Patient Navigator Program

Community Webinar 5- Cohort 1
August 10, 2016

Quality Improvement for Institutions

How this webinar is organized

Time	Topic
12:00pm	Welcome and Introductions
12:05pm	Pharmacy Engagement
12:20pm	Q&A
12:22pm	NCDR Annual Conference Posters and Abstracts
12:37pm	Q&A
12:39pm	Community Involvement
12:54pm	Q&A
12:56pm	Wrap-up and Next Steps

Quality Improvement for Institutions

Meds to Beds

Improving Transitions of Care

Wednesday, September 14, 2016
12pm – 1pm

St.Vincent's Medical Center

St. Vincent's Medical Center (SVMC)

- Member of Ascension
- 473-bed urban community, teaching, and referral hospital
- avg. MI population: 25-35 patients/mo
- Level II Trauma Center
- ACC Patient Navigator Program
- NCDR Cath/PCI, ACTION, GWTG-HF, STS/ACC TVT, ICD Registries
- Mission Lifeline
- STEMI Accelerator Project

St.Vincent's Medical Center

Core Values

SVMC is called to serve its communities by integrating into our daily work these Core Values:

* Service to the Poor - Generosity of spirit, especially for persons most in need
* Reverence - Respect and compassion for the dignity and diversity of life
* Integrity - Inspiring trust through personal leadership
* Wisdom - Integrating excellence and stewardship
* Creativity - Courageous innovation
* Dedication - Affirming the hope and joy of our ministry

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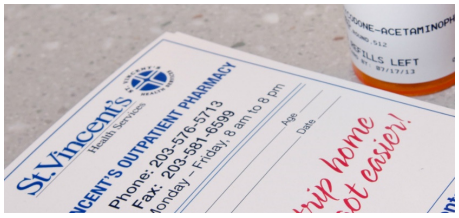
St. Vincent's Outpatient Pharmacy



* Opened September 2012
* Meds to Bed program implementation
* PGY1 Community Pharmacy Residency program implementation

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Data indicates that only about 40% of patients fill their prescriptions the day of discharge, and 22% have not filled their prescriptions by a median of 12 days after discharge.[1]

Kripalani S, Henderson LE, Jaconson TA, Vaccarino V. Medication use among innter-city patients after hospital discharge: patient-reported barriers and solutions. Mayo Clin Proc. 2008; 83(5):529-535

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A focus in quality-based healthcare

- Affordable Care Act of 2010
  - HCAHPS, star ratings, 30-day unplanned readmissions
- Transitions of care (TOC):
  - "…a set of actions designed to ensure the coordination and continuity of healthcare as patients transfer between different locations or different levels of care within the same location"[1]
  - hospitals, sub-acute/post-acute nursing facilities, patient's home, PCP offices, specialty offices, assisted living, LTCFs

AFFORDABLE CARE ACT

1. Coleman EA, Boult C. Improving the quality of transitional care for persons with complex care needs. J Am Geriatr Soc 2003;51:556–7. doi:10.1046/j.1532-5415.2003.51186.x

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Root Causes of Ineffective TOC

Communication breakdowns	Different expectations
	Lack of promotion in culture
	Inadequate time
	Lack of standardized procedures
Patient education breakdowns	Conflicting recommendations
	Confusing medication regimens
	Excluded from planning of TOC
	Lack of understanding/knowledge
Accountability breakdowns	No one person is responsible
	PCPs are not identified
	Limited discharge planning and risk assessment

Adapted from The Joint Commission: *Hot topics in health care: transitions of care: the need for a more effective approach in continuing patient care*, 2012. http://www.jointcommission.org/assets/1/18/Hot_Topics_Transitions_of_Care.pdf Accessed August 10, 2016.

