Virginia Long-Term Care Clinician Network Monthly Forum

December 13, 2023

Welcome!

As you join, please turn on cameras and mic or unmute your phone and say hello to your Virginia colleagues. We all have a common bond: the choice to serve in a unique area of health care. During the presentation we can mute ourselves until it is time for more interaction.

Virginia LTC-CN: Share Some Info

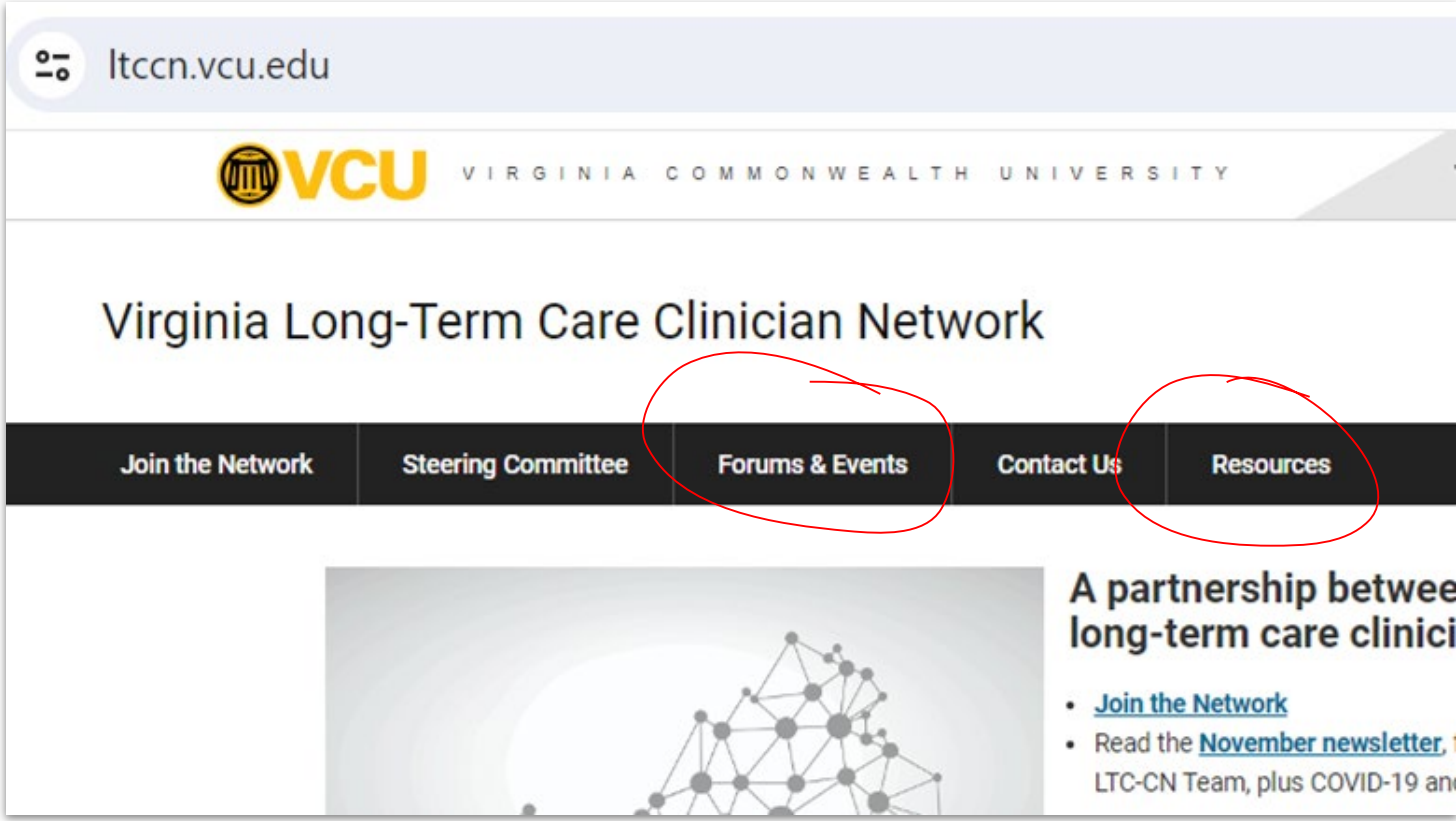
Please use the Chat box:

- Your Name and Region or City/Town
- Best article you have read lately

Thank you for taking care of Virginia's residents of PACE, assisted living and nursing homes!

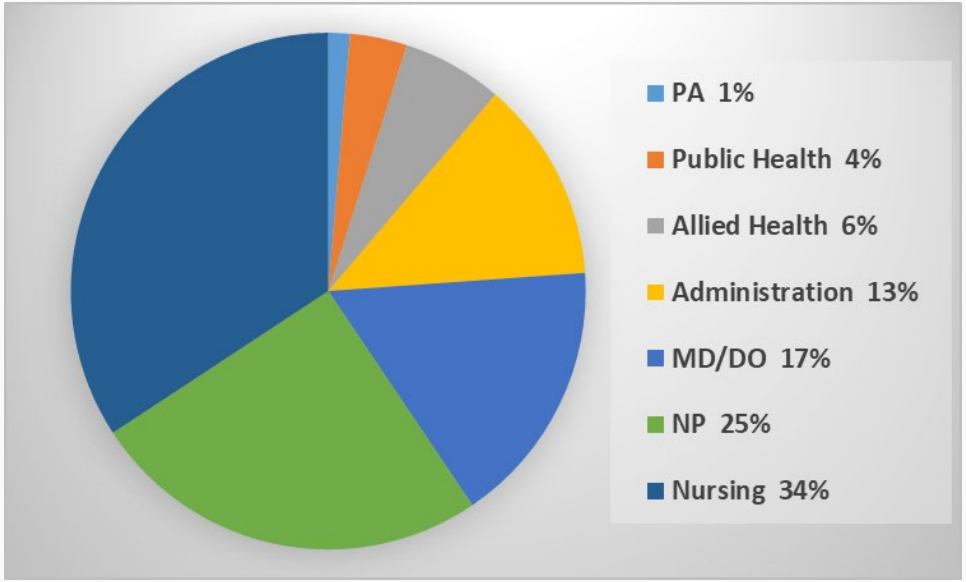
Where to find us, slides, monthly newsletter?

SCAN ME

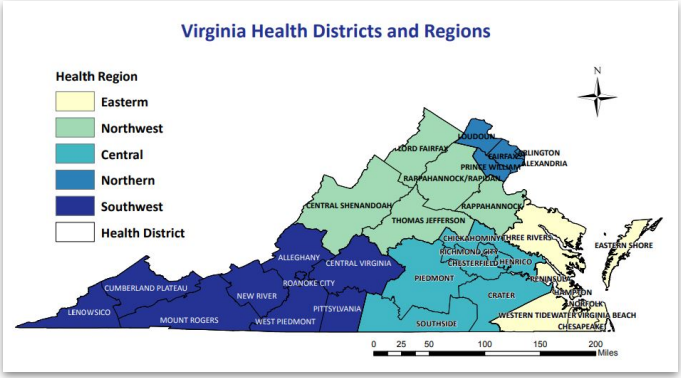


Welcome New Members!

Elaine Dunnivan, NP
Susan Moeslein, MSA, BSN, ACM, CIC
Shannon Green, LPN
Mohammad Salman, RN
Michael Hamilton, MDiv
Paula St. Hill, Public Health
James Thompson, PA-C, MMS



Who are we?



Staff

Christian Bergman, MD - Principal Investigator
Bert Waters, PhD - Project Director
Laura Finch, MS, GNP, RN - Clinical Coordinator
Kim Ivey, MS - Communications/Administration
Jenni Mathews - Registration/Evaluation Coord.
Kristin MacDonald, MS, RD - News & Content Editor

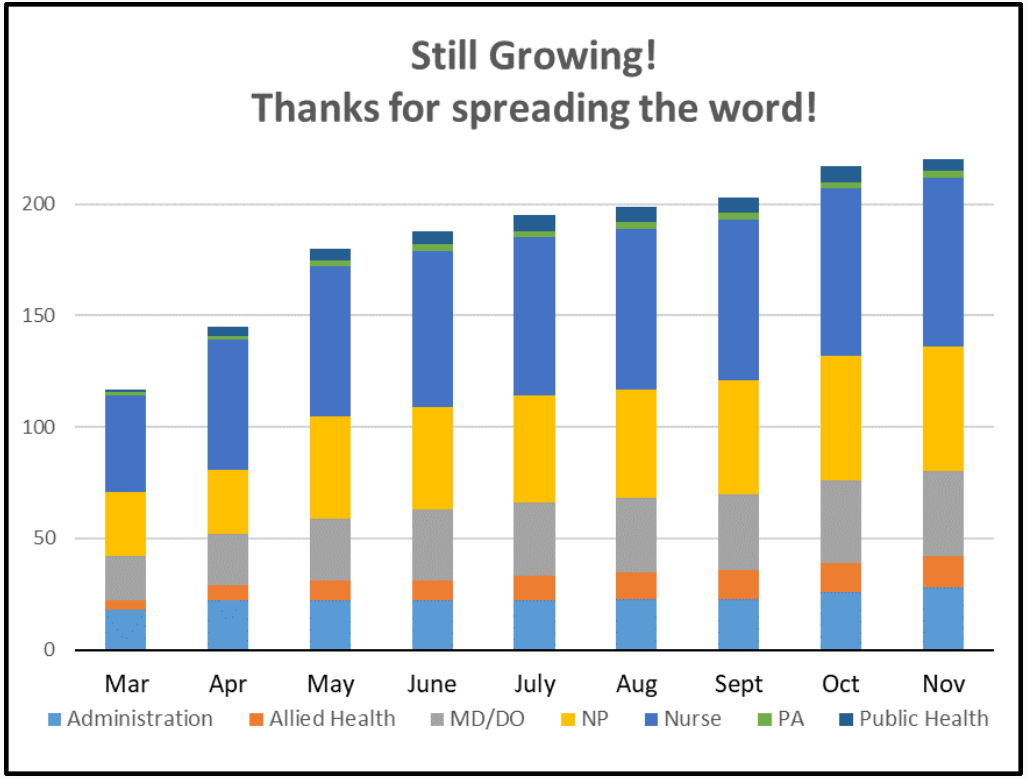
Steering Committee

Eastern Region: Rob Walters, MD & Mary Mallory, NP
Northwestern Region: Jonathan Winter, MD
Central Region: William Reed, MD & Tangela Crawley-Hardy, NP
Southwest Region: Katherine Coffey-Vega, MD & Jamie Smith, NP
Northern Region: Aabha Jain, MD & Noelle Pierson, NP
Statewide: Shawlawn Freeman-Hicks, NP

Our Members

ltccn.vcu.edu

Network Growth – 225 members



ltccn.vcu.edu

Poll Question 1

Are you tired of holiday music yet?

