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Clara Maass Medical Center

DSRIP Learning Collaborative 3 & 4

Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions

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About Us

- An affiliate of Barnabas Health
- 469 bed hospital located in Belleville, NJ
- Founded in 1868 as the Newark German Hospital, Clara Maass is staffed by more than 700 physicians and 2,000 employees delivering care to more than 19,000 residents each year. As the first hospital in the United States to bear the name of a nurse as its corporate identity, Clara Maass Medical Center carries on a rich tradition of health care
- Provide variety of services:
  - Women's Health Center
  - Nuclear Medicine
  - The Cancer Center at Clara Maass
  - Diagnostic Cardiac Services
  - The Pain Management Center
  - The Joint & Spine Institute
  - Vascular Center
  - Pediatrics
  - Same Day Surgery
  - The Wound Center at Clara Maass
  - The Center for Sleep Disorders
  - The Bariatric Surgery Center
  - Radiology services
  - Rehabilitation Services
  - Comprehensive Ophthalmology Services
  - Maternity Services and Parent Education
  - Community outreach programs

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Objective

- To create an evidence-based Care Transitions Intervention Model for the cardiac care population, specifically (HF and AMI), to reduce readmissions and result in better outcomes for our patients.

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Project Goals & Outcomes

- Reduce readmissions
- Reduce admissions
- Increase patient satisfaction
- Improve medication management
- Improve care processes

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Responses to December Survey

- Quality Improvement Plan – Completed 100%
- External Partners Activity – Sharing information of trends and Program Statistics. Investigating ways of collecting data for the pilot and the UPP Metrics in the future.
- Leadership Engagement Activities- Project updates are shared monthly at all Leadership Meetings. Dept of Medicine is shared by Senior Sponsors, they provide project status and readmission rates and in the future the attribution lists.

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Responses to December Survey

- PDSA Project Stage – We are in the STUDY stage.
  - Monitoring the effectiveness and areas for opportunity.
  - Monitoring why patients are missed in the program
  - Reasons for readmissions
  - Adjust the project process as needed
- Stage 1 Activities – 100% of all Stage 1 Activities are completed
- Stage 2 Activities – 100% of all Stage 2 will be completed by December 31st, 2014
- Activities Requiring Change – We revisit the people that need to be part of the project (i.e. Security) due to the need for escort in "difficult" areas for Home Visits

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Responses to December Survey

- Stage 3 Completion 30%-Reporting systems and processes to collect the data for inpatient metrics have been identified. Without the patient attribution we are unable to verify if the collection of data is being done on the correct patients and we cannot start outpatient data collection
- Stage 4 Completion 30%-Same response as above

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CMMC program

- All staff is trained in the Coleman Model for Transitions
- We have hired 2 FTE APN's and 2.5 FTE Care Coordinators
- Multidisciplinary DSRIP Steering Committee meets monthly to review status of pilot and outcomes
- CMMC Pilot started October 1, 2014
- Identification of initial admissions of AMI and HF patients and alerts built for readmission within 30 days
- Attendance at multidisciplinary telemetry rounds and LOS huddles weekly.
- Referral from Case Management /staff/physician
- Assessment and education begins in the hospital by the Transitional Care Coordinator with follow up from home visit by the APN when patient agrees to participation in the program

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CMMC program Continued

- Follow up cardiology appointment made prior to discharge (or at home visit) if patient receptive
- Home Visit consists of assessment, education, med reconciliation, development of the Personal Health Record (not limited to above)
- Scripted telephone calls by Transition Coordinators to follow up on Medication management, Red flags, Medical care/follow up and PHR

Project Observations & Challenges

- Lessons Learned –
  - Sticking to the “script” when doing the call backs to “catch” potential issues before the home visit
- Successes to Date –
  - Cardiologist and PMD are accepting of the program and they look for monthly readmission detail to identify any trends

Project Observations & Challenges

- Challenges
  - Identifying patients with CHF and AMI primary diagnosis
  - Convincing non-compliant patients to participate in the program
  - Conducting Home visits in some “difficult” areas in our service area.

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