Best Practice: Using Data to Drive Practice and Improve Patient Outcomes

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Baptist Health Lexington
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Objectives

• Objective 1: Translate the information shared through registry data and analysis into solutions for improving heart failure care in the hospital environment.

• Objective 2: Identify the importance of guideline-directed medical therapy and quality improvement initiatives in Heart Failure patient management.
Despite significant advances in treatment and prevention, the total number of CHF patients has remained stable over time, with more than 550,000 new cases diagnosed annually. The sheer complexity of CHF demands diligent follow up care and monitoring, as well as care coordination across multiple providers and sites of care.

Source: Engelberg Center for Health Care Reform at Brookings
“Innovation in Care Delivery. Treating Congestive Heart Failure and the Role of Payment Reform” May 2014

Baptist Health Lexington

- Community-based hospital in Lexington, KY
- 357 licensed beds, 4 OP Diagnostic Centers
- One of 3 hospitals in East Region
- One of 7 hospitals in Baptist Health System Kentucky
Population Geography for Baptist Health System of KY

Blue is our primary service area
Green is our secondary service area
Purple is our neighboring states' service area

Baptist Heart and Vascular Institute
- A Fib and Heart Rhythm Disorder Center
- Advanced Heart Failure Center
- Lexington Cardiac Research Foundation
- Heart and Valve Center
- Resistant Hypertension Center
- Chest Pain Center with PCI
- Lexington Cardiac Research Foundation
- Lexington Cardiac Research Foundation
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- Lexington Cardiac Research Foundation
The Role of Payment Reform (MACRA) and Heart Failure

6 MILLION
Number of Americans suffering from CHF

$273 BILLION
Direct costs spent annually on CHF care, including hospitalizations, outpatient care, medications, and devices.

24 PERCENT
CHF patients are readmitted to the hospital within 30 days

80 to 90 Percent
Cardiovascular disease diagnoses are attributable to lifestyle choices and behavior.

40 Percent
CHF patients have five or more co-occurring illnesses which accounts for 81% of the total CHF inpatient days

The new reimbursement environment favors “treating patients in the right place at the right time” so collaboration among hospitals and niche providers is critical to shift from an acute care institutional focus to physician focus in population care.”

Source: Engelberg Center for Health Care Reform at Brookings
“Innovation in Care Delivery. Treating Congestive Heart Failure and the Role of Payment Reform” May 2014

There are a Multitude of Motivators for Focusing on Heart Failure

1. Payment Penalties
2. Care Quality
3. Public Transparency
4. Migration Toward New Care Delivery Model with Population Health “the health outcomes of a group of individuals, including the distribution of such outcomes within the group.”
5. Individual providers and entire health systems are responsible for the health of a population, and new ways of addressing what goes on beyond the hospital and clinic walls are necessary.

*Clinical Advisory Board 2010 Member Survey on Readmissions; Clinical Advisory Board interviews and analysis.
Top Conditions for 30-Day Readmissions

<table>
<thead>
<tr>
<th>Condition at Discharge</th>
<th>30-Day Hospitalization Rate (%)</th>
<th>Proportion of All Hospitalizations (%)</th>
<th>Most Frequent Reason for Readmit</th>
<th>2nd Most Frequent Reason for Readmit</th>
<th>3rd Most Frequent Reason for Readmit</th>
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</thead>
<tbody>
<tr>
<td>All medical</td>
<td>21.0</td>
<td>77.6</td>
<td>Heart Failure</td>
<td>Pneumonia</td>
<td>Psychoses</td>
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<tr>
<td>Heart failure</td>
<td>26.9</td>
<td>7.6</td>
<td>Heart Failure</td>
<td>Pneumonia</td>
<td>Renal Failure</td>
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<td>Pneumonia</td>
<td>20.1</td>
<td>6.3</td>
<td>Pneumonia</td>
<td>Heart Failure</td>
<td>COPD</td>
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<td>COPD</td>
<td>22.6</td>
<td>4.0</td>
<td>COPD</td>
<td>Pneumonia</td>
<td>Heart Failure</td>
</tr>
<tr>
<td>Psychoses</td>
<td>24.6</td>
<td>3.5</td>
<td>Psychoses</td>
<td>Drug toxicity</td>
<td>Drug or alcohol misuse</td>
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<tr>
<td>All surgical</td>
<td>15.6</td>
<td>22.4</td>
<td>Heart Failure</td>
<td>Pneumonia</td>
<td>GI problems</td>
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<tr>
<td>Other vascular surgery</td>
<td>23.9</td>
<td>1.4</td>
<td>Other vascular surgery</td>
<td>Amputation</td>
<td>Heart Failure</td>
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<tr>
<td>Other hip or femur surgery</td>
<td>17.9</td>
<td>0.8</td>
<td>Pneumonia</td>
<td>Heart Failure</td>
<td>Septicemia</td>
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Targeting the High Risk Cardiovascular Patient Offers the Greatest Opportunity

