Integra CHF Post Discharge Disease Management Program

Tara Higgins

Clinical Pharmacy Director

RHODE ISLAND PHYSICIANS CORPORATION PRIMARY CARE

integra Community Care Network

Background

- Congestive heart failure (CHF) is one of the top cost and most frequent cause of hospital admissions and emergency department visits
- Key components of successful CHF disease state management include:
  - medication management
  - symptom control and management
  - patient disease state knowledge
  - patient self-management skills

Program Overview

1

Discharge notification (IP/ED) - RIQI alerts daily

2

All discharges with admission dx of CHF or shortness of breath with known dx of CHF sent to practice assigned pharmacist for outreach

3

First outreach

Within 72 hours of discharge

4

Second outreach

14-21 days post discharge

5

Third outreach

6-8 weeks post discharge

Patient Outreach

Standardized check-list for pharmacists

Standardized CHF patient education materials – Healthcentric Advisors, South County Hospital

Patient survey issued after second outreach

Program Outcome Measurement and Goals

- Increased % of patients with successful engagement within 72 hours of discharge
- Increase in medication adherence
- Increased use of appropriate evidence based medications
- Decreased re-admission rates for patients with CHF
- Improved patient outcomes based on patient survey results
- Quality measures – Focus for 2019
  - Increase post discharge med rec, increased follow-up appointments (7 days post discharge)
- Total % of patients completing patient survey

Results to Date

Integra Medicare population, regardless of dx, readmission rate is **greater than 18%**

Readmission rate of CHF patients in discharge program = **10%**

Noted increase in medication adherence for diuretics, ACE inhibitors

Average time to first engagement post discharge has decreased from 72 to 36 hours

Very low return rate on patient survey – opportunity to do survey as part of second and third outreach

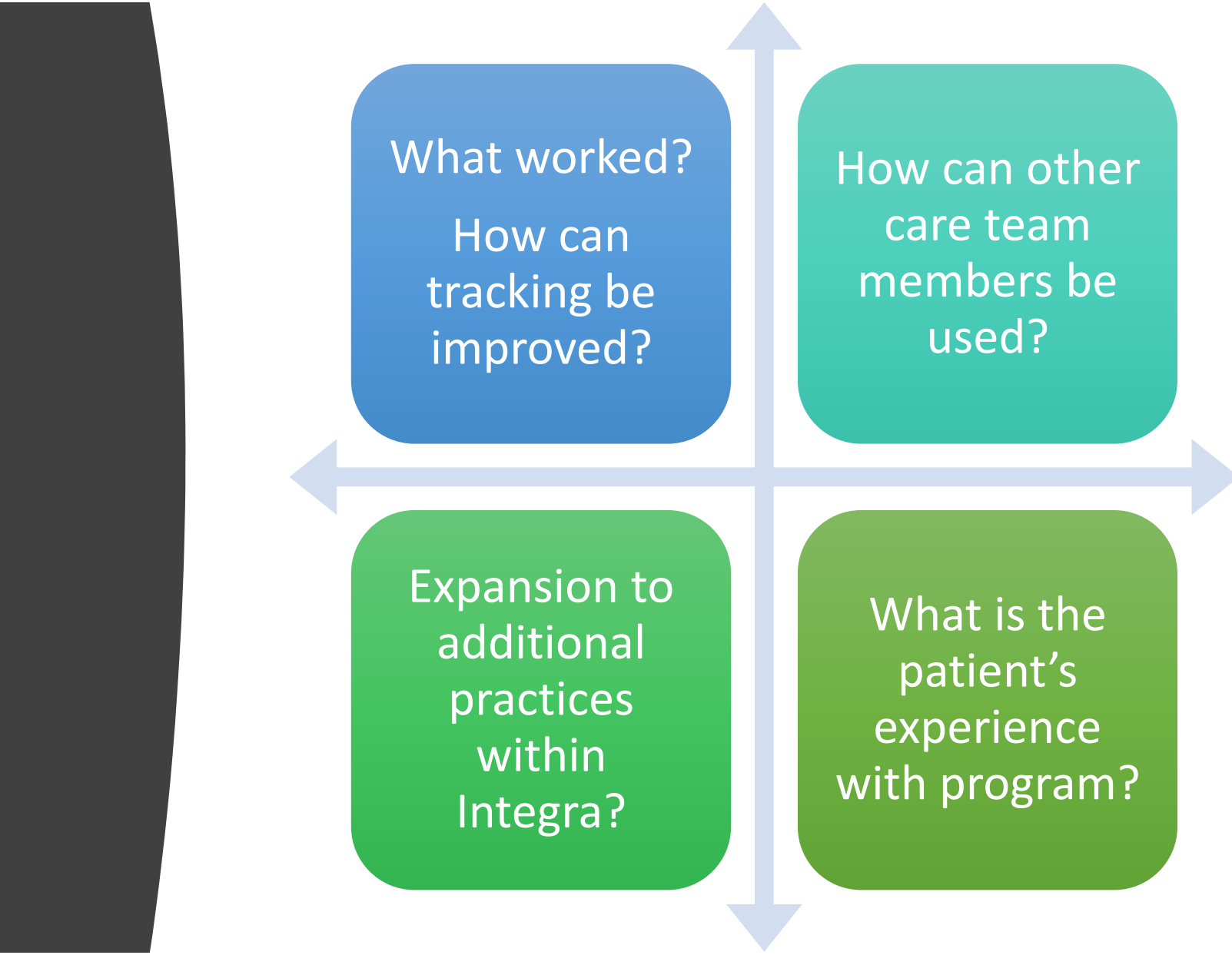
Patient Example #1

- 78 yr old male
- BCBSRI risk category Orange
- Hx of CHF exacerbations with 5 hospitalizations in 2017
- Discharge 7/18
- NCM and Pharmacist involvement – medication review and CHF disease management
- Med changes made during hospitalization – resulting in non-adherence due to cost/side effects
- Implemented CHF action plan with zones
- No readmissions to date, BP is controlled, adherent to medications, daily weights, and controlling sodium intake

Patient Example #2

- 73 yr old male
- Repeated admissions for CHF over last 2 years
- Discharge 9/18
- No diuretic in house, skipped doses for 2 days – pharmacist resolved issue with pharmacy and diuretic delivered home that day
- Home visit two weeks later identified that medication packing of diuretic was incorrect – pharmacist resolved with pharmacy
- Patient is now dosing diuretic correctly, no additional admissions to date

Plan-Do-Study-Act



Future State

Engage with care transition pharmacist/program at Integra in-network hospitals (Kent, South County) for warm hand off

Implement diuretic protocol with appropriate patients for self-management

Step down appropriate patients into Wellness Program for continued monitoring and outreach

Questions?