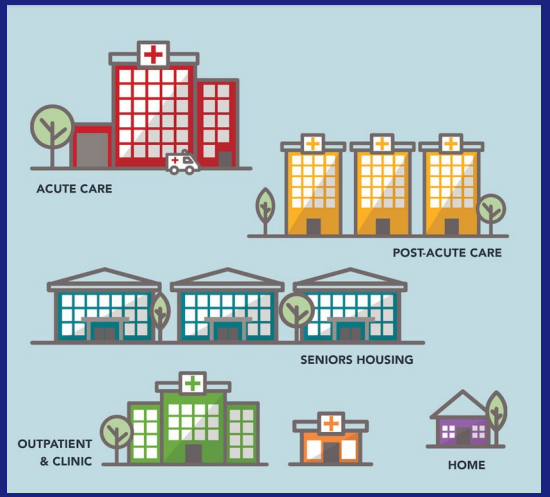
A- Yes

B- No

Heart Failure in PALTC

Carl J. "Christian" Bergman, MD, CMD, FACP
Assistant Professor, Division of Geriatric Medicine, VCU

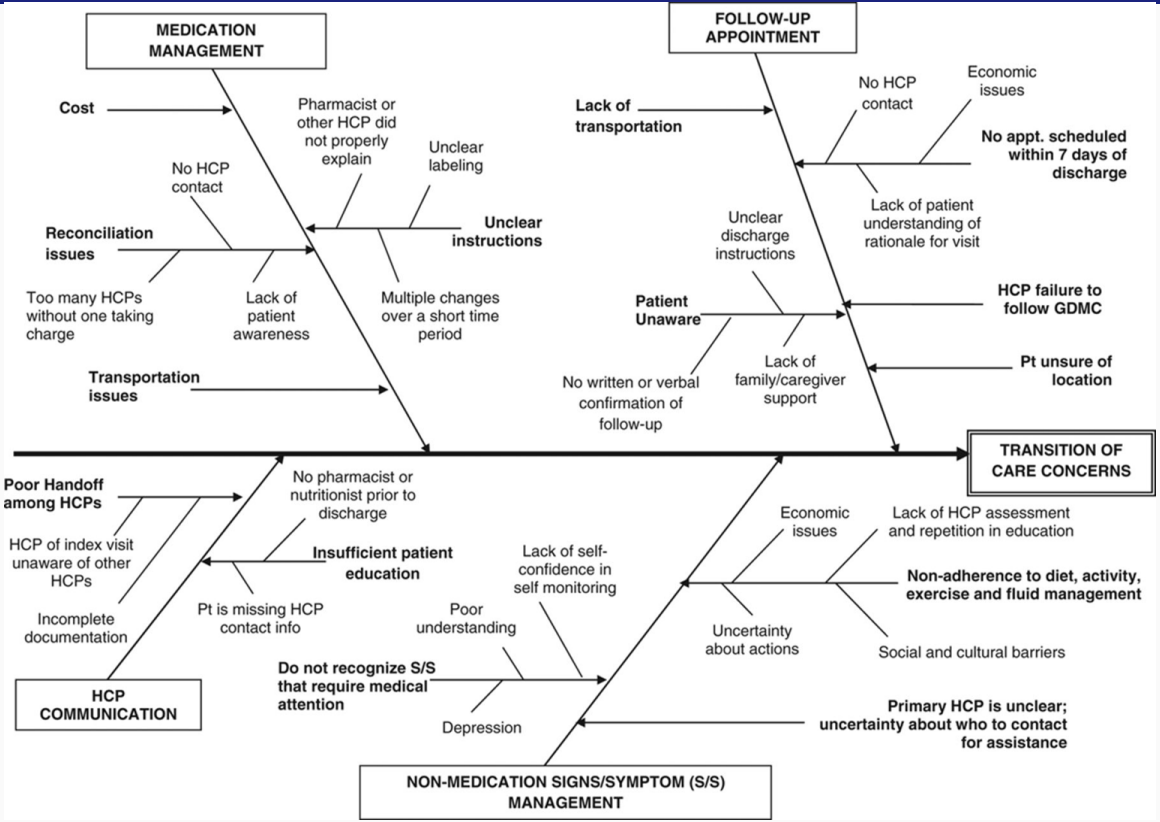
I have no relevant conflicts of interest.



CHF Background

- 6.2 million persons today, projected to increase to 8 million by 2030
- Cost of 30-day readmission is $41B in hospital costs alone
- Medicare beneficiaries hospitalized with HF from 2006 to 2008 were used, the 30-day all-cause risk-standardized rehospitalization rate was 24.7%
  - Of note, 6 month re-hospitalization rates are 50%
- For those ≥65 years of age, discharge to long-term care increased significantly from 17% in 2000 to 21% in 2010
- Predicting 30 day hospitalization: 1) Age, 2) # of hospitalizations within 6 months, 3) longer index hospital stay aLOS , and 4) # of ED visits 6 months after index hosp.

2015 Circulation Analysis



ltccn.vcu.edu

Poll Question 2

Which barrier from the 2015 paper do you encounter most frequently in managing PALTC Heart Failure Patients?

A – Medication management

B – Follow up appointment

C – Healthcare provider communication

D – Self-awareness of signs/symptoms of heart failure

PALTC Unique Care Issues

- Admissions are complex, i.e. not “just” heart failure
- Poor handoff between providers
- Nursing home staffing shortages
- Staff education / awareness of signs/symptoms
- Non-adherence to diet / fluid restrictions
- Poor psychosocial support in community

Course of Heart Failure

https://www.activehhh.com/home-health-blog/hospice-for-heart-failure/

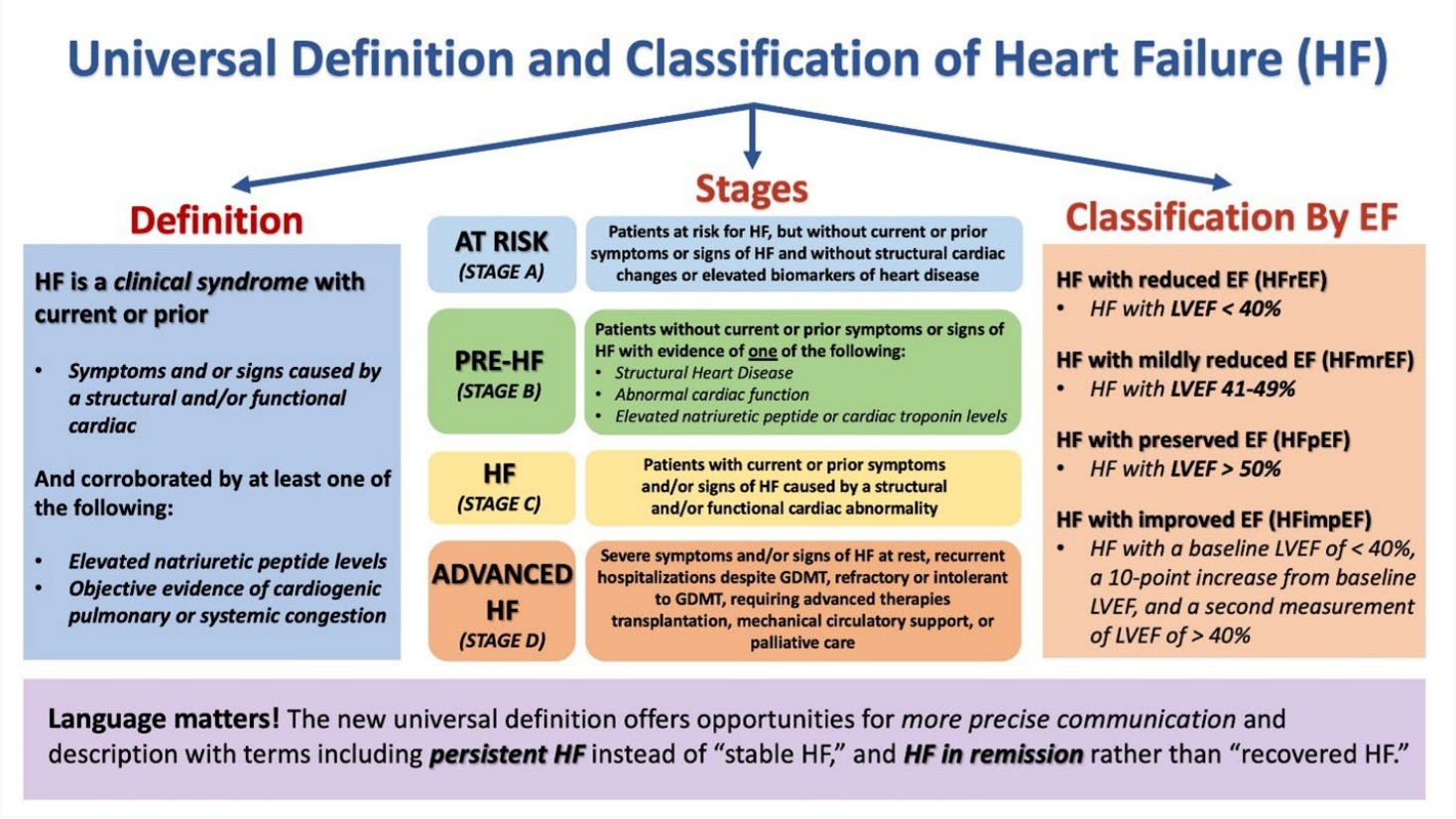
ltccn.vcu.edu

Let's look at Best Practices in CHF

Wait, what?

- Where do we start?

Words matter



Poll Question 3

Prior to today, had you heard of the category of mildly reduced EF (HFmrEF)?

A – Yes

B – No

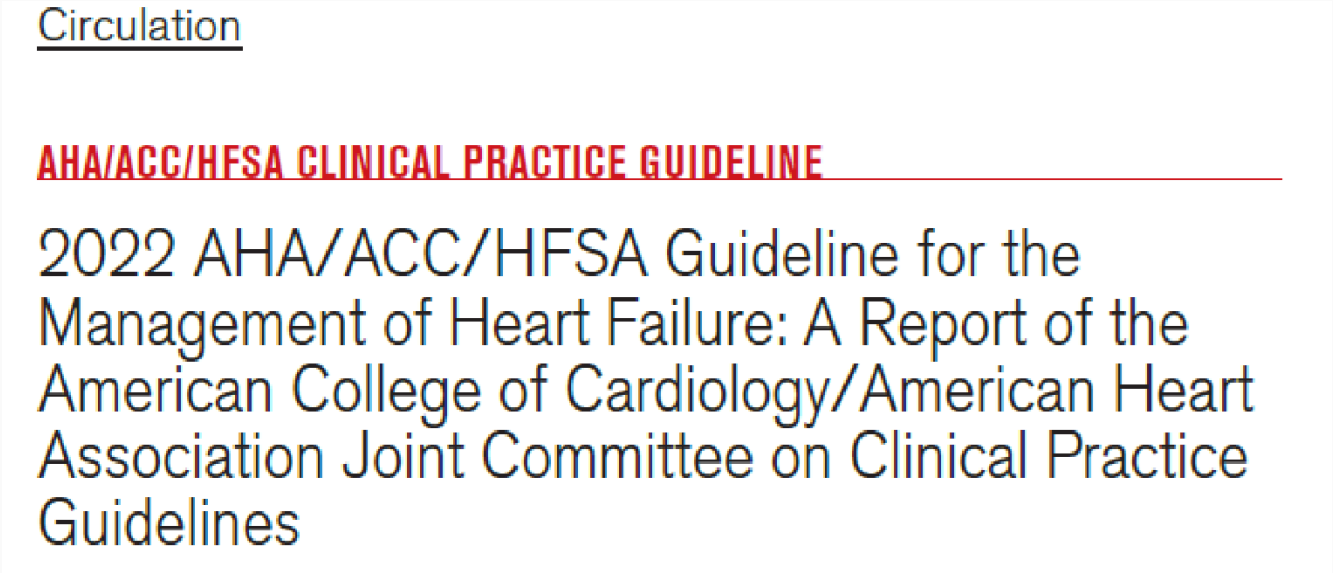
Poll Question 4

Prior to today, had you heard of the category of improved heart failure (HFImpEF)?

