Patient Navigator Program

Community Call #2- Cohort 2
July 22, 2015

Community Call Agenda

Time	Topic
12:00pm	Welcome and Introductions
12:00pm -12:15pm	• Cardiac Rehab Referral
12:00pm	*Lynchburg General Hospital*
12:15pm	Q&A
12:20pm -12:50pm	• Identifying High Risk Patients
12:20pm	*Indian River Medical Center*
12:35pm	*Newark Beth Israel Medical Center*
12:50pm	Q&A
12:55pm	Wrap-up and Next Steps

Submitting Questions

Patient Navigator Program

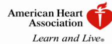
Please submit your questions for the moderated question and answer session into the chat box at anytime during the webinar.

Quality Improvement for Institutions

CENTRA

Cardiac Rehab

Cindi Cole BSN RN CCPC
Gordon Vordermark BSN RN
7/22/2015



Eligibility

Any patient who has had a cardiac event, i.e. AMI, PCI, CHF, CABG

Referral Process

- **Automatic EMR physicians order for MI/PCI patients**
- **CHF patients referred from CHF Outpatient Clinic**
- **Referral order entered by cath lab staff for patients who receive a cardiac catheterization without intervention**
- **Presentation conducted for cardiologists reinforcing the benefits of patient participation in cardiac rehab**
- **Follow up phone calls after discharge from cardiac rehab staff to enroll eligible patients in the program**
- **Constant Reinforcement to Cardiologist to refer**

Benefits

- Increase functional capacity
- Decrease or alleviate angina symptoms
- Reduce Disability
- Improve quality of Life
- Modify coronary risk factors
- Reduce mortality (21% to 34% lower in patients who participates in cardiac rehab)

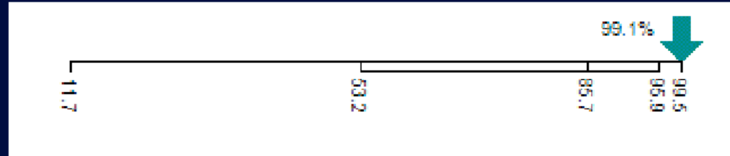
Centra Programs

- Phase II – located at Cardiologist Office
- Phase III – located at local YMCAs
- Phase IV – located at local YMCAs

NCDR

ACTION Registry – GWTG

Cardiac rehabilitation patient referral from an inpatient setting



My Hospital R4Q	US Hospitals 50th Pctl	US Hospitals 90th Pctl
99.1%	85.7%	99.5%

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AMI Disease Specific Certification by The Joint Commission

Performance Measure -

Cardiac Rehab Referral

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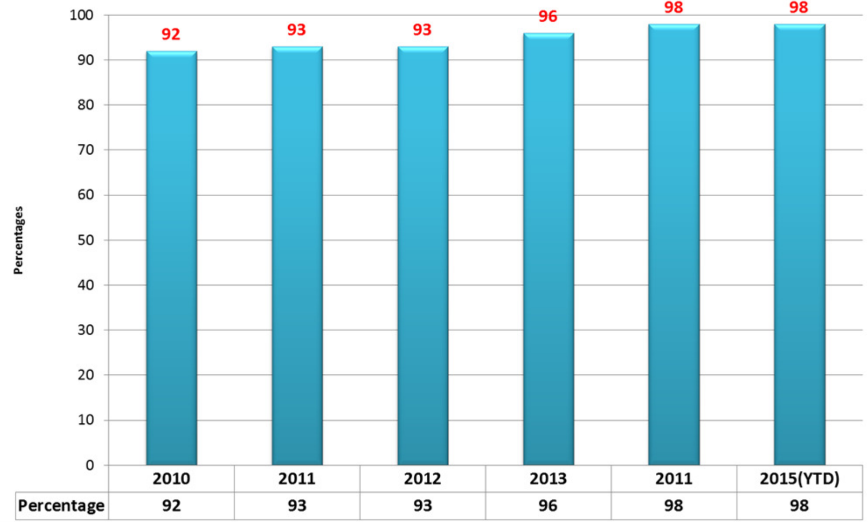
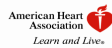


