The goal of the Stronger Hearts™ Best Practices Award program is to reduce the burden of heart failure on patients and their families by illuminating the use of identified best practices and sharing them for others to model. The 2017 recipients are The Ambulatory Heart Failure Care Management Team – Mercy Clinic East, Saint Louis, MO and ENABLE CHF-PC (Educate, Nurture, Advise, Before Life Ends: Comprehensive Heartcare for Patients and Caregivers) – University of Alabama at Birmingham (UAB).

The Ambulatory Heart Failure Care Management Team – Mercy Clinic East, Saint Louis, MO

The Ambulatory Heart Failure Care Management Team specifically targets high-risk heart failure patients, assisting them and their caregivers with the transition from hospital to ambulatory setting, with the goal to improve patient outcomes and quality of life.

The team treats the whole person, addressing mental, social, and physiological factors, including home visits made by nurses to monitor, review, and educate; and a social worker to address complex social and financial needs. Nurses stay engaged with patients long-term, acting as liaisons between patients and providers. Innovative care strategies, including home IV Lasix protocols, telemonitoring devices, automated text messages and phone calls allow for both quick intervention, and reaching many patients in a short amount of time.

A multi-disciplinary team (including emergency department physicians, primary care providers, cardiologists, hospitalists, nutritionists, home care, palliative care, hospice, cardiac rehab, inpatient care management, a social worker, and chaplain) meets weekly to support the team, discuss individual patient cases, identify causes of readmissions and to investigate breakdowns in the systems which led to readmissions.

To-date, the Ambulatory Heart Failure Care Management Team has followed 358 high-risk heart failure patients. The 30-day unplanned readmission rate of patients managed by the team is currently 7.7 percent, and the hospital’s current heart failure readmission rate is 16 percent (as compared to 18.9 percent in 2014) and the national rate of 21.9 percent.
ENABLE CHF-PC is a telehealth program with the primary goals of activating and empowering patients with advanced heart failure and a care partner – someone who knows the patient well and is actively involved in the patient’s care. ENABLE CHF-PC provides palliative care while patients are still well and also receiving their usual heart failure care.

ENABLE CHF-PC consists of a comprehensive in-person assessment by a palliative care specialist and weekly nurse coach sessions by telephone. The nurse coach uses the “Charting Your Course” guidebook to assist the patient (6 sessions) and their care partners (4 sessions) to develop skills in communication, symptom management, self-care, decision-making and advance care planning.

ENABLE CHF-PC targets rural, minority, Veteran, underserved, and older adults with advanced heart failure and their partners, allowing them to access needed services in their own communities. To date, more than 200 patients and their care partners have participated and more than 60 percent are African American.

During initial pilot studies, patients experienced improved symptoms and higher activation and their care partners experienced lower burden. Both also experienced improved quality of life and physical and mental health all while requiring only nominal healthcare resources. These improvements are compelling, as persons living in the Southeastern United States consistently have the lowest access to palliative care services.

By engaging patients, care partners, and clinicians, ENABLE CHF-PC was successfully translated from an effective approach for patients with cancer to a feasible and scalable program for patients with heart failure. ENABLE CHF-PC is now being tested in a National Institutes of Health-funded randomized clinical trial.