Patient Navigator Program

Community Call 4- Cohort 1
February 24, 2016

Quality Improvement for Institutions

How this webinar is organized

Time	Topic
12:00pm	Welcome and Introductions
12:05pm	Readmission Risk Assessment
12:20pm	Q&A
12:25pm	Early Follow-Up
12:50pm	Q&A
12:57pm	Wrap-up and Next Steps

Quality Improvement for Institutions

Readmission Risk Assessment

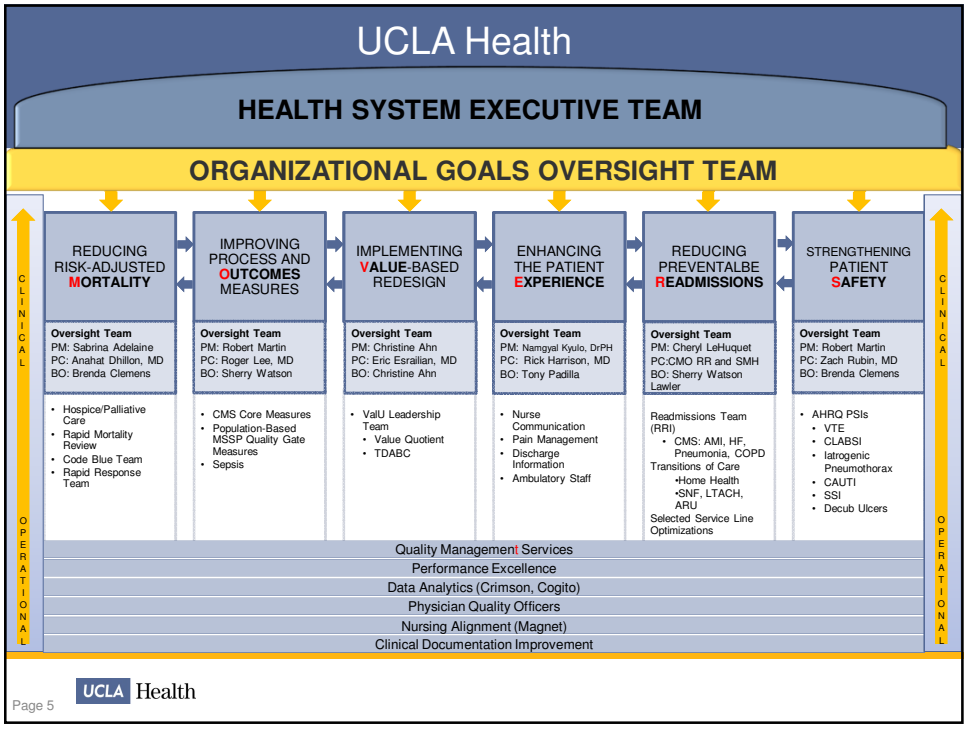
Ronald Reagan UCLA Medical Center

Anna Dermenchyan, BSN, RN, CCRN
Cheryl Le Huquet, MSN, RN

UCLA Health

Ronald Reagan UCLA Medical Center
Los Angeles, CA

UCLA Health



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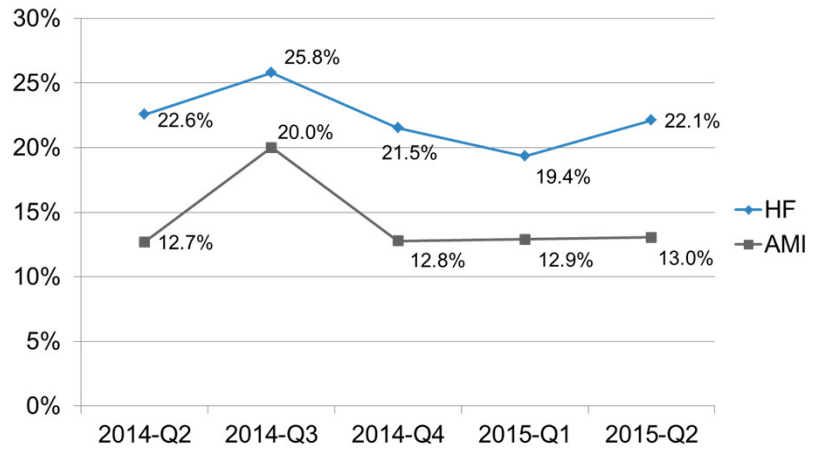
MOVERS Current Star Rating (UCLA Health):	Q2 2015 ***	* STAR 12 Points	** STARS 21 Points	*** STARS 25+ Points

