

# N-HEFT NEWS

## LETTER FROM CO-DIRECTORS



Dr. Ileana Piña  
Case Western Reserve University



Dr. Hector Ventura  
Ochsner Clinic

Greetings to everyone as we start an exciting new year filled with opportunities and challenges as we continue the wonderful work we do. Our research continues to lead us down new paths of scientific and clinical knowledge as we engage in the battle against heart failure. However, the number of patients and the cost continue to escalate despite our best efforts. Studies have shown us that the right treatment for each patient can improve health outcomes and can reduce the high cost of care. We also know through research that success in managing heart failure requires multi-disciplinary teams across the continuum who actively engage the patient and caregivers in the treatment plan. The combination of spiraling health care costs and the lack of consistent quality for cardiac care continues to drive the momentum towards payment for performance (P4P), a concept which can no longer be ignored.

We have included a summary of the ACC's position on P4P in this newsletter.

We also face the challenge of increasing public scrutiny of our financial relationships as physicians, researchers and teachers which requires us to maintain strict vigilance in our integrity regarding conflict of interest and adherence to regulations.

While all these challenges may at times seem overwhelming, they also provide us with a myriad of exhilarating opportunities. N-HeFT *Live and Online* gives us the opportunity to disseminate our best ideas and practices as experts, confident that we have safeguards such as our editorial board in place to remain free of bias. In addition we remain committed to broadening our support base of commercial supporters to eliminate even the perception of conflict of interest.

We now have 32 Centers of Excellence working together to share resources in our dedication to improving health care for heart failure patients. In addition, we are in the process of expanding N-HeFT *Online*. In the next few months we will be adding sleep apnea, depression, and co-morbidities to name a few. We are also working on a new one day preceptorship program entitled R-HePHT for right heart failure and pulmonary hypertension. Look for more information in our next newsletter.

Welcome Andrew Kao, MD of Cardiovascular Consultants, Directors of Mid America Heart Institute and his team as our newest site and Mark Drazner, MD, as the new director for UT Southwestern Medical Center. We look forward to the coming year with hope and enthusiasm.

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## Welcome New Sites and New Members

We welcome Saint Luke's Mid America heart Institute, directed by Cardiovascular Consultants. It is one of the largest teams of cardiologists and surgeons in the region with more than 100 active cardiovascular trials underway and winner of a 2006 Missouri Quality Award, the official state recognition for excellence in quality leadership. Saint Luke's is well-poised to provide best-practice training in heart failure. It also offers the only heart transplant program in the region with volumes in the top ten percent of hospitals nationally.

**Andrew Kao, MD**, serves as the Host Site Director. Dr. Kao of Cardiovascular Consultants, is the director of the Cardiac Transplant Program of Saint Luke's Mid America Heart Institute. He completed a fellowship at Duke University Medical Center, and Oregon Health Sciences University. His research interests include exercise physiology of HF and transplant patients, quality of life, and depression.



We also welcome **Mark H. Drazner, M.D.**, Associate Professor in cardiology and internal medicine. Dr. Drazner is the new N-HeFT Site Director for UT Southwestern Medical. His research interests include advanced heart failure, left ventricular hypertrophy and cardiac transplantation. He completed a fellowship in cardiology at Duke University and in heart failure/cardiac transplantation at Brigham and Women's Hospital.

