Adjunctive Therapy and Management of the Transition of Care in Patients with Heart Failure

Scott Feitell, DO, Shelley R. Hankins, MD,
Howard J. Eisen, MD, FACC, FAHA, FACP*

KEYWORDS

• Transition of care • Management • Adjunctive therapy • Heart failure

KEY POINTS

- Managing patients with heart failure in the outpatient setting is difficult, time consuming, and costly.
- A careful and well-orchestrated team of cardiologists, general practitioners, nurses, and ancillary support staff can make an important difference to patient care, improve quality of life, and improve mortality.
- A strong body of literature supports the appropriate use of pharmacologic therapy, and the careful implementation of evidence-based therapies can improve mortality and quality of life, and reduce hospital admissions.
- Adjunctive therapies such as exercise, diet, and quitting smoking can be important.
- Recognizing patients with refractory heart failure early on, investing extra time and resources in education and compliance, and taking a team approach can all help patients in the long term.
- Further research into pharmacologic therapies, new mechanical assist devices, and standardizations of care based on evidence-based approaches will continue to help these complicated patients and the clinicians responsible for their care.

INTRODUCTION: NATURE OF THE PROBLEM

More than 5.7 million people in the United States carry a diagnosis of heart failure, the incidence of which approaches 1 in 100 people more than 65 years of age.[1] The cost to society is estimated at $29 billion annually and more than 1.1 million hospital admissions.[1] Once hospitalized with heart failure, the 30-day readmission rate approaches 25%.[2] The cost to both the patient and society for these admissions is enormous and, as the population ages, these numbers are expected to grow.

To emphasize the importance of this cost, the US Centers for Medicare and Medicaid Services (CMS) began publishing outcome data for all patients with heart failure in 2007, with an emphasis on 30-day readmission and mortality for individual hospitals. To further reduce costs, effective October 1, 2012, 30-day readmission rates for heart failure play an active role in determining hospital reimbursements for care by CMS.[3]

These factors place further emphasis on the need for an integrated and seamless transition from inpatient care to the outpatient setting. This article reviews the current data and outlines various strategies entailed in discharging a patient with heart failure from the hospital. It also reviews current guidelines and recommendations regarding

The authors have no disclosures.
Division of Cardiology, Drexel University College of Medicine, 245 North 15th Street, Philadelphia, PA 19102, USA
* Corresponding author.
E-mail address: heisen@drexelmed.edu

Cardiol Clin 32 (2014) 163–174
http://dx.doi.org/10.1016/j.ccl.2013.09.007
0733-8651/14/$ – see front matter © 2014 Elsevier Inc. All rights reserved.

cardiology.theclinics.com

patient monitoring in the outpatient setting and discusses how to prevent future readmissions.

MANAGEMENT GOALS

As noted earlier, the task at hand is daunting. Thus it is important to focus on several key factors that will facilitate a smooth transition from inpatient to outpatient care while preventing readmission and not exposing the patient to an increased risk of mortality (**Box 1**). It is important to emphasize that disposition planning should begin almost immediately from the time of admission, which allows the maximal amount of time to educate the patient, arrange for follow-up care, and ensure that both the resources and support will be available to keep the patient out of the hospital.

The first step in transitioning care to the outpatient setting is identifying patients with de novo heart failure, as distinct from those who already carry the diagnosis. De novo patients require significantly more education on their disease state, and most importantly an introduction to the multidisciplinary heart failure team approach to heart failure. A great deal of time must be spent on dietary education, the importance of fluid balance and the meaning of congestion, and its effects on the body. The importance of pharmacologic therapy must be stressed, and access to what will likely be many new medications must be facilitated. Limitations in access, including a lack of insurance, a lack of social support, and a lack of understanding of the disease state, should immediately raise a red flag, and serve as a warning sign for future readmission.

Managing heart failure as an outpatient requires a multidisciplinary team approach and should take advantage of all resources available for the patient.

Box 1
Factors that facilitate the transition from inpatient to outpatient care

- Identify patients with de novo heart failure
  - Educate patients on the disease state
  - Introduce patients to the multidisciplinary heart failure team
- Teach patients to approximate their functional status and alert clinician to any red flags that warrant immediate evaluation
- Use a home scale for weight checks
- Address comorbid conditions
- Frequent and thorough reconciliation of medications at each office visit

Several trials have evaluated approaches such as immediate follow-up at time of discharge, frequent nursing assessments, nurse-driven education on a rotating basis, and home-based approaches to care.[4] Although most of these approaches are both labor and cost intensive, to varying degrees most of these studies have shown either a reduction in cost or a reduction in readmission rates over a short span of time. It remains hard to make broad generalizations and definitive recommendations based on current literature. Readying a patient for discharge home after a heart failure admission should be individualized, and must make use of easy-to-use and inexpensive metrics that can guide therapy and progress.

We emphasize a symptoms-driven approach that allows patients to approximate their functional status and alert our clinicians to any red flags that warrant immediate evaluation. Although patients do not necessarily need to correlate their own symptoms with a New York Heart Association (NYHA) functional class, having patients assess their ability to walk up and down a flight of stairs or a trip to the mailbox each day can serve as a good measure of their functional class. Assessing a 6-minute walk test and a careful assessment by a physical and occupational therapy team at time of discharge can help patients identify their performance status. Thus, on arriving home, any decrease in exercise tolerance should warrant an immediate call to the clinician and heart failure team so that medications may be adjusted or a more urgent outpatient appointment be made to assess a potentially deteriorating patient. Being mindful of other symptoms, including the need for additional pillows to sleep at night (orthopnea), waking up short of breath (paroxysmal nocturnal dyspnea), and the development of dizziness or lightheadedness, can be helpful as well. Assessing ankle/leg edema can be another useful tool for patients to assess volume status. Noting the height up the leg and the severity of pitting can be useful and easy enough for patients to understand.

In the outpatient setting, the use of a home scale for weight checks is essential. Checking a daily weight and recording it in a journal can allow patients to have an easy-to-use monitoring system of their heart failure. A steady increase in weight over a short period of time can immediately alert both the patient and clinician that the current regimen is failing, or that perhaps compliance with salt and fluid intake are not ideal. It is important to establish a dry weight for the patient either at time of discharge from the hospital or when medically optimized in the clinic. It is essential for patients to check their weight at home to allow for any discrepancies in calibration between a

Download English Version:

https://daneshyari.com/en/article/2897936

Download Persian Version:

https://daneshyari.com/article/2897936

Daneshyari.com