Patient Navigator Program

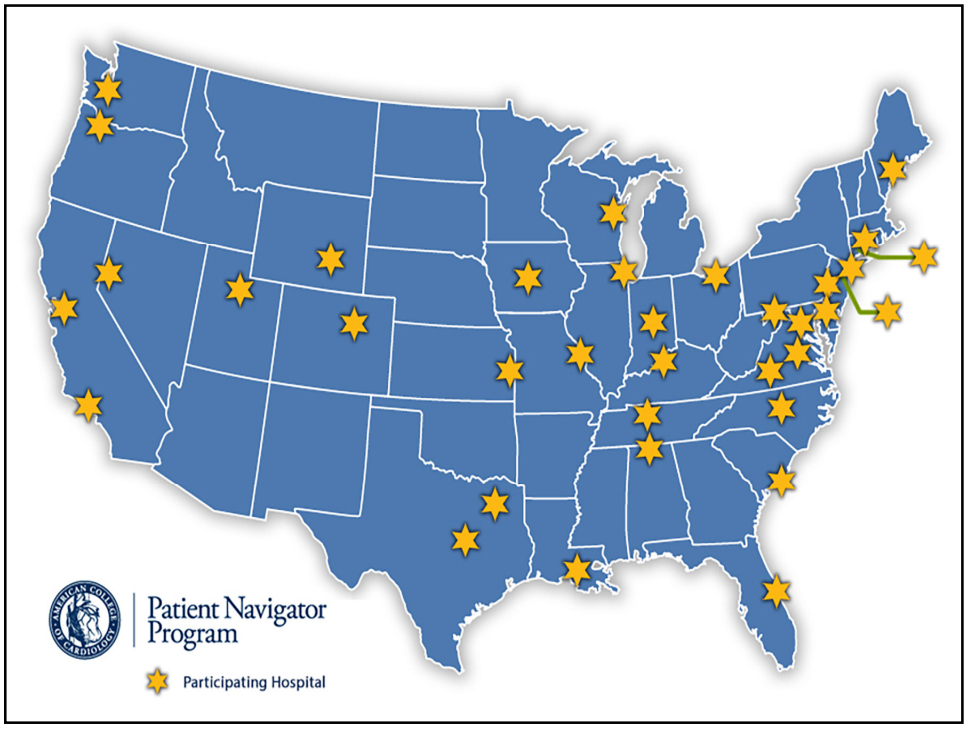
Webinar 4
May 11, 2016

Quality Improvement for Institutions

How this webinar is organized

Time	Topic
12:00pm	Welcome and Introductions
12:05pm	Physician Engagement
12:17pm	Q&A
12:22pm	Follow-Up Phone Calls
12:34pm	Q&A
12:39pm	Rapid Rounds
12:52pm	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.

