DSRIP

New Jersey Department of Health (NJDOH)

Delivery System Reform Incentive Payment

CarePoint Health-Bayonne

- CarePoint Health-Bayonne is a 278-bed, fully accredited acute-care hospital located in Hudson County, New Jersey.
- Celebrating our 125th Anniversary
- Part of a 3 hospital system
  - Bayonne Medical Center
  - Christ Hospital
  - Hoboken University Medical Center
- CarePoint Health is currently integrating our care processes.

CarePoint Health

360 Degree Coordinated Care

- CarePoint Health brings quality, patient-focused healthcare to Hudson County. Combining the resources of three area hospitals — Bayonne Medical Center, Christ Hospital in Jersey City, and Hoboken University Medical Center — CarePoint Health is a new approach to delivering healthcare that puts the patient front and center.
- **Our mission — to make Hudson County a healthier place for everyone through:**
- **Truly coordinated care.**
- We are a network of doctors, nurses and other medical professionals who surround you and your family with expertise and attentiveness. Everyone works together to provide complete coordination, from the doctor's office to the hospital to your own home.
- **Top doctors who really care.**
- Leading physicians join CarePoint Health because we give them the resources they need to provide the quality of care they want to deliver. CarePoint Health doctors take the time to listen to patients and their unique concerns, so that together, they can make the right decisions.
- **Three leading hospitals, united.**
- CarePoint Health brings together three prominent Hudson County hospitals. As a patient, you benefit from the expertise and capabilities of a broad network of specialists and specialized technology
- **A focus on preventive care.**
- At CarePoint Health, all of our medical professionals emphasize preventive medicine and focus on educating patients on how to make healthy life choices. –

Hospital Demographics

- CarePoint Health- Bayonne Medical Center is a **278-bed acute care medical/surgical hospital.**
- At present 178 beds are staffed

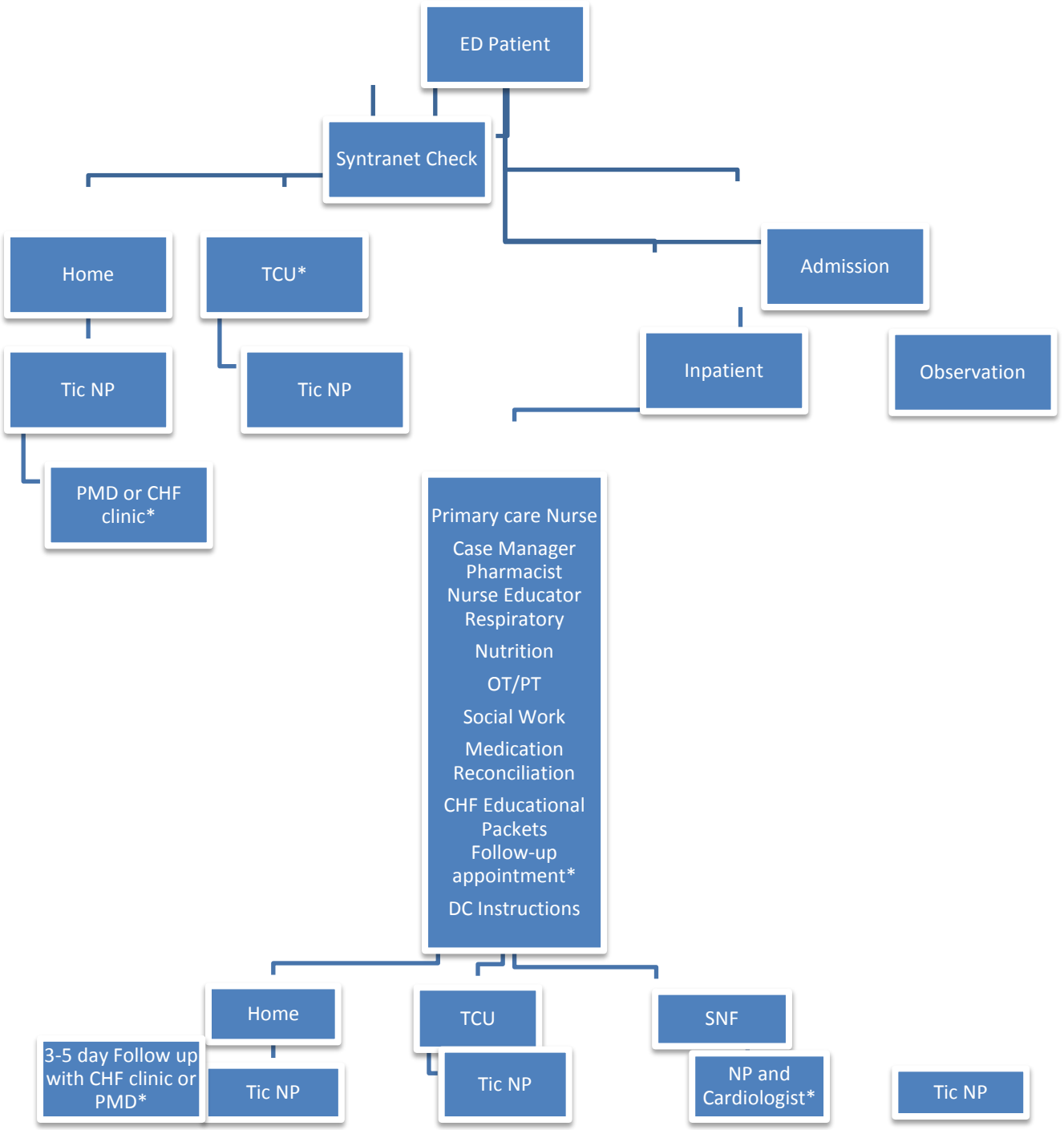
  - 14 bed Critical Care Unit
  - 15 bed acute psychiatric adult open unit
  - 17 bed Transitional care unit
  - Sleep Services offer outpatient sleep studies and treatment
  - Neighborhood Health Center provides ambulatory care services, including primary care and family practice.
  - Wound Care Services (PWCS) Provides clinically advanced healing and therapy and hyperbaric Therapy
  - 12 Chronic Renal Dialysis Services
  - Radiation Oncology
  - Cardiac Imaging Center East Brunswick
  - Retail pharmacy
  - Accredited Cancer Program

