

Spectrum of Health

Dear Colleague:

The American College of Cardiology Foundation and the American Heart Association (ACCF/AHA) state that 25% of patients hospitalized with heart failure will be readmitted within one month. Healthfirst sees this as an opportunity to implement an effective treatment plan and achieve control for those with heart failure (HF). Often, a patient's perception of well-being is directly related to how they feel physically. A lack of discomfort produces a false sense of security, and intervention becomes necessary because the patient is unaware of the danger and of how the choices they make contribute to exacerbating their condition.

As I visit and meet with you and your staff, I know this is a priority for you as well. Caring for our members living with HF requires collaboration and a multidisciplinary approach, with the central focus remaining on strict adherence to the ACCF/AHA Practice Guidelines for the Management of Heart Failure. Join with Healthfirst as we focus on optimizing health outcomes for our patients with HF by addressing domains of effective HF management:

Assessment, management, and monitoring of HF severity and control according to HF stage

- Stages C and D require extra attention to evidence-based interventions to avoid further deterioration
- Assess your patient's understanding of their condition and what factors (e.g., high sodium, sugary beverages, etc.) might cause an exacerbationⁱ
- Ensure comprehension of self-management skills and take into account cultural variation
- Provide a follow-up telephone call and/or scheduled visit within seven to 14 days of hospital discharge and during periods when patients are unstable
- If a life-threatening event or hospitalization occurs, referral to a cardiologist is recommended

Relate that the effective management of his/her condition relies on a cooperative approach between cardiologist, primary care physician, and patient

Control comorbid conditions (i.e., CAD, diabetes, COPD, etc.) that affect patients with HF

HF Medication Management

- Optimize therapy for each patient population according to ACCF/AHA classification. For example, although Class II-IV, loop diuretics in addition to an ACE or ARB and beta blocker is recommended, African Americans categorized as Class III-IV benefit from hydralazine isorbide dinitrate (BiDil), in addition to an ACE and beta blocker
- Ensure that only approved beta blockers for HF treatment are dispensed: bisoprolol, metoprolol succinate, and carvedilol

AVOID harmful medications and sudden treatment adjustments

- Carefully coordinate medications, post-discharge, with the cardiology team
- For example, "down-titrating medications" during the 30 days' post-discharge can often result in readmissions to the emergency department and/or hospital

