

Proactive Use of Protocols in Secondary Prevention- A Local Example: Heart Smart

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**Mercy Heart & Vascular Institute
of Greater Sacramento™**

A Dignity Health Member

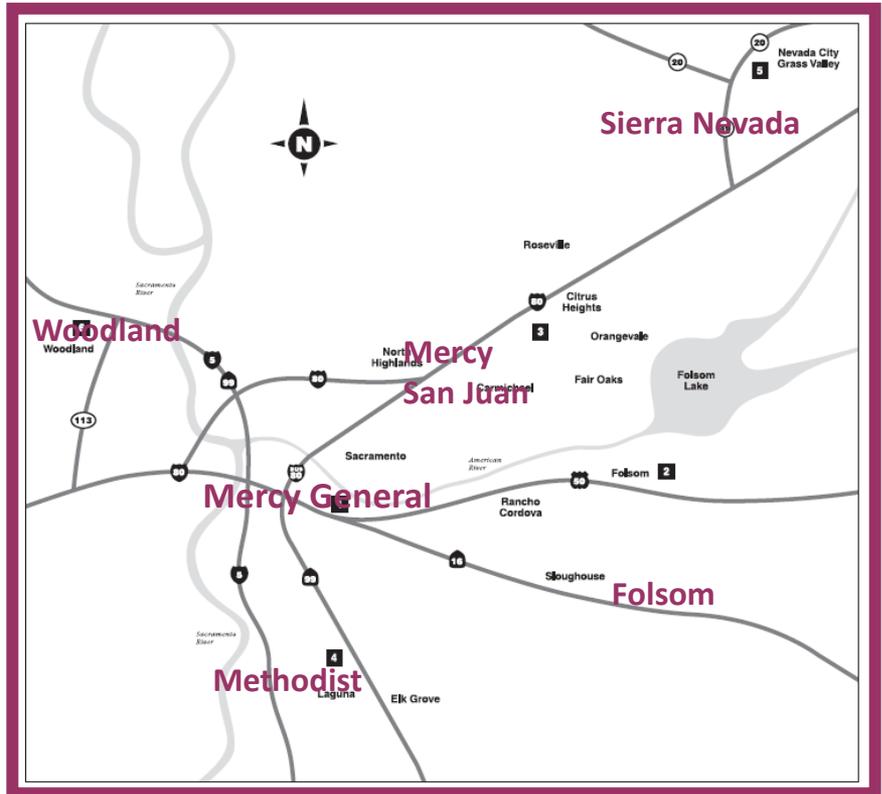
MERCY HEART & VASCULAR INSTITUTE

Provides Dignity Health Service

Area-Wide Access to Cardiac Care

- Mercy General Hospital
- Mercy San Juan Medical Center
- Mercy Hospital Folsom
- Methodist Hospital of Sacramento
- Woodland HealthCare
- Sierra Nevada Memorial Hospital

Sacramento has access to some of the highest volume and best ranked cardiac hospitals in the State and Nation



HEART SMART – PROGRAM DEVELOPMENT

What?

- Program pilot was initiated in 1999 with Mercy Medical Group and Mercy General Hospital as a clinical quality improvement project.

Why?

- Clinical Trials (The Scandinavian Simvastatin Survival Study (abbrev as 4S)) & West of Scotland Coronary Prevention Group (abbrev as WOSCOPS)) showcased the benefits of statin therapy, but our chart audit revealed low acceptance by medical community.

How?

- Built off of the successful launch of CHAMP[®] (heart failure disease management program) in 1997. Registered Nurse (RN) patient case management program using simple telephone surveillance technology that utilizes a standardized procedure* for diuretic medication management.



*Heart Smart intervention based on National Cholesterol Education Program (NCEP) ATPIII Guidelines; AHA/ACCF Secondary Prevention and Risk Reduction Therapy for Patients with Coronary and Other Atherosclerotic Vascular Disease.