	2010	2011	2012	2013	2011	2015(YTD)
Percentage	92	93	93	96	98	98



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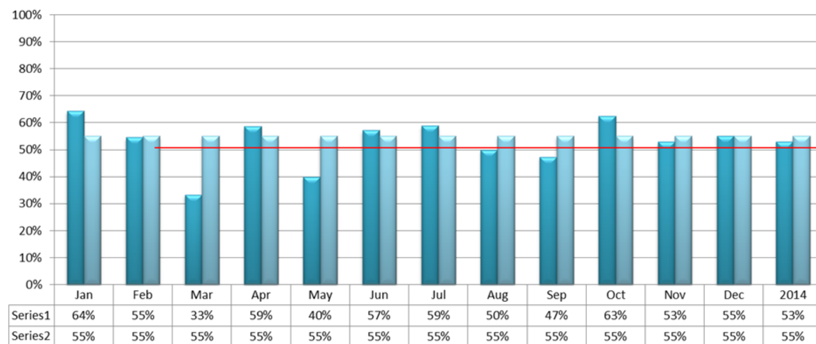
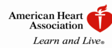


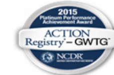
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2014
Series1	64%	55%	33%	59%	40%	57%	59%	50%	47%	63%	53%	55%	53%
Series2	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%	55%

CHF Cardiac Rehab Referrals

43 referrals from CHF Clinic and 32 patients participation 2015 (YTD)

71%





Cardiac Rehab Satellite Program

- **Centra Gretna**
- **Centra Bedford**
- **Centra Southside**
- **Halifax Regional**

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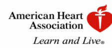
Barriers

- **Cost**
- **Distance**
- **Transportation**
- **Lack of Motivation**
- **Lack of Interest/Refusal**



CENTRA

Opportunities

- **Increase Cardiac Rehab Referrals from CHF Clinic**
- **Work with Phase lll Program to develop specific exercise plan for CHF**
- **Work with Physicians regarding rehab and benefits for AMI & CHF patient participation**
- **Make it more affordable and accessible**

Questions

Patient Navigator Program

1st Quarter Initiative Review

Diane Loveday R.N.

Patient Navigator Program

A two year grant from the ACC/AstraZeneca intended to improve patient outcomes and reduce readmissions for CHF/AMI patients

- Develop processes
- Provide multidiscipline involvement
- Measure outcomes
- Implement recommendations identified

Processes Developed

- Disease specific Risk assessment tool to identify high risk patients.
- Assessment of risk for readmission
- Pharmacist medication reconciliation and counseling
- Relationship enhancement with extended care facilities
- Focus study to analyze readmission causes

Risk Assessment Tool

ADMISSION ASSESSMENT ENHANCEMENT – Start Date 1/15/2015

Admission Assessment: for HAND, RAIL - Visit ID: 10100440 - Location: 4N/487/ A- DOB: 10/10/1975 - Unit Type: Med / Surg

ADMIT | ADL / DC NEEDS | VACCINES | ✓ ADMIT SCREEN | ✓ ADMIT SCREEN II | PSYCH | TEACH

Entry For Date: 01/09/2015 15:27

New Heart Failure / AMI Risk Assessment Screening Tool - Found in Admission Assessment

PT Screening	OT Screening	Speech Screening	Wound Care Screening
Can not ambulate	No bathe self > 48 hrs	Communication deficit	Stage II or > skin breakdown
Transfer > min assist	No dress self > 48 hrs	Cough w/intake	Deep Tissue Injury
Unsteady gait	No feed self > 48 hrs	Choke w/intake	Wound present on admission
Unsteady with assist device	Splint to prevent deformity	Pneumonia > 3x past year	Wound Vac present on admission
Unsafe with assist device	Splint to protect deformity	SLP assess if yes to any above	CWON assess if yes to any above
PT assess if yes to any above	Splint to support deformity	No needs identified	
No needs identified	OT assess if yes to any of the above		
	No needs identified		

