CARE NAVIGATION

"The program has allowed me to be more involved in my healthcare…I feel more confident managing my condition."

— Case Study Patient

READMISSION REDUCTION PILOT helps newly diagnosed Heart Failure patient make positive lifestyle changes

PATIENT BACKGROUND

This case study follows a 64-year-old male, newly diagnosed with Congestive Heart Failure (CHF), with preexisting diagnoses of diabetes, chronic kidney disease, hypertension, and a recent hospitalization for pneumonia. Based on these factors, this patient was identified as a high risk for readmission within 30 days post-discharge from the hospital.

PILOT OVERVIEW

A Dallas-area Hospital, recognized as a leader among providers in the DFW Metroplex, partnered with Care Navigation Services (CNS) to assess the clinical-quality and financial impact of managing high-risk patients using mobile health and CNS' post-acute coaching strategies.

Championed by the Hospital's Chief Financial Officer, CNS engaged several key groups within the Health System throughout the Pilot. By implementing their proven Care EMPOWER solution, CNS collaborated with the Facility's care management team during Pilot enrollment and escalated patients to the Health System's transitional care team during the monitoring phase when the CNS Remote Registered Nurse (RN) determined post-acute medical interventions were needed.

"We have existing transitional care programs available to our patients, but we continually seek opportunities to expand value-based initiatives that deliver patient-centric care ." — Hospital CFO

INTERVENTION

The patient was approached to participate in the Pilot while recovering in the Hospital. He was identified based on risk stratification (high-risk) and diagnosis (CHF and diabetes), among other qualifying criteria agreed upon by CNS and the Hospital's care management team. Although initially reluctant, this patient voluntarily agreed to participate in the program once educated about potential health and wellness benefits stating, **"It was time to make a change."**

- Participation in the Pilot involved high-risk patients taking home a personal health kit upon inpatient discharge. Participants received bedside training on the Kit prior to discharge.
- The Kit included a wireless tablet designed to ask the patient customized daily questions related to chronic conditions, as well as Bluetooth paired biometric peripherals to track vital signs daily.
- The Kit was used for 30-days post-discharge while a CNS Remote RN monitored patient responses and vital signs.
- The CNS Remote RN provided near-time patient education and coaching when patient responses indicated a decline in condition.
- The CNS Remote RN notified the Health System's transitional care team if post-acute medical attention was necessary.
- Upon completing the initial 30-day health Kit phase, all patients were transitioned to an additional 15-day period of telephonic follow-up and support by the CNS Remote RN.

"Care Navigation offered a solution designed to engage patients in their recovery process and demonstrate improved patient outcomes for the high-risk populations we serve." – Regional Director of Hospital Care Management Team

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PATIENT OUTCOMES

Clinical-quality outcomes for this patient demonstrate the importance of engaging patients in their own self-health governance, especially those newly diagnosed with a chronic condition. Below are highlights of the positive lifestyle changes implemented by this patient and the outcomes these changes produced.

TAKING VITAL SIGNS DAILY AND RECHECKING VITALS WHEN SYMPTOMS CHANGE

- This patient had a **93% compliance rate** during the 30-day period using the health kit.
- The patient was able to better manage his symptoms by understanding signs that his condition was worsening; customized education provided by the CNS Remote RN empowered him to self-manage a hypoglycemic episode at home by taking vital signs at the onset of symptoms and adjusting food and medication doses based on biometric readings.
- By tracking vital signs daily, the patient shared biometric readings during a follow-up appointment with the Health System's transitional care team; both patient and provider verbalized satisfaction with the program resources.
- This patient required no ER visits or rehospitalizations throughout the program.

"During the Pilot, the CNS clinical team became an extension of our transitional care team, providing meaningful updates about patient condition and helping engage patients who were otherwise unresponsive to follow-up calls." – APRN Health System Transitional Care Team

MAKING BETTER DIET AND NUTRITION CHOICES

- The patient verbalized a greater understanding of the correlation between diet and lifestyle choices and the negative (or positive) impact to his biometric readings and health condition.
- The patient's **Daily Health Score* improved 10%** during the 30-day period using the health kit.
- During the program, this patient had a low score of 48 and a high score of 92. The table below displays biometric measurements that were drivers for this patient's low or high score.

Daily Health Score	Blood Sugar	Heart Rate	Weight
Low Score = 48	400 mg/dL	105 bpm	5 lb increase from previous day
High Score = 92	118 mg/dL	79 bpm	Consistent weight from previous day

**The Daily Health Score is a value derived from responses to a series of disease-specific daily health questions and biometric readings (blood pressure, heart rate, oxygen saturation, weight, and blood sugar) to assess overall health status. It is a 1-100 scale, where 100 represents ideal health status.*

HAVING RESOURCES AND SUPPORT TO BETTER UNDERSTAND CHRONIC CONDITIONS

- The patient's perceived **understanding of his health condition improved 20%**, based on answers to a Self-Health Assessment completed by the patient on Day 1 and Day 30 of the program.
- Based on survey results, the **patient reported 100% satisfaction** with the Pilot services, including: RN coaching and education, program resources provided to track daily biometrics, and the easy-to-use technology.

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