

RHP Insight Education Curriculum
2024 Curriculum

The Chronic Disease Primer for Primary Care: Heart Failure

Nick Ulmer, MD CPC FAAFP

Value-Based Arrangement Education

The following is required reading as introduction to this educational session. Please pause the slides as you need to allow time to read this information

Value-Based Arrangement Education

This presentation follows our prior correspondence and meetings regarding the new value-based incentive component of the 2024 SRHS Primary Care Compensation Model. The Value-Based Incentive is detailed in the 2024 Primary Care Physician Employment agreement (Exhibit A-6). Spartanburg Regional Healthcare System has created a Value-Based Enterprise with employed primary care physicians. Through the Value-Based Enterprise, the parties will collaborate to achieve goals for patients in the district service area. These goals include coordinating and managing care, improving the quality of care, and transition in healthcare delivery and payment to mechanisms based on the quality of care and control of cost of care.

The Value-Based Enterprise will achieve these goals through the Value-Based Activities described in the Value-Based Incentive portion of the Physician Employment Agreement. These activities include successful completion of diagnosis code training and accurate diagnosis code utilization as measured through educational chart reviews and other activities.

Value-Based Arrangement Education (cont.)

Appropriate, accurate, and specific diagnosis code utilization is a core component of medical documentation and care coordination. Proper and accurate utilization of diagnosis codes strengthen the medical documentation and ensures the patient's conditions are fully memorialized in the medical record. These activities enhance both quality of care and efforts to coordinate and manage care of patients for the District. This training module is intended to provide additional training background and resources for accurate diagnosis code utilization.

The Value-Based Enterprise reflects a collaborative process, created by regulatory agencies. MGC, and in conjunction with RHP and the Districts Compliance Department, will oversee, monitor and administer the Value-Based Enterprise's activities. Exhibit A-6 of your Physician Employment Agreement describes the governance and operation of the value-based efforts.

Value-Based Arrangement Education (cont.)

As SRHS moves into value-based clinical arrangements, the importance of documentation accuracy cannot be overstated. Previous provider educational chart reviews have shown opportunities to better align clinical thought-work with chronic condition documentation of medical necessity in our encounters. The intent of this education is to help educate providers to be more “clinically correct” in the written expression of our work with the patients we care for.

Objectives

- Be able to state the various stages of heart failure (HF)
- Define the types of heart failure, appropriate diagnosis codes
- Understand the pharmacological basic medications used to manage HF

Congestive Heart Failure¹⁻⁴

- Approximately 6.2 million persons ≥ 20 years of age in the U.S. have been diagnosed with heart failure (HF) and about 1 million new heart failure (HF) cases are diagnosed annually.
- HF remains primary diagnosis in >1 million hospitalizations annually, with the total cost of HF care in U.S. exceeding \$30B annually.
- Mortality rates after hospitalization for HF remain high, approximately 20-25% within one year after diagnosis, and mortality rates are similar for both HF with preserved ejection fraction (HFpEF) and HF with reduced ejection fraction (HFrEF).
- HF is one of the hospital readmission reduction penalty conditions.

HF Signs and Symptoms

Symptoms

- Shortness of breath w or w/o activity, orthopnea, or paroxysmal nocturnal dyspnea (PND)
 - Cough or wheezing
- Edema often with increase in weight – 2-5 pounds over 48 hours

Physical findings

- Rales, elevated jugular venous pressure (JVP), hepatomegaly, “pulsatile liver”, ascites, peripheral edema

Heart Failure Stages: (2022 AHA/ACC/HFSA Clinical Practice Guideline)

- Stage A: At risk for heart failure but no signs/symptoms.
 - Patients with HTN, obesity, CVD, DM, +FH cardiomyopathy, exposure to cardiotoxic agents, genetic variant for cardiomyopathy
- Stage B: Pre-heart failure. No current/previous symptoms, but have evidence of one of
 - Structural heart disease, increased filling pressures, or risk factors (see above) with increased BNP or persistently elevated cardiac troponin which indicate cardiac stretch/injury
- Stage C: Symptomatic heart failure either presently or previously
 - Guideline-directed medical therapy (GDMT) is key in managing the condition
- Stage D: Advanced heart failure
 - Symptoms interfere with daily life and usually have associated recurrent hospitalizations. Guideline-directed medical therapy (GDMT) optimization is needed

Heart Failure Stages: (2022 AHA/ACC/HFSA Clinical Practice Guideline)

- **Stage A:** At risk for heart failure **but no signs/symptoms.**
 - Patients with HTN, obesity, CVD, DM, +FH cardiomyopathy, exposure to cardiotoxic agents, genetic variant for cardiomyopathy
- **Stage B:** Pre-heart failure. **No current/previous symptoms,** but have evidence of one of
 - Structural heart disease, increased filling pressures, or risk factors (see above) with increased BNP or persistently elevated cardiac troponin which indicate cardiac stretch/injury
- **Stage C:** Symptomatic heart failure either presently or previously
 - Guideline-directed medical therapy (GDMT) is key in managing the condition
- **Stage D:** Advanced heart failure
 - Symptoms interfere with daily life and usually have associated recurrent hospitalizations. Guideline-directed medical therapy (GDMT) optimization is needed

Heart Failure Stages: (2022 AHA/ACC/HFSA Clinical Practice Guideline)

- Stage A: At risk for heart failure but no signs/symptoms.
 - Patients with HTN, obesity, CVD, DM, +FH cardiomyopathy, exposure to cardiotoxic agents, genetic variant for cardiomyopathy
- Stage B: Pre-heart failure. No current/previous symptoms, but have evidence of one of
 - Structural heart disease, increased filling pressures, or risk factors (see above) with increased BNP or persistently elevated cardiac troponin which indicate cardiac stretch/injury
- Stage C: Symptomatic heart failure either presently or previously
 - Guideline-directed medical therapy (GDMT) is key in managing the condition
- Stage D: Advanced heart failure
 - Symptoms interfere with daily life and usually have associated recurrent hospitalizations. Guideline-directed medical therapy (GDMT) optimization is needed

Heart Failure Classification and Diagnosis

Echocardiogram

- Reduced ejection fraction (EF <40% = HFrEF)
- Preserved ejection fraction (EF >50% = HFpEF)

Chest X-Ray

Evaluate labs

- CBC
- CMP
- TSH
- BNP

HFrEF Treatment

- HFrEF:

- Initiate Guideline Directed Medical Therapy (GDMT) – 4 mainstays

- Begin with volume management using aldosterone antagonists w or w/o loop diuretics as needed
- Beta blockers (metoprolol succinate, carvedilol, bisoprolol), and ARNI/ACEI/ARB for all unless contraindicated

Titrate to target dose, even if symptoms are stable/improving

Get BP as low as tolerated without orthostasis. HR target 70bpm or less

- Add SGLT2 inhibitor: Dapagliflozin (Farxiga®) & Empagliflozin (Jardiance®) AND Sotagliflozin (Inpefa®) are approved for HFrEF

HFrEF Treatment

- HFrEF:
 - Initiate Guideline Directed Medical Therapy (GDMT) – 4 mainstays
 - Begin with volume management using **aldosterone antagonists** w or w/o loop diuretics as needed
 - **Beta blockers** (metoprolol succinate, carvedilol, bisoprolol), and **ARNI/ACEI/ARB** for all unless contraindicated
 - Titrate to target dose, even if symptoms are stable/improving
 - Get BP as low as tolerated. HR target 70bpm or less
 - Add **SGLT2 inhibitor**: Dapagliflozin (Farxiga[®]), Sotagliflozin (Inpefa[®]) and Empagliflozin (Jardiance[®]) are approved for HFrEF . Hold 3d prior to surgery. Only Sotagliflozin (Inpefa[®]) needs titration and renal concerns. (See HFpEF section).