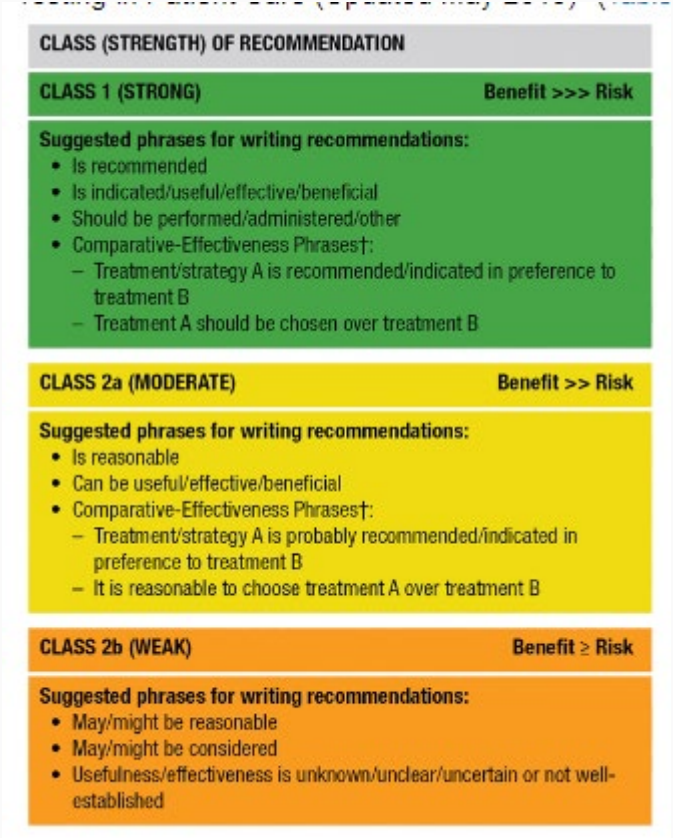
A – Yes

B – No

Heart Failure 2022 Guidelines



Heart Failure 2022 Guidelines



CLASS (STRENGTH) OF RECOMMENDATION

CLASS 1 (STRONG) — **Benefit >>> Risk**

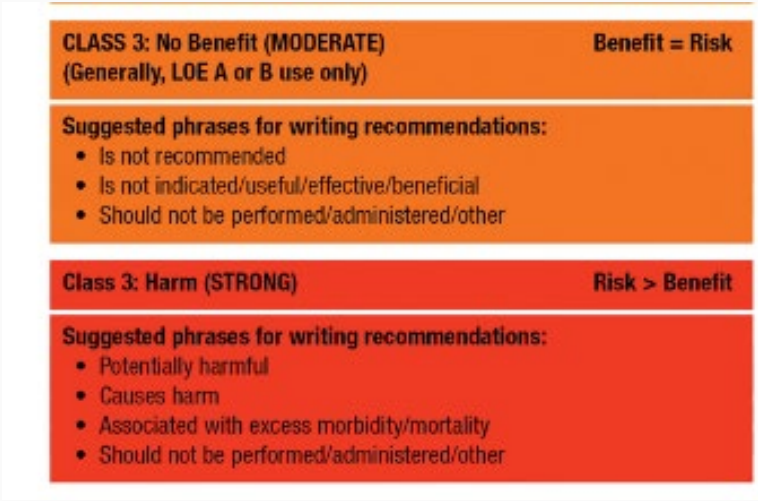
Suggested phrases for writing recommendations:
- Is recommended
- Is indicated/useful/effective/beneficial
- Should be performed/administered/other
- Comparative-Effectiveness Phrases†:
  - Treatment/strategy A is recommended/indicated in preference to treatment B
  - Treatment A should be chosen over treatment B

CLASS 2a (MODERATE) — **Benefit >> Risk**

Suggested phrases for writing recommendations:
- Is reasonable
- Can be useful/effective/beneficial
- Comparative-Effectiveness Phrases†:
  - Treatment/strategy A is probably recommended/indicated in preference to treatment B
  - It is reasonable to choose treatment A over treatment B

CLASS 2b (WEAK) — **Benefit ≥ Risk**

Suggested phrases for writing recommendations:
- May/might be reasonable
- May/might be considered
- Usefulness/effectiveness is unknown/unclear/uncertain or not well-established



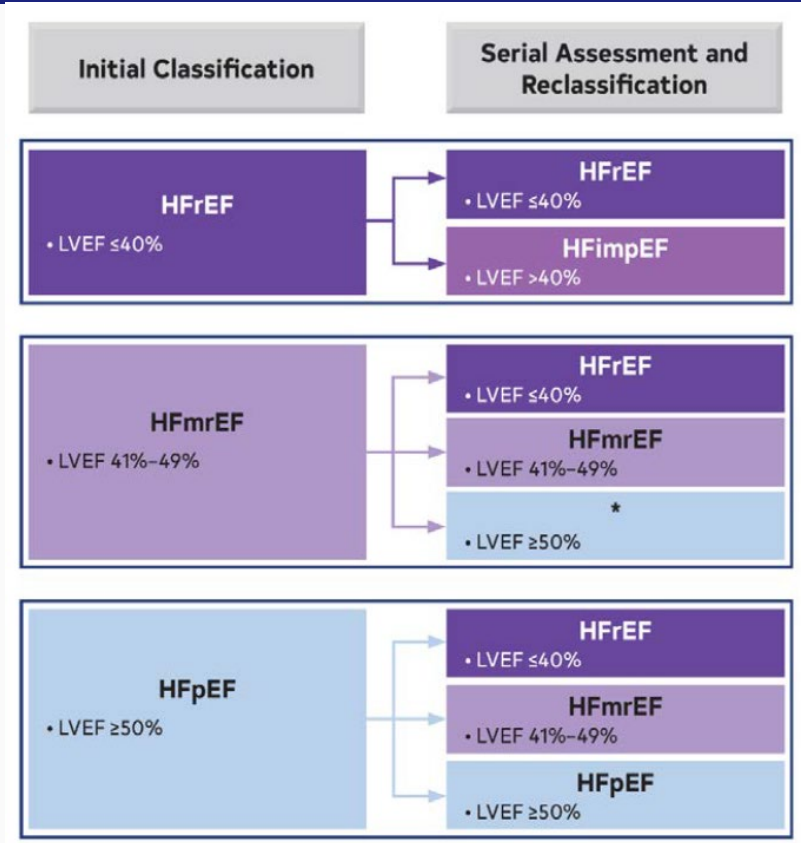
CLASS 3: No Benefit (MODERATE) — **Benefit = Risk**
(Generally, LOE A or B use only)

Suggested phrases for writing recommendations:
- Is not recommended
- Is not indicated/useful/effective/beneficial
- Should not be performed/administered/other

Class 3: Harm (STRONG) — **Risk > Benefit**

Suggested phrases for writing recommendations:
- Potentially harmful
- Causes harm
- Associated with excess morbidity/mortality
- Should not be performed/administered/other

Heart Failure 2022 Guidelines



Heart Failure 2022 Guidelines

1	A	2. In patients with chronic HF, measurements of BNP or NT-proBNP levels are recommended for risk stratification.[11,13–29]

Poll Question 5

In LTC patient whom have heart failure, are you checking serial BNP measurements to guide prognosis/management?

A – Yes

B – No

Heart Failure 2022 Guidelines

2a	B-NR	5. In patients hospitalized for HF, a predischarge BNP or NT-proBNP level can be useful to inform the trajectory of the patient and establish a postdischarge prognosis.[14,17,20–29]

Poll Question 6

In SNF patients whom have heart failure, are you checking serial BNP measurements during the SNF stay?

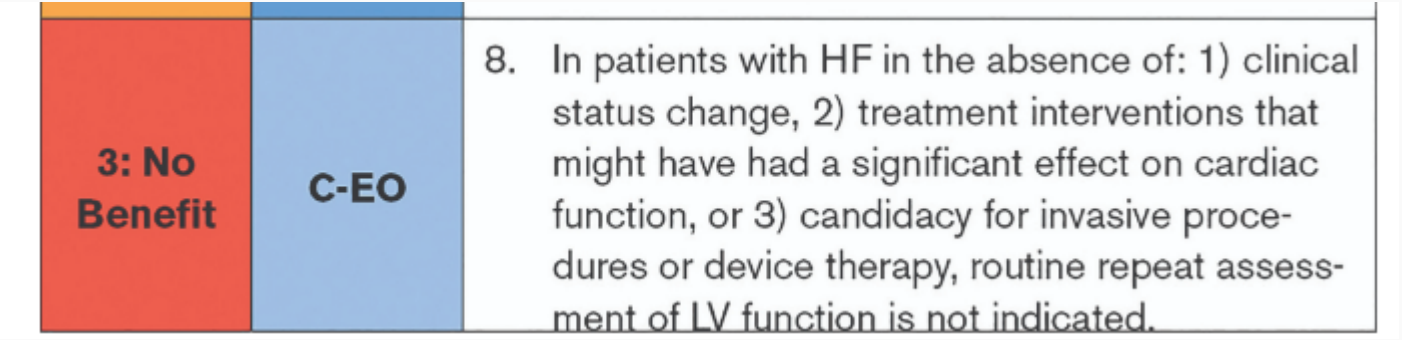
A – Yes, multiple times

B – Yes, at admission only

C – Yes, at discharge only

D – No

Heart Failure 2022 Guidelines



Heart Failure 2022 Guidelines

1	A	1. In patients with LVEF ≤40%, ACEi should be used to prevent symptomatic HF and reduce mortality.[1–4]
1	A	2. In patients with a recent or remote history of MI or ACS, statins should be used to prevent symptomatic HF and adverse cardiovascular events.[5–9]
1	B-R	3. In patients with a recent MI and LVEF ≤40% who are intolerant to ACEi, ARB should be used to prevent symptomatic HF and reduce mortality.[10]
1	B-R	4. In patients with a recent or remote history of MI or acute coronary syndrome (ACS) and LVEF ≤40%, evidence-based beta blockers should be used to reduce mortality.[11–13]

Heart Failure 2022 Guidelines

3: Harm	C-LD	8. In patients with LVEF <50%, nondihydropyridine calcium channel blockers with negative inotropic effects may be harmful.[16,17]

Nondihydropiridine calcium channel blockers diltiazem and verapamil are myocardial depressants and generally not tolerated in HF. In previous studies of patients with HF or reduced LVEF after acute MI, diltiazem was associated with increased risk of HF,[16,17] although in a smaller study of patients with nonischemic cardiomyopathy, diltiazem had no impact on mortality.[45] Verapamil had no impact on survival or major cardiovascular events after acute MI.[46] Although not specifically tested in asymptomatic patients with low LVEF, nondihydropyridine calcium channel blockers may be harmful in this population because of their negative inotropic effects.

Poll Question 7

In patients with an EF < 50%, do you feel comfortable using dihydropyridines such as amlodipine or nifedipine?