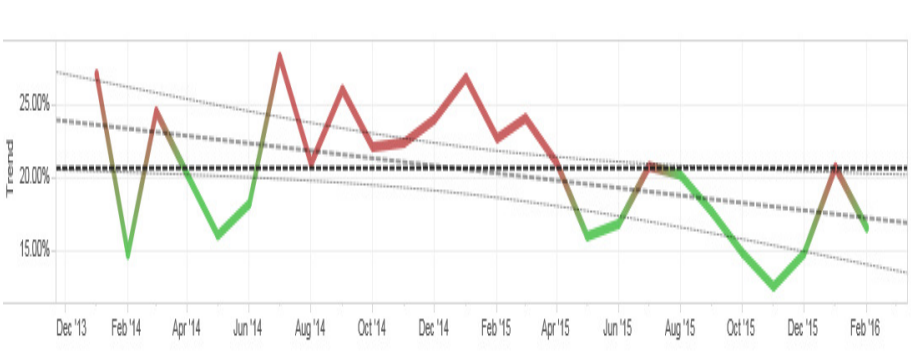
Quality Improvement for Institutions

Physician Engagement & Standardized 7-day follow-up

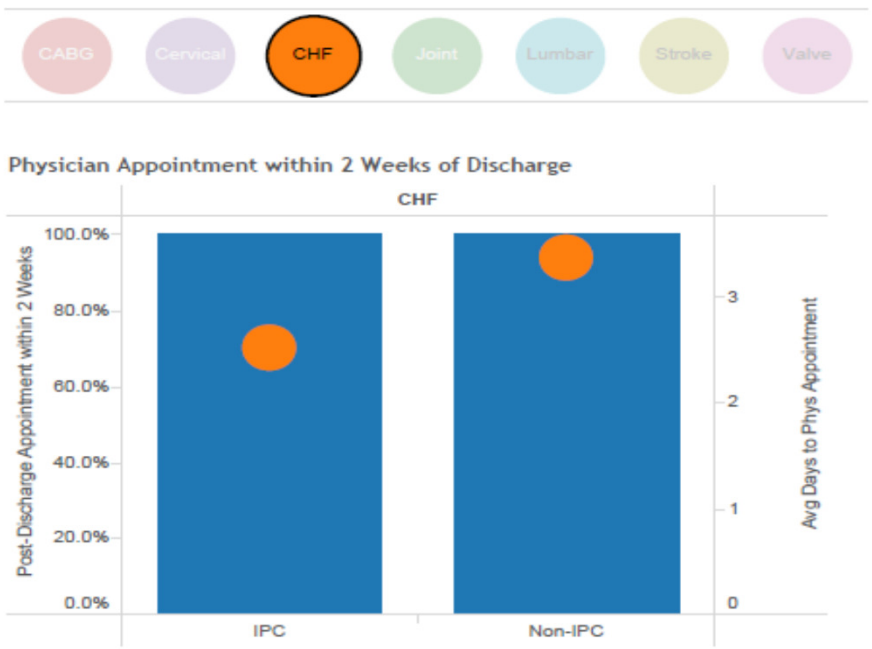
Mitchell T. Saltzberg, MD
Medical Director, Heart Failure Program

CHRISTIANA CARE HEALTH SYSTEM

Trends for 30 Day All Cause CHF Readmissions



CHRISTIANA CARE HEALTH SYSTEM



HF Readmissions: Transitions of Care

HF Navigator Services for all inpatient units & up to 90 days post-discharge

- ***48 hour phone call to assess symptoms:*** 99% call completion rate
- ***7 day follow up appointment made with Cardiology:*** 95% compliance for follow up appointments made prior to discharge
- ***10 day phone call to ensure appointment follow through:*** 83% compliance for attending the appointment
- ***Additional phone call check-ins depending on risk level up to 90 days:*** symptom assessment, remove transportation barriers, social work support

Inpatient Heart Failure Navigators

ED case manager alerts Inpatient Heart Failure Navigators (HFN) of HF admission or transfer

Daily Screening HF inpatients by HFN

HFN sees patient and obtains verbal patient agreement to be enrolled in the program

HFN addresses social, behavioral, transportation and financial assistance needs with patients and families

CHRISTIANA CARE HEALTH SYSTEM

Inpatient Heart Failure Navigators

Facilitate follow-up appointments with physician offices

Many Cardiology practices have designated specific HF hospital-discharge appointment slots

Communicate with post-acute care and other health care providers to support the physician's plan of care

Link patient with local & regional community resources as available

Transitional care with Christiana's CareLink services

CHRISTIANA CARE HEALTH SYSTEM

Heart Failure Transition Planning

Christiana's Care Link services is an interdisciplinary care coordination team comprised of Nurses, Case Managers, Pharmacists, Social Workers, and Support Staff who, under the leadership of a Medical Director, provide support to physician practices

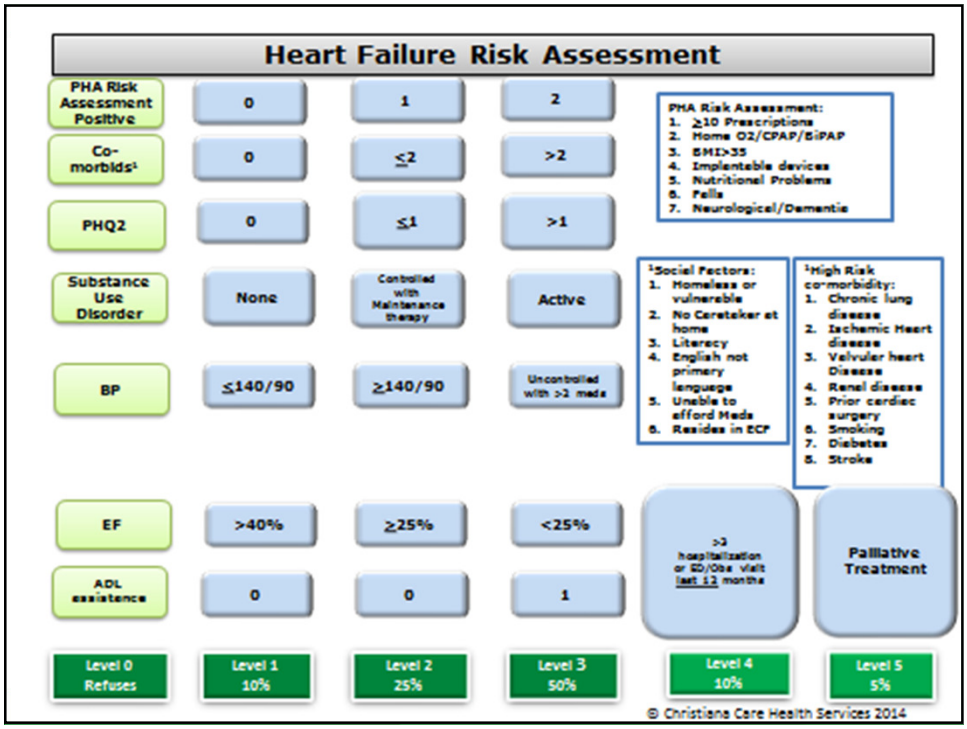
- **Communicate with post-acute care** and other health care providers to support the physician's plan of care along the care continuum
- **Promote patient engagement** and **help identify what is important to the patient**; including: self management of chronic conditions, medication management, facilitation of follow-up appointments, preventive care, testing and imaging

