Patient Navigator Program

Community Call #3- Cohort 1
July 15, 2015

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	*Providence St. Vincent*
12:20pm	*Huntsville Hospital*
12:35pm	*Advocate Sherman Hospital*
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

PROVIDENCE Heart and Vascular Institute

ACC Patient Navigator Program Implementation

July 15, 2015
Renee Swanson RN, BSN

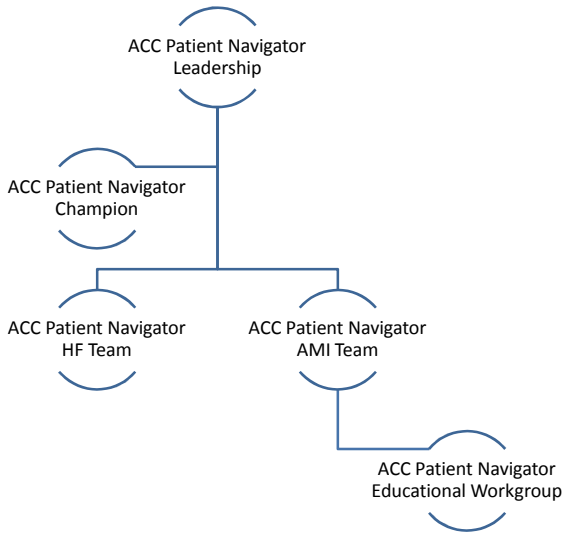
Providence St. Vincent Medical Center

PROVIDENCE Heart and Vascular Institute

ACC Patient Navigator Program Reports

- Gather baseline of available reports
  - Challenge, newer EMR
- Report Build Requests
- Roadmap of Reports
  - Created a tool that captures available reports, location and filters for each metric
- Dashboard
  - By creating the Roadmap, this eased the way for the Data Analyzers to enhance our Dashboards.
  - Updated the MI and HF Dashboards to include the ACC Patient Navigator Data points

ACC Patient Navigator Program Mtg Structure



PROVIDENCE Heart and Vascular Institute

ACC Patient Navigator Program Mtg Structure

- **ACC Patient Navigator Leadership Team Mtg (Monthly)**
  - Physician Champion
  - Nurse Champion
  - Heart and Vascular Institute Quality Manager
  - Heart and Vascular Data Manager
- **ACC Patient Navigator Champion Mtg (Monthly)**
  - Physician and Nurse Champion Touch Base

PROVIDENCE Heart and Vascular Institute

ACC Patient Navigator Program Mtg Structure

- **ACC Patient Navigator Program Team Mtg (Monthly, alternate focus between AMI and HF)**
  - Cardiologists
  - Hospitalists
  - Palliative Care
  - Inpatient and Ambulatory Cardiology Nurse Managers
  - Cardiology Inpatient RNs
  - Primary Care and Cardiology Ambulatory RNs
  - Cardiac Navigators
  - Cardiac Rehab RN
  - STEMI Coordinator
  - Home Health Educator
  - Clinical Informatics (RN)
  - Pharmacist
  - Care Management
  - Nutrition Services

PROVIDENCE Heart and Vascular Institute

Selecting Goals

Patient Navigator Program

Patient Navigator Program Assessment Scorecard- Providence

#	Program Metric
1	• 30-day unadjusted readmission rate for AMI and HF • 30-day risk standardized readmission rate for AMI and HF
2	• 30-day unadjusted mortality rate for AMI and HF • 30 day risk standardized mortality rate for AMI/HF
3	Patient satisfaction is: (monitored quarterly) • Patient/Provider Communication (HCAHPS Q's: 3,6,7,19,23) • Patient Understanding of Medications (HCAHPS Q's: 16,17,25) • Patient Understanding of Signs/Symptoms (HCAHPS Q's: 20,24)
4	Patient Quality of Life/Health Status *(Optional Metric)*
6	Metrics from Action Registry Get with the Guidelines Report: • STEMI Performance Composite (Metric 3) • NSTEMI Performance Composite (Metric 4) • Overall defect free care (Metric 2) • Aldosterone blocking agents at discharge for AMI patients (Metric 30) • Risk models for bleeding Risk Adjusted Bleeding Events (Detail line #1729) • Risk adjusted death-overall (Detail line #1707)
7	Heart Failure Performance Measures (ACC/AHA) • LV EF Assessment *(inpatient setting)* • ACE/ARB Therapy for patients with LVSD (also an HF Core Measure) (inpatient setting) • Beta Blocker Therapy for patients with LVS *(inpatient setting)*
8	HF and AMI patients are identified prior to discharge AND risk of readmission is determined.
9	Medication reconciliation is performed accurately as appropriate for every patient AND is documented in the medical record.
10	Follow-up visit or cardiac rehab referral (as appropriate) within 7 days is scheduled, documented in the medical record, AND patient is provided with documentation of the scheduled appointment (e.g., appointment card).
11	HF patient arrives at follow-up appointment, within 7 days of discharge from hospital.
12	Discharge summary (including summary of hospitalization, updated medication list) available to follow-up clinician within 72 hours.
13	Clinician discusses and provides documentation on the following: (1) specific education on their treatment regimen (self-care plan) and when to call their healthcare provider, (2) documentation of all prescribed medications, instructions on when and how they should be taken, and about any changes to medications, (3) community resources for healthcare.

