Patient Navigator Program

Webinar #2
August 19, 2015

Quality Improvement for Institutions

How this webinar is organized

Time	Topic
12:00pm	Welcome and Introductions
12:05pm -12:50pm	7-day post discharge appointment process
12:05pm	*Medstar Washington Hospital Center*
12:20pm	*Baptist Health*
12:35pm	*Einstein Medical Center*
12:50pm	Q&A
12:57pm	Wrap-up and Next Steps

Quality Improvement for Institutions

Navigator Hospitals- Cohort 1

- Advocate Sherman Hospital Elgin, IL
- Christiana Care Health Services Wilmington, DE
- Einstein Medical Center Philadelphia, PA
- Huntsville Hospital Huntsville, AL
- Indiana University Health Methodist Hospital IN
- MedStar Washington Hospital Washington, DC
- Montefiore Medical Center New York, NY
- Providence St Vincent Medical Center OR
- Ronald Reagan UCLA Medical Center CA
- St. Mary's Hospital Waterbury, CT
- Trident Health Charleston, SC
- Vanderbilt Heart and Vascular Institute TN
- VCU Pauley Heart Center Richmond, VA
- WakeMed Hospital Raleigh, NC
- Western Maryland Health System Cumberland, MD
- Wyoming Medical Center Casper, WY

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Navigator Hospitals-Cohort 2

- Aurora BayCare Medical Center Green Bay, WI
- Baptist Health Louisville Louisville, KY
- Barnes Jewish Hospital St. Louis, MO
- California Pacific Medical Center, San Francisco
- Centra Lynchburg General Hospital Lynchburg, VA
- Fairview Hospital Cleveland, OH
- Indian River Medical Center Vero Beach, FL
- Mercy Hospital Portland, ME
- Mercy Medical Center- Des Moines, IA
- Newark Beth Israel Medical Center, Newark, NJ
- Olathe Medical Center Olathe, KS
- Renown Institute Reno, NV
- Scott & White Healthcare Temple, TX
- St. Vincent's Medical Center Bridgeport, CT
- Multicare Tacoma General Hospital Tacoma, WA
- University of Colorado Hospital Aurora, CO
- University of Utah Health Care Lake City, UT
- UT Southwestern Medical Center Dallas, TX
- West Jefferson Medical Center Marrero, LA

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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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MedStar Washington Hospital Center

Knowledge and Compassion
Focused on You

POST ACUTE CARE COORDINATION

The Appointment Process

6

Presenters:
Wanda Johnson, RN
Latonya Armstrong, RN

MedStar Washington Hospital Center

- Not-for-profit 926 bed, major teaching and research hospital in the nation's capital.
- Among the 100 largest hospitals in the nation which is renowned for handling the Washington's regions most complex cases.
- Home to MedStar Heart and Vascular Institute , which formed a first-of- its kind clinical and research alliance with Cleveland Clinic Heart & Vascular Institute in 2013.
- Operates Assist Device program certified by The Joint Commission.
- Nationally-verified level I trauma center with a state-of-the art fleet of helicopters and ambulances, also operates the region's only adult Burn Center.

Post Acute Care Coordination Program Screening Criteria

- Diagnosis of CHF or AMI
- Medicare
- Must be willing to participate
- 1-2 ED visits in the last year**
- 1-2 hospital stays in the last year**
- 3-5 medications or more**
- 1-2 co-morbidities **
- Exclusions: SNF/LTAC residents

**Patient can have one or more of these indicators

PACC Daily Screening

- Daily review of patients who are potential candidates for the PACC program
- Complete a thorough review of all patients to determine who has a final diagnosis of CHF or AMI.
- Once the diagnosis is finalized, a bedside interview is complete

