

Catholic Healthcare West

Case Study

Post-discharge Support & Integrated Services Program for CHF Patients Improves Lives and Care Efficiencies

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Catholic Healthcare West

CHW

Congestive Heart Failure (CHF) Facts

- Nationally, more than 550,000 new patients are diagnosed with CHF each year (AHA, 2007)
- The estimated direct and indirect cost of heart failure in the United States in 2007 is \$33.2B (AHA, 2007)
- Heart failure is Medicare's most common diagnosis
- National readmission rates:
 - 18% within 30 days
 - 50% at 3-6 months (Phillips et al, 2004)

Marian Medical Center Background

- Santa Maria is the largest city in Santa Barbara County, California
- Marian Medical Center service area population: est. 90,000



Marian Medical Center Background (continued)

- 20-24% of the population served by Marian Medical Center's is uninsured or underinsured
- 51% of the population served by Marian Medical Center is Hispanic/Latino
- Heart failure is consistently identified as one of Marian Medical Center's top two admitting diagnoses
- Heart failure readmission rates at 30 days: 18-23% for Marian Medical Center patients

Disease Management Program Development

- In 2001 - Marian Medical Center received a Robert Wood Johnson Foundation grant to develop and implement a community-based disease management program for CHF

Goal: Avoid hospitalization, support self-care and decrease future cost per case

- In 2002 - Marian Medical Center hired a registered nurse case manager and implements the program
- To date - The program has helped **789** CHF patients

CHF Program Components

- Telephonic case management up to 1 year from initial enrollment into the program
 - Average patient contacts by RN: 18 calls/year
- CHF Program standardized relevant educational materials throughout the continuum
- CHF Program provides “real-time” clinical updates to physicians and other providers via the fax and/or intranet

CHF Program Components (continued)

- Program emphasizes self-care management in diet, medication compliance and other life-style/behavior modifications
- Program ensures seamless coordination with multidisciplinary Home Health team *
- RN makes initial contact with patient in the hospital for discharge instructions, smoking cessation education and to introduce the program

* 15% of program enrollees complete an episode of Home Health prior to enrollment; 5% are referred to Home Health/Hospice for additional service either during the program or upon discharge

CHF Program Components (continued)

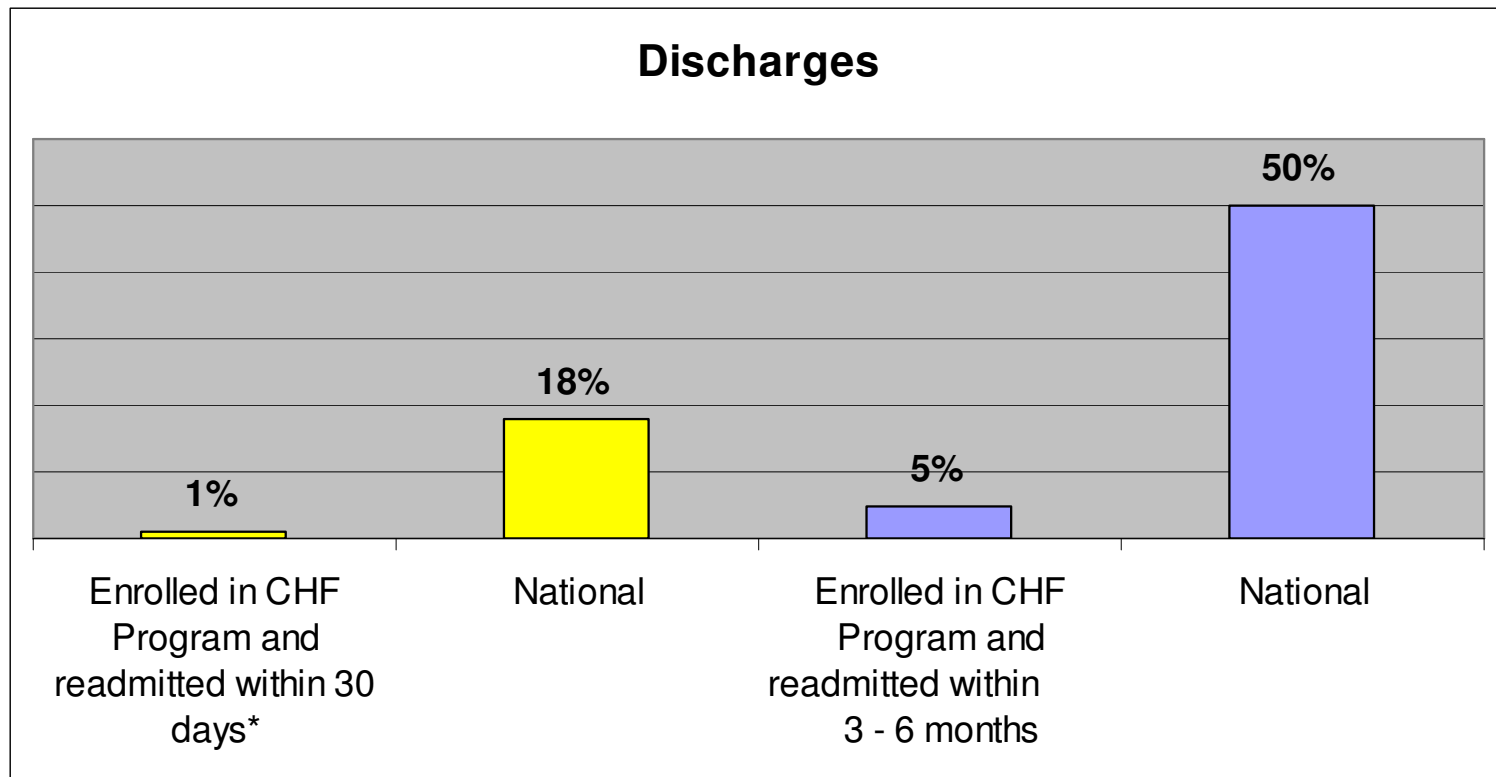
- Potential health disparities in the community are met through a Spanish-speaking CHF Case Manager and outreach to our community clinics. All literature is provided in English and Spanish.
- RN Case Manager is electronically notified when any patient coded with a DRG related to heart failure is admitted to the hospital, discharged from the hospital or seen in the Emergency Department.
- Program linked with community resources to provide medication assistance, nutritional services, senior home repairs, etc.