Meds to Beds

- Purpose: to facilitate patient discharge by delivering prescription medications to the bedside
- Benefits to patient and hospital
  - Service for all patients being discharged home
    - Not limited to certain risk or disease patient populations
- Available Mondays – Fridays 9am-5pm
  - No weekends due to staffing limitations
- Residency goals:
  - Update policy
  - Research project
  - Educate

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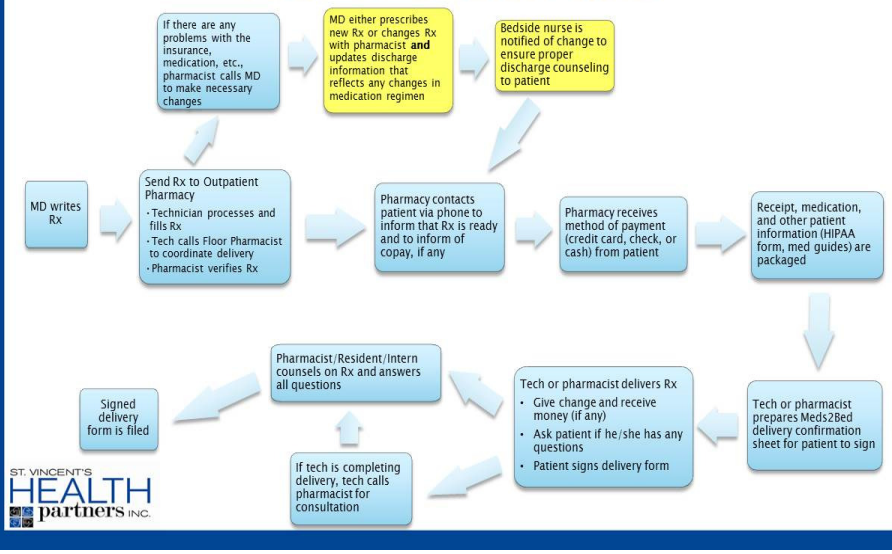
Meds to Bed Flowchart



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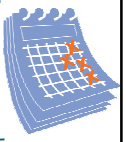
Follow-up Telephone Calls

- **1st Follow-up Call:** 24-48 hours post-discharge
  - Assess medication adherence and knowledge of indication(s)
  - Check to see if there are any changes to medication regimen
  - Inquire about side effects, adverse reactions, allergies, etc.
  - **Confirm next MD appt and phone follow-up dates**



- **2nd Follow-up Call:** 10-14 days post-discharge (after follow-up MD appointment)
  - Confirm that patient went to scheduled MD appointment
  - Inquire about any changes to medications or therapy

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Benefits of Meds to Beds

- Ease of discharge process for the patient
  - Bedside delivery
  - Patient satisfaction
- Improved multidisciplinary communication & continuum of care
- More complete medication reconciliation
- Assurance that medications are filled and counseled on
  - Reduce non-adherence and readmissions
- Time-saving when there are insurance issues
  - Prior authorization
  - Medication-related issues
- No additional cost to the patient
- Improved HCAHPS scores and star ratings

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Barriers

- Insurance denials
- High copays or unable to pay
  - In-person pickup at the outpatient pharmacy
- Inadequate time to prepare
- Not enough staff
  - Transportation/delivery
  - Consultation
- Logistics
  - Receiving the prescriptions
  - Prescription issues

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Logistics

- Resource utilization
  - Staffing- incorporated into our current workflow
- Paying for pharmacy resources
  - Clinical pharmacist on the floor, pharmacy residents, pharmacy interns/students, technicians
- 30-day medication supply
  - Currently do not provide free 30-day supplies
  - Billed through insurance
    - Copay savings programs and coupons
  - Not a 340B-eligible hospital
  - May be a "charity case patient" or referred to the Dispensary of Hope for free services

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Pharmacist Experience

- 82 y/o male with systolic CHF and EF of 30%
- Worsening HF symptoms on carvedilol, valsartan, and furosemide
- Cardiologist to start pt on Entresto™ (sacubitril/valsartan)
  - Not covered by insurance without prior authorization
- Helped pt receive 30 day free supply through manufacturer coupon
- Worked with outpatient pharmacy to get medication for pt next day
- Delivered medication to pts bedside and provided patient education
- Able to ensure patient was able to go home with this medication
  - Documented improvement by cardiologist with addition of Entresto™ (sacubitril/valsartan)

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Challenges

Education/Communication/Marketing

- Unaware of Meds to Beds service
  - Patient, prescriber, other healthcare professionals

Culture

- A healthcare provider may be used to providing all the discharge information with little-to-no help from the pharmacy
- A physician may not request help during medication reconciliation
- Little-to-no promotion or encouragement of Meds to Beds service

Timeliness

- Discharge times are not clearly stated
- Prescriptions may be requested for Meds to Beds right before discharge

Staffing issues

- Pharmacist unavailable

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Looking forward…

- Prospective results and goals to achieve with Meds to Bed
- Education, promotion, and research of TOC are needed
- Good metrics to evaluate service effects
- Promotion of completing HCAHPS surveys to patients
  - Currently only 23% of eligible patients completed the survey[1]

1. Centers for Medicare & Medicaid. (n.d.). *Hospital Compare*. Retrieved from https://www.medicare.gov/hospitalcompare/details.html?msrCd=prnt1grp1&ID=070028&stCd=CT&stName=Connecticut. Accessed August 19, 2016.

