

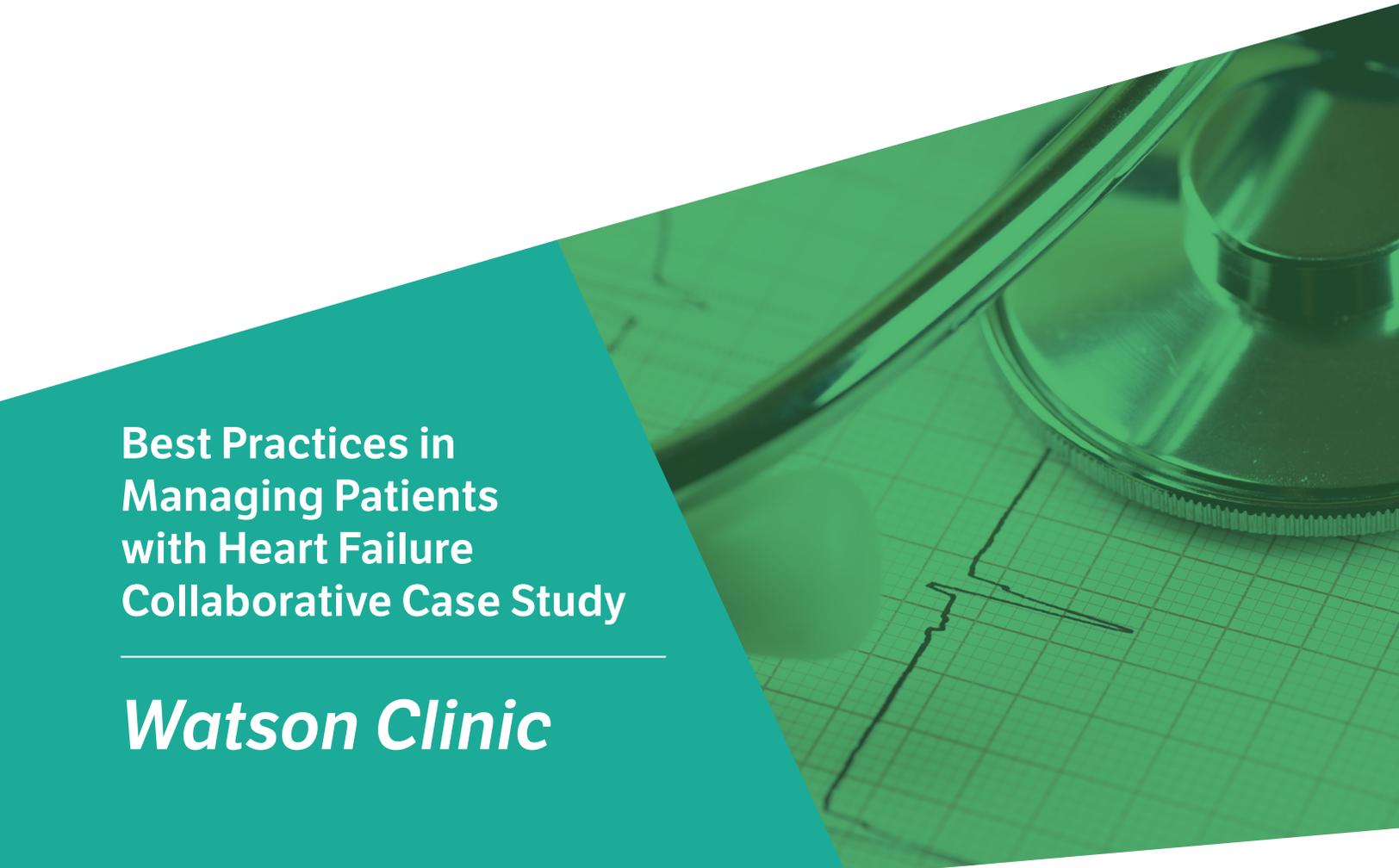


Advancing High Performance Health

AMGA Foundation

**Best Practices in
Managing Patients
with Heart Failure
Collaborative Case Study**

Watson Clinic



Organizational Profile

In 1941, two surgeons, two internists, and a urologist officially organized their Lakeland, Florida, medical group under the name Watson Clinic, LLP. Led by Dr. Herman Watson, their mission was to provide the very best health care to the people of Polk County and beyond.

