
2024 VIZIENT CONNECTIONS SUMMIT
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Team-Based Heart Failure Clinic: Impact on Improving Outcomes

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Learning Objectives

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- Describe the differences in GDMT management for patients seen within a team-based care HF clinic versus primary care alone.
- Discuss creating a team-based care HF clinic utilizing the outcome benefits shown in this presentation.

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ThedaCare

Serving 250,000+ patients from 18 counties across Northeast and Central Wisconsin

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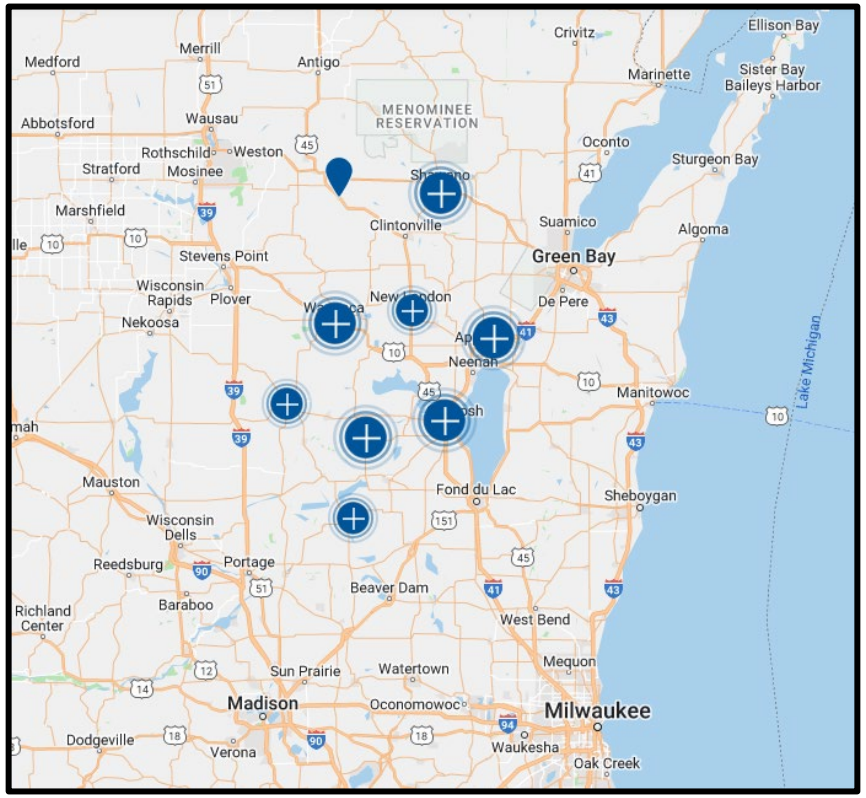

- 8 Hospitals
- 180+ Primary Care, Specialty, & Onsite Clinics including
  - 50+ Independent Partner Practices
  - 60+ Specialties
- 2 Long Term Care Facilities and an Assisted Living Facility
- Home Health and Hospice/Palliative Care
- 7,000+ Care Team Members, 1100+ Providers, and 3,000+ Nurses

ThedaCare is recognized as a:

- Vizient **Top Decile Performer**
- CMS **4 & 5 STARS** for hospital services
- MSSP ACO **#8** in the nation and **#2** in WI

Our lifeinspired mission is to improve the health and well-being of our communities by empowering each person to live their unique, best life.

