DSRIP – Cardiac Care Extensive Patient CHF-Focused Multi-Therapeutic Model

By: Elizabeth Moyano BSN RN
Director of PI and Quality
• St. Mary’s General Hospital is a community based medical center. It is the only hospital in Passaic and the closest ER to many of the surrounding communities.

• St. Mary’s General Hospital is a member of Prime Healthcare System family, which has been lauded as a “Top 15 Healthcare System” by Truven Health Analytics.
The Model the we chose:
DSRIP – Cardiac Care Extensive Patient CHF-Focused Multi-Therapeutic Model

• We use our Allscripts EMR and Crimson to identify our potential DSRIP CHF patients at the point they enter the ED. We are able to see if they have been readmitted within 30 days. Once identified at admission a team member will introduce him/herself to the patient and will educate the patient to the program.
We work in collaboration with our APNs, Case Management, Nutrition, Physicians and staff nurses to coordinate from entry to discharge. All education items, handouts, reminders appointments, DC instructions are all put into a discharge folder that the patient receives during admission so nothing is lost.
Patients are managed through a medical home model and are referred and seen by Patient Care. They also provide education communication and monitoring at home. Each patient receives a Welcome Package from Patient Care before they are discharged home. In the box there is a monthly pill box, a managing your medication guide, an appointment book, medication storage bag and hand sanitizer.
Patient Care’s CHF In Home Program provides:

• At home post discharge visits twice a week if needed for 3 weeks.
• Tele-monitor
• A scale that records daily weights
• Ongoing education on dietary, medication, weight and exercise.
St. Mary’s Post Discharge Clinic

- Patients are given an appointment within 3 days of discharge at our Post Discharge Clinic.
- We ensure the patients are compliant with their medications, diet and understand the need for self-monitoring of BPs and daily weights, this way they can manage their disease.

Goal:
- Reduce the need for emergent care and re-hospitalization
- Improves Quality of Life
- Reduction in total cost of care
Challenges:

- Patients do not answer the phone, or gave us the wrong number for follow up calls.
- Patients will make and accept the appointment but will not show up.
- Some patients have given the wrong address.
Goals for Next Improvement Cycle:

- To improve our no show rate.
- We are in the process of having a meeting to have a new PDSA and look at what other options we have to improve our patient’s compliance in showing up to their post discharge appointment.
• Thank You!