

OUR LADY OF LOURDES MEDICAL CAMDEN, NEW JERSEY

founded in 1950 by the Sisters of Allegheny New York
celebrating 65 years of service to the community



DR. ROBERT MOHAPATRA, MD, MPH

- * Board Certified
 - * Advanced Heart Failure and Transplant Cardiology
 - * Cardiovascular Disease



WHY THIS PROJECT

CHF is major readmission dx – 23.4%
(2013)

Improved outcomes & population health

Increased value

Decreased cost

30-DAY READMISSION REDUCTION FOR CHRONIC HEART DISEASE

- * Target Population
 - * CHF
 - * HTN
 - * Acute MI

OLLMC featured in the NY Times for Excellence in Door-to-Balloon Time June 26,2015

http://www.nytimes.com/2015/06/21/health/saving-heart-attack-victims-stat.html?_r=2

Review
Exam 1 | Seq 3
Frm 50 / 56
1 NIGHT • 2 ON CALL • 3 LIVES SAVED
LOURDES FEATURED IN NEW YORK TIMES STORY ON HEART ATTACK
51:00
ASK ME MORE
lourdesnet.org

TECHNOLOGY AND THE HEART FAILURE PATIENT

- * Our Lady of Lourdes Medical Center is the first facility in South Jersey to implant this new miniaturized, wireless monitoring sensor to manage heart failure (HF)
- * The CardioMEMS HF System is the first and only FDA-approved heart failure monitoring device that has been proven to significantly reduce hospital admissions when used by physicians to manage heart failure

PROJECT DESCRIPTION

- * Modified Coleman Care Transitions Intervention[®] approach
 - * Transitions RN makes initial contact during inpatient stay
 - * Establishes rapport and identifies readmission risk (IHI)
 - * Identifies barriers to therapeutic regimen adherence, e.g., inability to afford Rx, no reliable transportation, food, shelter, addiction, mental health issues
 - * Transitions RN consults with social worker, case managers, and discharge planners to assist with community resource referrals
 - * A home visit is scheduled ideally within 1-3 days post discharge. Coach targets 4 key areas “pillars”
 - * Medication Reconciliation
 - * Follow-up appointments
 - * Red Flags
 - * Personal Health Record completion

CURRENT ACTIVITIES

- * We have engaged our reporting partners (Primary Care Physician and Cardiology)
- * Transitions RNs use practice offices for home and follow-up visits
- * Collaborate/coordinate with practice staff, including HF clinics
- * Patient engagement through rapport building

PATIENT ENGAGEMENT

- * Offering financial services through vendor for MA,CC application
- * Budget to assist with Rx procurement and follow-up appointment co-pays
- * Contract with transportation vendor
- * Self-care skill development with the support of DME, digital scales (bariatric and multilingual), automatic BP cuffs, and pill organizers

SUCCESSSES

- * Development of low cost Rx list on hospital intranet for prescribers
- * Collaborative partnerships with physician practices
- * Collaboration with onsite retail pharmacist to develop pulmonary inhaler and insulin third party reimbursement reference table
- * Use of “blister-pack” dispensing to improve medication adherence
- * 340-B pricing
- * Addition of Social Worker to program
- * Hosted SJ DSRIP Learning Collaborative September Mtg
- * Six Sigma project to enhance the treatment of HF patients
- * Readmission Reduction Committee
- * Monthly Nursing Orientation
- * Development of patient and provider Care Transitions brochures (available in Spanish)
- * Community outreach to Southern Jersey FQHC, Food Bank of South Jersey, Camden Coalition, and County Health Departments

CHALLENGES

- * Identification and enrollment of attributed patients
- * Socio-economic, psychological, and resource barriers
- * Healthcare coverage application for Charity Care or Medicaid application and timely notification of coverage decision

LESSONS LEARNED

- * Inadequate discharge process
 - * Transitions RNs fill gaps
 - * Reinforcement of education on diet, activity, medications
 - * Lean Six Sigma Project Heart Failure
 - * Nursing Practice Council standardizing discharge process
 - * Develop process to schedule follow up appointments
 - * Reserved appointment slots at Clinic
 - * Heart Failure Clinic appointments w/in 48 hrs
- * New Heart Failure Product Line Director
- * Heart Failure Clinic partnership with HHAs to administer IV diuretics
- * Transportation not a significant barrier

CLOSING WORDS FROM A RECENT VISITOR TO PHILADELPHIA

* “We all have the duty to do good.”

- Pope Francis