CHRISTIANA CARE HEALTH SYSTEM

RN makes First call within 72 hours post discharge

- Carelink RN contacts patient to confirm follow-up appointment. If no appointment, will work with physician office
- Medication Reconciliation
- Risk Assessment
  - Patient's knowledge of HF: causes, signs and symptoms, management, and problem solving
  - Patient's knowledge of daily weight monitoring and recording, provide weight log
  - Determine if patient has scale in home
- Plan of Care & self-management goals

CHRISTIANA CARE HEALTH SYSTEM


Heart Failure Risk Assessment
PHA Risk Assessment Positive
Co-morbids[1]
PHQ2
Substance Use Disorder
BP
EF
ADL assistence
0
1
2
0
≤2
>2
0
≤1
>1
None
Controlled with Maintenance therapy
Active
≤140/90
≥140/90
Uncontrolled with >2 meds
>40%
≥25%
<25%
0
0
1
PHA Risk Assessment:
1. ≥10 Prescriptions
2. Home O2/CPAP/BiPAP
3. BMI>35
4. Implantable devices
5. Nutritional Problems
6. Falls
7. Neurological/Dementia
[1]Social Factors:
1. Homeless or vulnerable
2. No Caretaker at home
3. Literacy
4. English not primary language
5. Unable to afford Meds
6. Resides in ECF
[1]High Risk co-morbidity:
1. Chronic lung disease
2. Ischemic Heart disease
3. Valvular heart Disease
4. Renal disease
5. Prior cardiac surgery
6. Smoking
7. Diabetes
8. Stroke
>3 hospitalization or ED/Obs visit last 12 months
Palliative Treatment
Level 0 Refuses
Level 1 10%
Level 2 25%
Level 3 50%
Level 4 10%
Level 5 5%
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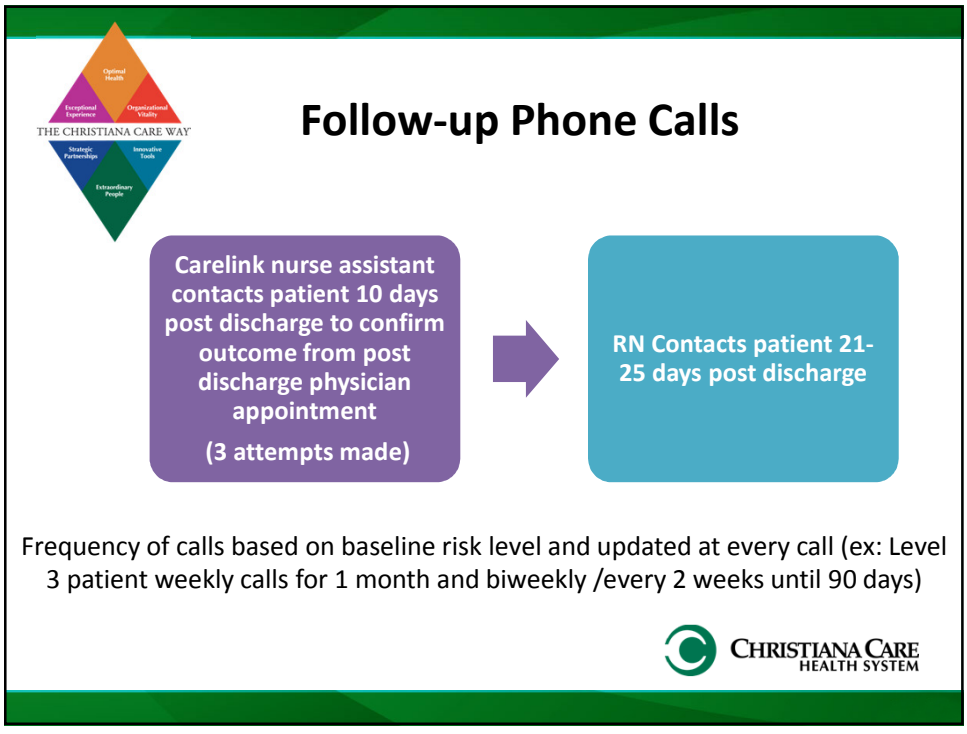

