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

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Transition of Care Coach

ANCC MAGNET RECOGNITION

Raritan Bay Medical Center

Advancing care every day

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