CHF / AMI Risk Assessment Screening Tool

- ✓ 1 Primary diagnosis of Heart Failure or AMI - reason for readmission
- ✓ 1 Polypharmacy more than 10 meds daily and/or high risk meds - diabetic,digoxin,coumadin,ASA,plavix
- 1 Poor health literacy - unable to verbalize illness and self-care plan ex. daily wt,diet,signs and symptoms,language barrier
- ✓ 1 Physical limitations - deconditioning,fragility,unable to perform ADLs
- 1 Poor social support - lives alone, no care giver, over 80 years of age
- 1 Prior hospitalization - unplanned non-elective readmit in the last 30 days
- 1 Palliative treatment concerns - end stage disease,DNR,advance directives
- ✓ 1 Psychological concerns - anxiety or depression

Total Score: 4

CHF / AMI RN and Case Management Referral for Total Score of 3 or More

- Consult CHF / AMI RN and Case Management

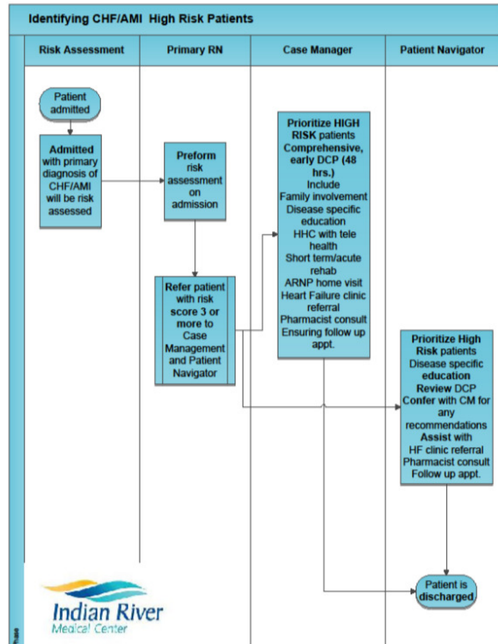
Complete New Tool for Primary Dx. of HF or AMI

If score is 3 or > Submit Consult Order to CHF RN and Case Mgmnt.

This will allow for focused intervention and services aimed at preventing readmission

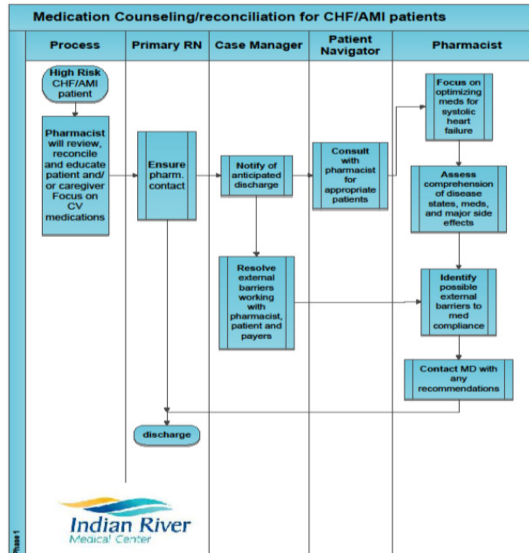
Risk Scoring

- Identifies high risk patients on admission
- Assessment provides a priority referral to Case Manager and Patient Navigator
- Previous compliance - 0%
- Current rate – 70%
- Goal - 95%



Pharmacist Medication Reconciliation and Counseling

- Pharmacist to review all medications, make recommendations and council patient prior to discharge
- Previous compliance - 0
- Current rate – 30%
- Goal-90%



Readmission Assessment Tool

User Fields Page 1 of 1

NON-MEDICAL TRANSPORTATION NEEDED? ○ Yes ◉ No

RISK FOR READMISSION: Moderate

If Risk is High, add Intervention Comment

Intervention Comment: met with patient and his cousin Deborah at bedside, patient is deaf and communicates best through writing and reading, I reviewed CHF education and self care plan with both, Deborah oversees and assists with his medical management, they have requested HHC, orders obtained from Dr. Khouri, discussed with Tara C. MSW