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Our Call to Action

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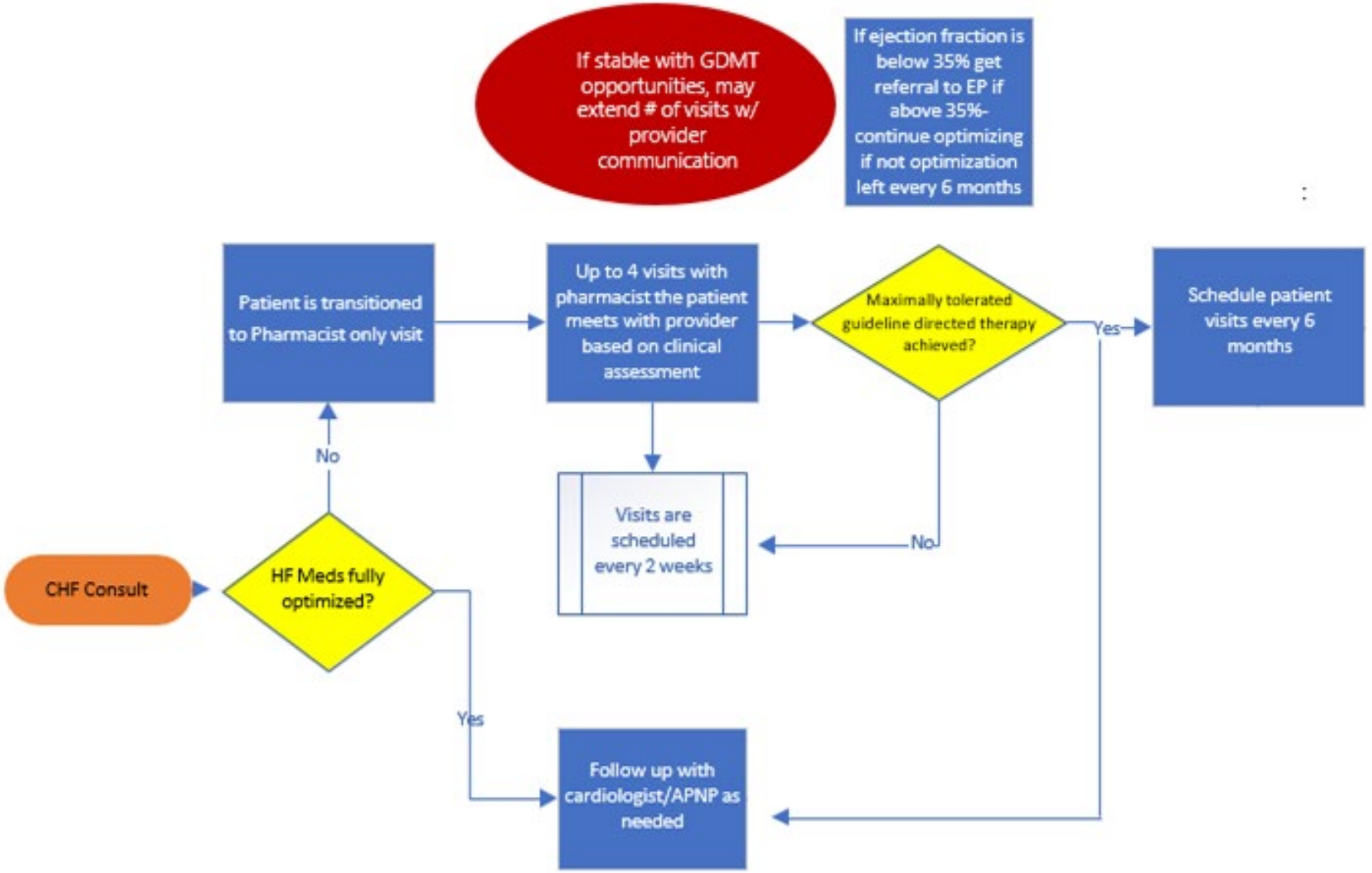
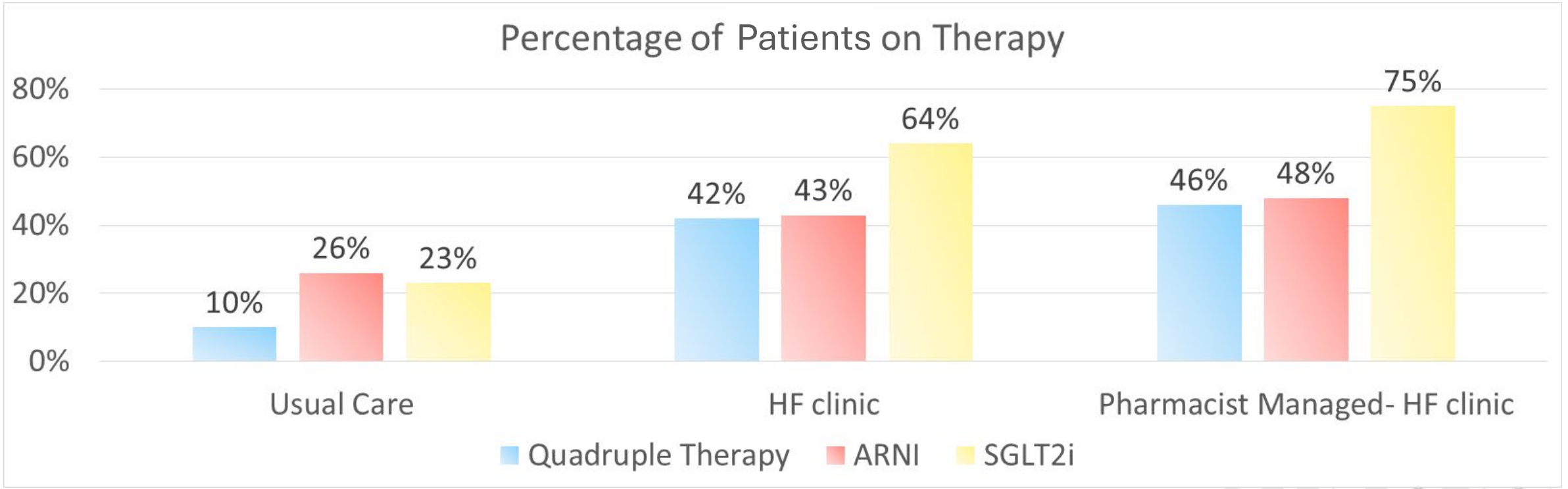
- We identified an opportunity to improve patient outcomes through optimizing Guideline Directed Medical Treatment (GDMT)
- At the same time, we recognized that we had a need to improve access within cardiology
- By implementing a team-based approach, that involves Heart Failure focused nurse coordinators and an ambulatory (clinic based) pharmacist, we believed we could improve GDMT, while increasing access to our cardiology providers for acute patients and new consults

