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DON'T SKIP A BEAT: TRANSITIONS OF CARE IN CARDIOLOGY

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November 10, 2026

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FACULTY DISCLOSURE

I have no relevant financial relationships with ineligible companies to disclose.

OBJECTIVES

- Define core concepts of transitional care management, focusing on high-risk cardiovascular patients
- Evaluate current data and literature on the impact of transitions of care clinics on cardiovascular outcomes
- Implement an outpatient cardiology transitions of care clinic, including a multi-disciplinary team and workflow

EXPECTED OUTCOME & EDUCATIONAL NEED/ PRACTICE GAP

- On this slide, please include the expected outcomes, the educational need, and the practice gap of your presentation.
  - **Expected Outcome:** Understand TCM services and application to patients with HF and AMI.
  - **Educational Need:** TCM services were implemented to reduce readmission rates. Despite this, TCM service uptake and data supporting benefit is limited.
  - **Practice Gap:** Despite hospital penalties for excess readmissions, readmissions rates remain high.

TRANSITIONAL CARE MANAGEMENT

What are transitions of care (TOC)?

- The movement of a patient from one healthcare setting or level of care to another

TRANSITIONAL CARE MANAGEMENT

What is Transitional Care Management (TCM)?

- Coordination of care within 30 days of discharge from a hospital or care facility helping to transition a patient back to the community

TRANSITIONAL CARE MANAGEMENT

2008

- 20% of Medicare beneficiaries were readmitted within 30 days of discharge[1,2]
- 12% were potentially avoidable[1,2]
- Readmissions associated with worse patient outcomes and increased cost[2]
- No incentive to reduce hospitalizations[2]

1. McIlvennan CK, et al. *Circulation*. 2015;131:1796-1803.
2. Centers for Medicare & Medicaid Services. Hospital Readmissions Reduction Program. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp

TRANSITIONAL CARE MANAGEMENT

2010

Centers for Medicare and Medicaid Services established the **Hospitalization Readmissions Reduction Program (HRRP)**

"A Medicare value-based purchasing program that encourages hospitals to improve communication and care coordination to better engage patients and caregivers in discharge plans and, in turn, **reduce avoidable readmissions**"

Centers for Medicare & Medicaid Services. Hospital Readmissions Reduction Program. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp

TRANSITIONAL CARE MANAGEMENT

2012

Section 1886(q) of the Social Security Act required the Department of Health and Human Services **to reduce payments to hospitals for excess readmissions**

Centers for Medicare & Medicaid Services. Hospital Readmissions Reduction Program. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp

TRANSITIONAL CARE MANAGEMENT

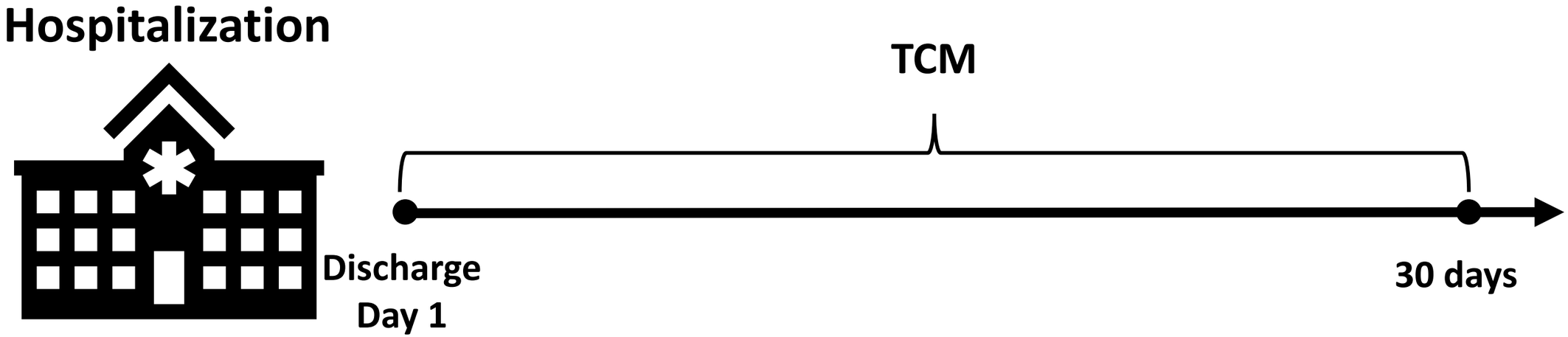
2013

CMS introduced TCM services

- Incentivized providers to provide transitional care services with discharge follow up and care coordination

Centers for Medicare & Medicaid Services. Hospital Readmissions Reduction Program. https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp

TRANSITIONAL CARE MANAGEMENT



TRANSITIONAL CARE MANAGEMENT – REQUIREMENTS

Required patient TCM services include:

- Supporting a patient's transition to a community setting
- Health care professionals accept patients at time of discharge without a service gap
- Health care professionals take responsibility for a patient's care
- Patients must need moderate or high complexity medical decision making

TRANSITIONAL CARE MANAGEMENT – REQUIREMENTS







Discharged from

- Inpatient acute care hospital
- Inpatient psychiatric hospital
- Inpatient rehabilitation facility
- Long-term care hospital
- Skilled nursing facility
- Hospital outpatient observation or partial hospitalization
- Partial hospitalization at a community mental health center

Community Setting

- Home
- Domiciliary
- Nursing facility
- Assisted living facility

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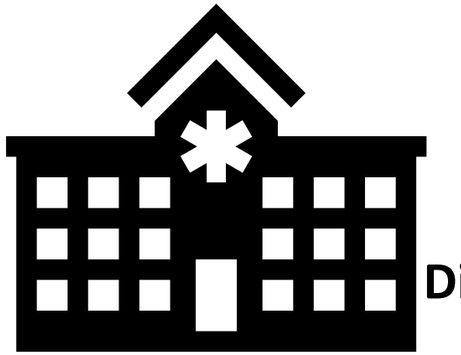
TRANSITIONAL CARE MANAGEMENT – REQUIREMENTS

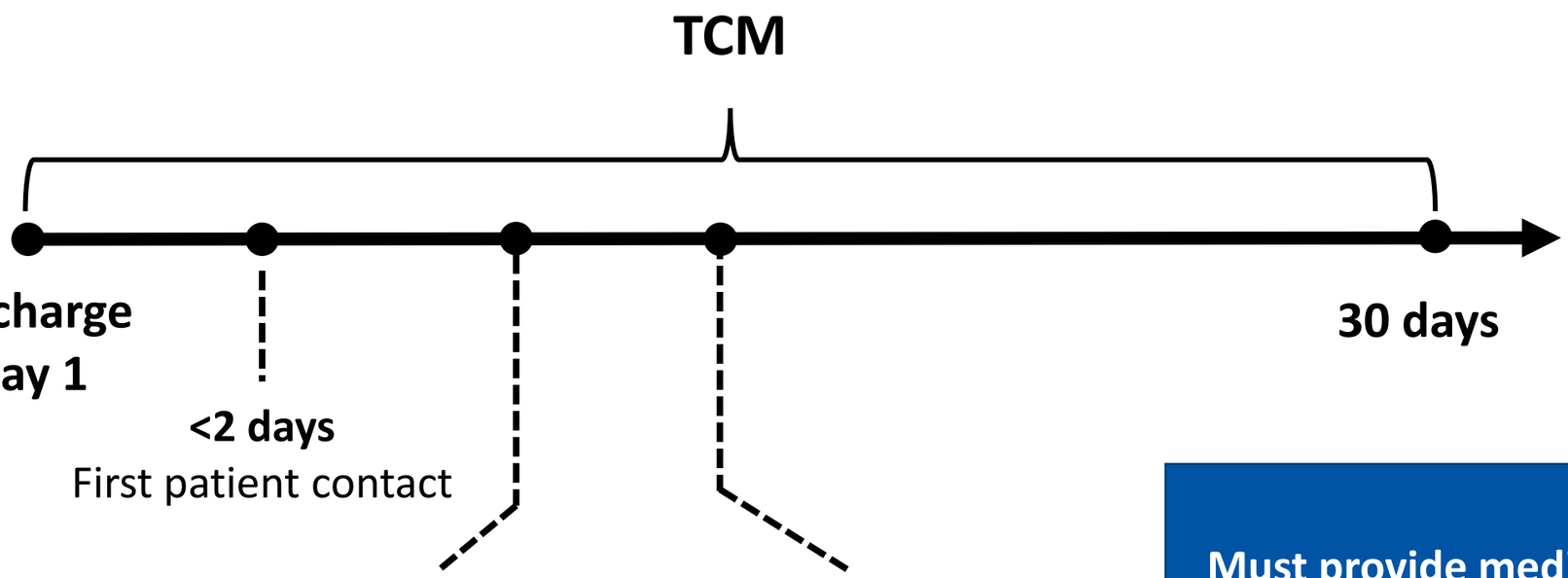
Who can provide TCM services?

- Physicians
- Non-physician practitioners
  - Certified nurse-midwives
  - Clinical nurse specialists
    - Nurse practitioners
    - Physician assistants

TRANSITIONAL CARE MANAGEMENT – COMPONENTS

Hospitalization





Must provide medication reconciliation and management on or before face-to-face visit

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HOSPITALIZATION READMISSIONS REDUCTION PROGRAM

2013

- Acute myocardial infarction
- Heart Failure
- Pneumonia

2015

- Acute myocardial infarction
- Chronic obstructive pulmonary disease
- Heart failure
- Pneumonia
- Coronary artery bypass graft surgery
- Elective primary total hip arthroplasty and/or total knee arthroplasty

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HOSPITALIZATION READMISSIONS REDUCTION PROGRAM

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- Acute myocardial infarction
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2015

- **Acute myocardial infarction**
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HIGH RISK POPULATIONS – HEART FAILURE & ACUTE MYOCARDIAL INFARCTION

Heart Failure

- 1.9-2.6% of Americans ≥20 years of age
- By 2030 expected to increase to >8 million
- ED visits: **1,446,070**
- Hospital Discharges:**1,215,174**

Acute Myocardial Infarction

- 2.6% of Americans >20 years of age
- Approximately every 40 seconds, an American will have an MI
- Hospital Discharges: **588,480**

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Palaniappan et al. Circulation. 2026;153:e275–e906.

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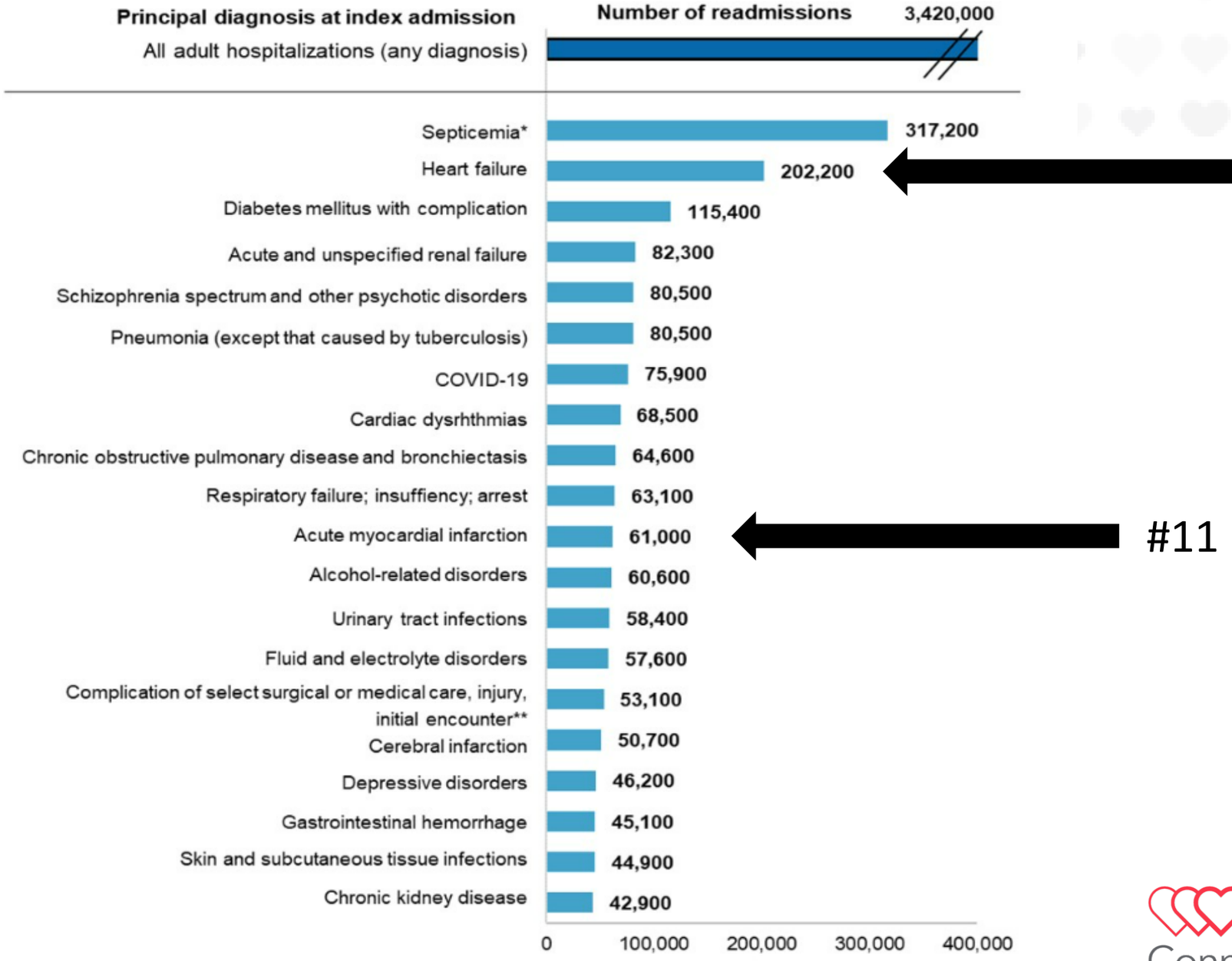
HIGH RISK POPULATIONS – HEART FAILURE & ACUTE MYOCARDIAL INFARCTION

