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