Team Based Care Clinic Workflow



GDMT Outcomes Across Three Compare Groups
January 2024 snapshot



Lessons Learned

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- Dual (joint) visits best support the workflow
- Explore the joint GDMT management partnership and then refine, refine, refine!
- Develop your team with clear goals, metrics along with champions and strong leadership

Key Takeaways

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- Consider including an ambulatory pharmacist provider within your HF clinic to drive accelerated GDMT improvements and improve patient outcomes
- The Team Based Care model provides the patient with a specialized and dedicated team to wrap our arms around our most vulnerable patients
  - Less likely to fall through a gap
  - Medication expertise more easily overcomes barriers
  - Support to the cardiology providers in terms of workload burden and stress

Rush University Medical Center (RUMC) at a Glance

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Academic Medical Center | Chicago, IL

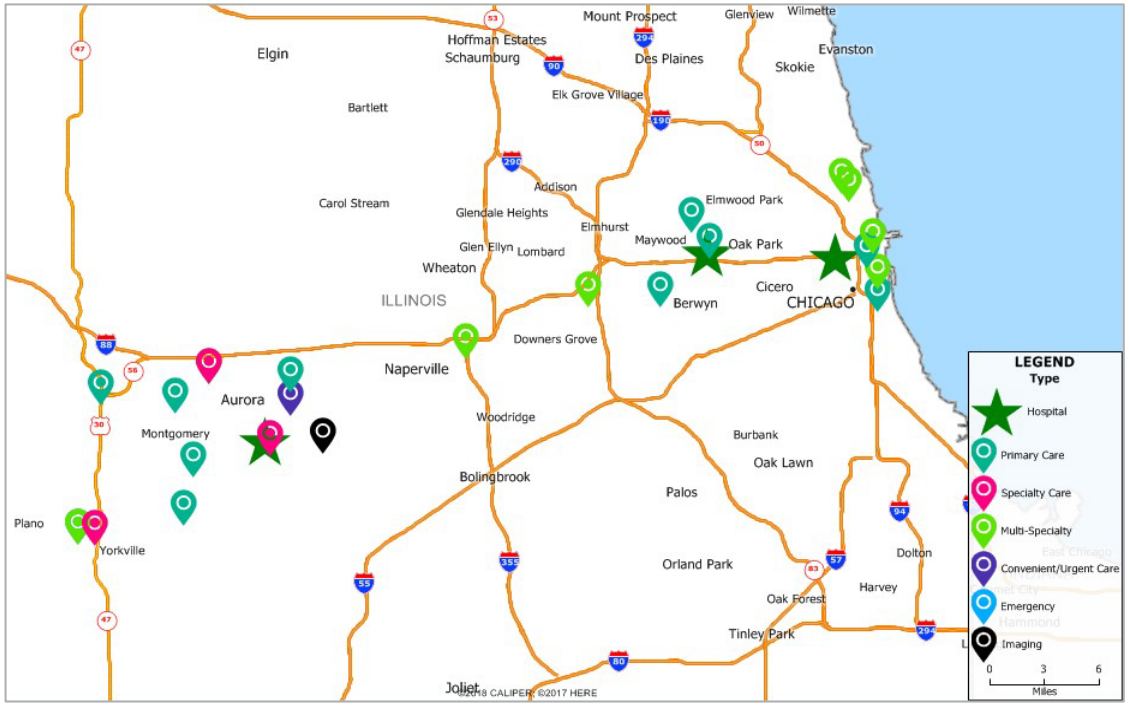
3 HOSPITALS	1124 BEDS	1396 PHYSICIANS
160,904 ED VISITS	1.1mil OUTPATIENT VISITS	45,367 ADMISSIONS

BEST HOSPITALS U.S.News & WORLD REPORT HEART & VASCULAR 2024-2025

RUMC is **ranked #2** among 93 leading academic medical centers for quality of care by the health care services company Vizient.

RUMC is recognized as a CMS Services **5-star organization**

RUMC serves a diverse patient population in the West side of Chicago and is committed to measurably **reduce inequities** across our patients, people, communities and organization