Table 26. Most Common Co-Occurring Chronic Conditions Among Medicare Beneficiaries With HF (N=4 947 918), 2011

Beneficiaries Age ≥65 y (n=4 376 150)*			Beneficiaries Age <65 y (n=571 768)†		
	n	%		n	%
Hypertension	3 685 373	84.2	Hypertension	461 235	80.7
Ischemic heart disease	3 145 718	71.9	Ischemic heart disease	365 889	64.0
Hyperlipidemia	2 623 601	60.0	Diabetes	338 687	59.2
Anemia	2 200 674	50.3	Hyperlipidemia	325 498	56.9
Diabetes	2 027 875	46.3	Anemia	284 102	49.7
Arthritis	1 901 447	43.5	CKD	257 015	45.0
CKD	1 851 812	42.3	Depression	207 082	36.2
COPD	1 311 118	30.0	Arthritis	201 964	35.3
AF	1 247 748	28.5	COPD	191 016	33.4
Alzheimer's disease or dementia	1 207 704	27.6	Asthma	88 816	15.5

Heidenreich PA, et al. Circulation. 2022;145:e895–e1032.

30 Day All-Cause Hospital Readmissions in Adults (2020)



#2

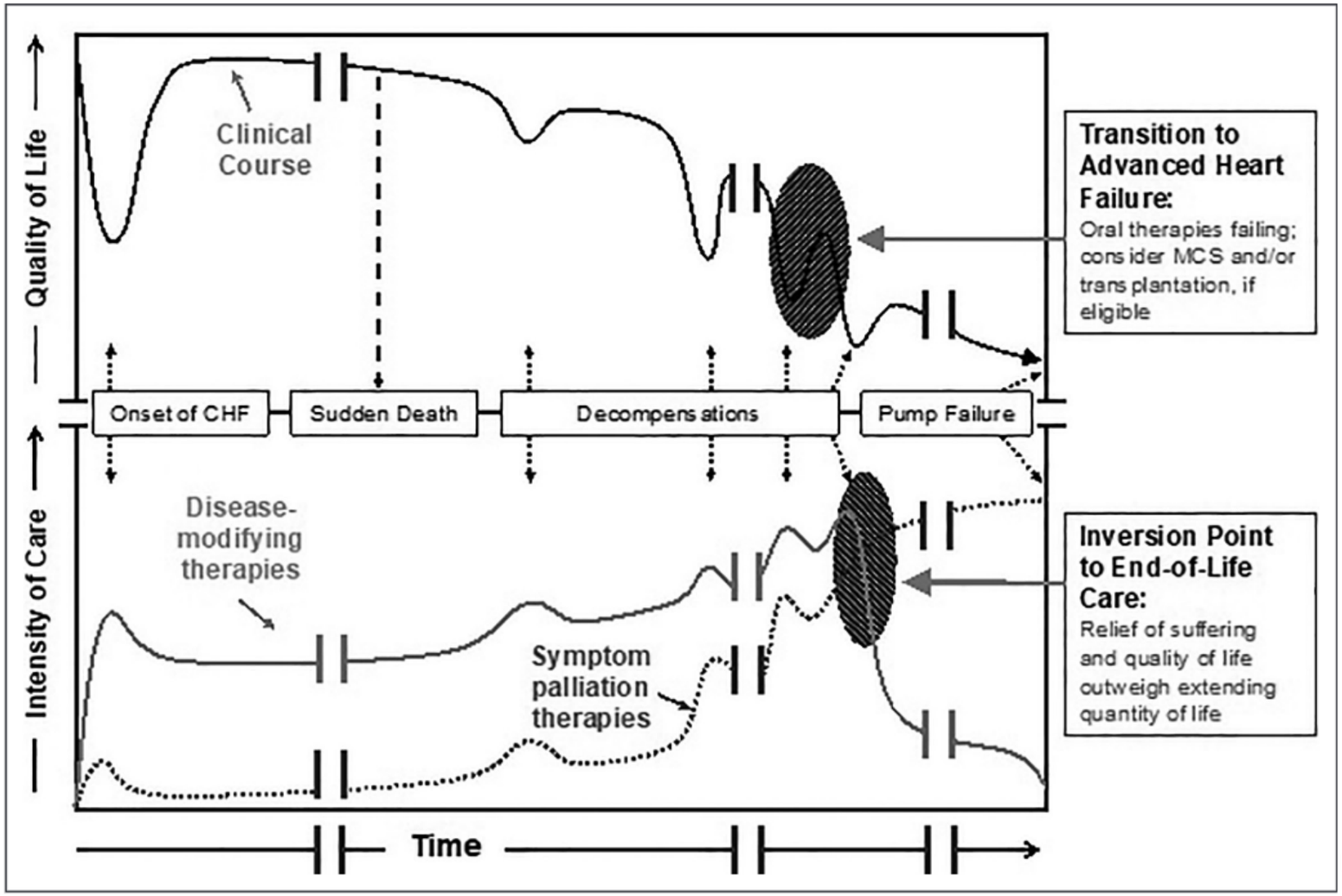
#11

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Agency for Healthcare Research and Quality. Clinical Conditions With Frequent, Costly Hospital Readmissions by Payer, 2020. https://hcup-us.ahrq.gov/reports/statbriefs/sb307-readmissions-2020.jsp

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HIGH RISK POPULATIONS – HEART FAILURE

