Transcript Details

This is a transcript of a continuing medical education (CME) activity. Additional media formats for the activity and full activity details (including sponsor and supporter, disclosures, and instructions for claiming credit) are available by visiting:
https://reachmd.com/programs/cme/what-are-the-keys-to-post-discharge-care-for-patients-hospitalized-for-hfref/14084/

Released: 06/30/2022
Valid until: 06/30/2023
Time needed to complete: 1h 07m

ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

What are the Keys to Post-discharge Care for Patients Hospitalized for HFrEF?

Dr. Butler:
Greetings. I am Dr. Javed Butler. I serve as the president of the Baylor Scott and White Research Institute in Dallas, Texas, and distinguished professor of medicine at University of Mississippi in Jackson, Mississippi. Delighted to give this short presentation, "What are the Keys to Post-discharge Care for Patients Hospitalized with Heart Failure and Reduced Ejection Fraction?"

So first, let's quickly level set as to why hospitalizations for heart failure is such a big issue, at least in the United States, and there is comparable epidemiology in other parts of the world including both developed and developing nations. Heart failure hospitalization is a big clinical and a societal issue in the United States. There are over a million hospitalizations where heart failure is the primary discharge diagnosis and another two million hospitalizations where heart failure is a contributory diagnosis. So in total, over three million hospitalizations where heart failure is a primary or contributory diagnosis. About 50/50 heart failure with reduced and preserved ejection fraction, but irrespective of ejection fraction, these patients are at a particularly higher risk of hospitalization, recurrent hospitalization. We're talking about 20% or so one month, 50% six-month repeat hospitalization and a one-year mortality rate ranging from 20-30%. More so, the cost of care in the United States for heart failure is estimated to be about 70 billion and about half of that cost is related to heart failure hospitalization. So big ticket item both from societal and an individual perspective. Now, why transitions of care and discharge management is so important and the reason for that is that unlike some other parts of the world, at least in the United States or in North America, the length of stay for these patients is about five days or so. But there are data that suggests that there are many patients who are not fully decongested, and there is, as I mentioned, a very high risk of readmission. Also, it's not the same physicians that take care of the patients in hospital setting versus the outpatient setting and there is handoff in care so there is a potential for dropping some things in that transition.

And then finally is the patient education issue because if the patient just considers hospitalization as just ingestion, but not really realize that it's a fundamental change in the trajectory of the disease, there may be an inadvertent misperception that, oh, you just have some extra fluid. You just take some IV Laxis and furosemide and then you just go home and it's not a big deal. So all aspects of this are really, really important. So what do the guidelines say? Well, the guidelines say that the transition process is really comprehensive to assess the volume status of the patient, the blood pressure, adjust the medication to optimize volume status and the hemodynamic status, that the patient is able to function and take care of their activities of daily living to assess the barriers. If you just write the prescription and there is no way for patient to get the prescriptions or followup in the outpatient, then it doesn't help. So limitations in support involve social work. See if some of those can be improved as well. Obviously, optimization of comorbidities, electrolytes, hemodynamics, all of these things are really important, and following that, optimization of GDMT is also very important. So I will come to that again in a second. Appropriate referrals during the hospitalization or post-discharge is important as well.

And then finally, a close follow up post-discharge including a phone call early post-discharge and say about two, three days after discharge, then a follow up visit in one to two weeks post-discharge to make sure if the patient is trending in the wrong direction that perhaps they could be optimized or all the plan that was initiated but not completed in the hospital can continue to go in the right direction. Now, also in the new guidelines is the indication to assess natruretic peptides. That is because these patients with very high levels of natruretic peptides are at a very high risk for recurrence. And therefore, we may guide the therapy. So for natruretic peptide, obviously, we have a lot of different roles, including diagnosis of heart failure when you're uncertain, risk assessment prognosis, there's

a debate about management of patients as well and targeting certain NT-proBNP level. But in the context of our today's talk, measuring NT-proBNP to assess the prognosis of the patient is recommended by the guidelines as well. And one can use some common clinical sense that if the natruretic peptide levels have been considerably lowered, then they can continue with routine followup. If they are modestly lowered, then perhaps this is a person that needs to have an early followup or have home nursing arrangement. And of those patients that have really persistently very high NT-proBNP, that perhaps the hospital stay can be prolonged or they may need to go to a rehab facility, home nursing, telemonitoring, early followup of these patients. So that can guide us a little bit about the acuity of treatment. Now, I will very highly recommend you all to see there was a 2019 American College of Cardiology Expert Consensus Decision Pathway, ECDP, about management of patients hospitalized with heart failure and part of the discussion was post-discharge management. And what this document does is that in the appendix, there are many different detailed forms that are ready to be used in the clinical setting just to date because it's easy to say educate patients, but educate patient about what? It's easy to say to have a early phone call or a early clinic follow up, but what should you do on that phone call? What should you ask? What should be done in the follow up visit? Similarly transitioning and referring the patient to the other clinicians for them to understand why certain things were done or should have been done, but not done with whether there was any reason. All of those things are really important in the transitions of care. So this document details patient education at the time of discharge, and there is a whole menu of checklists, including explaining the current medications, their activity, fluid and sodium, weight monitoring, monitoring for edema, smoking cessation, substance use, signs for decompensation, when to call, who to call, and all those things are in the patient education section. Similarly, very detailed, focused discharge handoff to other physicians, including medication planning and which medications are started, what the plan is and what needs to be started in the post-discharge setting. Phone call, what are the symptoms that needs to be asked? What are the objective parameters, like blood pressure and weight, medications, side effects, follow up. So what should be covered in the phone call for the patients as well as other clinician and the follow up visit?

So I will end by also saying that now the guidelines also have a recommendation that optimal medical therapy should be started in the hospital setting whenever possible. It's a Class recommendation because we know that if the therapies are not started in the inpatient setting and we make a plan to start them in the outpatient, many times with transitions of care, the ball gets dropped. So there's a recommendation that as much as it is feasible is start the foundational quadruple therapy for HFrEF while the patient is in the hospital setting. And many centers are also trying to optimize that by having a specific GDMT or guideline drive medical therapy clinic to be able to help these high-risk patients achieve the best care. Thank you so much.