**Training Sites****Albany Medical Center**

Edward Philbin, MD

**Allegheny General Hospital**

Srinivas Murali, MD

Jessica Lazar, PA

**Baylor University Medical Center**

Clyde Yancy, MD

Mae Centeno, MS, RN,  
CCRN, APRN, BC**The Cardiovascular Center**

Douglas Chapman, MD

**NEW! Cardiovascular Consultants, directors of Mid America Heart Institute**

Andrew Kao, MD

Felicia Menefee, RN,  
MSN, BC, M-S, CNS, ANP**Case Western Reserve University**

Ileana Piña, MD

Julie Gee, RN, MSN, CNP

**Duke University Medical Center**

Christopher O'Connor, MD

**Emory University Hospital**

Andrew Smith, MD

Pam Pursley, RN, CCRN,  
MN, ANP**Georgetown University Hospital**

Leslie Miller, MD

**Midwest Heart Specialists**

Maria Rosa Costanzo, MD

**Northwestern University**

William Cotts, MD

Kathleen Grady, PhD, RN,  
FAAN**Ochsner Clinic**

Hector Ventura, MD

Moriah Richie, PA

**Oklahoma Cardiovascular Associates**

Philip Adamson, MD

## Think TANK For Cardiovascular Research in Women

By Jeanne Hitch, MEd, MA, LPC

Thanks to the gracious hospitality of the American Heart Association, we were able to hold our third quarterly meeting on Saturday, Nov 11. Though the group had only two hours to meet, the air was filled with synergy and enthusiastic discussion. The group recognized endothelial dysfunction or vascular reactivity as one of the most important topics for women's heart disease.

Endothelial dysfunction (vascular reactivity) may have a dramatic impact on CAD, heart failure and surgical outcomes, and opens the door to further explore risk factors for women. The group now has the task of agreeing on a "centralized theme" and its many branches.

The following topics related to endothelial dysfunction were discussed:

1. Prediabetes
2. Diabetes as a whole vascular syndrome
3. Diabetes of pregnancy
4. Abnormal functional capacity of certain groups of women
5. Chest pain syndrome with minimal coronary disease
6. The women identified in the WISE studies
7. Heart failure symptoms including those with preserved systolic function
8. Hypertension in women and its relationship to hormonal issues
9. Metabolic syndrome
10. Tobacco use

The group has been charged with the task of identifying the central hypothesis and suggesting pilot data that may be available at the individual institutions. Before the next meeting in March, Think Tank members will submit their hypothesis and a summary of its importance along with its possible impact on public health. Everyone was also encouraged to support the Think Tank Policy Chairperson, Rita Redberg, MD, in her endeavors to change national policy.

The next meeting will be held in New Orleans on Saturday, March 24<sup>th</sup>, thanks to the gracious hospitality of the American College of Cardiology.

### Mission Statement

The National Heart Failure Training Program seeks to educate physicians and other healthcare professionals in best practices for treating heart failure by providing both didactic sessions and preceptorships through its network of heart failure centers across the country.

## Acknowledgements

Educational grants from the following companies are gratefully acknowledged: Actelion, Agency for Health Quality Research (AHRQ), Amgen, Astellas, CV Therapeutics, GlaxoSmithKline, Kos Pharmaceuticals, Medtronic, NitroMed, Novartis, Otsuka Pharmaceuticals, Inc., ResMed, and Women's Health Initiative. Acceptance of funding in support of this program does not constitute endorsement of any product or manufacturer.

## Marketing Tip

**Personally invite Physicians who refer patients to your heart failure clinic to attend N-HeFT by sending**

- **An invitation letter**
- **Brochures**
- **The N-HeFT Newsletter**
- **An application**

Applications can be downloaded from <http://www.nheft.org>  
Any Questions Please Email us at [nheft@case.edu](mailto:nheft@case.edu)

## Quality Corner

By Ileana L. Piña, MD

*"Quality is never an accident; it is always the result of an intelligent effort."*

John Ruskin, English essayist (1819-1900)

Health care payers and politicians are reacting to spiraling health care costs and fragmented care by moving towards payment for performance programs without necessarily waiting for health services research and solid supporting evidence regarding these programs. In response the American College of Cardiology (ACC), along with other organizations, convened working groups and developed principles to guide their members and payers through the transition to novel payment systems. Therefore, an official health policy statement regarding payment for performance (P4P) was recently published by the ACC. Below is a summary of the 12 principles to guide the development of P4P programs, but it is highly recommended that you take the time to read the entire statement. The citation is listed below.

The ACC fully recognizes the combination of spiraling health care costs and the lack of consistent quality cardiac care. They support the development of P4P programs and at the same time caution against outmoded quality assurance methods.