MOVERS Dashboard	2014/15 Goals Threshold 1 Point	Target 2 Point	Stretch 3 Points	Site	Original Baseline[1] 2013	New Baseline[3] 2014	Quarterly Scores (2014/15 Goals) Q4 2014	Q1 2015	Q2 2015	Q3 2015
MORTALITY										
- Reduce Risk-Adjusted Mortality - RR 57/123; SM 20/131	.93 (50%)	.89 (40%)	.84 (25%)	RRMC	0.94	0.92	0.89	0.86	0.81	0.94
	.90 (50%)	.83 (40%)	.74 (25%)	SMH	0.87	0.74	0.77	0.69	0.55	0.75
OUTCOMES										
- CMS Core Measures (TJC Composite)	95.60 (50%)	96.36 (40%)	97.50 (25%)	RRMC	93.10	95.98	95.30	92.70	93.90	Pending
	95.60 (50%)	96.40 (40%)	97.50 (25%)	SMH	95.60	95.38	95.60	90.70	94.30	Pending
- Pop-Based MSSP Quality Gate Measures	30.00%	50.00%	90.00%	AMB	75.13	73.95	73.95	73.95	73.95	73.95
- HBIPS (Psychiatry)	89.00%	89.30%	89.50%	NPH	87.00	89.93	89.00	91.70	88.70	Pending
VALUE										
- A3 initiated/ongoing across service lines	5	7	9	ALL	N/A	3.50	6.00	10.00	12.00	8.00
- A3 implemented across service lines	3	5	7	ALL*	N/A	0.00	5.00	6.00	6.00	3.00
EXPERIENCE										
- HCAHPS: Nurse Communication	79.30 (50%)	79.90 (55%)	80.50 (60%)	RRMC	72.80	76.80	79.60	77.50	80.30	80.20
	79.30 (50%)	79.90 (55%)	80.50 (60%)	SMH	72.20	77.73	78.50	80.90	79.50	78.00
- HCAHPS: Pain Management	71.60 (50%)	72.20 (55%)	72.80 (60%)	RRMC	68.10	71.48	74.10	71.40	73.80	72.30
	71.60 (50%)	72.20 (55%)	72.80 (60%)	SMH	65.80	72.08	71.10	68.00	67.00	73.00
- HCAHPS: Discharge Information	86.20 (50%)	86.80 (55%)	87.20 (60%)	RRMC	85.70	85.53	85.40	75.70	87.10	86.70
	86.20 (50%)	86.80 (55%)	87.20 (60%)	SMH	82.20	82.35	82.50	81.80	86.50	84.40
- PAS Medical Group (Office Staff Composite)	67.97 (40%)	69.36 (50%)	70.89 (60%)	AMB[2]	64.40	69.40	69.40			
- CG-CAHPS: Helpful, Courteous, & Respectful Office Staff	90.00 (25%)	91.00 (30%)	91.50 (35%)	AMB[2]	89.24	89.84	90.46	91.02	90.65	91.25
READMISSIONS										
- Reduce Preventable Readmissions - Q2 2014	11.51 (50%)	11.15 (40%)	10.04 (25%)	RRMC	12.09	11.74	11.59	10.97	11.24	12.67
	11.51 (50%)	11.15 (40%)	10.04 (25%)	SMH	10.47	10.17	10.30	10.47	9.78	10.19
SAFETY										
- Strengthen Patient Safety - RR 9/132; SM 1/131	.85 (50%)	.80 (40%)	.72 (25%)	RRMC	0.82	0.73	0.52	0.66	0.57	0.70
	.81 (50%)	.77 (40%)	.71 (25%)	SMH	1.02	0.71	0.78	0.52	0.53	0.68
MOVERS Points (UCLA Health):					9	20	19	28	27	20