Choose 3-4 Goals

- "Low Hanging Fruit"
- "Middle of the Road"
- "Pie in the Sky"

PROVIDENCE Heart and Vascular Institute

ACC Patient Navigator Program Goals

Metric: Insert Metric

Goal: Insert Goal Statement

Baseline State:

Data Source:

Goal State:

Timeframe:

*Goals are noted on Team Meeting Agendas

Action Plan

Patient Navigator Plan for Improvement HF
[Providence St. Vincent Medical Center]

The Plan for Improvement (sometimes called an action plan) is a detailed work plan that guides the team in reaching their goals. The plan lays out the steps for carrying out each strategy needed to meet a goal, i.e. they specify activities to be conducted during a designated time frame. Plans for Improvement help to organize your team and add structure to the details needed to get things done.

Components of the Plan for Improvement are:

- **Aim Statement:** A broad overarching statement that directs the program improvement efforts for an identified patient population.
- **Goals:** Quantifiable objectives describing the process to be improved. Goals are specific, measureable, actionable, relevant and time-sensitive (SMART).
- **Barriers:** Identifies issues related to current processes, organizational culture or other concerns that may delay/derail reaching the goal.
- **Strategies/Interventions:** Identifies proposed actions or changes in processes that will lead to achievement of the goal.
- **Action Steps:** Lists the activities or changes the will need to take place to implement the strategy. Depending on the strategy there may be a few basic activities or it may be very detailed.
- **Target Date:** Indicates the proposed date the action steps will be implemented.
- **Responsible Person(s):** Identifies the person(s) responsible for performing/implementing each activity.

Action Plan

Patient Navigator Plan for Improvement HF
[Providence St. Vincent Medical Center]

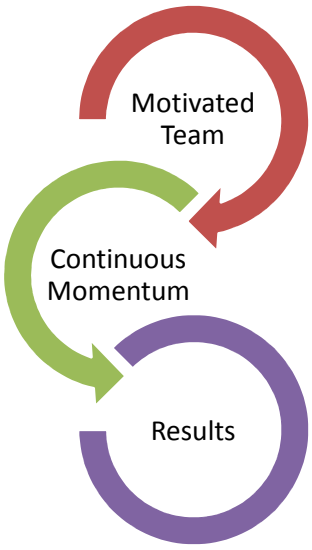
Aim Statement: To reduce avoidable hospital readmissions for patients discharged with acute coronary syndrome (ACS)/acute myocardial infarction (AMI) or heart failure (HF) by supporting a culture of patient-centered care during the hospital stay and in the weeks following discharge, thereby reducing mortality and improving Quality of Life.

Step 1: Select Goal	Step 2: Identify Barriers	Step 3: Choose a Method for Measurement
1. Metric 7 – Evidence based Beta Blocker Therapy for patients with LVSD (inpatient setting) **Goal:** All HF patients will be prescribed evidence based Beta Blocker Therapy (Bisoprolol, Carvedilol, or Sustained-Release Metoprolol Succinate) at discharge. **Baseline State:** **Data Source:** Premier **Goal State:** 100% **Timeframe:** 1 year	• Build Discharge Checklist • Provider Buy-in and compliance; Cardiology (Prov and Non-Prov) and Hospitalists	**Data Source:** Premier