- High cost, poorest outcomes and greatest avoidable utilization in the ED, Obs and IP status
- 97% of the highest cost CMS patients have at least 1 cardiovascular (CV) condition

- Readmission reduction—30 days and beyond
- Aligns with transition to Total Cost Management (MACRA)
- Lower ED utilization
- Provision of patient-centered care
- More appropriate use of low-margin services
Executive Summary

Challenges:
- Readmissions of high risk cardiac pts
- Little or no Data to educate MDs, no transparency of the data that is available
- Limited access to employed Cardiology offices for timely apmts,
- Increase in ED utilization
- Need for more appropriate use of low-margin services

Key players involved:
- Cardiology Medical Director
- Executive Director CV Services
- HF/AMI CV APRNs
- CV CNS Educator, Registry Coordinator

BHLex Initiatives to Improve Heart Failure Care Management

1. Pharmacy Resident Project-Established Admission Med Rec document error rates, categorized errors by type and educated nursing staff on type of reconciliation errors to monitor.
- Developed medication calendars for HF patients prior to discharge, allowing an easy patient reference to decrease med regimen issues at home and at f/u appointments.

2. Enrolled in GWTG Heart Failure for improved date collection and alignment with best practices.

3. Heart Failure Clinic began operation with 2 APRNs assisting with the management of HF for inpatients and outpatients.
- HF APRNs initiated follow up phone calls at 3 days, 7 days, and 21 days post discharge. Calls included medication and HF symptoms education.
### Get With the Guidelines: Heart Failure

