Patient Navigator Program

Community Call #3- Cohort 2
January 20, 2016

Quality Improvement for Institutions

How this webinar is organized

Time	Topic
12:00pm	Welcome and Introductions
12:05pm -12:50pm	Patient Navigator Program Implementation
12:05pm	*Aurora BayCare Medical Center*
12:20pm	*Mercy Hospital*
12:35pm	*Olathe Medical Center*
12:50pm	Q&A
12:57pm	Wrap-up and Next Steps

Quality Improvement for Institutions

Submitting Questions

Patient Navigator Program

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

Quality Improvement for Institutions

ACC Patient Navigator Program 1st Year Review

Presented by
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Care Coordinator

Aurora BayCare Medical Center

Aurora Health Care® BAYCARE CLINIC

Aurora BayCare Medical Center

Cardiology Related Awards and Certifications:

Level II Trauma center
Mission Lifeline Accredited Receiving Center-Silver Level Award 2015
Get With The Guidelines Gold Plus Award in Heart Failure 2013
ACC ACTION Registry Platinum Performance Award 2012, 2013, 2014, 2015
Truven Health Top 50 Cardiovascular Hospital, 2009, 2011, 2013, 2015

ACC Patient Navigator Journey

- January 2015 Kick-off Event
- Interdisciplinary team identified: Cardiology physician co-champions, Quality, Nursing, Case Management, Cardiac Rehab, Imaging, Emergency Department, TAP staff (scheduling FU appts), Pharmacy, Hospitalists, Cath Lab, Surgery, Home Health Care Liaison, EMS representatives
- Baseline data (September 2013-August 2014)

ABMC Baseline Data
(time period September 2013 - August 2014)

Aurora BayCare Medical Center
210574

Metric Name	Baseline September2013-August2014	My I 20
Outcome Metrics -Readmission/Mortality		
Annual CMS 30-day risk stratified readmission rate AMI	6%	
Annual CMS 30-day risk stratified readmission rate HF	14%	
Annual CMS 30-day risk stratified mortality rate AMI	4%	
Annual CMS 30-day risk stratified mortality rate HF	3%	
30-day unadjusted readmission rate AMI	6%	
30-day unadjusted readmission rate HF	14%	
Outcome Metrics - HCAHPS		
Patient Provider Communication Always Good	84%	
Patient understanding of medications during and after hospitalization	83%	
Patient understanding of their signs and symptoms during and after hospitalization	88%	
HF Patients Assessed for QOL/Health Status	0%	
AMI Patients assessed for QOL/Health Status	0%	
Process Metrics - Action Registry Report		
Overall defect free care	80%	
STEMI performance composite	99%	
NSTEMI performance composite	95%	
Aldosterone blocking agents for LVSD at discharge	17%	
High Risk for major bleeding AMI	4%	
High Risk for mortality AMI	4%	
Cardiac rehabilitation patient referral from an inpatient setting	82%	
Process Metrics - Heart Failure Performance Self-Reported		
Evaluation of LV systolic function	100%	
ACE-I or ARB for LVSD at discharge	100%	
Beta-blocker prescribed at discharge	80%	
HF Patients identified	100%	
HF Patients assessed for risk of readmission	0%	
AMI patients identified	100%	
AMI patients assessed for risk of readmission	0%	

AMI National readmit rate is 18.3%
CHF National readmit rate is 23%

AMI National Mortality rate is 15.2%
CHF National Mortality rate is 11.7%

Data that is 0% reflects that the process either was not done or was not audited during this time period.

Aldosterone antagonists for LVSD at discharge – National Top Decile is 41.8%

ABMC Baseline Data
(time period September 2013 - August 2014)

Process Metrics - Medication Reconciliation Self-Reported	
Medication Reconciliation Admission	0%
Medication Reconciliation Discharge	0%
Medication Reconciliation Admission/Discharge	0%
Process Metrics -Follow-up/Education Self-Reported	
Follow-up appointment scheduled within 7 days HF	74%
Follow-up appointment attended HF	0%
Discharge Summary sent HF/AMI	0%
Specific Education/documention treatment regimen AMI/HF	0%
Documentation prescribed medications, instruction and changes AMI/HF	0%
Community Resources	0%

First steps:

- Identified metrics for auditing (measures that were not audited or reported prior)
- Developed small groups to look at processes, identify barriers, create action steps
- Establish data transparency with physicians, nurses, administration and leadership
- Collaborate with physician groups to introduce the program and solicit feedback
- Engage pharmacists in the medication reconciliation process

