HEART FAILURE
CLINIC
A MULTIDISCIPLINARY APPROACH

Amy Benson, PA-C, MSPAS
Presbyterian Heart Group
Albuquerque, NM
Disclosure

- I have no actual or potential conflict of interest in relation to this program/presentation.
OBJECTIVES

1. Recognize the value of a “Team approach/Multidisciplinary Care.”

2. Recognize the value of utilizing Advanced Practice Clinicians in the Outpatient HF Clinic.
PHG HF TEAM

**Team**
- 3 Advanced Practice Clinicians, 1 Clinical Pharmacist, Heart Failure Physicians, Registered RNs, and a Clinical Care Coordinator
- 40+ patient visits/day
- Diagnosis, guideline-directed medical therapy, identification and timely referral for advanced heart failure therapies (AICD, CRT-D, LVAD and transplant)
- Medication titration with clinical pharmacist for heart-failure specific medication reconciliation

Approximately five million Americans are living with heart failure and these numbers are on the rise. While there is no known cure for heart failure, new treatment options and devices can provide patients with improved quality of life and greater life expectancy.

The Heart Failure Clinic provides patients with a team of healthcare specialists who can work together to create an individualized treatment plan. Our comprehensive team includes:

- Three advanced practice clinicians.
- One clinical pharmacist.
- One advanced heart failure doctor.
- Heart failure nurses (RNs).
- Clinical care coordinator.

Physician assistants and nurse practitioners are also an essential part of our care team. They are able to provide specialized care and confer regularly with your physician regarding treatment and medication changes.

Once patients have been diagnosed with heart failure, our team can work together to:

- Schedule patient visits for further treatment.
- Decide on the right therapy for your specific needs.
- Suggest different types of medication for treatment and monitor any necessary labs with same-day lab visits.
- Provide heart failure education, including nutritional counseling.
- Help coordinate admission to our Cardiac Rehabilitation Program, as needed.
- Schedule and coordinate imaging studies for diagnostic or follow-up testing.
- Help manage care to prevent emergency room visits as much as possible.
- Provide a full-care coverage team to help heart failure patients continue to live an active lifestyle.
• Hospital follow-ups seen within a week of discharge by an APC.

• Outpatient PCP referrals go directly to Dr. Macias, our Advanced Heart Failure Cardiologist.

• APC education of HF, review of recent events of hospital course, anticipated plan of care.

• RN heart failure education, including nutrition counseling at initial visit.

• Medication reconciliation/titration by our Clinical Pharmacist.

• Close monitoring of labs and f/u with aggressive up-titration of medications

• IV diuresis, only with recent labs
• Close outpatient follow up to avoid ED visits (days, weeks, months)

• Same-day imagining (Echo, MUGA)

• Same-day labs

• Onsite care coordination-maximize patient care home services

• Referrals to Cardiac Rehab when appropriate
COMPREHENSIVE DISEASE MANAGEMENT PROGRAM

- Expedited access for direct hospitalization
- Access to novel pharmacological treatment with financial assistance
- Timely referral of advanced heart failure therapies (ICD, CRT, etc)
- A nurse and Health Planet Heart Failure Registry care manager
- Monthly follow-up with Presbyterian HF Core Team
**HEART FAILURE RED-YELLOW-GREEN SELF MANAGEMENT TOOL**

By taking charge of your heart health you will do better than if you don’t take charge.

Your toolkit includes monitoring how you feel, watching your weight daily, limiting salt in your diet, taking your medications as directed, not smoking and keeping all of your medical appointments.