30-Day HF and AMI Readmission Rate

Ronald Reagan UCLA Medical Center



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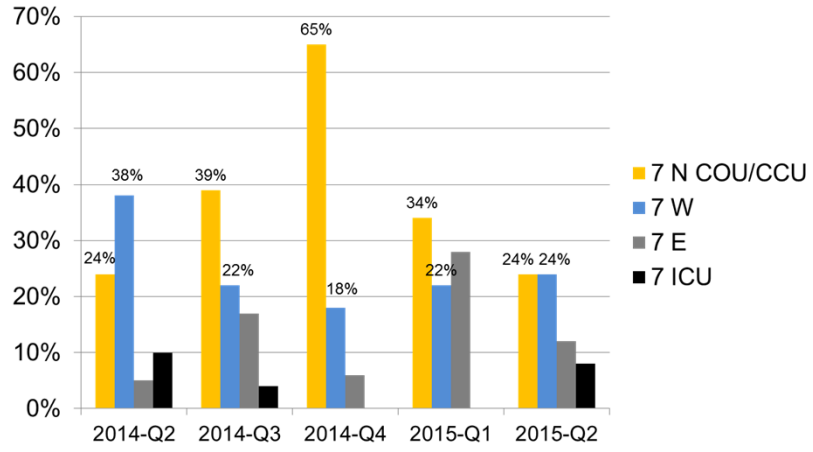
Data Source: UHC 2015 Risk Model

30-Readmission Rates by Unit

Heart Failure Service Line – Ronald Reagan UCLA Medical Center



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Data Source: UHC 2015 Risk Model

CMS Heart Failure Readmissions

Prior to the Navigator Program

Problem Statement	CHF readmission rate is 24% in Ronald Reagan and 20% in Santa Monica for Q4 2012 - Q3 2013 (all payer).
Key Finding	Of the cases readmitted for CHF, 32 of the 56 cases had one or more identified opportunities for possible readmission prevention from the areas of medication, diet, follow up, or more frequent follow up.
Recommendation	Standardize Heart Failure education in the following areas for all patients discharged from the hospital: • Medication • Diet / Nutrition • Follow-up appointments

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HF/ AMI Readmission Committee

& the ACC Patient Navigator Program Team Charter

Charge	To reduce avoidable hospital readmissions by providing personalized support to patients diagnosed with: • Acute Myocardial Infarction • Heart Failure
Guiding Principles	• Use data to understand all causes of AMI and HF readmissions at Ronald Regan Medical Center • The data will drive our interventions and improvements in quality
Goals	• Develop and apply patient-centered solutions that address functional disabilities, stressors, and other challenges confronting AMI and HF patients that increases these patients' risk of readmission.
Navigator Identified Opportunities for Improvement	• **Risk Model to identify high risk of readmissions prior to discharge** • Verifying follow-up appointments are documented in the medical record – 7-day follow-up appointments for all patients – Follow-up visit for cardiac rehab (MI patients) • Identify AMI and CHF patients to be part of our committee and give us timely feedback • Education (e.g. teach-back) and documentation – Treatment regimen (self-care plan) and when to call their health provider – Documentation of all prescribed medications and instructions on when and how they should be taken, and about any changes to medications – Community resources for patients • Performance and documentation of medication reconciliation

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LACE-PCDA at SMH

Anchoring Efforts in Team Approach- formed a cross-functional team

RNs / MDs	Pharmacists
Care Connect	Case Managers/Social Workers
Physical Therapy	Dietician
SNF	QMS & Many others….

"This is hard work, but the right thing to do!"