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<tbody>
<tr>
<td>HF Discharge Education</td>
<td>100.0% 93.0% 96.4% 95.0% 96.6% 94.7%</td>
<td>100.0%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>LV Function Resolved</td>
<td>100.0% 90.0% 108.0%</td>
<td>98.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>98.3%</td>
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<tr>
<td>NIV or IMI Prescribed at Discharge for Patients with CHF</td>
<td>100.0% 90.0% 108.0%</td>
<td>96.0%</td>
<td>95.0%</td>
<td>97.0%</td>
<td>93.0%</td>
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<tr>
<td>OT/CVT/NIV Prescribed or ordered on hospital day 2</td>
<td>98.0% 70.0% 108.0%</td>
<td>98.2%</td>
<td>100.0%</td>
<td>98.0%</td>
<td>95.0%</td>
</tr>
<tr>
<td>Advance Vaccination During Pic Disease</td>
<td>99.0% 90.0% 108.0%</td>
<td>101.0%</td>
<td>11.0%</td>
<td>9.0%</td>
<td>61.0%</td>
</tr>
<tr>
<td>Pharmacological Treatment</td>
<td>80.0% 80.0% 108.0%</td>
<td>100.0%</td>
<td>110.0%</td>
<td>100.0%</td>
<td>108.0%</td>
</tr>
<tr>
<td>Discharge for Patients with a LVEF &lt; 30%</td>
<td>83.0% 80.0% 80.0%</td>
<td>81.0%</td>
<td>78.0%</td>
<td>74.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Discharge for Patients with a LVEF &gt; 30%</td>
<td>80.0% 90.0% 90.0%</td>
<td>94.0%</td>
<td>90.0%</td>
<td>89.0%</td>
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<tr>
<td>Core Metric</td>
<td></td>
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<tr>
<td>ACE-I or ARB Prescribed at Discharge for Patients with LVSD</td>
<td>100.0% 96.0% 100.0% 96.0% 97.1% 100.0%</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>LV Function Assessed</td>
<td>100.0% 99.0% 100.0% 99.0% 100.0%</td>
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<tr>
<td>Influenza Vaccination During Flu Season</td>
<td>99.0% 99.0% 100.0% 100.0% n/a n/a</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>DVT/PTE Prophylaxis (by end of hospital day 2)</td>
<td>94.8% 78.3% 100.0% 88.2% 100.0%</td>
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<tr>
<td>Quality Metric</td>
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<tr>
<td>Evidence-Based Specific Beta Blockers Prescribed at Discharge for Patients with LVSD (bisoprolol, carvedilol, &amp; metoprolol)</td>
<td>93.3% 88.5% 90.0% 91.3% 97.8% 90.6%</td>
<td></td>
<td></td>
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<tr>
<td>Pneumococcal Vaccination</td>
<td>99.0% 99.0% 100.0% 100.0% 100.0%</td>
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<td>Aldosterone Antagonist Prescribed at Discharge for LVSD</td>
<td>28.9% 26.0% 0.0% 47.8% 42.2% 28.1%</td>
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<td>Hydralazine Nitrate Prescribed at Discharge for African American Patients with LVSD</td>
<td>22.8% 12.5% 0.0% 0.0% 14.3% 0.0%</td>
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<tr>
<td>Anticoagulation for Atrial Fibrillation or Atrial Flutter</td>
<td>81.7% 61.8% 83.3% 72.5% 84.4% 50.0%</td>
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</tr>
<tr>
<td>ICD Counseling Provided or Prescribed for LVSD</td>
<td>54.3% 34.7% 44.4% 65.8% 37.0% 40.0%</td>
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<tr>
<td>CRT-D or CRT-P Placed or Prescribed for LVSD</td>
<td>55.2% 47.3% 0.0% 63.6% 61.5% 68.3%</td>
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<td></td>
<td></td>
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<tr>
<td>Follow-Up Appt Within 7 Days or Less of Discharge</td>
<td>67.8% 48.8% 54.5% 61.3% 50.0% 44.4%</td>
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<td></td>
<td></td>
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<tr>
<td>Post Discharge Appt Scheduled on Discharge</td>
<td>89.3% 65.2% 54.5% 85.0% 82.1% 71.9%</td>
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<td></td>
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<tr>
<td>Referral to HF Disease Management, 60 Minutes Pt Education, or HF Interactive Workbook</td>
<td>83.9% 38.0% 53.6% 89.0% 97.1% 93.5%</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Referral for HF Disease Management Program</td>
<td>65.4% 21.2% 53.6% 83.2% 76.6%</td>
<td></td>
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</tr>
</tbody>
</table>

### System Metrics

- Hospital LOS (mean): 4.24 days, 5.56 days, 5.13 days, 5.64 days, 4.66 days, 5.56 days
- Hospital LOS Adjusted Mortality: 2.5%, 2.7%, 3.4%, 2.9%, 3.2%, 2.7%
- HF 30-Day Readmission Rate: 17.5% 13.6% 14.3% 12.9% 18.1% 16.8%

### Outpatient Complex Care Management

**Clinics Emerging to Meet High-Risk, Poly-Chronic Patient Needs**

**Characteristics of High-Risk Clinics**
- Small care manager case loads
- Interdisciplinary teams
- Longer Patient Visits
- Ability to provide multi-specialty care for comorbid patients

**High-Risk Clinics Specialty by Design**
- Premise of high-risk clinics is to elevate long-term care often provided by PCP, medical home
- Treating patients with multiple clinical, non-clinical comorbidities

**But Cannot Underestimate the Importance of CV**
- Cardiac conditions an underlying comorbidity for majority of patients
- CV must support clinics to ensure patients receive appropriate clinical care, have sustainable outcomes

*"A promising development is the high-risk clinic, which...can address the problem of traditional primary care practices lacking resources to support care management for their relatively small numbers of patients with complex care needs."