HFrEF Treatment

For ALL patients:

ACE Inhibitor *or* ARB *or* ARNI
AND Evidence based Beta Blocker
AND Aldosterone Antagonist (CrCl >30 ml/min, K⁺ <5)
AND SGLT2 inhibitor



Initiate loop diuretic
(dose prn or daily as clinically
indicated)



**Titrate ACE/ARB/ARNI, BB, Aldosterone
Antagonist to target doses as clinically tolerated**

Continue diuretic prn or daily
Follow up symptoms q1-6 months and prn

HFrEF Treatment

For ALL patients:
 ACE Inhibitor *or* ARB *or* ARNI
AND Evidence based Beta Blocker
AND Aldosterone Antagonist (CrCl >30 ml/min, K⁺ <5)
AND SGLT2 inhibitor



Initiate loop diuretic
 (dose prn or daily as clinically indicated)



Titrate ACE/ARB/ARNI, BB, Aldosterone Antagonist to target doses as clinically tolerated
 Continue diuretic prn or daily
 Follow up symptoms q1-6 months and prn

	Starting Dose	Target Dose
ARNI: *starting dose and timing dependent on current ACE/ARB dose		
Sacubitril/Valsartan (Entresto®)	24/26mg twice daily	97/103mg twice daily
ACE Inhibitors		
Enalapril	2.5mg twice daily	10mg twice daily
Lisinopril	2.5mg once daily	20-40mg once daily
Captopril	6.25mg three times daily	50mg three times daily
ARBs		
Valsartan (Diovan®)	20-40mg twice daily	160mg twice daily
Candesartan (Atacand®)	4-8mg once daily	32mg once daily
Losartan (Cozaar®)	25mg once daily	50-100mg once daily
Evidence Based Beta Blockers		
Bisoprolol	2.5mg once daily	10mg once daily
Carvedilol (Coreg®)	3.125mg twice daily	25mg twice daily
Metoprolol Succinate (Toprol XL®)	12.5-25mg once daily	200mg once daily
Aldosterone Antagonist		
Spirolactone	12.5-25mg once daily	25-50mg once daily
Eplerenone (Inspra®)	12.5-25mg once daily	25-50mg once daily

HFrEF Treatment

For ALL patients:
 ACE Inhibitor *or* ARB *or* ARNI
 AND Evidence based Beta Blocker
 AND Aldosterone Antagonist (CrCl >30 ml/min, K⁺ <5)
 AND SGLT2 inhibitor



Initiate loop diuretic
 (dose prn or daily as clinically indicated)



Titrate ACE/ARB/ARNI, BB, Aldosterone Antagonist to target doses as clinically tolerated
 Continue diuretic prn or daily
 Follow up symptoms q1-6 months and prn

	Starting Dose	Target Dose
ARNI: *starting dose and timing dependent on current ACEi		
Sacubitril/Valsartan (Entresto®)	24/26mg twice daily	97/103mg twice daily
ACE Inhibitors		
Enalapril	2.5mg twice daily	10mg twice daily
Lisinopril	2.5mg once daily	20-40mg once daily
Captopril	6.25mg three times daily	50mg three times daily
ARBs		
Valsartan (Diovan®)	20-40mg twice daily	160mg twice daily
Candesartan (Atacand®)	4-8mg once daily	32mg once daily
Losartan (Cozaar®)	25mg once daily	50-100mg once daily
Evidence Based Beta Blockers		
Bisoprolol	2.5mg once daily	10mg once daily
Carvedilol (Coreg®)	3.125mg twice daily	25mg twice daily
Metoprolol Succinate (Toprol XL®)	12.5-25mg once daily	200mg once daily
Aldosterone Antagonist		
Spirolactone	12.5-25mg once daily	25-50mg once daily
Eplerenone (Inspra®)	12.5-25mg once daily	25-50mg once daily

HFrEF Treatment

For ALL patients:
 ACE Inhibitor *or* ARB *or* ARNI
 AND Evidence based Beta Blocker
 AND Aldosterone Antagonist (CrCl >30 ml/min, K⁺ <5)
 AND SGLT2 inhibitor



Initiate loop diuretic
 (dose prn or daily as clinically indicated)



Titrate ACE/ARB/ARNI, BB, Aldosterone Antagonist to target doses as clinically tolerated
 Continue diuretic prn or daily
 Follow up symptoms q1-6 months and prn

	Starting Dose	Target Dose
ARNI: *starting dose and timing dependent on current ACE/ARB dose		
Sacubitril/Valsartan (Entresto®)	24/26mg twice daily	97/103mg twice daily
ACE Inhibitors		
Enalapril	2.5mg twice daily	10mg twice daily
Lisinopril	2.5mg once daily	20-40mg once daily
Captopril	6.25mg three times daily	50mg three times daily
ARBs		
Valsartan (Diovan®)	20-40mg twice daily	160mg twice daily
Candesartan (Atacand®)	4-8mg once daily	32mg once daily
Losartan (Cozaar®)	25mg once daily	50-100mg once daily
Evidence Based Beta Blockers		
Bisoprolol	2.5mg once daily	10mg once daily
Carvedilol (Coreg®)	3.125mg twice daily	25mg twice daily
Metoprolol Succinate (Toprol XL®)	12.5-25mg once daily	200mg once daily
Aldosterone Antagonist		
Spirolonolactone	12.5-25mg once daily	25-50mg once daily
Eplerenone (Inspra®)	12.5-25mg once daily	25-50mg once daily



HFrEF Treatment

For ALL patients:
 ACE Inhibitor *or* ARB *or* ARNI
 AND Evidence based Beta Blocker
 AND Aldosterone Antagonist (CrCl >30 ml/min, K⁺ <5)
 AND SGLT2 inhibitor



Initiate loop diuretic
 (dose prn or daily as clinically indicated)



Titrate ACE/ARB/ARNI, BB, Aldosterone Antagonist to target doses as clinically tolerated
 Continue diuretic prn or daily
 Follow up symptoms q1-6 months and prn

