The Advisory Board Company | Physician Executive Council

TOOLKIT OVERVIEW

Introducing the Heart Failure Toolkit

Resources for Reducing Care Variation in the Acute Setting

Heart failure is a high-volume, high-cost problem nationwide. Coordinated multidisciplinary care management is a challenge, and **providing care to clinically complex patients is difficult.**

Toolkit in Brief

While much of the emphasis on heart failure care improvement lies in the outpatient world—preventing unnecessary hospitalizations—heart failure is a critical challenge in the acute care setting as well. It's a common inpatient diagnosis, yet many hospitals struggle with both cost and quality of care. Research shows that nearly half of all heart failure hospitalizations incur costs that exceed their Medicare DRG reimbursement. Nearly 25% of heart failure patients are readmitted within 30 days.

In response, the Physician Executive Council created the Heart Failure Toolkit. The toolkit provides case studies, resources, and templates to support clinician leaders transforming heart failure within the acute setting. This booklet outlines six critical imperatives that many organizations struggle with and summarizes resources available to support improvement. The full version of the toolkit is available online and can be accessed any time, by any clinical leader at your organization.

Access and download all resources by visiting:
advisory.com/pec/heartfailuretoolkit

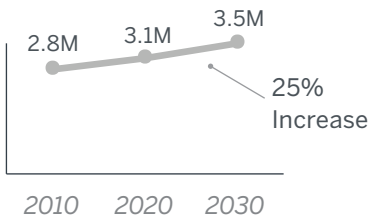
Heart failure patients are complex, making it difficult for physicians to standardize high-quality care.

	On-the-Ground Heart Failure Facts	Care Management Challenges
Average Patient	Aged 73 with an average 7.5 comorbidities	Age and comorbidity variables complicate care pathways and guidelines
Disease Progression	Highly variable, terminal illness	Poor patient comprehension of prognosis makes shared decision making difficult
Patient and System Engagement	Avoiding acute episodes relies on engaged patients and coordinated systems	Many factors influence patient engagement and care within hospitals' control today

Improving the heart failure care pathway to more effectively use resources is a critical imperative for clinical leaders shifting to value-based care models.

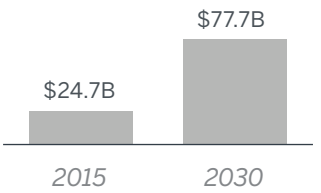
Increasing Prevalence

Projected HF Prevalence*



Increasing Cost

Projected Direct HF Medical Costs, 2015–2030[1]



50%
Heart failure hospitalizations with costs exceeding Medicare reimbursement[2]

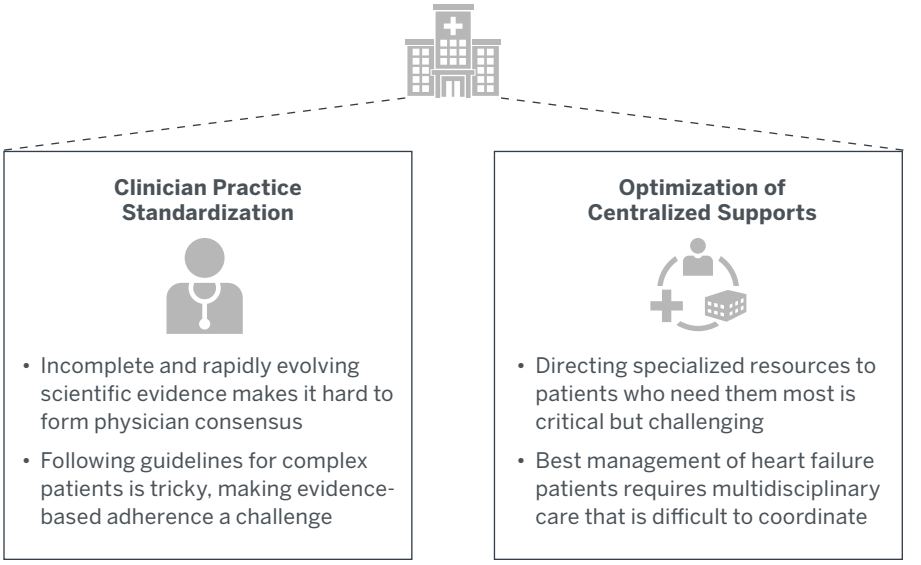
$2,104
Average loss per ADHF** patient in inpatient setting[3]

24.7%
Current national 30-day readmission rate for HF patients[4]

* Heart failure.

