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Project title: An Interdisciplinary Team Approach To Improving Outcomes in Heart Failure: A Pilot Test

Abstract:
Heart failure (HF) is a chronic health condition characterized by complex symptom management and costly hospitalizations with the prevalence of HF expected to increase by 46% from 2012 to 2030. There appears to be significant opportunities to decrease use of low value healthcare while improving quality of HF care and improving patient health. Improving the relationship between patient and physician is one such opportunity that has been associated with a better outcome with higher levels of patient engagement appearing to be a strong positive facilitator of the relationship. It is clear that lack of patient engagement in self-care behaviors negatively impacts disease progression and is closely linked to HF symptom exacerbation. Innovative clinic- and community-based care programs that maximize patient engagement in self-care of HF symptoms and bring a positive impact upon patient/physician interactions are needed. We propose to implement and evaluate a patient-centered, multi-disciplinary, team-based program for the support of HF patients that is evidence-informed and feasible for implementation within a typical cardiology clinic. Our approach is built on the integration of care across hospital, clinic, and community settings with an interdisciplinary care staff dedicated to patient engagement. The proposed program incorporates our prior experience in delivering the Care Transitions Intervention® for HF patients with other evidence-based practices, such as the use of heart failure specialist nurses (HFSNs). The Engagement in Heart Failure Care (EHFC) program is a clinic-based, nurse-led intervention that includes disease-specific education about HF, medication management, and nurse coaching (either by phone or home visit) to improve patient health and self-management behaviors, reduce all-
cause hospital admissions, and reduce emergency department (ED) utilization for older adults with HF. Three hundred and forty six individuals with HF will be randomized into the EHFC or Usual Care group. Enrollment will occur in a large cardiology clinic. Baseline and 6 month follow-up assessments will be conducted. Physicians will be blind to group assignment. The aims of the study are: AIM 1 – Develop all materials, assessments and protocols needed to implement the EHFC program to engage patients in symptom management and coach them in skills that foster the coordination of medical and supportive care services across community, clinic, and hospital settings; AIM 2 – Implement the Engagement in Heart Failure Care (EHFC) program in randomized trial of 40 patients (20 EHFC, 20 Usual Care); AIM 3 – Compare the impact of the EHFC program to usual care regarding patient utilization of formal healthcare services, as well as patient self-report of self-care for HF, the patient/cardiologist relationship, and measures of health quality of life.