Patient Navigator Program

Community Call #4- Cohort 2
June 29, 2016

Quality Improvement for Institutions

How this webinar is organized

Time	Topic
12:00pm	Welcome and Introductions
12:05pm	Readmission Reduction Teams
12:30pm	Q&A
12:35pm	Follow-Up
12:50pm	Q&A
12:55pm	Wrap-up and Next Steps

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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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Patient Navigator Program

Integration of a Patient Navigator Nurse into an Existing Readmission Reduction Team

Heart & Vascular Center

Barnes-Jewish Hospital | Washington University in St. Louis Physicians

NATIONAL LEADERS IN MEDICINE

Founding Sponsor:

AstraZeneca

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By the Numbers:
Over 9,000 employees
1500 physicians
800 residents
Over 80,000 ED visits/year
54,000 admissions/year
1,176 staffed bed

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Existing Readmission Reduction Team

- SHOP: Stay Healthy Outpatient Program
- Focus is the Big 4 (PNA, COPD, HF, MI)
  - Nurses and Social Workers employed by Case Management
    - Facilitate SHOP interventions:
      - MD appointments within 10 days
      - Stay Healthy Clinic appointments
      - Mobile Pharmacy
      - Home Care
- **Great job reducing readmissions 2012 to 2014, but difficulty sustaining the reduction with an increase in 2015.**

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Stay Healthy Clinic (SHC)

- Provides "transitional" care between hospital discharge and primary care physician's first appointment.
- Approach: SHC visit is a part of the patient's hospitalization.
- Accurate medication reconciliation.
- Communication with PCP. PCP is notified of patient's enrollment in Patient Navigator Program and benefits of the program. Updates are sent to the PCP at the end of clinic visit(s).

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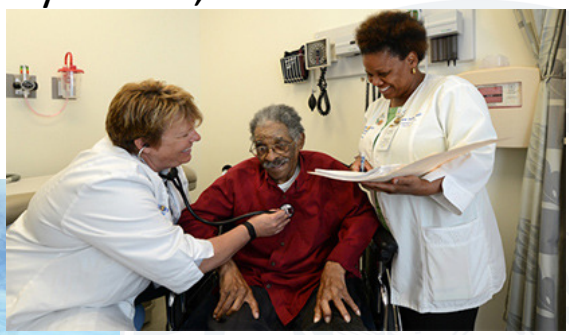
Stay Healthy Clinic

Dr. Lenise Cummings-Vaughn and Kelly Dodds, NP



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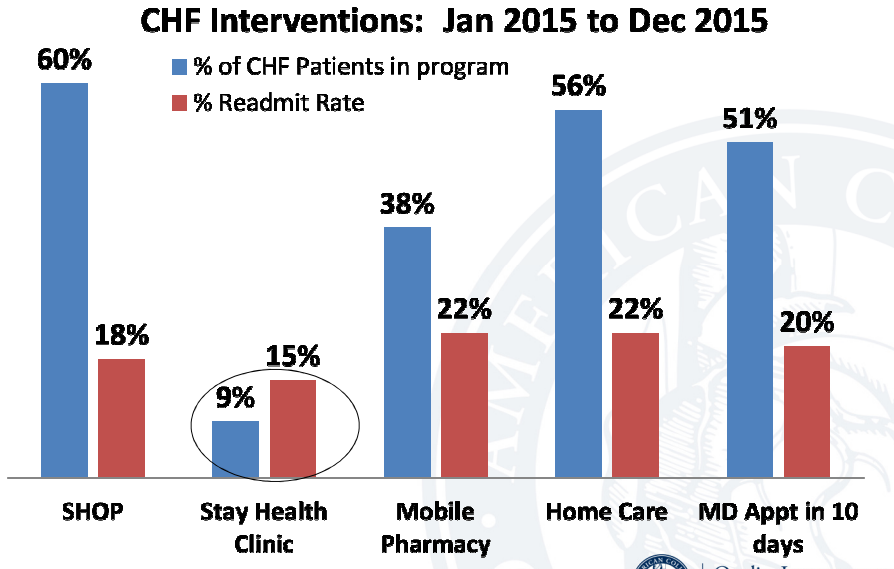
Baseline Data



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Opportunities for Improvement

- 97-98% of patients have PCP on admit, but only 60% of these patients are getting clinic/MD appointments prior to discharge. Earliest MD appts are 10 days after discharge.
- Highest readmission time period post-discharge is within 3-5 days of discharge.
- Cognitive function is directly linked to ability of manage medications but is not routinely being assessed.

