Strategies for Improving Heart Failure Patient Teaching

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ARKANSAS HEART HOSPITAL®
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Objectives

Engage primary care providers to educate and care for heart failure patients after discharge

Recognize and overcome roadblocks to compliance with heart failure therapies

Presenter Disclosure Information

Financial Disclosure
None

Unlabeled and Unapproved Uses Disclosure
None

Where CHF Education Takes Place

In hospital

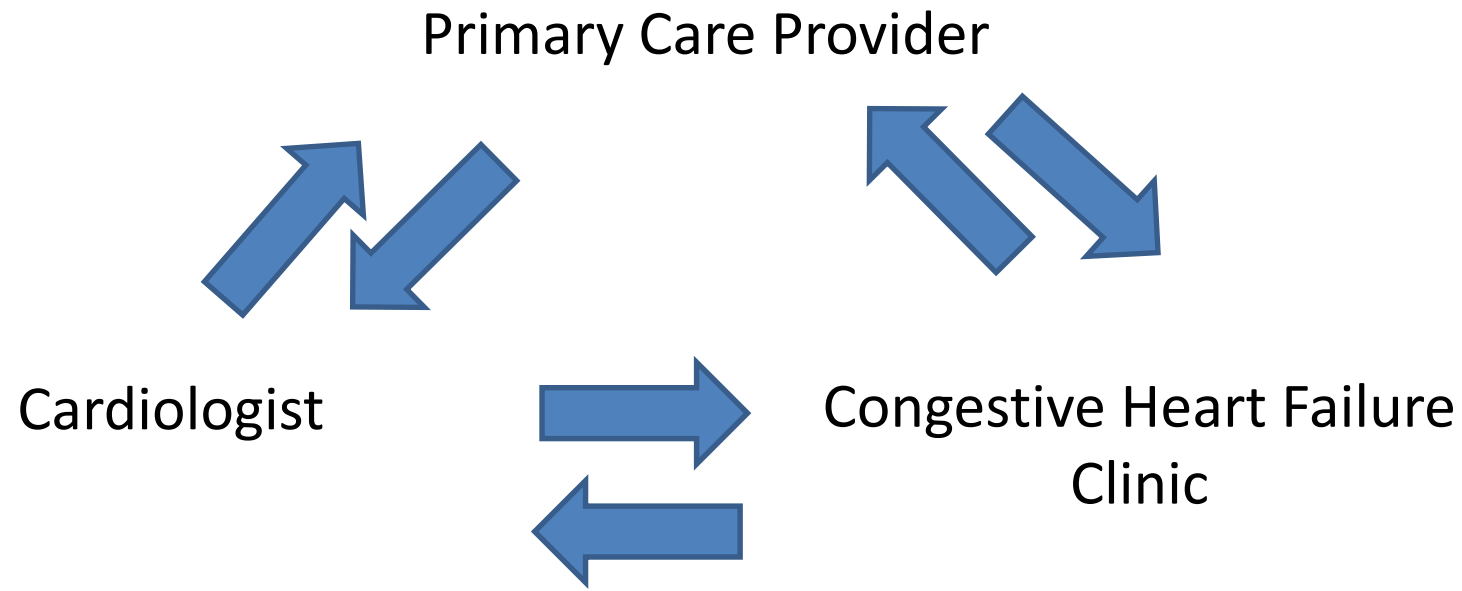
Outpatient Clinics

- Primary Care
- Cardiologist
- CHF clinic

Home

- Self Education
  - learning materials and on line

The Triad of Outpatient Care of Heart Failure Patients



Medicare Hospital Readmission Reduction Program

Why?

Part of the Affordable Care Act to reduce costly hospital readmissions: Medicare program covers 57 million Americans and accounts for 15% of all government spending

How?

Financial penalty for excessive hospital readmissions, initially 1%, then increased to 3% of all medicare payments

The Hospital Readmissions Reduction Program, JACC Heart Failure, vol 8, No1, Jan 2020, 1-11.

Medicare Hospital Readmission Reduction Program

Penalty phase began for CHF, MI, pneumonia in 2012

Later expanded to COPD, hip or knee replacement, and CABG

Pros

Improved quality of care and reduced costs

Heart failure readmissions decreased from 23.8% to 20.6% from 2008 to 2016

Medicare savings of 290 million in 2013 and 564 million in 2018

The Hospital Readmissions Reduction Program, JACC Heart Failure, vol 8, No1, Jan 2020, 1-11.

Cons

Gaming the System

Declines in readmissions resulted from:

1) increasing administrative coding of patient risk
2) delaying appropriate admissions
3) Treating admissions as observation stays
4) Increasing ER discharges

Increased CHF mortality seen

Disproportionally penalizes the safety net hospitals

The Hospital Readmissions Reduction Program, JACC Heart Failure, vol 8, No1, Jan 2020, 1-11.

"I've always been a high achiever, always striving for bigger, faster, greater...and now suddenly I'm expected to settle for *lower* blood pressure and *less* cholesterol?!"

Important Steps in Transition of Care from Inpatient to Outpatient

1) Begin CHF education in hospital
2) Phone call 24 to 48hrs after discharge
2) Arrange office visits in one to four weeks
3) CHF clinic involvement/cardiac rehab
4) Provide discharge summary ASAP to all providers
5) Ensure means to monitor CHF at home and provide easy/rapid line of communication for heart failure concerns

Essential CHF Education

Symptoms and symptom management
Weight and BP monitoring
Education on the use of medication
Physical activity and rest
Diet
Other: sexual activity, social activities

Barriers to Education

Low level of education
Cognitive impairment or dementia
Language barrier
Depression, denial, compliance
Low socioeconomic status
Poor family support
Not tech savy, no internet or smart phone

How to Deliver the Education

Speak in terms the patient can understand
Involve the family
Use multiple modalities
Teach important points multiple times
Assess understanding and retention

Use of New Technologies

Telemedicine

Phone Apps

Cardiomems

Device monitoring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"Would walking into McDonald's instead of using the drive-thru be considered more exercise?"


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Thank You!
Questions?

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