Your weight goal: _____________ pounds

<table>
<thead>
<tr>
<th>Green Zone: You're doing fine</th>
<th>Green Zone Means:</th>
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<tbody>
<tr>
<td>- No shortness of breath</td>
<td>- Your symptoms are under control</td>
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<tr>
<td>- No swelling</td>
<td>- Continue taking your medications as ordered</td>
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<tr>
<td>- No weight gain</td>
<td>- Continue daily weights</td>
</tr>
<tr>
<td>- No decrease in the ability to maintain your activity level</td>
<td>- Follow low salt diet</td>
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<td></td>
<td>- Keep all medical appointments</td>
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<thead>
<tr>
<th>Yellow Zone: You may be getting in trouble</th>
<th>Yellow Zone Means:</th>
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<tbody>
<tr>
<td>If you have any of the following signs and symptoms:</td>
<td>- Your symptoms may indicate that you need an adjustment of your medications</td>
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<tr>
<td>- Weight gain of 3 or more pounds in 2 days</td>
<td>- If you are in the YELLOW ZONE, call your physician, nurse, or home health nurse.</td>
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<tr>
<td>- Increased cough</td>
<td>Name: ________________</td>
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<tr>
<td>- Increased swelling</td>
<td>Number: ________________</td>
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<tr>
<td>- Increase in shortness of breath with activity</td>
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<tr>
<td>- Increase in the number of pillows needed</td>
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<tr>
<td>- Waking up at night because you can’t breathe</td>
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<tr>
<th>Red Zone: You need help!</th>
<th>Red Zone Means:</th>
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<tr>
<td>If you have any of the following signs or symptoms</td>
<td>- This indicates that you need to be evaluated quickly</td>
</tr>
<tr>
<td>- Unrelieved shortness of breath; shortness of breath at rest</td>
<td>- Call 911 for severe shortness of breath</td>
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<tr>
<td>- Wheezing or chest tightness at rest</td>
<td>- Contact your physician</td>
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<tr>
<td>- Need to sit in chair to sleep</td>
<td>Physician________________</td>
</tr>
<tr>
<td>- Weight gain of more than 5 pounds in 2 days</td>
<td>Number________________</td>
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<tr>
<td>- Confusion</td>
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Presbyterian Healthcare Services
v. 050611
Key Principles of Education

• Meeting educational needs

• Information should be provided in small amounts, at regular intervals, to improve uptake and retention.

• Information should be provided in oral and written formats, and other formats (ie: web-based, videos)

• Education should also involve family members/caregivers to ensure support in the home.

• Multidisciplinary team members should regularly follow-up with patients and caregivers to confirm understanding. (J.P.Riley and J. Masters)
• 2004-JACC “Multidisciplinary strategies for the management of patients with HF reduce HF hospitalizations. Those programs that involve specialized follow-up by a multidisciplinary team also reduce mortality and all-cause hospitalizations.”
• **IMPROVE HF**-Registry to improve the use of evidence-based heart failure therapies in the outpatient setting.

• Community-based practices with no academic affiliations.


• 7 Core Measures-4 involved drug therapies: ACEIs or ARBs, BBs, AC for atrial fibrillation, and aldosterone antagonists.

• Compared to no APCs, ≥ 2 APCs was associated with increased use of ICDs and delivery of HF education, and equivalent use of drug and CRTs.
Collaborative Care Model

“Adopting a collaborative care delivery model has been identified as one way to help ease the burden of physicians faced with an influx of patients insured under the Affordable Care Act and a projected shortage of PCPs and specialists, which is expected to reach 90,000 by 2020.”-ACC 2015 Press Release

- National Cardiovascular Data Registry PINNACLE Registry-records from 2012 (648,909 patients in 90 practices with 1,234 providers)
  - Determine compliance with established performance measures
  - BBs with hx of MI
  - Antiplatelet use
  - Smoking screening, interventions to quit
  - Cholesterol control
  - Referral to cardiac rehab
  - Anticoagulation with afib patients
• 459,669 patients were treated by physicians in practices with either PAs or NPs among 41 practices—Compared to practices with physician-only models

• Conclusion: compliance with performance measures for CAD, HF and afib were all comparable across all practice types and clinicians.
  • Higher rate of screening for smoking, interventions to quit, higher rate of referral to cardiac rehab amongst APCs compared to Physicians.
  • Collaborative care delivery model employing both physicians and APCs delivers quality care comparable to physician-only models.
  • Direct link between care and patient outcome still needed.
  • Change in cost with team-based care to changes in patient outcomes.
PHG QUALITY SURVEY

HF Quality Initiative Survey

- No preference
- APC
- Cardiologist
LIMITATIONS

- Patients don’t follow up as recommended
- Time, insurance, rural location constraints
- Lack of education for HF patients
- Poor compliance with diet, tobacco, ETOH, and drug abuse
- Difficulty with getting consults to our HF clinic
- Complex disease process, comorbidities
- Low income population with unavailability of resources
- Compliance to treatment & cost of medications
- Optimize data collection mechanism/coding
PHG OUTPATIENT RESOURCES

• Presbyterian Healthplex-Cardiac Rehab (HFrEF only)

• Presbyterian Hospital at Home

• Presbyterian Home Health Care

• Presbyterian Complete Care, Palliative and Hospice
PHG CHF CLINIC
FUTURE GOALS

• Social worker

• CHF support group for patients

• Dietician

• Inpatient HF Team

• HF Telemedicine program

• Dedicated Infusion Suite/Continuous Telemetry

• Continued surveying of patients/family/caregivers