**Key Players Involved in Team Based Model for HF Patients**

Baptist Health Lexington’s Advanced Heart Failure Center

Across the Continuum of Care

- APRN and RN
- Physician
- Pharmacy
- Dietician
- Implanting Center VAD/Coordinator
- Home Health
- Palliative Care
- Case Manager

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**Advanced Heart Failure Center at BHLEX**

Opened January 2013; Providers: 3.0 APRNs, recently added 1.0 PharmD and CNA

- **Disease center impetus:** Decrease readmission rate for high risk HF and AMI pts, improve morbidity and mortality with guideline recommended therapy and early identification of advance therapies

- **Services offered:** OP apmt within 7 days of pt’s DC from hospital, same day apmt for symptom mgmt, triage for med mgmt including IV diuresis; same/next day appts for ED pt f/u, telephone mgmt, Shared Care Program for LVAD began in November 2013 with 2 transplant/LVAD facilities, (First Shared Care Program in KY).

- **Facility:** Co-located with the A Fib Center, Heart and Valve and HTN Center; 6 exam rooms in same building as Cardiology practice and CT physician offices, cath and EP labs, CV Nuclear/PET Lab, Sleep Center, Cardiac Rehab; Echo lab in center

- **Impact of center:** Decrease in readmissions (HF clinic pts readmit rate < 5%, decrease ED visits, mgmt of high risk pts with multiple comorbidities, including AMI pts with low EF, awarded AHA HF “GWTG” Gold recognition 2014, 2015.
Outpatient APRN-Led Center – Delivering Care in Low Cost Setting

Typical Visit in the APRN Led CV Clinic

- Pharmacy Med Management Therapy 10 minutes
- APRN Treatment Plan 20-30 minutes (+/- TTEcho, diuresis, Lab, Neb tx)
- RN Education 10 minutes

Average monthly wRVU in clinic 425

Average Visit (CMA, APRN, RN, PharmD)

Average 280 visits/month (Providing care for high risk HF, AF, AMI, CT pts)

BHLex Initiatives to Improve Heart Failure Care Management Cont.

1. Case Management-Pharmacy consult for patients at high risk for readmission per the LACE scoring system.
   - With consult, pharmacy assessed/addressed any issues related to supra-therapeutic or sub-therapeutic drug levels, med interactions, potential adverse side effects, educational/economic barriers to med regimen, etc.

2. Standing HF Clinic appointment blocked for every Friday, allowing more timely access (< 7 days) to follow up for HF patients discharged on weekends/evening hours.
   - Initiated referral process from Call Center/CDMP to refer AMI patients with EF <40% to HF Clinic. This allowed for an initial follow up in clinic to monitor whether decreased EF was temporary related to AMI, or if ongoing HF management would be indicated.

3. Phone Triage: Hospital Call Center began making follow up calls, with referral of HF patients to HF Nurse Navigators or home health as needed.
   - High-risk pts called at 3, 7, 14 days of discharge
   - Help coordinate pt’s care with home health providers and our OP center
Outcomes Achieved: HF and AMI Readmissions Improved

(CMS Only) HF and AMI Readmissions 2013-2015

Readmission Intervention for the Co-Morbid Heart Failure Patients

- Appropriate patient assessment and follow-up is critical with the prescription of a self-adjusted diuretic.
- Self-adjustment of diuretics is not for every patient especially at a transition of care time such as discharge.
- Lack of accountability at discharge as to who will be responsible for following up with the patient.
- Potential for error and patient safety.
- Self-adjustment of diuretics prescribed at discharge is not standard of care.
- Participating in the HF Clinic is a prerequisite for patient is put on a self-adjusted diuretic protocol.

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Index Admit Diagnosis</th>
<th>Readmission Diagnosis</th>
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<tbody>
<tr>
<td>HF</td>
<td>27 (45.8%)</td>
<td>17 (28.8%)</td>
</tr>
<tr>
<td>HF/CKD Stage III-IV</td>
<td>13 (22.0%)</td>
<td>16 (27.2%)</td>
</tr>
<tr>
<td>HF/COPD State III-IV</td>
<td>13 (22.0%)</td>
<td>12 (20.3%)</td>
</tr>
<tr>
<td>Other</td>
<td>6 (10.2%)</td>
<td>14 (23.7%)</td>
</tr>
</tbody>
</table>
BHLex Initiatives to Improve Heart Failure Care Management Cont.

