HF or a history of recurrent admissions:

- **Oral regimen stable for 24 hours**
- **No IV inotrope or vasodilator for 24 hours**
- **Ambulation before discharge to assess functional capacity**
- **Plans for post-discharge management**
- **Referral for disease management, if available**

Strength of Evidence =C

Source ; HFSA 2010 Guidelines:

HFSA 2010 Practice Guideline (8.1)

Heart Failure Patient Education

- **It is recommended that patients with HF and their family members or caregivers receive individualized education and counseling that emphasizes self-care.**
- **This education and counseling should be delivered by providers using a team approach.**
- **Teaching should include skill building and target behaviors.**

- ***Strength of Evidence = B***

Source: HFSA 2010 Guidelines

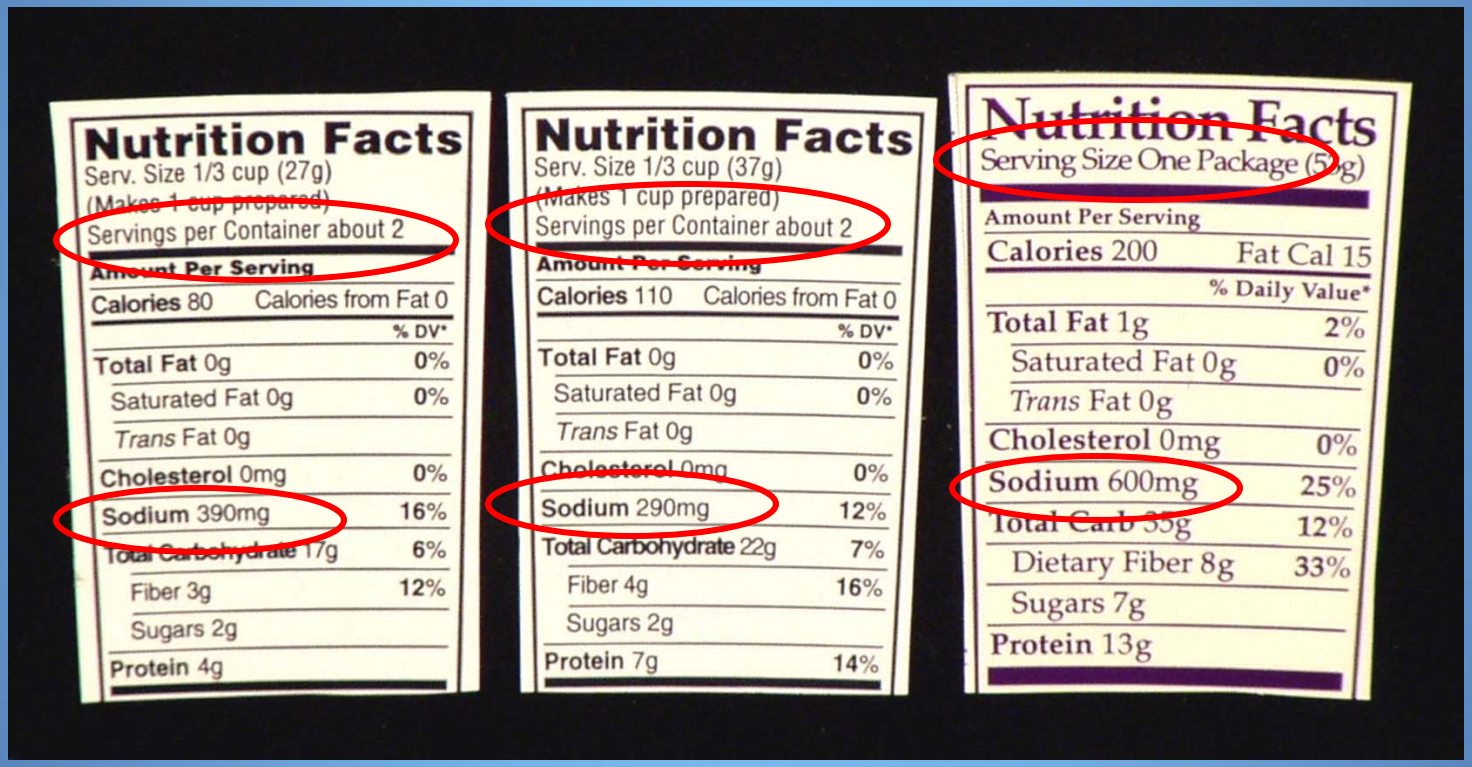
The Potential Impact of Effective Education on Patient Compliance

Nonadherence rate when patients . . .