Action Plan

Step 4: Develop strategies/interventions to achieve your goal			
Strategies/Interventions	**Action steps**	**Target Date**	**Responsible Person**
Discharge Checklist Contraindication	• Gather Coder's Dictionary/Data Definitions-4/14/15 GWTG HF Sandi Anderson, Terri Byers and Suzanne Upfield. • 4/10/15 Chart Abstractor Feedback	4/17/15	Renee Swanson
Discharge Checklist Content Approval	• Provider Champion-Dr. Joshua Remick • Approval of content from Dr. Ross, Dr. Abraham, Karen Rydell, Deb Dorst and Meegan Mangum.	5/1/15	Renee Swanson
Discharge Checklist Build	• 4/4/15 EPIC Provider Builders secured • 5/12/15 All Discharge Checklists Finalized and in the process of being formulated in	6/1/15	Ty Gluckman

Keys to Success



PROVIDENCE Heart and Vascular Institute

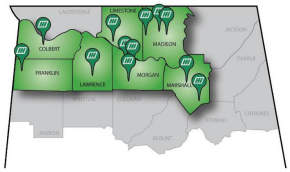
Contact Information

Renee Swanson RN, BSN
Cardiac Quality Coordinator
503-216-2079
renee.swanson@providence.org

Huntsville Hospital

James Murphy, MD
Arin Zapf, MSN, RN
Angie Bates, MSN, CRNP
Chrissy Fussell, CRNP
Joyce Loyed, PharmD
Dana Flores, PharmD

Health System



HH: our structure

Established in 1895 by community volunteers
Governed by the Health Care Authority of
the City of Huntsville

3rd largest public hospital system in U.S
Alabama's Largest Trauma/Emergency program
1,807 licensed beds & 941 at Main

35 employed Cardiologists
1,163 AMI Discharges FY14
1,205 Heart Failure Discharges FY14

Todays Discussion

- *Improving Patient Satisfaction for Communication & Understanding of Medications, Signs & Symptoms*
  - *Transition of Care Pharmacy Consults*
  - *Pharmacy First Fill*
  - *TARCOG*
- *Identifying Patients on the Off-Service Floors*
- *Role of the Navigator at HH*

HH Health System

Cardiac Transitions of Care (TOC) Process

- PharmD notified by cardiac CRNP of eligible patients
  - Multidisciplinary risk stratified list
- Profile review
  - Admitting diagnosis, comorbidities, labs, social barriers
- Discharge medication review
  - Compare all layers for consistency

Health System

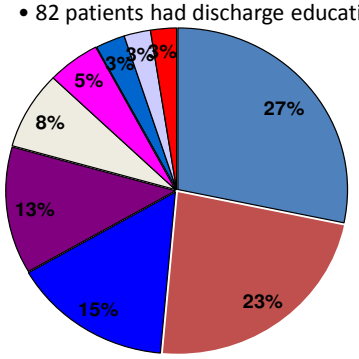
Cardiac Transitions of Care (TOC) Process

- Discharge medication education at bedside
  - Class of medication
  - Indication
  - Importance in heart failure, myocardial infarction
  - Administration
  - Side effects
- Reinforcement of disease state education given throughout hospitalization
- Facilitate patient cost issues along with social work

Health System

Cardiac Units TOC Interventions 3/1/15 to 4/30/15

- 91 patients reviewed at discharge
- 39 TOC interventions
- 82 patients had discharge education



- Promoted rxs filled at HH
- Rx Clarification
- Discharge Med Rec Clarification
- D/C inappropriate med
- Facilitated pt cost issue
- Other Intervention
- Med history clarification
- Lab monitoring
- Sub/supra-therapeutic dose change

Health System

Pharmacy First Fill

"Simple and Convenient"

- Improve patient satisfaction
- Increase medication compliance by removing barriers
  - Resolving prior authorizations
  - Manage drug shortage
  - Resolving incomplete or inaccurate prescriptions
- 90% of eligible patients accepted (183 out of 203 patients)

If RX are available prior to DC, nurse calls pharmacy to expedite process

HUA enters discharge order in EMR creating page to pharmacy tech

Pharm tech picks up RX and communicates with RN expected time of discharge

Pharmacy delivers prescription to patient room, collecting payment & answer questions

Health System

TARCOG

Top of Alabama Regional Council of Governments

- Helps local governments in three areas: aging, economic development, and planning.
- Region's Agency on Aging (AAA), TARCOG provides many services to the region's elderly population
- CMS provided grant funding to TARCOG for transition in care coaches.
  - Coaches are social workers trained in our med rec process and heart failure education
  - Coaches receive a daily list of Medicare patients admitted with a chronic illnesses
  - Coach will visit the patient and offer services. If patients agrees, transition coach will follow patient for 30 days