A – Yes

B – No

Heart Failure 2022 Guidelines

2a	C-LD	1. For patients with stage C HF, avoiding excessive sodium intake is reasonable to reduce congestive symptoms.[1–6]

Restricting dietary sodium is a common nonpharmacological treatment for patients with HF symptomatic with congestion, but specific recommendations have been based on low-quality evidence.[7] Concerns about the quality of data regarding clinical benefits or harm of sodium restriction in patients with HF include the lack of current pharmacological therapy, small samples without sufficient racial and ethnic diversity, questions about the correct threshold for clinical benefit, uncertainty about which subgroups benefit most from sodium restriction,[7,8] and serious questions about the validity of several RCTs in this area.[9–11] However, there are promising pilot trials of sodium restriction in patients with HF[3,5,6] The AHA currently recommends a reduction of sodium intake to <2300 mg/d for general cardiovascular health promotion[12]; however, there are no trials to support this level of restriction in patients with HF.[13]

Poll Question 8

When counseling heart failure patients about dietary intake, do you always recommend a heart healthy, low sodium diet <2.5 g?

A – Yes

B – No

C – Depends

Heart Failure 2022 Guidelines

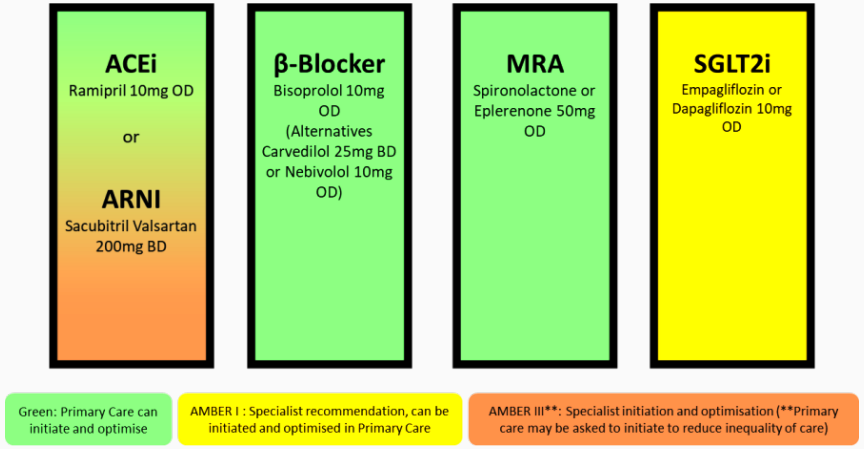
1	A	1. In patients with HFrEF and NYHA class II to III symptoms, the use of ARNi is recommended to reduce morbidity and mortality.[1–5]
Value Statement: High Value (A)		4. In patients with previous or current symptoms of chronic HFrEF, in whom ARNi is not feasible, treatment with an ACEi or ARB provides high economic value.[19–25]

Heart Failure 2022 Guidelines

3: No Benefit	A	1. In patients with HFrEF, dihydropyridine calcium channel-blocking drugs are not recommended treatment for HF.[1,2]
3: No Benefit	B-R	2. In patients with HFrEF, vitamins, nutritional supplements, and hormonal therapy are not recommended other than to correct specific deficiencies.[3–9]
3: Harm	A	3. In patients with HFrEF, nondihydropyridine calcium channel-blocking drugs are not recommended.[10–13]
3: Harm	A	4. In patients with HFrEF, class IC antiarrhythmic medications and dronedarone may increase the risk of mortality.[14–16]
3: Harm	A	5. In patients with HFrEF, thiazolidinediones increase the risk of worsening HF symptoms and hospitalizations.[17–21]
3: Harm	B-R	6. In patients with type 2 diabetes and high cardiovascular risk, the dipeptidyl peptidase-4 (DPP-4) inhibitors saxagliptin and alogliptin increase the risk of HF hospitalization and should be avoided in patients with HF.[22–24]
3: Harm	B-NR	7. In patients with HFrEF, NSAIDs worsen HF symptoms and should be avoided or withdrawn whenever possible.[25–28]

Heart Failure 2022 Guidelines – Summary

Guideline-directed medical therapy (GDMT) for heart failure (HF) with reduced ejection fraction (HFrEF) now includes 4 medication classes which include sodium-glucose cotransporter-2 inhibitors (SGLT2i).



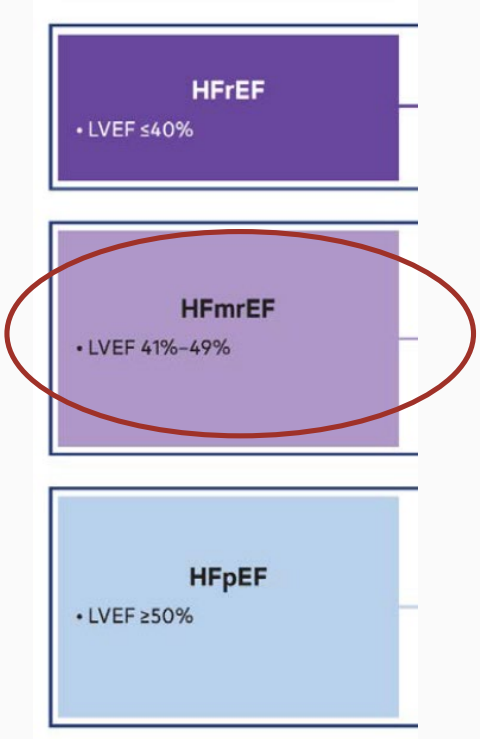
http://www.lhp.leedsth.nhs.uk/detail.aspx?id=6806

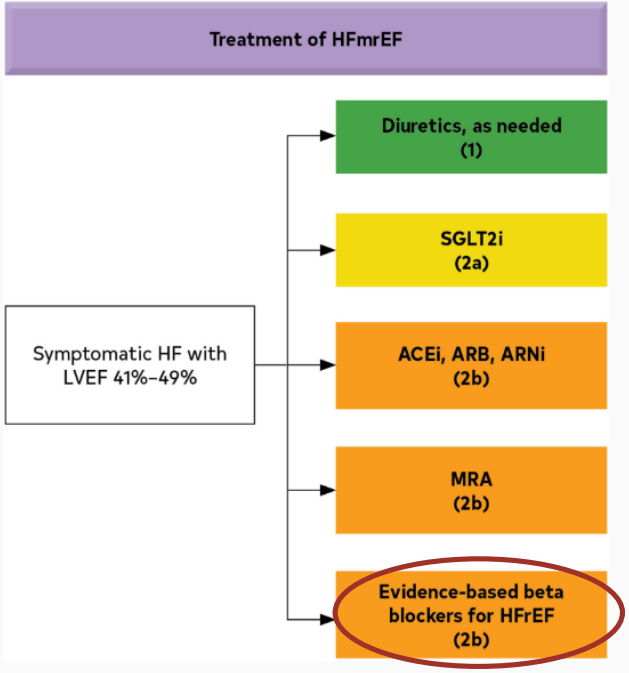
ltccn.vcu.edu

Heart Failure 2022 Guidelines

SGLT2 inhibitors have a 2a recommendation in heart failure with mildly reduced ejection fraction (HFmrEF).

Weaker recommendations (2b) are made for ARNi, ACEi, ARB, MRA and beta blockers in this population.



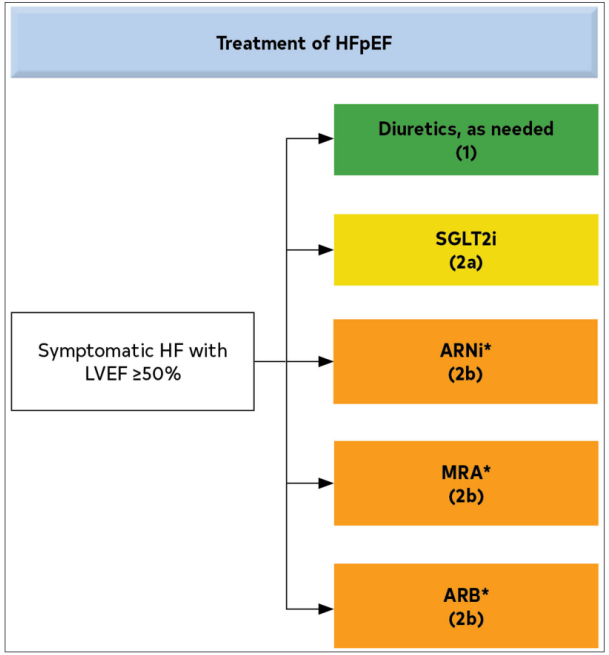


ltccn.vcu.edu

Heart Failure 2022 Guidelines – Top 10

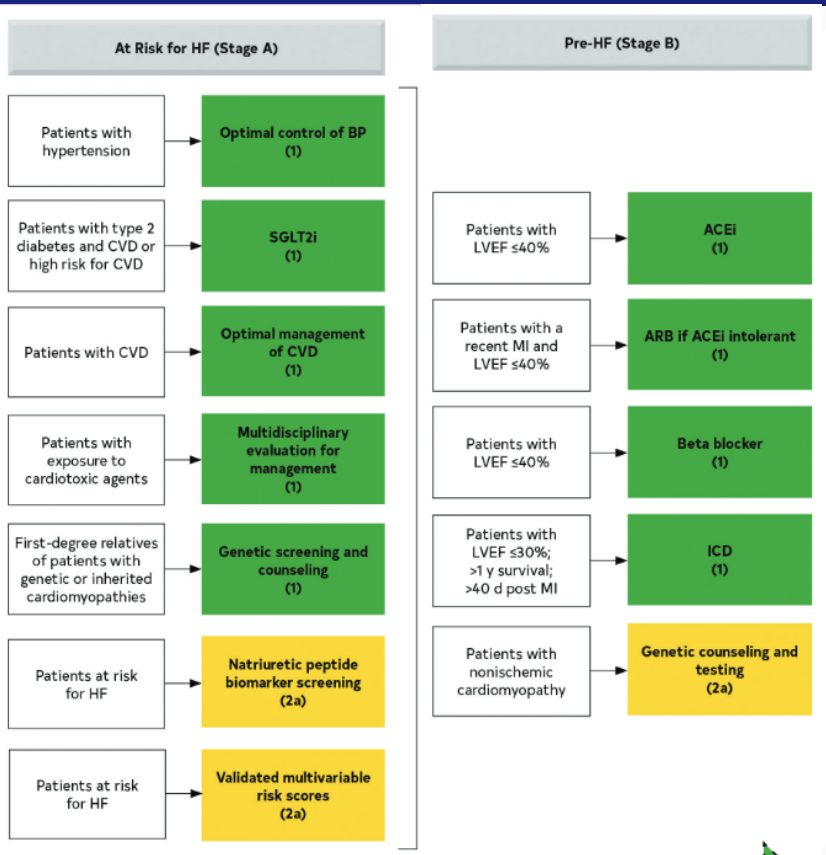
New recommendations for HFpEF are made for SGLT2 inhibitors (2a) , MRAs (2b)
ARNi (2b).

