Patient Navigator Program

Webinar 3
December 2, 2015

Quality Improvement for Institutions

How this webinar is organized

Time	Topic
12:00pm	Welcome and Introductions
12:05pm	Early Follow-Up
12:25pm	Q&A
12:35pm	Readmission Risk Assessment
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

Quality Improvement for Institutions

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

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

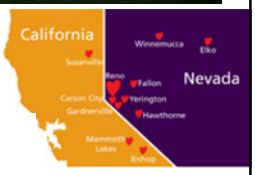
Heart Failure Follow-Up

Renown Regional Medical Center
Patient Navigator Program

Renown Regional Medical Center
Reno, Nevada

- 802 bed flagship of a locally owned and governed, not-for-profit health network
- The only Heart Attack Receiving Center and Trauma Center in Northern Nevada
- 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 18 BOARD CERTIFIED CARDIOLOGISTS



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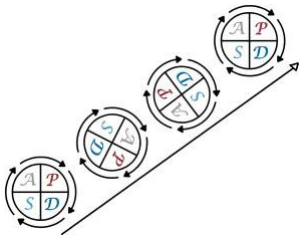
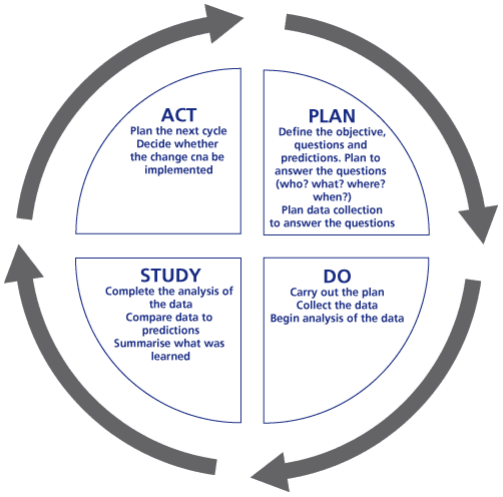
Problem

- Unable to consistently schedule 7 day heart failure follow-up appointments

Plan

- In 2013, we conducted a rapid process improvement workshop (RPIW) to evaluate our process for HF admissions
  - Analyzed from the time of admit to 30 days post-discharge
  - Formed a team including staff who make appointments
  - Measured the process
    - Perception/reality
  - Ideas documented





Process in 2013

- RN was responsible for scheduling
- Baseline: 62% HF patients leaving with follow-up appointment in 2012
- RN was spending a significant amount of time on the phone, trying to arrange follow-up
  - 20 minutes average time spent
- RN Heart Failure Navigator was spending a significant amount of time daily, arranging follow-up appointments
- We realized that this process was not working (we were not consistently getting appointments made) & this was not the best use of the RN's time (RN could be providing HF education)

Assessment of the State in 2013

- 80% of our patients follow up within the Renown Health organization
- Integrated EMR
- Centralized scheduling dept. that had capacity to absorb scheduling of follow up HF appointments

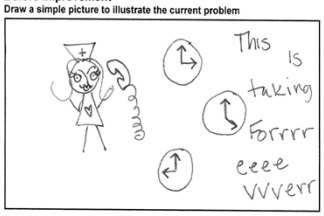
Idea Form

IDEA FORM

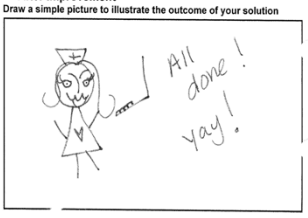
Follow-up Appointments

Employee / Area (Where or with whom is the problem occurring?)	Problems (What is the problem?)	Measures Taken (What is your proposed solution to the problem?)	Results (What would happen if your solution was implemented?)
UNITS SCHEDULERS	UNIT nurses says it takes 20 min to make follow-up appointments for CHF pts.	Nurse puts in an order for a follow-up. order goes to scheduling scheduler schedules appt and puts f/u in EPIC.	RNs have ↑ time with pts!