READMISSION ASSESSMENT CRITERIA

1. Requiring NH/extended care placement: ☐
2. 80+ with multiple diagnosis and/or lives alone: ☐
3. New chronic dx with significant lifestyle implcations (CVA,HF,COPD,ESRD,DM): ☐
4. Family dysfunction that may hinder post discharge care: ☐
5. Imparied cognitive ability with no carefiver support: ☐
6. Mental health or substance abuse issues: ☑
7. Significant financial hardship: ☐
8. Admitted from ALF/SNF or extended care facility: ☐
9. Actiive with HHC at admission: ☐
10. End of life issues requiring Palliative or Hospice Care: ☐

12. Requires assist with ADL/IADL: ☐
13. Decreased adherent to treatment plan: ☑
14. Recurrent hospitalizations/ ED visits: ☑
15. Requires assistance with medication management or>7 medications: ☑

CHECK ALL THAT APPLY

Score >5 - consider High Risk
Score 2 - 4 consider Moderate Risk
Score <2 consider Low Risk

http://midas/MidasWeb/midas/MAA/FocusStudy/Functions/UserFields.aspx?&BrowserI... 07/16/2015

Readmission Assessment Tool

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7/16/2015                     INDIAN RIVER MEDICAL CENTER                  PAGE 3
02:41 PM                             HCM WORKSHEET
                              CONFIDENTIAL PATIENT INFORMATION

                         For Facility: INDIAN RIVER MEDICAL CENTER

 Acct No.: 10340506          Patient Name: [redacted]            Age: 59Y DOB: 9/13/1955
 Facility: INDIAN RIVER MEDICAL CENTER

============================== PATIENT SUPPORT (continued) ================================

Was patient given this information?:
Pt/family informed:
Verbalized agreement to be financially responsible.:
RISK FOR READMISSION:                                      Moderate
Intervention Comment:                                      met with patient and spouse at
                                                           bedside, reviewed CHF education and
                                                           self care plan, demonstrated good
                                                           understanding, asked appropriate
                                                           questions, he is planning discharge
                                                           home (not returning to Consulate) and
                                                           is in agreement with HHC