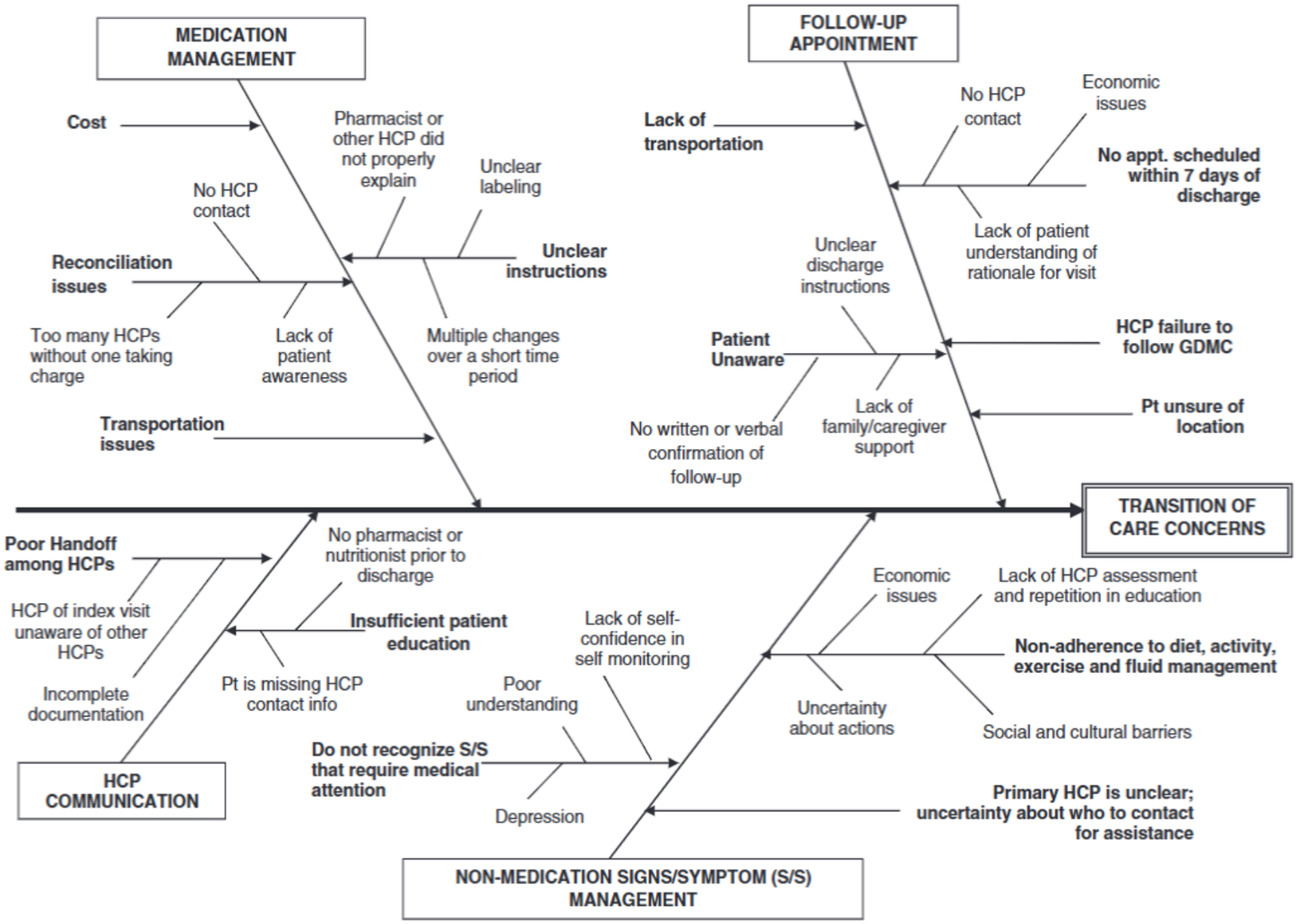


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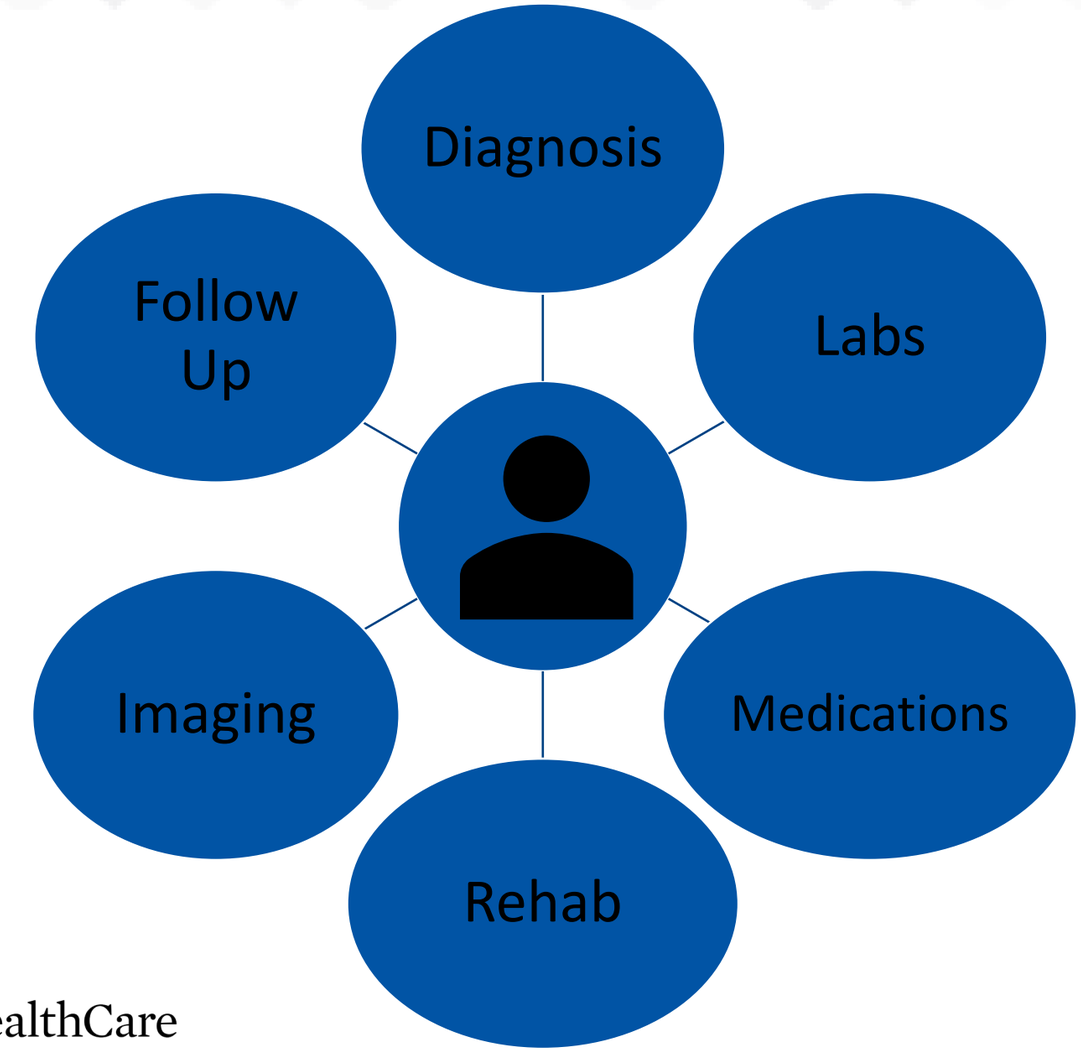
Heidenreich PA, et al. *Circulation*. 2022;145:e895–e1032.

NAVIGATING THE POST DISCHARGE PERIOD



Albert NM, et al. *Circ Heart Fail*. 2015;8:384-409.

NAVIGATING THE POST DISCHARGE PERIOD



- Functional
- Cognitive
- Financial

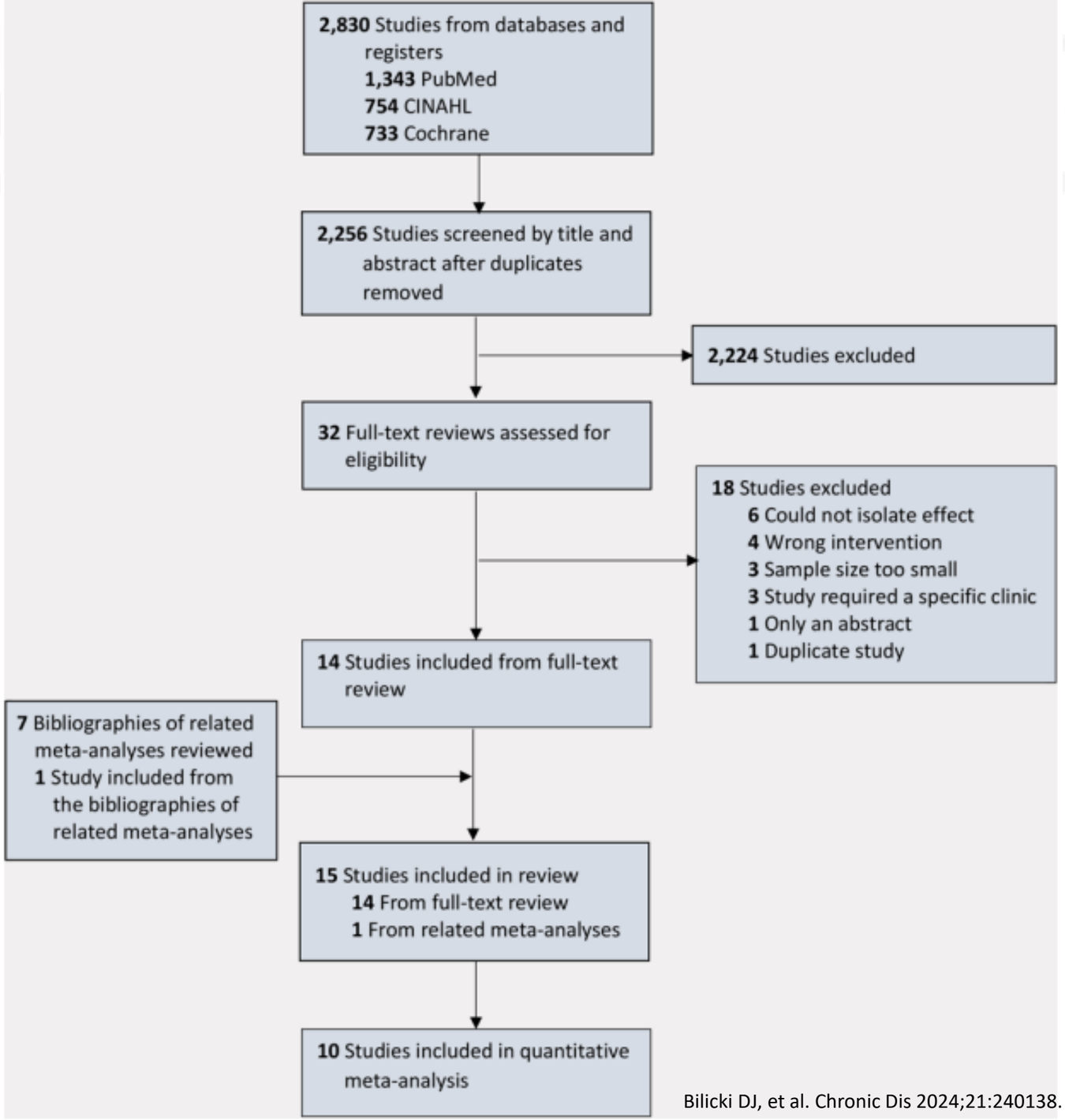
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TOC Clinic Outcomes

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Bilicki DJ, et al. Chronic Dis 2024;21:240138.

HF TOC OUTCOMES

	Study Design	Intervention	Patients	Team
Craigo CL, et al.[1]	Single center, retrospective	Post Discharge Clinic	Admitted for HF Age: 80 (mean); EF: NR	RN, NP, Ambulatory CM, pharmacist, CHW
Donaho EK, et al.[2]	Single center, retrospective	Post Discharge Clinic	Admitted for HF Age: 59 (mean); HFrEF EF: 25.9%; HFpEF EF: 51.7%	HF NP, pharmacist
Dev S, et al.[3]	Single center, retrospective	Post Discharge Clinic	Admitted for HF Age: 71 (mean); EF: ≤40%: 65%	RN, NP, HF cardiologist
Baecker A, et al. [4]	Multihospital, retrospective	Post Discharge Clinic	Admitted for HF Age: 73 (mean); EF: 44.3% (mean)	RN, NP, pharmacist, PCP, cardiologist
Harwood Z, et al. [5]	Single center, retrospective	Consult with dedicated HF coordinator	Admitted for HF Age: 69 (median); EF: NR	HF Coordinator

CM: care manager; EF: ejection fraction; HF: heart failure NP: nurse practitioner; NR: not reported; RN: registered nurse

1. Craigo CL, et al. *Heart Lung*. 2025;51:123–128. 2. Donaho EK, et al. *J Am Heart Assoc*. 2015;4:e002296.
3. Dev S, et al. *Am J Manag Care*. 2021;27(2):e42-e47. 4. Baecker A, et al. *JAMA Netw Open*. 2020;3(12):e2027410.
5. Harwood Z, et al. JACC Case Rep. 2026;31:10973.

HF TOC OUTCOMES

	Follow up
Craigo CL, et al.[1]	• Prior to discharge • ≤ 72 hour phone call (Pharmacist, Ambulatory CM) • ≤ 7 days clinic visit (in person or virtual)
Donaho EK, et al.[2]	• ≤ 7 days clinic visit • 4-6 week follow up visit
Dev S, et al.[3]	• Prior to discharge • ≤ 14 days clinic visit
Baecker A, et al. [4]	• ≤ 2 days phone call or home health visit (HHV) • ≤ 7 days phone call • ≤ 7 days clinic visit (in person or virtual)
Harwood Z, et al. [5]	• Prior to discharge • ≤ 72 hour phone call

1. Craigo CL, et al. *Heart Lung*. 2025;51:123–128. 2. Donaho EK, et al. *J Am Heart Assoc*. 2015;4:e002296.
3. Dev S, et al. *Am J Manag Care*. 2021;27(2):e42-e47. 4. Baecker A, et al. *JAMA Netw Open*. 2020;3(12):e2027410.
5. Harwood Z, et al. JACC Case Rep. 2026;31:10973.

HF TOC OUTCOMES

	30 Day Readmissions	Other Outcomes
Craigo CL, et al.[1]	Intervention (N= 930): 18.39% Preintervention (N= 687): 22.71% **4.32% reduction (p=0.0325)**	• 42% seen in post discharge clinic • 86% contacted by pharmacist
Donaho EK, et al.[2]	Intervention (N= 114): 12.3% Hospital Average: 22.1% **44.3% reduction (p=NR)**	• Status (@ visit 1): 25% were hypervolemic and 13% were hypovolemic • Med rec (@ visit 1) avg 2.1 med errors
Dev S, et al.[3]	Intervention (N= 119): 27% Preintervention (N= 142): 35% **(HR, 0.59; 95% CI, 0.37-0.96; P = .04)^**	• Appointment scheduled @ 7 days: **40 vs 12%*** • Appointment scheduled @ 14 days: **55 vs 31%*** • Completed visit @ 7 days: **24% vs 10%*** • Completed visit @ 14 days: **41% vs 23%***
Baecker A, et al. [4]	HHV or 7 day HF call compared to no visit or call; No difference# Completed 7 day visit vs no visit: **(HR, 0.88; 95%CI, 0.81-0.94)#**	• 66.1% received a HHV or telecare call ≤2 days • 87.6% received a care manger call ≤7 days • 72.5% completed a follow up visit
Harwood Z, et al. [5]	Intervention (N=700) Control (N=10,569) **92% reduction (OR: 0.08; 95% CI: 0.04-0.15; P < 0.001)**	• 85% reduction in CHF-specific readmission **(P <0.001)**

^30 day composite, ED visit, rehospitalization, or death; * p< 0.05; #30 day all-cause inpatient and observation stay readmission

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1. Craigo CL, et al. *Heart Lung*. 2025;51:123–128. 2. Donaho EK, et al. *J Am Heart Assoc*. 2015;4:e002296.
3. Dev S, et al. *Am J Manag Care*. 2021;27(2):e42-e47. 4. Baecker A, et al. *JAMA Netw Open*. 2020;3(12):e2027410.
5. Harwood Z, et al. *JACC Case Rep*. 2026;31:10973.