1. Build P4P programs on performance measures that are valid, reliable, uniform, evidence-based, interpretable, actionable, reliable, and feasible.
2. Create a sustainable business case for investing in structure, best practices, and tools that can lead to improvement and high-quality care by recognizing the true resource costs associated with achieving and maintaining high-quality care. Information technology systems are required to capture and report performance.
3. Reward process, outcome, improvement and sustained high performance being careful to include the ambulatory setting. The impact of patient adherence on outcomes calls for both patient and provider incentives.
4. Attribute physician performance in credible ways that encourage collaboration such as reporting aggregate data and offering incentives for collaboration among primary care and specialist groups.
5. Use clinical data rather than administrative claims data with the exception of data sources with a low misclassification rate such as pharmacy claims or laboratory data. This data allows physicians to supplement or correct data deficiencies without onerous appeals processes.
6. Set reasonable achievable targets for performance using benchmarks obtained from national databases. Be careful not to penalize participants that serve disadvantaged socioeconomic populations or because of baseline resource constraints.

7. Make decisions about appropriateness for what should and should not be done and reward based on solid clinical evidence where available, such as appropriateness criteria recently developed by the ACC and the American Society of Nuclear Cardiology or the appropriate standard of care determined by clinical studies.

8. Emphasize success and reward achievement and efficiency considering populations not individual cases, preferentially rewarding care teams, disease management programs, and programs with populations most in need who may have a chance for marginal improvement. P4P can be funded through the cost savings realized by that organization, not taken from one group of providers to pay another. Don't penalize providers with socioeconomic disadvantages, limited access to technology, and other constraints.

9. Provide self-audits and objective third party periodic audits of performance measure data, considering models such as ACC's National Cardiovascular Data Registry.

10. Prior to implementation seek physician participation to establish transparent provider rating methods with detailed measurement specifications and algorithms that combine scores from individual measures and/or group providers into performance tiers. Adhere to principles such as those outlined in the AHA Scientific Statement on Standards for Statistical Models Used for Reporting of Public Outcomes to publicly report data.

11. Recognize the potential for perverse incentives and maintain vigilance, ready to correct any design flaws that have unintended consequences.

12. Invest in outcomes and health services research in areas where the evidence base is inadequate or for which accurate performance measurement is not feasible and assess for impacts on access, costs, quality, health outcomes, and physician and patient satisfaction.

Brush JE, Jr., Krumholz HM, Wright JS, Brindis RG, Caccione JG, Drozda JP, Jr., Fasules JW, Flood KB, Garson A, Jr., Masoudi FA, McBride T, McKay CR, Messer JV, Mirro MJ, O'Toole MF, Peterson ED, Schaeffer, JW, Valentine CM. American College of Cardiology 2006 principles to guide physician pay-for-performance programs: a report from the American College of Cardiology Work Group on Pay for Performance. *J Am Coll Cardiol* 2006;48:2603-9.

### Training Sites Cont'd.

#### Rush University Medical Center

Stephanie Dunlap, DO

#### South Florida Medical Institute

Gervasio Lamas, MD  
Parandeh Alashti, PA-C

#### St. Vincent Hospital

Mary Norine Walsh, MD

#### St Luke's Episcopal Hospital

Reynolds Delgado, MD

#### Temple University Hospital

Alfred Bové, PhD, MD  
Judith Moore, RN, BSN

#### Tufts New England Medical Center

David DeNofrio, MD  
Linda Ordway, RNC, MS, ANP

#### University of California San Diego Medical Center

Barry Greenberg, MD  
Annette Contasti, RN, BSN

#### University of California San Francisco Medical Center

Theresa DeMarco, MD  
Amanda Brown, E.M., RN, MS, CNS

#### University of Cincinnati

Lynne Wagoner, MD  
Ginger Conway, MSN, RN, CNP

#### University of Colorado Health Sciences Center

JoAnn Lindenfeld, MD

#### University of Kansas Hospital

Charles Porter, MD  
Christy Russell, RN

#### University of Maryland School of Medicine

Stephen Gottlieb, MD  
Kay Blum, PhD, CRNP

## Training Sites Cont'd.

**University of New Mexico**

Robert Taylor, MD  
Elizabeth Shepherd, RN

**University of North Carolina**

Kirkwood Adams, Jr., MD  
Jana Glotzer, RN, MSN,  
CCRN, ACNP  
Valerie Johnson, RN