- The DSRIP collaborative that we have chosen is Cardiac Care – Heart Failure
- Charity Care, Medicaid, self pay, and dual eligible patients with a primary diagnosis of heart failure
- Patients are managed through a medical home model system with a focus on reducing readmission
  - Education, communication, monitoring, and support
  - Multidisciplinary team of providers
  - Identify patients utilizing a risk stratification tool
    - Lace score

Implementation

- Identify patient on admission
- Begin education process on admission
- All patients receive a take home binder during the assessment process
- Hospital based APN's work collaboratively with the care team (RN, Case Manager, Social Work, Physicians, Nutrition and Pharmacy) to coordinate care and ensure a safe discharge plan

- Transitional Care APN's (TiC APN) – work closely with the team to ensure early home visits.
- The Team meets regularly to discuss challenges and successes, problem solve and change policy if needed.
- Purchase supplies as needed


ED Patient
Syntranet Check
Home
TCU*
Admission
Tic NP
Tic NP
Inpatient
Observation
PMD or CHF clinic*
Primary care Nurse
Case Manager
Pharmacist
Nurse Educator
Respiratory
Nutrition
OT/PT
Social Work
Medication Reconciliation
CHF Educational Packets
Follow-up appointment*
DC Instructions
Home
TCU
SNF
3-5 day Follow up with CHF clinic or PMD*
Tic NP
Tic NP
NP and Cardiologist*
Tic NP

Objective

- Reduce Avoidable Readmissions for HF
- Improve Medication Safety:
  - Accurate and timely medication reconciliation
  - Reduce medication adverse event occurrence
- Guide patients and families to develop the self management skills needed to take control of chronic conditions
- Standardize care processes
- Improve discharge planning
- Improve collaboration across the continuum
- Improve Patient Satisfaction

Post Discharge

After Hospital Care Plan

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

Challenges

- Patients have transient addresses
- Patients don’t answer the door or phone when visit is agreed upon
- Patients do not adhere to dietary restrictions
- Patient do not get medications filled
- Low volume of patients

Successes

- The TiC APN's will increase phone consult if the patient has not kept visit appointment.
- The TiC APN's have done some creative dietary teaching (buying sample heart healthy meals and Nutrition departments at each institutions have done group dietary teaching open to all residents of the county)
- CarePoint had instituted Meds to Beds service where the patient's prescription is brought to the OPD Pharmacy and the medication is returned to the patient prior to discharge.
- The patients are given clinic appointments where the patient is examined and meds are renewed and filled as needed