Patient Navigator Program

Focus MI

Where Are We Now?

Patient Navigator Program: Focus MI

2 Years Later

Webinar #4

December 11, 2019

AMERICAN COLLEGE of CARDIOLOGY

Agenda

Time	Topic	Presenter
12:00pm EST	**Welcome and Introductions**	Susan Rogers MSN, RN, AACC
	Where Are We Now? Patient Navigator Program: Focus MI	
12:05	Overview	Julie Mobayed, MPH, BSN, RN
12:15	Patient Navigator Program: Focus MI Hospital Participants Sharing their Journey: Successes and Challenges -Improvements in Care	***Hardin Memorial Hospital*** *Jamie L. Wilkerson, MSN, MBA/HCM – Director of Cardiovascular Service Line* *Amber Shaw, RN – Clinical Data Coordinator* *Tresia Lee, RN – Case Manager* ***Memorial Hospital: University of Colorado Health*** *Melissa Barnes, BSHA Manager Clinical Quality* *Lisa Meyers BSN, RN Cardiovascular Coordinator Chest Pain Center*
12:45	**Q&A**	All
12:55	**Wrap-up**	Julie Mobayed, MPH, BSN, RN

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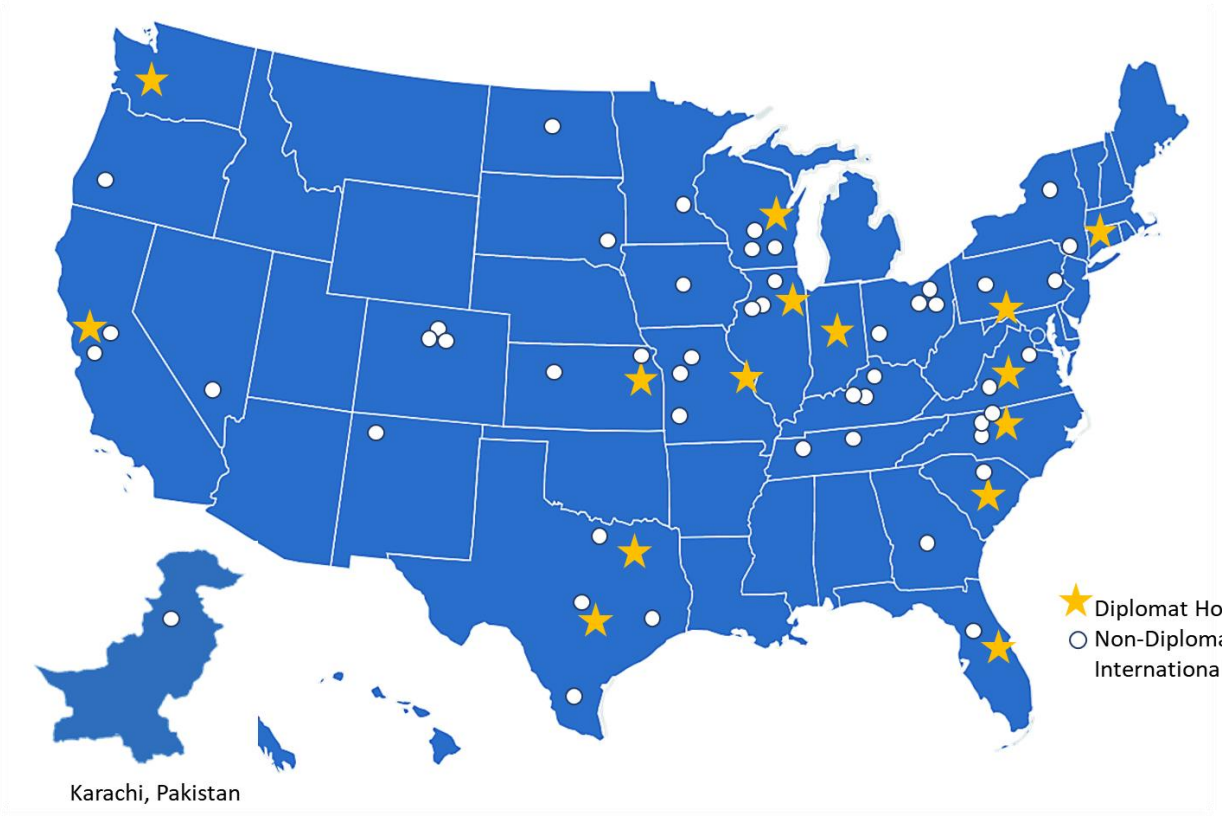
Patient Navigator Program: Focus MI Participating Hospitals 2 Years Later