Several prior recommendations have been renewed including treatment of hypertension (1), treatment of atrial fibrillation (2a), use of ARBs (2b) avoidance of routine use of nitrates or phosphodiesterase-5 inhibitors (3-no Benefit).



ltccn.vcu.edu

Heart Failure 2022 Guidelines – Other Diagrams



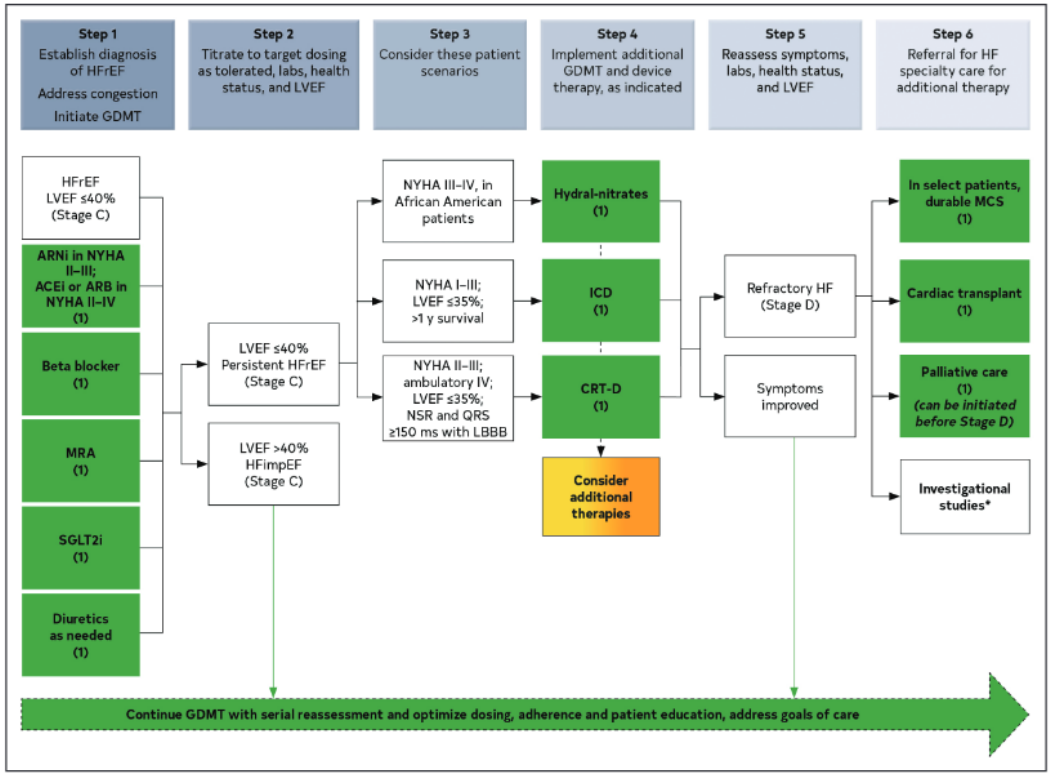


Figure 6. Treatment of HFrEF Stages C and D.

Heart Failure 2022 Guidelines – Other Diagrams

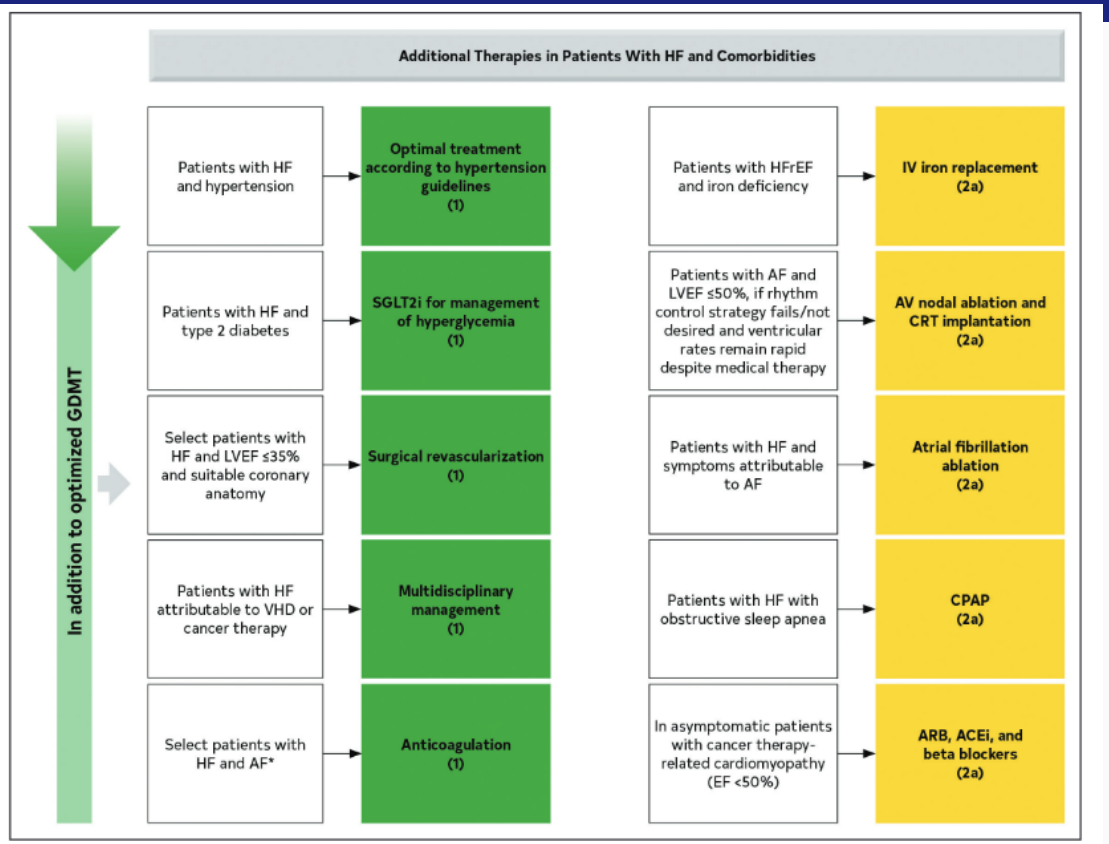


Figure 14. Recommendations for Treatment of Patients With HF and Selected Comorbidities.

ltccn.vcu.edu

Heart Failure 2022 Guidelines – Other Diagrams

Table 25. Important Components of a Transitional Care Plan

A transitional care plan, communicated with the patient and their outpatient clinicians before hospital discharge, should clearly outline plans for:
Addressing any precipitating causes of worsening HF identified in the hospital;
Adjusting diuretics based on volume status (including weight) and electrolytes;
Coordination of safety laboratory checks (eg, electrolytes after initiation or intensification of GDMT);
Further changes to optimize GDMT, including: Plans for resuming medications held in the hospital; Plans for initiating new medications; Plans for titration of GDMT to goal doses as tolerated;
Reinforcing HF education and assessing compliance with medical therapy and lifestyle modifications, including dietary restrictions and physical activity;
Addressing high-risk characteristics that may be associated with poor post-discharge clinical outcomes, such as: Comorbid conditions (eg, renal dysfunction, pulmonary disease, diabetes, mental health, and substance use disorders); Limitations in psychosocial support; Impaired health literacy, cognitive impairment;
Additional surgical or device therapy, referral to cardiac rehabilitation in the future, where appropriate;
Referral to palliative care specialists and/or enrollment in hospice in selected patients.

GDMT indicates guideline-directed medical therapy; and HF, heart failure.

HF-DMP Study – Colorado/Cleveland, published 2021 J AMDA

Objective: Patients discharged from the hospital to a skilled nursing facility (SNF) are not typically part of a heart failure disease management program (HF-DMP). The objective of this study is to determine if an HF-DMP in SNF improves outcomes for patients with HF.

Design: Cluster-randomized controlled trial.

Participants: The trial was conducted in 47 SNFs, and 671 patients were enrolled (329 HF-DMP; 342 to usual care).

Methods: The HF-DMP included documentation of ejection fraction, symptoms, weights, diet, medication optimization, education, and 7-day visit post SNF discharge. The composite outcome was all-cause hospitalization, emergency department visits, or mortality at 60 days. Secondary outcomes included the composite endpoint at 30 days, change in the Kansas City Cardiomyopathy Questionnaire and the Self-care of HF Index at 60 days. Rehospitalization and mortality rates were calculated as an exploratory outcome.

Results: Mean age of the patients was 79 ± 10 years, 58% were women, and the mean ejection fraction was 51% ± 16%. At 30 and 60 days post SNF admission, the composite endpoint was not significant between DMP (29%) and usual care (32%) at 30 days and 60 days (43% vs 47%, respectively). The Kansas City Cardiomyopathy Questionnaire significantly improved in the HF-DMP vs usual care for the Physical Limitation (11.3 ± 2.9 vs 20.8 ± 3.6; $P = .039$) and Social Limitation subscales (6.0 ± 3.1 vs 17.9 ± 3.8; $P = .016$). Self-care of HF Index was not significant. The total number of events (composite endpoint) totaled 517 (231 in HF-DMP and 286 in usual care). Differences in the 60-day hospitalization rate [mean HF-DMP rate 0.43 (SE 0.03) vs usual care 0.54 (SE 0.05), $P = .04$] and mortality rate (HF-DMP 5.2% vs usual care 10.8%, $P < .001$) were significant.

Conclusions and Implications: The composite endpoint was high for patients with HF in SNF regardless of group. Rehospitalization and mortality rates were reduced by the HF-DMP. HF-DMPs in SNFs may be beneficial to the outcomes of patients with HF. SNFs should consider structured HF-DMPs for their patients.

1. Boxer RS, Dolansky MA, Chaussee EL, Campbell JD, Daddato AE, Page RL 2nd, Fairclough DL, Gravenstein S. A Randomized Controlled Trial of Heart Failure Disease Management in Skilled Nursing Facilities. J Am Med Dir Assoc. 2022 Mar;23(3):359-366. doi: 10.1016/j.jamda.2021.05.023. Epub 2021 Jun 16. PMID: 34146521.

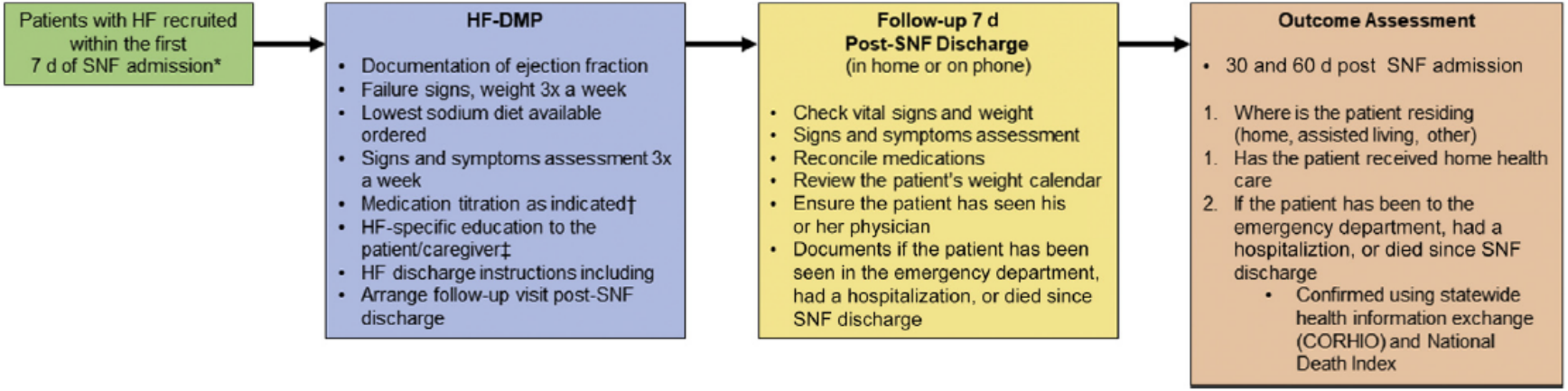
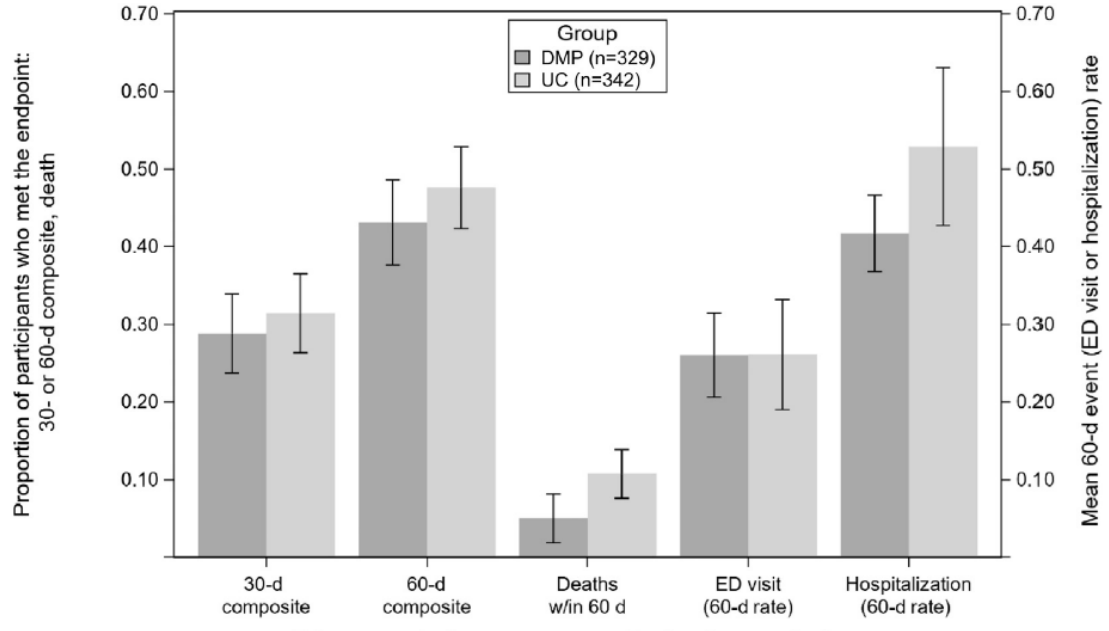