Sept 2013 – January 2015

42% reduction in readmissions for patients provided with Care Transition services

www.alarc.org/tarcog/

Health System

HCAHPS

Metric #3	FY14	FY15
Patient Provider Education Always Good	80%	81%
Patient Understanding of Medications During and After Hospitalization	77%	81%
Communication of Possible Side Effects of New Medicines	60%	73%

Vendor HealthStream®

Health System

Focus on the Off-Service Floors

Why

- HF 30 day readmissions hospital wide 23%
- Cardiology floors 17%

What

- NP Patient Navigator to mimic cardiology floor process

How

- Education (orientation, nursing, case managers, documentation spec.)
- If heart failure documented in the medical record, consult Navigator (Nurse Practitioner)
- Navigator Evaluates Patient
- Completes a Quality Sheet (next slide)

Health System

Quality Tool

	ASA	Beta Blocker	ACEI / ARB if EF < 40%	Statin LDL Goal < 100	Platelet Inhibitor
□ MI □ Stent If Yes □ None	□ **Yes** □ **No** □ Intol / Allergy □ GI Bleed/Ulcer □ Coumadin /thrombin or Xa Inhibitor □ Other	□ **Yes** Applies for MI □ **No** PCI w/o MI □ Intol / Allergy □ Bradycardia / Blocks □ Hypotension □ Wheezing □ Other:	□ **Yes** □ **No** Not Indicated □ EF > 40(HFpEF) □ Intol / Allergy □ Eval as outpatient □ Renal Insuf./Fail. □ Cough □ Hypotension □ Hyperkalemia □ Other:	□ **Yes** □ **No** □ Intol / Allergy □ Elevated LFT/ Hepatitis/Cirrhosis □ Other: LDL:_____	□ **Yes** □ **No** □ Intol / Allergy □ No Intervention □ Other: P2Y12_____ □ Cardiac Rehab
□ HF If Yes (ie; Hx of CHF cardiomyopathy, diastolic dysfunction, or systolic dysfunction, & pulmonary edema) □ NO HF *Do not hold up discharging a patient if BB / AA or HI are not addressed	**EF Percentage** HFrEF / HFpEF EF: _____% Date:_____ □ Echo □ TEE □ Cath □ Muga □ Stress □ Other NYHA Functional Class _____	**Beta Blocker if EF < 40% or MI/ICMY** □ **Yes** □ **No** Not Indicated □ EF > 40 (HFpEF) □ Intol / Allergy □ Bradycardia / Blocks □ Hypotension □ Wheezing □ Evaluate as an OP □ Other: Evidence Based BB: *bisoprolol,carvedilol, or metoprolol succinate	**ACEI / ARB if EF < 40%** □ **Yes** □ **No** Not Indicated □ EF › 40(HFpEF) □ Intol / Allergy □ Renal Insuf. /Fail. □ Cough □ Hypotension □ Hyperkalemia □ Evaluate as an Outpatient □ Other:	**Aldosterone Antagonist if EF < 35%** □ **Yes** □ **No** Not Indicated □ EF > 35(HFrEF) □ Intol /Allergy □ Normal EF □ Close patient monitoring cannot be ensured. □ Evaluate as an OP □ Other therapy not at max dose.	**Hydralazine and Isosorbide dinitrate** □ **Yes** □ **No** Not Indicated □ Not Indicated □ Hypotension □ PAH □ Evaluate as an OP □ Other:_____ **HF clinic F/U** □ One Time 7 day □ Enroll □ Phone Follow-Up *Risk Assessed

Health System

Next Steps……

7-Day follow-up
Standardizing the hand-off / process
How to handle the “no shows”

Thank you!

Health System

Implementation of Patient Navigator Program

Christina Hanson MSN, ACNS-BC, CHFN

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Patient Navigator Program
Advocate Sherman Hospital

2015 GET WITH THE GUIDELINES. STROKE
GOLD PLUS

About Advocate Sherman

- Located in Northwest suburb, 45 miles from Chicago
- 125 years of service to our community
- Joined 12 hospital system in 2013
- New hospital opened in 2009
- 255 beds; all private rooms
- Level 2 Trauma Center
- 4 outpatient centers; 1 skilled nursing facility
- 2,000+ associates; 600+ physicians on medical staff
- Fully accredited by DNV

Advocate Sherman Hospital

Objectives

- Identify role/responsibilities of patient navigator
- Understand strategies to collect data related to navigator program

