The Congestive Heart Failure Transition Program (CHF-TP)
University Hospital Fast Facts

- Independent academic medical center
  - Principal Teaching Hospital for New Jersey Medical School and School of Dental Medicine of Rutgers Biomedical and Health Sciences, Rutgers University
- New Jersey’s only public acute care hospital
- Level I Trauma Center
- NJ’s only Center for Liver Transplant
- TJC certification for advanced heart failure care
University Hospital Stats

- 519 licensed beds
- 549 Medical staff
- 3,373 employees
- 15,692 admissions
- 91,026 emergency room visits
- 171,909 outpatient clinic visits

- Fully Accredited by The Joint Commission
- AHA GWTG Gold Plus Awards in Heart Failure Care & Stroke Care [including Target Honor Roll]
- Health Grades Awards in Neurosurgery, Sepsis and Appendicitis Care
Outcomes

• Reduce Avoidable Readmissions for HF
• Reduce Avoidable All-Cause Readmissions
• Reduce Mean Admissions per patient
• Improve Medication Safety:
  – Accurate and timely medication reconciliation
  – Reduce medication adverse event occurrence
• Improve Patient Satisfaction
Key Drivers

• Use of Registry to manage population
• Medical home model
• Standardized care processes
• Patient self-management support
Population Criteria

CHF patients with high risk for readmission
Risk Stratification

- Risk assessment on admission which includes BOOST Tools – 8Ps and internal tools generated to address local population
- Internal HF discharge process and information from Re-Engineered Discharge (RED) for ensuring effective discharge process
Multi-therapeutic Medical & Support Team

Expand current staff to include a dedicated multidisciplinary team / PCMH

- MDs, APNs, Care Coordinators, Navigator, Pharmacist, Social Worker, Nutritionist, Rehab, etc.
Reporting Partnership

• Rutgers New Jersey Medical School Department of Medicine Faculty Practice
Education

• Patient / care-giver
  – Disease management book
  – 1:1 and group sessions
  – Teach back

• Staff
  – Familiarity with the project
  – Teach back
  – Medication management
Procure Space

Existing clinical space in the UH Ambulatory Care Building
Patient Supplies

Purchased scales, BP cuffs, pill boxes
Technical Resources / Data Needs

• Hardware in place for existing staff and ordered for new staff
• Software – EPIC
• NJ-HITECH for data management
Marketing

• Plan due by December 2014
Project Protocols & Interventions

• Discharge Planning tools
• Enhanced Care Coordination
• Patient / Care giver education
• Social support & referral
• Patient self-care skills (certified chronic disease self-management)
• Medical home plan
• Group visits
• Nutritional support
• Home visit plan
Quality Improvement

• Plan written - pending final approval
• PDSA projects outlined
  – IT to develop grouper to capture ICD9 codes for HF
  – Testing risk assessment tool
  – Testing enhanced care coordination process
Patient Satisfaction

• Existing HF survey modified to include transitions in care questions

• Use of CGCAHPS to balance bias of “home-grown” survey.
Pilot

• Planned implementation December 2014
Project Successes / Challenges

• Successes:
  – Recruitment of pharmacist, social worker and nutritionist
  – Completed quarter 2 goals

• Challenges:
  – Recruitment of dedicated staff (administrator, care coordinators, navigator)
  – Time management