	Starting Dose	Target Dose
ARNI: *starting dose and timing dependent on current ACE/ARB dose		
Sacubitril/Valsartan (Entresto®)	24/26mg twice daily	97/103mg twice daily
ACE Inhibitors		
Enalapril	2.5mg twice daily	10mg twice daily
Lisinopril	2.5mg once daily	20-40mg once daily
Captopril	6.25mg three times daily	50mg three times daily
ARBs		
Valsartan (Diovan®)	20-40mg twice daily	160mg twice daily
Candesartan (Atacand®)	4-8mg once daily	32mg once daily
Losartan (Cozaar®)	25mg once daily	50-100mg once daily
Evidence Based Beta Blockers		
Bisoprolol	2.5mg once daily	10mg once daily
Carvedilol (Coreg®)	3.125mg twice daily	25mg twice daily
Metoprolol Succinate (Toprol XL®)	12.5-25mg once daily	200mg once daily
Aldosterone Antagonist		
Spirolactone	12.5-25mg once daily	25-50mg once daily
Eplerenone (Inspra®)	12.5-25mg once daily	25-50mg once daily

HFrEF Subsequent Treatment

If persistent symptoms, continue to add as appropriate (Begin → End)

Add Hydralazine/ISDN (decrease mortality): self-identified African American or contraindication to ACE/ARB/ARNI

Add Ivabradine (Corlanor®) (decrease time to hospitalization): HR >70 on max tolerated BB and in normal sinus rhythm

Consider addition of Digoxin if patient w/ symptoms despite above therapies or if comorbid atrial fibrillation. Use low dose, ensure K⁺ and Mg⁺ are WNL

Consider Vericiguat (Verquvo®) (decrease CV death & HF hospitalization): eGFR >15 ml/min, EF <45%, contraindicated in pregnancy

HFrEF Subsequent Treatment

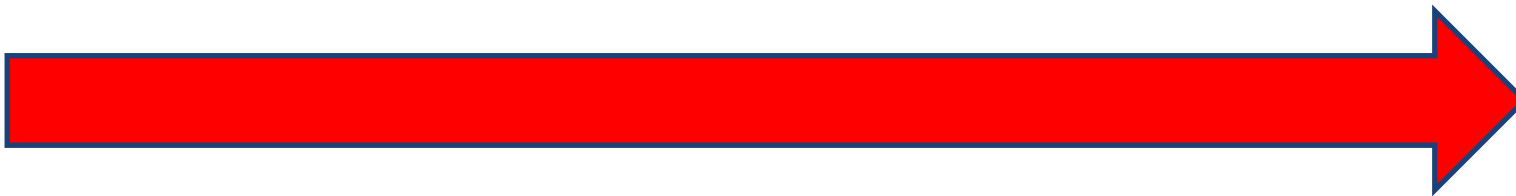
If persistent symptoms, continue to add as appropriate (Begin → End)

Add Hydralazine/ISDN (decrease mortality): self-identified African American or contraindication to ACE/ARB/ARNI

Add Ivabradine (Corlanor®) (decrease time to hospitalization): HR >70 on max tolerated BB and in normal sinus rhythm

Consider addition of Digoxin if patient w/ symptoms despite above therapies or if comorbid atrial fibrillation. Use low dose, ensure K⁺ and Mg⁺ are WNL

Consider Vericiguat (Verquvo®) (decrease CV death & HF hospitalization): eGFR >15 ml/min, EF <45%, contraindicated in pregnancy



HFpEF Treatment

- HFpEF:

- Start with loop diuretics for volume management. If significant edema despite loop, add aldosterone if eGFR/K+ normal
- Get BP and HR as low as tolerated – use beta blockers, diltiazem, verapamil (rate – 70bpm is target) as well as ACEI/ARB and consider nitrates, hydralazine
- Add SGLT2 Inhibitor (note to hold med at least 3d prior to surgery – DKA risk)
 - Empagliflozin (Jardiance®) – FDA approved for all types HF – no titration
Start 10mg qam as long as eGFR > 30.
 - Dapagliflozin (Farxiga®) – FDA approved for all types HF – no titration
Start 10mg qam. Avoid initiation of treatment if eGFR <25. May stay on if eGFR drops <25
 - Sotagliflozin (Inpefa®) – FDA approved (05/2023) – HF titration
Start 200mg qd, increase after 2wk. eGFR must be >90.

Global HF Treatment Overview

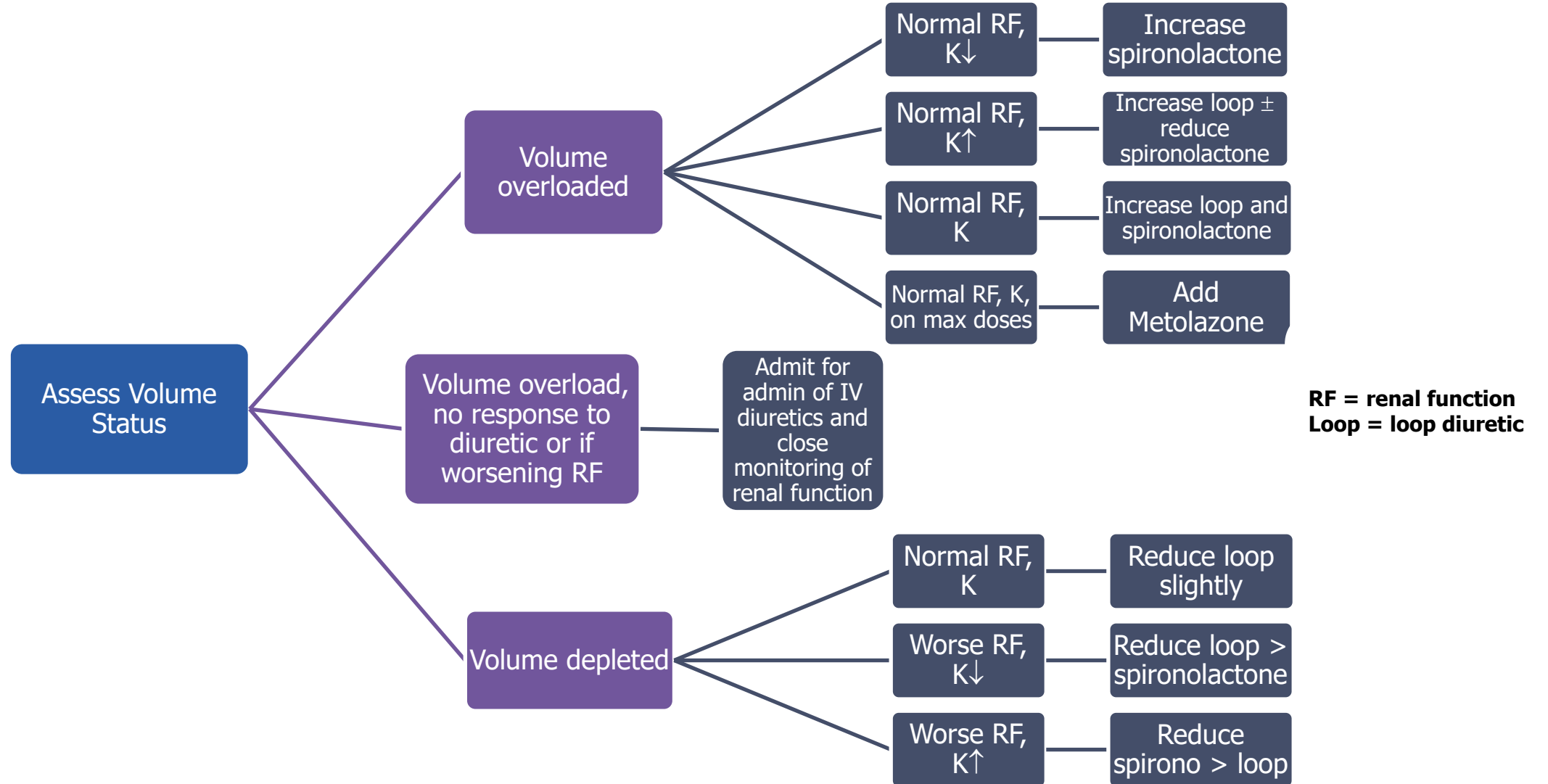
- HFrEF:
 - Begin with volume management using aldosterone antagonists w or w/o loop diuretics as needed
 - Initiate Guideline Directed Medical Therapy (GDMT) – 4 mainstays
 - Beta blockers (metoprolol succinate, carvedilol, bisoprolol), and ARNI/ACEI/ARB for all unless contraindicated
 - Titrate to target dose, even if symptoms are stable/improving
 - Get BP as low as tolerated without orthostasis. HR target 70bpm or less
 - Add SGLT2 inhibitor: Dapagliflozin (Farxiga®) & Empagliflozin (Jardiance®), and Sotagliflozin (Inpefa®) are approved for HF. SGLT2i meds hold 3-4d prior to surgery.
- HFpEF:
 - Start with loop diuretics for volume management. If significant edema despite loop, add aldosterone if eGFR/K+ normal
 - Get BP and HR as low as tolerated – use beta blockers, diltiazem, verapamil (rate <70 is target) as well as ACEI/ARB and consider nitrates, hydralazine (BP)
 - Add SGLT2 Inhibitor (Empagliflozin®), Dapagliflozin (Farxiga®), and Sotagliflozin (Inpefa®) are FDA approved. Hold 3-4d prior to surgery.
- Treat all comorbidities to goal (HTN, arrhythmias, diabetes, pulmonary conditions, sleep apnea, etc.)
- Counseling, education: salt restriction, fluid restriction (if hyponatremic) and other strategies based on conditions (smoking cessation, weight optimization, glucose control, etc.).