HEART SMART – PROGRAM IMPLEMENTATION

Strategies:

- Heart Smart added clinical pharmacy specialist to the care team who provides oversight of the program and procedures; designs protocol based on national guidelines; and ongoing literature review updates to the care team.
- The team of registered nurses (RN, BSN), clinical pharmacist and registered dietitians work with a patient's physician to help patients achieve their goals
- Intervention includes the use of Medical Staff approved Standardized Procedure/Protocol with algorithm that outlines nursing/pharmacy management and risk stratification.
- Roll out to medical group physicians with formal CME presentation by Cardiology Service Area Medical Director.
- Physicians encouraged to refer but not required.



HEART SMART – 2012 UPDATE

- The team focuses on lifestyle changes, but will prescribe/adjust cholesterol medication until lipid panel targets are reached.
- Since 2001, all Dignity Health affiliated physicians are eligible to refer.
- Heart Smart has earned The Joint Commission gold seal of approval disease-specific certification since 2005.

Process Flow:

1. Education & Enrollment
2. MD authorization/order & patient verbal/documentated consent
3. Initial assessment & therapy review: lab, medications, Therapeutic Lifestyle Change (TLC), education and goal setting
4. Laboratory follow-up and therapy modifications including diet and weight management, smoking cessation, exercise, and stress management
5. Ongoing monitoring until individualized target achieved.



HEART SMART – RISK MANAGEMENT TRACKS

PRIMARY PREVENTION:

- Patients stratified by major risk factors and Framingham risk score.
- *Mod-High Risk* LDL Goal - Less than 100mg/dL OR less than 130mg/dL AND greater than 30% reduction from baseline
- *High Risk* LDL Goal - Less than 70mg/dL OR less than 100mg/dL AND greater than 30% reduction from baseline.

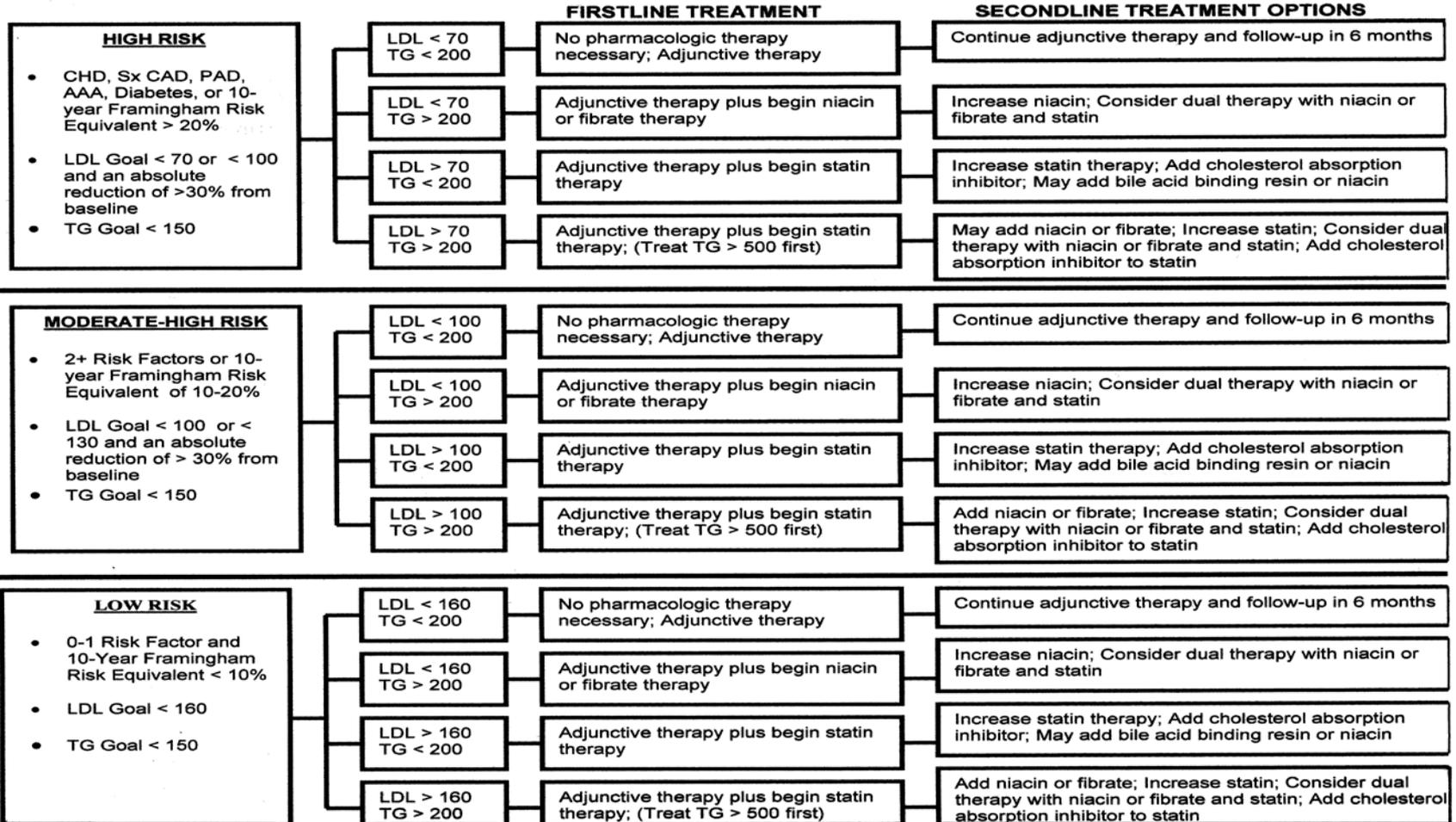
SECONDARY PREVENTION:

- Patients with history of CAD, PVD or stroke.
- LDL goal - Less than 70mg/dL OR less than 100mg/dL AND 30% reduction from LDL baseline.

DIABETES PREVENTION:

- LDL goal - Less than 70mg/dL OR less than 100mg/dL AND 30% reduction from LDL baseline.

HEART SMART – ALGORITHM



HEART SMART – TELEPHONE MONITORING PROCESS

NOT AT GOAL:

- Therapeutic Lifestyle Change
 - Dietary Modification
 - Exercise
- Medication addition/
adjustment per protocol
- Report to MD
- Ongoing Resource
- Health Coach

AT GOAL:

- Lifestyle Review
- Report to MD
- Re-evaluate at 6 months/
annually
- Ongoing Resource
- Health Coach



HEART SMART - PERFORMANCE MEASURES

Total # of Referred Patients Since Program Inception: 6,282

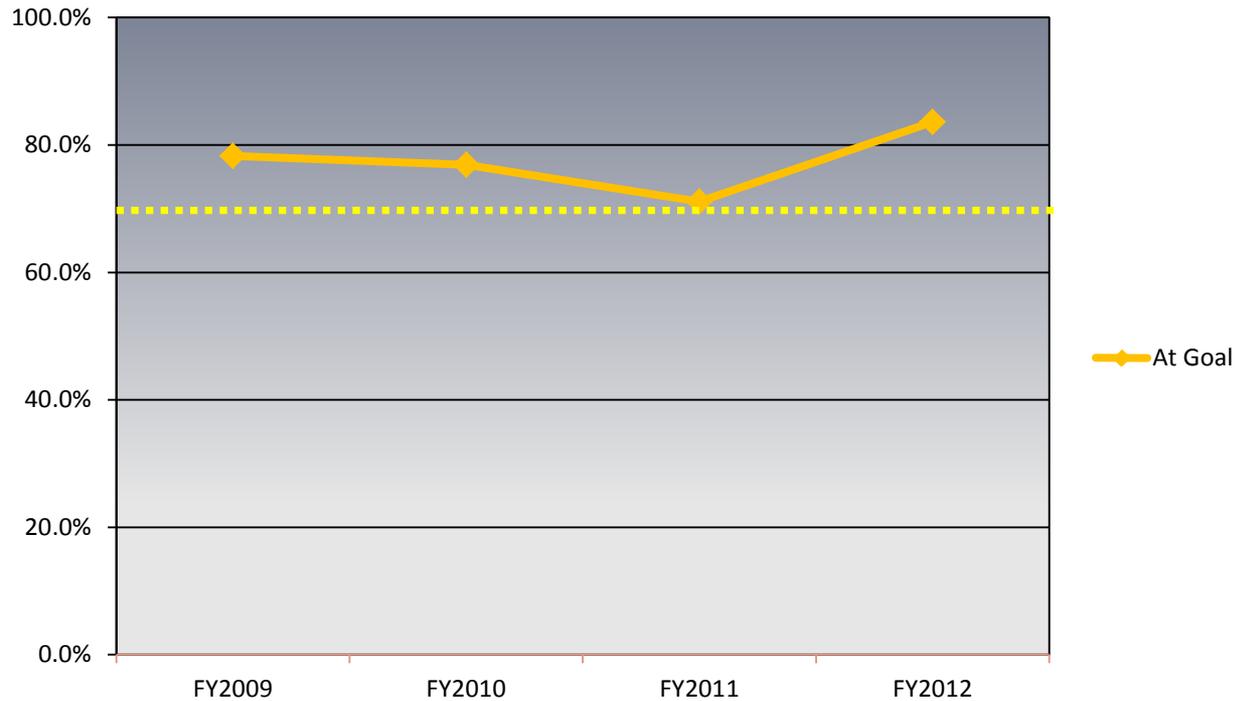
Current # Enrolled in HS Intervention: 825

FY 2012 Performance Measures:

- 70% of Patients in Primary Prevention Track Achieve LDL Goal
- 70% Patients in Secondary Track Achieve LDL Goal
- 70% of Patients in Diabetes Track Achieve LDL Goal
- 90% of Patients in Secondary & Diabetes Track on Aspirin