Barriers to Expansion

- Adequate funding from both private and government payers
- Adequate IT budget and infrastructure. Seamless interfaces are critical

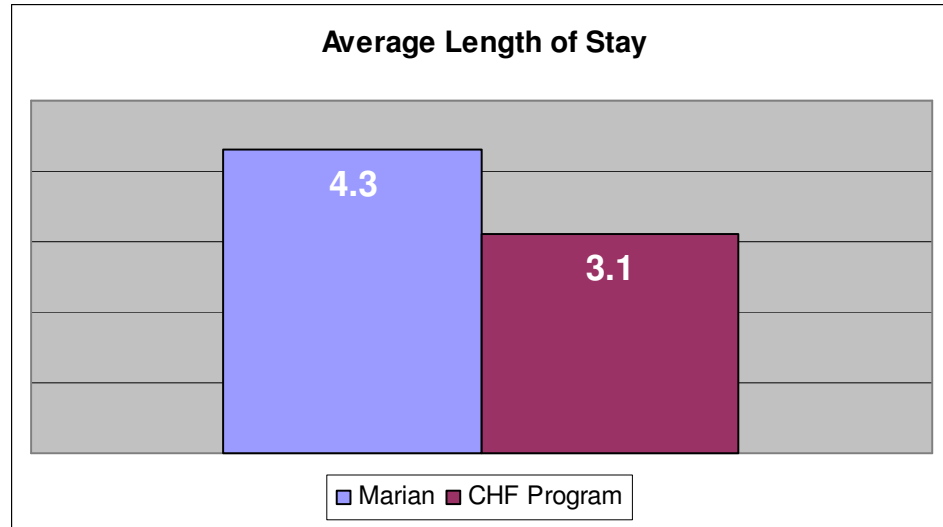
Measure(s) of Success – Impact

- Readmission rates FY 2006-2007
 - Total Marian Medical Center CHF patients within 30 days: 18
 - Total CHF Program patients within 30 days: 2
 - Total CHF Program patients within one year: 25