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AMI TOC OUTCOMES

	Study Design	Intervention	Patients	Team	Follow up
Bumpus et al. [1]	Single center, retrospective	Post Discharge Clinic	Admitted for ACS, HF, and AF without follow up ≤ 14 days of discharge ACS: 27.2%	NP	≤ 14 days clinic visit
Ashraf H, et al. [2]	Single center, retrospective	TOC Pathway with Post Discharge Clinic	Admitted for ACS	Pharmacist, cardiologist	• Prior to discharge with medication delivery and assistance forms • ≤ 10 days clinic visit

1. Bumpus et al. *J Fam Med Dis Prev.* 2017, 3:062
2. Ashraf H, et al. *Crit Pathways in Cardiol*. 2021;20: 71–74

AMI TOC OUTCOMES

	30 Day Readmissions	Other Outcomes
Bumpus et al. [1]	Attended follow up (N= 469): 6.4% Did not attend follow up (N=176): 13.1% **Reduced 30 day readmissions (p<0.006)**	• In patients not seen in TOC clinic, first follow up with cardiologist was on average 56 days after discharge
Ashraf H, et al. [2]	**Reduced 30 days readmissions (p=NR)**	• DAPT adherence increased from 56% to 92% (p<0.0001) • Scheduled follow up increased form 33% to 100%

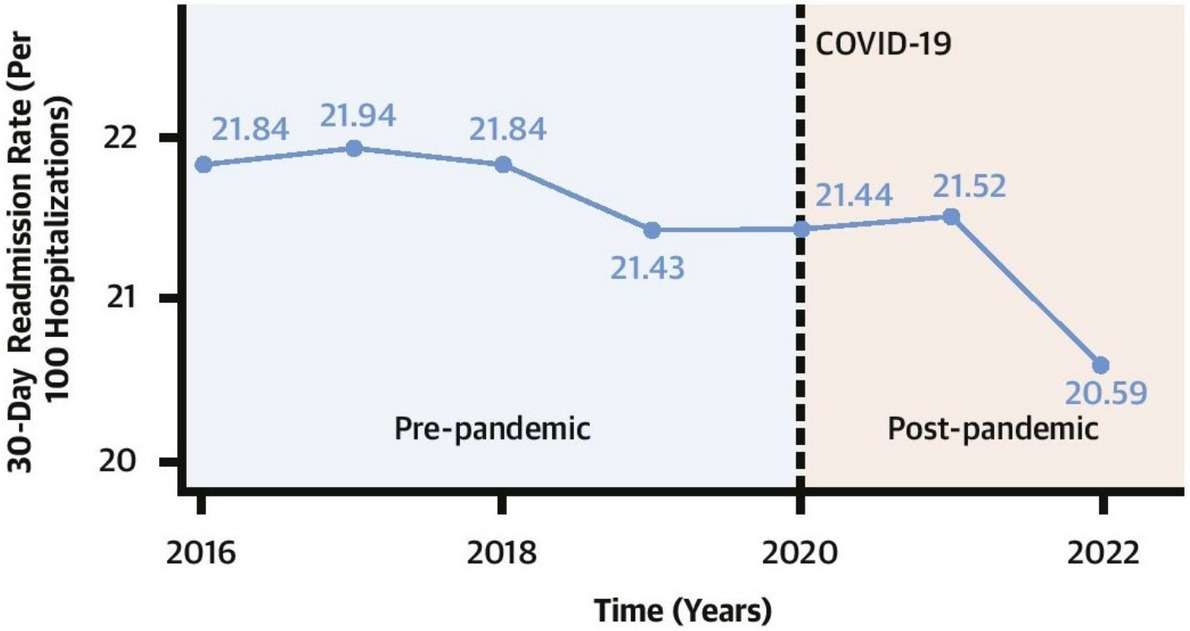
1. Bumpus et al. *J Fam Med Dis Prev.* 2017, 3:062
2. Ashraf H, et al. *Crit Pathways in Cardiol*. 2021;20: 71–74

TOC OUTCOMES

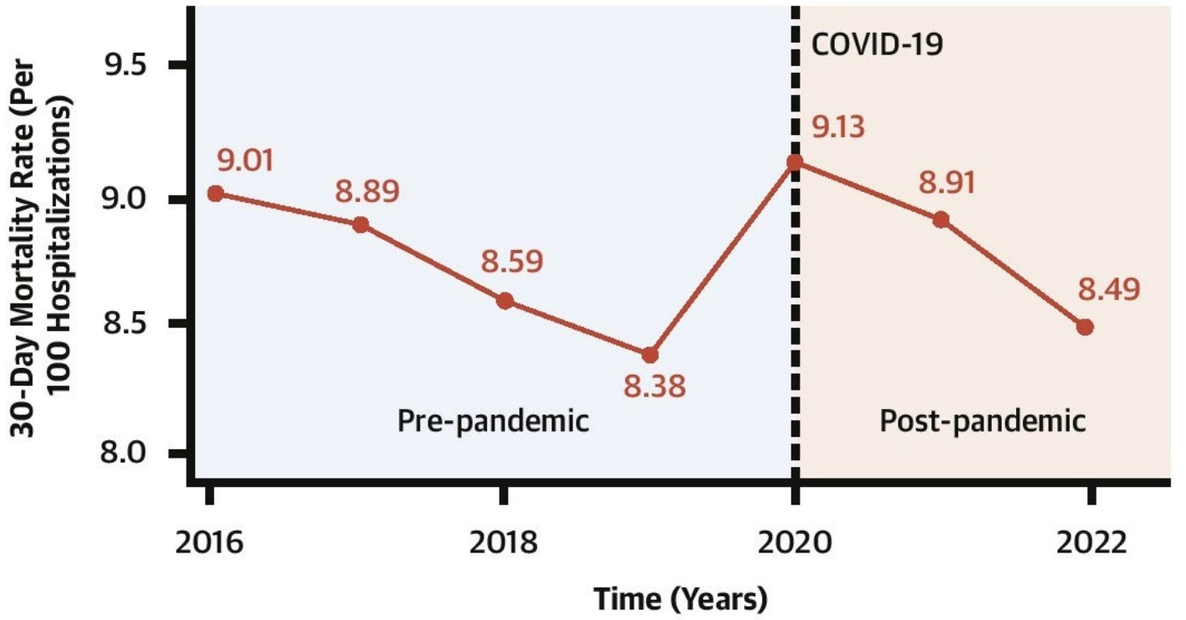
- Team
- Increased Touchpoints
- Follow Up
- Medication Reconciliation
- Disease State Education
- Care Coordination

TEMPORAL TRENDS IN HF HOSPITALIZATIONS

30-Day Readmission



30-Day Mortality

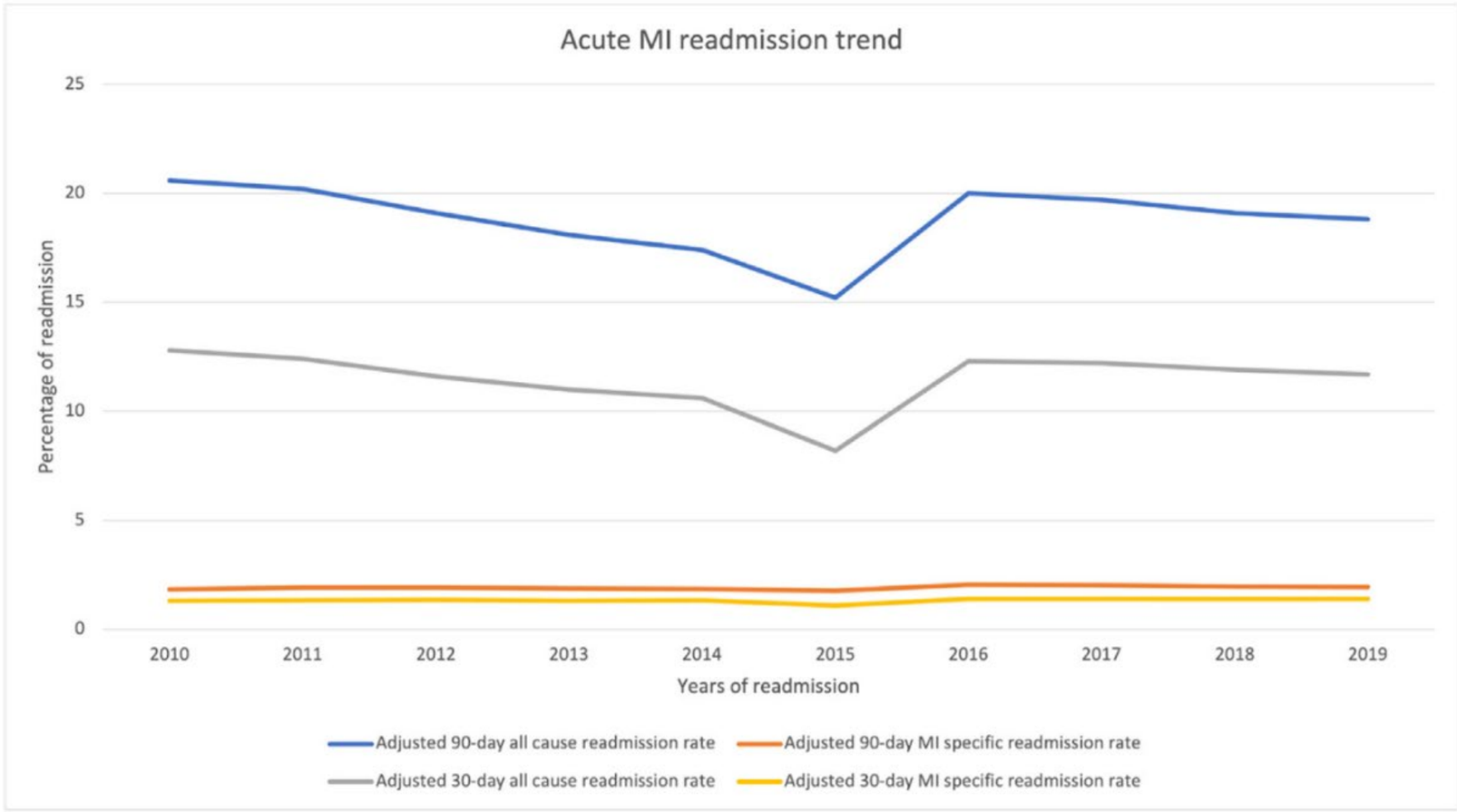


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Usman MS, et al. JACC Heart Fail. 2026;10.1016/j.jchf2026.103311.

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TEMPORAL TRENDS IN AMI HOSPITALIZATIONS



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Sana MK, Curr Probl Cardiol 2023;48:101696

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Implementation of an Outpatient TOC Clinic

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THE TOC TEAM

- Physician*
- Advanced Practice Registered Nurse
- Pharmacist*
- Nurse*
- Licensed Practical Nurse
- Medical Assistant*
- Patient Service Coordinator
- Fellows, Residents (Medical and Pharmacy), Students

PATIENTS

Hospitalized for a primary cardiovascular related condition

- Cardiology Floor/Observation Unit
- Cardiac Critical Care Unit
- Other services in which there was a cardiac intervention
- Excluded: Advanced HF

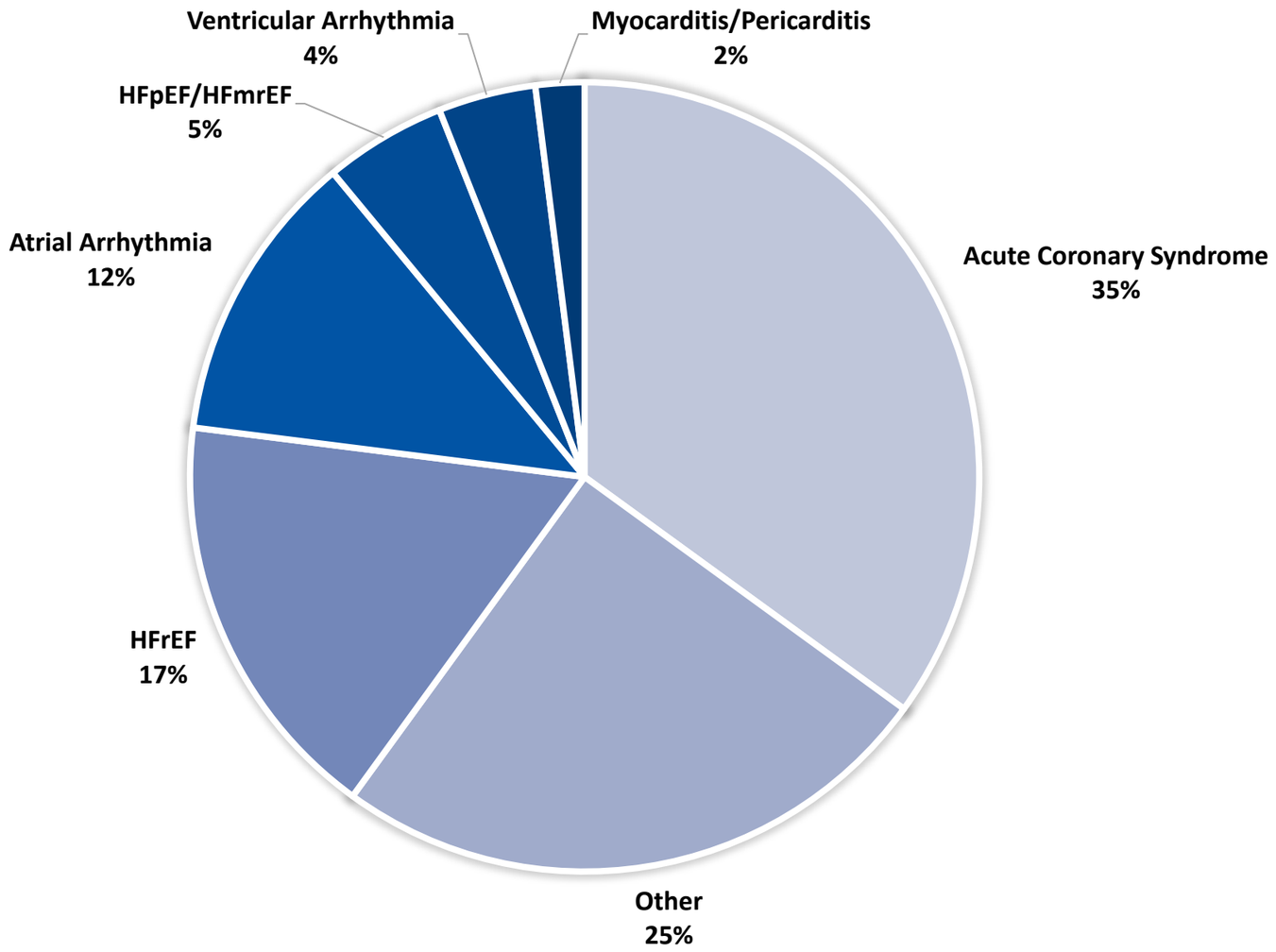
<u>Referral to the TOC clinic built into the discharge planning process</u>