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Summary

- Shift towards value-based healthcare and transitions of care
- Meds to Bed
  - Patient satisfaction and smoother discharge process for the patient
  - Improved multidisciplinary communication and continuum of care
  - Assurance that medications are filled and counseled on
  - Reduce non-adherence and readmissions
  - Improved HCAHPS scores and star rating
- Still many obstacles to overcome

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Questions?

Q&A

Patient Navigator Program

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

Quality Improvement for Institutions

NCDR Annual Conference Abstracts and Posters

Why each one of you should be submitting an abstract to NCDR.17

Patricia E. Casey, RN, MSN, CPHQ, AACC
NCDR Training and Orientation

NCDR
NATIONAL CARDIOVASCULAR DATA REGISTRY

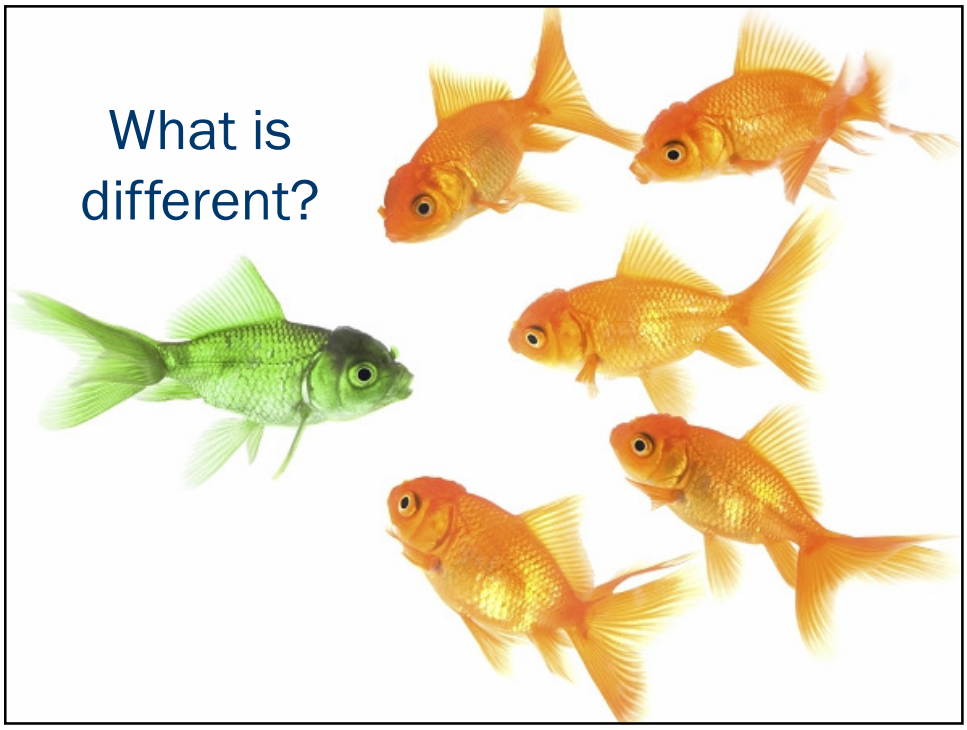
Objectives:

NCDR
NATIONAL CARDIOVASCULAR DATA REGISTRY


Identify one reason to Submit

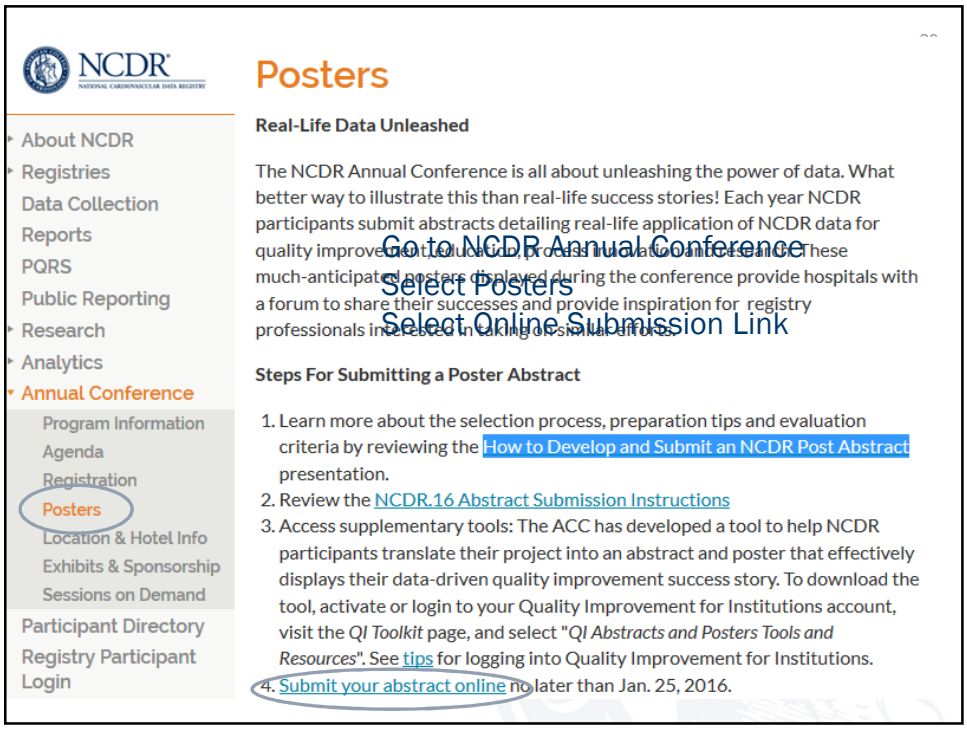

SUBMIT
Discuss the submission process


Backspace
Insert
Delete
Identify
Resources


What is
different?

4 Steps

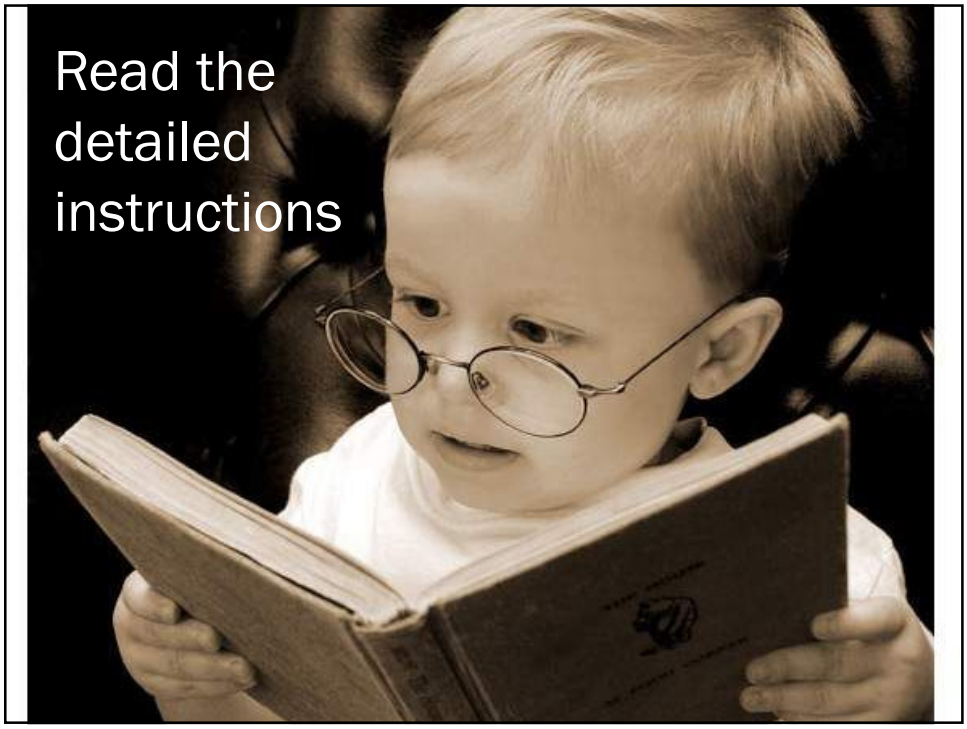
1. Background
2. Methods
3. Results
4. Conclusions



Go to NCDR Annual Conference

Select Posters

Select Online Submission Link



Presenter

This was a presentation given last year and revised for posting.
Stephanie Fine is a Sr. Clinical Business Intelligence Analyst with Providence Health & Services and is based in Portland, Oregon.