Before Improvement
Draw a simple picture to illustrate the current problem



After Improvement
Draw a simple picture to illustrate the outcome of your solution



DO

New Process Standard Work

Standard Process Description:
Follow-up Appointments

Renown HEALTH

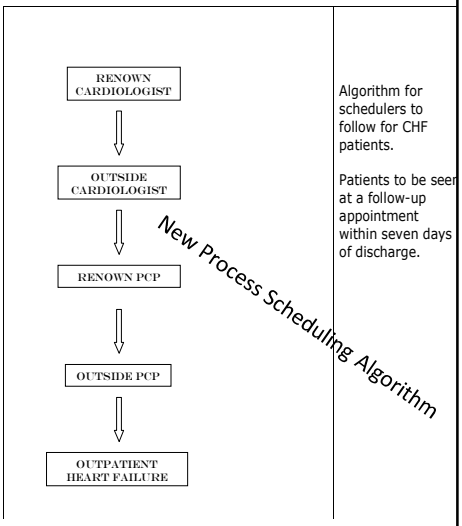
Quality Check	Safety Precaution	Standard WIP

Purpose: Reduce the time RNs spends scheduling outpatient follow-up appointments for CHF patients.

Related Policies or Evidence: Current observation time that RN spends on phone scheduling follow up appointments for CHF patients is approx. 20 minutes

Roles/Work Units Who Must Adopt This Process:	Takt Time:
All units caring for CHF patients and Centralized scheduling	

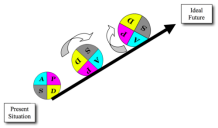
STEP Add Quality, Safety or system as needed	OPERATOR List role responsible for each task	TASK DESCRIPTION	TOOLS/SUPPLIES REQUIRED -PB in as needed to explain use of a specific tool or supply -Add photo if valuable to provide clear instructions	CYCLE TIME Add if converting to standard work
1.	Bedside RN	RN determines patient needs follow-up appointment within 7 days of discharge for CHF	Computer, EPIC access	
2.	Bedside RN	RN enters order for follow-up appointment under order entry in EPIC and signs order per protocol.	Computer, EPIC access	35 seconds
3.	Centralized scheduling	Centralized scheduling for Renown Medical Group receives order	Computer, EPIC access	1 min
4.	Centralized scheduling	Scheduler follows algorithm to investigate which provider to schedule patient with	Computer, EPIC access	1 min
5.	Centralized scheduling	If scheduler determines the patient has a Renown cardiologist: the scheduler will make an appointment in Cadence and document appointment provider, time,	Computer, EPIC access, Cadence access, telephone	1 min



Algorithm for schedulers to follow for CHF patients.

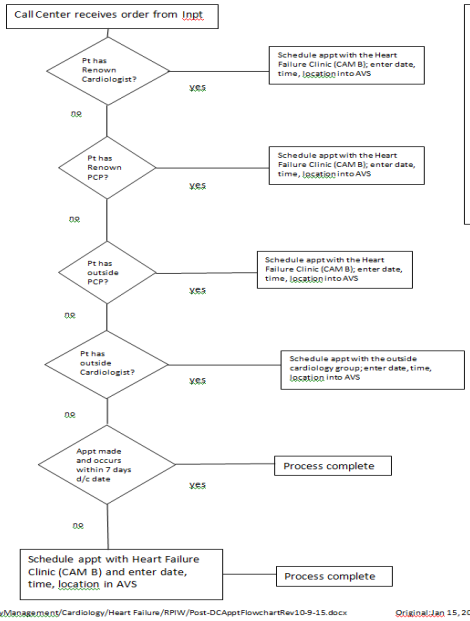
Patients to be seen at a follow-up appointment within seven days of discharge.