THE PATIENTS

- Age 64.4 (median)
- Sex
  - Male 59%
  - Female 41%
- Race/Ethnicity
  - White 86%
  - Black/African American 10%
  - Hispanic Latino 3%
  - Asian 1%

Comorbidities	N= 506	%
Hypertension	294	58
Tobacco Use	274	54
Heart Failure	149	29
Coronary Artery Disease	148	29
Diabetes Mellitus	129	25
Atrial Fibrillation/Atrial Flutter	119	24
Hyperlipidemia	107	21
Chronic Kidney Disease	64	13
Chronic Obstructive Pulmonary Disease	47	9
Peripheral Vascular Disease	28	6
Cerebrovascular Accident	21	4

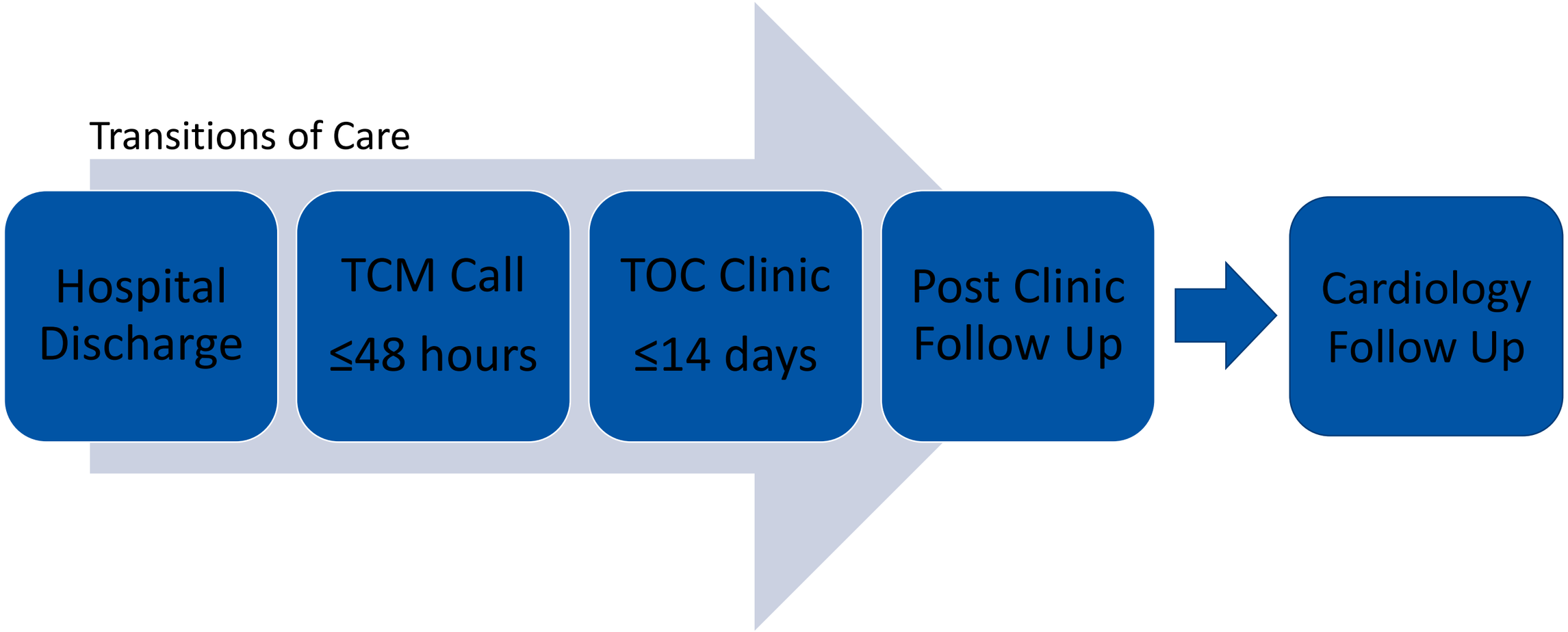
THE PATIENTS – ADMISSION DIAGNOSIS



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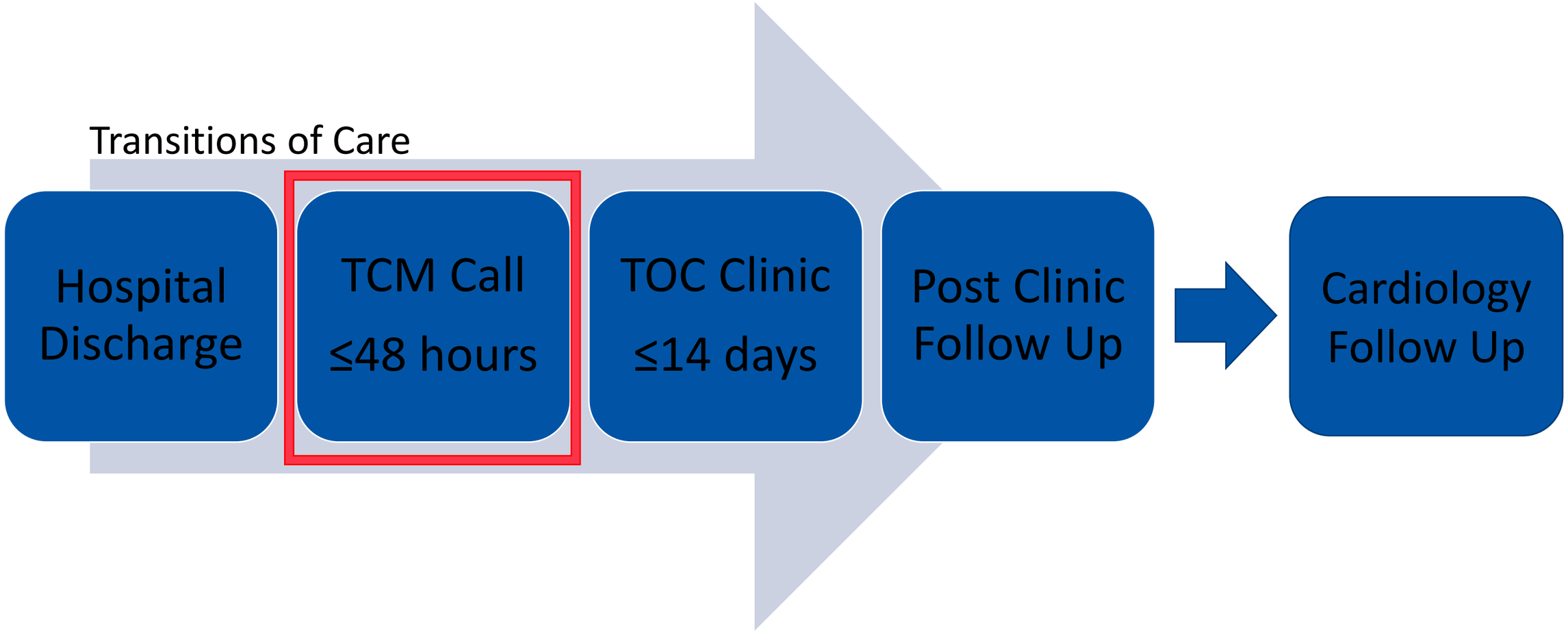
WORKFLOW



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WORKFLOW



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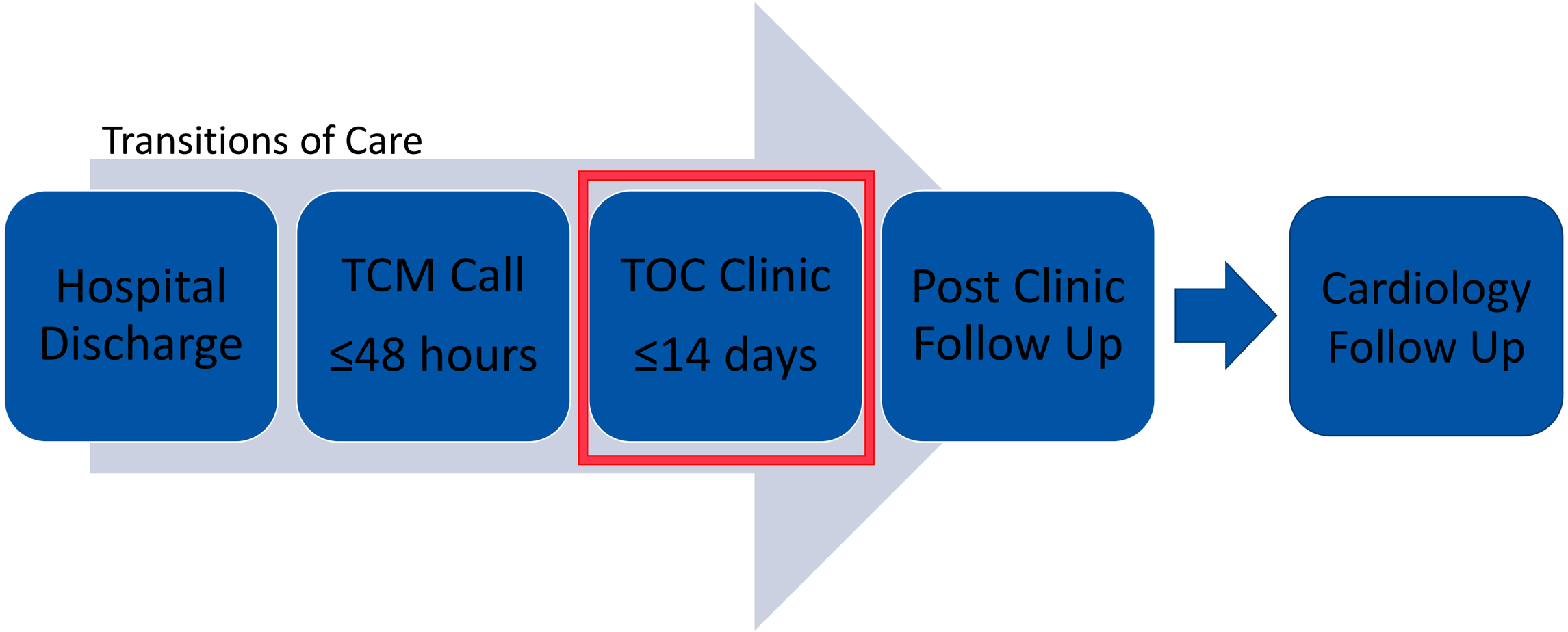
WORKFLOW

Transitional Care Management (TCM) Call

- Completed by a Licensed Practice Nurse (LPN)
- Within 48 hours after discharge
- Review After Visit Summary
- Review symptoms
- Review medications
- Assess social determinants of health
  - Community Health Worker
- Review upcoming clinic visits and provide clinic location and phone number