** Acute decompensated heart failure.

Two System-Level Challenges to Address in Heart Failure



Six Imperatives to Reduce Care Variation in Heart Failure

Imperative #1: Engage Physicians to Develop Consensus

Imperative #2: Provide Targeted Information to Improve Care

Imperative #3: Increase Use of Palliative Care

Imperative #4: Elevate the Hospitalist-Cardiologist Partnership

Imperative #5: Navigate Heart Failure Observation Status

Imperative #6: Optimize Discharge Planning

This Heart Failure Toolkit offers best practices, resources, and tools to help clinical initiative leaders improve heart failure care in ways that will most directly target sources of unwarranted variation.

Clinical Practice Standardization

Engage Physicians to Develop Consensus	Guideline Development Resources
Provide Targeted Information to Improve Care	Risk Segmentation Resources

Optimization of Centralized Supports

Increase Use of Palliative Care	Palliative Care Screening Tools
Elevate the Cardiologist-Hospitalist Partnership	Case Study on Building Hospitalist Expertise
Navigate Heart Failure Observation Status	Expert Insights on Observation Status
Optimize Discharge Planning	Optimizing Discharge Planning Compendium

Imperative #1

Engage Physicians to Develop Consensus

The evidence base for heart failure is constantly evolving and sometimes incomplete. As a result, physician consensus is often lacking, leading to unnecessary variation in care that impacts quality.

Physician leaders need to create evidence-based supports that reflect clinical consensus among clinicians managing heart failure patients.

Solutions

To address the complex gray areas in heart failure care, it is critical to:

1. Engage physicians to develop consensus
2. Create tailored guidelines to reduce variation

Tools

Case Study: Developing Tailored Standardized Guidelines for Heart Failure

Learn how Baylor Health Care System created enough clinical consensus to replace 60 distinct heart failure order sets with a single version that gained broad compliance.

Resource: Heart Failure Guideline Compendium

Get a full list of guidelines from specialty societies that have heart failure in their purview. Also includes a list of heart failure-specific resources available from specialty societies to help guide discussions.

Tool: Heart Failure Guidelines Checklist

Download this checklist to ensure your organization's heart failure guidelines are optimized to reduce variation and improve quality and cost outcomes.

Heart Failure Guideline Compendium *(excerpt)*

Institution	Guidelines	Year
Heart Failure Society of America	Comprehensive Heart Failure Practice Guideline	**2010**
American College of Cardiology Foundation / American Heart Association	Guidelines for the Management of Heart Failure	**2013**
European Society of Cardiology	Guidelines for the Diagnosis and Treatment of Acute and Chronic Heart Failure	**2012**

Access and download all resources by visiting:
advisory.com/pec/heartfailuretoolkit

Imperative #2

Provide Targeted Information to Improve Care

The complex nature of heart failure cases makes it difficult for physicians to find all the clinical data they need to target high-resource interventions appropriately. Physicians need support in evaluating the patient in front of them quickly and effectively so they can choose the best resources.

Solutions

Provide your clinicians with the **right clinical data at the right time** and segment patients by risk to target resources.

Tools

Case Study: Give Physicians the Right Clinical Data

Learn how Beth Israel Deaconess Medical Center created a smart heart failure sheet that elevates appropriate clinical information at the right time.

Case Study: Segmenting Patients by Clinical and Psychosocial Measures

Discover how Parkland Memorial Hospital uses a risk algorithm to identify high-risk patients, enabling physicians to better allocate resources for heart failure patients.

Resource: Risk Segmentation Library

Access insight pieces from experts across the Advisory Board that will help you lay the groundwork for a successful segmentation strategy.

Resource: Risk Stratification Model Compendium

Get a list of all the major risk stratification models, with a description and summary of assessment criteria.

