Best Practices in Managing Patients with Heart Failure Collaborative
September 1, 2016
Since we last spoke...
New Ideas

Original Goals and Objectives:
• Produce reports for gaps in care - to providers
• Create HF Treatment/Management Guidance
• Education of providers/staff, assure distribution of patient education materials
• Further expand the Cardiology CHF Achieve (weight reporting thru Patient Portal) project in Cardiology
• Future development of a Heart Failure Clinic

Update to Goals and Objectives:
• Create HF Management/Guidance
  – Cardiology using ACC/AHC guidelines
  – Recommending PCP utilize NYHA classification to identify CHF and refer to Cardiology and/or HF Clinic.
• Cardiology CHF Achieve stalled at this time; difficulty getting elderly patients to use portal
• Determined not to develop own HF Clinic but continue to use hospital HF Clinic.
Outcomes

Measure 1
- Baseline: 82.0%
- Year 2015: 86.0%
- 4/2015 - 3/2016: 89.0%

Measure 2
- Baseline: 80.0%
- Year 2015: 81.0%
- 4/2015 - 3/2016: 87.0%

Measure 3
- Baseline: 19.5%
- Year 2015: 15.1%
- 4/2015 - 3/2016: 14.9%
Celebrating Accomplishments

- Reports show ER visits and readmission rates down
- Majority of PCP have specific appointments on schedules for hospital follow up
- Hospitalist nurse schedules follow up with appropriate provider on day of discharge
- All discharged patients have follow up phone call with either Hospitalist nurse or Care Coordinator 2 days post discharge
- Data shows good compliance with medication prescribing – fairly small population with this gap in care
- EF being recorded in the vital signs field in EHR
Improvement Interventions

• Gap reports for patients not on ACE/ARB or BB and no reason documented sent to providers, with good feedback
• Plans for Clinic infusion unit still in progress
• Project focus is strong on preventing readmission
Improvement Interventions

• Care Coordination, Case Management, Operations, Palliative Care, Hospitalist Medicine, and ECF Advanced Practitioner as needed have daily huddles; review of:
  – Daily discharge list
  – 30-day readmission data
  – ED reports

• Targeted needs for patient are determined, either Case Management or Care Coordination intervene with individual patients to assist.
Increasing Utilization of a Heart Failure Clinic
Six Sigma Black Belt Project
Mary Haley-Emery, RN, BSN
Clinical Nurse Navigator
Business Case

• During the year 2015, O/E ratio for HF related admissions were 0.90 at Springfield Clinic. CMS 90\textsuperscript{th} percentile is 0.457.

• Treating patients with heart failure in a reactive manner can lead to negative outcomes, high medical costs and increased readmission rates. The average cost of a HF initial admission is $6882; average cost of readmission is $5630.

• According to AHRQ there is high confidence that referral to a HF Clinic can reduce hospital readmissions. Additionally, EBG from Up-To-Date suggest that HF Clinics can reduce 3-6 month readmission rates (RR 0.70, 95% CI 0.55-0.89).
Background

• Project development based on historical re-admission rates for CHF

• Can we mitigate index admissions or re-admissions by addressing problems from the onset rather than by reacting to a process that has escalated?

• How can we promote multi-disciplinary collaboration in a community health system?
No Referrals to Heart Failure Clinic

- PCP thinks cardiac refers
- Cardiac keeps patient
- Cardiac sends patient back to PCP

MD or Staff unaware of service
- Unaware of referral criteria
- Patient does not see cardiac
- Pt is non-compliant with care

PCP does not provide hospital care
- No education to provider of services
- Unaware of when to refer
- Unaware of how to refer
- Unaware of admission

Hospitalist sees pt in hospital
- No hospitalist or referral to HF Clinic
- No process to identify patient
- No process when discharged by other services than hospitalist

PCP does not refer to cardiac
- Patient cancels appt
- Issues tracking no shows/cancels
- Poor pt education
- Pt forgets about appt
- Multiple co-morbidities

PCP doesn’t refer to cardiac
- No ride, money, feels fine, too many appts

PCP doesn’t have enough follow up slots
- Pt confused about appts

PCP doesn’t refer to cardiac
- No ride, money, feels fine, too many appts

Patient cancels appt
- Issues tracking no shows/cancels

Issues tracking no shows/cancels
- Poor pt education

Pt confused about appts
- Pt forgets about appt

Multiple co-morbidities
- Multiple appts with multiple providers

No process to identify patient
- No care coordination in certain departments

No automatic referral to HF Clinic
- Pt sent to or lives in ECF/SNF

No notification to PCP of pt discharge from ECF
- Lose touch with patient

PCP may not round at ECF
What Qualifies a Patient for the HF Clinic?
-A Tale of Two Departments