Success will not be measured in penalties, but in overall improved community health

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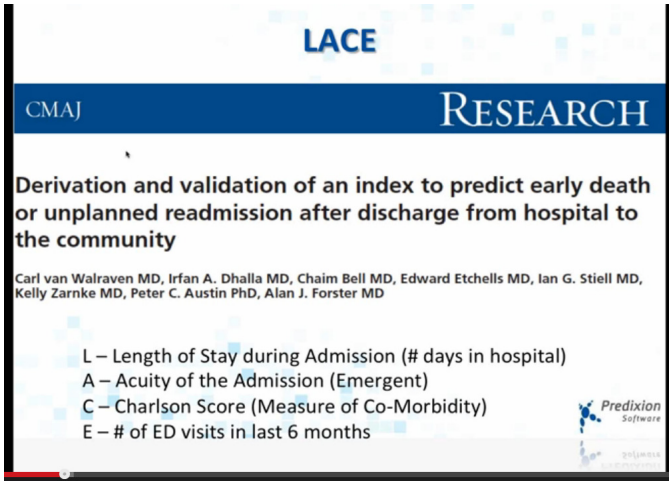
LACE-PCDA



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Strategies in Response to LACE Score

- Identify patients At Risk for Readmission
- Improve self-management skills
- Coordination of care along the care continuum
- Adequate follow-up and community resources

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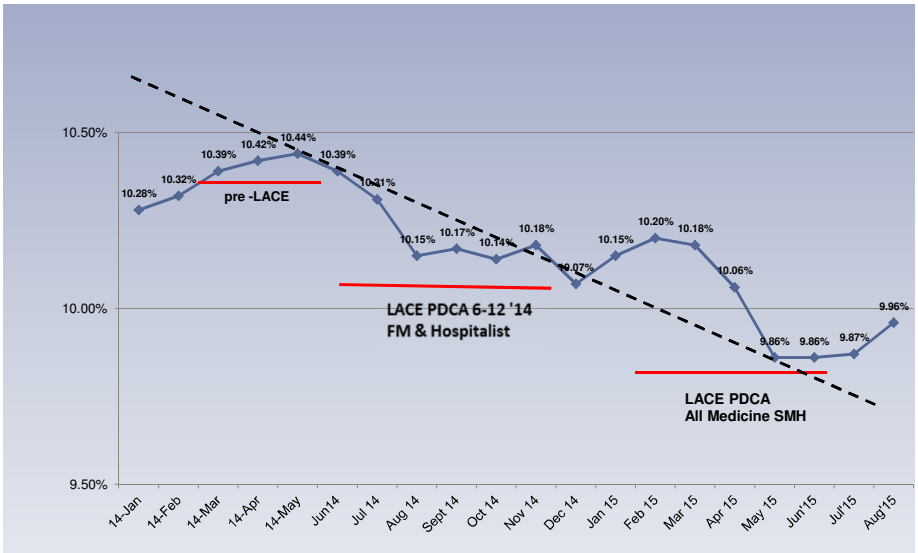
SMH Readmission Rate Rolling 12 months



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CCU/COU LACE Scores
September - November, 2015

	Total	Low	Medium	High	% of High
September	62	11	24	27	44%
October	76	7	40	29	38%
November	99	11	38	50	51%

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Heart Failure/AMI

LACE Risk Stratification Score & Bundled Interventions

RR HF & AMI Patients

Interventions	At Risk (LACE score)			Responsible
	Low (0-6)	Med (7-10)	High (≥11)	
Standardized D/C Summary (AVS)	X	X	X	UC-wide Initiative
Medication Reconciliation	X	X	X	MD/Pharm
Update Medication List	X	X	X	RN
Physical Therapy Consult (1st phase of cardiac rehab)		X	X	Physical Therapy
Social Work (Family Care/Complex Case Conference)			X	Multi-Disciplinary
Pharmacy 1:1 Teaching (Meds to Beds Program)		X	X	Pharmacy
Case Management 1:1 Teaching (Order Home Health, CCTP)			X	Care Coordination
Nutrition 1:1 Teaching			X	Dietary
Post Hospital Follow Up Visit with Physician	≤ 5 days	≤ 5 days	≤ 3 days/ Home Health RN	Dept. Staff/ Residents
Palliative Care (PRN)				