Risk Stratification Model Compendium *(excerpt)*

Risk Model	Description	Criteria Assessed
LACE Index	Predicts risk of readmission, death within 30 days, using both primary and administrative data. Sample form available here.	• LOS in days for index hospitalization • Acuity of illness at time of index admission • Charlson comorbidity score • ED visits in previous six months
Krumholz/ Yale Model	Predicts risk of 30-day all-cause readmissions for HF patients 65 years or older. Available as an online calculator and iPhone app.	• Demographics • Occurrence of in-hospital cardiac arrest • Medical history • Diagnostics on admission (e.g., LVEF)
Philbin Tool	Predicts risk of readmission for HF patients 65 years or older, using administrative data. Sample scoring system available here.	• Demographics • Comorbidities • Hospital type and location • Processes of care • Clinical outcomes

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Imperative #3

Increase Use of Palliative Care

Many heart failure patients are **severely ill and highly complex**, and disease progression can be unclear. A third of providers lack confidence talking about end-of-life care with heart failure patients, and many patients don't understand their diagnosis. Providing palliative care to these patients can yield significant quality benefits and reduce costs of care.

Solutions

To increase palliative care utilization for heart failure patients, clinical leaders should:

1. Grow the inpatient palliative care consult service
2. Empower clinical staff to provide palliative care
3. Implement heart failure-specific interventions

Tools

Research Study: Realizing the Full Benefit of Palliative Care

Identify best practices for increasing the value of your palliative care service by engaging physicians, growing referrals, and expanding palliative care skills across the medical staff.

Resource Library: Palliative Care Program Development Toolkit

Get tools to overcome the most common obstacles to building and running an effective palliative care program.

Tool: Heart Failure Palliative Care Trigger Tool Template

Implement this screening tool to make the referral process as easy as possible for heart failure.

10%

Patients with end-stage heart failure who enroll in hospice[5]

33%

Providers who lack confidence talking about end-of-life care with HF patients[6]

12%

Providers who have yearly discussions about end-of-life with HF patients[6]

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Imperative #4

Elevate the Hospitalist-Cardiologist Partnership

Optimal care delivery often requires multiple specialists, especially in the case of heart failure patients. To reduce system inefficiencies and care variation, hospital leaders should leverage the skills of both hospitalists and cardiologists.

Solutions

Progressive organizations tap into the expertise of their cardiologist colleagues through mentorship programs and virtual consults.

Tools

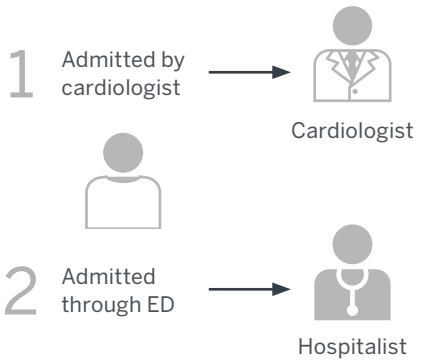
Case Study: Building Hospitalists' Expertise

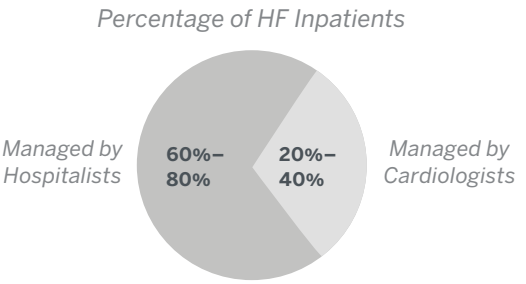
Learn how one hospital created the role of CV-hospitalists, trained to provide optimal care for heart failure patients through the ongoing support of a cardiologist mentor.

Case Study: Virtual Multidisciplinary Consults

See how one organization provided real-time, point-of-care access to research and content experts to better leverage their specialists.

Current HF Inpatient Management[7]





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Imperative #5

Navigate Heart Failure Observation Status

Observation status can yield many benefits for both hospitals and patients, but many hospitals struggle to optimize observation status for heart failure patients. Selecting the right patients for observation is difficult, and reimbursement policies make decision making more complex.

Solutions

To maximize cost and quality gains, hospitals must define observation protocols, better stratify patients, and consider implementing a dedicated heart failure observation unit.

Tools

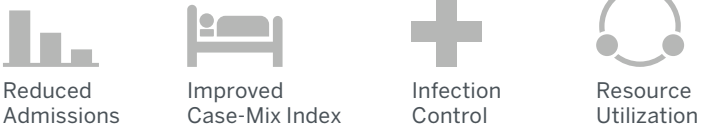
Special Report: Navigate Heart Failure Observation Status

Explore this report to lay the groundwork for improved observation protocols for heart failure patients at your institution.