Goals and Action Steps

Step 1: Select Goal

Increase aldosterone blocking agents for LVSD at discharge for AMI patients by 30% (from 17% to 22%) by December 2015. Increase to 45% by December 2016

ACTION STEPS:

- Data transparency
- Cardiology Best Practice template in EMR
- Concurrent review of eligible inpatients and discussion with attending physician

Goals and Action Steps

Step 1: Select Goal

Improve compliance with Medication Reconciliation at BOTH admission and discharge for AMI and CHF patients by 30% (from 71% to 92.3%) by December 2016

ACTION STEPS:

- Data transparency
- Review of workflows for pharmacy, nursing and physicians relevant to med rec
- Collaboration with Pharmacy for accurate medication history review at admission

Goals and Action Steps

Step 1: Select Goal

Increase compliance with follow-up appointment scheduled within 7 days of discharge for CHF patients by 30% (from 73% to 95%) by December 2016

ACTION STEPS:

- Data transparency
- Tertiary Access Program (TAP) staff schedule follow-up appointments with PCP and Cardiology within 7 days of discharge
- PCP offices have opened slots for Transitional Care Management (TCM) appointments for all discharged patients so TAP staff can schedule without a phone call
- Cardiology has recently opened up Wednesday at 8:00 AM for weekend discharges
  - Working on a process for nursing to add this appt to the paperwork and notify Cardiology office

Goals and Action Steps

Step 1: Select Goal

Improve compliance with routing of Discharge Summary to PCP for AMI and CHF patients by 20% (from 81% to 97%) by December 2016

ACTION STEPS:
- Data transparency
- Collaborate with EMR developers to streamline process

Goals and Action Steps

Step 1: Select Goal

Improve compliance with providing information on Community Resources for identified high risk patients (per ACC recommendations) AMI and CHF patients by 20% (from 75% to 97%) by December 2016

ACTION STEPS:
- Data transparency
- Created clear and consistent expectations for documentation of resources offered

Data

Metric	Baseline	Goal	Most Recent
Aldosterone antagonist	17%	30%	2Q2015 – 25%
Medication Reconciliation	71%	92.3%	2Q2015 – 65%, Nov 2015 – 67%
Follow-up appointment	73%	95%	2Q2015 – 81%
DC Summary Routing	81%	97%	Nov 2015 – 92.3%
Community Resources	75%	95%	Nov 2015 – 100%

Next steps:

- Collaborate with pharmacy for medication teaching at discharge
- Extend medication history taking service to 24/7/365
- Continue to work on processes for scheduling the follow-up appointment-auto-schedule weekend discharges with Wednesday 8:00 AM Cardiology appointment

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Aurora Health Care | BayCare Clinic

American College of Cardiology

Patient Navigator Program

Mercy Hospital, Portland ME

Implementation of the Patient Navigator Program at a small community hospital

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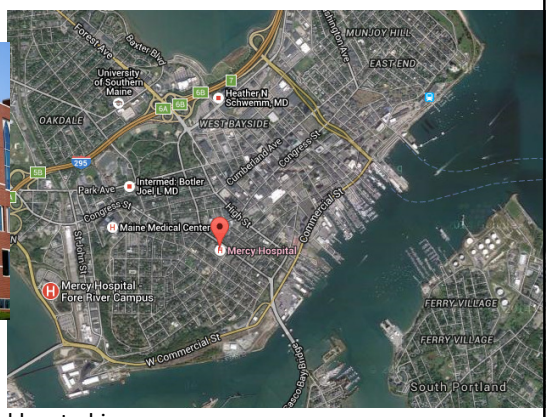

Mercy Hospital

A not-for-profit community Hospital located in Portland, Maine. It has two sites, Mercy State street and Mercy Fore River. It is a part of Eastern Maine Health Systems.

Founded by the Sisters of Mercy, with a history of providing compassionate care, with special concern for the poor and disadvantaged.

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Mercy Hospital has a combined total of 106 (private) beds

The Mercy Healthcare system employs greater than 2,100 employees.

Some Awards Include:

- NCQA Patient Centered Medical Home Level #3 for our practices
- Leap Frog "Grade A" award for patient safety
- GWTG Heart Failure Gold Award, 2014
- Joint Commission Top Performer on Key Quality Metrics, 2012
- Home Care Elite Status '07-'11

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How our program began

- The program began through a grant from Harvard Pilgrim in 2012.
- In 2014 the Patient Navigator Team was established, consisting of the Manager of Cardiology (Executive Sponsor), a cardiologist (Physican Champion) and two RN Patient Navigators (Team Member and Team Facilitator).