Do



- Goal: Assign task to appropriate role
- Everyone working at the top of their license
- RN inputs an order in electronic medical record for HF follow-up appointment
- Order routed to the Renown Call Center

Flowchart to Schedule Post-Discharge Outpatient Heart Failure Follow-up

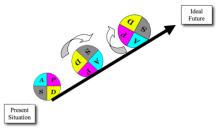


GUIDELINES:

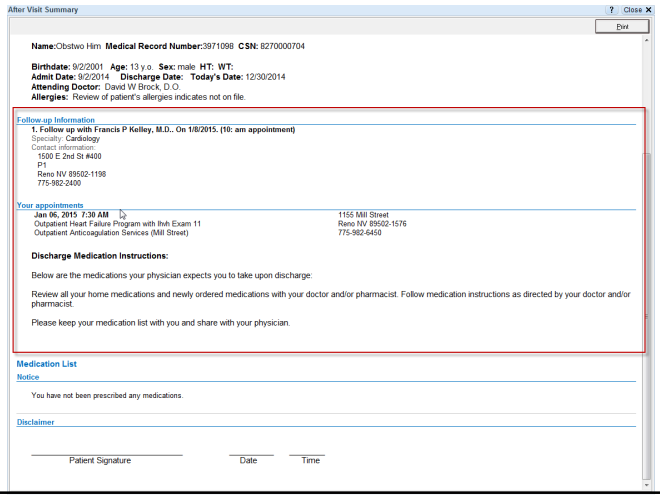
1. The HF follow up appointment must be scheduled within 7 days of discharge
2. The HF Clinic appointment should be scheduled with Thomas To, MD or Kara Paszek, APN
3. In addition to the providers in #2, prior to the provider appointment, schedule an appointment with Emily Bates, RN.

O:\QualityManagement\Cardiology\Heart Failure\RPIW\Post-DCApptFlowchartRev10-9-15.docx Original: Jan 15, 2014, Revised Oct 9, 2015

Do



- Appointment is entered into the EMR and is visible in the Discharge Navigator


After Visit Summary

Close

Print

Name: Obstwo Him **Medical Record Number:**3971098 **CSN:** 8270000704

Birthdate: 9/2/2001 **Age:** 13 y.o. **Sex:** male **HT:** **WT:**
Admit Date: 8/2/2014 **Discharge Date:** **Today's Date:** 12/30/2014
Attending Doctor: David W Brock, D.O.
Allergies: Review of patient's allergies indicates not on file.

Follow-up Information

1. Follow up with Francis P Kelley, M.D.. On 1/8/2015. (10: am appointment)
Specialty: Cardiology
Contact information:
1500 E 2nd St #400
P1
Reno NV 89502-1198
775-982-2400

Your appointments

Jan 06, 2015 7:30 AM
Outpatient Heart Failure Program with Ihvh Exam 11
Outpatient Anticoagulation Services (Mill Street)

1155 Mill Street
Reno NV 89502-1576
775-982-6450

Discharge Medication Instructions:

Below are the medications your physician expects you to take upon discharge:

Review all your home medications and newly ordered medications with your doctor and/or pharmacist. Follow medication instructions as directed by your doctor and/or pharmacist.

Please keep your medication list with you and share with your physician.

Medication List

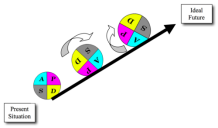
Notice

You have not been prescribed any medications.

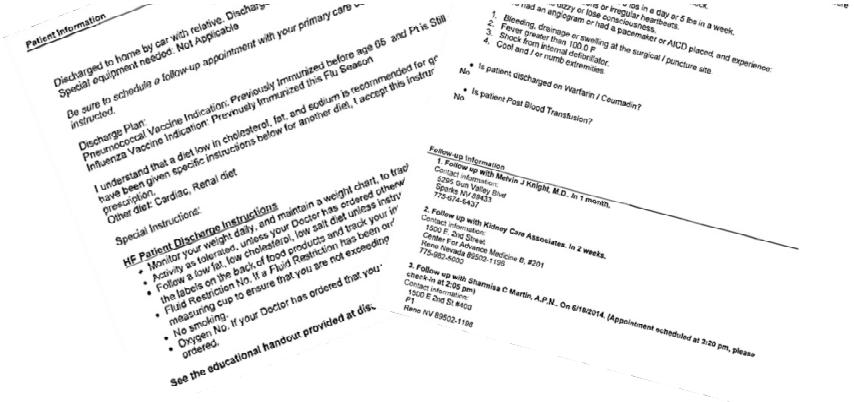
Disclaimer

Patient Signature Date Time

Do



- RN prints the After Visit Summary and reviews with patient and family or caregiver


Patient Information

Discharged to home by car with relative. Discharge
Special equipment needed: Not Applicable

Be sure to schedule a follow-up appointment with your primary care
instructed.

