Shattering Silos: A Collaborative Approach to Heart Failure Readmissions

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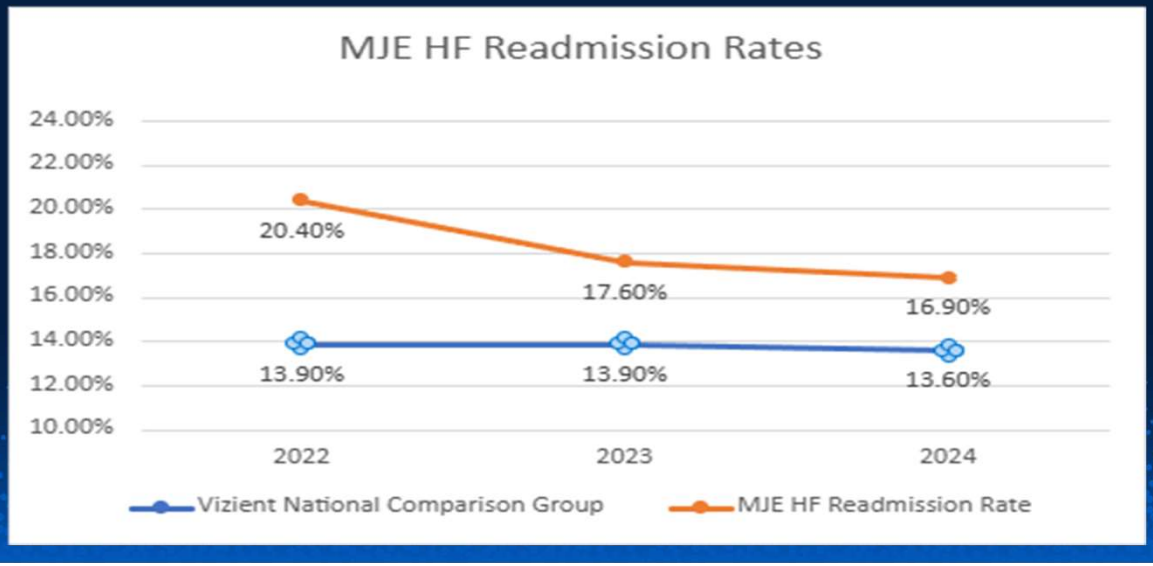
Heart Failure Readmission Concerns

- Heart Failure readmission rates well above national benchmarks
- Siloed workflows left patients unsupported between discharge and first follow up visit
- Heart Failure Collaborative Task Force uniting multidisciplinary partners



Comprehensive Multidisciplinary Approach

- Structured ownership in patient education
  - Inpatient Nursing
  - Cardiology
  - Pharmacy
  - Dietitian
  - Care Coordinator
  - Social Work

Empowerment: The Ultimate End-Point

Education:

- Teaching them *why* (physiology) so they understand the *what* (meds).

The Shift:

- From "Passive Recipient of Care" to "Active Owner of Health."

Success Metric:

- Not just "alive," but "living."

The “Invisible” Co-morbidities (SDOH)

Zip Code vs. Genetic Code:

- Where you live determines how you heal.

Real Barriers:

- Prescribing Lasix is useless if they have no car to get to the pharmacy.
- Dietary advice fails if they live in a food desert.

Our Approach:

- We treat the social situation as a vital sign.

Bridging Inpatient to Outpatient Success

- Case Management SDOH
- Follow up appointment secured prior to discharge
- Coordination with Cardiac Nurse Navigators

Navigation – Why Patients Fail

The Assumption Vs Reality

- Non-compliance – lack of resources
- Common Pitfalls:
  - Can't afford the co-pay.
  - Don't understand the discharge instructions.
  - Fear of the "unknown" symptoms.
- The Gap: The critical 48 hours after discharge.