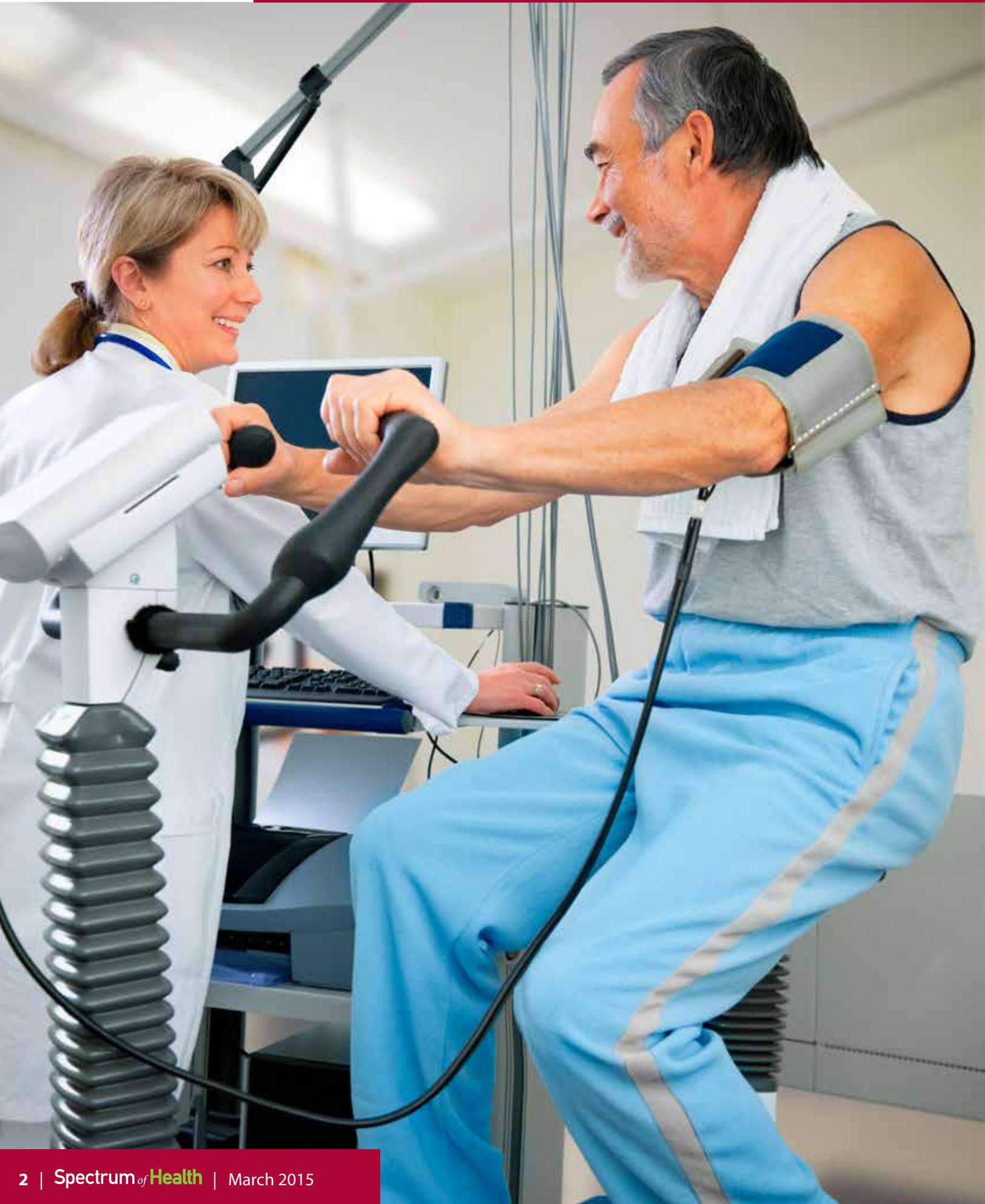
This Healthfirst Spectrum of Health bulletin contains a summary of the current 2013 ACCF/AHA Practice Guidelines for the Management of Heart Failure.

Contact me or the Healthfirst Care Management team if we can be of assistance as you promote optimal health outcomes for your patients.