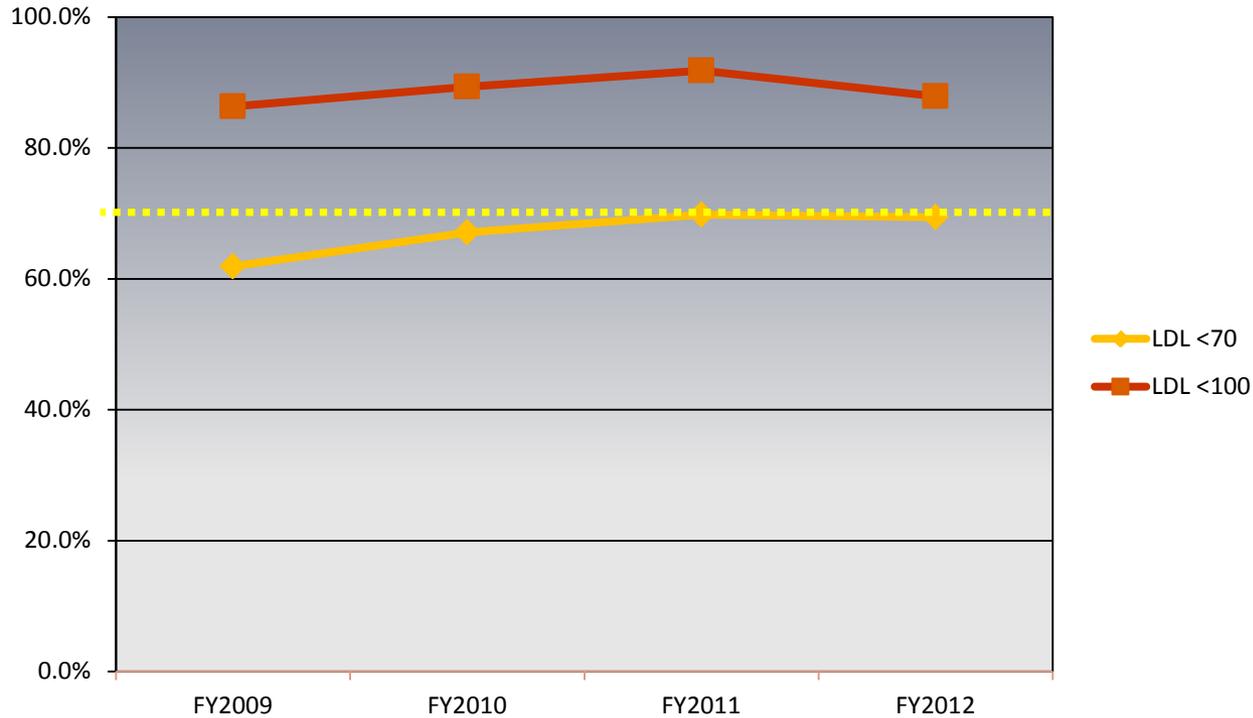


HEART SMART – PRIMARY INTERVENTION



LDL Goal (Mod-High Risk): Less than 100mg/dL OR less than 130mg/dL
AND greater than 30% reduction from baseline
