# Congestive Heart Failure
## Myrtue Medical Center Rural Health Clinics

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## Objective

Fewer ED visits and hospital admissions for patients with Congestive Heart Failure (CHF)

## Background

Hospital identified CHF as chronic condition for population health management and care coordination

Coders identified CHF as an opportunity for improvement based on ED utilizations & inpatient stays

## Actions Taken

Hired an additional RN Health Coach – for a total of 3 health coaches
Educated CHF patients to contact the clinic Health Coaches first before going to the ED
Redesigned work process for patients with CHF in nursing homes
ED notifies Health Coaches when CHF patient accesses service
Hospital utilization review team notifies RHC Health Coaches when CHF patient is admitted to begin discharge planning
Clinic developed a spiral bound education booklet all CHF patients receive when they begin working with Health Coaches. It covers:

- Description of what CHF is & its causes
- Description of the tests used to diagnose CHF
- Signs & symptoms of CHF
- Instruction for daily weight monitoring
- Examples of where salt can hide in diets & how sodium can be calculated from food labels
- Suggestions for exercise

Health Coaches use a tiered approach to managing patients with CHF (patients at highest risk receive the most care)
Created magnets for patients to refer to when at home with the intent of keeping them in the green (at home)
Clinic purchased non-battery-operated scales for patient's home use (first with grant money & now out of the capital budget), for patients to weigh themselves daily
Developed nursing care guidelines for health coaches

## Metrics

CHF Inpatient Readmission - Within 30 Days of Hospitalization FY data results:
2014-2015 = 4/41 = 9.8%
2015-2016 = 1/25 = 4.0%
2016-2017 = 6/44 = 13.6%
2017-2018 = 2/48 = 4.1%

Today, Health Coaches work with 78 CHF patients


## Analysis

When the project started, the clinic made it a priority to get all CHF patients a home health check – many patients declined this service
Clinic anticipated CHF patients would appreciate regular weekly follow-up with Health Coaches when necessary – this was not the case

- When patients declined frequent follow up with Health Coaches, clinic did not push this issue, instead they opted for less frequent follow up (monthly), assuming monthly follow-up was better than no follow up

Newly diagnosed CHF patients receive education about their condition that is tailored specifically to them by their providers and Health Coaches.
Patients get timelier (often same day access) to their health care team
Collaboration between staff in the clinic, ED & Hospital inpatient units at the beginning of this project through present day, ultimately contributed to better follow-up with & better outcomes for this vulnerable patient population.
Give Health Coaching staff as much education as they need & can handle.
Many of the tools & processes that the clinic & Health Coaches utilize to better manage patients with CHF are transferrable to other health conditions

## Next Steps

Continue to monitor CMS readmission measures through Hospital Compare

Include ACO readmission measures

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