Compendium of Best Practices

Strategies, Tools and Implementation
2 Years Later

Metric	Strategies/Tools Implemented
30-Day and 90-Day Unadjusted Readmission	• Readmission tracking tool to understand reasons for readmission. • Looking at social determinants and how they impact readmission rates. • Care Managers are taking on more responsibility with follow-up, risk assessment and education. • Specific disease medication cards created and used for targeted education.
Overall Defect Free Care/ Cardiac Rehab Referral and Attendance	• Standardized criteria and education • CR staff make initial patient visit while in hospital. • Connecting with CR centers within their communities. • Gym in the cardiac intermediate care unit, to exercise patients earlier. • Cardiac Rehab hours adjusted.
Revascularized Pts on P2Y12 D/C	• Consults flagged for Navigator, pharmacy, and dietary for F/U.
CABG patient on P2Y12 at D/C	• Improved documentation of treatment plan. • Improved collaboration w/cardiac surgeons

Let's hear from our Participants

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Patient Navigator Program - AMI

Jamie L. Wilkerson, MSN, MBA/HCM – Director of Cardiovascular Service Line

Amber Shaw, RN – Clinical Data Coordinator

Tresia Lee, RN – Case Manager

Hardin Memorial Hospital

- Acute care hospital with 300 beds located in Elizabethtown, Kentucky
- 75,000+ Emergency Room visits
  - Largest by volume in state

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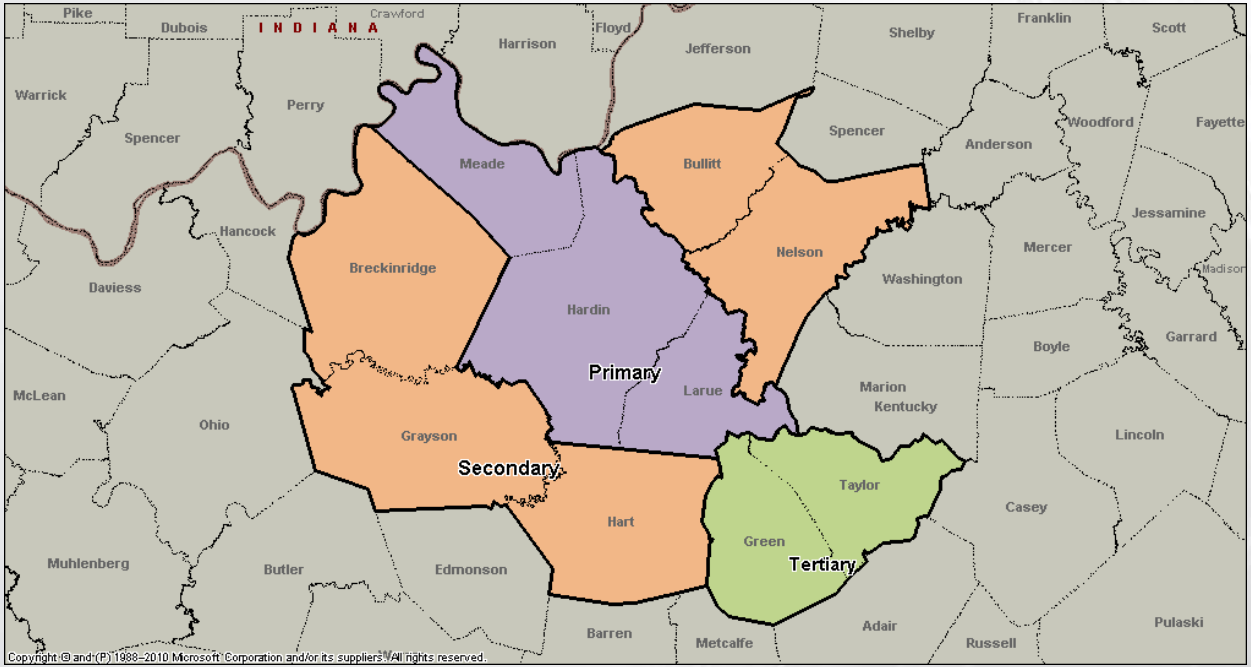
HMH Service Area



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Why HMH Chose to Participate

- AMI all cause readmission rates were noted to be higher than national average.

- Chief of Cardiology requested that HMH monitor all AMI patients.

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Primary Focus

- Concurrent Identification process to help facilitate education and discharge needs with the goal of reducing our readmission rates.

- Prior to participation with the Patient Navigator Program, HMH had AMI Bundles built into our EHR for the bedside RN. These addressed various cardiac medications received within 24h of arrival and at discharge.