Performance Goal: 70%

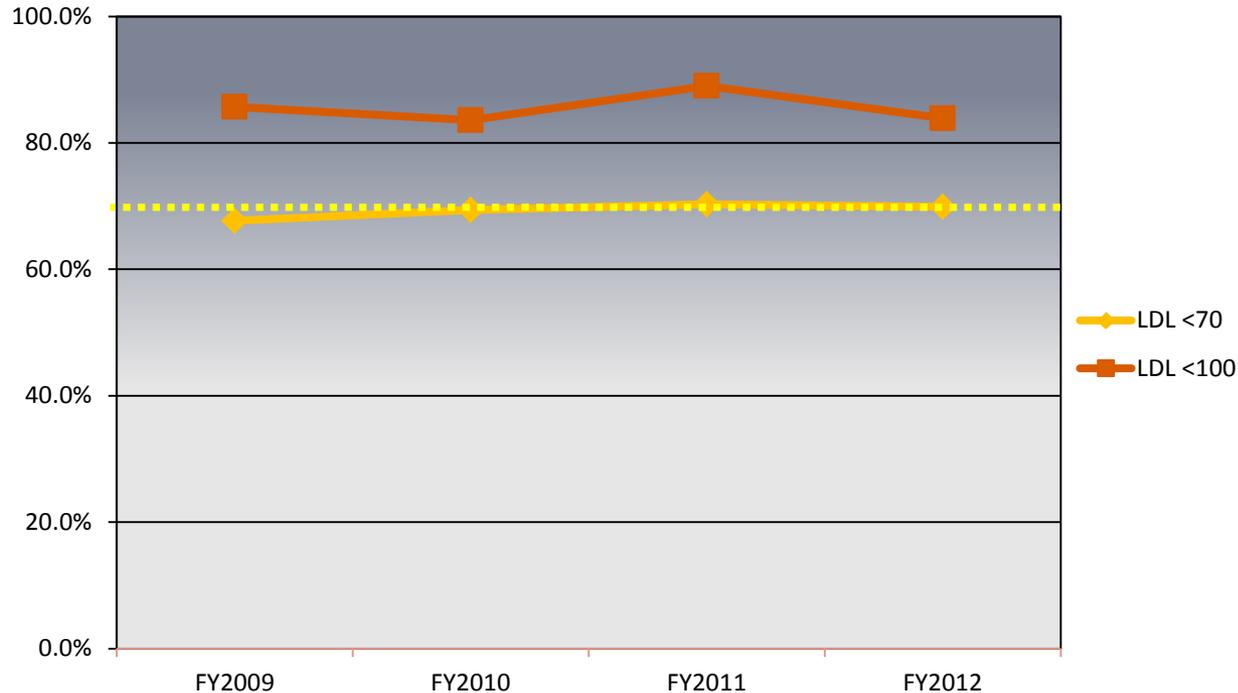
HEART SMART – SECONDARY INTERVENTION



LDL Goal: LDL less than 70mg/dL OR less than 100mg/dL AND 30% reduction from LDL baseline.