THE CHRISTIANA CARE WAY
Follow-up Phone Calls
Carelink nurse assistant contacts patient 10 days post discharge to confirm outcome from post discharge physician appointment
(3 attempts made)
RN Contacts patient 21-25 days post discharge
Frequency of calls based on baseline risk level and updated at every call (ex: Level 3 patient weekly calls for 1 month and biweekly /every 2 weeks until 90 days)
CHRISTIANA CARE HEALTH SYSTEM

HF Call Schedule

	Level One	
Day	**Intervention**	**Staff**
0	discharge	
1-2	Post d/c call Initiate care plan	CM, PC, SW
10	Follow-up	Nurse asst
21-25	Follow-up	CM, PC, SW
45	Follow-up	CM
65	Follow-up	CM
90	Follow-up Program completion	CM

	Level 4	
Day	**Intervention**	**Staff**
0	discharge	
1-2	Post d/c call Initiate care plan	CM, PC, SW
9-10	Follow-up call every other day as needed	CM
Week 2	Follow-up Update care plan	CM, PC, SW
Week 3	Follow-up	CM
Week 4	Follow-up	CM
Week 5	Follow-up	CM
Week 6	Follow-up weekly	CM
90	Follow-up Program completion	CM

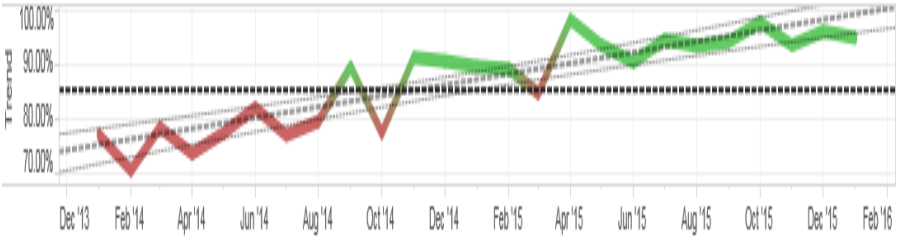
CHRISTIANA CARE HEALTH SYSTEM

Follow-up call weeks 4-12

- **Assess** patient's self-management skills related to disease condition
- Review and update **self-management goals** with patient
- Assess for **signs and symptoms** for progression of disease process
- **Reinforce knowledge** of HF management, medications, problem solving
- Re-assess for **barriers to medications**
- **Agree** on plan of care and follow-up calls/visit.
- If patient is being monitored through direct care visits, **re-assess** for continued need
- Agree on **goals** for dietary changes and exercise changes
- Reassess **knowledge of diet and exercise** related to heart failure
- If using community resources, **determine perceived value and outcomes**
- Re-assess patient goals against the **Plan of Care**
- **Involve** Practice Physician for modifications as needed

CHRISTIANA CARE HEALTH SYSTEM

End Result: Trend in 7 Day Follow Up Visits for CHF Patients



CHRISTIANA CARE HEALTH SYSTEM

Lessons Learned

- Setting clear goals: 100% 7 days or LESS follow up for all CHF patients
- Collaborative work with bedside nursing, Heart Failure Navigators, Community Providers, CHF Clinic and Care Link
- HF Navigators have been INSTRUMENTAL in care coordination and care transitions

Outcomes

- **Dramatic increase** in number of 7 day or LESS follow up visits
- Major contributor to sustained reductions in 30-day all cause readmission rates: **BELOW 15% for the past 7 months**

CHRISTIANA CARE HEALTH SYSTEM

Q&A

Patient Navigator Program

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

Quality Improvement for Institutions

VANDERBILT UNIVERSITY MEDICAL CENTER

Follow Up Phone Calls: Improvements and Value

Jay Morrison RN MSN CPPS
Randy Cox MPH LSS
Marie Glaser RN MSN

VANDERBILT UNIVERSITY MEDICAL CENTER

Vanderbilt University Hospital

- Located in Metropolitan Nashville, Tennessee
- VUH is VUMC's 649 bed adult hospital
- Admits over 50,000 patients annually
- Performs 37,000 surgical procedures
- Over 66,000 ED visits annually
- Middle Tennessee's only Level 1 Trauma Center

BEST Nationally Ranked Hospital
in 8 Adult Specialties, 10 Pediatric Specialties

BEST Regionally Ranked Hospital
#1 in Tennessee, Recognized in Middle Tennessee, #1 in Nashville metro area

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Navigator Goals

1. Improve the number of patients that are discharged with a 7-day follow up appointment printed on their discharge instruction sheet by 50% by July 1 2016.