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Facility Tracked Measures

5a – AMI patients assessed for risk of readmission prior to discharge

5b – AMI patients who are risk assessed for risk of readmission and have deployed interventions based on risk score

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5a – Assessed for Readmission Strategies Implemented

- Case Management Involvement
- Concurrent Process Developed – troponin list
- Updated EHR to facilitate documentation
- Education for Case Managers to review most current treatment of AMI patients
- Case Management collaborated with Cardiac Rehab to facilitate triggers

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5b – Interventions based on Risk Score – Strategies Implemented

- Standing orders
- Patient specific education
- PCP needs
- Financial needs
- Prescription Coverage
- Follow up phone calls
- Tele-monitoring

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Roadblocks Experienced/Underserved Populations

- Concurrent Identification of AMI patients – took several months working with our IT department to obtain an accurate Troponin list

- Missed Patients – no weekend coverage with case management and short staffed

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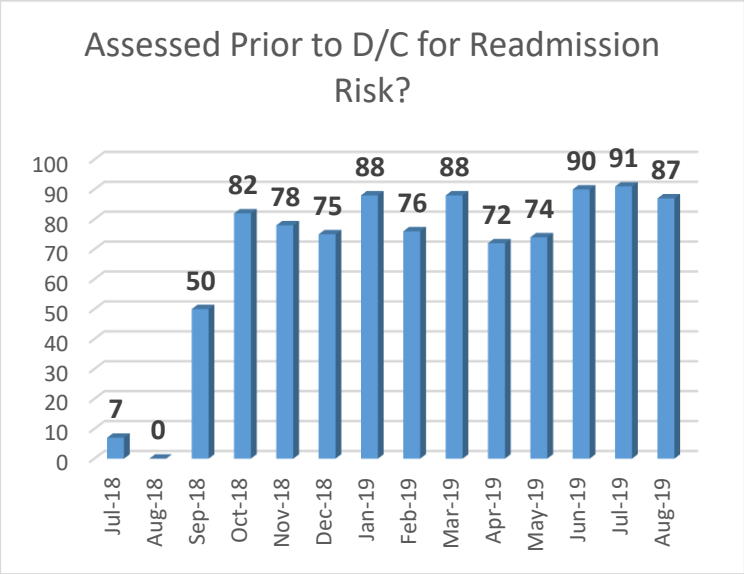
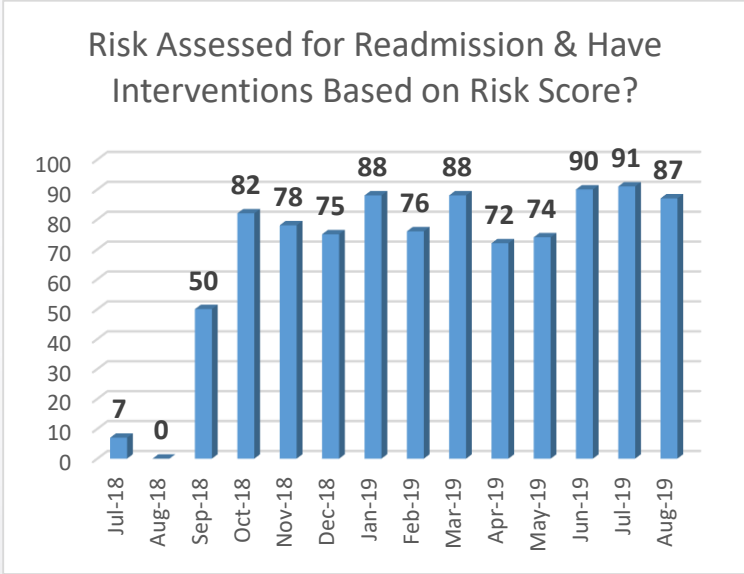
5a and 5b Data Improvement