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Patient Navigator Program

- Heart and Vascular service line of BJH pursued participation in the PNP. Outside case management scope.
- Looking at the identified opportunities for improvement, best use of PNP participation appeared to be the employment of a PNP nurse to focus on appointments within 3-5 days, cognitive assessment and patient/family teaching.

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Other Improvements

- PNP team also worked with IS to develop an automated, electronic daily listing of patients over 65 at moderate to high risk for readmission using the LACE tool.

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Challenges of Integrating PNP Nurse

- Communication to the SHOP team did not come from their service line, but from instead from Heart & Vascular.
- SHOP team was uncertain of the exact role of PNP nurse.
- Two separate goals for post-discharge appointments:
  - SHOP: 10 day MD appts:
  - PNP: 3 day MD appts
- Concern for SHOP positions.

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Integration Do-Over

- Meet and communicate with SHOP group. A lot of work to be done so no change in SHOP positions.
- Focus on common goals and differentiate roles.
- Agree to facilitate 3 day post-discharge appointment via the SHC especially for those living within 30 minutes of the clinic.
- Share data showing effect of cognitive function on med management and need to educate when family or home support is present.
- Share with case coordinators the automated daily list of potential patients using the LACE tool.

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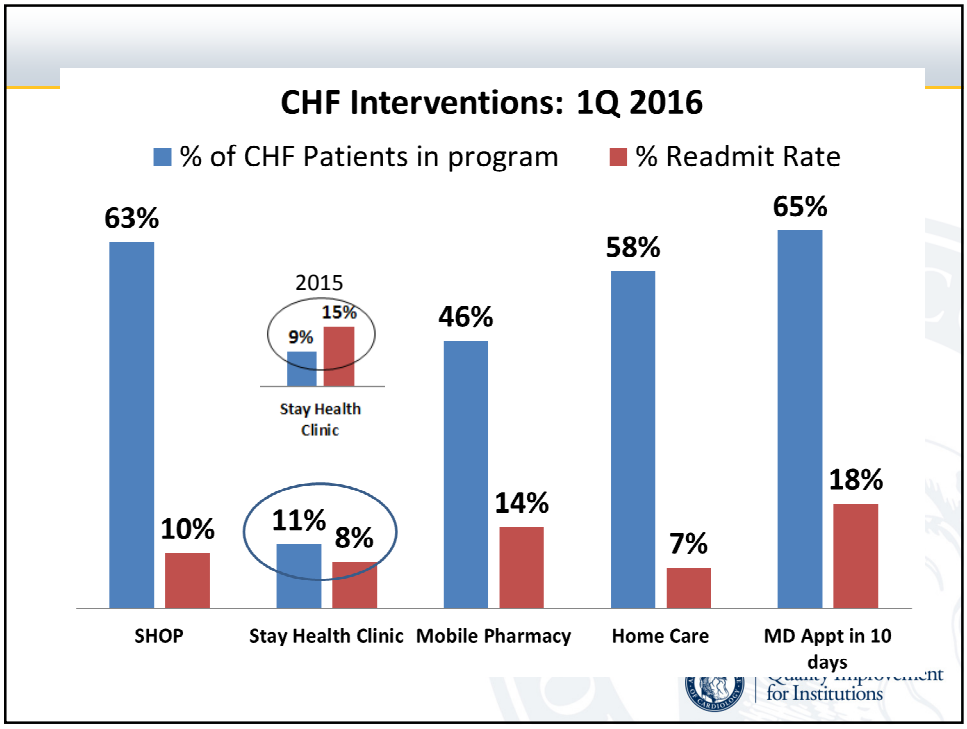

Follow-up

- 3-month Pilot
  - PNP nurse will be the sole scheduler for HF and MI patients to SHC.
- PNP nurse and SHOP nurse daily handoff
- Seeking administrative support to hold risk patient at discharge to wait for family or support to be physically present during discharge teaching

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Cleveland Clinic
Fairview Hospital

Heart Failure Readmission Reduction

Patient Navigator Program
Community Call #4

Meaghan Wohl, RN, BSN
Lori Orzech, RN, BSN

Cleveland Clinic

- Located in Cleveland, Ohio, Cleveland Clinic is a nonprofit, multispecialty academic medical center that integrates clinical and hospital care with research and education.
- Internationally known and founded in 1921, the Cleveland Clinic is based on mission, vision and values to provide better care of the sick, investigation into their problems, and further education of those who serve.