7
- Incorporated AHA Heart Failure Interactive Workbook into Logicare patient discharge education.
- Developed Care Measure/Nurse Discharge Checklist to monitor appropriate Aus/Afb, Med Rec, etc prior to discharge
- Individual physician outlier reports for GWTG metrics distributed with Quarterly Physician scorecard

8
- Developed coordinated approach with employed Cardiology office and ED physicians to refer high-risk pts to OP Center
- Provide same day/urgent appointments in Afib and HF center for acute pts and pts requiring IV diuretics
- PCP & ED Mds refer Afib pts post cardioversion to AF Center next day for med mgmt and education
- GWTG HF Best Practice – Fw appts within 7 days of discharge on all HF pts and all AMI pts with low EF
- CT surgery nurse navigator follow up appointments within 7 days for high risk patients

9
- East Region High Risk Readmission Team convened to standardize care of high risk for readmission cardiac patients across region.
- Plans to develop a comprehensive report to measure Returns to Acute Care within 30 days of Discharge across the BH system (for HF and AMI)

Nursing Discharge Checklist

Physician Outlier Review
Heart Failure Control Plan

**Your target weight:**

<table>
<thead>
<tr>
<th>Green Zone: All Clear (means your symptoms are under control)</th>
<th>Yellow Zone Caution (means you need to call your health nurse or your doctor to tell them about your symptoms)</th>
<th>Red Zone: Danger (means you need to call your doctor immediately)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• No weight gain</td>
<td>• Weight gain of 2 to 3 pounds in one day or 5 pounds in a week</td>
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<tr>
<td>• No swelling</td>
<td>• Increased swelling of feet, ankles or stomach</td>
<td></td>
</tr>
<tr>
<td>• No missed doses of medicine</td>
<td>• Missed one or more doses of medicine</td>
<td></td>
</tr>
<tr>
<td>• No change in appetite</td>
<td>• Some decrease in appetite</td>
<td></td>
</tr>
<tr>
<td>• No cough</td>
<td>• Cough during the day or night</td>
<td></td>
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<tr>
<td>• No shortness of breath with usual activity</td>
<td>• Mild shortness of breath but do not have to stop activity</td>
<td></td>
</tr>
<tr>
<td>• No shortness of breath while sleeping</td>
<td>• Have to use another pillow or raise head of bed to sleep</td>
<td></td>
</tr>
<tr>
<td>• No chest pain</td>
<td>• Do not feel like doing normal activities but are able to do important things</td>
<td></td>
</tr>
</tbody>
</table>

**Emergency**

If you feel like you are suffocating and cannot catch your breath — **CALL 911**

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A Fib: Incidence, Prevalence and Disease Burden and High Risk CV Patient

A Fib is the most common sustained heart rhythm disorder and increases the risk for heart disease and stroke, both leading causes of death in the United States

- Approximately 70% of A Fib patients are between 65 and 85 years
- Prevalence expected to double to 5.6 million adults
- Hospital admissions due to A Fib has ↑ more than 60% in the past 20 yrs
- Medicare spending for new A Fib is $15.7 billion
- Within the 1st year following A Fib diagnosis, 37% more likely to have HF
- A Fib is a common condition in AMI, HF, COPD and PN hospitalizations
  - A Fib independently increases the risk of hospital readmissions and frequent ED admissions for rate and/or rhythm control requiring Cardioversion
  - HRS Fact Sheet 2012