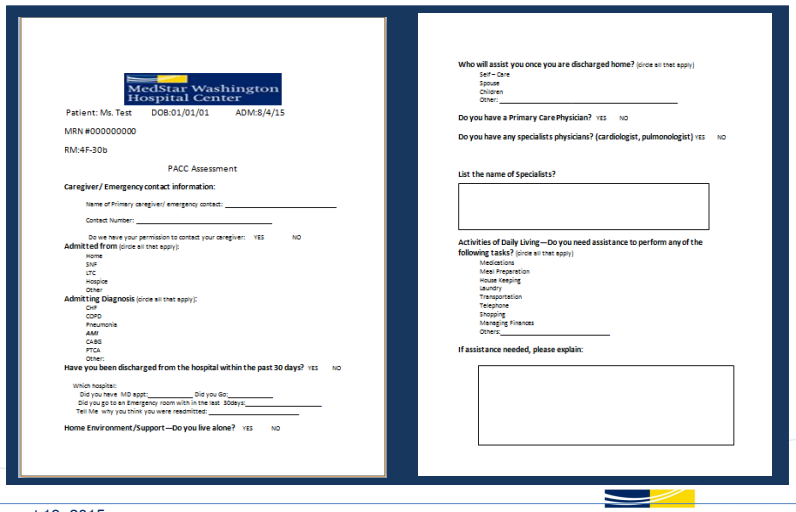
Post Acute Care Coordination Screening Tool

PACC Daily Active List

Name	AdmDtTm	Accou	MRN	A/S	EKGREADIN	Trop High	Trop Max	Unit	Complaint	R	C	Inactive?	ActiveDate	Roor
	08/12/2015 08:38	410(	3086	69M		1	3.580	4NE	new onset chf admit to imc for dr w					4N05PE
	08/11/2015 17:07	409(	7203	76M	Normal s	1	10.700	4F	nstemi w/ chf, anemia admit cath lab					4F24-A
	08/11/2015 15:14	410(	2793	74M		1	25.800	3H	+ trop sob cath lab					3H06-P
	08/11/2015 09:29	409(	5821	67M	Atrial fib	1	0.249	4D	nonstemi/afib/snycope b/t precath					4D03-P
	08/10/2015 21:32	409(	3015	67F	Sinus rhy	1	0.073	2D	chf exacerbation	Y	Y			2D03-A
	08/10/2015 08:53	409(	3067	73F	Normal s	1	15.500	4C	nstemi b/ card	Y	Y			4C06-A
	08/09/2015 20:06	409(	2817	70M	Normal s	1	0.194	2D	hyponatremia sob tired ha	Y	Y			2D19-B
	08/09/2015 18:17	409(	3085	75M	*** Poor	1	12.000	CVR	triple vessel disease inpt surg bed ca	Y	Y			CR11-P
	08/09/2015 15:44	409(	3042	71F			0.000	4C	hypoxia decompensated heart failur	Y	Y			4C10-B
	08/08/2015 10:36	409(	2844	83F		1	2.990	4NE	unstable angina card b/t	Y	Y			4N11PE
	08/06/2015 23:44	409(	2827	59M	Normal s		0.040	4NE	chf b/t 4ne	Y	Y			4N19PE
	08/06/2015 16:40	409(	3085	82M	Normal s	1	1.150	4C	nstemi bw/t pre cath	Y	Y			4C30-A
	08/06/2015 16:06	409(	8429	63F	Atrial-se		0.044	5E	abdominal pain chf exacerbation	Y	Y			5E29-B
	08/04/2015 19:44	409(	2807	66F	Normal s	1	200.000	4NW	non stemi elevation nstemi hyperter	Y	Y			4N03PV

Post Acute Care Coordination

Sample of Interview Tool



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Patient: Ms. Test DOB:01/01/01 ADM:8/4/15

MRN #000000000

RM:4F-30b

PACC Assessment

Caregiver/ Emergency contact information:

Name of Primary caregiver/ emergency contact: _____

Contact Number: _____

Do we have your permission to contact your caregiver: YES NO

Admitted from (circle all that apply):
Home
SNF
LTC
Hospice
Other

Admitting Diagnosis (circle all that apply):
CHF
COPD
Pneumonia
AMI
CABG
PTCA
Other:

Have you been discharged from the hospital within the past 30 days? YES NO

Which hospital:
Did you have MD appt:_____ Did you Go:_____
Did you go to an Emergency room with in the last 30days:_____
Tell Me why you think you were readmitted: _____

Home Environment/Support—Do you live alone? YES NO

Who will assist you once you are discharged home? (circle all that apply)
Self– Care
Spouse
Children
Other: _____

Do you have a Primary Care Physician? YES NO

Do you have any specialists physicians? (cardiologist, pulmonologist) YES NO

List the name of Specialists?

