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Medical Center
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Positive Results from Patient Navigator 1.0

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Background:

Aurora BayCare Medical Center's (ABMC) participation in the American College of Cardiology's (ACC) Patient Navigator Program facilitated improvement efforts within the Congestive Heart Failure (CHF) and Acute Myocardial Infarction (AMI) populations. At the start of the program, ABMC was excelling with the ACTION Registry®-GWTG™ metrics, the CHF Performance measures, identification of both AMI and HF patients, and providing specific patient education. Conversely, areas that needed more attention included assessing the risk of readmission, prescribing the aldosterone blocking agent as appropriate, scheduling the 7 day follow up appointment for CHF patients, and ensuring the appointment was attended. Prior to implementation, there was no process in place to account for patients discharged on the weekends to ensure that the follow-up appointment was on their discharge paperwork, and there was also poor compliance with attendance at the follow-up appointment. Additionally, there was not a process in place to assess risk for readmission or to ensure patients were prescribed the aldosterone blocking agent. At ABMC, a Transition of Care Nursing position was created to address these metrics and lead the way in reducing CHF and AMI 30 day readmissions.

Methods:

The data was analyzed to address the scheduling of the follow-up appointment, and it was identified that patients discharged on the weekends did not have their appointments scheduled before they left the hospital. Using a multidisciplinary approach and partnering with the Cardiology outpatient clinic, a process was developed in which a phantom appointment is created for weekend discharges and appears on the patient's discharge paperwork. An algorithm was established to account for the step by step procedure for nursing to follow to ensure the patient would have a follow up appointment prior to discharge. This phantom appointment is made for the patient for the following Wednesday and the nurse leaves this message with the answering service so the Cardiology office is alerted Monday morning; if there are any conflicts the office will resolve this.

Furthermore, the HF patients who did not attend their follow up appointments were interviewed to identify any trends. Several factors emerged – patients revealed that they did not understand the importance of the follow-up appointment and they also related a lack of understanding of the CHF education given to them at time of discharge. To address the education, the Transition of Care Nurse position that was created is used to provide a more thorough review of education to patients and their

families. The Transition of Care Nurse then telephonically contacts CHF patients after discharge at specific intervals for 30 days to ensure that they are comfortable managing their care at home, stressing the importance of attending their appointments, arranging services as needed, and providing further education.

Assessing the risk for readmission was another opportunity to intervene upon. The need to have this process automated was evident. Soon after the start of the Patient Navigator Program, the LACE tool was embedded within the electronic medical record, EPIC, and the Transitional Care Nurse uses the LACE score to assess the AMI and HF patients with each admission.

With respect to the aldosterone blocking agent, ABMC continues to look at processes to increase compliance. Since the start of the program, data transparency is used, showing the benchmark data during monthly Committee meetings. In addition, once identified as an eligible patient, Quality and/or the Transition Care Nurse will send an inbox message through the electronic medical record with the recommendation for the medication to the attending physician.

Results:

The goals tied to the above metrics were all met aside from the aldosterone blocking agent. Aldosterone blocking agent for LVSD at baseline was 17%, and although there were 2 quarters where ABMC was at 50%, the final March data revealed 40% compliance, and the goal was to be at 45%. Incidentally, the compliance for this within the HF population increased significantly to over 85% from below 40% compliance.

Prior to implementation, compliance in scheduling a follow-up appointment within 7 days for CHF patients AND having it on the discharge paperwork was 74% at baseline. Post implementation of the phantom appointment, compliance has improved to 96.7% by March 2017 meeting the 95% goal. For the metric regarding follow-up appointment attendance, baseline data showed 40% compliance. After implementation, compliance has improved by 49% to 98% by March 2017.

Assessing patients for risk of readmission was not documented prior to the program; however, by the end of the program, 100% of both AMI and HF patients were assessed for their risk for readmission using the LACE tool.

Conclusions:

The significance of the Transition Care Nurse has become extremely apparent throughout the Patient Navigator Program. Utilizing this nurse was key in leading improvement efforts with intensive patient education and post discharge follow up. Lessons learned from the creation of the phantom appointment are spreading to be replicated in other high risk populations such as Stroke. The Transition Care Nurse team will continue to monitor and identify high risk patients for readmissions with the LACE tool, and

there will be an ongoing targeted effort at improving prescribing the aldosterone blocking agent for those eligible at discharge.

Ongoing collaboration between the Transition Care Nurse, Quality, and ABMC's multidisciplinary Committees and physicians will remain in place to maintain processes that have been proven successful, and develop new processes as opportunities are established.