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Prior to Patient Navigation…

- CHF instruction was provided inconsistently,
  -patients usually received a handout which was geared for a high school reading level.
- TeleHealth existed but was seldom used, and wasn't initiated before discharge.
- Outpatient follow-up was limited to appointments with the patient's provider, which usually weren't scheduled during hospitalization.

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Specific Challenges for our Institution

- Socio-economic (low income/education background)
- Urban and rural (we serve a large geographic area, including islanders)
- A New Cardiology Practice
- Smaller patient population (means every readmission counts, very limited responses in HCAHPS)

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OUR PROGRAM'S DEVELOPMENT

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AMI/CHF Patient Recognition

- Challenges: No “response team” to recognize new patients.
- We chose to “manually” research new CHF/AMI patients. This is how we identify nearly all of our patients.
- Additionally we participate in rounds and have spread awareness of our program to the providers, care managers and nurses reach out to us regarding patients.
- While at times tedious, by “manually” researching new admits for CHF/AMI, we are able to identify patients with secondary (or historic) diagnoses allowing improved continuity.

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Step 2:
Networking and Integration

Met with…

- Care management
- Nursing staff
- Providers
- Our hospital-based Visiting Nurses
- Primary Care Offices
- Clinical Dieticians

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How we create(d) our Network

- We engage them by presenting our role and how we assist with patients.
- We provide education tools (brochure, CHF booklet, magnet, contact info)
- We consistently meet with them to engage new staff on the awareness of our roles.

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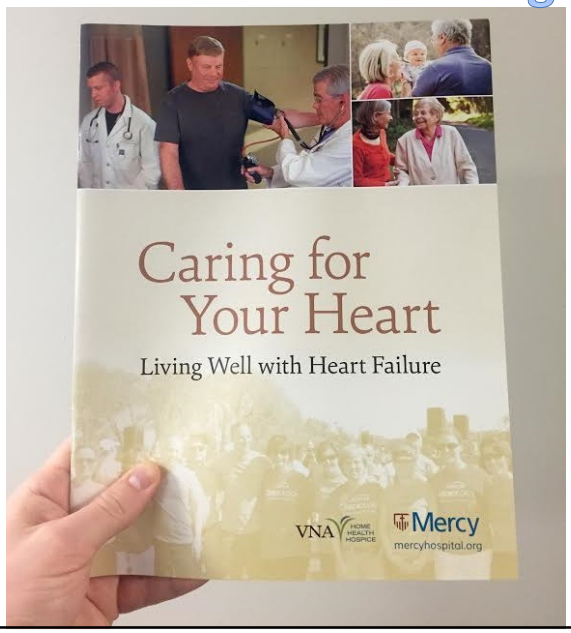
Our Teaching Tool



-5th grade reading level.

-Colorful, uses visual aids.

-Large print.

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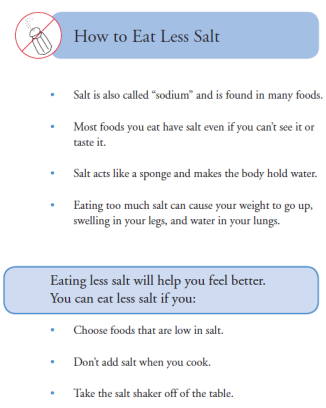
Our Teaching Tool cont.

- http://www.acumentra.org/assets/HF-UNC-Guide-2011-07-19.pdf



How to Eat Less Salt

- Salt is also called "sodium" and is found in many foods.
- Most foods you eat have salt even if you can't see it or taste it.
- Salt acts like a sponge and makes the body hold water.
- Eating too much salt can cause your weight to go up, swelling in your legs, and water in your lungs.

Eating less salt will help you feel better. You can eat less salt if you:

- Choose foods that are low in salt.
- Don't add salt when you cook.
- Take the salt shaker off of the table.

How to Eat Less Salt

Avoid or limit these high salt foods:

fast food | frozen meals | hot dogs, bacon, smoked meat | pizza

cheese | canned beans and vegetables | instant hot cereals | canned or potted meat

sauces and seasonings | snack foods | canned and smoked fish | canned soup

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Brochure

Mercy Care Navigators will:

- Attend to you as a whole person, making sure to care for your physical and emotional health.
- Provide you better access to Mercy Cardiology services
- Help you better understand heart failure
- Help you actively participate in your health care as an outpatient or in the hospital

Call your Care Navigator for help with:

- Symptom management
- Coordinating appointments with different providers
- Assistance with transportation if you are unable to get to an appointment
- Interpreting or understanding your providers or your care
- Referral for financial assistance or insurance coverage

Making the road to good health easier to follow.

