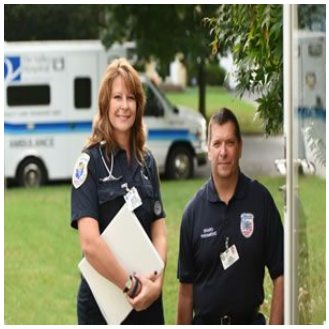
HealthManagement
Promoting Management and Leadership

Valley Hospital's Mobile Integrated Healthcare Program



An innovative program has been implemented at The Valley Hospital in Ridgewood, NJ that aims to reduce unnecessary emergency room visits and hospital stays. As part of the programme, teams comprising of a paramedic, critical care nurse and EMT will make house calls on heart patients soon after their discharge.

Lafe Bush, a paramedic and director of Emergency Services at Valley explains that patients with cardiopulmonary disease and especially those with heart failure and chronic obstructive pulmonary disease are vulnerable to re-hospitalisation. The chances of this happening are much higher during the transitional period after discharge from the hospital and their arrival at home. According to a study of Medicare data, the 30-day readmission rate nationwide for patients with heart failure is approximately 25 percent. Most of these readmissions occur within 15 days of hospitalisation.

The Mobile Integrated Healthcare Program will bring together Valley Hospital's Department of Emergency Services and Valley Home Care. It will provide post-discharge home check-ups to try and reduce readmissions.

The programme is expected to be launched in August 2014. It initially targeted heart failure patients but will now also include patients who have gone through the transcatheter aortic valve replacement (TAVR) as these patients have a high rate of readmission to the hospital. “Our TAVR patients often have multiple health problems, and their postop care can be very complex,” said Mary Collins, Supervisor of Cardiothoracic Surgery and the Cardiovascular Screening Program at Valley. “This unique service offers an advantage to these patients who are not only recovering from their heart valve procedure, but also must continue to cope with and manage their existing health problem. Early clinical assessment and appropriate intervention prevents complications and allows these patients to continue to recover at home.”

Patients with cardiopulmonary disease at high risk for readmission and who either decline or do not qualify for home care services will also be targeted.

The mobile team will provide a full assessment of the patient. This will include a physical exam, a safety survey of the patient's home, medication education, discharge instructions and confirmation of the patient's follow-up visit with his or her physician.

This new programme will complement Valley Home Care's comprehensive roster of services such as its nursing care, tele-management program, certified home health aides, diabetes support services and hospital-to-home care coordination. The goal of the programme is to ensure the patient is on the right path and is aware of the steps he needs to take to maintain his health.

The programme is part of Valley Hospital's continuum of care. Most of the hospital's patients are elderly with several medical problems and using a holistic approach with such patients is one of the many goals of this hospital.

Source: Valley Health Hospital

Image Credit: Valley Health Hospital

Published on : Thu, 23 Apr 2015