	Recall MD advice	Don't recall advice
Medications	8.7%	66.7%
Diet	23.6%	55.8%
Activity	76.4%	84.5%
Smoking	60.0%	90.4%
Alcohol	60.0%	81.8%

Kravitz et al. Arch Int Med 1993;153:1869-78

Sample Target Behavior: Be Able to Read and Understand Food Labels



Nutrition Facts
Serv. Size 1/3 cup (27g)
(Makes 1 cup prepared)
Servings per Container about 2

Amount Per Serving	
Calories 80	Calories from Fat 0
	% DV*
Total Fat 0g	0%
Saturated Fat 0g	0%
Trans Fat 0g	
Cholesterol 0mg	0%
Sodium 390mg	16%
Total Carbohydrate 17g	6%
Fiber 3g	12%
Sugars 2g	
Protein 4g	

Nutrition Facts
Serv. Size 1/3 cup (37g)
(Makes 1 cup prepared)
Servings per Container about 2

Amount Per Serving	
Calories 110	Calories from Fat 0
	% DV*
Total Fat 0g	0%
Saturated Fat 0g	0%
Trans Fat 0g	
Cholesterol 0mg	0%
Sodium 290mg	12%
Total Carbohydrate 22g	7%
Fiber 4g	16%
Sugars 2g	
Protein 7g	14%

Nutrition Facts
Serving Size One Package (5[illegible]g)

Amount Per Serving	
Calories 200	Fat Cal 15
	% Daily Value*
Total Fat 1g	2%
Saturated Fat 0g	0%
Trans Fat 0g	
Cholesterol 0mg	0%
Sodium 600mg	25%
Total Carb 35g	12%
Dietary Fiber 8g	33%
Sugars 7g	
Protein 13g	

Labels from cups of soup

HFSA 2010 Practice Guideline (8.7)