2022 AHA/ACC/HFSA Guideline for the Management of Heart Failure: A Report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines

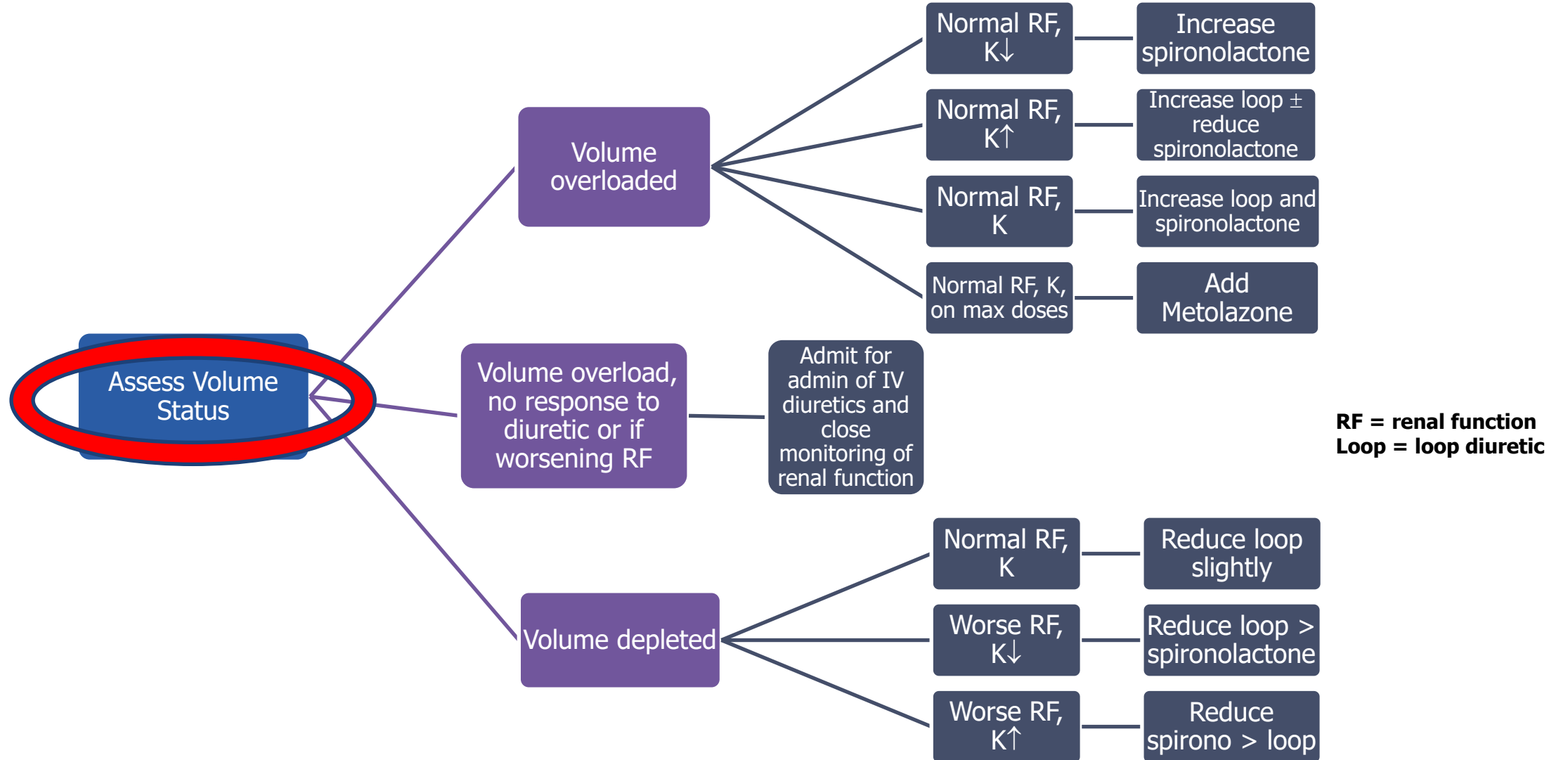
AHA/ACC/HFSA CLINICAL PRACTICE GUIDELINE