Discharge Plan:
Pneumococcal Vaccine Indication: Previously Immunized before age 65 and Pt is Still
Influenza Vaccine Indication: Previously Immunized this Flu Season

I understand that a diet low in cholesterol, fat, and sodium is recommended for
have been given specific instructions below for another diet, I accept this instru
prescription.
Other diet: Cardiac, Renal diet

Special Instructions:

HF Patient Discharge Instructions
- Monitor your weight daily, and maintain a weight chart, to trac
- Activity as tolerated, unless your Doctor has ordered otherw
- Follow a low fat, low cholesterol, low salt diet unless instru
- the labels on the back of food products and track your in
- Fluid Restriction No. If a Fluid Restriction has been or
measuring cup to ensure that you are not exceeding
- No smoking.
- Oxygen No. If your Doctor has ordered that you
ordered.

See the educational handout provided at dis

daily weight, activity and diet. This also explains more about Heart Fa
up and some of the tests that you have undergone.

Warning Signs of a Flare-Up Include:
- Swelling in the ankles or lower
- Shortness of breath

1. Bleeding, drainage or swelling at the surgical / puncture site.
2. Fever greater than 100.0 F
3. Shock from internal defibrillator.
4. Cool and / or numb extremities.

No • Is patient discharged on Warfarin / Coumadin?

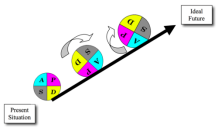
No • Is patient Post Blood Transfusion?

Follow up Information
1. Follow up with Melvin J Knight, M.D.. In 1 month.
Contact information:
6295 Guth Valley Blvd
Sparks NV 89433
775-674-5437

2. Follow up with Kidney Care Associates. In 2 weeks.
Contact information:
1500 E. 2nd Street,
Center For Advanced Medicine B, #201
Reno Nevada 89502-1195
775-982-5000

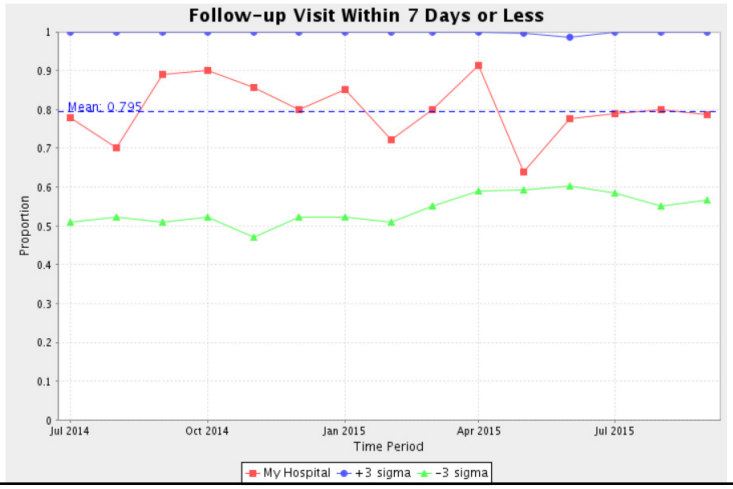
3. Follow up with Shamisa C Martin, A.P.N.. On 6/18/2014. (Appointment scheduled at 3:20 pm, please
check-in at 2:05 pm)
Contact information:
1500 E 2nd St #400
P1
Reno NV 89502-1198

Study



- Measure
- Appointment made within 7 days
- Documented on the After Visit Summary