Cleveland Clinic

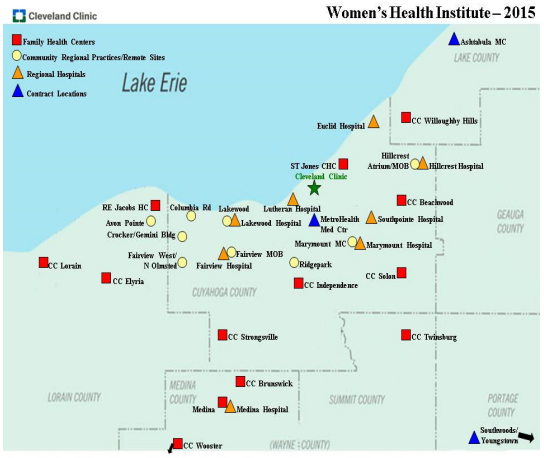
Main Campus

Statement of Values

- **Quality:** We maintain the highest standards and achieve them by continually measuring and improving our outcomes.
- **Innovation:** We welcome change, encourage invention and continually seek better, more efficient ways to achieve our goals.
- **Teamwork:** We collaborate and share knowledge to benefit patients and fellow caregivers for the advancement of our mission.
- **Service:** We strive to exceed our patients' and/or fellow caregivers' expectations for comfort and convenience.
- **Integrity:** We adhere to high moral principles and professional standards by a commitment to honesty, confidentiality, trust, respect and transparency.
- **Compassion:** We demonstrate our commitment to world-class care by providing a caring and supportive environment for our patients, patients' families and fellow caregivers.

CCF Enterprise

- **International:** Abu Dhabi, Canada and coming soon - London, England
- **National:** Las Vegas, Nevada and Weston, Florida
- **Ohio:**
  - 9 Regional Hospitals
  - 18 Full-Service Family Health Centers
  - 15 Express Care and 4 Urgent Care sites



Fairview Hospital

- Founded in 1892, Fairview Hospital is a 450-bed hospital located at the western edge of Cleveland, Ohio.
- Fairview Hospital's strong clinical Centers of Excellence include:
  - **Birthing Center –** only Level III NICU on West Side.
  - **Cancer Center –** part of the Integrated Network Cancer Program and has been awarded the Outstanding Achievement Award by the American College of Surgeons, Commission on Cancer.
  - **Emergency & Trauma Center –** only Level II Trauma Center on West Side since 1993 and new Helipad, opened in 2015.
  - **Surgery Center -** cardiothoracic, vascular, urology, colorectal, orthopedics, general surgery, bariatric surgery, breast surgery and surgery as a treatment for cancer.
- Fairview Hospital is accredited by the Joint Commission and is a Magnet recognized hospital for nursing excellence since 2009.

Fairview Hospital Heart Center

- **The Heart Center provides comprehensive diagnostic, medical and surgical heart services, including:**

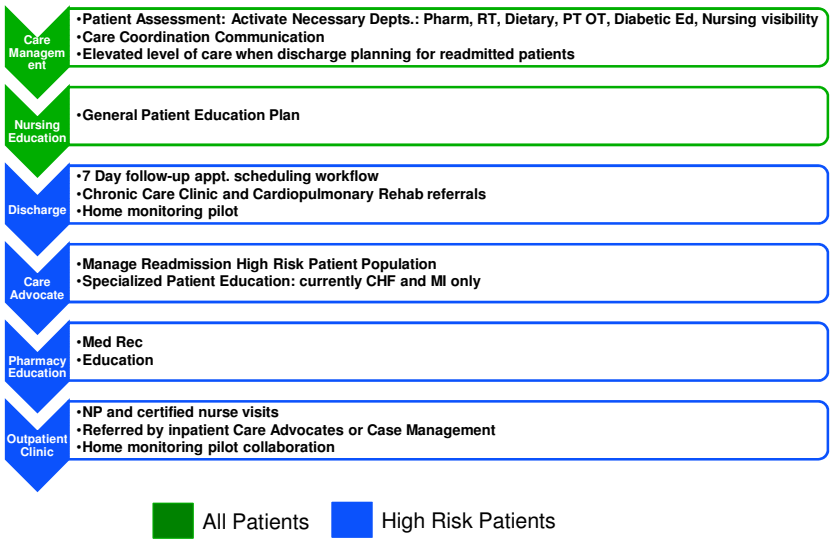
- Cardiac Catheterization Laboratory and Diagnostic Center
  - Interventional services
  - Cardiac Event Monitoring
  - Electrocardiograms (EKG's)
  - Echocardiogram/Stress Ultrasound
  - Holter Monitoring
  - Stress Testing
- Electrophysiology (EP) Laboratory
- Progressive Coronary Care Unit
- Chest Pain Center
- Congestive Heart Failure Clinic
- Kemper Coronary Care Center
- Open Heart Surgery
- Women's Preventative Heart Clinic
- Pediatric Cardiology
  - Pediatric echocardiograms and heart ultrasounds
- Cardiac Rehabilitation