Kristi Verschelden is the registry site manager for 2 NCDR registries at The Heart Hospital Baylor Plano, a freestanding heart and vascular hospital in North Texas.

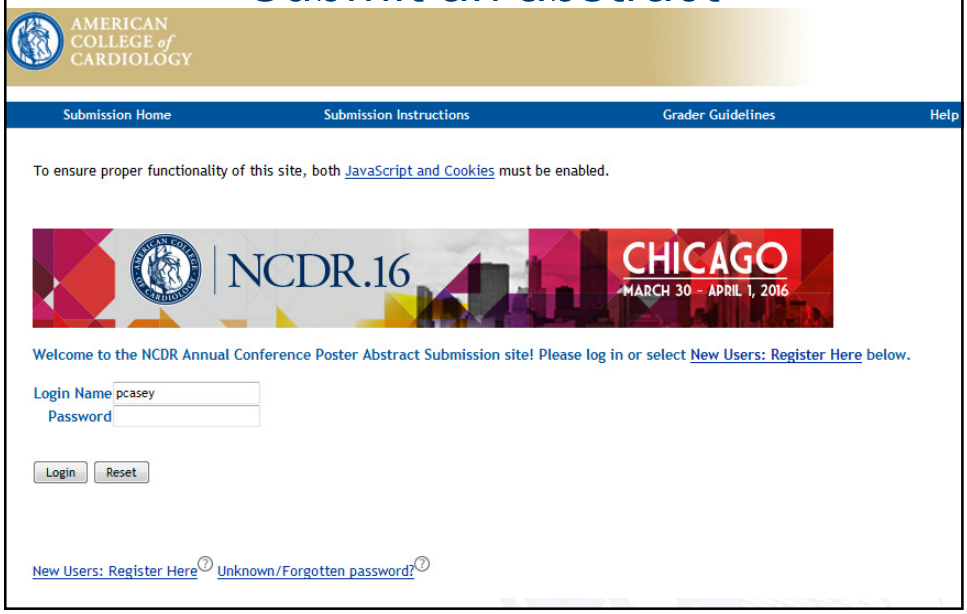
Pat Casey works at ACC and is responsible for NCDR Education and Training.

velop and Submit
Poster Abstract

Stephanie Fine, MA
Kristi Verschelden, BSN, RN-BC
Patricia E. Casey, MSN, RN, CPHQ, AACC

NCDR® NATIONAL CARDIOVASCULAR DATA REGISTRY

Submit an abstract



Angela Bates, MSN, RN, CRNP

Huntsville Hospital, Huntsville, Alabama

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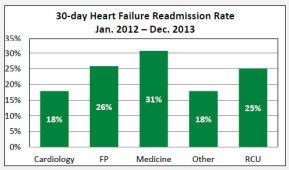
The Patient Navigator: Data to support nursing's effort for organization-wide improvement

Angela Bates, MSN, RN, CRNP; Arin Zapf, MSN, RN; Christine Fussell, MSN, RN, CRNP; James Murphy, MD; Gennifer Baker, DNP, RN, CCNS
Huntsville Hospital Heart Failure Clinic, Huntsville, Alabama

Background

- Grant awarded through the American College of Cardiology in 2014.
- After grant was awarded, a team met to discuss the establishment of a Patient Navigator to coordinate collaboration between multiple disciplines in the hospital.
- The Patient Navigator's role is to offer heart failure and acute myocardial infarction patients tools to successfully manage disease process post discharge.



- Patient care on the Cardiology units at Huntsville Hospital successfully identified and provided services to patients being discharged with heart failure.
- The success is evidenced by lower than national average readmission rates of 18% versus non-Cardiology units rates of 18% to 31%.
- It was this discovery that prompted Huntsville Hospital to replicate the existing Cardiology model on the non-Cardiology units.