Heart Failure Disease Management

- **Patients recently hospitalized for HF and other patients at high risk should be considered for referral to a comprehensive HF disease management program that delivers individualized care.**
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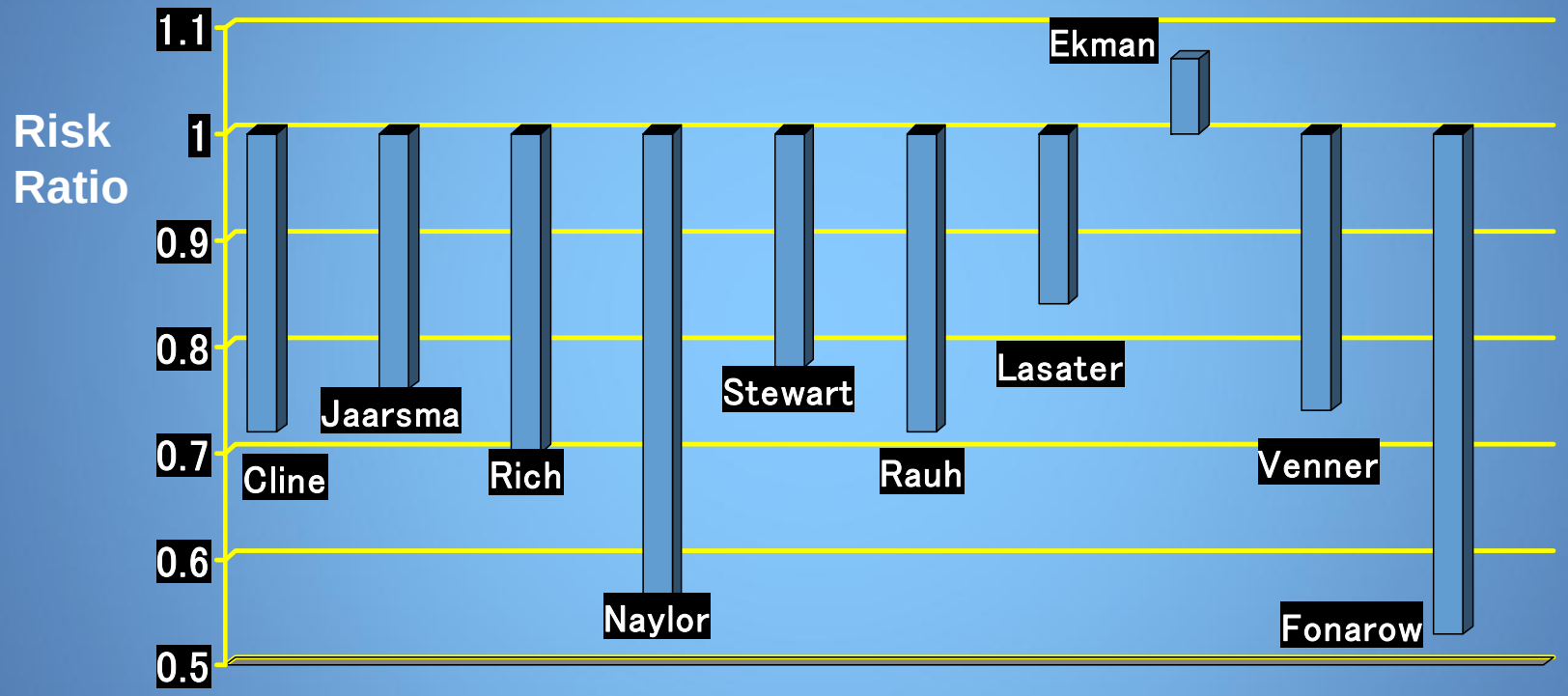
Strength of Evidence = A

