Pathway to achieving the Triple Aim.

DSRIP Journey through the good, the bad and the ugly.
Our Hospital
Our Team
Our Processes

The Good

Robert Wood Johnson University Hospital
* Robert Wood Johnson University Hospital is a 965-bed hospital with campuses in New Brunswick and Somerville.

* Robert Wood Johnson Health System is New Jersey’s premier health system of choice.

* Has more than 10,100 employees, 3,250 medical staff members and 1,733 beds.

* Currently has $1.5 billion dollars in revenue.
* Project Champion
* Project Leader
* PI coordinator
* Administrative Assistant
* Social Worker
* Pharmacist
* Dietician
* Palliative Care
* Clinical integration
* Reimbursement
* IT team
* Finance team
* PI team

Our Team
Members:
1. Project Director: - Andrew Thomas
2. Director Clinical Integrations: - Lois Dornan
3. Director Reimbursement: - Tina Ford
4. PI Coordinator: - Augusta Agalaba
5. Administrative Assistant: - Lilian Folks
6. Social Worker: - Arianna Illa
7. Pharmacist: - Laurie Eckert
* Patient Identification
* Patient Screening
* Patient Encounter
* Home Visit
* Clinic Visit
* Follow up Phone Calls
* IT Program identifies and generates a list of all low income patients that hits the ED in the previous 24 hours.
* List is sorted by Name, MRN, Age, Admit date, Diagnosis, Days since last discharge and payer.
* List is sent as an email alert to the DSRIP team at 7:05 AM daily.
*APN reviews each patient chart to identify patients to be enrolled in the program.

1. Pregnant patients are excluded
2. CHF or AMI
3. History DM and/or HTN
4. History of COPD or Pneumonia
5. Patients with LACE Score > 11
6. Patients with < 30 days since last discharged

**Patient Screening**
* APN visits each enrolled patient at the bedside to introduce the program, assess social needs and schedule follow up appointment at the Discharge Clinic.

* Social Worker, Dietician, Pharmacist and Palliative care team are consulted as needed.

* “Soft medical management” to ensure patient is discharged on the most appropriate medications.
* AMI and Heart Failure patients are seen at home within 24-48 hours of discharge by an APN.
* Patients without AMI/HF who are discharged to tertiary care facilities, are seen at that facility within 7 days by an APN.
* Patients without AMI/HF who cannot afford transportation to the Discharge Clinic are seen by an APN in the home within 7 days.
* Medication reconciliation
* Symptom check
* Patient teaching on diagnosis, red flags and expectations.
* Scales are provided to HF patients who do not have one.
* Medication reconciliation
* Reinforce education on disease processes and Red Flags.
* Assist with insurance or payer applications.
* Schedule and establish primary care follow up.
* Pharmacy and Social needs are addressed on site.
* Pertinent DSRIP data collected.

*Clinic Visits*
Follow up visits scheduled for:
- BP monitoring
- INR monitoring
- Lab reviews
* Every patient receives three weekly follow up phone calls, starting the week after clinic visit.
  * Status update

* Follow up Phone Calls
Language Barrier
Medication Affordability
Homelessness
Partnerships
Milestones and Timelines
Unintentional Paradox
The Money
Attribution list
Attribution list
The Ugly
Questions

Andrew.thomas@rwjuh.edu
(609) 529 8130