**University of Rochester**

John Bisognano, MD  
Sheila McCart, AOS

**University of South Florida**

Douglas Schocken, MD  
Mary Ann Yarborough, RN

**University of Washington Medical Center**

Carol Buchter, MD  
Alison Wynne, RN, MS,  
ARNP

**Washington University**

Gregory Ewald, MD  
Cindy Pasque, RN

## Clinical Coordinator Corner

By Julie Gee, RN, MSN, CNP

Welcome to **Felicia Menefee, RN, MSN, BC, M-S, CNS, ANP**, the clinical coordinator for Cardiovascular Consultants. She serves as the midlevel program developer and clinical coordinator of the outpatient heart failure clinic and is one of the directors of the *Innovative Therapy for Heart Failure: An Interactive Program*. Her experience includes co-investigator in clinical trials, speaker, and faculty member.

We are looking forward to a wonderful year. Thanks to all who participated in our N-HeFT survey and first coordinator's conference call. Our survey assessed personal interests as well as training site strengths and weaknesses. Didactic lectures were ranked as the strongest asset at 82% of the sites. Setting goals and following-up after a training were the most challenging. Research is the most popular committee, followed by marketing, curriculum/case development, and continuing education. Disease management, patient adherence, and medication protocols were the top choices for future calls. Staff availability was the greatest challenge for training.

Our next conference call will be Wednesday, March 14<sup>th</sup> at 4 pm EST (1 pm PST). We will review current curriculum topics and evaluate a training module. We will continue to discuss new areas of interest. Please bring your ideas for improving disease management and thoughts about future research projects. We look forward to our next conference call and to hearing from you. Please contact me with ideas, questions or comments at [Julie.Gee@med.va.gov](mailto:Julie.Gee@med.va.gov) or 216-791-3800 extension 4898.

## N-HeFT Goes Home

By Jeanne Hitch, MEd, MA, LPC

Heart failure is the most common hospital discharge diagnosis in the United States for patients 65 years and older. Increasing hospital readmission rates for this patient population translate into spiraling health care costs. The hospital readmission rate (which exceeds 40% per year, with a disproportionate percentage among the medically underserved) and the associated cost of treating patients with heart failure continue to escalate.<sup>1</sup> In response, home health agencies are increasingly interested in developing heart failure management programs as they strive to meet the demands of the Medicare program by addressing high rates of acute care hospitalization.

Although clinical studies have made many advances towards decreasing morbidity and mortality and improving the patient's quality of life, the knowledge of treatment choices (surgical and medical), and the application to

patient care is fragmented and inconsistent, especially with the growing numbers of patients and the complexity of the disease. Many studies have shown that a multi-disciplinary approach reduces hospitalizations significantly.<sup>2</sup>

The home care nurse assumes a pivotal role in the management of these patients, but many home health care practice guidelines are not founded on data-based research. Education and training focused on home health care and based on the most current research on care of HF patients can help to improve patient outcomes.

N-HeFT has been approached by hospitals, nursing homes, hospice and home care agencies to offer training for heart failure patients and is addressing the needs of these organizations by developing customized training to address specific areas such as practice change, provider education, real-time application of quality measures, consistent use of guidelines, pharmaceutical interventions, patient education, advocacy, communication, end-of-life decision making and palliative care. Supplemental courses will also be available on the N-HeFT website <http://www.nheft.org>.

The three main goals of the Home Care Program are as follows: improving patient outcomes by improving adherence to the treatment plan, providing meaningful data to physicians regarding outcomes related to their management of heart failure, and improving the utilization of evidence-based therapies based on current guidelines for patients with heart failure.

The expected outcomes are to improve the quality of care of patients with heart failure participating in the project in these specific areas: improved use of evidence-based therapy, reduction in hospitalizations, decrease in total medical costs, and consistent education for patients.

The program will be available through N-HeFT Host Sites in 2007.

1. Deaton, C., Bennett, J.A., & Riegel, B. (2004). State of the science for care of older adults with heart disease. *Nursing Clinics of North America*, 39(3), 495-528
2. Holland R, Battersby J, Harvey I, et al. Systematic review of multidisciplinary interventions in heart failure.

### TWO-FOLD PURPOSE OF THE NETWORK

- Maintain and disseminate best practices in the care and treatment of heart failure
- Continuously improve the quality of the program itself as an educational delivery system with the goal of improved patient outcomes