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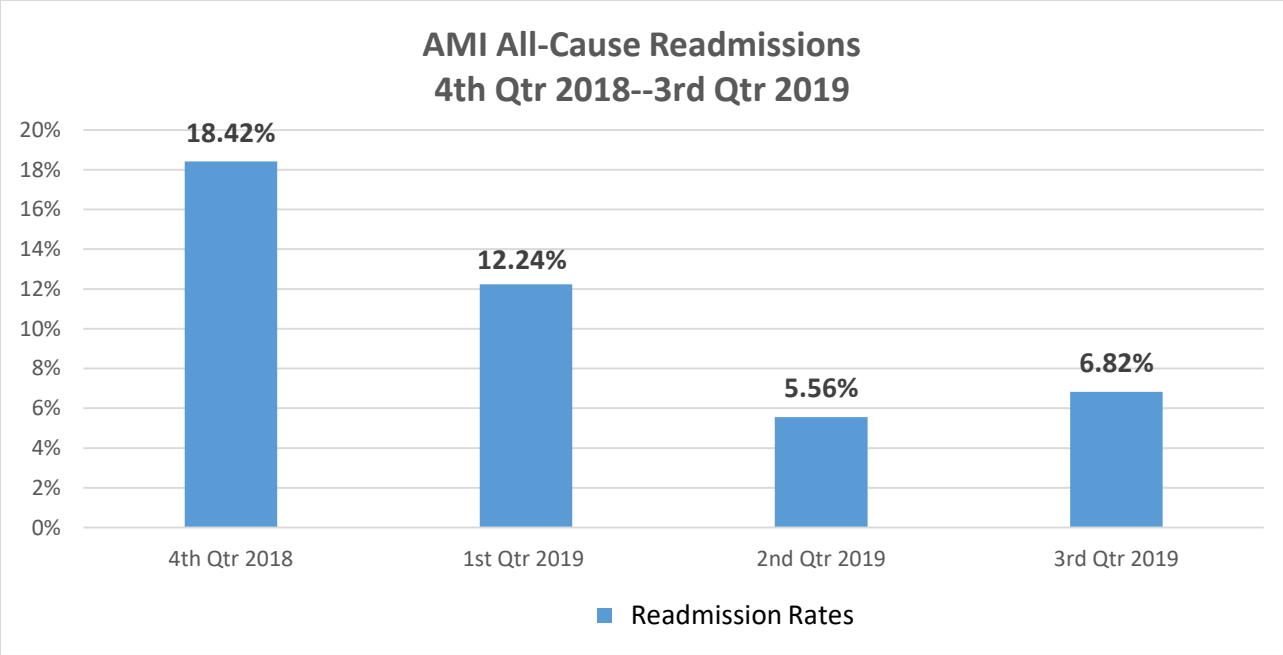
Readmission Rate Improvement



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Questions

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ACC Patient Navigator Program
Focus MI National Webinar

Lisa Meyers BSN,RN
Cardiovascular Coordinator – Chest Pain Center
UCHealth Memorial

Melissa Barnes, BSHA
Manager Clinical Quality

uchealth

UCHealth Memorial Hospital Colorado Springs

UCHealth Memorial Hospital serves El Paso County in Colorado Springs as well as surrounding areas which make up approximately 677,022 residents.

We are accredited or certified in the following areas: Chest Pain Center with PCI & Resuscitation, Atrial Fibrillation, Level 1 Trauma Center, Comprehensive Stroke Center, Get with the Guidelines Gold in Heart Failure.

We felt that participating in this program would allow us to review our readmission rates for the MI patient and take what we learn from this program to other disciplines so that we can lower our readmissions.

Benefits:

- We are reviewing each of our patients that come back as a readmission.
- We have seen a drop in readmissions for our AMI.
- Collaboration between **interested** parties.
- A review of our discharge process to make sure it is meeting the needs of the patients.

Top 3 Strategies Implemented

1. We will review readmissions with leadership to include –medical directors, CVSL director.
2. Work with departments prior to discharge for medications and home therapies.
3. Work with Nursing to identify patients that are at a high risk for readmission to make sure case Management is involved as well as social work.

Roadblocks Experienced

1. Our data- are we pulling our patients from the right place.
2. Are patients being coded appropriately.
3. Navigating through our EMR.
4. In order to better serve our underserved population, we need more buy in from case management.

How are we to continue and be better

1. Continue to work with leadership so they can help with roadblocks that discourage the importance of this program.
2. Work with the team to ensure that patients and family are getting appropriate education and medications prior to discharge. As well as an understanding of how important it is to follow up with their physicians.

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Metric for Patient Navigator -AMI

2019 Readmissions (related readmission, unplanned)													
	Jan	Feb	March	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
	Readmissions												
AMI Readmissions (IP)	1	2	1	1	2	0	1						8
AMI Discharges (IP, Prim Diagnosis)	43	43	64	56	63	35	35						339
AMI Readmission Rate	2.33%	4.65%	1.56%	1.79%	3.17%	0.00%	2.86%						2.36%

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QUESTIONS???

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Key Lessons Learned 2 Years Later

Best Practices -Important to share and learn from others

Data Collection -Build your teams, dedicate resources

Pharmacy -Integral part of the care team

What are we doing? -Understanding goals and reasons for change

Communication -Better team communication helps address issues before they become problems/readmissions

Collaboration -Physicians, communities

Automation –Improves processes

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Where do we go from here?

- Don’t Forget -The underserved population and the challenges this population presents
- Sustaining your Programs –Show and share your data
- Continuous Learning and Sharing
  - Listserv
- Promoting Your Work:
  - 2020 Quality Summit Poster Presentations

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Learning Network - Listserv

Join the Patient Navigator Community:

patientnavigatorfocusmi@lists.acc.org

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