2. Improve the number of patients that receive a post discharge follow-up phone call within 72 hours of discharge by 50% by July 1 2016.

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Post Discharge Follow Up Phone Calls

- Institutional rollout began in July 2015
- The expectation was for Clinic RNs to call 100% of patients within 72hrs of Discharge

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People / Process / Technology

- Individual outpatient clinics were not given any new FTEs to assist with calls
- A list of discharged patients placed on a “dashboard” in EMR for filtering by clinic RNs
- A standardized form with talking points was created to document conversation and interventions
- Performance dashboard was created to show improvement over time

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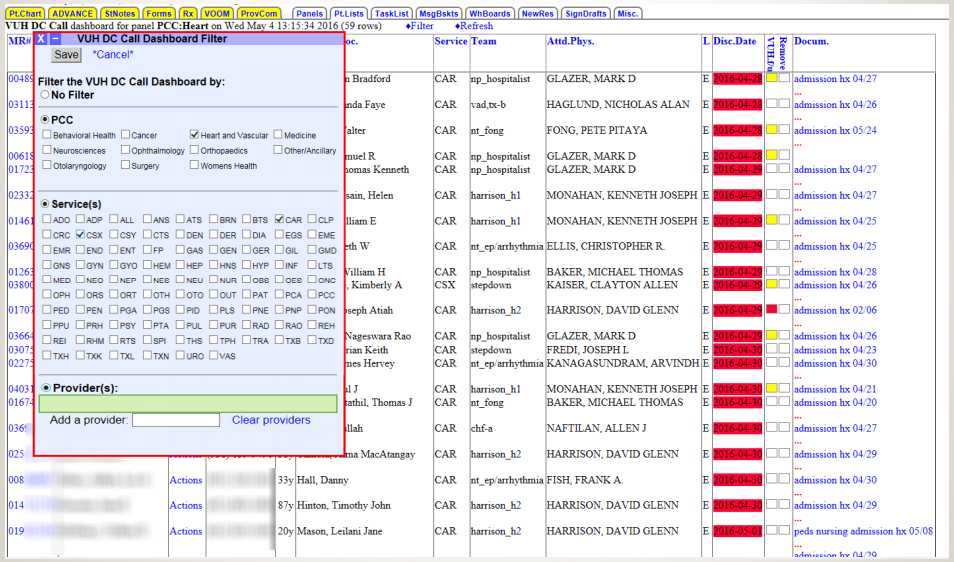
VUH DC Call Dashboard