Warm regards,

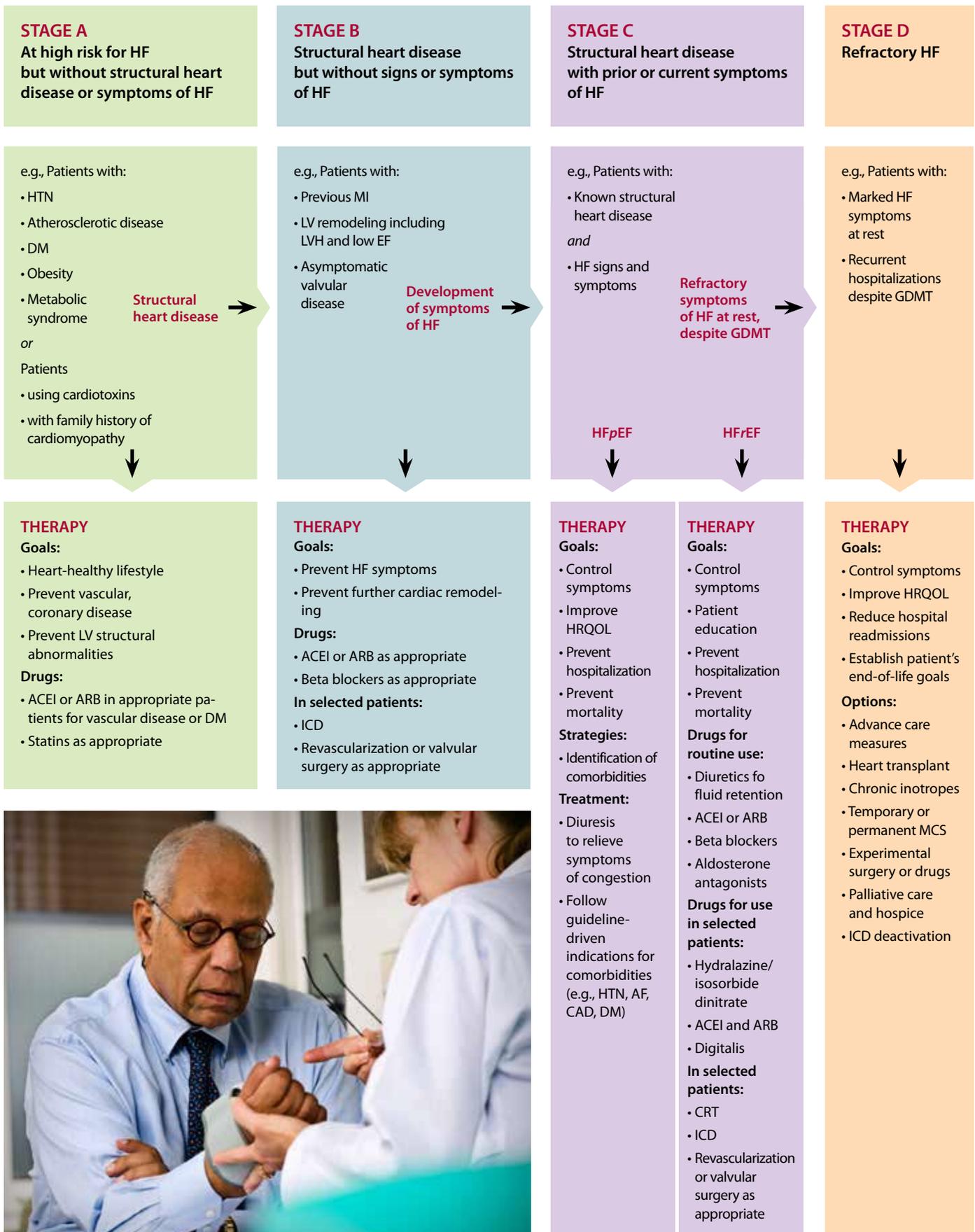


Susan J. Beane, M.D.
VP, Medical Director
Healthfirst
1-212-823-2437
sbeane@healthfirst.org



At Risk for Heart Failure

Heart Failure



2013 ACCF/AHA Guideline for the Management of Heart Failure: Executive Summary

A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines

Definitions of HFrEF and HFpEF

Classification	EF (%)	Description
I. Heart failure with reduced ejection fraction (HFrEF)	≤40	Also referred to as systolic HF. Randomized controlled trials have mainly enrolled patients with HFrEF, and it is only in these patients that efficacious therapies have been demonstrated to date.
II. Heart failure with preserved ejection fraction (HFpEF)	≥50	Also referred to as diastolic HF. Several different criteria have been used to further define HFpEF. The diagnosis of HFpEF is challenging because it is largely one of excluding other potential noncardiac causes of symptoms suggestive of HF. To date, efficacious therapies have not been identified.
a. HFpEF, borderline	41 to 49	These patients fall into a borderline or intermediate group. Their characteristics, treatment patterns, and outcomes appear similar to those of patients with HFpEF.
b. HFpEF, improved	>40	It has been recognized that a subset of patients with HFpEF previously had HFrEF. These patients with improvement or recovery in EF may be clinically distinct from those with persistently preserved or reduced EF. Further research is needed to better characterize these patients.

EF indicates ejection fraction; HF, heart failure; HFpEF, heart failure with preserved ejection fraction; and HFrEF, heart failure with reduced ejection fraction.

Comparison of ACCF/AHA Stages of HF and NYHA Functional Classifications

ACCF/AHA Stages of HF (37)	NYHA Functional Classification (38)	
A. At high risk for HF but without structural heart disease or symptoms of HF	None	
B. Structural heart disease but without signs or symptoms of HF	I	No limitation of physical activity. Ordinary physical activity does not cause symptoms of HF.
C. Structural heart disease with prior or current symptoms of HF	I	No limitation of physical activity. Ordinary physical activity does not cause symptoms of HF.
	II	Slight limitation of physical activity. Comfortable at rest, but ordinary physical activity results in symptoms of HF.
	III	Marked limitation of physical activity. Comfortable at rest, but less than ordinary activity causes symptoms of HF.
	IV	Unable to carry on any physical activity without symptoms of HF, or symptoms of HF at rest.
D. Refractory HF requiring specialized interventions	IV	Unable to carry on any physical activity without symptoms of HF, or symptoms of HF at rest.