Special Report: Expert Insights on Observation

Access some of the Advisory Board's best insights on improving the use of observation status and observation units.

Benefits of Effective Observation Units



Potential Savings for Hospitals

> "Changing the disposition status from admission to an observation unit stay in merely 5% of the 400,000 non-high-risk HF patients would result in savings of 80,000 hospital days and more than $80 million annually in the United States."[8]

Dr. Sean Collins, et al.
In the *Journal of the American College of Cardiology*

Access and download all resources by visiting:
advisory.com/pec/heartfailuretoolkit

Imperative #6

Optimize Discharge Planning

While many organizations have made significant improvements to discharge planning, it can be difficult to **prioritize additional opportunities for improvement**. There are many ways to improve discharge planning, but there is no way to implement them all. The key is to prioritize improvements that are worth the resource investment.

Solutions

We have selected the biggest "bang for your buck" tactics for **improving discharge planning** for heart failure patients, including discharging patients with more complete information, developing penalties for patient delays, and utilizing alert programs.

Tools

Resource Library: Readmissions Reduction Toolkit

This toolkit is a step-by-step guide to lowering readmission rates and includes resources on discharge education and care coordination. It includes full access to supporting tools, including readmitted patient interview forms, heart failure clinic staffing benchmarks, teach-back scripting, and more.

Tool: Intermountain's "The Perfect Transfer" Heart Failure Pathway

Access Intermountain's heart failure care pathway, which enables comprehensive discharge planning throughout the patient's stay.

Special Report with Case Studies: Optimizing Discharge for Heart Failure Management

A compendium of best practices, this report will help you prioritize tactics that improve discharge planning procedures.

Readmissions Reduction Toolkit *(excerpt)*

Your toolkit road map: Where to focus your efforts

We've mapped common readmission reduction challenges to specific sections of this toolkit. Click on any of the statements below that apply to you, and you'll be directed to the relevant best practices, supporting tools, and expert advice.

"I'd like tools and guidance to help me..."

- Find the root cause of a readmission
- Improve patient compliance with care plans
- Identify and tailor care for high-risk patients
- Determine the right type of post-acute care for my patients
- Improve PCP compliance with care plans
- Improve PAC care quality
- Develop a patient-specific, yet efficient, telemanagement strategy
- Provide post-discharge support for my highest-risk patients
- Start or optimize transition clinics

Access and download all resources by visiting:
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The Physician Executive Council

The Physician Executive Council is a research membership focused on supporting the CMO and team with best-demonstrated practices, insights, tools, expert consultations, and networking opportunities. Research is targeted at three main pillars:

Physician Leadership

- Developing next-generation physician leaders
- Redesigning leadership structure to unlock the value of roles and teams
- Ensuring today's leadership can succeed on high-priority initiatives

Reducing Care Variation

- Identifying and prioritizing clinical areas where CMO influence will achieve greatest cost avoidance and quality improvement
- Importing the most practical, replicable, and impactful solutions for overcoming obstacles that undermine performance
- Optimizing use of evidence-based practice support resources, including physician leaders and data systems

Medical Staff Engagement

- Partnering with physicians to achieve new quality standard
- Engaging physicians in patient experience
- Aligning physician incentives to support performance goals

Targeted Services for All CMO Team Members

Chief Medical Officers

- CMO summit
- CMO peer roundtables
- Member surveys/benchmarking

Senior Clinical Leaders (VPMA, CMIO)

- National meeting series
- Real-Time analysis and insights

Quality Executives

- Best practices
- Performance dashboards

Emerging Physician Leaders

- On-Demand webconferences
- Implementation toolkits

To learn more about Physician Executive Council resources, visit: advisory.com/pec

Project Director
Julie Riley, MPH

Contributing Consultants
Anita Joseph
Todd Lewis
Elizabeth Trandel

Designer
Wilson Fujinaga

Practice Manager
Amanda Berra, MA

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Physician Executive Council research and analysis.

The Advisory Board Company

2445 M Street NW, Washington DC 20037
P 202.266.5600 | F 202.266.5700

advisory.com