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

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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

- 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

Outcome Oriented Case Management

- **Why Evaluation?**

  “If you don’t know where you are going, you’ll end up someplace else.”

  Yogi Berra

Heart SMART Logic Components

- **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

Working Backwards

Solving the Mystery:

- Piecing together the evidence
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”

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

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

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

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

► 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

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

- Josef Albers

Putting It All Together

► 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

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Identifying Quality of Care

for those with Heart Conditions

- HEDIS Rates
  o Beta Blocker after MI
- Readmission Rates/ED visits
- Quality of Life Issues
  o Satisfaction with Medical Care
  o Motivation to make lifestyle changes
  o 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.