Fig. 1. Overview of SNF Connect intervention, the HF -DMP, follow-up, and collection of outcomes. NYHA, New York Heart Association; PCP, primary care physician; CORHIO, Colorado Regional Health Information Organization. *The 7-day time frame allowed the best chance for successful informed consent. †Medication titration was tailored to HF with reduced ejection fraction or HF with preserved ejection fraction according to the HF Guidelines. Loop diuretics were titrated throughout the SNF stay based on weight. Medication titration recommendations according to pre-established protocols for angiotensin-converting enzyme inhibitors (ACE-Is), angiotensin receptor blockers (ARBs), and beta blockers for those with HF with reduced ejection fraction and a loop diuretic protocol for weight gain (a gain of 3 lb in 3 days or 5 lb in a week) and blood pressure protocol regardless of ejection fraction. The clinician was prompted by the nurse but made his or her own clinical decision if he or she would like to initiate a medication protocol. ‡HF self-management education for 5 sessions using the teach-back method: (a) recognizing signs and symptoms of HF, (b) daily weight monitoring and documenting it on a calendar and how to compare weight trends, (c) recognizing and understanding HF medication, (d) following a low sodium diet, and (e) when to call the doctor.[15,16].

1. Boxer RS, Dolansky MA, Chaussee EL, Campbell JD, Daddato AE, Page RL 2nd, Fairclough DL, Gravenstein S. A Randomized Controlled Trial of Heart Failure Disease Management in Skilled Nursing Facilities. J Am Med Dir Assoc. 2022 Mar;23(3):359-366. doi: 10.1016/j.jamda.2021.05.023. Epub 2021 Jun 16. PMID: 34146521.



Met endpoint (n)	95	108	142	163	17	37				
Proportion	0.28	0.31	0.43	0.47	0.05	0.10				
Total ED/Hosp							83	85	131	164
60-day rate							0.26	0.26	0.41	0.52
Lower CL	0.23	0.26	0.37	0.42	0.01	0.07	0.20	0.19	0.36	0.42
Upper CL	0.33	0.36	0.48	0.52	0.08	0.13	0.31	0.33	0.46	0.63
P value	.45		.24		.016		.98		.039	

Fig. 2. Outcomes from Heart Failure Disease Management Program vs usual care in SNFs. The left side of the figure shows the primary composite outcome (rehospitalization, ED visit, and mortality) at 30 and 60 days post SNF admission. The right side of the figure shows exploratory analysis of the rates of ED visits and rehospitalizations at 60 days. CL, confidence limit; ED, emergency department; Hosp, hospitalization; UC, usual care.

1. Boxer RS, Dolansky MA, Chaussee EL, Campbell JD, Daddato AE, Page RL 2nd, Fairclough DL, Gravenstein S. A Randomized Controlled Trial of Heart Failure Disease Management in Skilled Nursing Facilities. J Am Med Dir Assoc. 2022 Mar;23(3):359-366. doi: 10.1016/j.jamda.2021.05.023. Epub 2021 Jun 16. PMID: 34146521.

Table 2
Fidelity of HF-DMP

HF-DM in SNF	Component	Description	Eligible, n	Met Requirement, n (%)
Clinical Care	Documentation of ejection fraction	Ejection fraction documented	329	306 (93.0)
	Sign and symptom assessment	Blood pressure taken at every study visit	306*	257 (84.0)
		Signs and symptoms documented at every study visit	306*	255 (83.3)
	Daily weights and dietary surveillance	Diet documented at every study visit	306*	283 (92.5)
		Weight taken at every study visit	306*	160 (52.3)
	Medication titration	Medication recommendation followed	98†	34 (34.7)
		Medication recommendation not followed but clinician reason reported	64‡	42 (65.6)
Discharge Care	Patient and caregiver education	At least 1 education module completed	272§	253 (93.0)
		All 5 education modules completed	154‖	112 (72.7)
	Discharge instructions	Personalized discharge instructions reviewed	278**	177 (63.7)
	Follow-up visit 7 d post SNF discharge	Physician follow-up visit scheduled	278**	167 (60.1)
		Nurse follow-up visit completed	278**	101 (36.3)

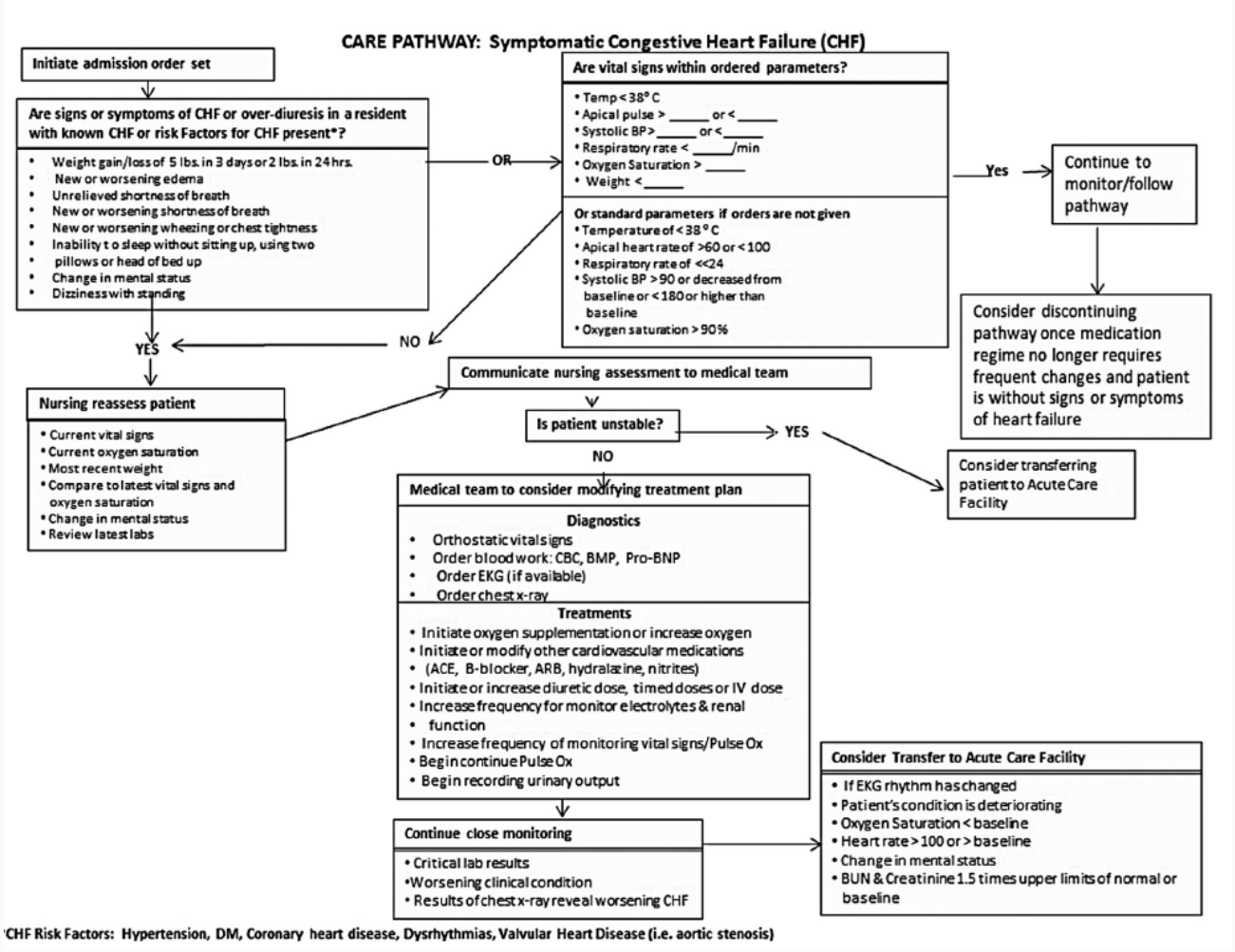
The HF-DMP required that the nurse delivered the repetitive intervention components such as blood pressure, symptom assessment, weight 3 times in 7 days.
Overall, n = 329 participants in the HF-DMP arm of SNF Connect.

1. Boxer RS, Dolansky MA, Chaussee EL, Campbell JD, Daddato AE, Page RL 2nd, Fairclough DL, Gravenstein S. A Randomized Controlled Trial of Heart Failure Disease Management in Skilled Nursing Facilities. J Am Med Dir Assoc. 2022 Mar;23(3):359-366. doi: 10.1016/j.jamda.2021.05.023. Epub 2021 Jun 16. PMID: 34146521.

J-CHiP Study – Hopkins, published 2023 J AMDA

Objectives: This study evaluated the impact of standardized care protocols, as a part of a quality improvement initiative (J10ohns Hopkins Community Health Partnership, J-CHiP), on hospital readmission rates for patients with a diagnosis of congestive heart failure (CHF) and/or chronic obstructive pulmonary disease (COPD) after being discharged to skilled nursing facilities (SNFs).
Design: A retrospective study comparing 30-day hospital readmission rates the year before and 2 years following the implementation of the care protocol interventions.
Settings and Participants: Patients discharged from Johns Hopkins Hospital or Johns Hopkins Bayview Medical Center to the participating SNFs diagnosed with CHF and/or COPD.
Methods: The standardized protocols included medical provider or nurse assessments on SNF admission, multidisciplinary care planning, and medication management to avoid unplanned readmissions to the hospital. Descriptive analyses were conducted to illustrate the 30-day readmission rates before and after protocol implementation.
Results: There were 1128 patients in the pre-J-CHiP cohort and 2297 patients in the J-CHiP cohort. About half of the patients with a recorded diagnosis of CHF without COPD had the standardized protocol initiated, whereas 47% of the patients with a recorded diagnosis of COPD without CHF had the standardized protocol initiated. Of patients with recorded diagnoses of COPD and CHF, 49% had both protocols initiated. A reduction in the readmission rate was observed for patients with COPD protocols, from 23.5% in 2011 to 12.1% in 2015. However, fluctuations in the readmission rates were observed for patients who initiated the CHF protocols.