From these modest beginnings, Watson Clinic has developed into one of the largest and most respected clinics in the Southeast. Their mission remains unchanged.

In response to the needs of the local community—and the ongoing progressive nature of the healthcare field—Watson Clinic continued to recruit physicians from the best medical schools in the world and expanded their roster of specialties and locations.

Watson Clinic now touches every corner of the community. With more than 1,600 employees, 200 physicians, 40 specialties, and 16 state-of-the-art locations in 4 counties, Watson Clinic conducts more than 1,000,000 outpatient visits per year.

Primary care physicians (PCPs) make up half of the 200 physicians on staff. There are a total of 100 advanced practice providers (APPs) on staff at Watson.

The cardiology division that worked with the AMGA Managing Patients with Heart Failure Learning Collaborative (HF Collaborative) boasts 10 cardiologists and 5 physician extenders or APPs. All 15 providers are located on the main campus of the Watson Clinic.

The growing reputation and range of Watson Clinic operations set the community standard for excellence in health care. Watson Clinic's commitment to the community has remained constant. As medical advancements have developed new and exciting possibilities, Watson Clinic has led the way by continuing to offer the latest innovations in technology and research, becoming a nationally respected healthcare organization.

Watson Clinic LLP – Accreditations/Certifications

- Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)
- Patient Centered Medical Home (PCMH) Level 3 through National Committee on Quality Assurance (NCQA)

- American Association of Cardiovascular and Pulmonary Rehabilitation (AACVPR)
- Commission on Cancer (CoC)
- American College of Radiology (ACR)
- American Diabetes Association
- Intersocietal Commission for the Accreditation of Echocardiography Laboratories (ICAEL)
- College of American Pathologists (CAP)
- American Academy of Sleep Medicine
- National Accreditation Program for Breast Centers (NAPBC)
- Agency for Health Care Administration (AHCA)

Executive Summary

Watson joined the HF Collaborative with two primary goals:

1. To properly identify our population of HF patients
2. To improve overall outcomes through a collaborative team approach

With HF being one of the most common admitting diagnoses, Watson decided to focus its efforts on trying to minimize hospital readmissions in HF cases.

To reduce the readmission rate, Watson instituted specialized care coordination for patients admitted to the hospital for HF. The protocol included contacting the patient within two business days of discharge to discuss self-management in the following areas:

- Medications
- Diet
- Activity
- Monitoring blood pressure, heart rate, and weight daily
- Recognizing early signs and symptoms of HF

An action plan was also developed in the event self-management began to fail.

The 22 patients enrolled in the care coordination transition of care program demonstrated an understanding of self-

management, as evidenced by the fact that none of them were readmitted to the hospital in the 30 days following discharge.

It quickly became obvious that outcomes could be greatly improved with: (1) care coordination; and (2) emphasis on education in self-management, targeted to both patients and caregivers.

Program Goals and Measures of Success

Watson's primary goals for its HF Collaborative project were to:

- Properly identify the HF patient population
- Improve overall care of the HF patient population through a collaborative team approach
- Reduce admission and readmission rates for HF patients by introducing transition of care after discharge and care coordination specific to HF cases
- Increase satisfaction among HF patients and provide education about disease management
- Increase follow-up appointments with physicians within seven days of discharge from the hospital
- Increase patient and caregiver education related to the HF disease process, medications adherence to increase compliance, and helpful lifestyle changes
- Provide education related to recognizing symptoms and exacerbation management to reduce hospital admissions and readmissions
- Ensure HF patients were placed on an ACE or ARB and a beta blocker, barring any contraindications
- Decrease mortality and morbidity associated with HF
- Conduct appropriate data collection and measurement.