Activities of Daily Living—Do you need assistance to perform any of the following tasks? (circle all that apply)
Medications
Meal Preparation
House Keeping
Laundry
Transportation
Telephone
Shopping
Managing Finances
Others:_____

If assistance needed, please explain:

11

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MedStar Washington Hospital Center

The Appointment Process (current state)

- Contact information for physician is obtained from the patient/caregiver during the bedside interview.
- PACC RN offers to make appointment for Cardiologist and PMD prior to discharge from the hospital.
- Appointments are scheduled within 7 days after discharge from the hospital.
- Once the appointment is made, the patient is given an appointment card and the PACC RN's business card.
- If the discharge occurs before appointment is scheduled, the PACC RN calls the patient within 1-2 days at home to schedule the appointment.

12

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Knowledge and Compassion ***Focused on You***

MedStar Washington Hospital Center

Sample Appointment Card

Patient Name:

Room #:

MedStar Heart Institute

My "After Hospital" Care Plan

Follow-up call from the nurse:

Nurse coordinator: _____ Date of call: _____

If you have questions, you may call the nurse at: _____

Symptoms I need to watch. Report these to my doctor:

Weight gain of 3 pounds within 24 hours **OR** weight gain greater than 5 pounds in one week
Trouble breathing or shortness of breath with minimal activity
Swelling of feet, ankles or lower legs

Follow-up appointment at my doctor's office:

Dr. _____ Date of appointment: _____

Phone: _____ Time: _____

Address: _____

Dr. _____ Date of appointment: _____

Phone: _____ Time: _____

Address: _____

Appointment Process Barriers

- Patients prefer to make appointments independently, therefore, decline the assistance of the PACC RN.
- Hospitalist / Attending make appointments beyond our 7 day protocol.
- Short length of stay

Appointment Process Changes

- In lieu of offering to make appointments, inform the patient that the PACC RN will automatically make the appointment prior to discharge.
- Instruct the patient to reschedule the appointment if necessary.
- Once the patient is enrolled into the PACC program, the RN will call the Attending/Hospitalist to inform him/her that an appointment will be made 7 days after discharge.
- Place PACC sticker on the chart of patients enrolled into the program

Post Acute Care Coordination

Post Acute Care Coordination

Patient has been enrolled into the Post Acute Care Coordination Program (PACC)

CHF ☐

AMI ☐

PLEASE NOTIFY THE PACC NURSE ONE DAY PRIOR TO DISCHARGE

▸ ***For referrals or to ask questions — Contact Us:***

- Wanda Johnson: 240-286-1493
- Latonya Armstrong: 240-383-5642
- PACC nurses are available Monday – Friday, 8:30 a.m. – 5:00 p.m. *PACC not available on Weekends*