Source: HFSA 2010 Guidelines

HF Disease Management and the Risk of Readmission

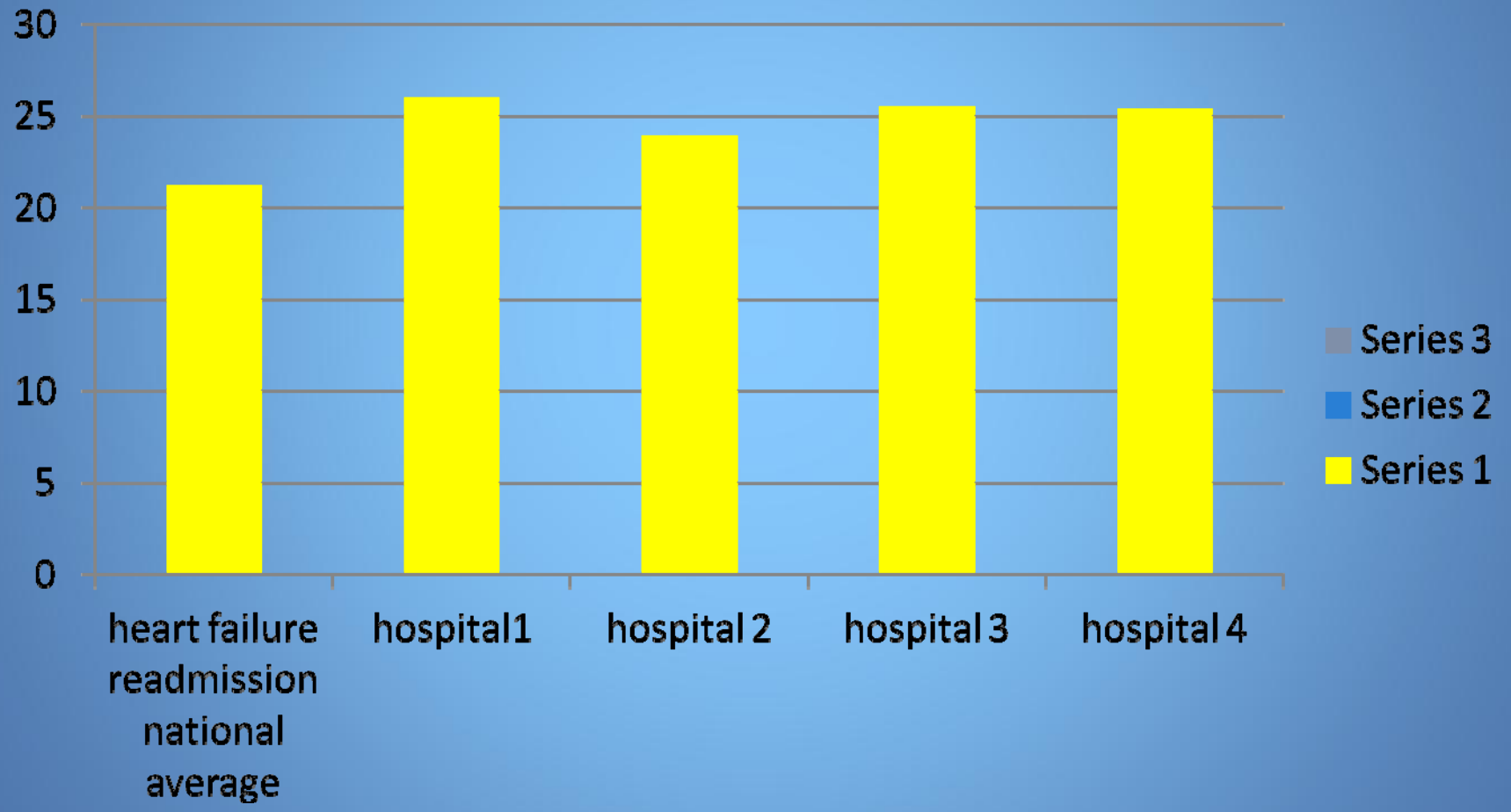


Summary RR = 0.76 (95% CI .68-.87)
Summary RR for randomized only = 0.75 (CI = .60-.95)