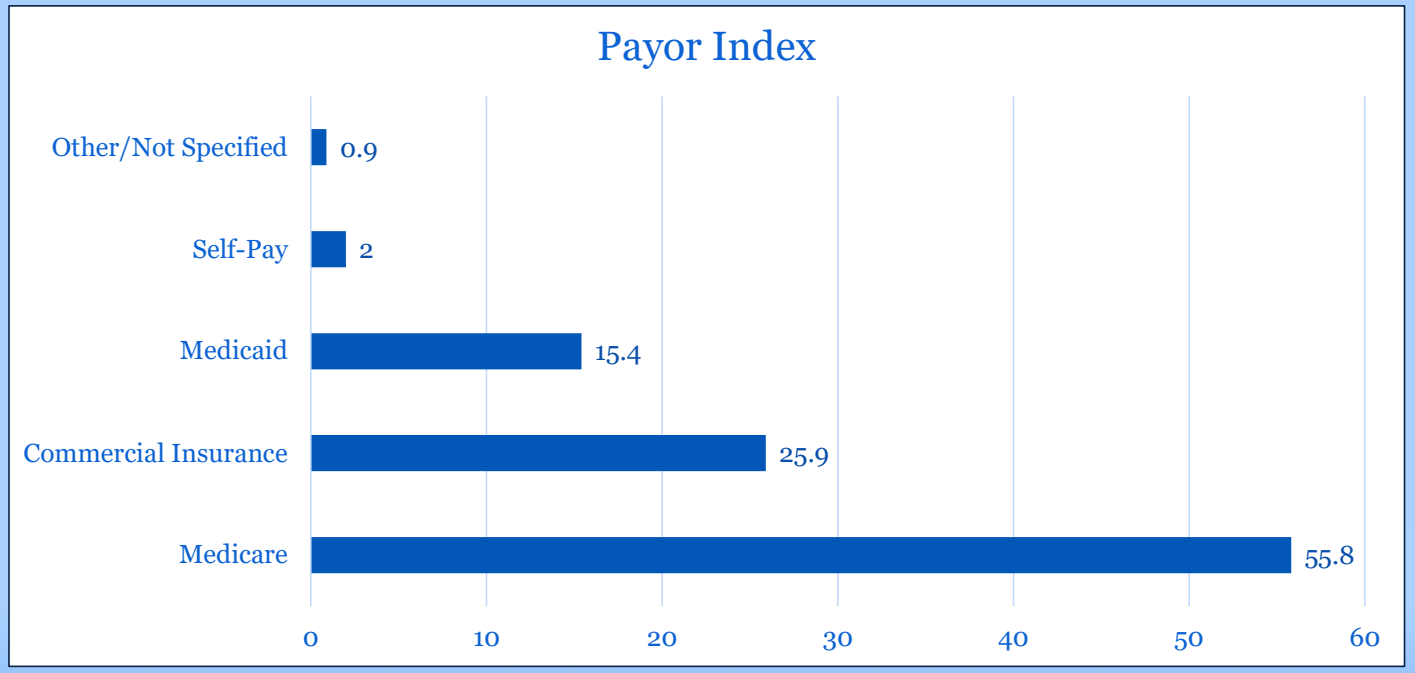
Building Bridges

- **The Check-In:** The power of a phone call. "We catch the issue before it becomes a readmission."
- **Education:** Share & review Living Well with Heart Failure booklet, CHF action plan, daily weight calendar & Heart Failure Nutrition handout.
  - Reinforcement!
- **Resource Deployment:**
  - Transportation Vouchers (getting them to the clinic).
  - Medication Assistance (samples/coupons)
  - Provide scales, pulse oximeters, BP monitors
- **The Result:** Navigation converts "No Shows" into "Success Stories."

Barriers to Care

- Demographics
- Medicare Type
- Medicaid (Changes)
- Social Determinants of Health (SDOH)
- Access to Care
- Health Literacy

Insurance Breakdown: Why This Matters



Medicare Types

Medicare A, B, and D: advantages vs Disadvantages

- More expensive
- Patient may have a limited income
- Better coverage
- More accepted

Medicare Advantage (part C): Is it an advantage?

- Is it an advantage?
- Low-cost premiums
- Covers vision, provides incentives
- Is it accepted? Maybe?