Performance Goal: 70%

HEART SMART – DIABETES INTERVENTION

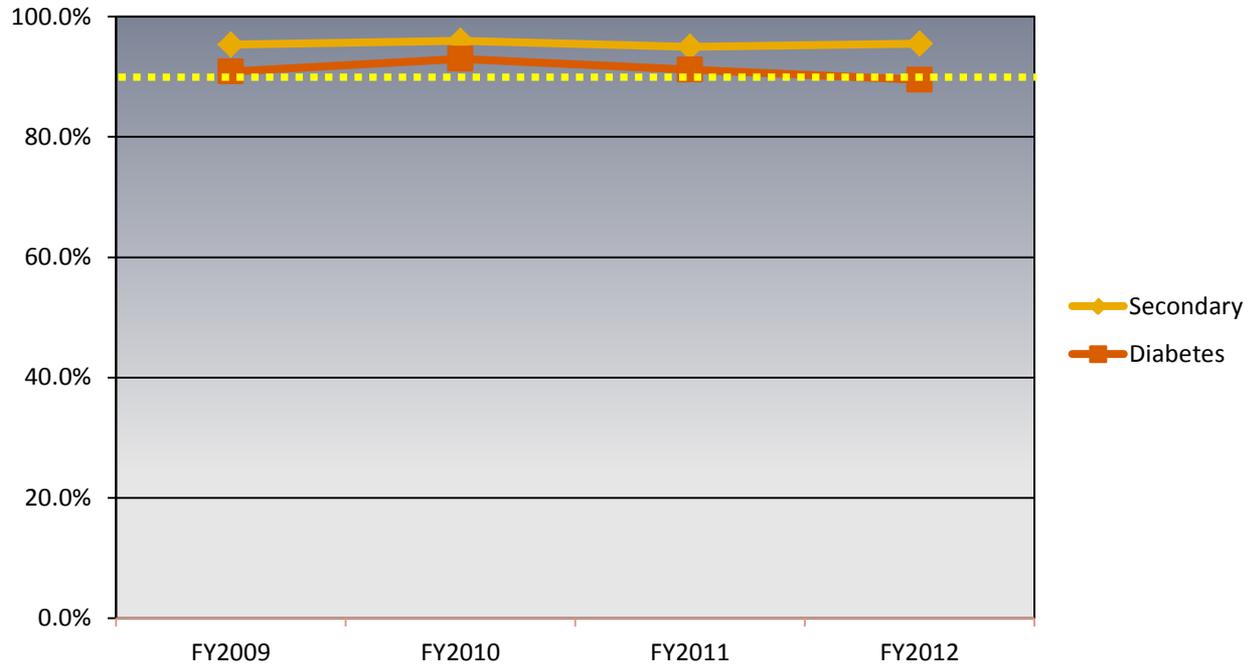


LDL Goal: LDL less than 70mg/dL OR less than 100mg/dL AND 30% reduction from LDL baseline.

Performance Goal: 70%

HEART SMART – PATIENTS ON ASPIRIN

Secondary & Diabetes Track Pts on Aspirin



Performance Goal: 90%

HEART SMART - 2013 AND BEYOND



- Right Care Sacramento University of Best Practices participation and community-wide engagement to change the community standard of care to reduce MI & Stroke.
- Explore methods to incorporate hypertensive, blood glucose measures, & cardio-protective medication bundle intervention(s) into Heart Smart program.
- Release recent program protocol update to incorporate AHA Effectiveness-Based Guidelines for the Prevention of Cardiovascular Disease in Women.
- Hope for National Cholesterol Education Program update!
- Monitor risk factor calculation tools that reflect national guideline updates.

Thank you!