MedStar Washington Hospital Center

Form 2715.11/19/14

Improving Care Transitions by Scheduling Follow Up Appointments

Sherri Allen, MSN, RN, CPHQ
Director of Quality & Clinical Outcomes

August 19, 2015

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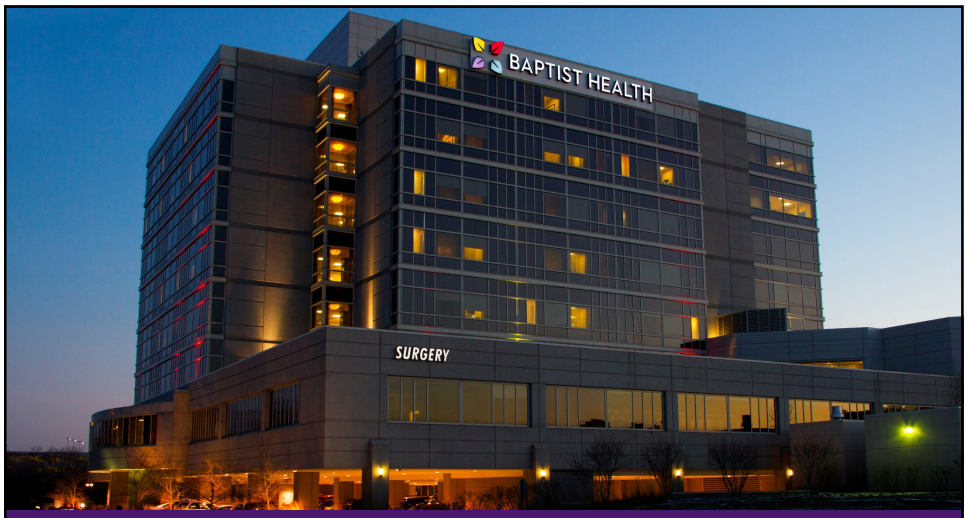
17



About Baptist Health Louisville (BHLou)

- Founded in 1975
- 519 Licensed Beds
- Member of Baptist Health, one of Kentucky's largest not-for-profit healthcare providers

18

Serving **Louisville, Kentucky** and surrounding areas.

19

Our Mission: To demonstrate the love of Christ by providing and coordinating care and improving health in our communities.

20

Our Vision: To lead the transformation to healthier communities.

21

The Importance of the Follow Up

- More than 50% of patients readmitted within 30 days did not have a follow up visit with their physician (Jencks, 2009)
- All major readmissions prevention programs promote scheduling follow-up appointments (Care Transitions Intervention, Project RED, Project BOOST)
- Experts agree that gold standard for follow up is within 7 days of discharge

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Follow Up Appointment Challenges

- Average wait times for Family Practice MD range from a high of 45 days in Boston to 5 days in Dallas
- Many physicians do not accept Medicaid as a form of payment

Merritt Hawkins, 2014 Survey of Physician Appointment Wait Times, 2014, available at: www.merritthawkins.com/pdf/mha2014waittimesurvey.pdf

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Follow Up Appointments

- Baptist Health Louisville will schedule a 7 day follow up appointment for 90% of AMI and HF patients prior to discharge by January, 2016

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Identifying Patients

- AMI
  - Daily Cath Lab log
  - Elevated Troponin Report
- HF
  - Last 24 hours admission report
    - Search key words

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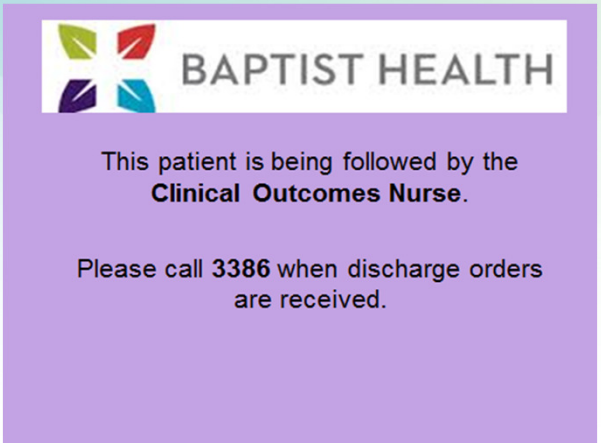
Identifying Patients

- Chart is labeled with sticker



26

Clinical Outcomes Nurse

- Identifies AMI / HF patients
- Identifies patients at high risk for readmission
- Communicates with nurses / physicians regarding ACC Navigator Program goals and interventions
- Ensures documentation for compliance with discharge medications and LV assessment per Get with Guidelines

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Clinical Outcomes Nurse

- Schedules follow up appointment within 7 days of discharge
- Calls patients for follow up at days 3, 7, 14, and 21

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Scheduling the Appointment

- Staff nurse calls Clinical Outcomes Nurse when discharge orders are received
- Outcomes Nurse reviews orders for direction regarding follow up appointment
- If there is not an order for an appointment within 7 days, an appointment is made with PCP
- Home Health appointments within 7 days of discharge meet the intent of the metric

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Scheduling the Appointment

- Added to patient's discharge instructions
- Appointment card given


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Provider Contact:

NAME: _____

You have an appointment

ON: _____ AT: _____ ❑ a.m. ❑ p.m.

