

The Role of the Mid-Level Provider in a Heart Failure Practice

Michael G. Dickinson, M.D., F.A.C.C.

Advanced Heart Failure Cardiologist
Transplant Medicine Cardiologist
Mechanical Circulatory Support Specialist
Chair for Research and Education



Medical Director for Heart Failure

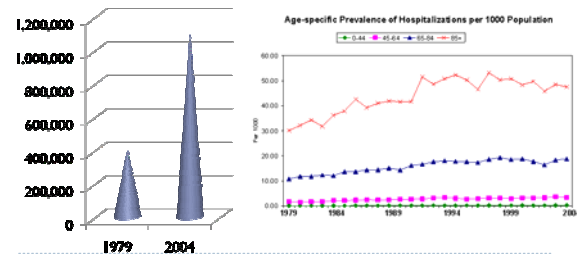


Clinical Assistant Professor

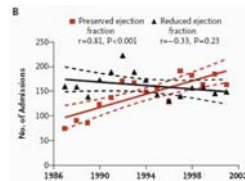
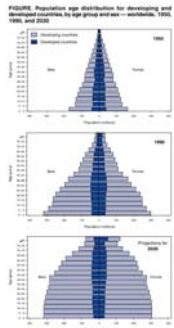


The burden of heart failure care is increasing in magnitude and complexity.
We are going to have to figure out how to do things better...

HF Hospitalizations



The population is getting older...
With more comorbid conditions.



- The job is going to be getting harder.
- The resources are not going to be increased.
- We will be forced to do more with less.

The Quality Theory

- ▶ There is a lot of "buzz" around **quality**.
- ▶ The concept is:
 - ▶ If we could achieve **high quality**, then
 - ▶ We will realize improved patient outcomes, then
 - We will reduce health care costs.
- ▶ Is this true?
 - ▶ One center recently instituted a digital system and improved their compliance with the CMS heart failure quality core measures from around 80% to near 100%
 - ▶ There was absolutely **NO CHANGE** in the in hospital mortality or the rate of 30 day readmissions.
 - ▶ Quality then does not automatically mean reduced costs.
- ▶ Perhaps a better term is **Value**

Value

- ▶ **VALUE**: Latin *valēre* to be of worth, be strong
- ▶ We need a system that is designed to:
 - ▶ Provide the best care:
 - ▶ Right things done at the right time.
 - ▶ Use each provider to their maximal capabilities:
 - ▶ Full team approach from MA to RN to MLP to MD to Subspecialist.
 - ▶ Honest recognition of capabilities and limitations.
 - ▶ Subspecialization at each level:
 - ▶ Training and past experience helping each provider to:
 - Readily recognize what is going on.
 - Know exactly what to do.

What is different between quality and value?

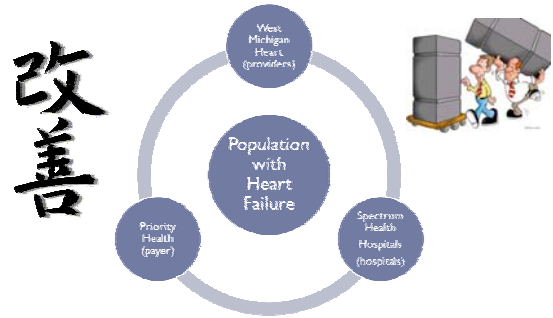
- ▶ Quality focuses on getting certain **things** done like percent ACEI, discharge instructions, etc...
- ▶ Value focuses on what resources are expended and how to use them best to improve outcomes.
 - ▶ What is the **best** use of physician resources?
 - ▶ Where can we use MLPs instead of physicians?
 - ▶ What is the **best** use of a mid level provider?
 - ▶ When is it better to use a mid level provider than a physician?

We can no longer look at just what we as physicians do.

The next ten years in heart failure care is going to require us to use our energy to design and implement SYSTEMS that efficiently provide excellent care.

VALUE

H2O: Hospital "2" Office Program Coming together to achieve "value"



Realistic Assessment Number 1

- ▶ Increased frequency of patient follow up improves outcomes in heart failure.
 - ▶ There have been multiple recent research trials where the increased follow up for the trial improved outcomes in the placebo group.



