



ENGLEWOOD

HOSPITAL AND MEDICAL CENTER





Who We are?

- 520 licensed beds
- Top Doctors in Bergen County
- Magnet Hospital
- Leapfrog Top Hospital
- Affiliate Mount Sinai School of Medicine
- Internal Medicine Residency & Vascular Surgery Fellowship
- Joint Commission Disease Specific Certification Hips/Knees, Spine & Primary Stroke Certification



DSRIP PROJECT: Chronic Cardiac Conditions

- Formed team in 2013



ENGLEWOOD HOSPITAL AND MEDICAL CENTER DSRIP INTERDISCIPLINARY MEDICAL & SUPPORT TEAM

<i>Position</i>	<i>Title/Job Description</i>
1	Chief of Hospital Medicine/MD Champion
2	Chief Department of Medicine
3	SR. VP & Chief Quality Officer/Project Leader
4	SR. VP & Chief Nursing Officer
5	Advanced Practice Nurse (Cardiac Care Navigator)
6	Director Quality Development & Accreditation
7	Quality Improvement Specialist
8	Director Revenue Management
9	Director Care Coordination
10	Director Community Affairs
11	Visiting Nurse RN
12	Resident
13	Administrative Assistant (2)
14	Pharmacists
15	Case Manager/Discharge Planner/Social Worker
16	Medical Service Line Administrator
17	Hospitalist
18	Hospital Intern
19	Information Technology- Report Writer
20	VNA Partner -Leadership
21	Care One Partner-Leadership
22	Director Health Information Management (ADHOC)
23	Clinical Documentation Specialist
24	Patient Care Director 6 Dean
25	Assistant Patient Care Director 6 Dean
26	Clinical Education Coordinator
27	Patient Relations
28	Patient Relations
29	Patient Care Director 7 Dean
30	Coordinator Patient Care Experience (2)



DSRIP PROJECT: Chronic Cardiac Conditions

- Began pilot in October 2014
- Expanded program in July 2015



Framework

- Evidence based guidelines for framework:
Eric Coleman's Transitions of Care Model
- Tools from BOOST
(**B**etter **O**utcomes by **O**ptimizing **S**afe **T**ransitions)
Supported by the Society of Hospital
Medicine



Process

- Use a modified version of a known readmission risk assessment tool (LACE tool)
- Risk assessment done by primary nurse directly into the electronic health record on admission on designated units
- Daily report generated with patient's location, score and payor status
- Report reviewed daily to identify patients with chronic cardiac conditions. If score greater than 7 with payor status of Medicaid, charity, or self-pay will be enrolled in the program



Process

- Seen by Nurse Practitioner (Care Navigator)
- Care Navigator completes a tool for assessing patient's risk for adverse events after discharge called the **8 P'S Screening Tool**



8 P'S Identify Areas of Concern

1. Polypharmacy
2. Psychological issues
3. Complex and multiple diagnoses
4. Physical limitations
5. Poor health literacy
6. Patient support
7. Prior hospitalizations in past 6 months
8. Palliative care



Interventions

- Use tool to determine areas of need
- Engage interdisciplinary providers to help meet needs (dietary, pharmacy, care coordination, physicians, clinic)
- Care navigator sees patient prior to discharge
- Reinforcement of discharge teaching
- Enlist community resources
- Arrange for home visit if applicable or excepted and discusses follow up phone calls



Program Volume
to date
132 Patients



Challenges

- Transportation to visits
- Lost to follow up
- Level of motivation
- Health literacy
- Medications
 - Affordability
 - Compliance



Evaluation

- Tracking of readmissions
- Follow up patient survey



What Works

- Careful screening on admission
- Relationship with patient/family
- Individualized approach
- Follow through
- Follow up



Successes

- Patients prescriptions filled through pharmaceutical company or assistance through retail pharmacy
- Follow up appointments
- Community referrals
- Call backs from patients
- Learning opportunity
- Physician Buy in
- Senior Leadership Support



Thank You