1. Requiring  NH/extended care placement:                  False
2. 80+ with multiple diagnosis and/or lives alone:         False
3. New chronic dx with significant lifestyle implcations:  True
4. Family dysfunction that may hinder post discharge car:  False
5. Imparied cognitive ability with no carefiver support:   False
6. Mental health or substance abuse issues:                False
7. Significant financial hardship:                         False
8. Admitted from ALF/SNF or extended care facility:        True
9. Actiive with HHC at admission:                          False
10. End of life issues requiring Palliative or Hospice C:  False
12. Requires assist with ADL/IADL:                         False
13. Decreased adherent to treatment plan:                  False
14. Recurrent hospitalizations/ ED visits:                 True
15. Requires assistance with medication management or>7 :  True
-------------------------------------------------------------------------------
```

Bridging with Extended Care Facilities

- Monthly meetings and quarterly on site visits have improved communication, trouble shooting and problem solving
- Quality review submitted for each occurrence of readmission
- Readmission rate from extended care for Dec 2014-May 2015 has reduce 11%

Discharge Planning

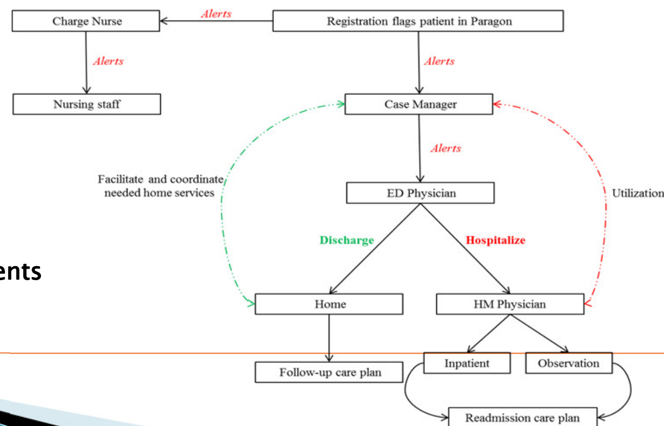
- **October 2014-March 2015 : 66 readmissions**
  - 19% expired or transferred to Hospice care on 2nd discharge
  - 21% had an upgrade to their plan on 2nd discharge
- **Concerns**
  - 42% of these patient had gone home without any services on their index admission
  - 59% had no change to their plan on 2nd discharge

Identification of Palliative Care needs

- If identified on the index admission the readmission rate could have been reduced by 19%
- Suggest automatic Palliative Care consult based on specific criteria
  - NYHA Class III or above
  - Hospitalization in the prior 6 months
  - Prolonged Hospitalization > 7 days
  - Uncontrolled symptoms

Utilizing Observation Status

- Identify readmits in ED
- Work flow development in progress



Schematic to identify and appropriately disposition and treat those patients at high risk for readmission

Expanding Heart Failure Clinic services

- Provide follow up and ongoing support
- Quarter 1 2015 307 patients seen
- Quarter 2 2015 326 patients seen
- These numbers are currently 7% above *bench mark numbers for patient to Practitioner ratio
- Some appointments are outside the 1 week window

*reference information from Duke Heart Failure Clinic and H2H program

Readmission Rate

- Pre Patient Navigator Program
  December 2013- May 2014 19.5%
- Post Patient Navigator Program
  December 2014- May 2015 17.25%
- **2.25% reduction**

Needs for Advancing to the next level

- Case Management development, ownership and implementation of a discharge plan protocol
- Dedicated pharmacist for admission and discharge medication reconciliation
- Automatic palliative care consults when criteria met
- Expanded hours and full time ARNP for the Heart Failure Clinic
- Support for initial use of observation status with 30 day readmissions

Contact Informaton

Diane Loveday, RN
Heart Failure Acute MI Care Coordinator
Indian River Medical Center
Diane.Loveday@irmc.cc
772-567-4311 ext. 2234

Monica Feinberg, RN, BSN Newark Beth Israel Medical Center

LACE Tool

Modified LACE Tool:

- Readmissions are costly and often preventable
- The Modified LACE tool is used to assist Barnabas Health in identifying patients at high risk for readmissions
  - The LACE index was selected as a valid and reliable tool to prospectively identify patients who may directly benefit from a more intense post discharge care and follow up due to the likelihood of readmission. This will ensure that we can take the most appropriate steps to prevent an unplanned readmission.
  - For more information, go to
    - http://www.iha.org/pdfs_documents/news_events/Breakout%20Session%202B%20-%20Richard%20Fraioli,%20John%20Muir.pdf

Goal:

- Prevent patient readmissions
