Heart Failure remains to be one of the number one diagnosis in the Medicare population with frequent hospitalizations and general utilization

This adds increased costs to the Healthcare systems, and increased personal suffering to patients and families

Studies have shown that interventions by RN Case Managers can improve Patient outcomes, improve quality of life and decrease costs
Heart Failure
A Growing Epidemic

4.7 million symptomatic patients, estimated 10 million in 2037

Incidence: About 550,000 new cases/year

More deaths from heart failure than from all forms of cancer combined

Prevalence is 1% between the ages of 50 and 59, progressively increasing to >10% over age 80

~ $30 billion/year (5% to 7% of total health care cost)

American Heart Association. 2001 Heart and Stroke Statistical Update.
The CHF Case Management Program was implemented at Group Health in 1998 based on the Rich study which demonstrated that a Nurse led CM program can improve outcomes and save costs.

Initially was attached to Cardiology, now managed by Department of Complex Case Management with close Cardiology connections.

A Cardiologist remains the Medical Director and Mentor.

Staff of 3 RNs expanded to 7 RNs, covering three Regions.
Supports optimal Heart Failure medical treatment per national Heart Failure Guidelines

Has been shown to be the most important move in reducing acute care episodes in Heart Failure patients

Patient and Family/Caregiver Education to support self care strategies

Schedule Pt contact via phone or in person to monitor status
Follow medication/treatment protocols

Anticipatory care planning when symptoms arise (sick day plan of care)

Monitor other chronic or acute conditions

Care coordination

Paving the way for End-of Life care: Palliative and Hospice referrals
CHF CM Program Goals

Improve quality of care

Increase patients functional capacity and quality of life

Patients are able to follow a self care plan and are able to recognize and report changes in status and symptoms early on

Decreasing hospital admissions/readmissions

Overall reduction in cost

Increase patient satisfaction
Admission/Exit criteria

Follow established admission and exit criteria

This helps avoid taking care of patients who’s main problem is not Heart Failure
Referral Sources

- Hospital staff
- Cardiology
- Internal Medicine
- Primary Care
- Pulmonary
- Emergency Room
- Urgent Care
- Home Health
- Self-referrals
Objective data collection

Initial call to Pt or clinic visit to assess status, provide education and support self management

Planned follow up calls and interventions

Assess any other care needs and risk factors (depression, Anemia, sleep apnea, diabetes etc.)

Educational material

Free scales send to those in need
Medical plan of care developed individually with Cardiologist or other MDs

Monitoring of medical treatment plan: medications, blood tests and functional status assessment is ongoing

Other: referrals to Social Services, Home Health, Physical Therapy and others

Advanced Care Planning
Intermittent educational reinforcement

Setting goals with Pt

Evaluate for discharge if all goals are met

End of life care transfer to Hospice

Care Coordination
“Jerry’s heart stopped while he was taking a bath last year. I threw the toaster in the tub and saved his life.”
Documentation and IT support

Caretracker Program: tracks hospital, skilled care and home health admissions and discharges

All electronic charting in EPIC: facilitates real time charting and provides all staff with current status information and plan of care

Ability to standardize work with use of smart text and phrases

Secured staff and patient messaging

EPIC identifies if Case Managers are involved
Hospital readmission study after three years into the program: findings were equal to the Rich study.

The program got full blessings by administration to continue.
Previous HF Case Management Analysis

All pts hospitalized with HF 1/98-4/01

Subsequent CM enrollees were compared to non-CM patients

CM patients had 32% fewer readmissions for HF after enrollment
Heart Failure Co-Morbidities

- CAD: 51%
- HTN: 44%
- Diabetes: 32%
- Anemia: 21%
- OSA: 11%

% of Patients
Case Managed HF Patients
Group Health Central

Current Clinical Status

<table>
<thead>
<tr>
<th>Status</th>
<th>% of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>56%</td>
</tr>
<tr>
<td>Stable</td>
<td>28%</td>
</tr>
<tr>
<td>Imp/Stable</td>
<td>84%</td>
</tr>
<tr>
<td>Worse</td>
<td>16%</td>
</tr>
</tbody>
</table>
Current Program Development

Team meetings on regular basis

Monthly phone conference to discuss cases with medical director

Heart Failure treatment updates

Updated educational materials

Ongoing Review of CHF Case Management
New Focus

Increase referrals to CHF Case Management

Routine Data collection and analysis of CHF CM activity

Routine feedback to CHF CM

Transfer of stable, high risk Pt to our new Complex Case Managers

Address other risk factors early on
Conclusions

CHF Case Management has been an effective way for Group Health as an Organization to help improve care for Heart Failure patients, make use of care coordination between departments, improve outcomes, and decrease costs.

CHF Case Management supports patients self care and knowledge of disease, and Pt satisfaction.

Helps optimize medical treatment plans.

Improves quality of life.

Supports physicians in an effort to improve care.