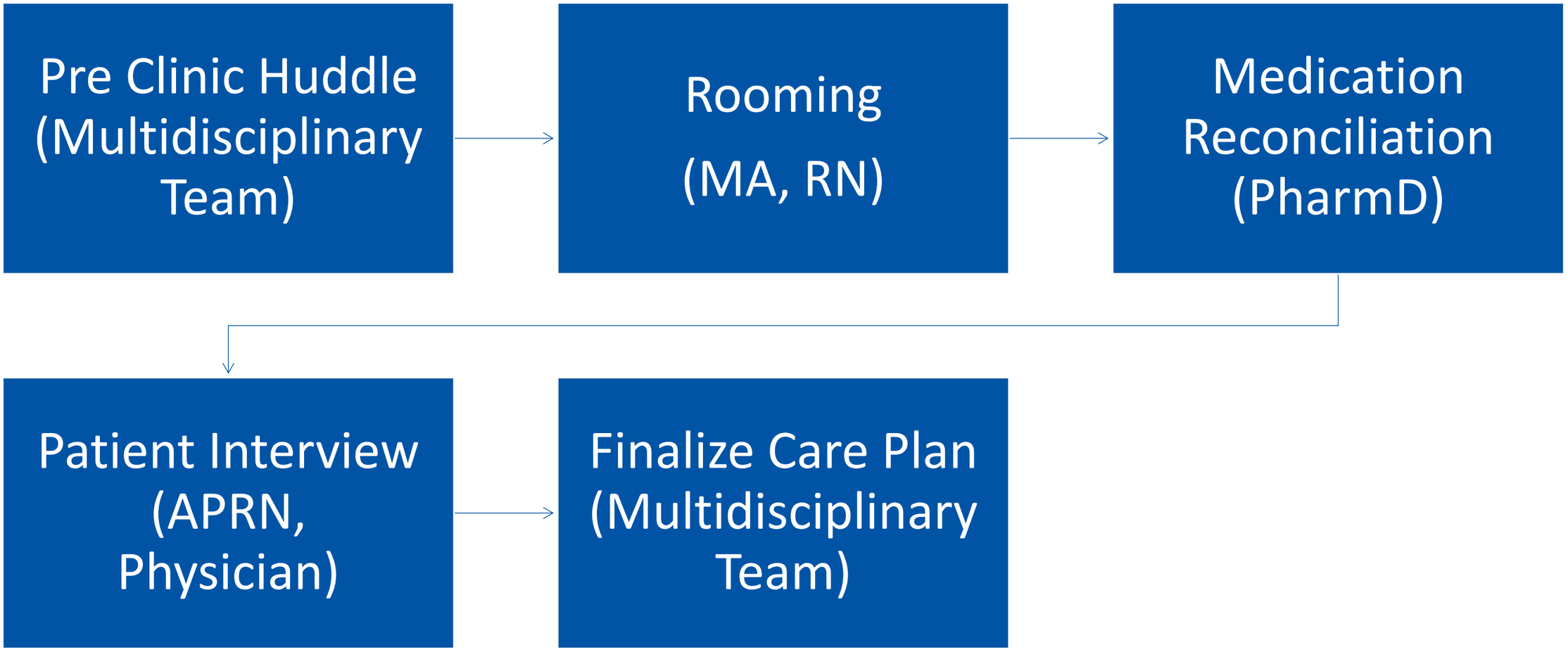
WORKFLOW



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WORKFLOW – DAY OF CLINIC



WORKFLOW – MEDICATION RECONCILIATION

Medication History

- A list of all prescription medications, OTCs, vitamins, and supplements
- Goal: **Complete and accurate** medication list

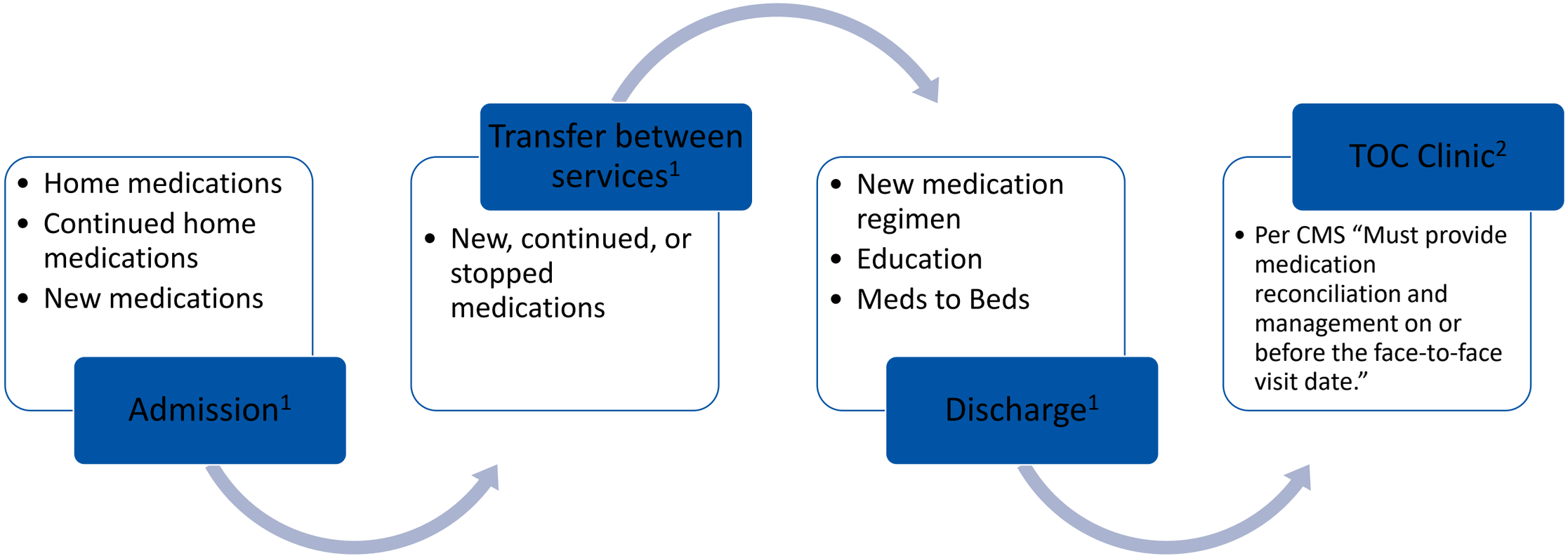
Medication Reconciliation

- Process of comparing the medications a patient is taking (or should be taking) with newly ordered medications[1]
- Goal: Resolving duplications, omissions, interactions, and need to continue current medications[1]

1. ASHP Statement on the Pharmacist's Role in Medication Reconciliation. *Am J Health-Syst Pharm*. 2013; 70:453-6.

WORKFLOW – MEDICATION RECONCILIATION

When should a medication reconciliation be completed?



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1. Hennen CR, et al. Pharmacy Times. Importance of Medication Reconciliation in the Continuum of Care. https://www.pharmacytimes.com/view/importance-of-medication-reconciliation-in-the-continuum-of-care. Published April 2014.
2.Medicare Learning Network Booklet. Transitional Care Management Services. August 2025

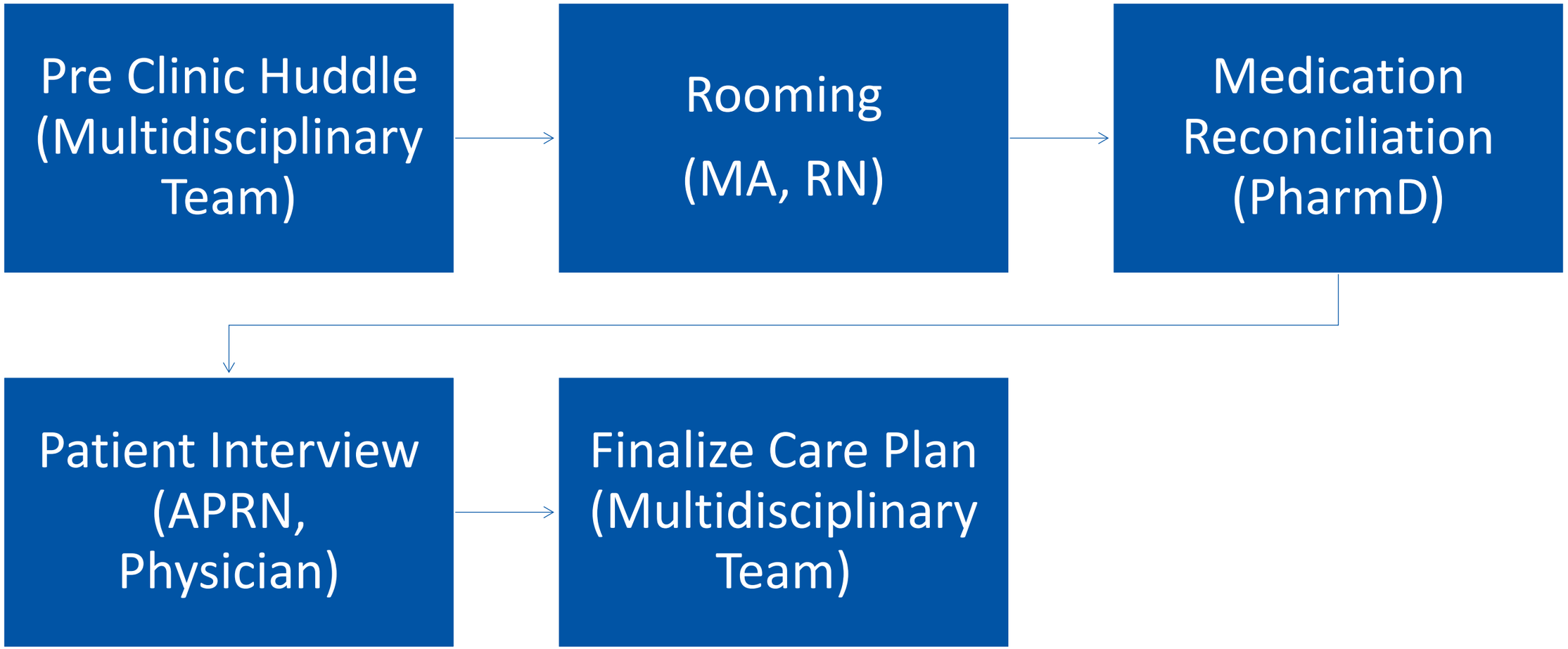
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MEDICATION ERRORS AND ADVERSE DRUG EVENTS

- Adverse drug events (ADE) are a leading cause of injury and death within health systems and account for 500,000 hospitalizations per year[1,2]
- Approximately 50% of all hospital-related medication errors and 20% of ADE occur during transitions of care[3]
- Up to 67% of medication histories taken on admission have ≥1 medication errors with up to 40% having discrepancies at discharge[1,4]
- Medication reconciliations reduces medication errors and supports safe medication use[3]

1. World Health Organization. High 5s Standard Implementation Protocol for Medication Reconciliation. September 2014.
2. Centers for Disease Control and Prevention. FastStats: Medication Safety Data. https://www.cdc.gov/medication-safety/data-research/facts-stats/index.html
3. ASHP Statement on the Pharmacist's Role in Medication Reconciliation. *Am J Health-Syst Pharm*. 2013; 70:453-6
4. Bishop MA, et al. *Am J Heatlh Syst Pharm*. 2015 Sep 1;72(17 Suppl 2):S120-6.