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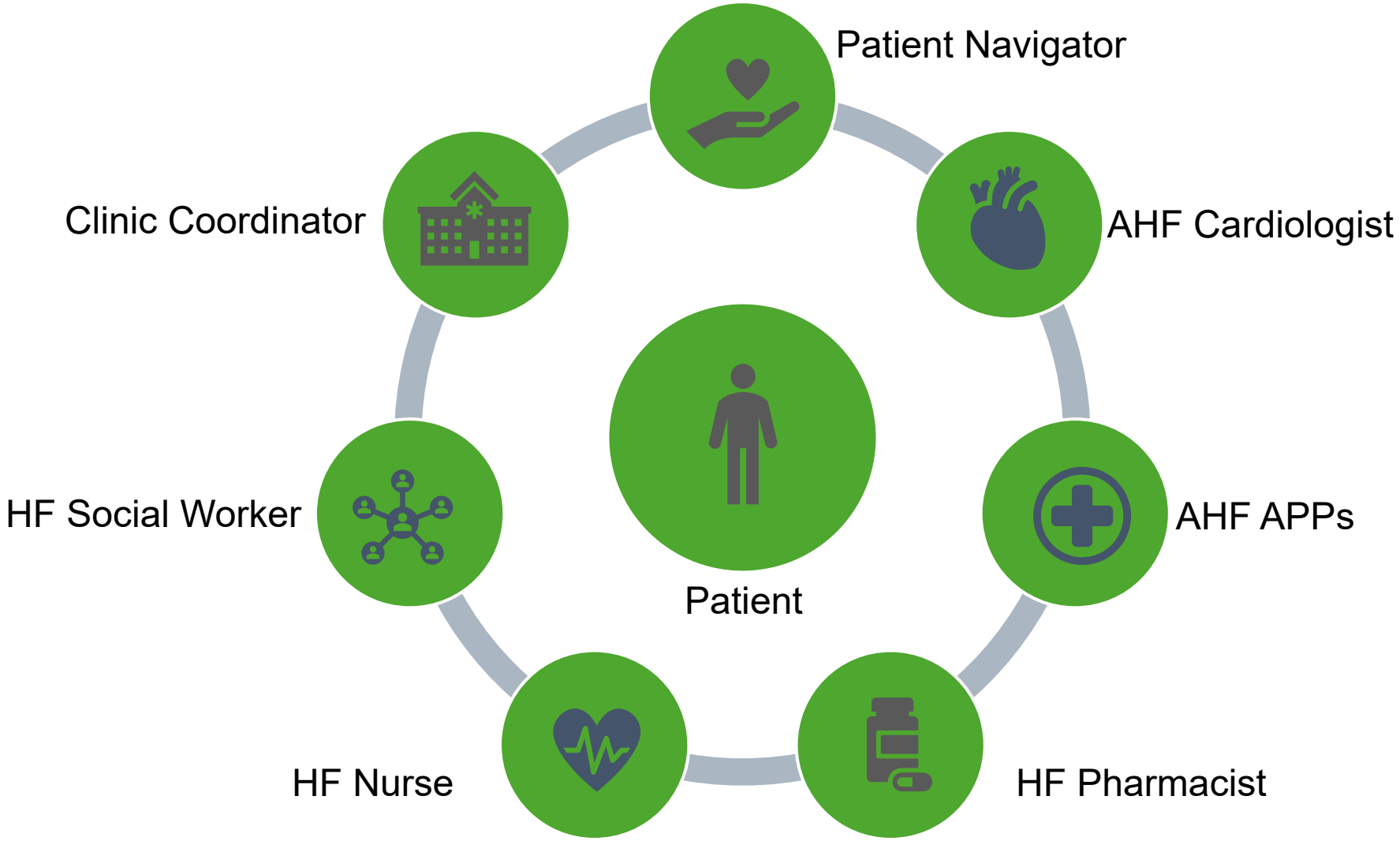
Heart Failure Care-Team Model



Since Implementing HF Care Model, HF Readmissions Decreased; Improved Access to Care and Clinic Growth

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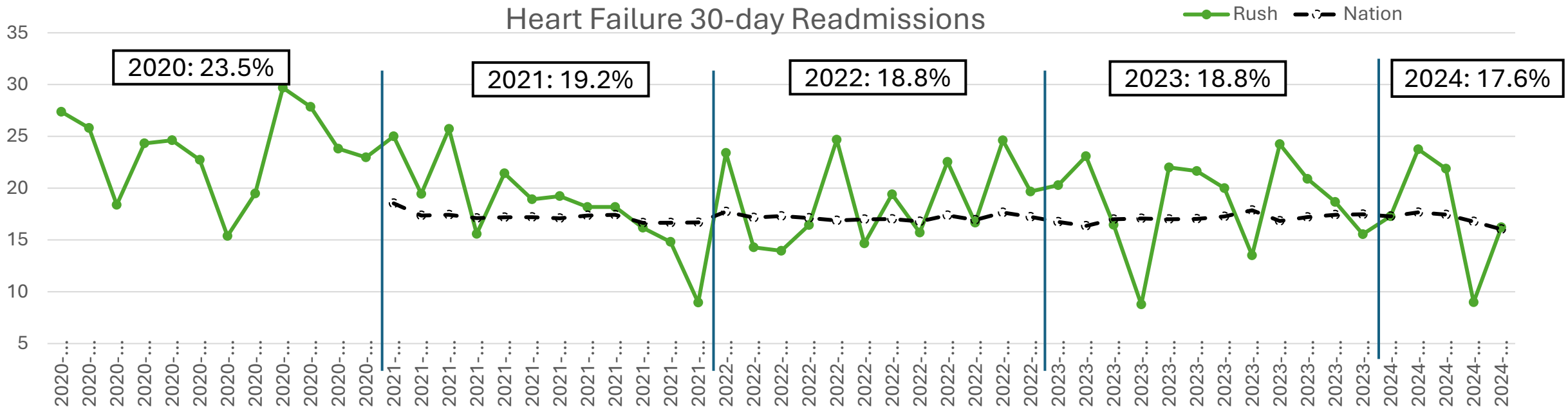