Acute Treatment to Avoid Hospitalization: Volume Status Management

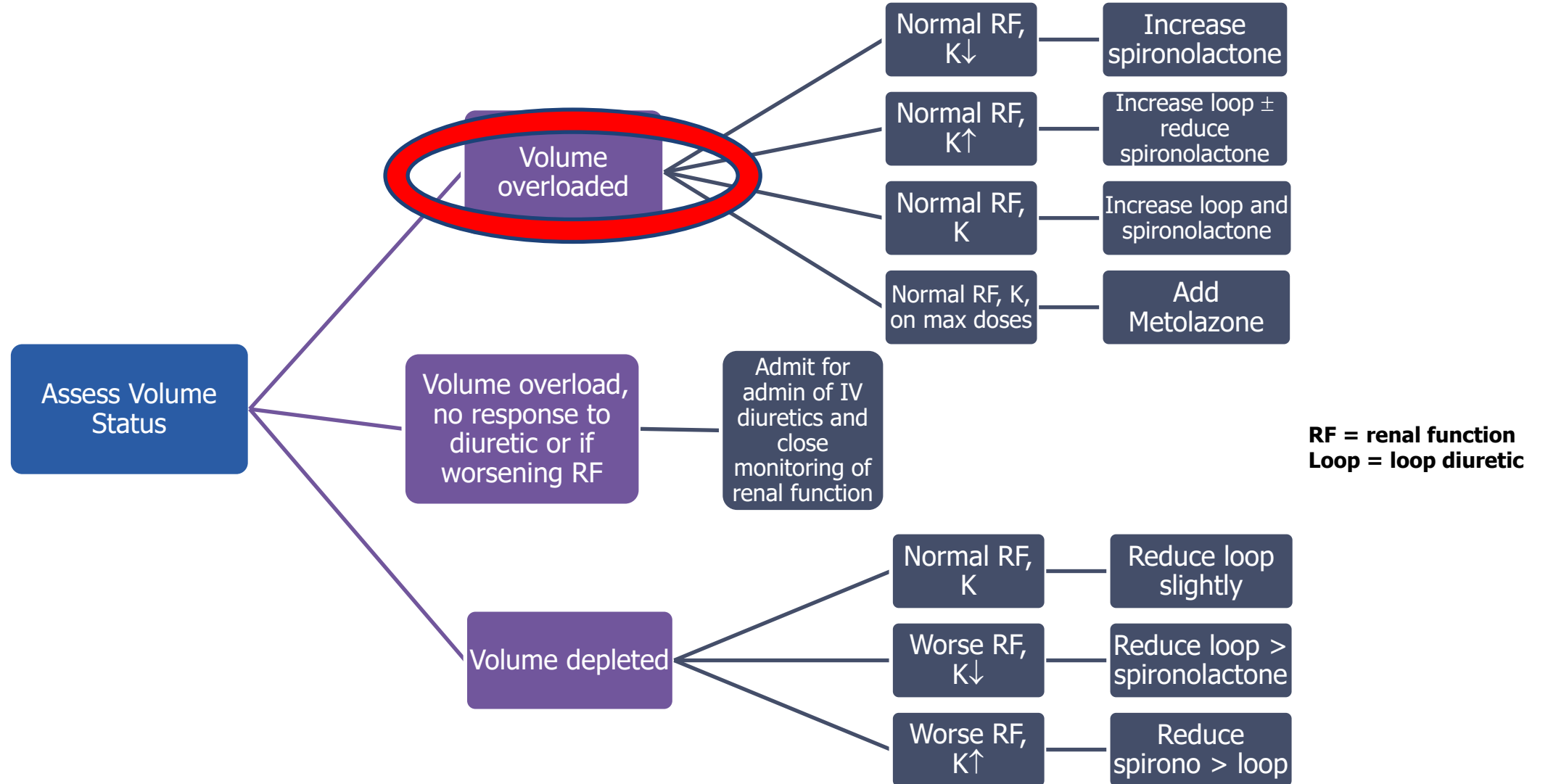
Acute Treatment to Avoid Hospitalization: Volume Status Management



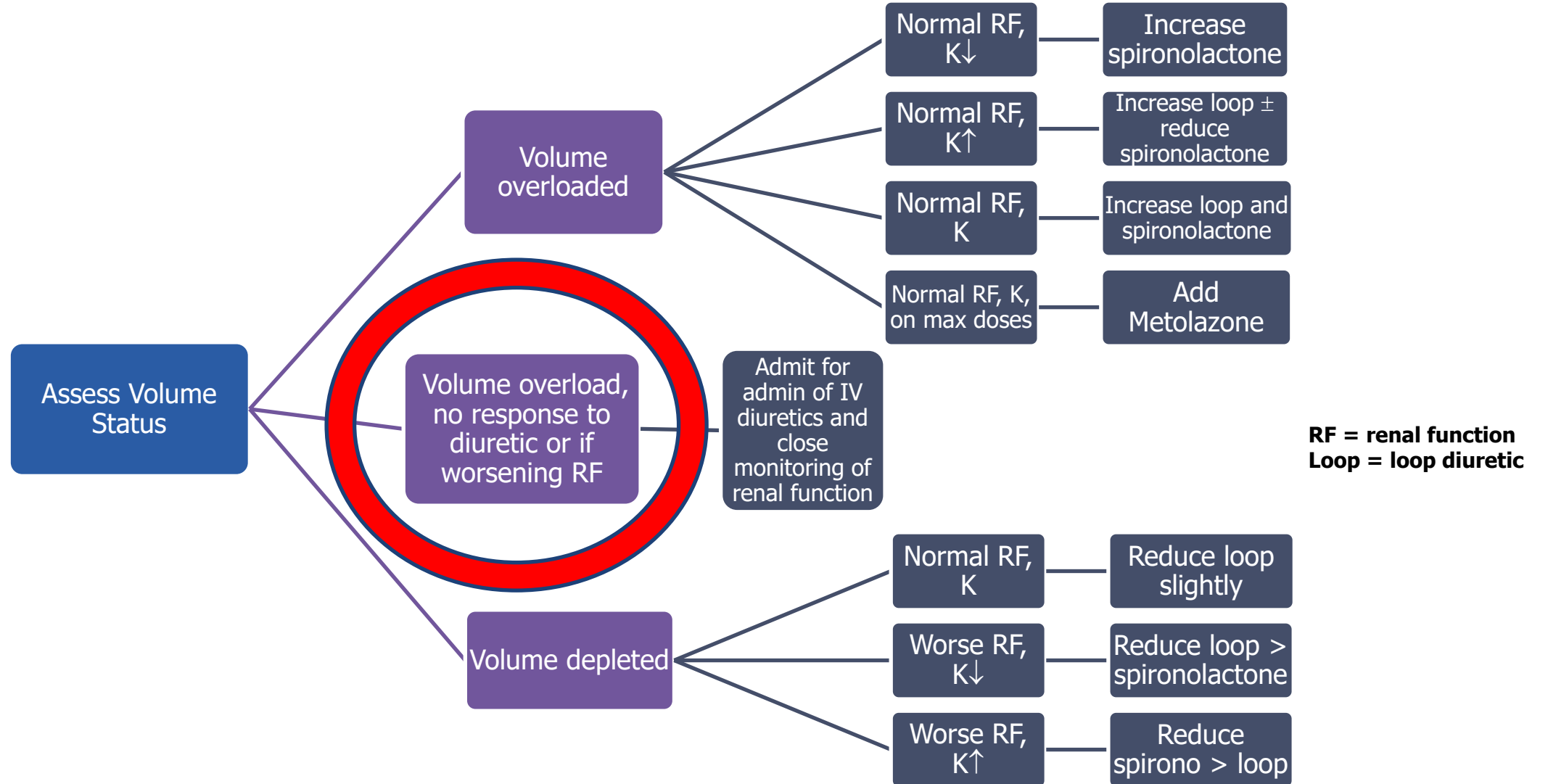
Acute Treatment to Avoid Hospitalization: Volume Status Management