ACCF indicates American College of Cardiology Foundation; AHA, American Heart Association; HF, heart failure; and NYHA, New York Heart Association.

Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA Guideline for the Management of Heart Failure: Executive Summary: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol.* 2013;62(16):1495-1539. doi:10.1016/j.jacc.2013.05.020.

ACCF/AHA/AMA-PCPI 2011 HF Measurement Set

Measure	Description*	Care Setting	Level of Measurement
1. LVEF assessment	Percentage of patients \geq 18 yrs. with a diagnosis of HF for whom the quantitative or qualitative results of a recent or prior (any time in the past) LVEF assessment is documented within a 12-mo. period.	Outpatient	Individual practitioner
2. LVEF assessment	Percentage of patients \geq 18 yrs. with a principal discharge diagnosis of HF with documentation in the hospital record of the results of an LVEF assessment performed either before arrival or during hospitalization, OR documentation in the hospital record that LVEF assessment is planned for after discharge.	Inpatient	<ul style="list-style-type: none"> • Individual practitioner • Facility
3. Symptom and activity assessment	Percentage of patient visits for patients \geq 18 yrs. with a diagnosis of HF with quantitative results of an evaluation of both current level of activity and clinical symptoms documented.	Outpatient	Individual practitioner
4. Symptom management [†]	Percentage of patient visits for patients \geq 18 yrs. with a diagnosis of HF and with quantitative results of an evaluation of both level of activity AND clinical symptoms documented in which patient symptoms have improved or remained consistent with treatment goals since last assessment OR patient symptoms have demonstrated clinically important deterioration since last assessment with a documented plan of care.	Outpatient	Individual practitioner
5. Patient self-care education ^{†‡}	Percentage of patients aged \geq 18 yrs. with a diagnosis of HF who were provided with self-care education on \geq 3 elements of education during \geq 1 visits within a 12-mo. period.	Outpatient	Individual practitioner
6. Beta-blocker therapy for LVSD (outpatient and inpatient setting)	Percentage of patients aged \geq 18 yrs. with a diagnosis of HF with a current or prior LVEF $<$ 40% who were prescribed beta-blocker therapy with bisoprolol, carvedilol, or sustained-release metoprolol succinate either within a 12-mo. period when seen in the outpatient setting or at hospital discharge.	Inpatient and outpatient	<ul style="list-style-type: none"> • Individual practitioner • Facility
7. ACE inhibitor or ARB therapy for LVSD (outpatient and inpatient setting)	Percentage of patients aged \geq 18 yrs. with a diagnosis of HF with a current or prior LVEF $<$ 40% who were prescribed ACE inhibitor or ARB therapy either within a 12-mo. period when seen in the outpatient setting or at hospital discharge.	Inpatient and outpatient	<ul style="list-style-type: none"> • Individual practitioner • Facility
8. Counseling about ICD implantation for patients with LVSD on combination medical therapy [‡]	Percentage of patients aged \geq 18 yrs. with a diagnosis of HF with current LVEF \leq 35% despite ACE inhibitor/ARB and beta-blocker therapy for at least 3 mos. who were counseled about ICD placement as a treatment option for the prophylaxis of sudden death.	Outpatient	Individual practitioner
9. Postdischarge appointment for HF patients	Percentage of patients, regardless of age, discharged from an inpatient facility to ambulatory care or home healthcare with a principal discharge diagnosis of HF for whom a follow-up appointment was scheduled and documented, including location, date, and time for a follow-up office visit or home health visit (as specified).	Inpatient	Facility

N.B.: Regarding test measure no. 8, implantation of an ICD must be consistent with published guidelines. This measure is intended to promote counseling only.

* Refer to the complete measures for comprehensive information, including measure exception.

[†] Test measure designated for use in internal quality improvement programs only. These measures are not appropriate for any other purpose (e.g., pay for performance, physician ranking, or public reporting programs).

[‡] New measure.

ACCF indicates American College of Cardiology Foundation; ACE, angiotensin-converting enzyme; AHA, American Heart Association; AMA-PCPI, American Medical Association-Physician Consortium for Performance Improvement; ARB, angiotensin-receptor blocker; HF, heart failure; ICD, implantable cardioverter-defibrillator; LVEF, left ventricular ejection fraction; and LVSD, left ventricular systolic dysfunction.

