

# Case Study

## The Heart House Personal Concierge

### PROGRAM DESCRIPTION:

The Heart House Personal Concierge program was created to strengthen connections with patients facing systolic and diastolic heart failure, many of whom also manage co-occurring conditions including diabetes, kidney disease, and smoking-related health issues.

The program’s mission is to boost treatment adherence and empower patients to take charge of their physical and mental health, with a focus on achieving healthy weight, reducing behavioral risks such as tobacco use, and building a more hopeful outlook for their future quality of life.



### PROGRAM AUDIENCE:

Patients diagnosed with systolic or diastolic heart failure



PROGRAM OBJECTIVES:	PROGRAM OUTCOMES:
<ul style="list-style-type: none"> <li>➤ Improve care coordination for patients with systolic and diastolic heart failure with digital engagement tools</li> </ul>	<p><b>Strong GoMo Chat engagement for clinical inquiries and scheduling areas, enhancing patient support and operational workflows. Top engaged areas:</b></p> <ul style="list-style-type: none"> <li>• 71% triage nurses</li> <li>• 67% access center scheduling</li> <li>• 60% medical assistant (MA) refills</li> <li>• 54% front desk</li> </ul>
<ul style="list-style-type: none"> <li>➤ Increase compliance with self-care in a remote setting</li> <li>➤ Reduce ER visits and readmissions</li> </ul>	<p><b>19,193 digital escalations received, ensuring care team’s ability to intervene in the moment of need to prevent adverse events and avoidable ER visits. Top issues reported:</b></p> <ul style="list-style-type: none"> <li>• 22% noted perceived weight gain not related to heart condition</li> <li>• 21% noted moderate shortness of breath</li> <li>• 17% noted weight gain of 5+ pounds</li> </ul> <p><b>58,270+ wellness survey submissions allowed care team to provide more personalized and timely support within the patients lived environment</b></p>
<ul style="list-style-type: none"> <li>➤ Reduce common behavioral risks, including tobacco use</li> </ul>	<p><b>18% have stopped smoking and 64% have decreased tobacco intake since enrolling in the program</b></p>

## Program Components:



### Care Communications:

Upon enrollment, participants receive text messages that nurture, guide, and support them throughout their cardiac health management journey. Some messages contain links to online resources with additional educational information in the form of interactive surveys, videos, and music tracks (see Care Companion). Topics include medication management, clinical management, quality of life messages, peer stories, and health literacy.



### Care Companion:

This cloud-based learning management system (LMS) provides vetted educational content that is personalized by participants' self-expressed priorities and interests, structured into easy-to-follow sections to promote independent education, learning, and self-care management.



### GoMo Chat:

Much like a typical text conversation, GoMo (secure) Chat allows live messaging between participants and their care team, enabling in-the-moment, on demand conversations.



### Secure Data Collection and Reporting:

Engagement and experience data is deidentified, analyzed, and reported back to providers for ongoing quality, clinical delivery, and service improvement.

Over 1.4 million  
personalized messages sent,

which resulted in a significant  
increase in appointments kept  
and scheduled tests performed.



*“One of the aspects of the GoMo Health program that is most helpful in offloading our nurses and case management team is its ability to monitor patient response to simple triage questions related to non-adherence to medication, swelling of extremities and progressive weight gain. Feedback that we merit as needing clinical intervention is then escalated to our nurse triage team enabling them to deliver more proactive and high impact care to avoid unnecessary emergency visits or readmissions.”*

- Sandy Gips, MD, FACC, FSCAI, The Heart House