Heart Failure Transitions of Care Checklist

Patients admitted with Acute Decompensated Heart Failure
Providing robust support in transitioning patients from in-patient to out-patient can reduced 30-day HF readmission and improve outcomes — https://effective-healthcare.ahrq.gov/topics/heart-failure-transition-care/policymaker

INPATIENT CARE MANAGEMENT
1. Assess patient’s understanding of heart failure, education about warning symptoms
   – At admission, every post discharge phone call, in outpatient clinic
2. Refer to Website/Educational materials:
   https://infonet.nyp.org/PatientED/Pages/Rresources.aspx
3. Educate about follow-up care and daily weights
   – At admission, every post discharge phone call, in outpatient clinic
4. Medication Overview
   – At admission, every post discharge phone call, in outpatient clinic
5. Which pharmacy is used? Is a specialty pharmacy better
   (language, color coding, pre-pour, blister packs)?
6. Diet education
   – At admission, every post discharge phone call, in outpatient clinic
7. Assess needs for home services (Ex: HHA, food delivery services, PT)
8. Follow-up appointment scheduled within 7-10 days

TRANSITION CARE MANAGEMENT (ALL OF THE ABOVE)
9. Discharge follow up call within 72 hours
   a. Medication Reconciliation
   b. Confirmation of follow-up appointment
   c. Confirmation of who patient/family will call if worsening heart failure signs/symptoms
   d. Review of any special instructions from discharge summary
      Ex: If weight increases 2lbs in a day or 5lbs in a week then increase diuretic and who to call
CONSIDER REFERRALS

**Advanced Heart Failure Specialist**

**CONTACT NUMBERS:**
- NYP/Columbia, NYP Allen, NYP Lawrence, NYP Hudson Valley: 212-305-9268
- NYP/Weill Cornell, NYP Lower Manhattan, NYP Queens: 212-746-2381
- NYP Brooklyn Methodist: 718-780-7830

**TeleHealth**
- MJHS/VNS
- NYP/Weill Cornell specific – Paratelemedicine
- NYP/Columbia, NYP/Weill Cornell – CardioMEMS – remote implantable hemodynamic monitor 212-305-9268

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**Heart Failure Transitions of Care Guideline Card**

**SECTION 1: PATIENT ASSESSMENTS & HF SYMPTOMS**

- Assess primary language and ability to read / understand information
- Assess understanding of hospitalization
- Assess understanding of heart failure diagnosis

**Review / Educate Regarding Heart Failure Symptoms**
- Does patient have a WORKING scale at home?
- Does patient recognize warning signs?
  - Weight gain of 2lbs in one day, or 5lbs in one week
  - Swelling / edema: feet, ankles, abdomen and upper extremities
  - Cough (dry)
  - Sleeping with > 2 pillows, or sitting up
  - Restless sleep
  - Fatigue / low energy level
  - Dyspnea / shortness of breath
- Provide action plan to address warning signs
  - Take extra medications (as instructed by Provider)
  - Call provider
- Does the patient know to go to ED or to call 911 for any of the following?
  - Struggling to breathe
  - Unrelieved shortness of breath while sitting still
  - Chest pain
  - Confusion or inability to think clearly
- Heart failure education material
  - Infonet Link: https://infonet.nyp.org/PatientED/Pages/Resources.aspx
- Follow up care:
  - Do you have an NYP Doctor/NP/PA to call / contact if needed
  - *If yes, does that person respond when contacted?*

**PT/OT**
- Consider PT/OT order for every patient
- Consider cardiac rehab for every patient (especially outpatient cardiac rehab for those patients going home)
SECTION 2: MEDICATION
• Perform medication reconciliation
• Assess knowledge regarding medication regimen
  • Does patient know to only stop taking medication when instructed to by provider?
  • What medication(s) do you take? (Have patient’s medication list on hand)
  • Do you take your medication as prescribed?
  • Are there any barriers to getting your medications (cost, transportation, understanding)
  • How often do you miss taking your medications?
  • Which pharmacy (ies) do you use?
    Special needs: language, color coding, pre-pour, blister packs
• If needed, instruct about his / her medication
• Remind patient to bring medications to follow up appointments

SECTION 3: DIET
• Do you follow a heart failure diet?
• Educate on salt / sodium and fluid restriction
  • 2gram sodium diet
  • 1.5—2L fluid restriction
  • Specialty diets (Vitamin K controlled, Renal diet, etc.)
• Educate on significance of food labels (Ex: Sodium and Glucose content)
• Refer to registered dietitian
• Educate on food delivery services (Meals On Wheels, Gods Love We Deliver)
• Provide info on SNAP Program (if needed)

SECTION 4: SOCIAL
• Do you have a primary care physician
  • If yes...name, number
  • If No...do you need help in obtaining one?
• Who is (are) your support person/s?
• How do you get to your appointments?
  • Do you need transportation?
  • Does your health insurance cover transportation?
• Do you have MLTC (Managed Long Term Care) insurance?
• Do you have HHA or home attendant?
  • Assess the need for help at home
• Are you eligible for SSI, or Medicaid?
  • Would you like more information?
SECTION 5: POST DISCHARGE FOLLOW UP

- Call patient within 72 hours of discharge
  - Do you have an appointment with your provider?
  
  *If no* make appointment for patient with PCP, Cardiologist,
  Heart Failure Specialist, or Transition Center

  - Within 7-10 days
  - Remind patient of appointment
  - Send (Fax, Email) discharge summary to provider, if provider does not
    have access to discharge summary/discharge meds

- Have you filled your discharge prescriptions?
  Name of pharmacy?

- Medication reconciliation and review

- Review low sodium diet / fluid restrictions

- Caregiver / support contact information
  Permission to contact?

- Review action plan with patient and caregiver

SECTION 6: ADVANCED HEART FAILURE

Consider Recommending referral to Advanced Heart Failure Specialist
if 1 or more High Risk features:

- 2 or more ED visits/Hospitalizations for heart failure
- Intolerance to HF Medications
- Need for chronic IV inotropes
- Persistent symptoms of exercise limitations, profound fatigue, dyspnea at rest or during activities of daily living
- Hypotension
- Renal insufficiency (Cr >1.7, BUN >43)
- Arrhythmias or ICD shocks

Advanced HF Outpatient New Patient:
NYP/Columbia – 212-305-9268 (NYP Allen, NYP Lawrence, NYP Hudson Valley)
NYP/Weill Cornell – 212-746-2381 (NYP Lower Manhattan, NYP Queens)
NYP Brooklyn Methodist – 718-780-7830

SECTION 7: PALLIATIVE CARE

Every patient – Discussion about health care proxy

Consider Palliative care referral for end stage heart failure patients:

NYP/Columbia – Palliative Care Team: Inpatient (pager) Outpatient – 212-305-7340
NYP/Weill Cornell – Palliative Care referral: Geriatrics – 212-746-1677
NYP Hudson Valley – Palliative Care: Dr. Heckman – 914-941-1334
NYP Queens: Palliative Care outpatient: Dr Elina Yushuvayev – 718-631-0500
Home Palliative Care MJHS – 212-240-3370