
Healthy Heart Program
University Hospital

What is the UH Healthy Heart Program?

It is a program designed to result in better care for individuals and better health for the population, including access to care, quality of care and health outcomes

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Program Goals

The overall goals of the Healthy Heart Program are:

1. Enhance access to quality health care
2. Accelerate meaningful improvement through intensive learning and sharing

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Why do we need the UH Heart Healthy Program?

- To improve transitions of care from inpatient to primary care services
- To strengthen a weak healthcare safety net
- To reduce healthcare inequalities and improve health care quality

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How are Heart Failure patients identified for Healthy Heart Program

- Patients **admitted** to UH with any diagnosis of heart failure [whether HF is the primary or secondary diagnosis]
- Patients **referred** from their PCP or other specialist via consult, tiger-text, in-basket
- Heart failure **clinic** patients
- **ED/Observation** patients with HF
- Patients on the HF registry
- Patients with the colored banner in EPIC indicating they are a Healthy Heart patient
- EPIC sends alert to the MD/APN when patient is in hospital (in planning stage)

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Healthy Heart – Medical Home Principles

1) Personal Provider
   - Each patient has an ongoing relationship with a personal physician and APN, who provide comprehensive, continuous clinical care
2) Physician-Directed Practice
3) Comprehensive Care
4) Coordinated Care
5) Enhanced Access to Care

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Physician-Directed Multidisciplinary Medical Home Practice

- Through the medical guidance of Dr. Pallavi Solanki, the Healthy Heart Team collectively ensures a comprehensive medical visit, transitioning from inpatient hospitalization to Ambulatory Care for all HF patients
- Our Team Members:
    - Team Leader: Pallavi Solanki, MD, FACC, Director, Advanced Heart Failure and MCS, Director, Healthy Heart Program
    - Business Manager: Lauren Singh
    - APN: Daisy Seby, APN, ACNP-BC
    - APN: Zabrina Lacqui, ANP-C
    - Pharmacist: Jeff Macaluso, Pharm D, BCPS
    - Clinical Care Coordinator: Patricia L. Jones, RN,CCRN,MPA,MSJ,NE-BC
    - Dietitian: Paulina Beristain, RDN
    - Patient Navigator: Dernsta Pierre, MSW
    - Social Worker: Danielle Friday, MSW, LSW
    - Ambulatory Care Technician: Natalia Rodriguez, ACT

Comprehensive Care

- The care team visits patients in both the inpatient & outpatient settings to provide individualized education and assistance for continuity of care
- Care team provides group sessions for patients to provide education on key topics such as:
    1) Substance Abuse
    2) Tobacco and its impact on Heart Failure
    3) Understanding Heart Failure
- Patients are given an appointment for follow-up care to the ambulatory care Cardiac Heart Failure clinic within 7 days of discharge

Heart Failure Clinics

- Tuesdays
- Fridays
- Heart Failure Walk-In clinic Monday - Friday
- Shared-Medical Visit
- 48 hr. automated phone call reminder and 24 hr. phone call by ACT/Patient Navigator prior to scheduled visit
- Follow - up calls are made 24 hrs. after a missed appointment

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Coordinated Care

- Risk assessments are conducted by the Clinical Care Coordinator on all HF patients.
- Referrals are provided to the care team for each patients based on the outcome i.e. pharmacist, social worker, and the nutritionist.
- Follow-up care is conducted in timely manner.
- Provider and Clinical Care Coordinator discuss patient risk factor prior to clinic visit to ensure patients receive a comprehensive visit.
- Letters will be sent to primary care providers advising of the program and the care provided.
- The Pharmacist sees every Healthy Heart patient during their visit and provides them with a comprehensive medication plan to ensure every patient has a clear understanding of their medication regimen.

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Committed To Quality and Safety

- Electronic medical records are the primary source for documentation for patient care.
- Patients are provided continued access to My Chart, their personal health record.
- They also receive the Healthy Heart Booklet, which provides more information on their medications, nutrition, and overall health.

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Patient Education

Patient Education Opportunities:

- Healthy Heart Booklet
- Daily medications schedule
- Ask Me
- Shared medical visit
- Group workshops
- 1:1 counseling
- Telephone
- Community outreach

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Enhanced Access

Patients have enhanced access to their physicians and their practices as a result of ***open scheduling and additional options for communication*** between patients, physicians, and staff.

Telephone access

(973) 951-0239

Call Center Scheduling

(973) 972-9000

Email address:

HealthyHeartProgram@uhnj.org

Benefits of the Healthy Heart Program

- Fewer ER visits
- Fewer hospital admissions
- Lower mortality rates
- Better preventive service delivery
- Better chronic disease management
- Higher patient satisfaction
- Patient Self Management

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Healthy Heart Program

Refer all your Heart Failure patients to our multi-disciplinary team today

Call us at **(973) 951-0239**

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Ambulatory Care Center
140 Bergen St.
Newark, NJ 07103

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