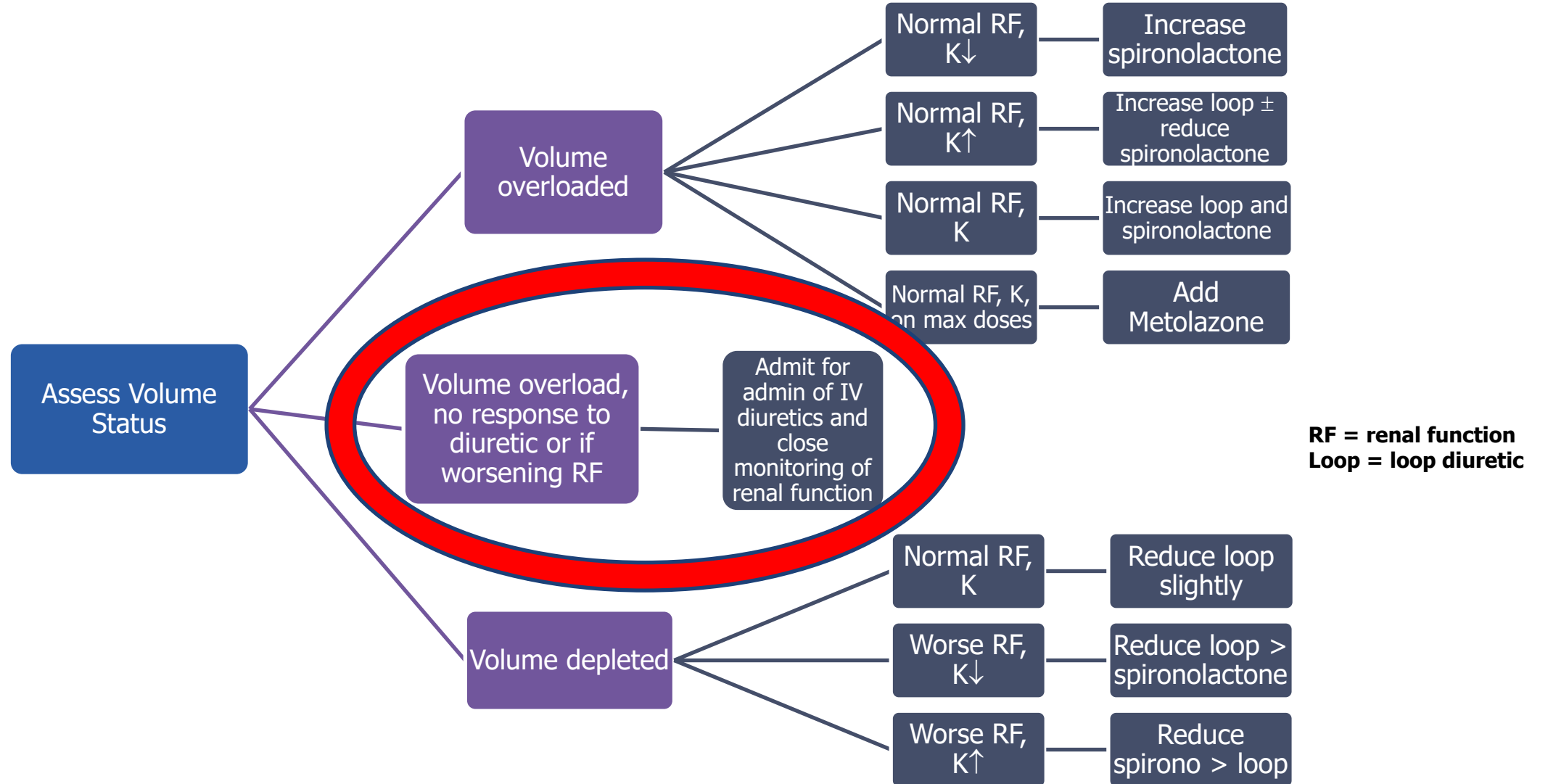
Acute Treatment to Avoid Hospitalization: Volume Status Management



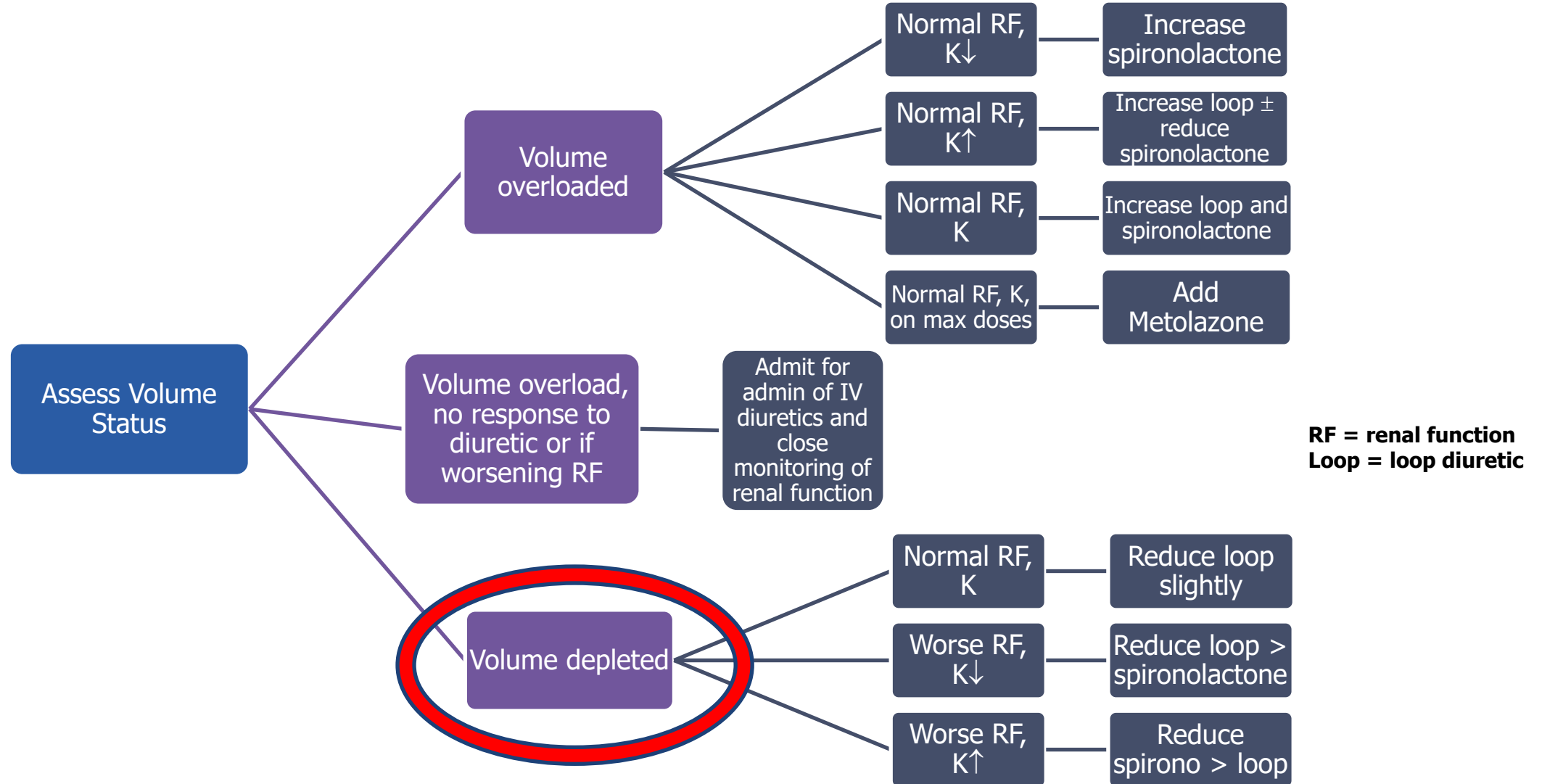
Acute Treatment to Avoid Hospitalization: Volume Status Management