- Identify patients who may be at risk for readmission due to their recent hospital visits (both inpatient and emergency), current admission status and any co-morbidities
- Initiate a plan of care to address the high risk for readmission

Modified LACE Criteria:

- ***Modified LACE Criteria includes:***
- *L*ength of Stay - Anticipated
- *A*cuity of Admission/Observation
- *C*o Morbidities
- *E*D Visits in the Past 6 Months

Modified LACE Tool

- Complete during the admission process
- Located in the 'Admission History Adult'
  - Follow your normal process
    - Either via the 'Ad Hoc Charting' path or via the 'Task' path

Then select the **Modified LACE Tool:**

Modified LACE tool

- The information needed to complete the LACE tool is obtained via the interview process.
- You can also obtain information about previous admissions, if the patient was in a Barnabas Health facility

go to the Menu -Patient Information Tab Patient Information **then select Patient Visit**

Patient Demographics | Visit List | PPR Summary

Patient Demographics | Visit List | PPR Summary

Visit Type	Location	Admit Date	Discharge Date	FIN	Service	Visit Reason
Inpatient	TE6 6202 A	01/27/14 10:37:00 EST		0880003687	Medical	HEART DISEASE NOS

- Note: Information about previous admissions and emergency department visits is for the past six (6) months in any facility

Modified Lace tool

Length of Stay of the Prior Admission **(Only for A Prior Admission within The Last 6 Months)**	○ Less 1 day ○ 1 day ○ 2 days ○ 3 days	○ 4-6 days ○ 7-13 days ○ 14 or more days ○ Not applicable
Emergency room visits (within past 6 months)	○ 0 visits ○ 1 visit ○ 2 visits	○ 3 visits ○ 4 or more visits
Present Acute Admission	○ Inpatient ○ Observation	
Comorbidity: Past or Present Illness	☐ No prior history ☐ Comorbidities Grouping 1 ☐ Comorbidities Grouping 2 ☐ Comorbidities Grouping 3 ☐ Comorbidities Grouping 4 ☐ Comorbidities Grouping 5	
LACE Score	Lace Score	

Note: There may be slight changes to the wording in the left hand column in the future

Comorbidities Definition Reference

Comorbidities Grouping 1

Diabetes mellitus without Known Complications (Treated with Diabetes Medication),

Cerebrovascular Disease (TIA, Stroke with or without Residual Symptoms, Not Including Hemiparesis/Paraparesis or Hemiplegia/Paraplegia)

Myocardial Infarction (Documented with or without Need for Thrombolysis/Angioplasty/Stent/CABG)

Peripheral Vascular Disease (Intermittent Claudication Periph. Arterial Bypass for Insufficiency, Gangrene, Acute Arterial Insufficiency, Untreated Aneurysm (>+ 6 cm)

Ulcer disease (Patients who have required treatment for PUD)

Comorbidities Grouping 2

Cerebrovascular Disease with Hemiparesis/Paraparesis or Hemiplegia/Paraplegia

Congestive Heart Failure (Diastolic or Systolic CHF Requiring Any Chronic Medical Therapies)

Chronic Obstructive Pulmonary Disease (Chronic Lung Disease (Chronic Bronchitis, Emphysema, Asthma) That Requires Chronic Use of Any Inhaler)

Mild Liver Disease (Cirrhosis without PHT, Chronic Hepatitis),

Cancer (Any Solid Tumor, Leukemia, Lymphoma; Excludes Non-Melanoma Skin Cancer, or in situ Cervical Cancer)

Diabetes Mellitus with Any Type of Related Complication

Moderate or Severe Renal Disease (Creatinine >3 mg% (265 umol/l), Dialysis, Transplantation, Uremic Syndrome)

Comorbidities Grouping 3

Dementia (Chronic Cognitive Deficit),
Connective Tissue Disease (SLE, Polymyositis, Mixed CTD, Polymyalgia Rheumatica, Moderate to Severe RA)

Comorbidities Grouping 4

Moderate - Severe Liver Disease (Cirrhosis with PHT +/- Variceal Bleeding)
HIV Infection (with or without AIDS)

Comorbidities Grouping 5

2nd Metastatic Solid Tumor: Self-Explaining

Comorbidity: Select all that apply

Modified LACE Tool

- Previous Admission section:
  - If the patient was an inpatient in the past 6 months, enter the total number of days for their last admission
    - Include Barnabas Health and other facilities
- Emergency visits:
  - Enter the total number of visits to the Emergency Department in the past 6 months
