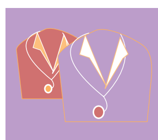

Congestive Heart Failure Program

Blue Care Network of Michigan in conjunction with Alere Medical

Purpose

To increase physicians' use of effective methods for treating congestive heart failure, increase members' adherence to recommended medications and services, and help avoid unnecessary hospitalizations and emergency room visits

Target Population

Members age 18 and older who can benefit from a congestive heart failure (CHF) management program

Goals

- Reduce the high incidence of repeat hospital admissions among heart failure patients
- Assist patients with diet restrictions, medical regimens, and recognition of worsening symptoms
- Improve communication between patients and their providers

Years in Operation

1999 – present

Results

- In 2005, 70 percent of members enrolled in the program used angiotensin-converting enzyme (ACE) inhibitor medications as recommended, and 70 percent reported using beta-blockers as prescribed.
- In 2005, 98 percent of members rated the program as "very good" or "excellent," and 98.4 percent of these members said they would recommend the program to others.
- Total savings from the program from 2003 to 2004 were more than $1.3 million, attributable to reductions in emergency room visits and inpatient admissions.
- In 2004, the number of inpatient admissions per thousand members at high risk for complications who were enrolled in the CHF program was 1,337, compared with 1,953 per thousand members in the same risk group who were not enrolled in the program.
- The number of emergency room visits per thousand members enrolled in the program in the two highest risk groups was 1,849, compared with 2,179 members with the condition who were not enrolled in the program.

Funding

Blue Care Network of Michigan funds the program.

Key Partners

Blue Care Network of Michigan (BCN); Alere Medical, Inc.

What Works and Why

To reduce the high incidence of repeat hospital admissions among heart failure patients and to help patients with diet restrictions, medical regimens, and recognition of worsening symptoms, BCN partnered with Alere Medical, Inc. to reach this high-risk population. Relying on a variety of monitoring devices used by the patient twice a day, it has been possible for Alere staff to monitor the defined clinical parameters and alert the provider if a weight or symptom change occurs. Preliminary data indicate a favorable trend in member utilization and cost.

Structure and Operations

Blue Care Network uses a variety of sources to identify members with congestive heart failure, including claims, direct referrals from health care practitioners, member self-referrals, and other BCN departments. As members are identified, they are added to the disease management registry. Unless they opt out, members in the registry receive introductory packets and regular mailings on chronic care issues. Each member enrolled in the case management program receives an initial phone call from a nurse case manager, who conducts a health risk assessment and evaluates his or her functional status as well as physical and emotional well-being.[11]

An electronic scale and DayLink® monitor are installed in participating members' homes, and participants are asked to weigh themselves twice a day and answer a few short questions about their symptoms. The information is then transmitted to Alere automatically through a standard telephone line. The entire process takes less than a minute.[12]

Barriers to Success

Individuals with congestive heart failure often suffer from depression that can impair their ability to follow care plans.

For More Information

Additional information is available online:
http://www.ahipresearch.org/PDFs/Innovations_InCC_07.pdf