Methods

- The Certified Nurse Practitioner was determined as the key level of expertise needed for the Patient Navigator role.
- The Patient Navigator is consulted when the diagnosis of heart failure is entered into the medical record. Once heart failure diagnosis is validated, the navigation of care and guideline directed medical therapy is executed and documented using the Quality Measure tool as replicated from the cardiology units.
- The Patient Navigator addresses global barriers such as multidisciplinary care, medication reconciliation, social deficiencies, education on disease process, dietary restrictions, daily weights, and securing the seven day follow-up appointment.

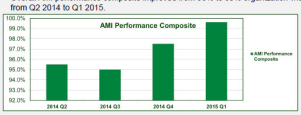
Results

- The program has facilitated the process for expert clinicians to provide self-care management education to a statistically underserved, at risk population.
- From June 30, 2014, to Dec. 31, 2014, Heart Failure Core Measure Data improved from 96% to 100% on medical and surgical floors.

Results continued

- The Patient Navigator enabled 75 patients per month to be evaluated and transitioned to a seven day follow-up appointment at discharge.

- Overall AMI performance composite improved from 95% to 99% organization wide from Q2 2014 to Q1 2015.



Conclusion

- NCDR facilitated our efforts towards improving patient outcomes by:
  1. Measuring how often we are successfully identifying heart failure patients on the non-cardiology units.
  2. Monitoring our compliance with AMI data.
  3. Providing measurable indicators to ensure evidence-based health care delivery.
- The identification directly correlates to our ability to transition those patients.
- The effects of this initiative will hopefully lead to a reduction in readmission rates.

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NATIONAL CARDIOVASCULAR DATA REGISTRY

Q&A

Patient Navigator Program

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

Quality Improvement for Institutions

Hospital to Home: Partnering to Meet the Needs of Vulnerable Populations

September 14, 2016

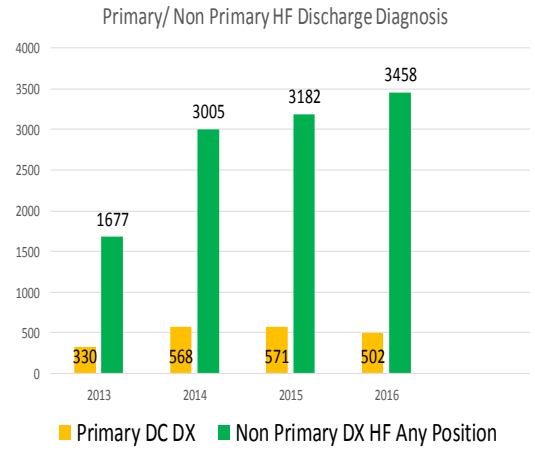
Renown HEALTH

Renown Regional Medical Center
Reno, Nevada

- 802 bed flagship of a locally owned and governed, not-for-profit health network
- Serving an 80,000 square mile catchment area
- Receiving patients from 29 rural referring hospitals
- Rural Nevadans comprise 40% of our patient population

A REGION-WIDE NETWORK OF HEART CARE
THROUGH 21 BOARD CERTIFIED CARDIOLOGISTS

Renown Regional Heart Failure Population



Source:

Crimson Clinical Advantage
Continuum of Care

REMSA

Regional Emergency Medical Services Authority

- REMSA Paramedic Ambulance Service
  - 42 ambulances & 400 employees serving 6,000 square miles
  - Nationally accredited (EMD ACE, ECNS ACE, COAEMSP, CAAMTS, CAAS), regional medical disaster coordination center, special events coverage
- Care Flight Medical Helicopter Service
  - Four aircraft serving 40,000 square miles
- Extensive Investment in Community Service Programs
  - Largest community & professional medical training center in NV
  - Specialized TEMS team supporting 3 local SWAT agencies
- Private non-profit serving Northern Nevada for 30 years
  - Nationally acclaimed for high performance, quality, innovation

COMMUNITY PARAMEDICINE

- Launched April 2013
- CMS Innovation Award Grant
- Specially-trained Community Health Paramedics provide in-home services to improve the transition from hospital to home, including:
  - Medical care plan adherence
  - Medication reconciliation
  - Point of care lab tests
  - Personal health literacy

Protocols: CHF, COPD, MI, Cardiac Surgery

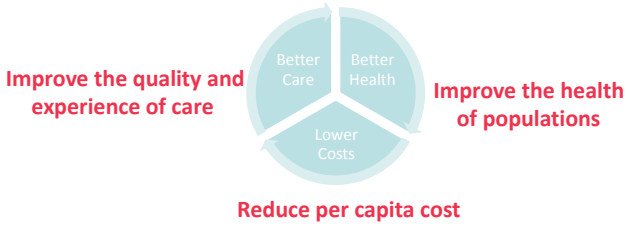
Hospital Admission/Readmission Avoidance Program

This program is in place to help patients through the transition from Hospital to Home.