Readmission Rates as a Quality Measure

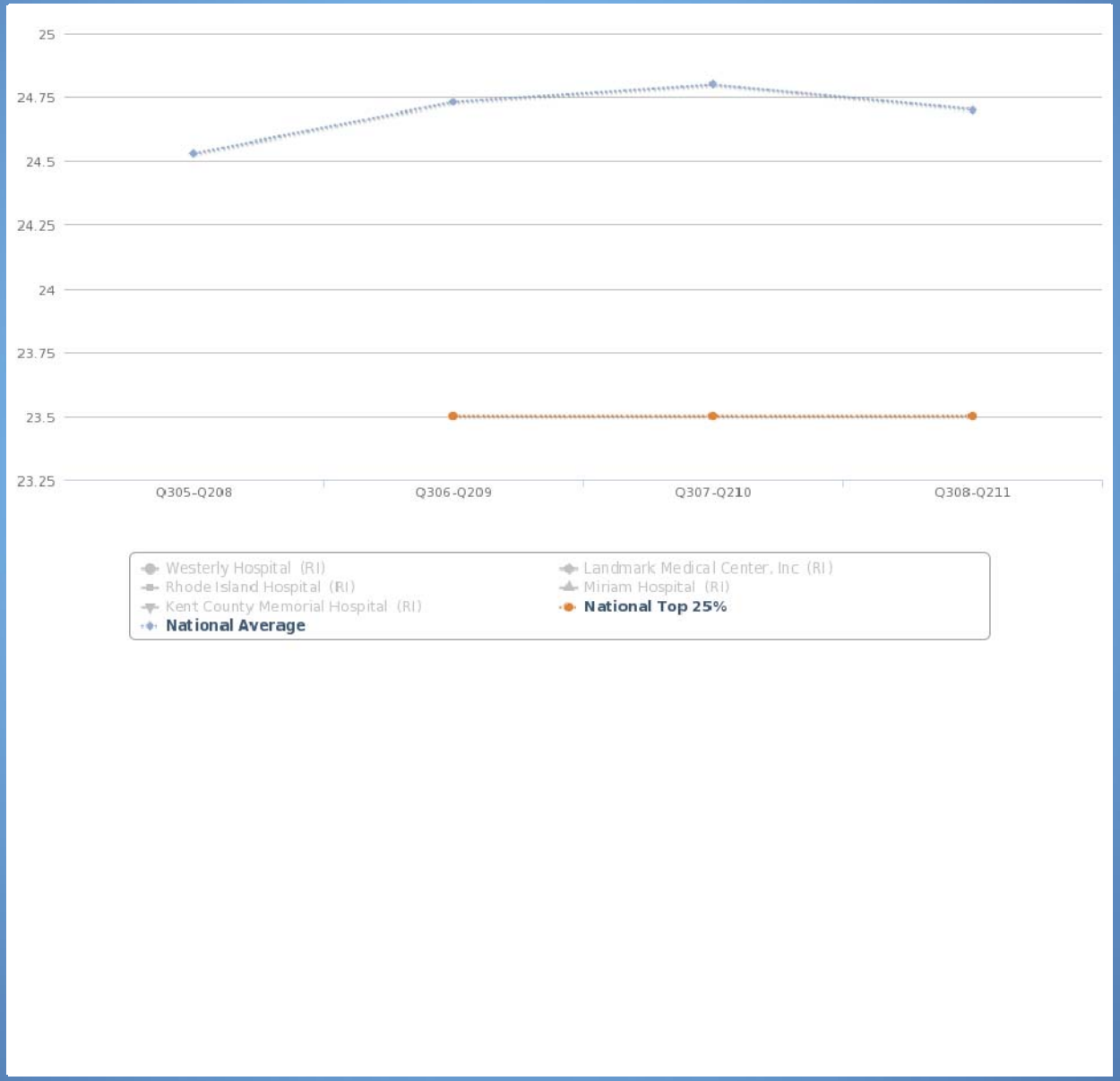
Patient Protection Affordable Care Act of 2010 creates both incentives and penalties with the potential for a 3% Medicare reimbursement cut by 2015 for hosptials with high heart failure readmission rates

Heart Failure Readmission Rates Among RI Hospitals



Source: Commonwealth fund data www.whynotthebest.org

Heart Failure Patients Readmitted to Hospital Within 30 Days



Hospital Strategies Associated with Reduced 30-Day Heart Failure Readmission Rates

- Partnering with communicty physicisans or physician groups (0.33%)
- Partnering with local hospitals (0.34%)
- Having nurses responsible for med reconcilliation (0.18%)
- Follow up appointments arranged befor discharge (0.19)
- Process in place to send discharge information to primary care provider (0.21%)
- Assigned staff to follow up on test results received post discharge (0.26%)

Source: Bradley et al; Circulation:Cardiovascular Quality and Outcomes 2013:6:444-450

Primary Care Initiative

- To achieve this goals: active program
- Grant to hospital system
- Mid level run program (NP/PA)
- Heart failure transition “clinic”
- Bridge between inpt, outpt
- Improve patient care
- Make available early post discharge visit (2 day goal)
- Reduce readmission

HFSA 2010 Practice Guideline (8.13)

End-of-Life Care in Heart Failure

- **End-of-life care should be considered in patients who have advanced, persistent HF with symptoms at rest despite repeated attempts to optimize pharmacologic, device, and other therapies, as evidenced by one or more of the following:**
  - **HF hospitalization** *Strength of Evidence = C*
  - **Chronic poor quality of life with inability to accomplish activities of daily living** *Strength of Evidence = C*
  - **Need for continuous IV inotropic therapy support** *Strength of Evidence = C*

Death is still the cheapest health care alternative

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Our Task

- Make sure the quality measures represent quality
- Make sure that care remains the focus of accountable care

Thank You