NewYork-Presbyterian

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**

TRANSTION 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: 212-746-2381
NYP Brooklyn Methodist: 718-780-7830
NYP Queens: 718-670-2087

TeleHealth

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

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/Rresources.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?
  - Who prepares 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 Brooklyn Methodist – 718-780-7830
NYP Queens – 718-670-2087

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