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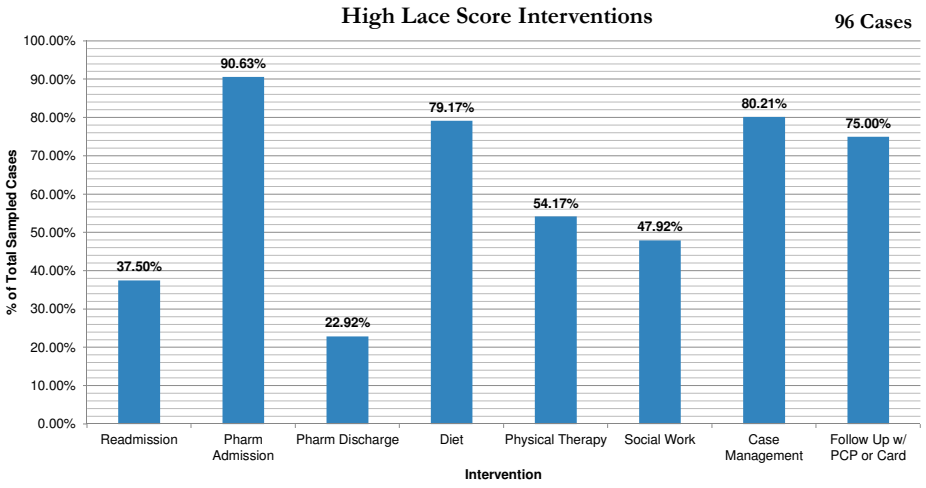
LACE Interventions: 9/15/15-11/30/15



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Visual Management

LACE Score ≥ 11 ☐ Yes ☐ No		
Care Coordination		Completed
PT Consult (MD order needed)		☐
Pharmacy 1:1 Teaching		☐
Social Work Consult		☐
Case Management Consult		☐
Nutrition Consult		☐
Follow Up Visit Scheduled (AVS)		☐
Nursing Interventions		Completed
Day 1	Education assessment/identify primary caregiver	☐
Day 2	Education: diagnosis/condition, medications & self-care (TEACH BACK)	☐
Day 3		☐
Discharge Day: AVS reconciliation		☐

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Physician Reminders

LACE Score ≥ 11

- ✓ **Document comorbidities in CareConnect Problem List**
- ✓ **Place an order for Physical Therapy and Home Health**
- ✓ **Place discharge medication orders to the UCLA outpatient pharmacy 24 hours prior to discharge**
  - This ensures 1:1 pharmacy teaching for patients.
- ✓ **Post hospital follow up visit with a Cardiologist or PCP within 3 days**
  - Request appointment on Friday if the patient will be d/c on the weekend.
  - STAT request: appointment will be scheduled prior to patient discharge or within 24 hours of patient discharge on business day.

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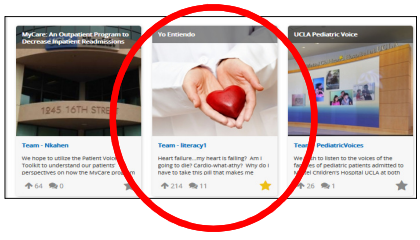
Help reduce readmissions for our AMI/HF patients!

The Patient Voice Contest

The "Yo Entiendo" Patient Voice journey was designed to help us better understand the health disparities related to health literacy and cultural barriers faced by our Spanish-speaking heart failure



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Putting the Patient's Voice into Action

The Process:

1. Patient interviews
2. Map interview findings
3. Synthesis session
4. Ideation session

The Outcomes:

1. Cultural competency training
2. Interpreter services and communication

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Shark Tank – The Bridge… across linguistic and cultural gaps

- The goal:
  - Bring awareness / identify other groups with similar experiences
  - Find a champion for this cause
- Linguistic and cultural barriers, which ultimately prevented providers from delivering true patient centered care – speaking to patients in their *preferred language*?
  - Lack of resources to provide culturally competent care
  - Barriers to utilizing the phone interpreter services
  - Questionable accuracy of preferred language in Care Connect
  - Only 55% of physicians and 41% of nurses requested a qualified interpreter

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Thank You!

