Team 2:

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# **Value-Based Care and Management of Heart Failure Patients**

# Heart failure (HF) is a complex clinical syndrome that poses significant challenges to healthcare systems worldwide. The rising prevalence of HF, coupled with its substantial economic burden and impact on patients' quality of life, necessitates a shift towards value-based care models. For this project, we aim to explore the implementation of value-based care strategies for managing heart failure patients and focusing on evidence-based interventions across the continuum of care.

# The concept of value-based care in heart failure management emphasizes the importance of delivering high-quality, patient-centered care while optimizing healthcare resources. This approach aligns with the broader transition in healthcare from volume-based to value-based models. For heart failure patients, this translates to a focus on improving outcomes, enhancing quality of life, and reducing hospitalizations and healthcare costs.

# Recent literature highlights a multifaceted approach to improving patient outcomes through various systems of care, integrated models, and self-management strategies. A systematic review by Driscoll et al. (2016) identified 29 studies categorized into four environments of delivery: workforce, primary care, in-hospital, and transitional/community systems of care. Their findings emphasize the importance of an experienced workforce, noting that specialized heart failure teams significantly enhance patient outcomes, particularly in inpatient settings.

# Building on this, MacInnes & Williams (2018) explored integrated heart failure care models, asserting that the complexity of HF necessitates a collaborative approach among various healthcare professionals. They highlight the need to identify effective practices tailored to specific patient populations and contexts, reinforcing the notion that integrated care can lead to improved quality and efficiency in managing heart failure.

# Most recently, (Koikai & Khan, 2023) focused on the effectiveness of self-management strategies for patients with heart failure, emphasizing the critical role of patient engagement in managing their condition.

# To implement these evidence-based approaches in a value-based care framework, several key interventions can be explored:

# **Multidisciplinary Care Team Approach:** Develop a comprehensive care team including cardiologists, nurse practitioners, pharmacists, dietitians, and social workers. Regular team meetings can be hosted to discuss complex cases and develop individualized care plans. This aligns with Driscoll et al.'s findings on the importance of specialized heart failure teams.

# **Remote Monitoring and Telehealth:** Implement remote monitoring tools to track vital signs and symptoms, such as heart rate, blood pressure, and weight, enabling early intervention. Create protocols for patients to report symptoms through an app or telehealth service, fostering proactive management. This intervention supports the growing trend of utilizing health informatics and telemedicine monitoring.

# **Patient Education and Self-Management:** Create a patient education program focusing on medication adherence, diet (sodium restriction), and recognizing early signs of exacerbation. Encourage patients to keep a daily log of their symptoms and vital signs, fostering accountability and engagement in their care. This aligns with the findings of Koikai & Khan (2023), who emphasized the effectiveness of self-management strategies in reducing hospitalization rates and mortality.

# **Day Hospital Initiative:** Establish a day hospital model where patients can receive treatment during the day and return home in the evening, aiming to reduce emergency department visits for heart failure.

# **Structured Follow-Up and Transition Care:** Implement a structured follow-up program that includes regular in-person or telehealth appointments to assess patient progress, review medications, and make necessary adjustments. Establish protocols to ensure smooth transitions from hospital to home, including comprehensive discharge planning.

# **Psychosocial Support:** Create peer support groups for patients with heart failure to share experiences, resources, and encouragement, recognizing that heart failure is a progressive disease. Provide access to mental health services to address the psychological aspects of managing a chronic condition.

# These interventions collectively address the various stages of heart failure care such as pre-hospital care, acute care and post-discharge care.

# **Implementation and outcomes of Value-Based Care**

# The transition to value-based care in heart failure management requires strategic partnerships between healthcare systems, health plans, and clinicians to deliver personalized, timely, and affordable care. While this shift presents challenges, including the need for physician education, significant technological investments, and real-time data utilization, organizations like UnitedHealth have demonstrated successful implementation through integrated clinical models, enhanced care coordination, and advanced data analytics. The efficacy of these value-based approaches is evident in research comparing fully accountable care plans to traditional Medicare fee-for-service models. Patients in value-based care programs showed significantly improved outcomes, including an 18% lower chance of inpatient admission, 11% fewer emergency department visits, and a 44% reduction in hospital admissions for COPD or asthma complications. Moreover, these patients experienced lower rates of hospital readmissions, avoidable ER visits, and admissions for serious conditions like stroke or myocardial infarction. To say the least, these outcomes underscore the potential of value-based care strategies to enhance patient health while optimizing healthcare resource utilization, particularly in the management of complex chronic conditions like heart failure.

# **Questions for Professor Mary Frances Luce**

# What strategies can be employed to ensure effective communication among the care team? How do we facilitate seamless handoffs between team members? What challenges might arise in coordinating care across different specialties, and how can we address them? How can we leverage technology to enhance patient care and communication? What role do electronic health records play in tracking patient progress and facilitating collaboration among care team members?

How can we ensure that our team of healthcare professionals are fully incentivized/ bought into a value-based care system?

# How do we define and measure improvements in quality of life for heart failure patients? Could the metrics be hospital readmission rates, patient-reported outcomes, quality of life assessments, and medication adherence rates or mix of these?

# How can we effectively engage patients in their care? What strategies can be employed to motivate patients to actively participate in self-management and adherence to treatment plans?

What are some common issues that healthcare systems encounter when transferring from a fee-for-service to value-based care system? How can we overcome these barriers?

If we were to transfer our healthcare model from a fee-for-service model to a value-based care model, we believe it would be a slow transition that starts with a smaller population that would eventually scale to a larger population/all patients in the hospital. What challenges occur from scaling from a small to large program?

How can we create trust among multidisciplinary team members in a value-based care model for heart failure, ensuring that each provider feels confident in the team's collective goals? Additionally, how can we create personalized incentives for each healthcare professional that are aligned with their individual contributions, while still encouraging collaboration, so that they don’t feel as though their success is entirely dependent on others and "out of their hands"?

# References:

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