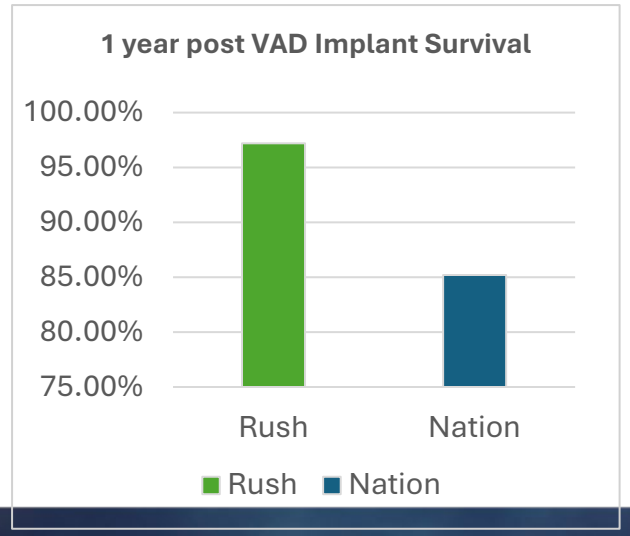

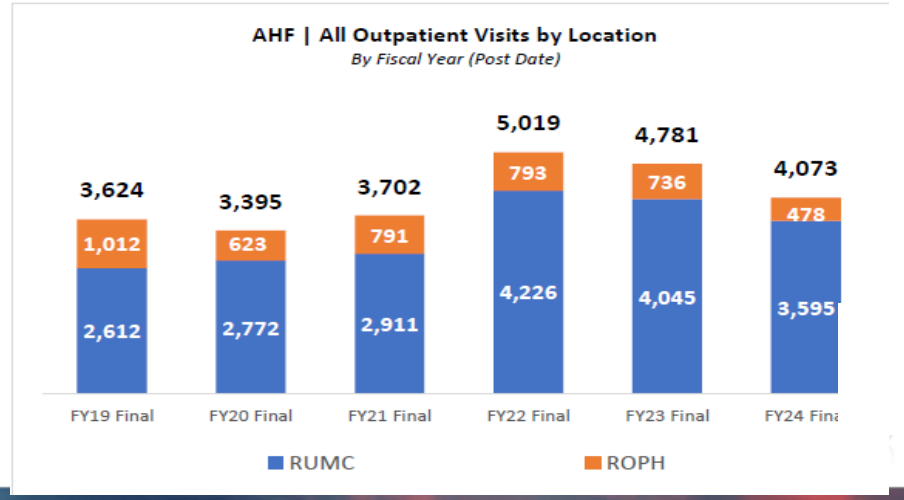

Lessons Learned

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- Risk stratification and early identification by leveraging technology
- Open communication and multidisciplinary approach
- Patient optimization during index hospitalization and ensuring access to guideline directed medical therapy
- Review of previous admissions to identify areas of improvement
- Consideration of advanced therapies and/or pulmonary artery devices

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Key Takeaways

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- Power of multidisciplinary approach
- Focus on social determinants of health to overcome patient barriers
- Need for process workflow implementation and frequent review
- Ongoing support from executive leadership
- The HF Ambulatory Care-team model is crucial for quality patient outcomes, preventing HF readmissions, and increasing program growth


Panel Discussion
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Questions?

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Thank you:

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