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Q&A

Patient Navigator Program

Please submit your questions for the moderated question and answer session.

Quality Improvement for Institutions

Indiana University Health

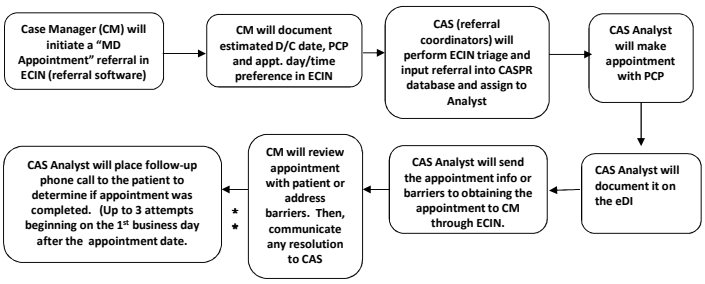
Coordinating Post-discharge Appointments

February 24,2016

Background

- Post discharge appointments are recognized as an effective intervention to manage readmission risk
- The administrative burden to the RN Case Manager scheduling post-discharge appointments is untenable
- Readmission Risk Assessment implementation helped quantify the need for the intervention
- LEAN event further defined the need with beginning steps of process development.
- Pilot go-live in January 2015

Follow-Up Physician Workflow



Scope:
- 11 units for patients discharging home at IU Health Methodist and University. Expand as staff resources allow
- Prior to discharge, obtain and document on the eDI (electronic discharge instructions) a PCP follow-up appointment within 5-7 days of discharge

Goals:
- Increase the number and percent of appointments on the eDI in the 5-7 days range.
- Gather data on completion of the PCP appointments
- Reduce readmission rate

Foreseen obstacles:
- Weekend admission/discharges
- Staffing

Lessons Learned

- Process needs to be driven by the Case Manager/Discharge Planner to avoid wasted resources, man hours
- Essential to validate anticipated discharge date, discharge disposition, and physician (PCP or Specialist) at the time the appointment request is submitted
- Use existing tools, software, and processes especially if they can be modified to enhance the process
- Solidify process steps to assure discharge instructions are reviewed with patients adequately to increase adherence
- Develop scripting to encourage patient buy-in. For example, many times this short notice appointment (5 – 7 days) is not convenient for the patient/family so staff (RN, CM, etc.) need to take extra time to clarify the clinical need due to disease process. This can improve patient attendance at the 'inconvenient' appointment.
- Process is win/win for patients and case managers!

Project Outcomes

Indiana University Health

2015 CAS Projects		Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	YTD
Methodist	MD Appointments Sent to CAS	63	45	107	159	179	285	188	264	252	438	392	495	2867
	MD Appt Scheduled	37	41	91	140	156	226	166	244	233	359	327	410	2430
	MD Appt Completed	14	15	47	57	77	110	78	98	99	160	150	137	1042
University	MD Appointments Sent to CAS	0	0	4	40	24	26	33	29	32	32	31	19	270
	MD Appt Scheduled	0	0	3	34	16	25	27	26	25	22	26	15	219
	MD Appt Completed	0	0	2	10	4	10	6	7	10	11	12	3	75
Total	MD Appointments Sent to CAS	63	45	111	199	203	311	221	293	284	470	423	514	3137
	MD Appt Scheduled (5-7 days)	20	34	61	116	121	150	133	172	168	263	146	170	1554
	MD Appt Scheduled (All)	37	41	94	174	172	251	193	270	258	381	353	425	2649
	MD Appt Completed	14	15	49	67	81	120	84	105	109	171	162	140	1117
	MD Appt Sch/MD Appt Sent(5-7 days)	32%	76%	55%	58%	60%	48%	60%	59%	59%	56%	35%	33%	50%
	MD Appt Sch/MD Appt Sent(All)	59%	91%	85%	87%	85%	81%	87%	92%	91%	81%	83%	83%	84%
	MD Appt Comp /MD Appt Sch	38%	37%	52%	39%	47%	48%	44%	39%	42%	45%	46%	33%	42%