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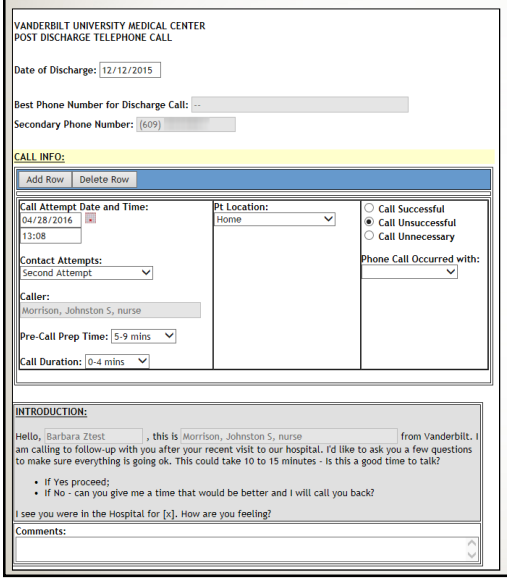
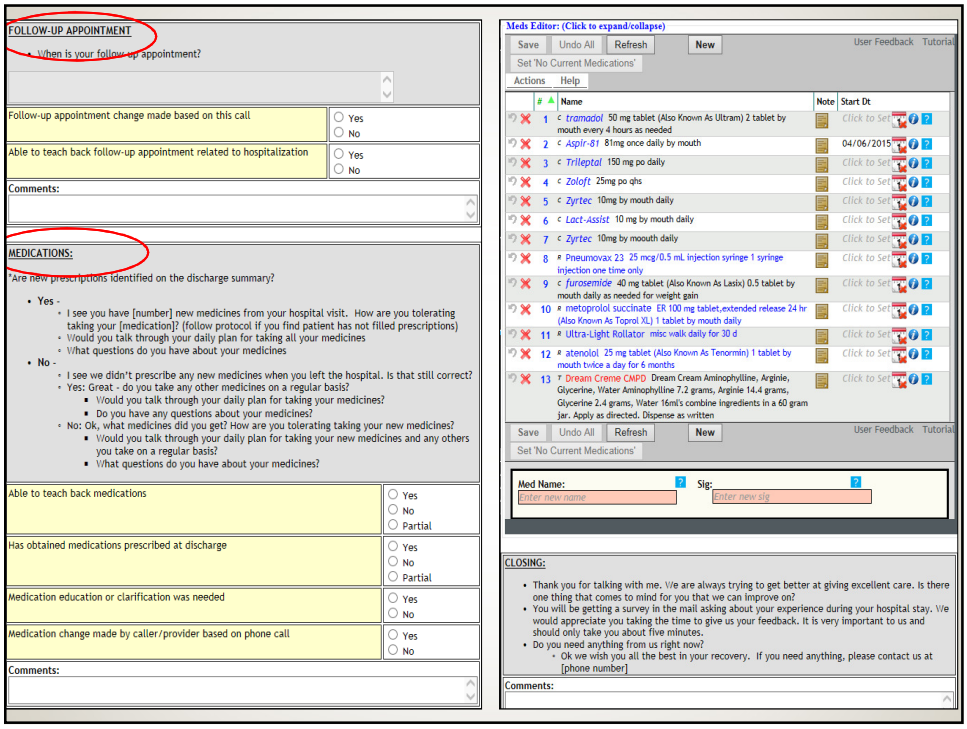
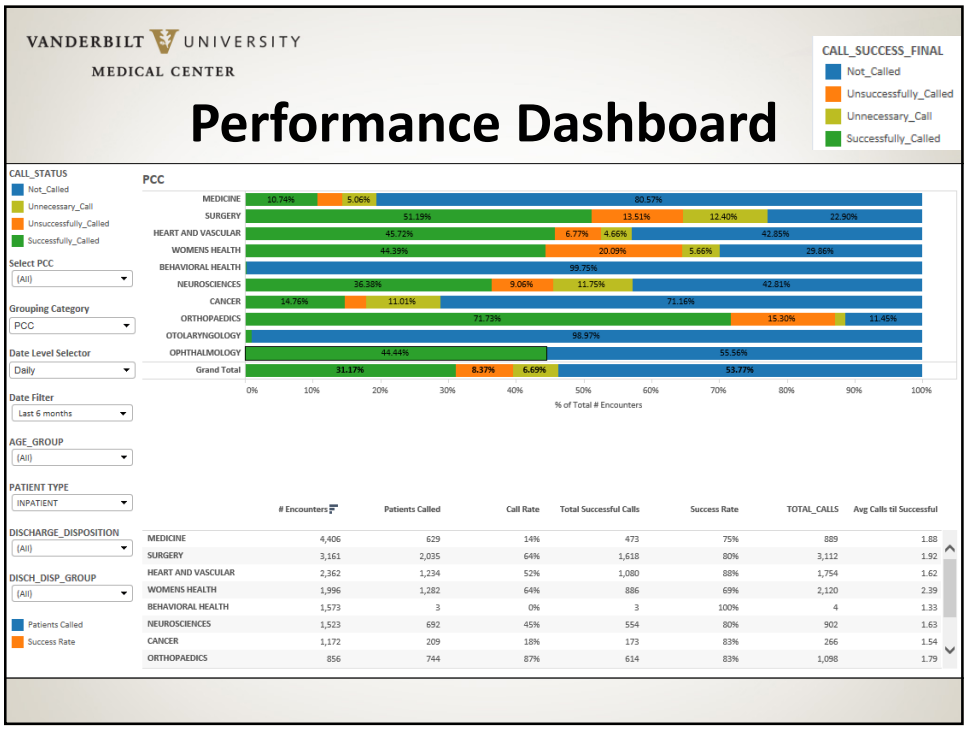
Standardized Documentation Form



Areas of Focus:

- Discharge Instructions
- Follow Up Appointment
- Medications
- HCAHPS Survey Reminder