Advocate Sherman Hospital

Building Your Team

HEART FAILURE TEAM

- Physician Medical Director
- Executive sponsor
- Team Chair
- Nursing staff from in-patient cardiac units
- In-patient nursing managers
- Case managers
- Clinical documentation specialist
- Data abstractors
- Cardiopulmonary Rehabilitation
- Nursing informatics
- Out patient Heart failure Clinic staff
- Pharmacy
- Medical Coding

ACUTE MI TEAM

- Physician Medical Director (cardiology and ED)
- Executive sponsor
- Quality RN
- ED staff RN
- ED nursing manager and director
- EMS representative
- Cath Lab staff
- Pharmacy
- Medical Coding

Advocate Sherman Hospital

Defining Role of Navigator

- Create job description
  - BSN
  - Cardiac experience preferred
  - Heart failure certified
  - CPR certified

Advocate Sherman Hospital

Defining Role of Navigator

- Daily rounding on in-patient units to identify HF patients, ensure GWTG measures are met
- Daily chart review for AMI patients
- Initiate patient education
- Collaborate with MD's/case managers to establish plan of care
- Coordinate patient follow up upon discharge
- Assist in out-patient HF clinic
- Participate in community outreach (ex: HF Support Group)

Advocate Sherman Hospital

Patient Identification

- Daily BNP/Troponin list generated from laboratory
- Daily report with diagnosis codes
  - 410.9 AMI
  - 428.0 CHF
  - 786.09 Dyspnea and respiratory abnormality
  - 786.5 unspecified chest pain
- Protocol usage

Advocate Sherman Hospital

Data Collection

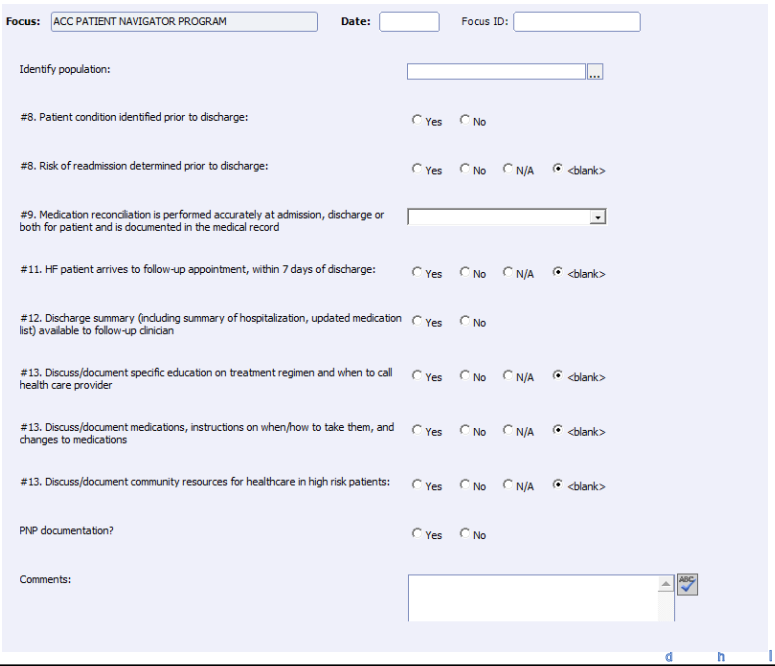
- Retrospective
- Final diagnosis of heart failure/AMI
- AMI data abstracted by clinical quality RN
  - ACTION Registry
- HF data abstracted by non-RN from clinical quality
  - Get With the Guidelines

Advocate Sherman Hospital

Data Collection

- Self reported metrics for Patient Navigator Program
- Created a focus study through MIDAS
  - Integrated medical software for hospital data analysis
- Review data on a scorecard at monthly team meetings
- Identify areas of improvement (Use of aldosterone antagonist)

Advocate Sherman Hospital



Questions?

Contact information

Christina Hanson MSN, ACNS-BC, CHFN

Christina.Hanson@AdvocateHealth.com

Advocate Sherman Hospital

Q&A

Patient Navigator Program

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

Quality Improvement for Institutions

Upcoming Calls and Webinars

Cohort 1:

- Community Call 4: Wednesday, Nov 11th from 12-1pm ET

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

Quality Improvement for Institutions

Thank You!

Patient Navigator Program

pnp@lists.acc.org

cvquality.acc.org/patientnavigator

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