Population Identification

The target population for Watson's HF Collaborative work included any patient within the Watson service area with a diagnosis of HF, of all genders, age ranges, races, and causes of condition. A registry was created to identify and manage HF patients, and it was updated monthly. The cardiology division that worked with this HF Collaborative is made up of 10 cardiologists and 5 physician extenders, all of whom are located on the main campus of the Watson Clinic.

Intervention

The Watson HF Collaborative team received a list of patients who were admitted to the hospital with a diagnosis of heart failure. One RN was assigned to the care coordination for this specific patient population. Patients were contacted within two business days after discharge. During this contact their follow up appointments would be scheduled. There was also a review of their prescribed medications to ensure the HF patient was:

- Taking the most effective medication
- Taking the medication as prescribed
- Able to afford all necessary medications

The HF patients were educated regarding signs and symptoms of HF exacerbation and self-management to prevent exacerbations. An action plan was also implemented in the event exacerbation could no longer be self-managed. The patient was instructed to call the RN with any questions or concerns, and the RN followed up with the patient throughout the 30-day period after discharge to reinforce the plan of care.

The RN implemented a care path for all HF patients focusing on education and self-management. The care path was individualized for each patient's needs. Since one RN was coordinating the care of this population, the HF Collaborative RN was in constant contact with the providers and their care teams.

The HF Collaborative RN quickly realized HF patients were receiving inconsistent preparation, education, and information upon discharge from the hospital. For example, when most HF patients were asked if they were following a low-sodium diet, they agreed they were. However, when questioned about their typical daily meals, most patients did not realize how much sodium they were actually consuming. An important aspect of the HF Collaborative's RN interventions with HF patients involved correcting misconceptions and addressing gaps in HF patients' understanding of their condition and appropriate protocols for treatment.

Outcomes and Results

The 30-day readmission rates have consistently trended downward since participation in the AMGA HF Collaborative. From 39.1% at the start of the Collaborative, readmission rates have been reduced to 9.4. Rates for ACE/ARB therapy, already

high when the Collaborative began, remain high at 78.5%. Beta blocker use has increased approximately 2% over the course of the Collaborative, and is now at 67.3%.

Lessons Learned and Ongoing Activities

It became clear that HF patients would benefit from a care path that began at admission and continued through to outpatient treatment. One of the challenges was determining what the patients already knew about HF and what aspects of care required reinforcement. Doing so required an individualized approach, which included determining each individual patient's barriers to learning. Once those were established, the HF Collaborative could begin the education process that best suited each patient's needs and gaps in patient care.

The patients involved in the HF Collaborative did not express concerns with provider availability, nor issues with location. The HF patients also expressed both pleasure and trust with their cardiology providers. The appropriate level of patient care and education was already in place. What the HF Collaborative process highlighted was that giving the patient instructions on what to do was not enough. Engagement was the key to having the patient follow through in self-management—not only with their HF condition, but any chronic condition.

To improve the health and quality of life for these HF patients—as well as to maintain success in reducing admission and readmission rates in the HF population—it is important to begin keeping up with the progress of these HF patients on a long-term basis, rather than simply implementing short-term interventions. It will be essential to implement a chronic care management program to help sustain these results for HF and other chronic conditions.

