Quality Improvement Program: Congestive Heart Failure Care Pathway: An Interdisciplinary Approach
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BACKGROUND

- The Program of All-Inclusive Care for the Elderly (PACE) is to provide holistic and comprehensive health care services for the aging population, thus, empowering older adults to stay in the community and maintain their independence at home. AltaMed Health Services has eight PACE sites to service older adults in Los Angeles County.
- Congestive Heart failure (CHF) is a complex, relapsing, and severe chronic disease. It causes multisystem dysfunction resulting in a high burden of morbidity, mortality, and healthcare costs. Thirty- two (32) percent of AltaMed participants have been diagnosed with CHF. Our data shows that .73% of hospitalizations in 2017 and .43% of hospitalizations in 2019 was due to exacerbation of the disease.
- An interdisciplinary team (IDT) disease management has evolved into consensus ‘best practice’ in the care of patients with CHF. It is considered the gold standard model for the delivery of CHF care. To shape effective interdisciplinary CHF services, it is crucial to understand the relevant evidence-based essential components of an IDT approach and how services might evolve.
- In an effort to improve functional status, reduce hospitalizations, optimize the quality of care and quality of life of PACE participants, AltaMed PACE is providing a wraparound IDT care approach for CHF Care participants. This individualized action plan allows participants to take specific measures to control of their disease and actively participate in their care. Post intervention provided to decrease in CHF hospitalization.

LEARNING OBJECTIVES

- Integrating IDT accountability to reduce hospitalizations, improve outcomes for CHF patients, and participant satisfaction.
- Gain an overview of evidence-based guidelines relating to an interdisciplinary approach to heart failure care.
- Determine the effectiveness of the CHF Care Pathway IDT Guide in slowing the progressive decline in cardiac function, improving symptoms, and long term survival.

LITERATURE REVIEW

<table>
<thead>
<tr>
<th>Authors</th>
<th>Population</th>
<th>Interventions</th>
<th>Outcome</th>
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<tr>
<td>Davidson, Patricia M et al.</td>
<td>CHF patients in older population</td>
<td>CHF multidisciplinary management</td>
<td>Improved health outcomes, Decreased cost, Enhanced patient experience</td>
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<tr>
<td>Trugo SE, Laverger E et al.</td>
<td>Only patients with stable CHF</td>
<td>Combination of low-to-moderate intensity aerobic (endurance) exercise on most days of the week and individually prescribed low-to-moderate intensity resistance (strength) training at least twice per week</td>
<td>Improved survival and quality of life. Exercise training are important for improved outcomes.</td>
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<tr>
<td>Jillian P., et al.</td>
<td>With Acute CHF patients</td>
<td>Multidisciplinary team delivery of patient education Post-discharge follow-up and long-term monitoring</td>
<td>Improved co-ordination and continuity of care, Reduced healthcare utilization</td>
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<tr>
<td>Ballard D, et al.</td>
<td>CHF patients</td>
<td>A standardized heart failure order set was developed internally (EMR)</td>
<td>Reduce cost of care and increase adherence to evidence-based processes of care.</td>
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CONCLUSIONS

- The prevalence of congestive heart failure (CHF) is increasing. Most patients with CHF are elderly, and CHF is the most common dismissal diagnosis in elderly hospitalized patients. Assessment and management of elderly patients are complicated by comorbidities, increased susceptibility to side effects and concerns about the appropriate use of costly and invasive procedures.
- This structured experience poster presentation illustrates how each IDT member views their role and how they contribute to caring for participants with CHF.

Figure A indicates the number of participants with CHF diagnosis per PACE Provider. Participants with CHF are included in the High-Risk report. The purpose of the High-Risk report is to help us improve chronic disease management, and to quickly identify participants that need close follow up and routine monitoring.

Figure B indicates the top 14 ER visits diagnosis from 2017-2019. The top 3 ER visits diagnosis from 2017-2019 are: Unspecified abdominal pain= 112, Chest pain= 68 and Shortness of breath= 51. Heart Failure had the lowest number. There were 7 ER visits diagnosis due to Heart Failure (2017-2 ER visits, 2018-5 ER visit and 2019-0).

Figure C indicates the top 19 Admission diagnosis from 2017-2019. The top 3 Admission diagnosis from 2017-2019 are: Chest Pain(unspecified)= 130; Septicemia= 120; Pneumonia= 100. Heart Failure was at the top 3. There were 97 admissions due to Heart Failure (2017-39 Admissions, 2018-46 Admissions and 2019-12 Admissions).

Figure D indicates the top 12 Readmission diagnosis from 2017-2019. The top 4 Readmission diagnosis are: Chest Pain(unspecified)= 21; Altered Mental Status= 17; Pneumonia= 16 and Sepsis= 16. Heart Failure ranked #6 on the list. There were 13 readmissions due to Heart Failure (2017-8 Readmission, 2018-12 Readmissions and 2019-1 Readmission).

Results suggest that close monitoring and follow-up, Participant education, Self Management skills, IDT strategies, and best practices have been effective in maintaining low ER visit, Admission, and Readmission rates and improving health outcomes.

ACKNOWLEDGMENT

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REFERENCES

- Ballard D, Selig SE, Levinger I et al. Only patients with CHF are included in the High-Risk report. The purpose of the High-Risk report is to help us improve chronic disease management, and to quickly identify participants that need close follow up and routine monitoring.
- Trugo SE, Laverger E et al. With Acute CHF patients Multidisciplinary team delivery of patient education Post-discharge follow-up and long-term monitoring Improved co-ordination and continuity of care, Reduced healthcare utilization.