

**Heart Failure Management Program
St. John's Health System
2002 Acclaim Award Honoree**

In 1995, clinic leaders, working in conjunction with system leadership, identified the opportunity to improve care for congestive heart failure (CHF) patients. Leaders were unanimous in the belief that treatment and follow-up care could be standardized across the clinic and health system, thereby improving patient care and quality of life.

Goal

To improve outcomes and quality of life for patients with congestive heart failure

Intervention

- Tele-management follow-up program and specialized exercise program for patients
- Standardized physician orders, care pathways and clinical guidelines for physicians
- Patient education materials
- Computer tracking system

Highlights

- Tele-management program serves as the critical mechanism for providing ongoing patient education, monitoring patient progress, and improving compliance with treatment.
- All patients admitted to the hospital are immediately enrolled in the CHF program and the first follow-up call is made within five days of discharge. In the early stages, patient contact occurs at least once a month then moves to as-needed basis once the patient is stabilized.
- Patients are encouraged to participate in a CHF exercise program.
- Monthly reports are shared with team members, physicians, and leadership.

Results

- 1,229 CHF patients are active in the tele-management program.
- Admission and readmission rates for CHF have decreased.
- Quality of life for CHF patients has been improved.
- Due to decreased admissions and readmissions, the program has resulted in annualized savings of approximately \$1.5 million dollars in billed charges.