PROVIDER: _____

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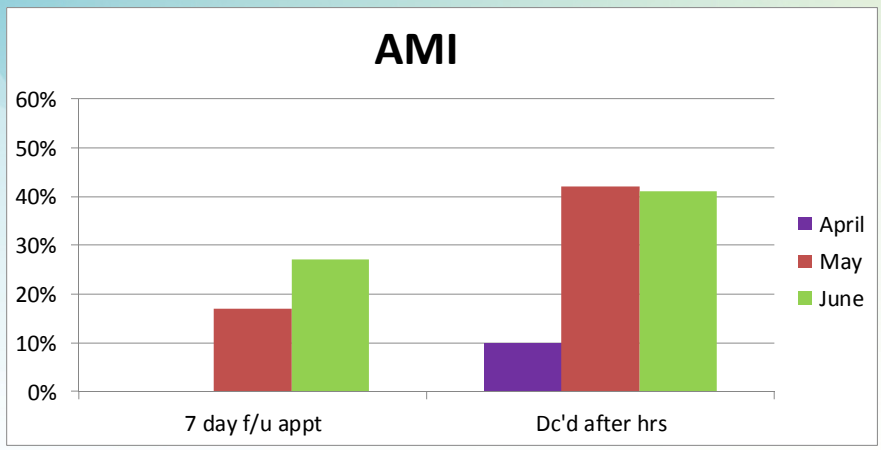
30

How are we doing?



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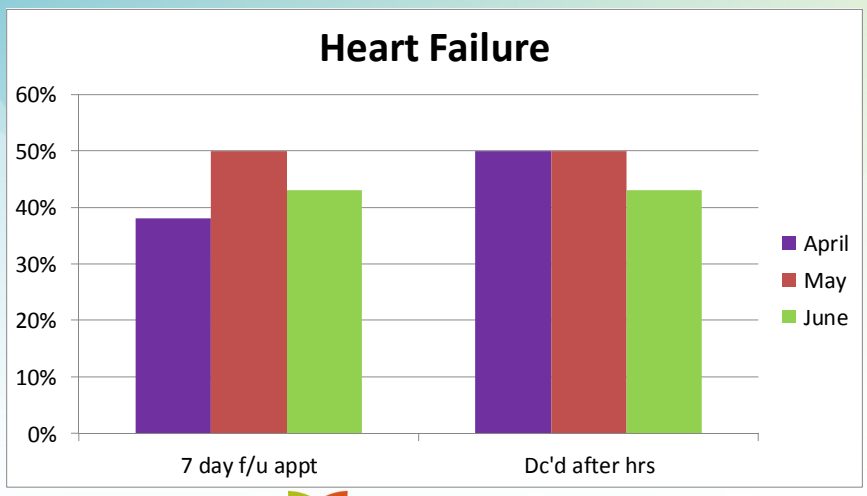
31

How are we doing?



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32

Challenges

- Staff nurse forgets to call Clinical Outcomes Nurse at discharge
- Patients without a Primary Care Provider
- Patients discharged after hours / weekends
- PCP appointment not available
- Knowing the appointment date for the first Home Health visit

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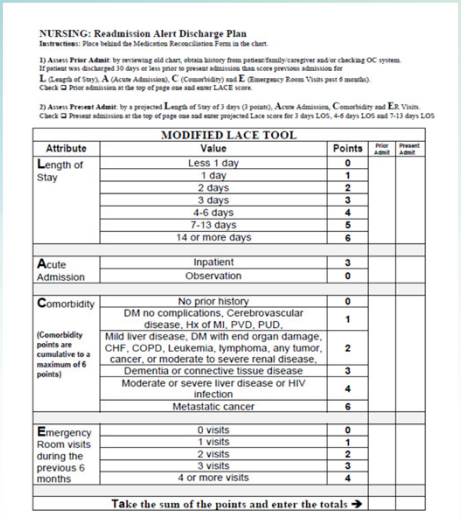
33

High Risk Readmission Patients



NURSING: Readmission Alert Discharge Plan
Instructions: Place behind the Medication Reconciliation Form in the chart.