HF Clinic Criteria
• NYHA Symptom Classification 2-4
• AHA/ACC Stage 3 & 4
• Actively treated with HF med adjustments (titrating meds, IV Lasix, additional HF meds added)
• Exceptions: Renal insufficiency on dialysis & Severe aortic stenosis planning surgical tx

Cardiology Criteria
• Patients can be referred at any Stage or Class but are typically referred at Class 2 & Stage C – if they are not followed closely and admission/re-admission starts
• Elevated BNP
• Any h/o Heart Failure
• Use of IV Lasix
Random Sample
N=101
Appointment with PCP Between July 2015 to December 2015

HF Patients Qualified for Referral

<table>
<thead>
<tr>
<th>Patient Category</th>
<th># of Referrals</th>
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<tbody>
<tr>
<td>Not Qualified for Referral</td>
<td>78</td>
</tr>
<tr>
<td>Qualified for Referral</td>
<td>23</td>
</tr>
<tr>
<td>Referred to HF Clinic</td>
<td>6</td>
</tr>
</tbody>
</table>

94.4%
PCP/Cardiology/HF Clinic Appointments

# of PCP & Cardiology Appointments/Patient
N=23

- Blue line: # of Appts with PCP between July and December
- Orange line: # of Appt with cardiologist between July and December
- Purple line: Referral to HF Clinic
Patients with Known Cardiologist

Number of Patients with Known Cardiologist

<table>
<thead>
<tr>
<th>Cardiologist</th>
<th>Total</th>
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<tbody>
<tr>
<td>Ahmed</td>
<td>25</td>
</tr>
<tr>
<td>Chen</td>
<td>5</td>
</tr>
<tr>
<td>Hamirani</td>
<td>5</td>
</tr>
<tr>
<td>Jha</td>
<td>1</td>
</tr>
<tr>
<td>Mak</td>
<td>1</td>
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<tr>
<td>Nester</td>
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<td>None</td>
<td>2</td>
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<tr>
<td>Singla</td>
<td>22</td>
</tr>
<tr>
<td>Zellner</td>
<td>18</td>
</tr>
</tbody>
</table>
Patients Qualified for HF Clinic

# of Patients Qualified for HF Clinic by Cardiologist

- Ahmed: 8
- Chen: 1
- Hamirani: 4
- Jha: 1
- Nester: 2
- None: 2
- Singla: 2
- Zellner: 3

Total: 28
HF Patients by PCP
(from Random Sample)
Patients Qualified for HF Clinic by PCP

HF Patients Qualified for HF Clinic by PCP

Qualified for HF Clinic

Count of Qualified for HF Clinic

HF Patients Qualified for HF Clinic by PCP

PCP

Total
Microproblem Statement

• Referral to the Heart Failure clinic from Primary Care lacks a consistent approach for patient identification and appropriate referrals. Based on a randomized sample of 101 patients at Springfield Clinic with a diagnosis of heart failure, 78 (77%) patients do not qualify for referral, however, 23 (22%) patients would qualify. Of the 23 qualified patients, only 6 were referred.

• Lack of a consistent approach in Heart Failure Clinic referrals leads to hospital admissions & re-admissions, negative outcomes and missed opportunities in the care & education of the patient with heart failure.
5 Why’s

• Why do our HF patients not get referred to the HF Clinic?
  • Providers are unaware of referral guidelines

• Why are we unaware of referral guidelines?
  • Because no one educated providers on them

• Why has no one educated providers on the guidelines?
  • Because there is lack of consensus regarding who should refer

• Why is there lack of consensus on referrals?
  • Because there is no process to follow
Critical X’s

• Why are patients not being referred to the HF Clinic?

• Lack of knowledge regarding Heart Failure Classification and Staging criteria

• Lack of knowledge regarding Heart Failure Clinic referral guidelines

• Lack of triggers from PCP office for appropriate referral

• Lack of standardized process for referral
Hypothesis Statement

• $H_o$ - Development of a standardized process for referral of HF patients to the HF Clinic will not increase referrals

• $H_a$ - Development of a standardized process for referral of HF patients to the HF Clinic will increase referrals
Next Steps

• Impact/Effort Matrix to help drive the interventions
• Develop or utilize existing algorithm to assist with appropriate referrals
• Work with staff to educate patient regarding self care
• Develop CHF specific questionnaire for acute visits
• Incorporate Care Guide/Pathway into EMR for multi-site standardization
• Pilot interventions in yet to be selected PCP office