At Mercy Hospital, we want every patient to get the full value of our medical care. Successfully treating heart failure requires specialized treatments, careful monitoring and extensive lifestyle changes. We know following your personalized treatment plan can seem overwhelming, especially for patients with other conditions or stress factors. That's why Mercy Cardiology provides heart failure patients with a Care Navigator, free of charge - just one more way Mercy is by your side, every step of the way.

Call Lisa Casher, RN, at (207) 535-1927 to learn more.

- This was distributed to primary care practices in our system.

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Heart Failure Magnet

Provided to all of our HF patients

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VNA/TeleHealth

- Met weekly with visiting nurses association (VNA), now communicating frequently via email, telephone.
- Introduced TeleHealth to patients as inpatients, made referral during hospital stay.
- VNA provided access so that we may monitor patients in program (via Lifestream)
- We will have five units for outpatients for our Cardiology practice (for patients that don't qualify for VNA)

The TeleHealth process

- Patient navigator identifies CHF/AMI patient
- Coordinates with care management, obtains consent
- Care Management activates VNA and TeleHealth who obtain order from provider (usually Hospitalist)
- PCP or Cardiologist signs order for home diuretic protocol

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Our Process Today

- Identify patients through H&P, Labwork, echo, etc…
- Provide education, determine post-acute care needs for additional services.
- Schedule 7-day f/u appointment
- Monitor (if on TeleHealth)
- Visit patient during their Mercy Cardiology follow-up.
- Follow-up by phone

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Follow-up Phone Call

- Check to ensure…
  - Patient is safe, asymptomatic.
  - Instruction was understood and has been incorporated, i.e., daily weights, low Na diet, fluid restriction.
  - Prescriptions were received, filled at pharmacy.
  - The patient has transportation to follow-up appointments.
  - Ensure services, i.e., VNA/TeleHealth are in place.
  - All Questions regarding their care during hospitalization, and plans for after discharge have been answered.

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Persistent Challenges

- That “challenging” patient
  - Our small patient volume makes each readmission significant.
- Readmissions from SNF, Rehab, LTC
  - We have begun to reach out to facilities in our community, providing informative presentations for patients and staff.

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In Conclusion

- The size and demographic of an institution's unique patient population may present both challenges as well as opportunities.

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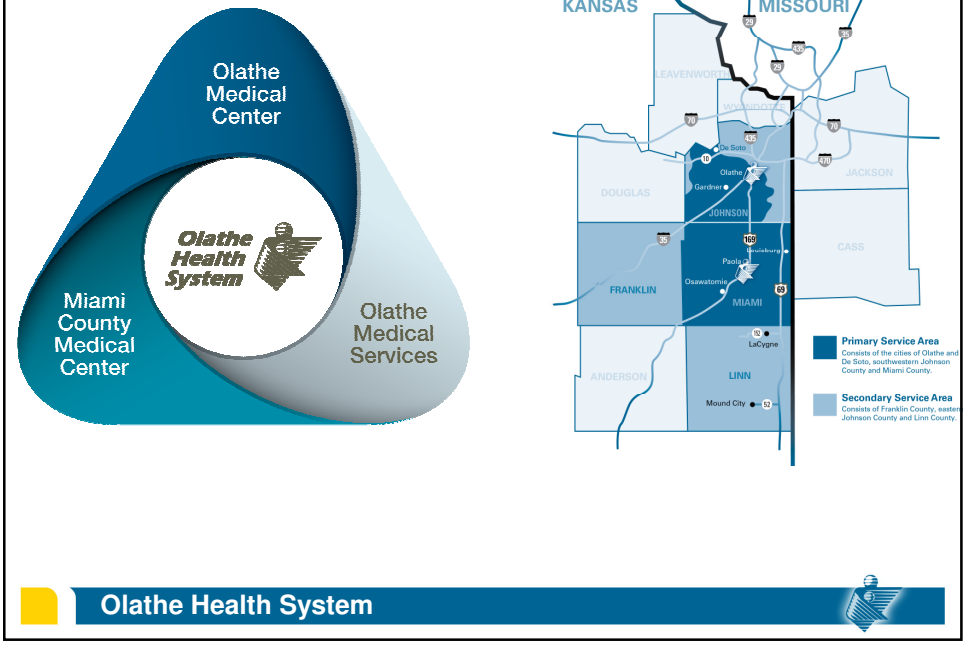