WORKFLOW – DAY OF CLINIC



WORKFLOW – DAY OF CLINIC

Pre Clinic Huddle (Multidisciplinary Team)

→

Rooming (MA, RN)

→

Medication Reconciliation (PharmD)

↓

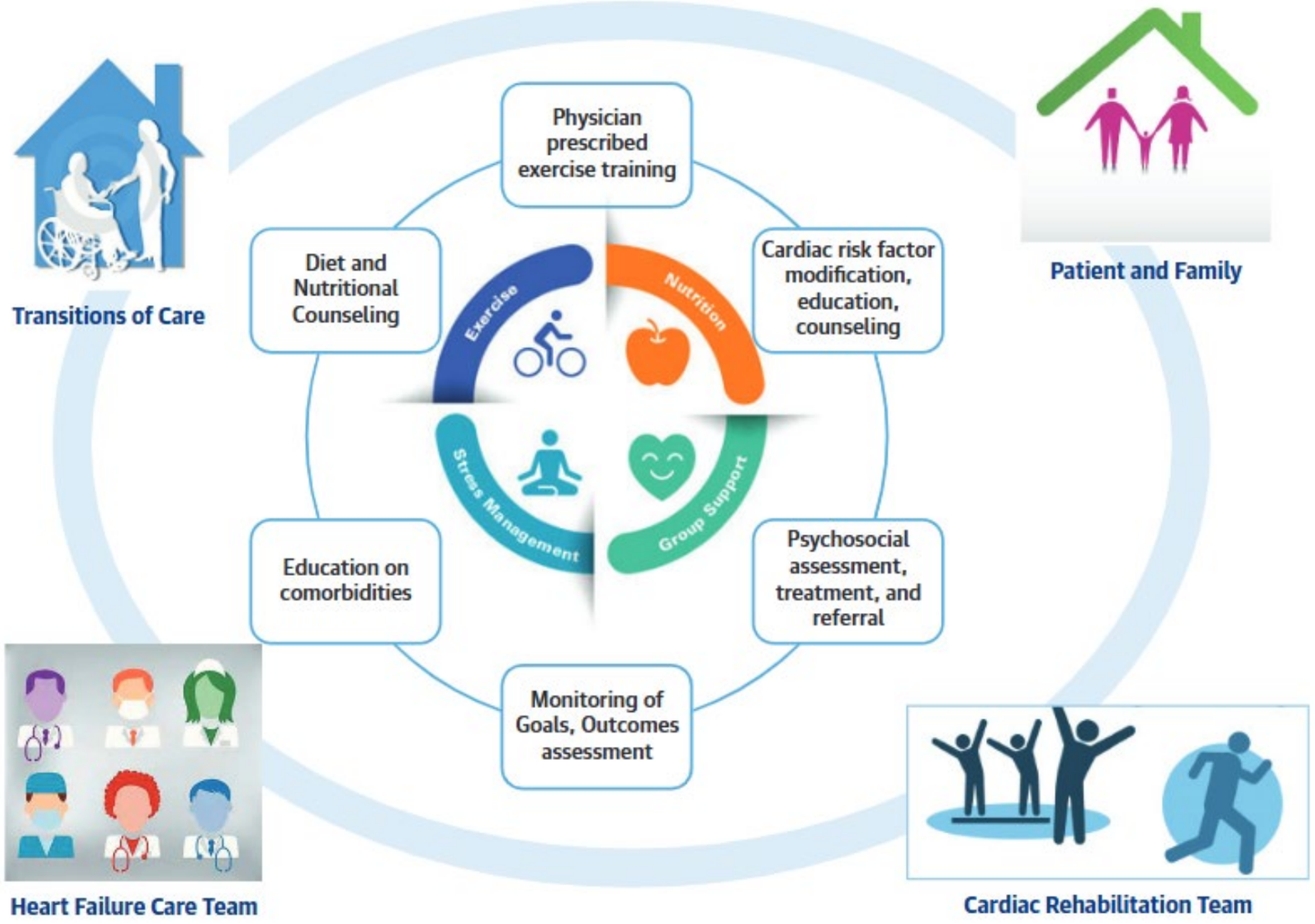
Patient Interview (APRN, Physician)

→

Finalize Care Plan (Multidisciplinary Team)

- Follow up
- Referrals
- Recommended labs or testing
- Medication changes
- Medication education
- Medication access

REFERRALS – CARDIAC REHAB



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Bozkurt B, et al. *J Am Coll Cardiol*. 2021;77(11):1454–69.

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WORKFLOW – DAY OF CLINIC

Pre Clinic Huddle (Multidisciplinary Team)

→

Rooming (MA, RN)

→

Medication Reconciliation (PharmD)

↓

Patient Interview (APRN, Physician)

→

Finalize Care Plan (Multidisciplinary Team)

- Follow up
- Referrals
- Recommended labs or testing
- Medication changes
- Medication education
- Medication access

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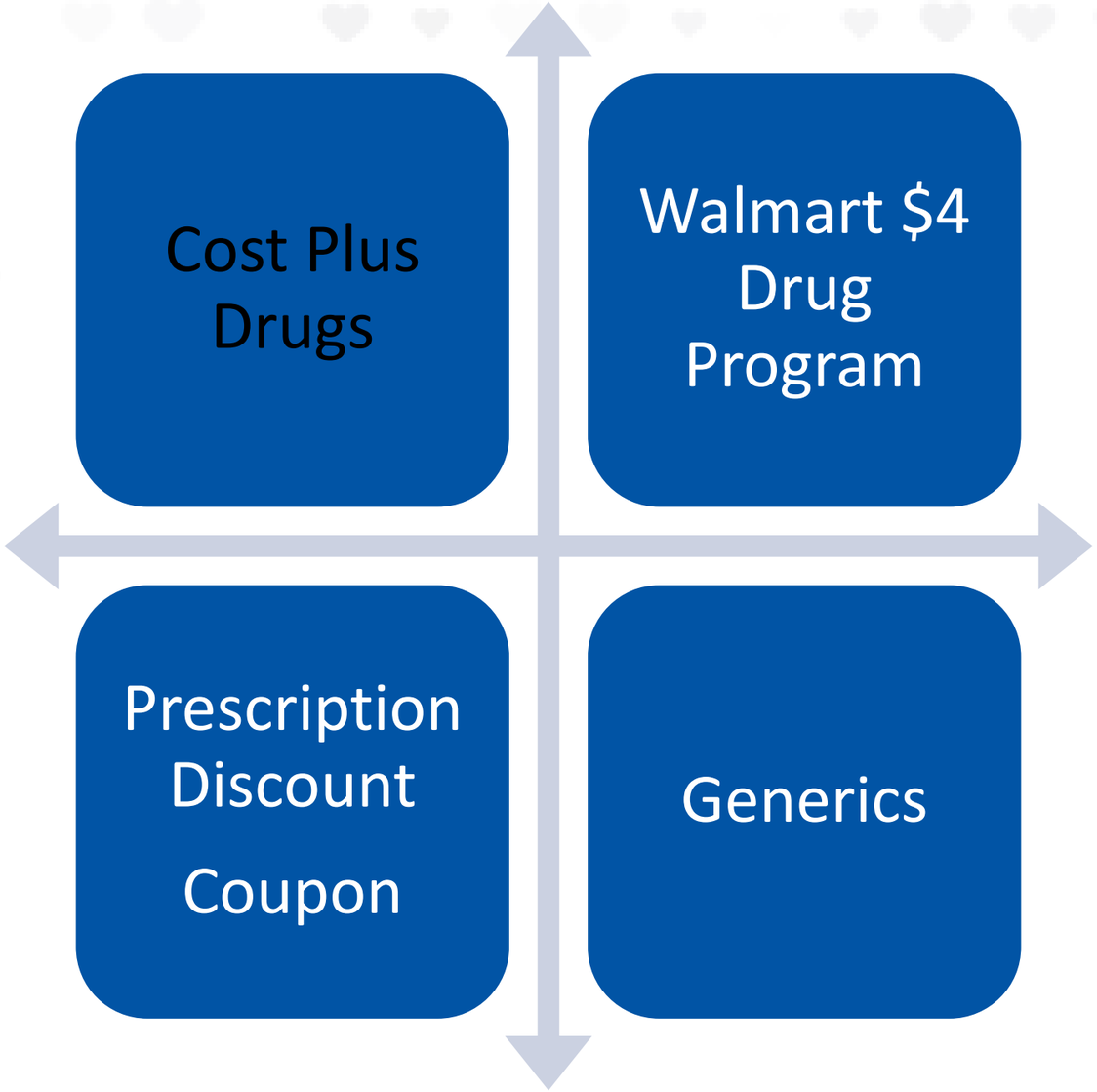
MEDICATION ACCESS – 340B PROGRAMS

- Created to enable covered entities to "**stretch scare federal resources as far as possible, reaching more eligible patients and providing more comprehensive services**"
- Discounts cost of drugs to pharmacy
- Savings can be used to make medications more accessible through prescription drug programs
- Used to support and expand health services offered

1. 340B Health. 340B Drug Pricing Program Overview. https://www.340bhealth.org/members/340b-program/overview/
2. Health Resources & Services Administration. 340B Drug Pricing Program. https://www.hrsa.gov/opa

MEDICATION ACCESS – PHARMACY

- **Dabigatran** 150 mg x 90 days: $46.78
- **Dapagliflozin** 10 mg x90 days: $12.28
- **Sacubitril/Valsartan** 24/26 mg x 90 days: $26.88



Dabigatran. Cost Plus Drugs. Available at https://www.markcubancostplusdrugcompany.com/. Accessed October 19, 2026.
Dapagliflozin. Cost Plus Drugs. Available at https://www.markcubancostplusdrugcompany.com/. Accessed October 19, 2026
Sacubitril/valsartan. . Cost Plus Drugs. Available at https://www.markcubancostplusdrugcompany.com/. Accessed October 19, 2026

MEDICATION ACCESS – PHARMACY



Includes 39 cardiac medications

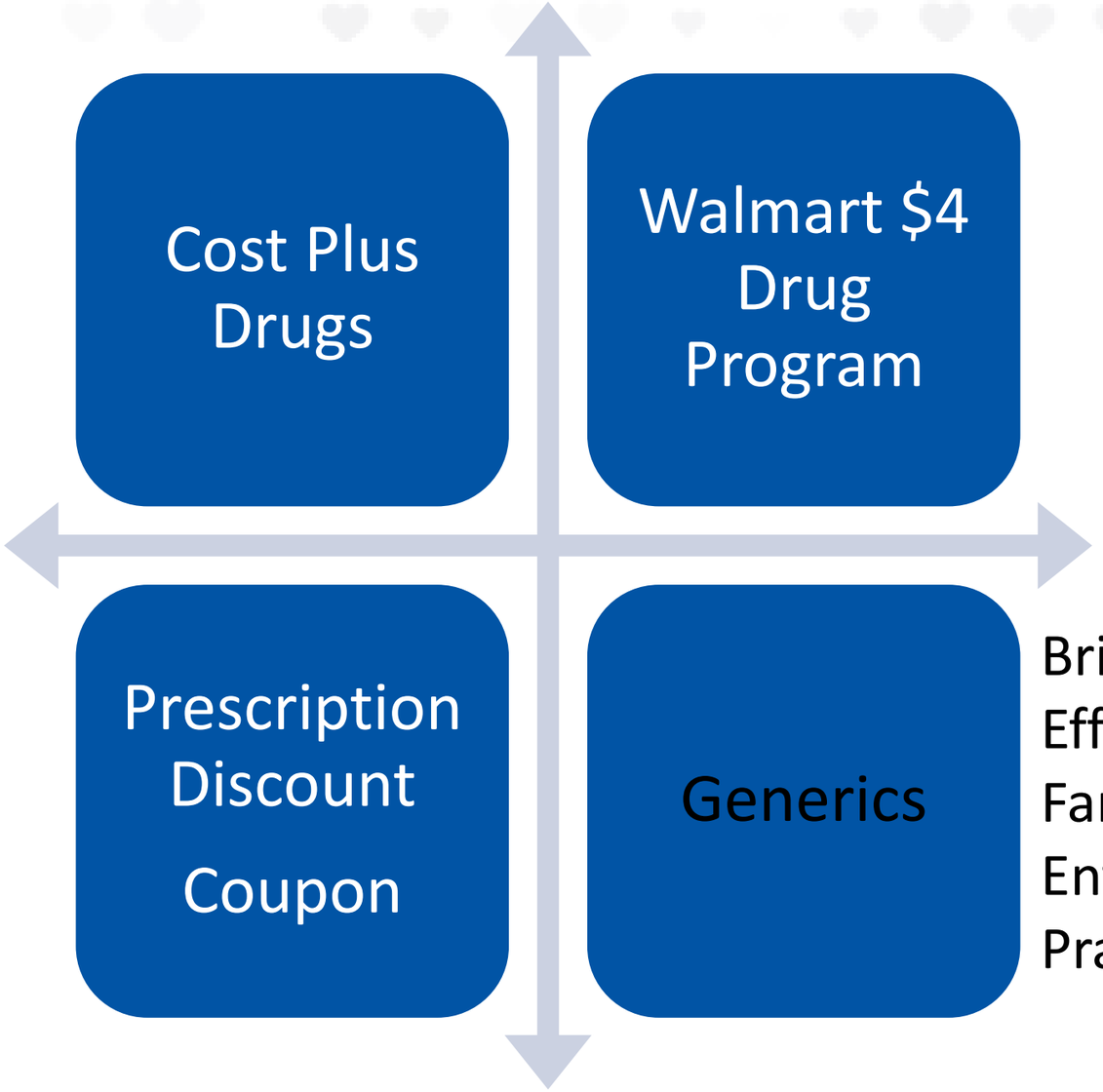
$4 Prescriptions. Walmart. Available at https://www.walmart.com/cp/4-prescriptions/1078664. Accessed October 19, 2026

