



Use of Mid-Level Providers for Heart Failure Management

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History of the Heart Failure Inpatient Program

- Concerns specific to standard heart failure care
 - Inconsistent patient care handoffs and discharges by resident service
 - Inconsistent HF education to the patients
 - Resident work-hour restrictions (80 hrs/wk)
 - MLP team was created to address these concerns



Goal of HF Program

- Decrease transfer time for direct admits from outside hospitals
- Decrease length of stay
- Decrease readmission rates
- Improve inpatient hand-off of care to and from the outpatient telemanagement team



Current State

- Faculty - 8 cardiologists
- Inpatient mid-level providers - 8.8 FTE (\$100,00 per FTE)
- Telemanagement
 - Nursing 5.5 FTE (\$80,000 per FTE)
 - Clerical 2 FTE (\$32,000 per FTE)
- Telemanagement service size
 - 2008 = 1928 (5 cardiologists)
 - To date in 2009 = 1807
 - 385 patients per RN FTE



MLP Inpatient Team

- Service started February 14, 2008
- Current State
 - 8.8 MLP's (NP and PA) with no resident coverage
 - 24/7
 - MLP's follow all patients managed by our outpatient telemanagement team
 - MLP's follow all heart transplant recipients regardless of admitting diagnosis
 - All direct referrals to heart failure/transplant cardiologists

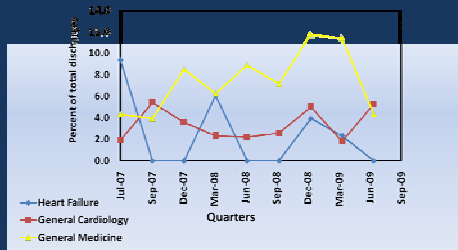


Metrics of Inpatient Team

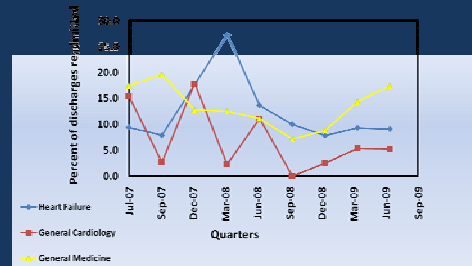
- 6-8 patients per MLP per day
- Median of 21 discharges/month (range 18-23)
 - Does not include transfers to ICU or cardiac surgery
- Median LOS – 6.7 days
- Presenting to ED in 3 days after d/c – 1.2%
- 30-day HF DRG readmission – 10%



HF Discharges Presenting to ED within 3 days



Readmission for HF DRG within 30 days



History Outpatient Team

- Access to clinics was limited, 28% of patients were not able to be seen, because of wait time for physician visit
- Calls to patients were managed by Telemanagement RN's with no collaboration with inpatient team
- Disease management was solely the responsibility of the outpatient RN's



Current Outpatient Team

- Joint Commission Certified Program for 6 years
- Nurse Coordinator experts
- Algorithm based call schedule
 - HFPSI four grades similar to NYHA
- Bridge Clinics staffed by MLPs
 - Bridge Clinic goal to see patients within 7-14 days of discharge



Outpatient Team Metrics

- Call within 2 days following hospital discharge
- Calls to each patient
 - Median of 13 calls per year per patient (max = 130)
 - Core competencies/performance dashboards in place
- Total calls from the program (2100 per/mth)
- Satisfaction with handoffs increased among staff



Challenges

- Recruitment
 - Difficult to compensate for giving up nights weekends and holidays
 - Critical number of MLP's required to provide night coverage and unexpected absence coverage
- Clinical Experience
 - General Internal Medicine issues are common, such that those with solid general medicine training add value to the team
 - Few programs with heart transplant population or high LVAD volume



Challenges

- Training/Orientation
 - Standardizing care process among MLP's
 - Educational Sessions
 - MLP clinical skill sets vary



Questions



Thank you