Readmission Workforce

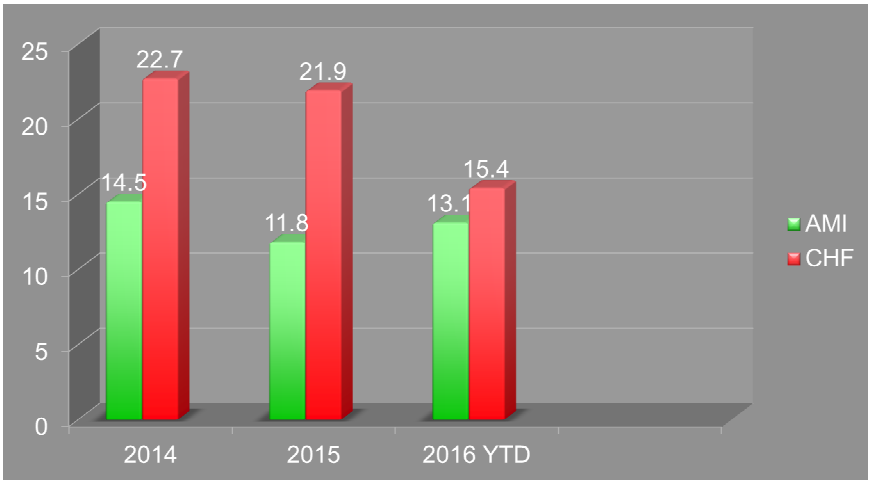
- Multidisciplinary team collaborating together to reduce hospital readmissions while continuing to provide the best care possible for our patients.
- Increasing the utilization of outpatient services to decrease the number of hospitalizations and ED visits.
- Coordination of care from admission to discharge to ensure all patient needs are met across the healthcare continuum.

- **Workforce Team**
  - Hospital Administration
  - Physician Champion
  - Nursing
  - Care Advocates
  - Case Management
  - Pharmacy
  - Respiratory Therapy
  - Cardiopulmonary Rehab
  - Outpatient Clinic

Readmission Workforce Tasks



Readmission Stats



Care Advocate Interventions

- Daily chart review and identification of CHF inpatients to follow.
  - Risk Stratification Tool
  - Deliver list to daily hospital briefing meeting for nurse managers
  - Currently readmitted patients
  - Patients at high-risk for readmission
- Focused education plan and tailored teaching to specific patient needs.
- Assist in discharge planning with Case Management team.
  - Order follow up appointments
  - Review appointments kept after discharge
  - Follow up discharge phone calls to patient and/or appropriate provider
- Chronic Care Clinic.
- Home Monitoring Pilot Program.

Heart Failure Home Monitoring Pilot Program

- Remote telehealth monitoring for 100 patients of daily weight, blood pressure, pulse ox and heart rate for a 30-day period to reduce the number of heart failure related hospitalizations to less than 17%.

- Goals:
  - **Reduce readmissions** to Fairview Hospital by increasing Care Coordination through a partnership with home health care.
  - **Improve overall quality of life and** chronic disease self-management of patients.
  - **Increase support to physicians** in the community through close monitoring and care coordination of patients with heart failure through the Chronic Care Clinic.

Telehealth Home Monitoring Specifics

- Care Advocates identify appropriate patients and work with Case Management for facilitating referrals to home health.

- Any abnormal findings are directly communicated to the PCP, as well as the Chronic Care Clinic, regarding the next steps in the patient-specific care plan throughout the duration of being enrolled in the program.