VCUHealth

Cardiology Navigator Program: Shared Medical Appointments

Nicholas Fischetti MS, RD
Corey Reed BSN, RN, CHFN
Amy Patton BSN, RN, PCCN
Megan Maltby MSW
Patricia Uber PharmD
Sarah Paciulli MS, RN, NP

February 24, 2016

Agenda

1. About VCU Medical Center
2. Our Team
3. Outpatient Shared Medical Appointments
   - Structure and logistics
   - Benefits
   - Barriers
4. Next Steps
5. Questions

VCU Health System - 36,000+ admissions and 630,000+ outpatient visits

- MCV Hospitals
  - 805 licensed acute care beds
  - 89,000 emergency department visits, which is the region's only Level I Trauma Center
  - ~900-Heart Failure admissions per year
- VCU Community Memorial Hospital
  - 99 licensed acute care beds
  - 161 licensed long-term care beds

- MCV Physicians
  - ~700-physician, faculty group practice
  - Provides all teaching and training for medical students and residents
  - Major funding source for the VCU School of Medicine
- Virginia Premier Health Plan
  - 189,000 member Medicaid Health Plan

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Our Team

From left to right: Amy (Nurse navigator); Megan (Social worker); Sarah (NP): Nick (RD); Corey (Nurse navigator); Patty (Pharmacist)

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Where we started

27.06% Readmission rate

48th out of 50 for UHC hospitals

Shared Medical Appointment

- For patients and caretakers
- Started end of July 2015
- Located onsite
- Once a week from 1-3 PM
- Recruitment sources:
  - Inpatient
  - Outpatient clinics
  - Flyers
  - Information boards

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Class Flow

Arrive
- Checked in
- Vitals obtained by care partner

Class
- NP visits conducted simultaneously
- Leader presents topics with other providers present to help

Depart
- Passports signed
- Graduate certificates presented
- Checked out and scheduled for next class

VCUHealth

Class Curricula

Nutrition: Nicholas Fischetti	Pharmacy: Patricia Uber	Physical Exercise: Corey Reed	Self Care: Amy Patton
Overview of HF & nutrition	Learn common HF drugs	Benefits of exercise	HF BINGO!
Sodium & Fluid restriction	Uses	How to get started	Variety of topics
Shopping/Cooking	Side effects	Overcoming barriers	Prizes awarded
Best Practices	Best Practices	Best practices	Best Practices

- 4 classes total
- Can be completed in any order
- All providers present to answer questions on other topics

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Benefits and Barriers

Benefits

- Patient involvement and participation
- Learn from one another
- Patients want more (ex. Monthly support group for graduates)

Barriers

- Scheduling and timing
- Permanent location
- Parking and transportation

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Next Steps

- Clerical support for scheduling and reminder calls
- Opening up 2nd clinic in the morning
- Developing low literacy education materials
  - Hands on cooking demonstrations
  - Fitness trackers
- Expanding monthly support group

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"It's amazing what you can accomplish if you do not care who gets the credit."
-Harry S. Truman

Submitting Questions

Patient Navigator Program

Please submit your questions for the moderated question and answer session at anytime during the webinar.

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Upcoming Calls and Webinars

ACC. 16

- Patient Navigator Program Hospital Dinner Meeting- April 1
  6:30-9:00pm CT in Chicago, IL

Cohort 1:

- Community Call 5: Wednesday, August 10 from 12-1pmET

Webinar 4: Wednesday, May 11, from 12-1pmET

Webinar 5: Wednesday, November 9th from 12-1pm ET

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Thank You!

Patient Navigator Program

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