    - Include Barnabas Health and other facilities
- CoMorbidities
  - Select the grouping that is appropriate,
  - If the patient falls into multiple groupings, select all that apply

Modified LACE Tool (continued)

Medications Screening Tool

Patient Response to "I Feel That The Medications I Take Help Me and Are Needed to Treat My Health Problems."
- Agree Completely
- Agree Somewhat
- Disagree Somewhat
- Disagree Completely

Patient Response to Question "When You Are at Home/Work, How Often Do you Skip or Cut in Half Doses of Your Medications?"
- Never
- Once A Week
- Two to Three Times A Week
- More Than Three Times A Week

Patient Response to "How Often Do You Experience Side Effects from Your Medications?"
- Never
- Occasionally
- Always

Pharmacy Screening Score

Patient Response to "How Difficult Is It for You to Obtain Your Medications?"
- Not Difficult
- Difficult

Next step

- In the General information section of the Admission History Adult, complete the following:

Demonstrates Signs, Symptoms of the Following Condition

- ☐ None stated
- ☐ Acute coronary syndrome
- ☐ Asthma
- ☐ Heart failure
- ☐ Pneumonia
- ☐ Stroke
- ☐ Venous thromboembolism

Scoring

- The Modified LACE tool will automatically generate a score based on the responses.
- **If** the Modified LACE tool score is 11 or greater **AND** at least one of the conditions is selected in the 'Demonstrates Signs and Symptoms … ' section, **THEN** the IPOC – High Risk Transition will be recommended.
  - *Note: The IPOC is currently in the final stage of development*

IPOC - High Risk Transition

Initiate the recommended IPOC

IPOC - HIGH Risk Transition (Initiated)
Last updated on: 04/10/2014 09:02 EDT by: Pirl RN, MaryCarol

	Item	Status	Details
Outcomes			
	Prevent Re-Admission Through Education & Follow-Up		Activated, By Phase End
	Ensure Patient Capable of Maintaining Care Outside the H…		Activated, By Phase End
Interventions			
	Social Work Assessment for Psychosocial/Financial Factors		Activated, 04/10/2014 09:00 EDT - Phase End
☑	Referral to Social Worker	Ordered	Priority: Routine, for Psychoscoial and Financial Assessment, 04/10/14 9:00:00 EDT
	Call PCP Office/Notify of High Risk Admission		Activated, 04/10/2014 09:00 EDT - Phase End
☑	Notify PCP of High Risk Admission	Ordered	04/10/14 9:00:00 EDT
	Provide Disease Education with Teach Back		Activated, 04/10/2014 09:00 EDT - Phase End
☑	Disease Education with Teach Back	Ordered	04/10/14 9:00:00 EDT, Stop Date: 04/10/14 9:00:00 EDT
	Plans for Prescription Routing		Activated, 04/10/2014 09:00 EDT - Phase End
☑	Plans for Prescription Routing	Ordered	04/10/14 9:00:00 EDT
	Pharmacy Reviewed Medication Purpose, Compliance and …		Activated, 04/10/2014 09:00 EDT - Phase End
	Evaluate for Post Acute Services		Activated, 04/10/2014 09:00 EDT - Phase End
☑	Referral to Case Management	Ordered	Priority: Routine, Reason: Evaluation for Post Acute Services, 04/10/14 9:00:00 EDT
☑	Referral to Social Worker	Ordered	Priority: Routine, Reason: Evaluation for Post Acute Services, 04/10/14 9:00:00 EDT
	Ordered DME Required for Discharge Completed		Activated, 04/10/2014 09:00 EDT - Phase End
☑	Order DME Required for Discharge	Ordered	04/10/14 9:00:00 EDT
	Schedule PCP Appointment Within 7Days of Discharge		Activated, 04/10/2014 09:00 EDT - Phase End
☑	Referral to Case Management	Ordered	Priority: Routine, Reason: Schedule PCP Follow-Up Appointment within 7 Days, 04/10/14 9:00:00 …
☑	Referral to Social Worker	Ordered	Priority: Routine, Reason: Schedule PCP Follow-Up Appointment with 7 Days, 04/10/14 9:00:00 EDT

Q&A

Patient Navigator Program

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

Quality Improvement for Institutions

Upcoming Calls and Webinars

Cohort 2:

- Community Call 3: Wednesday, Dec 9th from 12-1pm ET

Webinar 2: Wednesday, August 19th from 12-1pm ET

Webinar 3: Wednesday, December 2nd from 12-1pm ET

Quality Improvement for Institutions

Thank You!

Patient Navigator Program

pnp@lists.acc.org

cvquality.acc.org/patientnavigator

Quality Improvement for Institutions