



DSRIP Project:

Care Transitions to Reduce 30 Day
Readmissions in Cardiac Patients

LC 3

January 08, 2015

Project Objectives

- ✓ To roll out our current Project RED Initiative to the low income population.
- ✓ Decrease readmissions for CHF and AMI patients
- ✓ Improve a “broken” discharge processes
- ✓ Mirror the Population Health Management techniques used with our MSSP beneficiaries

Goals & Outcomes

- ✓ Guide patients and families to develop the self management skills needed to take control of chronic conditions
- ✓ Improve discharge planning
- ✓ Improve collaboration across the continuum
- ✓ Reduce readmissions of congestive heart failure (CHF) and acute myocardial infarction (AMI) patients

Project Interventions

Standardized CHF and AMI Educational Materials

- ✓ Created by nursing staff
- ✓ All units use the same materials and processes
- ✓ Shared with Sub-Acute and Acute Rehabs to provide continuity
- ✓ Used in our Group education meetings with patients and families

Project Interventions

After Hospital Care Plan

- ✓ Calendar of appointments and testing needed
- ✓ Contact information for Physician, Nurse Navigator and Transitions Nurse
- ✓ Disease management information
- ✓ Medication information
- ✓ Exercise and Diet information
- ✓ Cardiac Rehab information
- ✓ Home Care Services being provided (if any)
- ✓ Pharmacy Contacts

Project Interventions

Transitional Care Nurse

- ✓ Home Care nurse trained in the Mary Naylor model
- ✓ With patient consent, makes home coaching visits
- ✓ Disease management
- ✓ Medication reconciliation
- ✓ Self-management skills
- ✓ Dietary Education: Trips to Supermarket

December Survey Responses

- **Project Support**
 - ✓ Our Quality Plan has been completed
 - ✓ Met and discussed collection of quality data with our partner
 - ✓ Our VP of Quality and Safety and CMO sit on our Discharge and Care Transitions Committee
 - ✓ Updates on DSRIP are done quarterly with our Quality and Safety Committee

December Survey Responses

- **Project Tracking**

- ✓ Pilot on 3 Units began Nov 19, 2014
- ✓ All Stage 1 Activities complete as of Sept 30, 2014
- ✓ Stage 2 Activities at approx 75% completion
- ✓ Stage 3 measure data collection processes for tracking and collecting of measure data at approx 60%
- ✓ Stage 4 measures at approx 30% completion: A concern is that the core measure data need for Stage 4 measures is reported by our vendor with a 3 month lag. We are not sure that the information will be available for reporting when needed

December Survey Responses

- **Project Observations**
 - ✓ Implementation Challenges:
 - ❖ Staffing and resources, hiring freeze
 - ✓ Successes to date:
 - ❖ Pilot started Nov 19, 2014, physicians, patient and family feedback has been positive
 - ❖ Our overall Readmission rates reported by CMS continue on a downward trend, our penalties have been decreasing

December Survey Responses

- **Project Observations**
 - ✓ Lessons Learned:
 - ❖ Big Frustration: No matter how good your processes are, the patient still has the right to refuse Home Care, Transitional Care Coaching and it is their choice whether they follow medication and self care regimens.
 - ✓ No attribution lists distributed to date