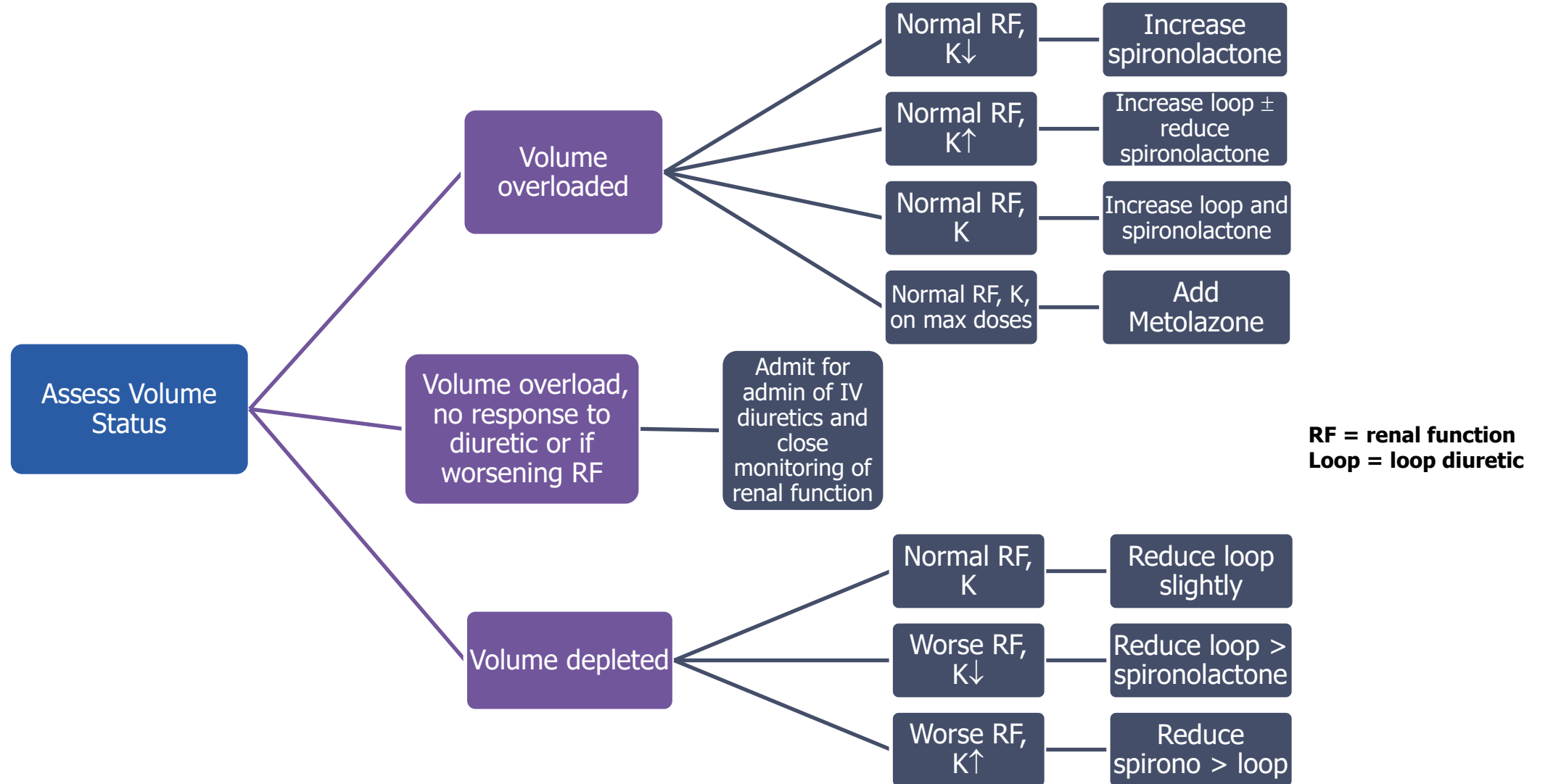
Acute Treatment to Avoid Hospitalization: Volume Status Management



Acute Treatment to Avoid Hospitalization: Volume Status Management



Acute Treatment to Avoid Hospitalization: Volume Status Management



Ambulatory Heart Failure Management

- Recall this is an Ambulatory Care Sensitive Condition (ACSC)
 - Be available for these patients to manage outpatient to avoid ED/hospitalization
 - More frequent office visits are usually merited (4...5...6x/year?). If med change due to clinical instability, consider a 7-14 day follow-up for response (think labs – electrolytes, eGFR)
- After hospitalization, recommendations are for TCM within ONE week
 - Think Cardiac Rehab and Advance Care Plan discussion. CardioMEMS HF monitoring?
- After ED visits, CMS is measuring frequency of office visits within TWO weeks (???)
 - Cardiology referral. Think Cardiac Rehab and Advance Care Plan discussion.
- Laboratory attention: CMET, BNP, TSH (at least initially), CBC. Watch K/eGFR.

