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

Diana Reid, APN.C, MSN, CCRN, CHFN
Cardiac Nurse Practitioner

Marie Perrino, RN
Transition of Care Coach
Raritan Bay Medical Center

- Location: Middlesex County
- 2 campuses: Perth Amboy and Old Bridge
- 501 Beds
- Specialties:
  - Primary Stroke Center: Stroke Bronze Award
  - Bariatric Surgery and Weight Loss Center
  - Joslin Diabetes Center
  - Center for Wound Healing
  - Center for Sleep Medicine
  - Center for Women
  - Center for Continence and Pelvic Rehabilitation
  - Human Motion Institute
Community Needs

- 36% community report high blood pressure
- 17% diagnosed with Diabetes
- Middlesex County among worst performing counties in NJ for diabetes care
- Middlesex county with highest primary cesarean section rates in NJ
- Perth Amboy with high teen pregnancy rate
- Diabetes rate in Perth Amboy is twice county rate
- Rising rate of renal failure in Perth Amboy
- High ED use rates in county
- High ED visit rates for Mental Health
Community Needs

- 55% restaurants are fast food establishments
- 15% did not complete high school
- English proficiency rates (21%) in Middlesex County are poorest in NJ
- Median income 47,696
- 78% population is Hispanic with Spanish as first language
- 15.2% unemployment rate
- 24% below poverty level
Care Transition Team

- APN
- 2 RNs: Transition of Care coaches
- Interdisciplinary team meets monthly
  - Dietician
  - Pharmacy
  - Social worker
  - Case management
  - Physical therapy
  - Community health nurse
Care Transition Process

- Daily Heart Failure List generated by nursing supervisor daily
- Coach meets with patient/family to discuss program
- Assess knowledge, PHR, discharge checklist
- MD appointment prior to discharge
- Weekly phone calls for 4 weeks (home, sub-acute, LTC)
  - Medication reconciliation, red flags, confirm follow up appt, daily weights, symptoms etc
- Home visit
Care Transition Process

- Tracking: scales, 1st phone call <72 hours, interpreter minutes, barriers, appointment made prior to discharge

- Performance improvement: Patient education chart review to ensure heart failure education complete and appropriate discrepancies with language
Successes

- Pilot started: 70 enrolled, 12 completed program
- Quarterly Transition of Care meeting with VNA and sub acute facility staff
- Partnership with Central Jersey VNA to perform home visits
- Created Red Yellow Green Zone card
- Created Transition of Care brochure
- Created Transition of Care Document for medical records
- Created spreadsheet for data tracking
- Performance measures completed??
Barriers

- Lack of administrative support
- Unknown future.....merger in process, no long term plan in place
- Language barrier  Limits ability to perform home visits
- Need social worker and PharmD
- Hospital staff works within a box....no ownership
- No project or reporting partnership with physician practice, clinic
- Low volume...high drop out rate 42%
- Patient Satisfaction Surveys
Future

- Visit skilled nursing facilities weekly to review patient plan of care and medications
- Create new heart failure education materials including calendar
- Joint venture with Jewish Renaissance Center for patient education sessions monthly
- Purchase scales
- Possible reporting partnership