FOLLOW-UP APPOINTMENT
When is your follow-up appointment?
Follow-up appointment change made based on this call
Yes
No
Able to teach back follow-up appointment related to hospitalization
Yes
No
Comments:
MEDICATIONS:
*Are new prescriptions identified on the discharge summary?
Yes -
I see you have [number] new medicines from your hospital visit. How are you tolerating taking your [medication]? (follow protocol if you find patient has not filled prescriptions)
Would you talk through your daily plan for taking all your medicines
What questions do you have about your medicines
No -
I see we didn't prescribe any new medicines when you left the hospital. Is that still correct?
Yes: Great - do you take any other medicines on a regular basis?
Would you talk through your daily plan for taking your medicines?
Do you have any questions about your medicines?
No: Ok, what medicines did you get? How are you tolerating taking your new medicines?
Would you talk through your daily plan for taking your new medicines and any others you take on a regular basis?
What questions do you have about your medicines?
Able to teach back medications
Yes
No
Partial
Has obtained medications prescribed at discharge
Yes
No
Partial
Medication education or clarification was needed
Yes
No
Medication change made by caller/provider based on phone call
Yes
No
Comments:
Meds Editor: (Click to expand/collapse)
Save
Undo All
Refresh
New
Set 'No Current Medications'
Actions
Help
User Feedback
Tutorial
A
Name
Note
Start Dt
1 tramadol 50 mg tablet (Also Known As Ultram) 2 tablet by mouth every 4 hours as needed
2 Aspir-81 81mg once daily by mouth 04/06/2015
3 Trileptal 150 mg po daily
4 Zoloft 25mg po qhs
5 Zyrtec 10mg by mouth daily
6 Lact-Assist 10 mg by mouth daily
7 Zyrtec 10mg by moouth daily
8 Pneumovax 23 25 mcg/0.5 mL injection syringe 1 syringe injection one time only
9 furosemide 40 mg tablet (Also Known As Lasix) 0.5 tablet by mouth daily as needed for weight gain
10 metoprolol succinate ER 100 mg tablet,extended release 24 hr (Also Known As Toprol XL) 1 tablet by mouth daily
11 Ultra-Light Rollator misc walk daily for 30 d
12 atenolol 25 mg tablet (Also Known As Tenormin) 1 tablet by mouth twice a day for 6 months
13 Dream Creme CMPD Dream Cream Aminophylline, Arginie, Glycerine, Water Aminophylline 7.2 grams, Arginie 14.4 grams, Glycerine 2.4 grams, Water 16ml's combine ingredients in a 60 gram jar. Apply as directed. Dispense as written
Med Name:
Enter new name
Sig:
Enter new sig
CLOSING:
Thank you for talking with me. We are always trying to get better at giving excellent care. Is there one thing that comes to mind for you that we can improve on?
You will be getting a survey in the mail asking about your experience during your hospital stay. We would appreciate you taking the time to give us your feedback. It is very important to us and should only take you about five minutes.
Do you need anything from us right now?
Ok we wish you all the best in your recovery. If you need anything, please contact us at [phone number]
Comments: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Performance Dashboard
CALL_SUCCESS_FINAL
Not_Called
Unsuccessfully_Called
Unnecessary_Call
Successfully_Called
CALL_STATUS
Not_Called
Unnecessary_Call
Unsuccessfully_Called
Successfully_Called
Select PCC
(All)
Grouping Category
PCC
Date Level Selector
Daily
Date Filter
Last 6 months
AGE_GROUP
(All)
PATIENT TYPE
INPATIENT
DISCHARGE_DISPOSITION
(All)
DISCH_DISP_GROUP
(All)
Patients Called
Success Rate
PCC
MEDICINE 10.74% 5.06% 80.57%
SURGERY 51.19% 13.51% 12.40% 22.90%
HEART AND VASCULAR 45.72% 6.77% 4.66% 42.85%
WOMENS HEALTH 44.39% 20.09% 5.66% 29.86%
BEHAVIORAL HEALTH 99.75%
NEUROSCIENCES 36.38% 9.06% 11.75% 42.81%
CANCER 14.76% 11.01% 71.16%
ORTHOPAEDICS 71.73% 15.30% 11.45%
OTOLARYNGOLOGY 98.97%
OPHTHALMOLOGY 44.44% 55.56%
Grand Total 31.17% 8.37% 6.69% 53.77%
0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
% of Total # Encounters
# Encounters
Patients Called
Call Rate
Total Successful Calls
Success Rate
TOTAL_CALLS
Avg Calls til Successful
MEDICINE 4,406 629 14% 473 75% 889 1.88
SURGERY 3,161 2,035 64% 1,618 80% 3,112 1.92
HEART AND VASCULAR 2,362 1,234 52% 1,080 88% 1,754 1.62
WOMENS HEALTH 1,996 1,282 64% 886 69% 2,120 2.39
BEHAVIORAL HEALTH 1,573 3 0% 3 100% 4 1.33
NEUROSCIENCES 1,523 692 45% 554 80% 902 1.63
CANCER 1,172 209 18% 173 83% 266 1.54
ORTHOPAEDICS 856 744 87% 614 83% 1,098 1.79

