

Strategies for Developing a Successful HF Clinic

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A focus on treating acute illnesses is inherent to the culture of our current health care system. We can have patients triaged, diagnosed and treated shortly after they present to a local emergency room, and the patient's role throughout this process is largely passive. In contrast, successful treatment of people with chronic diseases, such as heart failure, hypertension and other conditions, requires active patient participation in concert with a truly interested health care system.

Our present health care system provides little incentive for patients to develop self-management skills, yet these skills are critically important in slowing progression of any chronic disease state, as evidenced by Wagner's chronic care model. Outpatient clinics that focus on management of subacute disease can help to address this conspicuous gap in patient care.

It Takes Two

Whether it is a heart failure (HF) or other chronic

disease management clinic, a successful clinic requires two crucial building blocks. The first is educated patients engaged in their own health care. The second is a well-organized health care team armed with protocol-driven algorithms based in the latest clinical evidence. This alliance results in productive interactions and improved outcomes in heart failure or any chronic disease management.

In effective clinics, experienced practitioners rapidly assess a patient's clinical status and self-management skills and then tailor their medical management according to evidence-based protocols and guidelines. The resulting collaboration between the patient and the provider team leads to effective problem solving and the creation of an individualized long-term plan with mutually advantageous goals. The care program should call for consistent, regular and often frequent follow-up. Ultimately, payers should find that the relatively low costs of close monitoring and frequent clinic visits will decrease the rate of costly hospitalizations and testing.

Developing an Educated, Involved Patient

What transforms a passive, uninformed, newly diagnosed patient into an educated, involved health care partner? First, it's important not to confuse patient education with patient self-management. Merely handing information to patients does not make them successful self-managers. Practitioners must assess each patient's individual needs, concerns, values, beliefs, preferences, goals and lifestyle. This knowledge helps identify what will motivate a patient and what barriers to effective self-management might exist.

These other strategies also work:

- Provide educational materials in multiple formats — print, electronic, periodicals.
- Be clear with expectations and explain their importance.
- Write everything down for the patient. Keep directions clear and concise.
- Use every resource available. Build a multidisciplinary team that might include social work, hospice, cardiac surgery, palliative care, nutrition and so on.
- Offer regular support group meetings.
- Be accessible 24/7 with a dedicated team interested in chronic disease management.
- Be responsive, call back quickly and arrange tests and procedures smoothly.
- Push patients until they push back. Encourage better diet, medication up-titration and more physical activity.

Most important, don't give up. What doesn't work today may work tomorrow. This is particularly important in medication up-titration in heart failure patients as the initial steps may yield side effects that must be managed. Discourage discontinuing a drug with life-lengthening benefits at the first sign of side effects and try again the next month.

Putting the HF Team Together

Follow some of these practical concepts to help develop a well-organized, proficient heart failure team —

- Look for a dedicated medical director who is interested in HF management and understands the huge benefits that can be achieved from the available treatments.

- Set up an advanced practice nurse who is experienced in the care of HF patients to guide patients and manage other nursing and office staff in their interactions with the patients.
- Set up a multidisciplinary team to address the complex issues that surround chronically ill patients.
- Follow established research-based protocols and guidelines.
- Anticipate a minimum of one half hour for each patient follow-up and have daily appointments available for “urgent” visits, particularly on Mondays.

The HF Continuum

- Comprehensive history and physical
- Review medications
- Routine HF testing, including labs, ECG, echo, functional status, arrhythmia screening
- Hunt for any reversible causes of heart failure
- Expect that the benefits of medical therapy may take months to become evident; always keep options such as transplant and destination ventricular assist device therapy in mind — both yours and the patient's — when appropriate
- Conduct specialized testing, for example, stress, viability, echo, coronary angiography and right heart catheterization
- Refer in timely fashion for testing, transplant, ventricular assist devices, hospice and palliative care.

- Assess a patient's understanding of disease and treatment plans and look for compliance concerns.
- Screen patients on the “HF Continuum”

In successful heart failure clinics, it is the patient who drives the care. The heart failure team's job is to mold the health care system in such a way that it supports the patients and provides the tools and guidance they need to close the gap between acute and chronic care.

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¹ Wagner EH. Chronic disease management: What will it take to improve care for the chronic illness? *Eff Clin Pract* 1998; 1:2-4.