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
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.
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
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
Patient-Centered Booklet (English):
Patient-Centered Booklet (Spanish):

ADMINISTRACIÓN DE SU CONDICIÓN DEL CORAZÓN

Nombre del paciente

Palisades Medical Center
Hackensack University Health Network
Collaborating for Community Needs Assessment

- DSRIP Cardiac Transition Care Assessment Checklist

- DSRIP Cardiac Transition Care Assessment Checklist

  Date of Admission ___________________________ Primary Diagnosis □ CHF □ AMI
  Date of Discharge ___________________________ Co-morbidity □ CHF □ AMI
  Readmission Date ___________________________ Primary Physician
  Re-admission Discharge Date

  □ 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 Socran 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 NH-CAC? (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: ___________________________
  □ Re-admitted within 30 days
    □ Case Managers assessment (ACMA tool) by: ___________________________
    □ DSRIP Re-admission Interview Tool by: ___________________________
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
Collaborating for Community Needs Assessment

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
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.
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.
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