The Center for A Fib and Heart Rhythm Disorders

- Disease center impetus: Free up MD capacity for new pts and EP procedure time; establish niche market; optimize pt med management; reduce comorbid in A Fib (i.e. progression of HF). First Accredited Afib with EPS program in US
- Referral: MD referral or self referral
- Advanced EP services offered: FIRM and Stereotaxis AF ablation, LAA occlusion, concomitant Maze, Watchman
- Clinic services: Same day ED patient appointments, same day ECV, 30 day follow-up post ablation, AF nurse navigator coordinates pre procedure visit, IP rounds and follow up appointments for all PVA patients, “Lunch and Learn” Outreach education to PCP and APRN offices
- Facility: Co-located with HF Center, Heart and Valve Center and HTN Center; 6 exam rooms, same building as MD offices, Cath and EP labs, Cardiac rehab; Echo lab in clinic; MD office anticoagulation clinic
- Impact of center: Opened in January 2013. Focused follow-up visits with high risk ED A Fib admissions, Post procedure AMI, CT patients with new onset of A-Fib; ED A-Fib referrals to the clinic are up >25%, thus avoiding IP A Fib admissions. A fibr Clinic referrals has seen at least 30% increase in referrals for new pts to the clinic from PCP, ED, Hospitalists and self referrals. All pts are referred to our employed Cardiology practice.
Readmissions

Overall CMS readmission rate for CY15 was 12.7%
Heart Failure Clinic patient readmission rate for CY15 = 1.9%.

BHLex Initiatives to Improve Heart Failure Care Management Cont.

- Revise HF orders to include Cardiac Rehab Referral
- Update order sets for Heart Failure Medications for ARNI/ACEI, ARB
- Med rec by Pharmacy Director at admission on Heart Failure, AFib and CT Surgery patients.

- Medication reconciliation by Pharmacists at admission and discharge
- A patient medication calendar is prepared on discharge with teaching by Pharmacist
- FTE 1.0 PharmD: Med rec and education by pharmacist on all OP HF/AF and CT pts at each clinic visit
- Epic conversion required significant “enhancements” to HF, AFib Standardized orders (for consultations, f/u appointments, etc.)
2016 ACC/AHA/HFSA Focused Update on New Pharmacological Therapy for Heart Failure: An Update of the 2013 ACCF/AHA Guideline for the Management of Heart Failure

A Report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines and the Heart Failure society of America

<table>
<thead>
<tr>
<th>COR</th>
<th>LOE</th>
<th>Recommendations</th>
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| I   |     | The clinical strategy of inhibition of the renin-angiotensin system with ACE inhibitors (Level of Evidence: A) (9-14), OR ARBs (Level of Evidence: A) (15-18), OR ARNI (Level of Evidence: B-R) (19) in conjunction with evidence-based beta blockers (20-22), and aldosterone antagonists in selected patients (23, 24), is recommended for patients with chronic HFrEF to reduce morbidity and mortality.

Hospital ARNI DATA from GWTG- HF

![Graph showing data over time]
1. To align for total cost management, identify the CV patients with the highest cost, poorest outcomes and greatest risk in future Healthcare Reform.

2. Key to an OP strategy is appropriate identification and triage of pts “eligible” for treatment in an OP setting with same day/urgent OP appointments

3. Coordinate a multidisciplinary and efficient approach to care in a low cost setting to increase patient compliance and system loyalty.

The problem is...

97% of the highest cost CMS pts have at least one high-risk cardiovascular condition

Our solution: Target the high risk HF patients to offer the greatest opportunity to improve CV patient management and reduce risk in future Healthcare Reform.

1. Active participation in GWTG-HF can help your hospital recognize opportunities to improve processes of care, reduce variation in care, decrease readmissions and enhance collaboration with all providers, stakeholders. 

1. To align for total cost management, identify the CV patients with the highest cost, poorest outcomes and greatest avoidable utilization in the ED, Obs and IP status (HF and Afib, Afib co-morbid with HF, Afib with post Cardiac surgery).

2. Key to an OP strategy is appropriate identification and triage of pts “eligible” for treatment in an OP setting with same day/urgent OP appointments

    - Optimize the APRN role includes IP/OP management, coordination with specialist and pt/family navigation for resources. This expedites LOS, decreases cost and will expand your physician’s productivity

3. Coordinate a multidisciplinary and efficient approach to care in a low cost setting to increase patient compliance and system loyalty.

