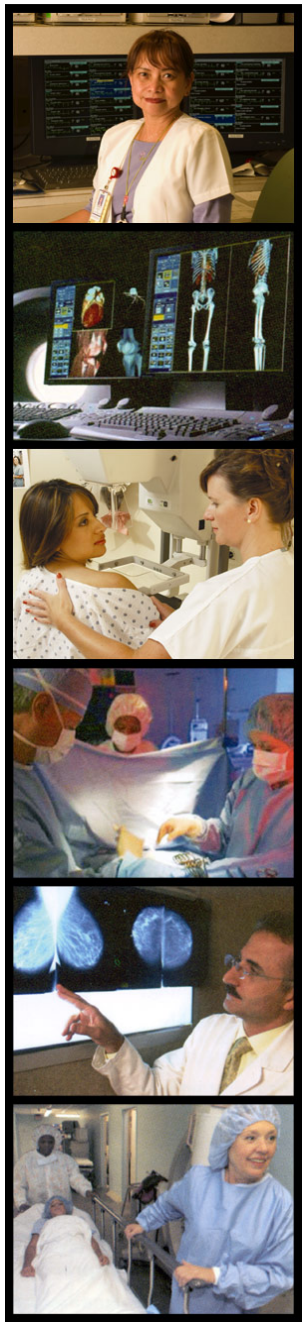

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# DSRIP Learning Collaborative 3 & 4
# Cardiac Care #1

## Care Transitions Intervention Model to Reduce 30-Day Readmissions for Chronic Cardiac Conditions


Presented by:

Annarelly “Annie” McNair

Project Leader


Thursday, August 14, 2014, 11:00am -12:00pm

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- Objective
  - To create and implement an evidence-based Care Transitions Intervention model for cardiac care. This includes the support of a Readmission Reduction Initiative (RRI) Committee and development and use of the Cardiac Care Transitions Team (CCTT) to assist in accessing prevention and follow-up treatment for patients experiencing chronic cardiac illness.

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- Goals and Outcomes
  - Increase patient understanding of their disease and medication management through patient self-management
  - Increase patient satisfaction through improved discharge planning
  - Improve care processes
  - Reduce readmissions of congestive heart failure (CHF) and acute myocardial infarction (AMI) patients

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- Project Interventions

**Comprehensive patient-centered health booklet**

- Symptoms and warnings of heart disease
- Self-management skills
- Medication tracking
- Discussion of family caregiver
- Care across the continuum: follow-up visits
- Questions for multiple health care providers
- Discharge Preparation Checklist

**Cardiac Transition Care Assessment Checklist**

- Process Evaluation

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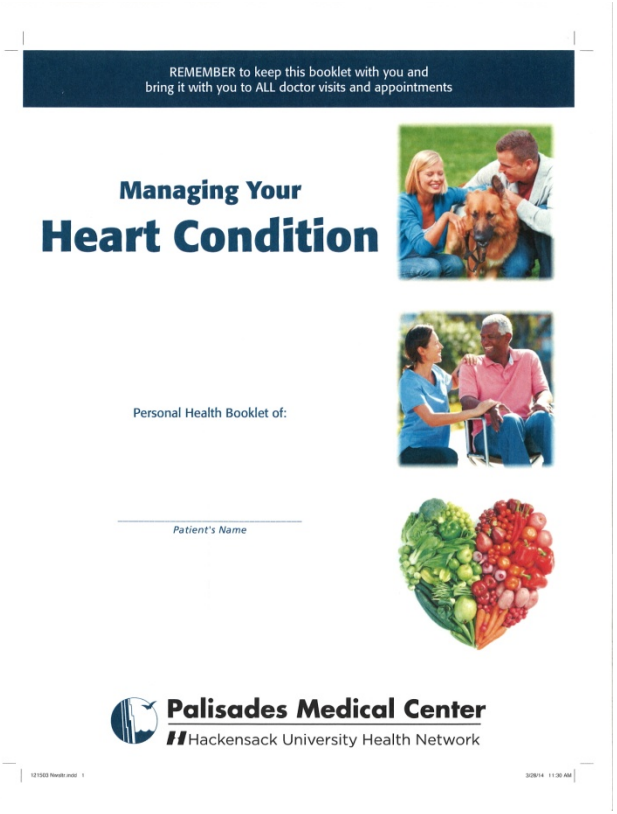
- Patient-Centered Booklet (English):



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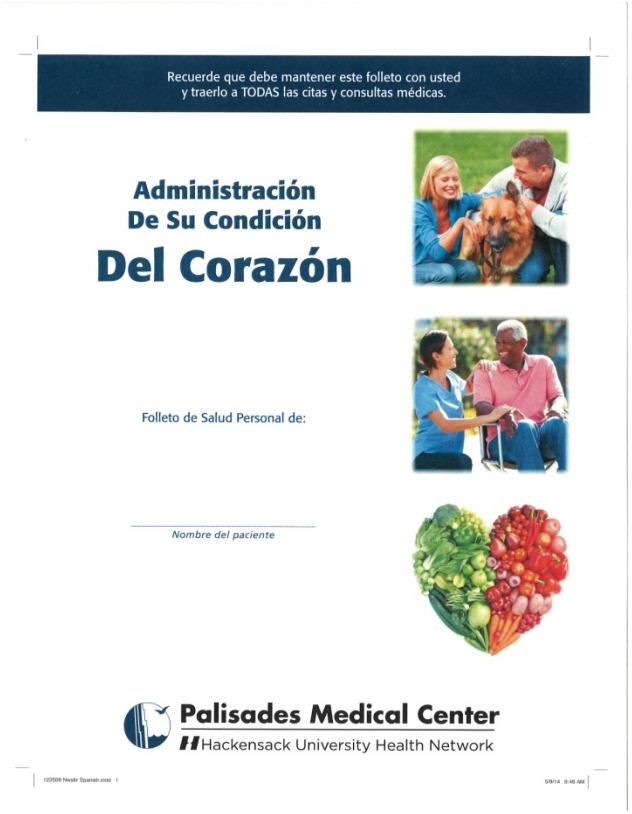
- Patient-Centered Booklet (Spanish):