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COMPASS-HF chair **Dr Robert C Bourge** (University of Alabama, Birmingham), addressing the panel as a consultant to Medtronic, attributed the lack of difference to a lower-than-expected event rate in the control group. In their diligence to maintain blinding to therapy, he said, the COMPASS-HF physicians supervised the management of all patients far more closely than might have occurred outside of a clinical trial.

Implications:

- ▶ I (as a heart failure cardiologist) am too busy to be able to provide the frequency of care that I should to have optimal outcomes.
 - ▶ We can't do it all, so we must strategize and prioritize.
 - ▶ We MUST use MLPs to see these patients.
 - ▶ Discharge and see in a month or so does NOT work.

We need to see patients more frequently than we usually do.

We must use mid level providers to achieve this.

Realistic Assessment Number 2

- ▶ There are differences in the nature of the care delivered by a mid-level provider and a physician.

I: *Nurse Pract.*, 1999 Mar;24(3):94-6, 99-100, 102-3.

Client characteristics and practice patterns of nurse practitioners and physicians.

Moody NB, Smith PL, Glenn LL.

Department of Professional Roles/Mental Health Nursing, College of Nursing, East Tennessee State University, Johnson City, USA.

- ▶ NPs focused more on education and primary prevention than on secondary prevention.
- ▶ NPs were more likely to review lifestyle modifications such as diet and exercise rather than medications.

Realistic Assessment Number 2

- ▶ There are differences in the nature of the care delivered by a mid-level provider and a physician.

I: *Am J Manag Care.* 2009 Jun;15(6):373-80.

Treatment decisions for complex patients: differences between primary care physicians and midlevel providers.

Subramanian U, Kerr EA, Klamerus HL, Zikmund-Fisher BJ, Holleman RG, Hofer TP.

Roudebush VA Medical Center, 250 University Blvd, IF 122, Indianapolis, IN 46202, USA. subrama@iupui.edu

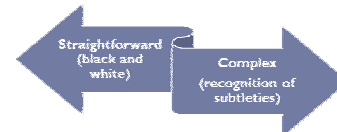
- ▶ NPs and PAs were less likely to address elevated blood pressure in diabetic patients at routine follow up (despite BPs >140/90).
- ▶ Reasons?
 - ▶ Focus on prevention, lifestyle, and education rather than medications.
 - ▶ Incomplete ownership of the patients? Varying practice styles of supervising docs?

Implications:

- ▶ There is value in a MLP seeing a patient that goes beyond being a physician extender.
 - ▶ Patient education, preventive measures, "patient empowerment".
 - ▶ MLP visit is a qualitatively "different" visit.
- ▶ Sometimes MLPs may be less likely to "pull the trigger" to make significant medication changes.
 - ▶ Systems need to empower MLPs to implement medication changes and other important parts of the disease management process.
 - ▶ Guidance
 - ▶ Permission and support (allow MLPs to use their judgment)

Realistic Assessment Number 3

- ▶ "I didn't know what I didn't know."
 - ▶ During my advanced heart failure fellowship I discovered things that surprised me. (I thought I knew ALL about heart failure!)
 - ▶ It wasn't just that there were things that I didn't know, but what bothered me was that **there were things that I didn't know that I didn't know.**



- ▶ Cardiologist involvement is needed to help with the big picture, major management decisions, and for failures to respond to standard therapy.

A mid level provider visit is NOT a substitute for a physician visit.

A mid level provider visit is NOT JUST a substitute for a physician visit.

Our systems need to be designed so that we get what we need to out of provider visits.

Realistic Assessment Number 4

- ▶ The acceptance of MLPs has increased significantly over the past several years.
 - ▶ The use of the MLP is no longer taboo even in a subspecialty practice.
 - ▶ Most referring docs are now using MLPs.