Medicaid

- Covers expensive medications
- Do you qualify? First Source screenings
- Copays, Transportation, Prior authorizations
- Medicaid Wavers

SDOH

- Housing
- Transport
- Addictions
- Socially isolated
- Lack of resources or access to resources (food insecure, medication copays, can't afford high dollar medications, utilities)

Access to Care

- Collaborating with providers
- Referring to care navigators, home health, skilled rehabilitation
- Transportation: to/from appointments after dc, home, out of state arrangements

Health Literacy

- What does the patient know?
- What learning barriers do they have?
  - Sight, hearing, intellectual delays, mental health barriers
- Collaborating with other team members
  - Dietician, wound care, pharmacy
- Simplifying handouts and following up

Patient Example

75-year-old male.

Last admission for cellulitis of a foot, inability to walk, acute CHF, acute on chronic renal insufficiency, diarrhea d/t medication.

Hx of: alcohol abuse, bipolar disorder, CHF, CKD, HTN, Narcoleptic syndrome, previous meth use, veteran, lives alone, home environment barriers

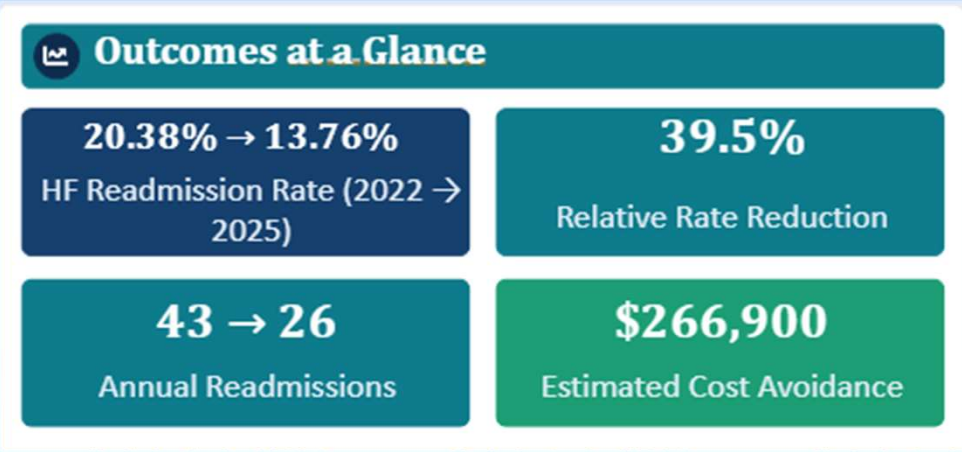
- Patient had four readmissions. Patient has been admitted to 2 SNF. Referrals to VA, Connections agency on Aging, CN, equipment given, transport, medication delivery

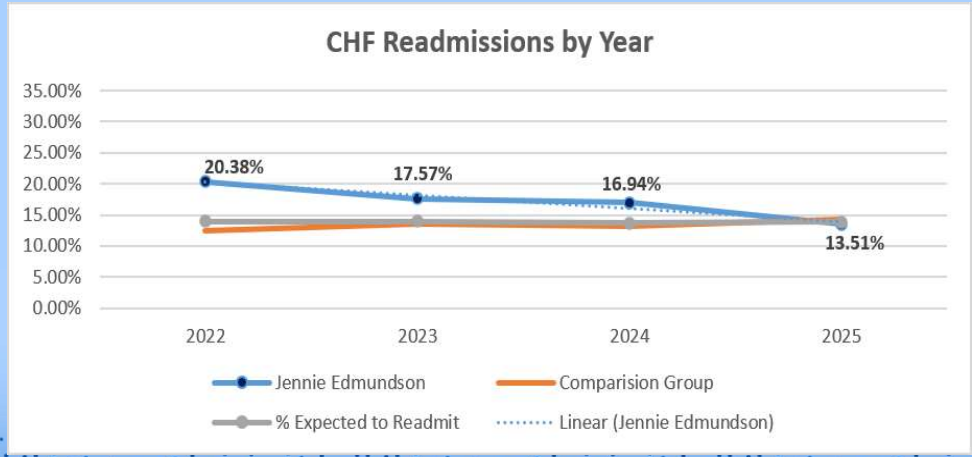
- Outcome: CN called 3 times for follow up at facility. Last call unknown location for discharge.

The Takeaways

We cannot do this in silos.

- **To the Healthcare Workers:** Look beyond the chart. Ask about the ride home.
- **To the Community:** We are here for you, not just to fix you, but to keep you well.
- **Final Call:** "Time is Muscle, but Trust is the Cure."





References

Questions