- Standard skilled patients

- "Transitional" patients
  - Patients who are unable to receive standard home health services, such as people who work, drive and are unable to be considered home-bound by CMS or private insurance approved guidelines.
  - Most are newly diagnosed, which leads to a high risk for readmission due to non-compliance and misunderstanding of the disease process.
  - Many have not seen a healthcare provider in many years, therefore do not have a PCP and are referred to the Chronic Care Clinic to get established.
  - Funding from community resources since skilled criteria is not met and would not be approved by insurance.

Current Telehealth Stats

- 35 patients enrolled in program since starting March 2016
- 25 patients hit 30-days post-discharge (71%)
- 3 readmits (8%)
- Chronic Care Clinic
  - 14 FVH
  - 6 Avon CHF Clinic
  - 1 Lakewood CHF Clinic
  - 1 Lutheran CHF Clinic

- **Barriers identified:**
  - Transitional contract still pending with CCF Legal team.
  - Patients unable to use equipment.
  - Patient preference – they can say NO at any time.
  - Physicians and patients refusing Chronic Care Clinic.

Chronic Care Clinic

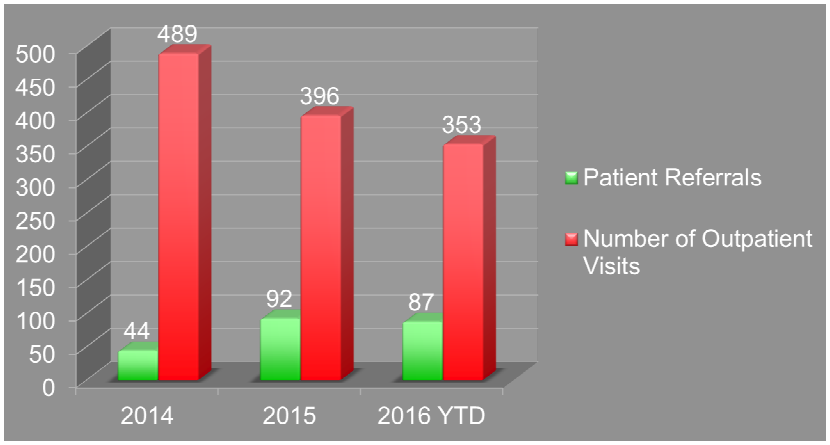
- The Chronic Care Clinic at Fairview Hospital is an office setting that provides services needed to manage one or more diseases that require frequent monitoring and attention over a lifetime.
- The goal of our staff is to help keep patients out of the hospital and maintain the highest quality of life possible.

- The care coordination of chronic conditions by our specialized staff will include:
  - Understanding of chronic disease and its cause
  - Recognition of worsening symptoms and self-care techniques to prevent a flare-up
  - Creating a personalized plan of care
  - Education and coping strategies that fit into each patient's lifestyle
  - Early treatment for identified symptoms to prevent hospitalization
  - Ongoing patient and family-centered care coordination
  - Medication adjustments
  - Follow up assessments
  - Referrals to appropriate providers to meet individual needs

Chronic Care Clinic Specifics

- Outpatient clinic opened in September 2015.
- Staffed 3 days per week by CNP and certified heart failure nurses.
- Started accepting COPD patients in January 2016.
- Care coordination of telehealth pilot program patients with home health care.

Chronic Care Clinic Stats



Cleveland Clinic

Every life deserves world class care.

Q&A

Patient Navigator Program

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

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CHF and AMI Follow Up

A. Gordon Vordermark, RN, BSN
Chronic CV Disease Coordinator, Centra Health, Lynchburg General Hospital
Lynchburg, Virginia

Cindi Cole, RN, BSN, CCC
Cardiovascular Quality Manager

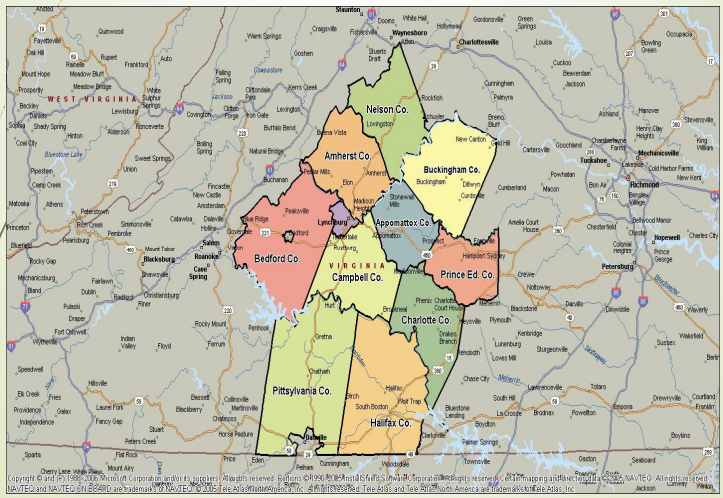
Centra Health, Lynchburg General Hospital