Care Plans: Communication and Empowerment

Patient Care Goals: (check and circle where appropriate)

- Reassess fluid status and adjust diuretics to achieve normal intravascular fluid status (anticipate increase / decrease in dose will be needed)
- Up-titrate medications to maximal tolerated doses (≥2 weeks based on BP and symptoms)
 - Up-titrate β-blocker first
 - Up-titrate ACE/ARB first
 - Alternate β-blocker with ACE/ARB titration
 - Up-titrate losartol / Hydrochlorothiazide (circle which to increase, or if no circle, then alternate agents)
- Start (or re-start) ACE / ARB with close lab (u if creatinine stable)
- Follow labs closely (special concerns about K or Cr, may need weekly labs)
- Other: _____

- ▶ Encourage MLPs to "pull the trigger"



Allow MLPs to make decisions "you have the controls"

Messages on MLP use for hospital follow up

- ▶ Advantage of "same system" to be able to set up early follow up.
 - ▶ Not reliant on primary care to ensure stability and compliance.
 - ▶ Standing working relationships so understand practice styles, etc...
- ▶ Transmission of care plan.
 - ▶ MLPs able to "take the con" and run with it.
- ▶ Frequent follow up can be implemented if needed.

Hospital to Office Transition

- ▶ A work in progress...
- ▶ Hospital PAs coming to the office
 - ▶ Same provider seeing on the day of discharge as seeing on the follow up in the office.
 - ▶ Continuity of Care.
 - ▶ Concept of "one more hospital day" occurring in the office.
 - Could this result in earlier discharge?
 - ▶ Follow up within 7 days of hospitalization (2-5 day follow up).

Office use of MLPs: CHF clinic management and leadership

- ▶ RN Supervision and Guidance within the CHF Clinic
 - ▶ MLP is always available to RNs on the phones for advice and input.
 - ▶ Work in for problem or questionable patients.
- ▶ Integral part of the tele-health and patient compliance program.
 - ▶ Track and ensure that patients get recommended tests and that results are reviewed and addressed.
 - ▶ Order and review follow up labs.
 - ▶ Respond to abnormal device readings.
 - ▶ Device clinic faxes reports with atrial fibrillation or Optivol.
 - ▶ CHF clinic NPs have their own Carelink login to request and review device data.

Office use of MLPs: Subspecialty Follow Up

- ▶ Post-transplant follow up:
 - ▶ NP maintains binder, schedules biopsies and labs, tracks down biopsy results, etc...
- ▶ LVAD follow up:
 - ▶ HF Clinic NPs are LVAD trained to be able to do:
 - ▶ Dressing changes and driveline inspections.
 - ▶ LVAD interrogation and programming adjustments and waveform downloads.
 - ▶ Patient education and assistance.
- ▶ Pulmonary hypertension follow up:
 - ▶ Education and counseling on medications.
 - ▶ Assistance with navigating the financial issues related to meds.

Possible future use of MLPs?

- ▶ Multiple daily rounds?
 - ▶ Repeat rounds with adjustment of management and plan.
- ▶ Open access scheduling as an outpatient?
 - ▶ Reduce the amount of phone medicine that we do.
 - ▶ Have MLPs available same day to assess and treat patients that call with issues.
- ▶ Refine the hospital to office transition?
 - ▶ Use office EHR at discharge so it is primed for follow up?
 - ▶ Refine care plan communication.
- ▶ Use of MLPs for procedures?
 - ▶ Swan Ganz insertions?
 - ▶ Dual lumen ELC (Aquapheresis) line insertions?
 - ▶ Work in the cath lab?

Conclusions:

What is the vision of 'value'?

- ▶ Push the patient from admission to discharge in the quickest way possible.
 - ▶ MLPs providing immediate effective therapy, continual reassessment and adjustment of therapy.
- ▶ More frequent contacts with the patient especially in the high risk period early after discharge.
 - ▶ MLP visits available earlier and much more frequently than could be achieved with physicians.
- ▶ MLP based systems of care improve our "footprint" of current, sophisticated, and advanced cardiology care.
 - ▶ Tele-health, device monitoring, LVAD, PH drugs, etc...



Thanks for Your Attention!

Questions / Comments?