The patients who get referred to this program have either and primary or secondary diagnosis of CHF, or COPD. Or are Post MI or Post Open Heart surgery.

This program is built to deliver better care, improve the patients health, and do so at a low cost.

TRIPLE AIM



Source: Berwick, DM, et al; *The Triple Aim: Care, Health & Cost*; May/June 2008; Health Affairs

WHAT DO THE COMMUNITY PARAMEDICS DO?

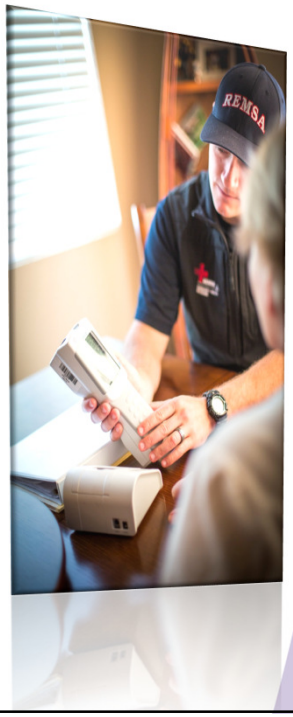
- Hospital Admission/Readmission Avoidance - The Community Paramedics work with hospitals, PCPs, Cardiologist, Pulmonologists, and Open Heart surgeons to safely avoid unneeded Admissions or re-admissions to the hospital.
- Hotspotter - Work with “Hotspotters” and redirect there use of the 911 system to more appreciate resources. (Urgent Cares, clinics, PCPs, Ect.).
- Evaluate/Refer - This program is in place to avoid initial hospital admissions by intervening with a Patient before their condition requires hospitalization.

Evaluate/Refer

- This program is in place to avoid initial hospital admissions by intervening with a Patient before their condition requires hospitalization.
- Typically a patient’s doctor will contact the CP’s requesting us to evaluate and treat at patient who they are unable to see and/or if the patient is unable to come to them.
- At these appointments we evaluate the patient, report findings to the referring Dr., and treat as appropriate. The referring Drs. office is sent a copy of the chart and contacted to schedule the pt. for a follow up visit.

Partnership with Acute Care

- Began as a grant funded program with no limitations related to payer source
- Assessment by inpatient nurse navigator, social services, bedside nurse, provider
- Referral to Community Paramedic
- Consent
- Paramedic meets with patient prior to discharge



What Happens in the Home?

- Point of care lab work
  (BMP, H&H, Blood glucose, Blood alcohol, clean catch UA, INR)
- Home Blood Draws
- 12 Lead ECGs
- IV Diuresis and Hydration
- Measure Peak Flow Rates
- Medications
  - ✓ Lasix PO or IV
  - ✓ Toradol
  - ✓ Prednisone
  - ✓ Potassium
- Collaboration with Cardiology Office

Preliminary Outcomes Show Progress Achieving the Triple Aim June 2013 – June 2015

- Safely avoided hospital readmission while improving care coordination, patient quality of life and satisfaction scores
- 982 enrolled patients
- 1,121 ED visits avoided
- 206 ambulance transports avoided
- Estimate of savings $1,517,961 (avg payments)
- 150% Return on investment

*All savings estimates are calculated based upon average charges from data provided by the Nevada Center for Health Statistics & Informatics at University of Nevada Reno. The estimate of payments avoided is based upon a generic 35% reimbursement rate.

Evolution of the Partnership

- Grant ended ☹
- Successful outcomes
  - ✓ Medicaid approved by CMS for reimbursement
  - ✓ Extended grant period
- Exploring options of sustainability
- Path forward with populations “at risk” in the Health Network
- Formalizing a partnership

Questions

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

Next Webinar

Webinar 5

Wednesday, November 9th

12-1pm ET

Quality Improvement for Institutions

Thank You!

Patient Navigator Program

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cvquality.acc.org/patientnavigator

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