Patient Story

The story of the Heart Failure Collaborative from the perspective of the nurse who worked directly with every patient in the project:

“Every patient I called was eager to learn more about their disease process and how to care for themselves at home. They appreciated the time I was giving them to ask all the questions they didn’t ask their doctors or forgot to ask at the hospital when they were being discharged. Almost universally, the patients seemed to want to be more involved in their own health care. They want the knowledge that will allow them to depend on themselves more and their doctors less. With increasing age and debilitating illnesses, these are patients who typically already have to rely on others in one or more areas of their lives. The more independence they can have, the happier they are. At the end of the 30-day intervention, the majority of the patients were *beyond pleased* with their progress. It was exciting to watch their progress. They especially appreciated having an additional avenue to reach out—since many of them did not want to “bother the

doctor.” Most of them were happy to have someone to talk to about their lives and their medical condition, and I think it made a difference just to feel like someone cared enough to listen. On that last phone call, I always made sure the patient still had my phone number and told them to call me any time they had any concerns. This Heart Failure Collaborative has not only changed the way these patients will manage their health care related to heart failure, but will impact all of their chronic conditions. I can unequivocally say that this Collaborative has helped all of the patients and their family members who were involved. It has changed me too. Patient education is more than simply spouting off facts. It is a matter of knowing your patient and understanding how those facts can best impact your patient’s life. It means not just knowing the facts but actually seeing them put into motion to improve and extend someone’s life. I have become a better nurse through being a part of this Collaborative.”

– Allison Dickson, R.N., CHF Care Coordinator

Figure 1A: Measure 1 - ACE/ARB/ARNi (Watson)

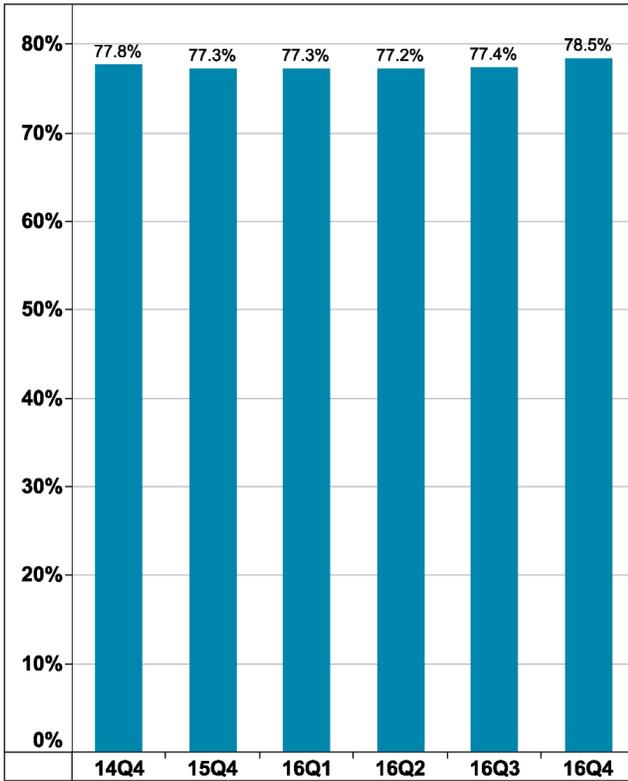


Figure 1B: Measure 2 - Beta Blocker (Watson)