2012 Baseline: 62%
2015 Jan – Sept 79%



Act

- We have 20% of patients outside of the Renown system
- Measure the number of patients who attend the follow up appointment within 7 days
- Validity of data is currently in question (51% attendance)
- Analysis of barriers for non attendance

Renown Regional Medical Center

- Wende Schwake, BSN, RN, CHFN
  - wschwake@renown.org
- Jessica Frank, MSN, RN, CCRN
  - jfrank@renown.org
- Karen Meskimen, DNP, RN
  - kmeskimen@renown.org

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West Jefferson
HEART FAILURE RESOURCE CENTER
NEW ORLEANS PHYSICIAN SERVICES, INC.

7 Day Post Discharge Appointments

Actions

Care Transition Clinic (CTC)--Hospital wide initiative to reduce readmissions

- No charge, NP follow-up visit within 72 hours
- Medication reconciliation/ensure follow-up plan

Physician Offices

- Worked with physicians offices to open f/u appointment time slots
- Worked with Cardiology group to develop protocol for 3-5 day f/u for CHF & AMI patients

Process for making f/u appointments

- Unit clerk makes PCP and any specialty physician appointments and documents it in the chart
- Discharge nurse provides documentation of appointment to patient/caregiver with D/C papers
- Any refusal to schedule appointments is also documented

Actions

After Hour/Weekend Process

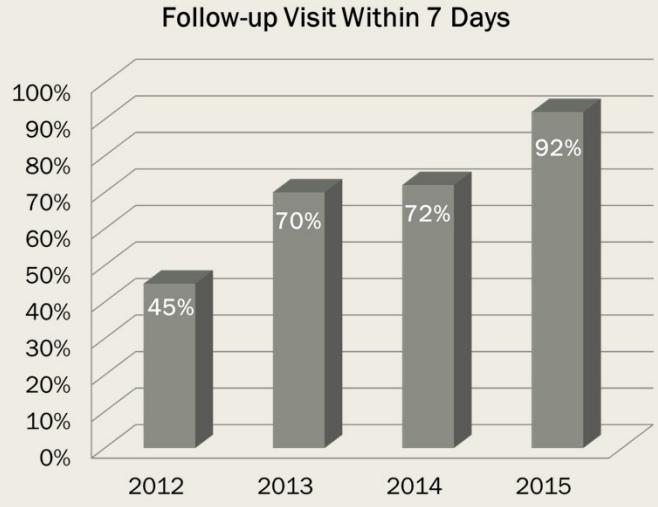
- Created process to make appointments after hours & weekends through the nursing staff office for CTC

Developed Heart Failure Resource Center

- NP led outpatient clinic for Heart Failure patients
- Inpatient HF nurse makes referral and arranges appointment prior to discharge

Challenges

- Not all physicians able to accommodate timely appointments
- Staff turnover ---EDUCATION IS KEY
- Patient complaints of too many appointments
- Transportation



GWTG HF Registry Data
West Jefferson Medical Center

Q&A

Patient Navigator Program

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

Quality Improvement for Institutions

Readmits on the rise for AMI Patients

S At the end of 2012 we had an increase in our AMI readmissions

B The % of readmissions was high enough that we had a reduction in our DRG payment that cost the hospital $$$

A Retrospective analysis on these patients and develop means for early identification

R Utilize risk assessment tool & other strategies to assist in lowering AMI readmission rate

Initial tool

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 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, Cancer, Leukemia, lymphoma, any tumor, cancer, moderate to severe renal dz	2		
	Dementia or connective tissue disease	3		
	Moderate or severe liver disease or HIV infection	4		
	Metastatic cancer	6		
Emergency Room visits during 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 total →				

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Lace Tool Scoring. (2013). Retrieved from http://www.besler.com/lace-risk-score

Readmission Risk Tool Development

Our team of dedicated nurse clinicians & abstractors reviewed the readmission charts and observed consistent findings:

- Age
- Socio economic status
- Psychosocial status and family history
- Payor mix
- Diagnosis of NSTEMI more prevalent in our readmission population
- Many of readmitted patients had multiple comorbidities

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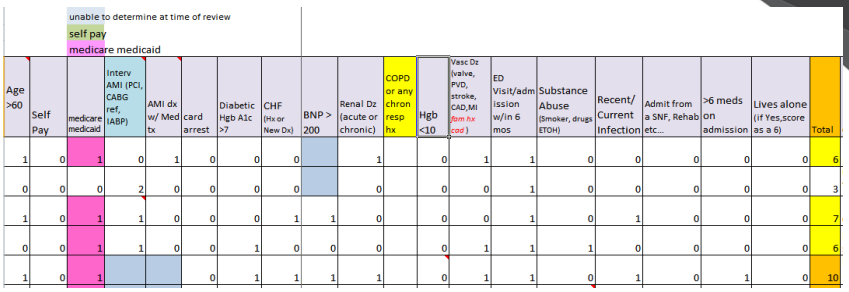
Early Readmission Risk Stratification Tool



unable to determine at time of review
self pay
medicare medicaid

Age >60	Self Pay	medicare medicaid	Interv AMI (PCI, CABG ref, IABP)	AMI dx w/ Med tx	card arrest	Diabetic Hgb A1c >7	CHF (Hx or New Dx)	BNP > 200	Renal Dz (acute or chronic)	COPD or any chron resp hx	Hgb <10	Vasc Dz (valve, PVD, stroke, CAD,MI from hx card)	ED Visit/admission w/in 6 mos	Substance Abuse (Smoker, drugs, ETOH)	Recent/ Current Infection	Admit from a SNF, Rehab etc...	>6 meds on admission	Lives alone (if Yes,score as a 6)	Total
1	0	1	0	1	0	0	0		1		0	1	1	0	0	0	0	0	6
0	0	0	2	0	0	0	0		0		0	0	1	0	0	0	0	0	3
1	0	1	1	0	0	0	1	1	0		0	0	1	0	1	0	0	0	7
0	0	1	1	0	0	1	0	0	0		0	1	1	1	0	0	0	0	6
1	0	1			0	1	1	1	1		0	1	1	0	1	0	1	0	10

Initially Started Sept 2013

January 2014 WakeMed selected as participant in ACC AMI-HF Patient Navigator Program

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Accuracy of tool

Initially selected value of 6 for risk

Time frame	# of readmits	# readmits score >/= 6	# of readmits not screened	Readmit risk score to actual readmit on screened patient %
Jan- Mar 2015	15	12	2	92.31%
Apr-Jun 2015	21	16	3	88.89%
Jul-Sep 2015	8	5	3	100.00%

Daily Chart Reviews

Concurrent review of inpatients for education needs/ deficits and deploy resources to meet those needs

MR#	PT#	Name	current Unit/ Rm	RISK Score	est DC date *Green cell is actual dc date*	LVEF & date	Currently on Diuretics/ Anti BX/ other pertn. Meds	ACE inh./ ARB ?? Nitrates	Beta blockers & STATINS	Is pt on (plavix, effient, brilinta)	Summary of hsp stay and any additional concerns	Seen by CV educ Card Rehab ord	In house follow up Case Mgmt Soc Work Diab. Educ have pcp or not	PHARMACY Review *document if you asst pt home w/ 30 day supply of meds*	DC appt's/ comments	dc'd to *(add if any HH , Crd REH or reh or SNF at DC)*
9	01/14/15	60-65% 1.6.15	Lasix oxycod. Zyrtc. Insul		valsartan ntg sl prn	lopressor lipitor Mag Ox	ASA 81 Effient Zofran	71F *1.5 STEMI Promus prx RCA stnt occluded pt intub.* Hx: CAD PVD HTN diab obes dyslip		CV educ v 1.12 BH	live w fam Has pcp in hsp PT	2 meds		*Rsl Cards PA Feb 3 PCP Jan 22nd 1045A*	Home w/HHPT HHRN OP Car Reh ref