1) Assess **Prior Admit**: by reviewing old chart, obtain history from patient/family/caregiver and/or checking OC system.
If patient was discharged 30 days or less prior to present admission then score previous admission for
L (Length of Stay), **A** (Acute Admission), **C** (Comorbidity) and **E** (Emergency Room Visits past 6 months).
Check ☐ Prior admission at the top of page one and enter LACE score.

2) Assess **Present Admit**: by a projected **L**ength of Stay of 3 days (3 points), **A**cute Admission, **C**omorbidity and **E**R Visits.
Check ☐ Present admission at the top of page one and enter projected Lace score for 3 days LOS, 4-6 days LOS and 7-13 days LOS

MODIFIED LACE TOOL

Attribute	Value	Points	Prior Admit	Present Admit
Length of Stay	Less 1 day	0		
	1 day	1		
	2 days	2		
	3 days	3		
	4-6 days	4		
	7-13 days	5		
	14 or more days	6		
Acute Admission	Inpatient	3		
	Observation	0		
Comorbidity (Comorbidity points are cumulative to a maximum of 6 points)	No prior history	0		
	DM no complications, Cerebrovascular disease, Hx of MI, PVD, PUD,	1		
	Mild liver disease, DM with end organ damage, CHF, COPD, Leukemia, lymphoma, any tumor, cancer, or moderate to severe renal disease.	2		
	Dementia or connective tissue disease	3		
	Moderate or severe liver disease or HIV infection	4		
	Metastatic cancer	6		
Emergency Room visits during the previous 6 months	0 visits	0		
	1 visits	1		
	2 visits	2		
	3 visits	3		
	4 or more visits	4		
	Take the sum of the points and enter the totals →			

34

High Risk Readmission Patients

- Flag charts with LACE placard
- Unit Secretaries assist in making 7 day follow up appointments

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35

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My Daily Medication Calendar

Generic	Brand	Dose	What it's for...	Before Breakfast	Breakfast	Lunch	Supper	Nighttime
aspirin		81mg	Protects the heart		x			
atorvastatin	Lipitor	40mg	Improves your cholesterol					x
calcium	Caltrate 600	1 tab	supplement		x			
carvedilol	Coreg	6.25mg	↓ blood pressure & heart rate		x			x
donepezil	Aricept	10mg	memory					x
lisinopril	Zestril	5mg	↓ blood pressure		x			
multivitamin		1 tab	supplement		x			

Take if needed:

Generic	Brand	Dose	What it's for...
acetaminophen	Tylenol	650mg	take every 4 hours as needed for pain / fever

Patient/Guardian Signature: _____ Date: _____ Time: _____

Clinical Outcomes Nurse Signature: _____ Date: _____ Time: _____

Nurse Signature: _____ Date: _____ Time: _____

Plan for Improvement

- Plan – 90% of AMI / HF patients will have 7 day follow up appt scheduled prior to discharge
- Do – Charts flagged, appointments being made
- Check – Large % of patients being discharged after hours / weekends
- Act – Need plan for making after hours appointments

BAPTIST HEALTH

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EINSTEIN MEDICAL CENTER PHILADELPHIA
Patient Navigator Program

August 19, 2015

Presenter:
Doreen Bearden BSN, RN MBA-HA

Structure

- Acute Care (575 Beds)
  - **Einstein Medical Center Philadelphia: 509 licensed acute care beds including 47 psychiatric beds**
  - **CCU**
  - **Cardiology inpatient unit**

Einstein HEALTHCARE NETWORK

Comprehensive Team- Medicine, Nursing, Social Work, Pharmacy, Care management, Nutrition, Outpatient transition

Patient Selection: RN and Social Worker

HF/MI

- Daily Heart Failure list
- Daily Heart Failure and AMI list
- Cross reference this list with daily Cardiology unit patient census list
- Use HF Inclusion and Exclusion Criteria for appropriateness for program
- Input from Care Management

Enroll patients:

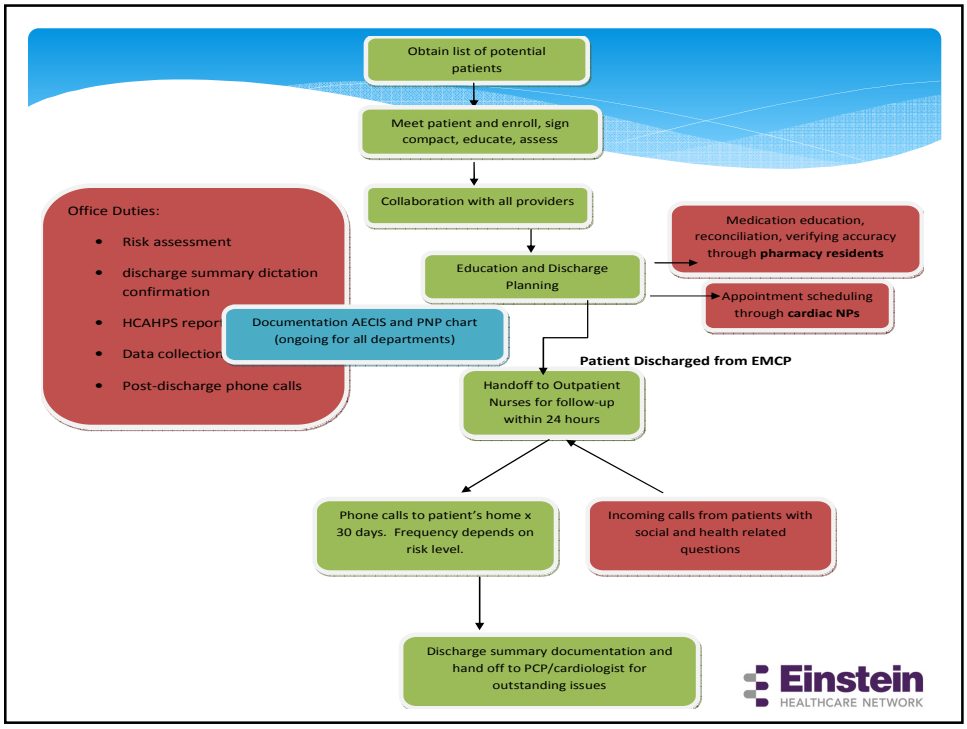
RN and Social Worker
Complete Patient Agreement
Patient signs Authorization of Release PHI

Einstein HEALTHCARE NETWORK

Process improvement for 7 day appointment

* 7-day Follow-up Appointment
  - Documented in medical record
  - Providing patient with documentation
* Verifying Patient arrives at follow-up appointment
* Discharge summaries w/in 72h to f/u provider

Einstein HEALTHCARE NETWORK



Risk Assessment:

- If patient is assessed to be at high risk, try to make follow up appointment within 3 or 4 days of hospital discharge.
- Assess needs for RN and SW

Outpatient *Tasks to be conducted by Navigators:*

- Initial phone call to patient is to be made within 24 hours of discharge (or 48 if over the weekend) – this phone call will be made by RN
- Social Worker to follow up with phone calls as needed
- Social Worker to follow up with patient at 7 day appointment if needed

Einstein
HEALTHCARE NETWORK

POLICY:

The purpose of this policy is to ensure that the patient has a follow-up appointment prior to discharge with a PCP/cardiologist. Bedside education about the appointment is to be conducted to assess compliance and to ensure patient understanding.

Confirm follow-up provider.
All patients: call NP Pager, discuss the patient and day of probable discharge.

- **NPs will arrange appointment.**
- **Document in discharge instructions** and in narrative (AECIS) the date, time of appointment.
- Educate patient about appointment, provide **"appointment card"** and discuss transportation or other possible hindrances.
- Communicate with residents.

Einstein HEALTHCARE NETWORK

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, November 11th from 12-1pm ET

Cohort 2:

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

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

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Thank You!

Patient Navigator Program

pnp@lists.acc.org

cvquality.acc.org/patientnavigator

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