Frequently Asked Questions About Improving Outcomes for Heart Failure

1. Metoprolol succinate (Toprol XL) is considered an acceptable beta blocker to treat Heart Failure. What about metoprolol tartrate (Lopressor)?

These two salt forms are commonly mistaken for one another in the treatment of HF, but it should be noted that the TARTRATE form is NOT recommended. Only metoprolol succinate (Toprol XL) should be prescribed to patients with Heart Failure.

2. a. Supplements

In patients with current or prior symptoms, vitamins, nutritional, and/or hormonal supplements failed to show any benefit.

Exception: Omega-3 fatty acids as adjunctive therapy in treating CVD for HF NYHA Class II-IV showed a 10%–20% risk reduction in fatal and nonfatal cardiovascular events.

b. Antiarrhythmic

Show an increase in mortality in HF populations, particularly Classes I & III, due to their inotropic effects.

Exception: *Amiodarone & Dofetilide* have neutral effects on mortality and are the only recommended drugs for treatment of arrhythmias in Heart Failure.

c. Calcium channel blockers (CCBs)

In general, CCBs should be avoided due to their myocardial depressant activity.

Exception: *Amlodipine* is an acceptable treatment option to manage hypertension or ischemic heart disease.

d. Nonsteroidal anti-inflammatory drugs

Both selective and nonselective NSAIDs should be avoided due to their salt- and water-retaining effects on the body, which blunt the effect of diuretics.

e. Thiazolidinediones

Associated with Heart Failure events in patients with or without prior history of clinical Heart Failure.

3. How can I access a quick reference version of the NYS Department of Health HF Management Guidelines?

You may find the guidelines at <http://on.ny.gov/1HV5C5c>.

4. My patient is homebound. What can I do?

If the patient is frail, homebound, and unable to make regular office visits, Healthfirst has available care managers to assist patients in getting the help they need. You may contact our Care Management department at 1-888-394-4327, Monday–Friday, 8am–6pm.

5. I do have a few patients who seem to end up in the emergency room, or have even been admitted to the hospital, in spite of everything I’ve tried. What do you suggest?

Healthfirst encourages you to utilize a cardiologist to support you in managing patients with complex needs, such as:

- Emergency room visits
- Hospitalization (whether or not there was a need for ICU)
- Lack of control in spite of following the recommendations

6. Does Healthfirst have tools that can assist me in explaining HF and HF care to my patients in language that they can understand?

Yes. Our website provides helpful tools for you and your patients. The patient handouts are available in English, Spanish, and Chinese at www.healthfirst.org/live-healthy/?flp=84&slp=109 (please see pages 7 and 8 for excerpts from our “Understanding Congestive Heart Failure” brochure).

7. How can Healthfirst assist me with members who may have other challenges, such as housing, smoking, or difficulty coordinating with the school nurse?

Please reach out to our Healthfirst Spectrum Care Management team by calling our toll-free number at 1-866-237-0997.

ⁱ Go AS, Mozaffarian D, Roger VL, et al; Heart disease and stroke statistics—2013 update: a report from the American Heart Association. *Circulation*. 2013;127:e6-245.

ⁱⁱ Ibid (adapted from Bonow RO, Ganiats TG, Beam CT, et al. ACCF/AHA/AMA-PCPI 2011 performance measures for adults with heart failure: a report of the ACCF/AHA Task Force on Performance Measures (Writing Committee to Develop Performance Measures for Heart Failure). *J. Am. Coll. Cardiol*. 2012; 59:1812–32. Accessed March 25, 2015.

Excerpts from Healthfirst's "Understanding Congestive Heart Failure (CHF) educational brochure (available in English, Spanish and Chinese at www.healthfirst.org/heart-health)

What is CHF?

CHF occurs when the heart cannot pump enough blood through the body. The heart fails because of underlying problems. Clogged arteries, high blood pressure, a heart defect, or other medical conditions that affect the heart.

The symptoms of CHF take many years to develop. Common symptoms are weakness, feeling tired, and being short of breath. You're unable to do everyday physical activities— like walking and carrying groceries.