1. Hsiao YL, Bass EB, Wu AW, Kelly D, Sylvester C, Berkowitz SA, Bellantoni M; Johns Hopkins Community Health Partnership (J-CHiP) Team. Preventing Avoidable Rehospitalizations through Standardizing Management of Chronic Conditions in Skilled Nursing Facilities. J Am Med Dir Assoc. 2023 Dec;24(12):1910-1917.e3. doi: 10.1016/j.jamda.2023.08.010. Epub 2023 Sep 7. PMID: 37690461.



1. Hsiao YL, Bass EB, Wu AW, Kelly D, Sylvester C, Berkowitz SA, Bellantoni M; Johns Hopkins Community Health Partnership (J-CHiP) Team. Preventing Avoidable Rehospitalizations through Standardizing Management of Chronic Conditions in Skilled Nursing Facilities. J Am Med Dir Assoc. 2023 Dec;24(12):1910-1917.e3. doi: 10.1016/j.jamda.2023.08.010. Epub 2023 Sep 7. PMID: 37690461.

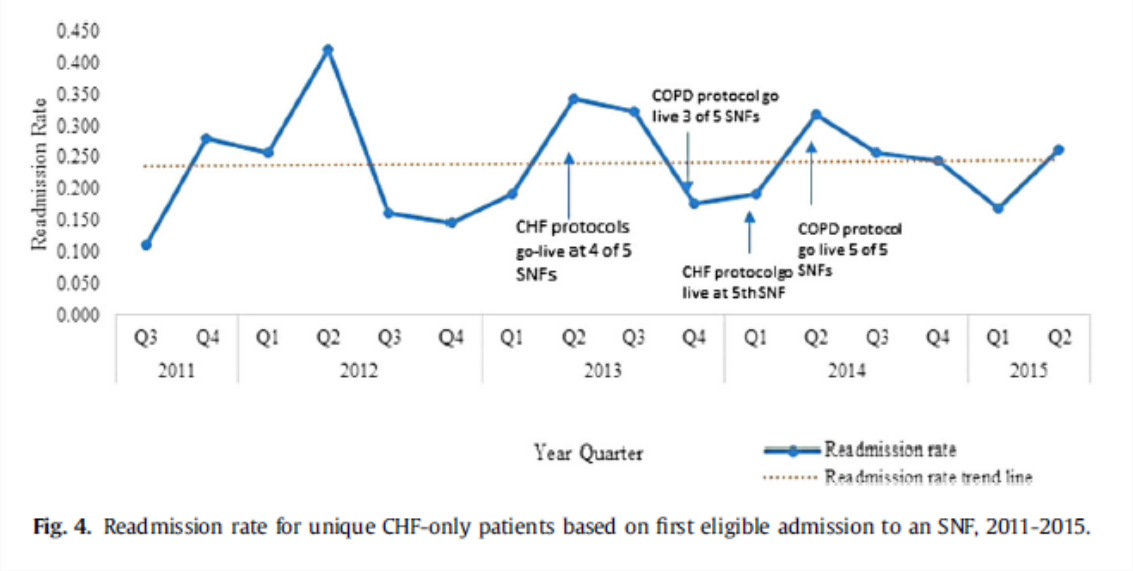
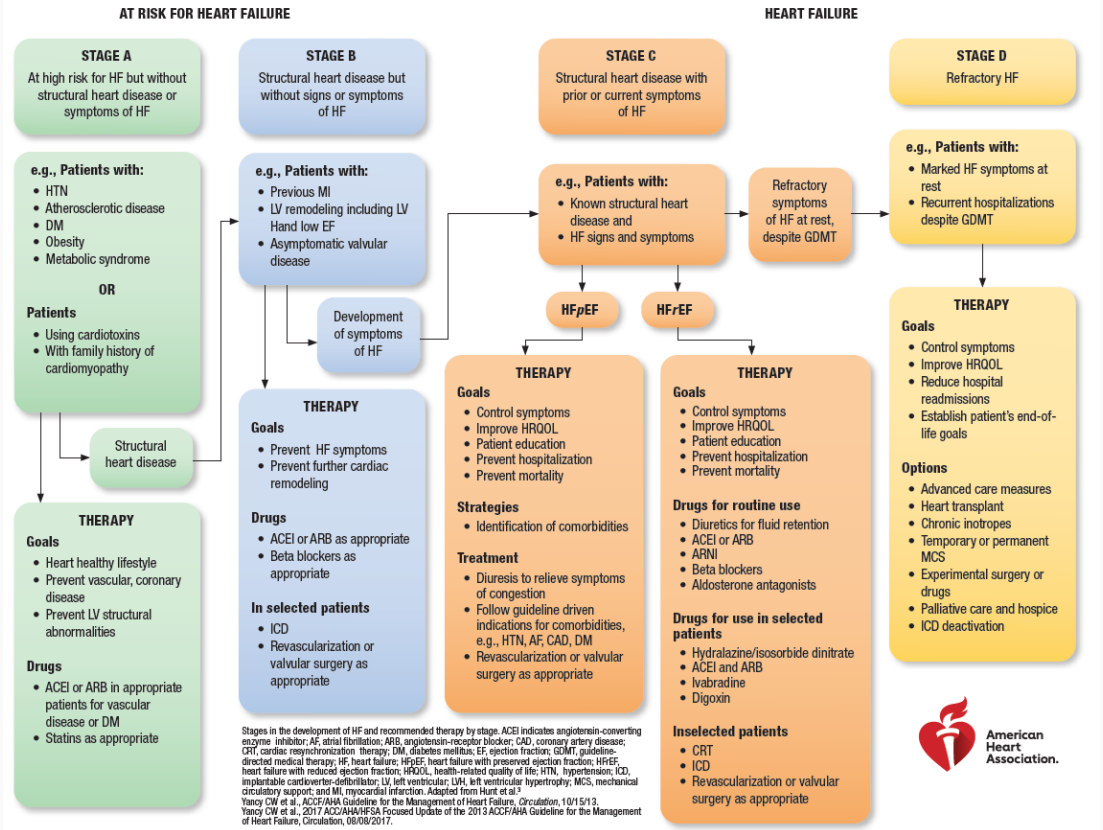


Fig. 4. Readmission rate for unique CHF-only patients based on first eligible admission to an SNF, 2011-2015.

"Reducing 30-day readmissions for patients with CHF and COPD is an ongoing process for hospitals and SNFs in the United States. Partnerships between hospitals and SNFs can improve transitions in care and reduce hospital readmissions. A key implication of the collaborative is the implementation of standardized care protocols and having a nurse educator train SNF staff on the deployment of the protocols and working on-site with SNF staff to monitor patients and track adherence. During the intervention, the nurse educator communicated with the hospital and SNF teams to agree on a care plan with the protocols when the patient is discharged to the SNF.
…Integrated into the EMRs"

1. Hsiao YL, Bass EB, Wu AW, Kelly D, Sylvester C, Berkowitz SA, Bellantoni M; Johns Hopkins Community Health Partnership (J-CHiP) Team. Preventing Avoidable Rehospitalizations through Standardizing Management of Chronic Conditions in Skilled Nursing Facilities. J Am Med Dir Assoc. 2023 Dec;24(12):1910-1917.e3. doi: 10.1016/j.jamda.2023.08.010. Epub 2023 Sep 7. PMID: 37690461.

AHA Resources – Stages of HF



Stages in the development of HF and recommended therapy by stage. ACEI indicates angiotensin-converting enzyme inhibitor; AF, atrial fibrillation; ARB, angiotensin-receptor blocker; CAD, coronary artery disease; CRT, cardiac resynchronization therapy; DM, diabetes mellitus; EF, ejection fraction; GDMT, guideline-directed medical therapy; HF, heart failure; HFpEF, heart failure with preserved ejection fraction; HFrEF, heart failure with reduced ejection fraction; HRQOL, health-related quality of life; HTN, hypertension; ICD, implantable cardioverter-defibrillator; LV, left ventricular; LVH, left ventricular hypertrophy; MCS, mechanical circulatory support; and MI, myocardial infarction. Adapted from Hunt et al.[3]

Yancy CW et al., ACCF/AHA Guideline for the Management of Heart Failure, *Circulation*, 10/15/13.
Yancy CW et al., 2017 ACC/AHA/HFSA Focused Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure, Circulation, 08/08/2017.

Heart.org/HFGuidelinesToolkit

ltccn.vcu.edu

AHA Resources - Checklist

The following checklist is intended to assist healthcare providers in reducing the risk of readmission for patients with heart failure transitioning to home care. Use this checklist to ensure that your patient/caregiver understands the discharge instructions and has the ability to perform self-care.

Medication Management

- ☐ Was a prescription given?
- ☐ Is the patient/caregiver able to get the prescription filled?
- ☐ Is the prescribed medication listed on patient's insurance formulary?
- ☐ Were medications and instructions on how to take them listed for the patient?
- ☐ Are there any known adverse reactions to the medications?
- ☐ Was a list with instructions on how to take the medications provided to a caregiver?
- ☐ Does the patient/caregiver understand the importance of medication adherence?

Self-Management

- ☐ Does the patient have access to transportation?
- ☐ Does the patient have financial barriers?
- ☐ Does the patient have language barriers?
- ☐ Is the patient able to perform care?
- ☐ Does the patient understand and know how to recognize new or worsening signs and symptoms of HF?

Will the patient be able to adhere to:

- ☐ Medication regimen?
- ☐ Low-sodium diet?
- ☐ Daily weigh-in?
- ☐ Exercise/activity plan or recommendation to participate in cardiac rehab?
- ☐ Monitoring new or worsening signs or symptoms of HF?

Lack of Communication (pending diagnostic results not communicated with PCP)

- ☐ Was transition/discharge summary sent to Primary Care Provider?
- ☐ Did a PCP note at the time of transition that a provider had been found prior to discharge?

Referral/Outpatient Needs Process

- ☐ Was a referral noted?
- ☐ Was there a referral follow-up?
  Name: _____
- ☐ Was there a referral to an agency that was unable to meet individual needs?
  Name: _____
- ☐ Was there an unaddressed comorbidity?
- ☐ Was mobility/home safety assessed?

