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In the Literature

Highlights from Commonwealth Fund-Supported Studies in Professional Journals

What Works in Chronic Care Management: The Case of Heart Failure

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Authors: Julie Sochalski, R.N., Ph.D., Tiny Jaarsma, R.N., Ph.D., Harlan M. Krumholz, M.D., Ann Laramee, R.N., M.S., John J. V. McMurray, M.D., Mary D. Naylor, R.N., Ph.D., Michael W. Rich, M.D., Barbara Riegel, R.N., D.N.Sc., and Simon Stewart, Ph.D.

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Contact: Julie Sochalski, School of Nursing, University of Pennsylvania, julieas@nursing.upenn.edu, or Mary Mahon, Senior Public Information Officer, The Commonwealth Fund, mm@cmwf.org

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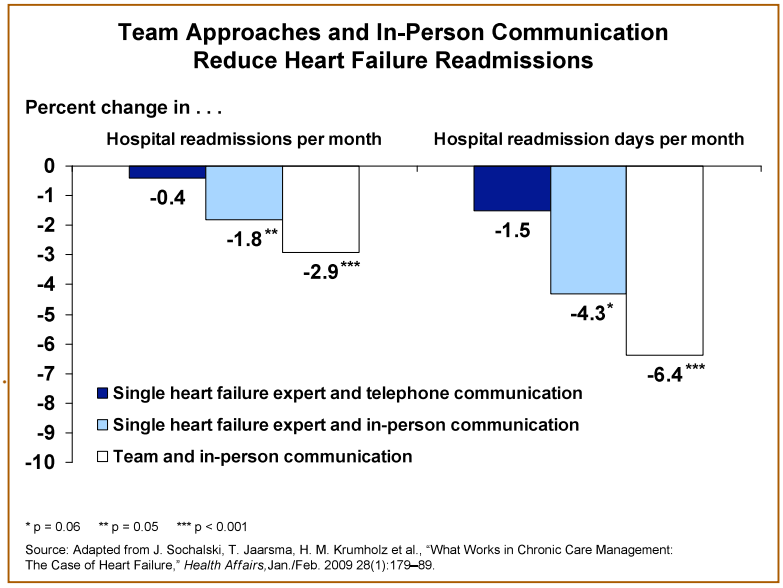
http://content.healthaffairs.org/cgi/content/full/28/1/179?ijkey=bixBowwo2gUJA&keytype=ref&siteid=healthaff

Synopsis

A study that reexamined data from 10 clinical trials of care management programs for heart failure patients found that multidisciplinary teams and in-person communications led to fewer hospital readmissions and readmission days.



The Issue

Private health plans and public payers have implemented chronic care management programs with the goals of improving quality and health outcomes and saving money. Results range from encouraging to disappointing, with little conclusive evidence on what works. To determine which programs are most effective for managing heart failure—the leading cause of hospitalization among the elderly—this study assembled some of the world's top heart failure experts to reexamine data from notable randomized trials.

Key Findings

- Program patients had 25 percent fewer readmissions and 30 percent fewer readmission days than patients receiving routine care.
- Patients in chronic care management programs carried out by a single heart failure expert relying on telephone follow-up did not see a significant reduction in hospital readmissions and readmission days over patients in routine care.

- In-person communication greatly improved the outcomes of programs using a single heart failure expert, reducing hospital readmissions per month by 2 percent and readmission days per month by just over 4 percent, on average, over routine care.
- Patients in chronic care management programs that used a multidisciplinary team approach and in-person communication had significantly fewer hospital readmissions (3%) and readmission days (6%) per month than did routine-care patients.
- Based on published national estimates of hospitalization and readmission rates for people with heart failure, the authors estimate that a 3 percent reduction in hospital readmissions per month from implementing programs using team-based care and in-person communication could result in 14,700 to 29,140 fewer hospital stays annually.

Addressing the Problem

Private and public insurers alike have embraced an array of chronic care management programs to enhance quality and cost-effectiveness for chronically ill populations. In seeking which programs work best for management of heart failure—a condition that accounts for roughly 10 percent of total Medicare spending on inpatient care—this study provides important evidence, but the authors recommend additional testing of team and communications methods.

"[P]rograms using multidisciplinary teams and in-person communication methods resulted in significant reductions in readmissions and days per month over routine care."

About the Study

The researchers pooled and re-analyzed data from 10 randomized clinical trials of heart failure care management programs, conducted from 1990 through 2004 and comprising 2,028 cases in the United States, Australia, the Netherlands, and the United Kingdom. Researchers focused on two measures—hospital readmission and readmission days—to discern how program delivery methods (team-based care vs. a single heart failure expert, and telephone vs. in-person communication) contribute to patient outcomes.

The Bottom Line

Chronic care management programs that employ multidisciplinary teams and in-person communication lead to fewer hospital readmissions for heart failure patients.

Citation

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This summary was prepared by Christopher Gearon and Deborah Lorber.