    - Offer one-call access, one-stop “shop” for the pt (the pt’s visit and testing is available same day, same place).
    - APRN visit documentation in chart within 24-48 hrs of visit; maintaining close communication with acute pts and their physician
    - Pts’s test results and clinic evaluation is readily available for next steps with their Cardiologist, PCP, Nephrologist visit.
Next Steps …

Broaden the scope of intervention in pts with secondary diagnosis of AF & HF-anemia, COPD and CKD

Increase Palliative Care consults during initial hospitalization

Bridge gap for care to follow high risk pts from acute setting past 30 days to in-home RN/Coach

Targeted marketing benefits to PCP – know your data – what is MDs readmit rate?

Formalize partnerships with post-acute care and Home Health

Integrated financial structure with physicians and hospital system

Use the following tool to determine whether a patient should receive a consultation with the inpatient palliative care team during his admission. Patients scoring 6 points or more should be targeted for the palliative care consult.

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Weight</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nilotraze</td>
<td>1 point</td>
</tr>
<tr>
<td>1st dependent of daily living (ADL)</td>
<td>2 points</td>
</tr>
<tr>
<td>5 or more dependent ADLs</td>
<td>4 points</td>
</tr>
<tr>
<td>Heart failure</td>
<td>2 points</td>
</tr>
<tr>
<td>Cancer-loc</td>
<td>3 points</td>
</tr>
<tr>
<td>Opiate utiliza</td>
<td>8 points</td>
</tr>
<tr>
<td>Dementia: Mini-Mental State Exam &lt; 20</td>
<td>2 points</td>
</tr>
<tr>
<td>Nutritional index Albumin 3.0-3.4</td>
<td>1 point</td>
</tr>
<tr>
<td>Nutritional index Albumin &lt; 3.0</td>
<td>2 points</td>
</tr>
</tbody>
</table>

Activities of Daily Living

<table>
<thead>
<tr>
<th>Activities</th>
<th>Independence No Suppension, Directed or Sustained Assistance</th>
<th>Dependability Walk, Suspension, Directed, Personal Assistance, or Total Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>Bathes self completely, or needs help in bathing only a single part of the body, such as the back, genital area, or disabled extremity.</td>
<td>Needs help with bathing more than one part of the body, getting in and out of the tub or shower. Requires hand holding.</td>
</tr>
<tr>
<td>Dressing</td>
<td>Gets clothes on/ taken off and walks/pulls own chair or wheelchair with walker/rollator.</td>
<td>Needs help with dressing self or needs to be completely dressed.</td>
</tr>
<tr>
<td>toileting</td>
<td>Goes to toilet, gets on, off, arranges clothes, clears the area without help.</td>
<td>Needs help positioning to the toilet, cleaning self, or uses bedpan or commode.</td>
</tr>
<tr>
<td>Transferred</td>
<td>Moves on or off bed or chair unaided. Mechanical handling aides are acceptable.</td>
<td>Needs help in moving from bed to chair or moves completely independent.</td>
</tr>
<tr>
<td>Continence</td>
<td>Exercise complete self-control over urination and defecation.</td>
<td>Is incontinent of bowel or bladder.</td>
</tr>
<tr>
<td>Feeding</td>
<td>Gets food or drink into mouth without help. Preparation of food may be done by another person.</td>
<td>Needs supervised help with feeding or requires parenteral feeding.</td>
</tr>
</tbody>
</table>
Bibliography


- Source: Engelberg Center for Health Care Reform at Brookings “Innovation in Care Delivery. Treating Congestive Heart Failure and the Role of Payment Reform” May 2014

- Clinical Advisory Board 2010 Member Survey on Readmissions; Clinical Advisory Board interviews and analysis.

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2016 Baptist Health Lexington Heart & Vascular Institute Awards and Accreditations

- 2016 Mission: Lifeline® Gold Plus Recognition
- 2016 Get With The Guidelines® Gold Plus Recognition
- Blue Distinction® Center for Coronary Artery Disease and Stent Placement
- STS® ACC/SCAI Accredited Percutaneous Coronary Intervention (PCI) Program
- ACCREDITED AFib Center of Excellence™
- ACCREDITED PCCPRACP®
- U.S. News & World Report: High Performing Hospitals 2016-17 Heart Failure
- U.S. News & World Report: High Performing Hospitals 2016-17 Heart Bypass Surgery
Questions?

Thank you!