Best Practices in Managing Patients with Heart Failure Collaborative

Improving Care for HF Patients in a Primary Care Setting

University of Utah Community Physicians Group

September 1, 2016
Re-cap of Original Plans

- Epic Healthy Planet Heart Failure Registry
- Primary Care Adult Risk Registry
- Care Conferences with provider, care manager, clinical pharmacist, social worker, MA, and RN to develop care plans
- Transition calls to patients 48 hours post discharge
- Depression and anxiety screening
- Social Workers embedded in care team
- Chronic Disease Self-Management classes and MyChart self-monitoring tools
- Care Team process improvement measures and dedicated meeting time
- RVUs awarded for care conferences and team process improvement meetings
Since we last spoke...
New Ideas and Interventions

• Care Conference Outline for HF Patients
• Home-monitoring telehealth pilot
• Collaboration and Coordination
  – Program level
    • Coordination meetings with HF Specialty Clinic
    • Co-management agreement with HF specialists
    • Primary/Specialty Care Immersion Education (… Shadowing field trips)
    • **Contingency Plan template with ability to customize for patient**
    • Primary Care Care Navigation Team making transition calls for all HF discharges, not just our group’s attributed patients
    • 7 day post discharge follow up visits with HF Clinic, if available, and primary care as back up
    • Epic-generated Discharge Summaries to PCP
    • Standardized Hospital Discharge Checklist for Acute Decompensated HF
  – Patient level:
    • Care Managers coordinating communication between Primary Care, HF Clinic, and Cardiology care teams
    • Including Specialty Care representative in Primary Care care conferences
    • **Collaborative Practice Agreement with Clinical Pharmacists**
HF Care Conference Outline

- Contact person for coordination/co-management with HF Specialist
- Medication review and recommendations
- Echo needed?
- ED/Hospital Admits and contributing factors
- Behavioral Health
- Lifestyle and Treatment Goals
- Contingency Plans (red flags and what to do if something goes wrong)
- Eligibility for Clinical Pharmacy Collaborative Practice Agreement
- Other chronic conditions
- Health Maintenance and Best Practice Alerts
- Ongoing Care Management/Care Coordination needs
A Case for Home Monitoring . . .

• Before the study started, our patient . . .
  – did not own a scale or B/P cuff to monitor condition at home
  – had 2 ED visits within a month because she started to feel out of breath
  – didn’t understand what was happening with her Heart Failure
• During the study . . .
  – patient diligently took her vital signs every day
  – Care Management
    • checked in with her when results out of recommended range
    • notified her PCP and Cardiology team who changed her medications and avoided hospitalizing her for diuresis
  – Cardiology referral for behavioral health was handled by Social Worker imbedded in primary care team
• After the study, our patient . . .
  – was given a scale of her own so she can continue to take her daily weights
  – expressed gratitude for being able to participate in this study and feels she has benefited from being included
  – has had no ED visits since starting the program
• Care Manager, PCP, and Cardiology are now all working in an integrative approach with patient’s chronic condition
Heart Failure Patient Contingency Plan

Green light – all clear
- Feel okay
- Within 1 – 2 lbs. (~ 1%) of normal weight
- Breathing is fine
- Little or no swelling

What to do
- Continue medications
- Keep diet on track
  - Keep all medical appointments

Yellow light – caution
- Weight gain of more than 3 lbs. (~ 2%) in 48 hrs. or 5 – 6 lbs. (~ 4%) in one week
- More shortness of breath or increase in fatigue with normal activity
- Increased swelling
- Need to prop up on more pillows to sleep
- Feeling bloated or nauseated

What to do
- Double furosemide (Lasix) dose for 48 hrs.
- If symptoms worsen or do not improve after 24 hrs. on increased furosemide, get appointment with your physician

Red light – Medical alert
- Gain of more than 5 lbs. (~ 4%*) in one day
- Short of breath with little or no activity
- Have to sleep in a chair or wake up gasping for air
- Lots of swelling in feet, ankles, hands, or stomach
- Chest discomfort