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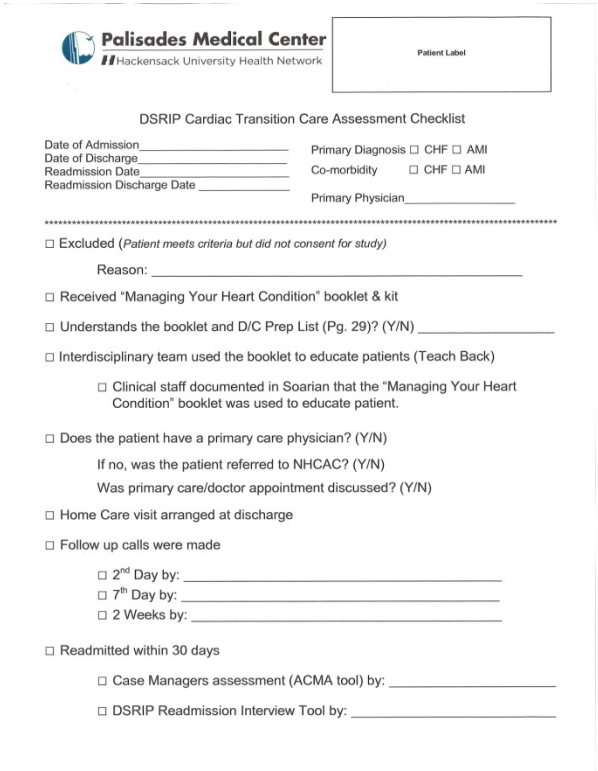
- DSRIP Cardiac Transition Care Assessment Checklist



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Patient Label

DSRIP Cardiac Transition Care Assessment Checklist

Date of Admission_____
Date of Discharge_____
Readmission Date_____
Readmission Discharge Date _____

Primary Diagnosis ☐ CHF ☐ AMI
Co-morbidity ☐ CHF ☐ AMI
Primary Physician_____

☐ Excluded (*Patient meets criteria but did not consent for study)*

Reason: _____

☐ Received "Managing Your Heart Condition" booklet & kit

☐ Understands the booklet and D/C Prep List (Pg. 29)? (Y/N) _____

☐ Interdisciplinary team used the booklet to educate patients (Teach Back)

☐ Clinical staff documented in Soarian that the "Managing Your Heart Condition" booklet was used to educate patient.

☐ Does the patient have a primary care physician? (Y/N)

If no, was the patient referred to NHCAC? (Y/N)

Was primary care/doctor appointment discussed? (Y/N)

☐ Home Care visit arranged at discharge

☐ Follow up calls were made

☐ 2nd Day by: _____
☐ 7th Day by: _____
☐ 2 Weeks by: _____

☐ Readmitted within 30 days

☐ Case Managers assessment (ACMA tool) by: _____

☐ DSRIP Readmission Interview Tool by: _____

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- Responses to July Survey
  - Yes, there is a team in place
  - Yes, we have a Quality Improvement Plan, currently getting updated
  - Working with home health agency, external partner, on ways to recruit patients and provide home visits
  - Hospital leaders are provided with updates on a weekly basis or as deemed necessary
  - We were in the planning stage, delayed due to patient Consent Forms

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- Responses to July Survey
  - 80% completion for Stage 1 activities
  - 0% completion for Stage 2 activities
  - No activities were changed
  - Manually tracking performance via checklist and progress via a Critical Path Schedule, as far as impact, there is no data to track yet
  - Greatest implementation challenge has been educating all nursing staff in a timely manner
  - Overcame this challenge by directly training staff on their floors

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- Responses to July Survey
  - Our notable success has been to utilize current vendor, StuderGroup, to assist us with additional follow-up calls that we will implement with the study
  - Lessons learned: that training physicians is going to be challenging and we would like to learn more about Transitional Care Management Services as an incentive for physicians
  - Summary: I met Andrew Thomas in the June 23rd meeting and I'm glad he was selected to co-chair our LC.

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- Project's Achievement to date
  - We began the Intervention Phase of our project in August and started recruiting patients for the study on August 4th
  - We are obtaining positive feedback from hospital personnel and so far, every staff member that I have encountered on the floors is aware of the DSRIP project

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- Project's Observations & Challenges
  - Challenge in identifying patients, since most come to the hospital with CHF and AMI as a secondary diagnosis
  - Recruiting non-compliant patients to the study