CENTRA

- 385 bed community-based hospital (total of four hospitals in the Centra Health system)
- Magnet in nursing, 50 Top Cardiovascular Hospital, Certified Chest Pain and Acute MI Center, 3 star rating for CT Surgery (highest)
- CHF annual discharges: 988
- AMI annual discharges: 844

Centra Health, Lynchburg General Hospital

- Service Area



CHF

- Discharge planning starts at admission
  - Inpatient navigator meets with patient and family to review CHF education. Also meets with case manager, CHF team, etc., to help determine best long term plan for patient.
- CHF clinic composed of two physicians, two NPs, and an outpatient RN
  - A faction of the Cardiology office
- 24-48 hour post discharge phone call (or 72 hours if over the weekend) to patients by inpatient navigator, then patient is "handed off" to CHF clinic team.
  - Review Med Rec, follow up appointments, and general CHF education.
  - Transition of care call billing
- 3-5 day follow up with provider in CHF clinic (maximum of 7 days)
- Try to touch base once a week (for first month) with patient, if not with visit in CHF clinic than by phone call from outpatient nurse.
  - Ex: 1st week: Discharge phone call and first visit. 2nd week phone call. 3rd week visit. 4th week phone call.

AMI

- Follow up with NP/PA within 7 days.
  - Has proven challenging d/t availability in clinic and not wanting to take "urgent need" spots.
- H20 clinic started ("Hospital to Office")
  - Nurse visit (can bill insurance for these)
  - Reviews medications (ask patients to bring medications in bottles with them), take BP, possible EKG if having issues, etc.
  - Patients have greatly appreciated the nurse visit prior to having the NP/PA visit, feel that they have a "go-to" person and have reached out many times to H20 clinic nurse vs. inpatient navigator.
  - Also helpful for people who return to ED within 30 days (nurse follow up after ED or EDO discharge until provider available).
  - Criteria: AMI (or Diastolic CHF to be added in July), with social support needs, insurance needs (don't bill for these patients), or 7 day appointment not able to be met.
  - Still gathering preliminary data on effectiveness of H20 clinic on readmissions…

ABC Education Stratification

- What level is the patient's understanding of disease?
- Absent/Basic/Complete
  - Homemade "patient knowledge assessment" of what patient's understanding of basic CHF education is (things like sodium restriction, recommended fluid intake, need for daily weights, when to call Cardiology vs. when to call 911, etc).
  - Answers and answer key given to patient/family
- Lessons learned
  - Most patients are an "A/Absent"
    - Makes sense why they are in the hospital
    - Does not assess willingness to take charge of health, only if the patient and family know how to care for him/herself.

When the patients come back to the ED unbeknownst to Cardiology…

- Icon created with automatic email alerts to inpatient Navigator
  - Name, MRN, which "patient category" (AMI vs. CHF), location of ED, and chief complaint
- Icon is "put on the patient's record" for 30 days and then taken off. This happens prior to coding so coding is checked prior to "sounding the alarm of a potential readmission" when the patient comes back.
- Access to ED documentation system so can see chart updates. Also can see emergency "level" of patient, labs, vitals, nurse documentation, etc.
- Touch base with ED providers, bedside RN, case managers to let them know Navigation is following the patient.
  - If patient discharging home, Navigation gets close follow up with Cardiology and/or PCP.
  - Also call patient 24-48 hours after ED discharge.
  - See patient in ED or EDO, they feel a lot better having someone with them, explaining what is going on.
- Data being collected on "saves/near misses" with this, but information is definitely helpful to have regardless of whether statistically helpful or not.

Questions

Upcoming Calls and Webinars

Cohort 1:

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

Cohort 2:

- Community Call 5: Wednesday, September 14th 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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