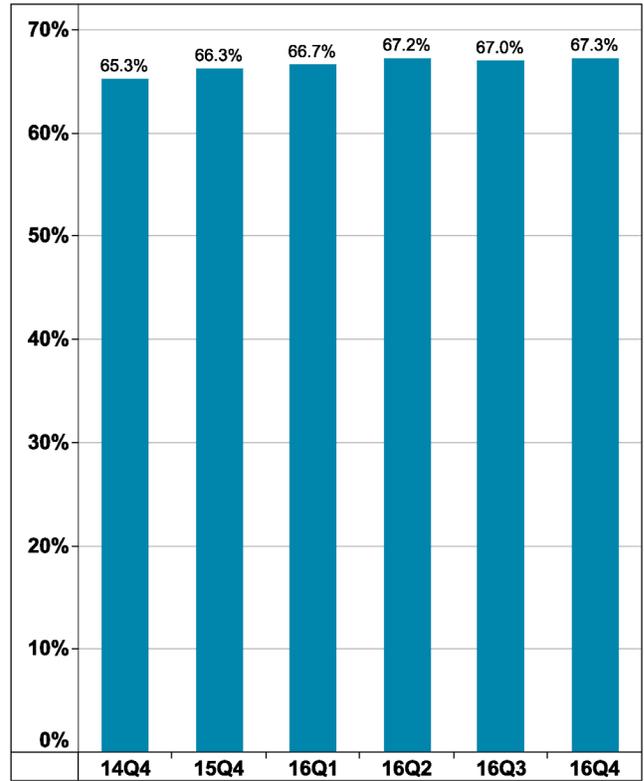
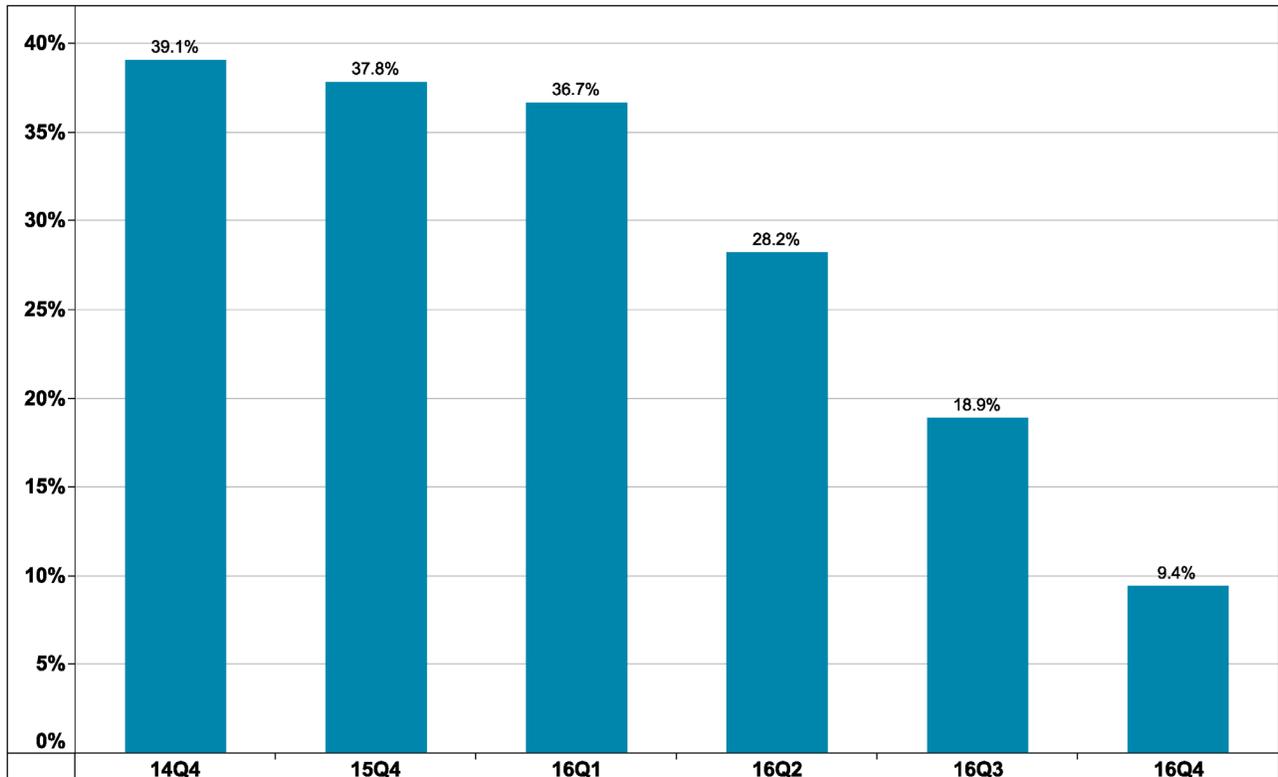


Figure 2: Measure 3 - Readmission Rate (Watson)



Project Team

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