Olathe Health System

Artist's Rendition of the Future of Olathe Medical Center


2,800 Patient Encounters
Per Day
2,500 employees
200+ Volunteers
Among largest employers
In Johnson and Miami Counties
Olathe Health System


CARDIOVASCULAR CARE
Platinum award 4 years in a row
2014
Platinum Performance Achievement Award
ACTION Registry – GWTG
NCDR
More than 100 life-saving heart attack treatments per year
Next closest KS Metro Hospital – 63 per year
Heart Attack
News & Honors

Our Journey

Patient Navigator Program

Readmission Penalty

FY 2015: Measured July 2010 to June 30 2013

- Penalty for AMI
  - 15.9% predicted rate compared to expected rate of 15.3% (July 2010 to June 30 2013)
- No penalty for HF

FY 2016 payment: Measured July 2011 to June 30 2014

- Penalty for AMI
  - 15.8% predicted rate compared to expected rate of 14.9%
- Penalty for HF
  - 21.2% predicted rated compared to expected rate of 21.0%

These penalties equated to a 0.19% payment reduction from Medicare which was low compared to our peers locally, but the goal is 0%

Prior to ACC Navigator

Chest Pain team (previously STEMI team)

- Goals
  - Ensure community has access to evidence based, quality care.
  - Ensure providers have access to the most current education
  - Ensure providers utilize the evidence/education in their care
  - Ensure the community has access to educational opportunities
  - Ensure active and collaborative QI process for chest pain patients

  (including the community at large when appropriate).

Team included Cath Lab leadership, cardiologists, Telemetry management, ER leadership, ICU leadership, Local EMS, surrounding hospitals, quality, pharmacy

Prior to ACC Navigator

2012 HF Quality Improvement team established

- Need identified by the palliative care team with focus on:
  - Patient education – patients not aware of the diagnosis
  - Cognitive deficits – patients called "non-compliant"
  - Readmission

- Mission of the team
  - Prolong life with improved quality of life for patients
  - Utilize evidence to enhance care
  - Reduce readmissions
  - Seamless care throughout continuum
  - Prolong life
  - Educate staff
  - Increase communication in community
  - Patient centered

Team included APRN, Telemetry charge nurse, Rehab, Dietary, Pharmacy, Heart Failure Clinic practitioner and Education

Implementation of the Program

HF team had many initiatives planned, but needed coordination to accomplish goals
- Cardiology Navigator hired around the same time ACC Navigator program initiated
- Brought HF and AMI teams together as many of the issues cross diagnoses
- Initial focus on Heart Failure for Navigator position

Team includes:
- APRN
- Cardiology Nurse Navigator
- Rehab
- Dietary
- Pharmacy
- Heart Failure Clinic practitioner
- Cardiac rehab
- Home health
- Education
- Case Management

Data Utilized to Develop Goals for ACC

ACC Goals established based on data from initial submission
- Difficulty identifying HF patients
  - High risk especially difficult
- Teach back challenges – RN teach back to Cara
- Cardiac Rehab Referral for both AMI and HF

- Other areas for improvement
  - Community resources and education (both patient and facilities)
  - Effective follow up phone calls
  - Re-evaluate risk for readmission – Effective utilization of the LACE tool
  - Focus on patient/staff education
  - Providing scales to patients in need
  - Increased utilization of the HF pathways
  - Cohesive documentation with transitional care in mind

Current Initiatives

- Coordination of the inpatient and outpatient management of heart failure to bridge burden of care in the community
- Development of relationships for heart failure management with Skilled and LTC facilities
- Offer heart failure and coping with chronic disease group class in conjunction with heart failure specialty clinic
- Consideration of chronic disease interdisciplinary team to address the impact of other co-morbidities with heart failure
- Assessment and diuretic treatment of patients who present to ER in mild heart failure and if appropriate, their referral to an outpatient clinic for management instead of admission.

Challenges

- Many people to assist, but no one person dedicated to assuring that initiatives were completed
- As an independent community hospital, staff are utilized on multiple teams and "wear multiple hats"
- Support for Palliative Care
- Patient co-morbidities → Need a coordinated effort to manage this population.
- Community transitions

Q&A

Patient Navigator Program

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

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Upcoming Calls and Webinars

Cohort 1:

- Community Call 4: Wednesday, Feb. 10th from 12-1pmET
- Community Call 5: Wednesday, August 10 from 12-1pmET

Cohort 2:

- Community Call 4: Wednesday, June 29, from 12-1pmET
- Community Call 5: Wednesday, September 14th 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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