MEDICATION ACCESS – PHARMACY

Good Rx



MEDICATION ACCESS – PHARMACY



Brilinta (ticagrelor)
Effient (prasugrel)
Farxiga (dapagliflozin)
Entresto (sacubitril/valsartan)
Pradaxa (dabigatran)

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MEDICATION ACCESS – PHARMACY

Johnson & Johnson Patient Assistance Program

- Xarelto

Bristol Myers Squibb Patient Assistance Foundation

- Eliquis

Boehringer Ingelheim Cares Patient Assistance Program

- Jardiance

Amgen Safety Net Foundation

- Repatha

MyPraluent Patient Assistance Program

- Praluent

MEDICATION ACCESS – MEDICARE

- Medicare Weight Loss GLP-1 Bridge Program (July 1, 2026, and December 31, 2027)
- Allow beneficiaries access to certain GLP-1 agents who are not eligible to receive a GLP-1 through their Part D plan
- Covers Wegovy, Zepbound, and Foundayo
- $50.00

Centers for Medicare and Medicaid Services. Medicare GLP-1 Bridge.
https://www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge/information-providers

MEDICATION ACCESS – FREE CLINICS

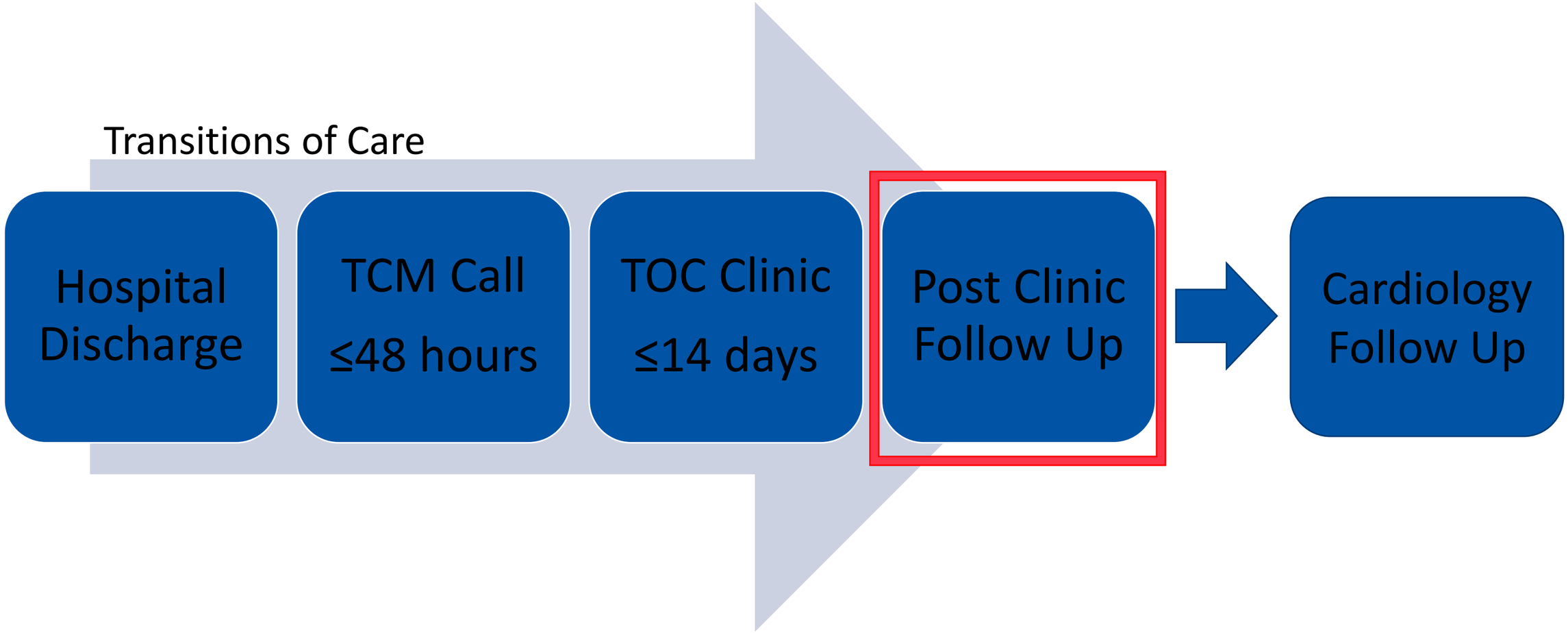
Mission Health Lexington

Faith Pharmacy (Saturday, 8:30-1030a)

THE SALVATION ARMY

UK Salvation Army Clinic

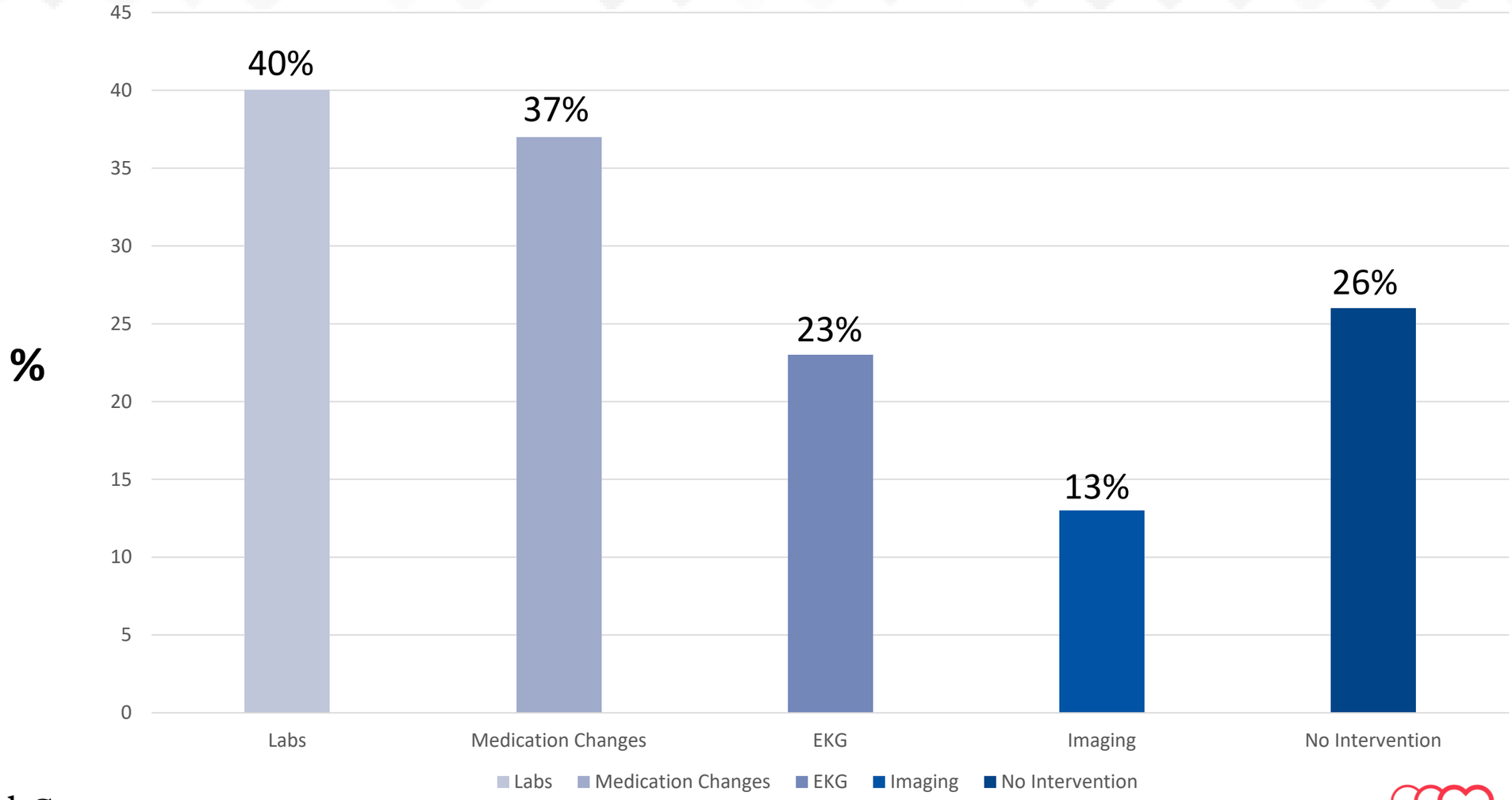
TOC WORKFLOW



WORKFLOW – POST CLINIC FOLLOW UP

Patient Status	Medications	Monitoring	Care Coordination
• Symptoms	• Medication Changes • Optimization of GDMT • Medication Access	• Labs • Blood pressures • Weights	• Follow up appointments • Referrals

UK TOC CLINIC INTERVENTIONS

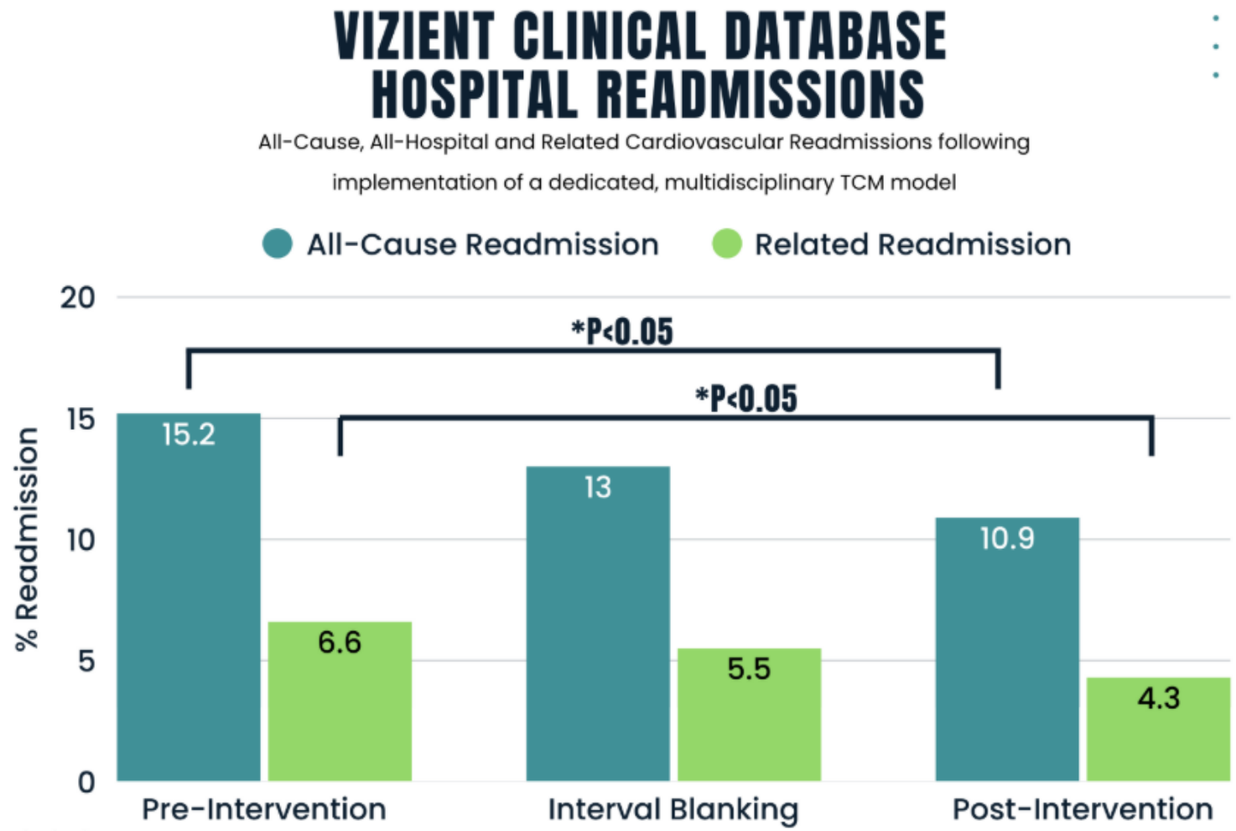


Interventions

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UK TOC CLINIC OUTCOMES – 30 DAY READMISSIONS



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KEY TAKEAWAYS

- Patients with HF and AMI are at high risk for readmission
- TCM services help bridge the gap as patients transition back to the community with the goal of reducing readmissions
- Transitions of care services are not one size fits all
- Ultimately provide a “landing place” for these patients

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THANK YOU FOR ATTENDING THIS SESSION!

Questions/Discussion

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