



Newark Beth Israel Medical Center, a 673-bed regional care, teaching hospital established in 1901, provides comprehensive health care services to its local communities and is a major referral and treatment center for patients throughout the northern New Jersey metropolitan area.

- ❖ The Medical Center has over 300,000 outpatient visits and 25,000 admissions annually.
- ❖ More than 800 physicians
- ❖ 3,200 employees
- ❖ 150 volunteers

- ❖ One of two hospitals in New Jersey where heart transplants are performed
- ❖ The only hospital in New Jersey certified to perform lung transplants.
- ❖ The Medical Center has New Jersey's most comprehensive Robotic Surgery Center
- ❖ The State's first accredited Sleep Disorders Center
- ❖ The largest hospital-based dental program in New Jersey

- ❖ The Barnabas Health Heart Center at Newark Beth Israel Medical Center, which offers the best in cardiology services and cardiac surgery programs
- ❖ The hospital also offers the nationally recognized Pacemaker & Defibrillator Center; Frederick B. Cohen, MD, Comprehensive Cancer and Blood Disorder Center; The Center for Geriatric Health Care; and a Regional Perinatal Center, offering the highest quality maternity care for both normal and high-risk pregnancies

- ❖ Home to Children's Hospital of New Jersey, the state's premier children's health facility; Children's Hospital provides state-of-the-art care in nearly 30 pediatric subspecialties

Project 8: The Congestive Heart Failure Transition Program

- ❖ Population Criteria: CHF Patients with High Risk Stratification for Readmission
- ❖ Algorithms & Decision Tree: Data Mining Tool utilizing LACE Criteria, Socio-Economic Criteria & Polypharmacy
- ❖ Utilize Existing Staff: Multidisciplinary Staff, Leaders, MDs, Transition RN, Case Management, Social Work, etc.
- ❖ Utilize New Staff: APN run Transition Clinic, data analytics, dedicated pharmacist, new hires as pilot grows
- ❖ Partnerships: 3 Hospital Based Medical Homes
- ❖ Determine Education Method: Developed Project Specific Education Plan
- ❖ Procure Space: Clinic Space

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- ❖ Patient Supplies: Scales, pill boxes, etc.
- ❖ Technical Resources: including hospital based information systems and vendor systems
- ❖ Data needs: Utilizing existing data sources and possible vendor sources for data collection
- ❖ Marketing: Marketing materials in development both for internal and external communication
- ❖ Discharge Planning Tools: Created Discharge Checklist focusing on medication reconciliation and prescription needs
- ❖ Enhanced Care Coordination: NP run transitional clinic
- ❖ Patient/Care Giver Education: Booklet developed with self care skills included

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- ❖ Social Support: Case Management and Social Work are active partners in project
- ❖ Patient Self Care Skills Plan: In place with focus on nursing education on “Teach Back” Methodology
- ❖ Enhance Screening Tools: Implemented the Coleman Patient Activation Assessment
- ❖ Medical Home Plan: 3 Hospital Based Medical Homes are our partners
- ❖ Quality Improvement Plan is project specific and approved by Board of Trustees
- ❖ Patient Satisfaction Survey developed and will be implemented with each pilot project patient



Newark Beth Israel Medical Center
Children's Hospital of New Jersey
Barnabas Health

Project 8: The Congestive Heart Failure Transition Program

- ❖ Staff Education: Initial focus on “Teach Back” and “Medication Reconciliation”
- ❖ Project Staff educated and evaluated on effectiveness with project
- ❖ Initiate Pilot: We have seen our first patient in the Transition Clinic a debriefing was conducted, patient feedback obtained and will follow PDCA changes for next patient

PDSA: Scheduling Follow Up Prior to Discharge

Goal: Ensure compliance with scheduling and documenting specific follow up appointment prior to discharge

Data Source: Discharge Summary in Electronic Medical Record (EMR) for all patients seen by Transitional of Care (TOC) Team in June 2014

Findings: Of 28 patients seen by TOC Team, only 4 (14%) had actual discharge follow up appointment date documented. 96% included documentation with whom the patient needed to follow up and included statements such as' " see Dr. X within one week" which does not meet the intent of the indicator *Post-Discharge Appointment for Heart Failure*.

Plan / Do: Investigation revealed that staff did not understand the specificity of the requirement. The following was implemented, team was educated during the first week of July:

- On a daily basis, the Transitions of Care (TOC) staff will give the LINK concierge staff a list of patients who have been enrolled by the TOC team. The LINK person will meet with each in-patient, if a follow-up appointment is not already scheduled, they will:
 - Schedule a follow-up appointment with their PMD or cardiologist, or
 - Assist in finding and setting up with a PMD/medical office (Medical Home) to follow up with and schedule an appointment, including the outpatient practice partners, and
 - Document the appointment date, time and location in EMR system.
- During daily rounds, a member of the TOC team will
 - Confirm the follow up appointment with the patient, and
 - Write the appointment date and time in their Heart Failure Patient Guide (patient's self care skills plan) if it not already entered which will ensure discharging staff will have the information for entry into the discharge summary

Study: Review of July charts revealed 52% compliance; 15 of 29 patients seen had the specific documentation as required. Non compliance was equally spread across the 3 discharging units and equally across days of the week.

Plan /Do: Team will continue the process and re-measure August compliance.