CHF is serious, it's one of the most severe symptoms of having heart disease. It is a life-long condition. Your future condition depends on age, the severity of the heart failure, overall health, and other factors.

What causes CHF?

The major risk factors for CHF are hypertension (high blood pressure) and diabetes. Uncontrolled high blood pressure doubles the likelihood of CHF. Diabetics, especially women, have two to eight times the risk. Age is another factor.

You may also experience CHF because of arrhythmias, or irregular heartbeats. Another cause is damage to the heart, especially valves from coronary heart disease.

Recognizing the signs

CHF doesn't happen overnight. However, the symptoms are usually very clear. If you recognize any of these signs, see your doctor.

- Dyspnea – Shortness of breath during activities or even while sleeping
- Coughing or wheezing – The lungs fill with fluid, sometimes producing a white or pink frothy phlegm
- Too much fluid in body tissue (edema) – Feet, ankles, and legs swell and weight increases
- Tiredness and fatigue – Constant tired feeling and an inability to walk, climb stairs, or do the simplest chores
- Loss of appetite, nausea – No interest in food, feeling sick to your stomach
- Confusion – Loss of memory or concentration
- Increased heart rate – A racing or throbbing heart

The team approach to treatment

Managing CHF is a partnership between you, your cardiologist, and health care providers. Greatest success will come from:

- Checking your weight daily
- Reporting any sudden weight gain (2–3 lbs. in 24 hrs. or 3–5 lbs. in a week)
- Taking medicine as directed
- Planning meals to avoid sodium
- Balancing movement/activity with rest
- Monitoring signs and symptoms, and reporting them to your cardiologist
- Seeing your PCP, cardiologist, and other health care providers regularly
- Seeking support from your family, friends, and community resources

Following these guidelines regularly will help you breathe easier, feel more comfortable, and have more energy for your activities.

What kind of medical tests will my doctor do for CHF?

The most common CHF tests are:

- Blood tests – test for electrolytes and kidney function
- Echocardiogram (or Echo) – uses ultrasound to show a real-time picture of the heart in action and tells what amount of blood the heart can pump with each beat
- Electrocardiogram (EKG or ECG) – records the electrical activity of the heart
- Chest X-ray – produces a picture of the heart and lungs

Your cardiologist may order other tests depending on your condition.

Excerpts from Healthfirst’s “Understanding Congestive Heart Failure (CHF) educational brochure (Cont.)

What type(s) of CHF treatments will my cardiologist prescribe?

CHF treatment can vary based on how severe your condition is. Some examples include prescribed medications such as:

- ACE (Angiotensin-converting Enzyme) inhibitors – Helps the blood move through the body with ease
- Beta Blockers – Improves how the heart pumps blood
- Digitalis – Increases the pumping action of the heart
- Diuretics – Helps the body get rid of salt and water when there is too much
- Vasodilators – Helps the blood move through the body with ease

You can help yourself to lead a comfortable life. Get good medical care, follow your cardiologist’s instructions, and learn about CHF.

Life Saving Tips

Contact your cardiologist right away if you:

- Gain three or more pounds in a day
- Have swollen feet, ankles, or other parts of your body
- Find it hard to breathe
- Cannot do the activities you did the day before
- Have the flu or a bad cold
- Get a fever
- Have chest pain

Lifestyle Changes

1. Quit smoking
2. Control your blood pressure
3. Control your blood cholesterol
4. Increase your physical activity
5. Eating healthy



Making the Most of Your Doctor Visit

Don’t hesitate to ask questions for a better understanding of your condition. Also, ask your cardiologist to rephrase a reply you cannot understand.

You may want to take a family member or friend to the appointment with you. They can help you better understand and remember what is said. Here are some points you may want to discuss with your cardiologist:

- Briefly describe your symptoms, even those you feel may not be important. You may want to keep a list so you will remember them.
- Tell your cardiologist about all of the medications you take—including over-the-counter drugs—and any problems you may be having with them.
- Be sure you understand all of the cardiologist’s instructions— especially for medications.
- Know what drug to take when, how often, and in what amount.
- Find out what side effects are possible from any drug your cardiologist prescribes for you.
- Ask the meaning of any medical term you don’t understand.
- If, after your appointment, you still have questions or are uncertain about your treatment, call your cardiologist’s office to get the information you need.