Informed Health Solutions

Heart Failure is the most expensive chronic disease diagnosis in the United States. There are currently almost six million people in the United States with Heart Failure; each year, approximately 1 million of these individuals are hospitalized. According to The National Institutes of Health, heart failure is the top reason older adults are hospitalized. Of those who are hospitalized, more than one in five will be readmitted to the hospital within 30 days; more than half will be readmitted within 180 days. Unnecessary and repeat hospitalizations can be avoided if patients receive timely and appropriate medical care in an outpatient setting. More than 50% of heart failure hospitalizations are attributed to poor medication and dietary compliance. Significantly, more than half of all heart failure patients experience significant depression.

CareConnext, a service of Informed Health Solutions, is an evidence-based, community care transitions program that improves the emotional lives of heart failure patients while maintaining their physical wellness. Patients and care givers are invited to attend four patient engagement sessions, held weekly, for one month. Each session lasts for two hours, and includes a complete physical and emotional assessment. Patients are coached by a multidisciplinary team and encouraged by their peers. The care team includes an advanced practice registered nurse (APRN), a nurse (BSN) and a licensed clinical social worker (LCSW) who are specially trained to meet the emotional and clinical needs of patients with heart failure.

Approximately one-third of our patients bring caregivers. Between each session, patients complete personalized action plans that include monitoring their mood, weight and blood pressure. The LCSW plays a key role in the multidisciplinary team, connecting patients with vital community resources, strategies for surviving Medicare's "donut hole," and sources for low-cost medicines. The LCSW also offers brief, intensive therapy for those with high depression scores. Efforts to decrease hospital readmissions among heart failure patients have been largely focused on nurse-led post discharge interventions that monitor for clinical deterioration and provide education to improve dietary and medication compliance. These nurse-led interventions are typically delivered via phone calls or home healthcare visits.

The CareConnext solution is based on multidisciplinary group clinic appointments designed and tested in a five-year random clinical trial at Kansas University Medical Center. The RCT demonstrated that the CareConnext solution of group appointments effectively decreases hospital readmissions by 34 percent. CareConnext delivers several advantages over the traditional nurse-led interventions including i) peer support which engages patients in enhanced problem solving, ii) emotional assessment and tools that address depression which is a major factor leading to dietary and prescription non-compliance, iii) and data analytics and reporting which enables the coordination of treatment across multiple providers.