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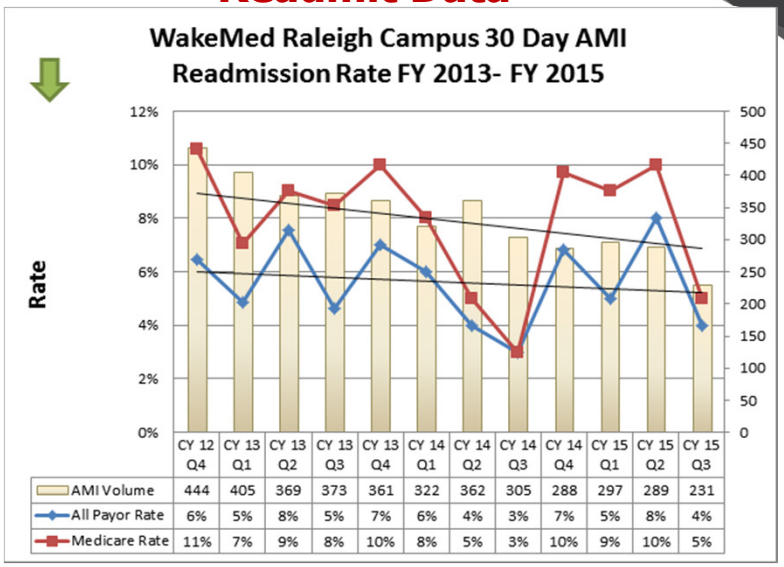
Daily Screening and Scoring tool

Daily Audit tool for Screening and Scoring of AMI patients 11/27/2015

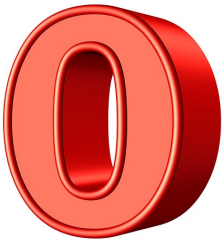
Name MR #	Last Name, First Name	AGE	Insurer	Adm MD	# of hm meds	STEMI NSTEMI HF other & Intervention	HX diab or Hgb A1c >7	Hx CHF or new HF	Hx COPD Chr resp dx	*Family hx cad* CAD CVA TIA Valve surg PVD
ACCT# Room#		SEX	Educ doc	PCP	Card Arrest this adm		Hx Renal Dx/ CR >2.0	BNP	Substance abuse	ED/Hsp adm in 6 months
Adm Date From X COUNTY							Hgb ↓10	EF/date	Infection	Lives With/or From X facility
Meds this hospital stay (circle) + *others* ASA 81 ASA 325 Plavix Effient Brilinta Lopressor Coreg Toprol XL Lipitor Pravachol Crestor Zocor losartan Lisinopril Ramipril Enalapril Capoten Imdur Lasix Bumex Protonix Pepcid Norvasc NTG Pste/ptch						Risk score	Adm. Diag/ present Course:		Other hx:	MISC

Most Recent AMI 30-Day Readmit Data



	CY 12 Q4	CY 13 Q1	CY 13 Q2	CY 13 Q3	CY 13 Q4	CY 14 Q1	CY 14 Q2	CY 14 Q3	CY 14 Q4	CY 15 Q1	CY 15 Q2	CY 15 Q3
AMI Volume	444	405	369	373	361	322	362	305	288	297	289	231
All Payor Rate	6%	5%	8%	5%	7%	6%	4%	3%	7%	5%	8%	4%
Medicare Rate	11%	7%	9%	8%	10%	8%	5%	3%	10%	9%	10%	5%

Outcome FY 2016



NO REDUCTION IN DRG PAYMENT!!!

Next Steps

- Apply same tool for use in Heart Failure patients
- Implement tool in our Electronic Health Record (Epic)
- Ongoing collaboration with team members for additional strategies to reduce readmissions

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

Cohort 2:

- Community Call 3: Wednesday, Jan 20th from 12-1pmET
- 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

Quality Improvement for Institutions

Thank You!

Patient Navigator Program

pnp@lists.acc.org

cvquality.acc.org/patientnavigator

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