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In-hospital Collaboration and Management of HFrEF: Who's Part of the A Team?

Dr. Greene:
Hello, and welcome to our session today. I'm Dr. Stephen Greene, a heart failure cardiologist and clinical researcher at Duke University in the Duke Clinical Research Institute. I'm pleased to be joined today with two of my very close friends and colleagues who also work with me at Duke. We have Cody Carson, who is a clinical pharmacist at Duke University, and we also have Jaime McDermott, who is an advanced practice provider at Duke University, and I'm really happy to be joined by both Cody and Jaime today because we are really going to be discussing a very important topic as relates to HFrEF care, and that is the idea of in-hospital collaboration and management. We know that patients hospitalized for heart failure are a very vulnerable population, and I think the idea of a team-based approach in hospital is really the key to setting patients up for success, both in the hospital and then when they leave. So to get us started with thinking about this team-based approach, Cody, I really value, I say it all the time on rounds, I really value having you, specifically, but then just our pharmacy colleagues in general with me on rounds. I always learn from you guys every day, and I think it definitely improves the quality of care that we're delivering for our patients, but from the pharmacy perspective, how do you view your role for our in-hospital management of patients with HFrEF?

Dr. Carson:
Yeah, thank you, Steve. So back in 2013, the Heart Failure Society of America published a joint opinion paper with the American College of Clinical Pharmacy, supporting the value of pharmacists and helping to improve heart failure outcomes. So there are a lot of helpful services that a pharmacist can offer as a member of the multidisciplinary team. One of the first things that comes to mind for me is assisting with transitions of care. So pharmacists can perform admission medication reconciliation at the start of admission to help the team get an understanding of baseline GDMT and diuretic doses, assess medication adherence, and then also identify any allergies or intolerances that may limit our ability to use some of our guideline-directed therapies. On the other end at discharge, pharmacists are also able to provide discharge medication reconciliation that helps us ensure that the changes that we're making to GDMT are being done in a way that's safe in regard to renal function and any follow up lab monitoring that may be required and also that these changes are made in a way that's sustainable for the patient. So for instance, are medications being sent to the correct pharmacy in appropriate quantities? Are they going to be affordable for the patient, or will they require prior authorization with insurance, things like that? This is also a great opportunity for pharmacists to make sure that we're helping to limit polypharmacy and watching out for any harmful or suboptimal medications that we can de-prescribe, such as NSAIDs, thiazolidinediones and sulfonylureas and then even some herbal supplements that patients may have been taking at home.

Dr. Greene:
Now, I mean, fantastic points, Cody, and I think you hit on so many key elements. I mean, I think medications are really the focus of how we treat patients with HFrEF, and the in-hospital period is such a key opportunity for really getting these patients on the best possible therapy, but at the same time, yes, we have our therapies for heart failure that we're focusing on so stringently and trying to make sure patients are getting those medications, and you mentioned prior authorizations and going through logistical hurdles potentially to make sure patients have access to those but, at the same time, trying to de-prescribe some of these potentially harmful or ineffective medications for patients that have HFrEF and have comorbidities, and I think a common example nowadays is type two diabetes medications. Now we have SGLT2 inhibitors are approved for both HFrEF, but they also are used for glucose lowering. Sometimes when we start those therapies, SGLT2 inhibitors, we might be able to stop some of these other type two diabetes or should stop some of

these type two diabetes medications, especially type two diabetes medications that may be associated with harm, like thiazolidinediones, as you said. So truly can't agree more with those key points, but now, Jaime, obviously the advanced practice provider is such a central piece in taking care of these patients when they're in the hospital, and again, I always enjoy working with you on rounds and learning from you, as well, but what do you view as your key things that the APP is responsible for or really can help with during the heart failure hospitalization?

Dr. McDermott:
Thank you, Steve. So yes, I am an advanced practice provider. I may be a little biased, so I will be talking about all the amazing things that we do in the hospital, but in general, advanced practice providers play an important and central role within the interdisciplinary team. Our role is quite broad, but essentially, we have a role in direct patient care, coordination of care, and collaboration with other clinicians. Often, the advanced practice provider is the first point of contact for patients, and we really act as a bridge between the patient and the rest of the healthcare team. We do provide first line medical management in relation to diagnosis and intervention and collaborate to make decisions during the hospitalization, though our focus is not only management and treatment of symptoms. We also engage in health promotion with the patient, healthcare education, and also try to build a good rapport with the patient and their family, and we really aim to create a partnership between the healthcare team and the patient. Advanced practice providers are communicators of information. We collect information, we interpret it, and we relay this patient information to the rest of the healthcare team. We see what's going on in the current situation, and we really do have a whole picture of the care and treatment. We follow the patient along the continuum from hospitalization admission, right up until the discharge, and with the HFrEF population, there really are many complex patients who do require thorough care coordination within the hospital and are discharged. So we really need to keep that in mind.

We really work in collaboration with other members of the healthcare team, and we attempt to resolve any fragmentation and facilitate a team approach to these patients. We do have strong collaborative relationships with physicians, as well as other members of the interdisciplinary team, including registered nurses, pharmacists, and other allied health professionals, and I think that this is one thing that we've done really well in our own healthcare delivery model. We do coordinate with various consultants as needed to optimally manage comorbidities, something we see as vital in HFrEF patients, and through this collaboration, I think we compliment one another's expertise and coordinate moving towards realistic and guideline-directed treatment goals for the patient. So again, working with others is super important. There is a large focus on patient disposition right from the time that the patient's admitted, and so working with care managers and social workers to facilitate the patient's transition within and between healthcare settings really is important. We really work alongside these team members, and we see that really it's critical to the transitional care of the patient. So hopefully, I've provided you with our role in the management and collaboration, and I've convinced you how important the advanced practice provider is.

Dr. Greene:
No, I didn't need any convincing Jaime, but I totally agree with those points you made there, and I mean, again, I'm so appreciative to work with both of you guys on the in-hospital setting, and I think it really helps optimize our care for HFrEF, and I think just a couple things from the cardiologist perspective, aside from my appreciation for the multidisciplinary care and how I think it really helps improve our patient outcomes. It also is key for me, as the cardiologist, to now think about not only the nitty gritty of some of the things that others are focused on in terms of logistics and everything, but trying to think about the bigger picture, too, in terms of where's the trajectory for this patient? What tools in our toolkit do we have left to use to try to improve this patient's outcome, and can we actually use them right now, and then if there's things that are not going well for this patient, do we need to even think about bigger picture ideas, like advanced heart failure therapies, palliative care, or other kind of reaching out to various consultants to try to, again, improve the outcome for the whole patient, including their heart failure outcomes, but with that, I really want to thank Jaime and Cody for joining me today, and I think the team-based approach to HFrEF is clearly something that we all strongly believe in and advocate for, and I hope you, as a listener, will take that back to your care for your patients, as well. Thanks, again.

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