Documentation and Coding for Heart Failure⁶

- Be specific: *correct capture adds 0.360 RAF to the patient with HF*
 - (Acute/chronic) (systolic/diastolic) heart failure
- Add pertinent conditions:
 - ASCVD – CABG/CAD *correct capture adds 0.240 RAF to the patient*
 - Heart Arrhythmias – afib/flutter, SSS, PSVT, Ht blocks, *adds 0.299 RAF to the patient*

Documentation and Coding for Heart Failure⁶

- Be specific: *correct capture adds 0.360 RAF to the patient with HF*
 - (Acute/chronic) (systolic/diastolic) heart failure – I50.9
- Add pertinent conditions:
 - ASCVD – CABG/CAD *correct capture adds 0.240 RAF to the patient*
 - Heart Arrhythmias – afib/flutter, SSS, PSVT, Ht blocks, *adds 0.299 RAF to the patient*
- Capture everything: Disease interactions exist here

Disease Interaction	Pt. in Community Setting, Non-Dual, Aged into Medicare	Pt. in Community Setting, Non-Dual, Disabled (reason for MCR)
HF + Diabetes (DM w, w/o, unspecified)	0.112	0.023
HF + Chr Lung D/O (COPD, trsplts, CF, PFibrosis, etc.)	0.078	0.062
HF + Kidney (CKD Stage III, IV, V)	0.176	0.314
HF + Specified Heart Arrhythmias (SSS, Afib/Flut, Ht blk)	0.077	0.257
Chr Lung D/O+ Cardiorespir. Failure (home O ₂ , trach)	0.254	0.242

Documentation and Coding for Heart Failure⁶

- Be specific: *correct capture adds 0.360 RAF to the patient with HF*
 - (Acute/chronic) (systolic/diastolic) heart failure – I50.9
- Add pertinent conditions:
 - ASCVD – CABG/CAD *correct capture adds 0.240 RAF to the patient*
 - Heart Arrhythmias – afib/flutter, SSS, PSVT, Ht blocks, *adds 0.299 RAF to the patient*

Disease Interaction	Pt. in Community Setting, Non-Dual, Aged into Medicare	Pt. in Community Setting, Non-Dual, Disabled (reason for MCR)
HF + Diabetes (DM w, w/o, unspecified)	0.112	0.023
HF + Chr Lung D/O (COPD, asthms, CF, PFibrosis, etc.)	0.078	0.062
HF + Kidney (CKD Stage III, IV, V)	0.176	0.314
HF + Specified Heart Arrhythmias (SSS, Afib/Flut, Ht blk)	0.077	0.257
Chr Lung D/O+ Cardiorespir. Failure (home O ₂ , trach)	0.254	0.242

Documentation and Coding for Heart Failure⁶

- Be specific: *correct capture adds 0.360 RAF to the patient with HF*
 - (Acute/chronic) (systolic/diastolic) heart failure – I50.9
- Add pertinent conditions:
 - ASCVD – CABG/CAD *correct capture adds 0.240 RAF to the patient*
 - Heart Arrhythmias – afib/flutter, SSS, PSVT, Ht blocks, *adds 0.299 RAF to the patient*
- Capture everything: Disease interactions exist here

Disease Interaction	Pt. in Community Setting, Non-Dual, Aged into Medicare	Pt. in Community Setting, Non-Dual, Disabled (reason for MCR)
HF + Diabetes (DM w, w/o, unspecified)	0.112	0.023
HF + Chr Lung D/O (COPD, aspts, CF, PFibrosis, etc.)	0.078	0.062
HF + Kidney (CKD Stage III, IV, V)	0.176	0.314
HF + Specified Heart Arrhythmias (SSS, Afib/Flut, Ht blk)	0.077	0.257
Chr Lung D/O+ Cardiorespir. Failure (home O ₂ , trach)	0.254	0.242

Documentation and Coding for Heart Failure⁶

- Be specific: *correct capture adds 0.360 RAF to the patient with HF*
 - (Acute/chronic) (systolic/diastolic) heart failure – I50.9
- Add pertinent conditions:
 - ASCVD – CABG/CAD *correct capture adds 0.240 RAF to the patient*
 - Heart Arrhythmias – afib/flutter, SSS, PSVT, Ht blocks, *adds 0.299 RAF to the patient*
- Capture everything: Disease interactions exist here

Disease Interaction	Pt. in Community Setting, Non-Dual, Aged into Medicare	Pt. in Community Setting, Non-Dual, Disabled (reason for MCR)
HF + Diabetes (DM w, w/o, unspecified)	0.112	0.023
HF + Chr Lung D/O (COPD, aspts, CF, PFibrosis, etc.)	0.078	0.062
HF + Kidney (CKD Stage III, IV, V)	0.176	0.314
HF + Specified Heart Arrhythmias (SSS, Afib/Flut, Ht blk)	0.077	0.257
Chr Lung D/O+ Cardiorespir. Failure (home O ₂ , trach)	0.254	0.242

Documentation and Coding for Heart Failure⁶

- Be specific: *correct capture adds 0.360 RAF to the patient with HF*
 - (Acute/chronic) (systolic/diastolic) heart failure – I50.9
- Add pertinent conditions:
 - ASCVD – CABG/CAD *correct capture adds 0.240 RAF to the patient*
 - Heart Arrhythmias – afib/flutter, SSS, PSVT, Ht blocks, *adds 0.299 RAF to the patient*

Disease Interaction	Pt. in Community Setting, Non-Dual, Aged into Medicare	Pt. in Community Setting, Non-Dual, Disabled (reason for MCR)
HF + Diabetes (DM w, w/o, unspecified)	0.112	0.023
HF + CHF (ang D/O (cor D/ trsp lts, CE, PFibrosis, etc.))	0.078	0.062
HF + Kidney (CKD stage III, IV, V)	0.176	0.314

References (resources folder handouts)

¹Bozkurt B, Hershberger RE, Butler J, et al. 2021 ACC/AHA key data elements and definitions for heart failure: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Data Standards (Writing Committee to Develop Clinical Data Standards for Heart Failure). *Circ Cardiovasc Qual Outcomes*. 2021;14:e000102.

²Jackson SL, Tong X, King RJ, et al. National Burden of Heart Failure Events in the United States, 2006 to 2014. *Circ Heart Fail*. 2018 Dec;11(12):e004873. doi: 10.1161/CIRCHEARTFAILURE.117.004873. PMID: 30562099; PMCID: PMC6424109.

³Heidenreich PA, Albert NM, Allen LA, et al. American Heart Association Advocacy Coordinating Committee; Council on Arteriosclerosis, Thrombosis and Vascular Biology; Council on Cardiovascular Radiology and Intervention; Council on Clinical Cardiology; Council on Epidemiology and Prevention; Stroke Council. Forecasting the impact of heart failure in the United States: a policy statement from the American Heart Association. *Circ Heart Fail*. 2013 May;6(3):606-19. doi: 10.1161/HHF.0b013e318291329a. Epub 2013 Apr 24. PMID: 23616602; PMCID: PMC3908895.

⁴Bhatia RS, Tu JV, Lee DS, et al. Outcome of heart failure with preserved ejection fraction in a population-based study. *N Engl J Med*. 2006;355:260–9.

⁵2022 AHA/ACC/HFSA Clinical Practice Guideline

⁶Codify HCC calculator, accessed 10.2022

⁷American Family Physician Practice Guidelines 2023; 108(3):315-320.

Closing

- Thanks for taking this Chronic Disease Primer session on HF
- There is a post test – good luck!!
- Reach out for questions:
 - Nick Ulmer, MD – EUlmerMD@srhs.com

Practice Enhancement Through
Clinically Correct Documentation and Coding
2024 Curriculum

The Chronic Disease Primer for Primary Care: Heart Failure

Nick Ulmer, MD CPC FAAFP