

Heart SMART: Developing Congestive Heart Failure Case Management Program for Improved Quality of Healthcare

Theresa Herzog, NP, MSN
CenCal Health
Santa Barbara, CA

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Local. Quality. Healthcare.

SMART: Successful Management Always Requires a Team

- Outcome Oriented Case Management:
  Develop program evaluation plan
- Chronic Care Model Framework:
  Improve congestive heart failure case management outcomes
- Teach Back Case Management:
  Strategy to improve patient outcomes and quality of care

Objectives

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- Outcome oriented case management- develop program evaluation plan
- Chronic Care Model as framework to improve congestive heart failure case management outcomes
- Teach Back case management strategy to improve patient outcomes and quality of care

Working Backwards

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Solving the Mystery:

- Piecing together the evidence

Outcome Oriented Case Management

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- **Why Evaluation?**

"If you don't know where you are going, you'll end up someplace else."

Yogi Berra

Heart SMART Logic Components

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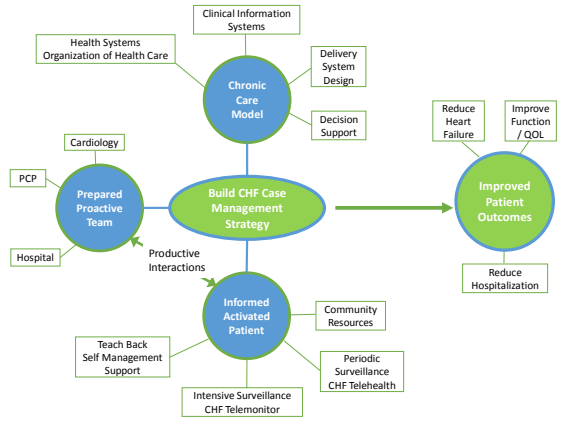
- Inputs: Develop CHF CM program, CHF patient toolkit/teach back materials, outreach hospital, PCP and cardiology partners, CHF/AMI data claims
- Outputs: Patient population identified, patient follows CHF action plan, medication adherence, enhanced PCP patient partnership
- Outcomes: Improved CHF self-care management, improved quality of care, reduced inpatient hospital readmissions; program first evaluated on care process then on program outcomes

Heart SMART Program Evaluation

- Teach Back pre/post test evaluation (Care process)
- CHF/AMI hospital readmission rates (Program outcomes)



"Health literacy is fundamental to quality care"

Institute of medicine, 2004

Health Literacy

- Health literacy is the ability to understand health information and to use that information to make good decisions about your health and medical care.
- It includes written and verbal communication

Medline Plus 2011 (NIH)

Limited Health literacy Can Affect:

- Ability to fill out forms
- Locate providers and services
- Share health history
- Ability to care for self
- Manage a chronic disease
- Understand how to take medications

Medline plus 2011 (NIH)

Teach Back Strategy to Improve CHF Quality of Care

Increase health literacy aligned with improved quality of care.

Low health literacy may lead to:

- Longer hospitalizations (Baker et al., 1997, 2002)
- Chronic disease (CCL, 2008)
- Earlier Death (Baker et al., 2007:Sudore, 2006)

"Teach-Back" Used to Curb Readmissions

SMART

Case Study: Griffin Hospital successfully implements "Teach-Back" to reduce CHF readmissions (2010)

136 CHF patients teach-back used post-discharge instructions

Results: readmission time for teach-back 130 days; control 82 days

Example teach-back method

www.youtube.com/watch?v=UZUCqgHXTV4

Heart Failure Teach Back

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- What was your discharge diagnosis?
- When is your F/U visit with your PCP?
- What is the name of your water pill?
- What weight gain should you report to your doctor?
- What foods should you avoid?
- What symptoms should you report to your doctor?

Teaching

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"Good teaching is more a giving of right questions than a giving of right answers."

~ Josef Albers

Putting It All Together

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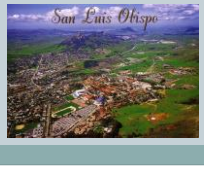
- Develop a case management program evaluation plan for outcome oriented care
- Chronic Care Model for case management strategy
- Consider Health Literacy for improved patient outcomes

Heart SMART
Improving Quality of Care

PAULA CURRAN, RN, BS
QUALITY IMPROVEMENT MANAGER
CENCAL HEALTH
SANTA BARBARA AND SAN LUIS OBISPO



Identifying Quality of Care for those with Heart Conditions

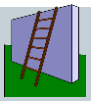
- HEDIS Rates
  - Beta Blocker after MI
- Readmission Rates/ED visits
- Quality of Life Issues
  - Satisfaction with Medical Care
  - Motivation to make lifestyle changes
  - Knowledge of health conditions and ways to manage

Identifying Barriers to Quality Care

- Decreased access to PCPs/ Specialists
- Lack of systems/staff to identify and treat members with fragile conditions
- Complexity of medical system; RAFs, MRF/ TARs
- Patients may have multiple comorbidities and psychosocial issues
  - Homeless
  - Substance Abuse
  - Mental Health Issues

Identify Opportunities to Maximize Care

- **Provide enhanced access to PCP care**
  - PCP post hospital visits within 7 days
  - Urgent care; Nurse Triage service
- **Assist Physicians with coordination of care**
  - Specialty visit referrals
  - Transportation
  - Medication refills and adherence
  - Education regarding health condition
  - Home monitoring; weight, blood pressure
  - Heart SMART – CM-Ongoing support and navigation



Measuring Improvement

- Not everything can be measured with a ruler
- Success may come in tiny increments
- Data can tell any story
- Making a connection and influencing a person to improve their health is a huge success
- Keep doing what you do….IT MATTERS.