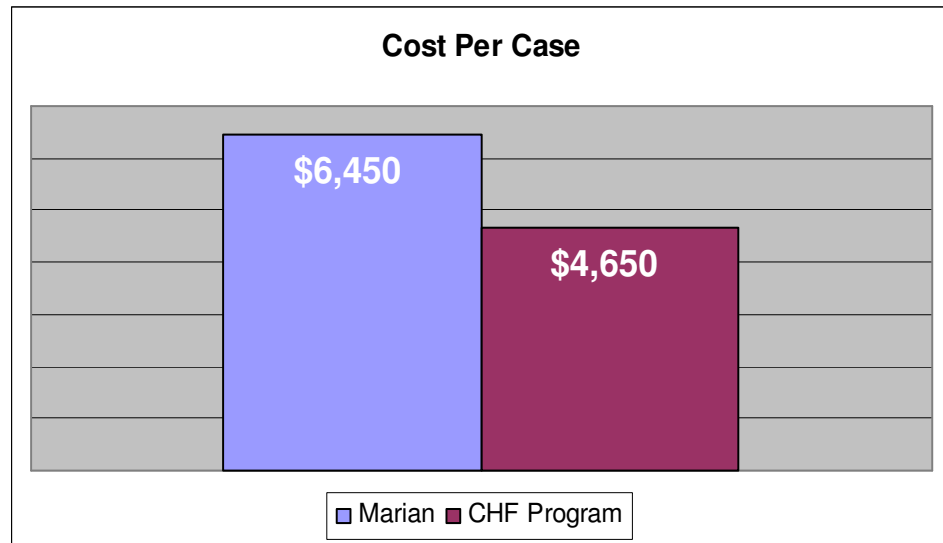


Measure(s) of Success— Impact

- Average Length of Stay

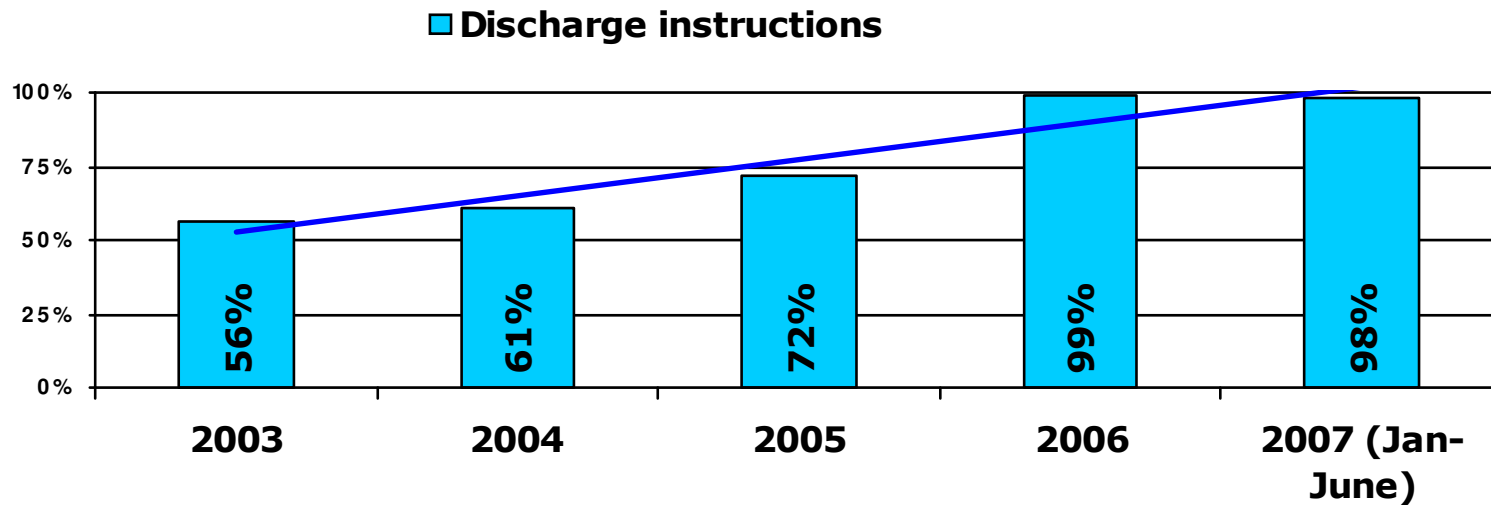


- Cost Savings of \$1,800 per case



Measure(s) of Success– Impact

- Significant improvement providing discharge instructions to CHF patients before leaving the facility



Key Learnings

- A dedicated cardiac Case Manager is essential
- Numerous synergies with Home Health department; telephonic “visits” augment Home Health workforce
- Strategic linkage with palliative care program improves outcome for both programs
- IT involvement is critical
- Program well-positioned for potential grant funding
- Physician involvement is key
- Free medication programs and scales enhance compliance