What to do
- First, try to get a same day appointment with your physician
  - If unable to get an appointment the same day, go to the emergency room
Collaborative Practice Agreement

• Upon referral, the pharmacist(s) may:
  – initiate, discontinue, or adjust medication for heart failure in accordance with current treatment guidelines
  – order laboratory tests appropriate to the disease or drug therapy
  – issue prescriptions or prescription renewals on behalf of the referring health care provider
  – document allergies and adverse drug reactions prior to initiation of medications
  – educate and provider appropriate counseling on all new medications
  – perform a medication reconciliation

• Coordination with PCP
  – the patient must be seen by their UUHC primary care provider at least once per year
  – new referrals to the service must be issued at least once a year
  – all pharmacist encounters will be routed to the appropriate provider for review
Care Team Population and Process Measures
All High Risk Patients, Multiple Conditions - Pilot Compared to System

High Risk Patients in Population

- April 16: 82
- May 16: 92
- June 16: 93
- July 16: 114
- August 16: 120

- April 16: 1467
- May 16: 1516
- June 16: 1342
- July 16: 1382
- August 16: 1371

- Percent High Risk (System): 2.2%
- Percent High Risk (Pilot): 2.9%
Care Team Population and Process Measures
All High Risk Patients, Multiple Conditions - Pilot Compared to System

Referral to Care Management
- Referral to Care Mgt (System)
- Referral to Care Mgt (Pilot)

Treatment Goal
- Treatment Goal (System)
- Treatment Goal (Pilot)

Depression Screening
- Depression Screen (System)
- Depression Screen (Pilot)

Referral to Clinical Pharmacy
- Referral to Clin Pharm (System)
- Referral to Clin Pharm (Pilot)

Lifestyle Goal
- Lifestyle Goal (System)
- Lifestyle Goal (Pilot)

Anxiety Screening
- Anxiety Screen (System)
- Anxiety Screen (Pilot)

Referral to Social Work
- Referral to So Wrk (System)
- Referral to So Wrk (Pilot)

Contingency Plan
- Contingency Plan (System)
- Contingency Plan (Pilot)

Encounter in Past 30 Days
- Encounter in Past 30 Days (System)
- Encounter in Past 30 Days (Pilot)
Outcomes – System (10 Clinics)

ACE/ARB Use

- 2014 Q4: 233 (74%)
- 2015 Q4: 248 (75%)
- 2016 Q1: 274 (77%)

Beta-Blocker Use

- 2014 Q4: 233 (85%)
- 2015 Q4: 248 (85%)
- 2016 Q1: 274 (88%)

30 Day HF Readmission Rate

- 2014 Q4: 194 (14%)
- 2015 Q4: 216 (17%)
- 2016 Q1: 226 (22%)
Challenges and Lessons Learned

• Data continues to be hard . . .
• Coordination between Cardiology and Primary Care
  – Navigating the structure of Cardiology
    • Heart Failure Clinic vs General Cardiology
    • Multiple cardiology sub-specialists
• Co-managing patients
  – Identifying co-managed patients
  – Provider acceptance of standardization
  – Primary Care Provider hesitancy to suggest changes when cardiology is involved
• Major Lesson Learned: Communication is key
  • Verbal
    – Care Managers
    – Primary and Specialty Providers
    – Clinical Pharmacy
    – Patient
  • Standardized documentation in EMR
    – Adding to Care Team
    – Goals
    – Contingency Plans
    – Care Coordination Note
Next Steps

• Understand the data and clinical factors impacting readmission rate
• Move beyond just on the right medication to look at right dose
• Organization-wide Common Care Plan (Expansion of Longitudinal Care Plan)
• Field trips into each other’s clinical areas
• Standardized education plan for CHF patients used in primary and specialty care
• Implement standardized contingency plan
• List of co-managed patients
• Care team measures for HF patient population
• Plan a Party
Questions for the Group

• How many times did the word “care” appear in these slides?
• What are you doing for palliative care support?
• How are you involving the patient in managing their condition at home?