South Carolina Heart Failure Learning Network

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Objectives

- Briefly review current heart failure statistics
- Discuss the breakdowns in transitions of care
- Discuss opportunities in transitions of care in the heart failure patient
- Discuss the South Carolina Heart Failure Network
Approximately 5 million people in the United States have HF – annual incidence of approximately 700,000

One in five people who have HF die within one year from diagnosis

HF was a contributing cause of death in 275,000 patients in 2010

In 2010, HF will cost the United States $32 billion. This total includes the cost of health care services, medications, and lost productivity

Approximately 1,000,000 discharges and 3,500,000 ambulatory visits in 2010

Statistics

- At 40 years of age, the lifetime risk of developing HF for both men and women is 1 in 5
- At 80 years of age, remaining lifetime risk for development of new HF remains at 20%
- The lifetime risk for people with blood pressure (BP) $\geq 160/90$ mm Hg is double that of those with BP $\leq 140/90$ mm

Heart Failure vs Cancer

www.cancer.org
Heart Failure vs Cancer

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Heart Failure vs Cancer

5 YEAR SURVIVAL (%)

Prostate: 99%
Breast: 90%
Colorectal: 65%
Heart Failure: 50%
Lung: 16%
Pancreas: 6%

ALL STAGES
Length of Stay

- 8.6% in 93-94
- 6.4% in 05-06

Year

Days

Bueno, H. et al. JAMA 2010;303:2141-2147
30 Day Mortality

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Bueno, H. et al. JAMA 2010;303:2141-2147
Discharge Disposition

Bueno, H. et al. JAMA 2010;303:2141-2147
30 Day Readmission

Bueno, H. et al. JAMA 2010;303:2141-2147
The Costs of Heart Failure

- Hospitalization: $18.8 (53%)
- Physicians/Other Professionals: $2.3 (14%)
- Drugs/Other Medical Durables: $3.1 (10%)
- Home Healthcare: $3.2 (8%)
- Lost Productivity/Mortality: $3.1 (8%)
- Nursing Home: $4.3 (7%)

Heart Disease and Stroke Statistics—2008 Update
All-Cause Mortality After Each Subsequent Hospitalization for HF

Kaplan–Meier cumulative mortality

Time since admission (years)

1st hospitalization: 30-day mortality = 12%; 1-year mortality = 34%

Causes of Hospital Readmission for HF

- Diet Noncompliance: 24%
- Inappropriate Rx: 16%
- Failure to Seek Care: 19%
- Rx Noncompliance: 24%
- Other: 17%

Annals of Internal Medicine 122:415-21, 1995
Disease Management Program

- Meta-analysis
- 54 trials – 27 randomized
- Approximately 5000 patients
- Variable use of evidence based therapies
- Variable program design

Disease Management Program

- HF/CARDIOVASCULAR READMISSION: 0.70 (0.62 - 0.79)
- ALL CAUSE READMISSION: 0.88 (0.79 - 0.97)
- READMISSION/DEATH: 0.82 (0.72 - 0.94)

Care Transition
Transitions of care refer to the movement of patients between health care practitioners, settings, and home as their condition and care needs change.
An 80-year-old retired school teacher visited the emergency department four times in a month for exacerbations to a mild heart failure condition, twice requiring hospitalization. When provided with discharge instructions, she is able to repeat them back accurately. However, she doesn’t follow through with the instructions after returning home because she has not yet been diagnosed with dementia.
A 68-year-old man is readmitted for heart failure only one week after being discharged following treatment for the same condition. He brought all of his pill bottles in a bag; all of the bottles were full, not one was opened. When questioned why he had not taken his medication, he began to cry, explaining he had never learned to read and couldn’t read the instructions on the bottles.
Transition of Care Breakdowns

- Risk assessment
  - ineffective methods
  - inadequate time
  - different expectations

- Patient education
  - conflicting recommendations
  - confusing regimens
  - unclear follow-up plans
  - lack of understanding of disease severity

- Accountability
  - lack of responsibility for coordination of care
  - lack of communication between providers
Transition of Care Opportunities
Heart Failure

■ Admission
  ■ Standardized “Team” notification of admission
  ■ Risk assessment
  ■ Early referrals (dietician, social worker, chaplain, palliative care)
  ■ Post-discharge needs (rehab, home care)

■ Hospitalization
  ■ Teach the teacher – every patient encounter is a teaching opportunity
  ■ Education – “teach-back” techniques, short teaching sessions (build and reinforce)
  ■ Patient feedback (advisory groups)

■ Discharge
  ■ Standardized “Team” notification of discharge
  ■ Formal handoff – identify primary clinical contacts
  ■ Follow-up appointment with physician within 7 days of discharge given prior to discharge
  ■ Follow-up telephone call to patient within 7 days of discharge – repeat 14 days
  ■ Referral to needed services – home care within 48 hours
  ■ Communicate/collaborate with clinicians across the continuum of care
  ■ Identification of high risk patients (house calls, walk-in clinic)
Transition of Care Opportunities
Heart Failure

- Build A Team
- Build Interest
- Understand current care processes
- Identify Opportunities – “Low Hanging Fruit”
- Pilots
- Collect data and analyze your patterns
South Carolina Heart Failure Learning Network

Mission Statement

To improve the quality of care and outcomes related to the prevention and treatment of heart failure across the care continuum, through a system of active communication, knowledge, sharing and education.
South Carolina Heart Failure Learning Network

Objectives

- To support all S.C. hospitals and providers in applying evidenced-based protocols in their respective facilities and practices
- To establish an educational framework that actively promotes knowledge sharing, and dissemination of the most recent evidenced-based guidelines and clinical research
- To improve collaborative healthcare provider partnerships across the continuum of care
- To share relevant quality improvement resources and tools
- To actively communicate the work of this Network with all stakeholders statewide
“Knowing is not enough; we must apply. Willing is not enough; we must do.”

Johann von Goethe