Heart.org/HFGuidelinesToolkit

ltccn.vcu.edu

AHA Resources – PAC HF Certification

REQUIREMENT NUMBER	POST-ACUTE CARE HEART FAILURE CERTIFICATION REQUIREMENT OVERVIEW	Skilled Nursing Facility
1	Program Management The post-acute care heart failure program defines its mission, goals, scope, and organizational structure. It identifies a heart failure program champion(s) and organizes an interprofessional committee which oversees the post-acute care heart failure program.	√
2	Personnel Education Staff have the education, experience and training for the monitoring and management of heart failure patients. The education program should be provided regularly and tailored to all levels of healthcare providers	√
3	Patient/Caregiver Education & Support The heart failure program provides the patient and caregiver individualized heart failure education and support	√
4	Care Coordination The program demonstrates care coordination across the system of care for the heart failure patient in three domains: pre-admission, throughout the patient's admission to the facility, and at discharge.	√
5	Clinical Management The heart failure program's ability to provide post-acute care to persons with a heart failure diagnosis.	√
6	Performance Improvement Ongoing quality improvement measuring adherence to evidence- based guidelines aimed at improving care and outcomes for heart failure patients in the post-acute setting.	√

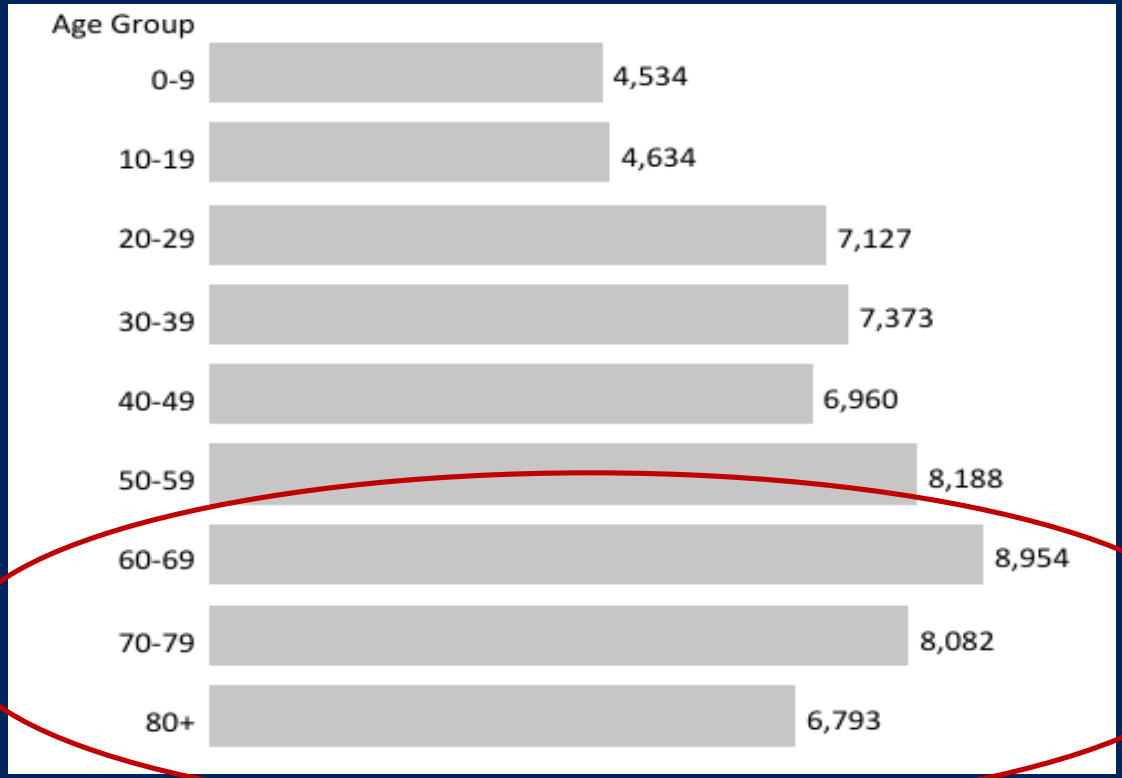
To learn more about Post-Acute Care Heart Failure Certification visit www.heart.org/certification or contact us at certification@heart.org

References

1. Albert NM, Barnason S, Deswal A, Hernandez A, Kociol R, Lee E, Paul S, Ryan CJ, White-Williams C; American Heart Association Complex Cardiovascular Patient and Family Care Committee of the Council on Cardiovascular and Stroke Nursing, Council on Clinical Cardiology, and Council on Quality of Care and Outcomes Research. Transitions of care in heart failure: a scientific statement from the American Heart Association. Circ Heart Fail. 2015 Mar;8(2):384-409. doi: 10.1161/HHF.0000000000000006. Epub 2015 Jan 20. PMID: 25604605.
2. Heidenreich PA, Bozkurt B, Aguilar D, Allen LA, Byun JJ, Colvin MM, Deswal A, Drazner MH, Dunlay SM, Evers LR, Fang JC, Fedson SE, Fonarow GC, Hayek SS, Hernandez AF, Khazanie P, Kittleson MM, Lee CS, Link MS, Milano CA, Nnacheta LC, Sandhu AT, Stevenson LW, Vardeny O, Vest AR, Yancy CW. 2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: Executive Summary: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. J Am Coll Cardiol. 2022 May 3;79(17):1757-1780. doi: 10.1016/j.jacc.2021.12.011. Epub 2022 Apr 1. PMID: 35379504.
3. Hsiao YL, Bass EB, Wu AW, Kelly D, Sylvester C, Berkowitz SA, Bellantoni M; Johns Hopkins Community Health Partnership (J-CHiP) Team. Preventing Avoidable Rehospitalizations through Standardizing Management of Chronic Conditions in Skilled Nursing Facilities. J Am Med Dir Assoc. 2023 Dec;24(12):1910-1917.e3. doi: 10.1016/j.jamda.2023.08.010. Epub 2023 Sep 7. PMID: 37690461.
4. Boxer RS, Dolansky MA, Chaussee EL, Campbell JD, Daddato AE, Page RL 2nd, Fairclough DL, Gravenstein S. A Randomized Controlled Trial of Heart Failure Disease Management in Skilled Nursing Facilities. J Am Med Dir Assoc. 2022 Mar;23(3):359-366. doi: 10.1016/j.jamda.2021.05.023. Epub 2021 Jun 16. PMID: 34146521.

COVID UPDATE

COVID Cases by Age Group in 35 Selected Districts VA Past 13 Weeks



Source: https://www.vdh.virginia.gov/coronavirus/see-the-numbers/covid-19-in-virginia/

COVID-19 Vaccine Effectiveness (VE)

- Monovalent mRNA vaccination was **76% effective in preventing COVID-19–associated invasive mechanical ventilation and death** up to 6 months after the last dose and remained 56% effective at 1–2 years. (Source)

- Among adults aged ≥18 years without immunocompromising conditions, **bivalent booster VE was sustained against critical COVID-19-associated outcomes,** including intensive care unit admission or death. (Source)

- **Among nursing home residents** who were up to date with COVID-19 vaccination (most had received a bivalent vaccine), **VE against SARS-CoV-2 infection was 31.2%**. (Source)

Source: https://covid.cdc.gov/covid-data-tracker/#vaccine-effectiveness

Open Forum

Share an idea. Anything you need help with? What's new in your Virginia Health District? Any announcements?

Chat Waterfall

Answer in chat, but do not press send until we count down:

As we enter state budget time, if you had all the money in the world, how would you improve where you work in LTC?

Monthly Forum - Every 3rd Wednesday, 4-5 PM

Forum topics will be in areas of interest to clinicians working in long term care. We will continue to integrate COVID-19 topics in our discussion. Share the membership QR code with your work colleagues so they can get a unique link.

Upcoming Forums

- January 17, 2024 **Trauma Informed Care**
- February 21, 2024 **COPD Update**

SCAN ME

ltccn.vcu.edu

Respiratory Virus Season Resources

CDC - Respiratory Virus Updates NEW updated 12/8

https://www.cdc.gov/respiratory-viruses/whats-new/index.html

- CDC posts weekly updates during respiratory illness season
- Includes links to: COVID Variant Proportions, COVID Data Tracker, Respiratory Virus Hospitalization Surveillance Network

VDH - Respiratory Diseases in Virginia - Epidemiology

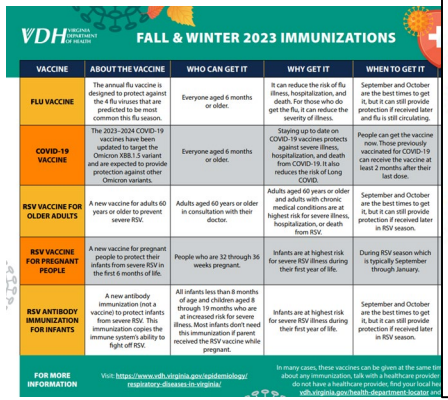
https://www.vdh.virginia.gov/epidemiology/respiratory-diseases-in-virginia/

- Landing page for COVID, Flu, and RSV

VDH - Respiratory Diseases Toolkit

https://www.vdh.virginia.gov/news/tool

- Flyers and Social Media Images
- Topics include Healthy Respiratory Habits, Symptom Comparison Chart, Fall & Winter Immunization Chart



Accreditation

	In support of improving patient care, VCU Health Continuing Education is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
	VCU Health designates this live activity for a maximum of ***1.00 AMA PRA Category 1 Credits***^{TM}. Physicians should claim only the credit commensurate with the extent of their participation in the activity.
	VCU Health Continuing Education designates this activity for a maximum of ***1.00 ANCC*** contact hours. Nurses should claim only the credit commensurate with the extent of their participation in the activity.
	VCU Health Continuing Education has been authorized by the American Academy of PAs (AAPA) to award AAPA Category 1 CME credit for activities planned in accordance with AAPA CME Criteria. This activity is designated for ***1.00 AAPA Category 1 CME credits***. PAs should only claim credit commensurate with the extent of their participation.

Disclosure of Financial Relationships

Disclosure of Commercial Support:

We acknowledge that no commercial or in-kind support was provided for this activity.

Claiming Credit

Submit Attendance

1. *If you have **not participated in a VCU Health CE program** in the past:*
   a. Go to vcu.cloud-cme.com to create an account – make sure to add your cell phone number
2. Once you have registered or if you **have participated before:**
   a. Text the course code to (804) 625-4041.
   b. The course code for today's event is: **#####** (please note this is only active for 5 days)

Complete Evaluation & Claim Credit, within 60 days of the event

1) Go to https://vcu.cloud-cme.com
2) Sign in using email address used above
3) Click "My CE"
4) Click "Evaluations and Certificates"

OR

1) Open the CloudCME app on your device
2) Click "My Evaluations"
3) Click the name of the activity to complete evaluation

Need help? ceinfo@vcuhealth.org

ltccn.vcu.edu

Thank you for joining us!

Next Newsletter - coming to you in FEBRUARY (date change)

Next Monthly Forum - January 17, 4pm. Scroll down in the Zoom registration confirmation email you received today for a calendar link you can use to update your calendar automatically with your Zoom link for future meetings.

On your way out of Zoom, kindly answer a brief feedback survey.

Stay in touch! Email us at ltccn@vcu.edu

Invite your colleagues! They can register at ltccn.vcu.edu

Disclosures

The speakers and presenters for today have no relevant financial conflicts of interest.

Funding Disclosure: This work is supported by the Virginia Department of Health, Office of Epidemiology, Division of Healthcare-Associated Infections (HAI) and Antimicrobial Resistance (AR) Program and the Centers for Disease Control and Prevention, Epidemiology and Laboratory Capacity (ELC) Program under federal award number NU50CK000555 and state subrecipient number VCULTC603GY23 in the amount of $820,002. The content presented is solely the responsibility of the authors and does not necessarily represent the official views of the Centers for Disease Control, the Virginia Department of Health, or Virginia Commonwealth University.

Virginia Long-Term Care Infrastructure Pilot Project (VLIPP) funding will be utilized in nursing homes and long-term care facilities to assist with the ongoing COVID-19 response and to bolster preparedness for emerging infections. The projects are based on identified needs that align with funding objectives