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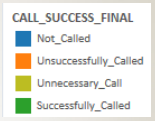
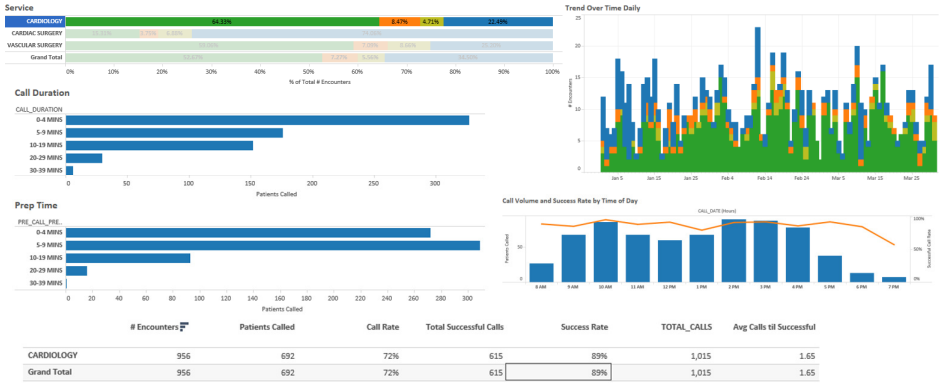
Performance Dashboard





	# Encounters	Patients Called	Call Rate	Total Successful Calls	Success Rate	TOTAL_CALLS	Avg Calls til Successful
CARDIOLOGY	956	692	72%	615	89%	1,015	1.65
Grand Total	956	692	72%	615	89%	1,015	1.65

Service: Cardiology

Timeframe: 1/1/16 – 3/31/16

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Improvement over Time

4th Qtr 2015									
Row Labels	Not_Called		Successfully_Called		Unnecessary_Call		Unsuccessfully_Called		Grand Total
65+	370	47.2%	69	46.9%	4	23.5%	14	53.8%	457
Under_65	414	52.8%	78	53.1%	13	76.5%	12	46.2%	517
Grand Total	**784**		**147**		**17**		**26**		**974**
	80.5%		**15.1%**		**1.7%**		**2.7%**		

1st Qtr 2016									
Row Labels	Not_Called		Successfully_Called		Unnecessary_Call		Unsuccessfully_Called		Grand Total
65+	86	40.0%	293	47.6%	22	48.9%	29	35.8%	430
Under_65	129	60.0%	322	52.4%	23	51.1%	52	64.2%	526
Grand Total	**215**		**615**		**45**		**81**		**956**
	22.5%		**64.3%**		**4.7%**		**8.5%**		100%

- Process Review with End User Feedback
- Nurse Triages the Dashboard
- "Orphan Message Basket" owner
- Increased accountability by Nursing Leadership
- Increased ownership of patients by nursing staff
- Data Transparency

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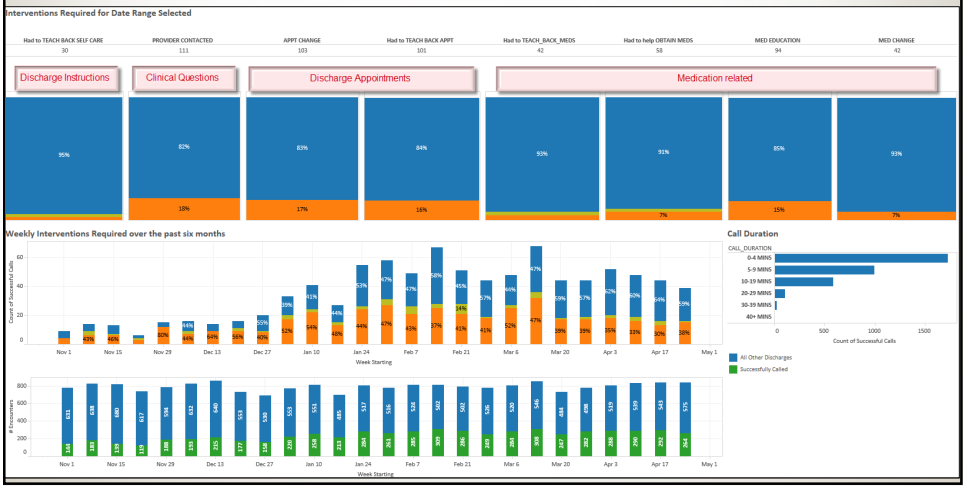
How to define Value of Post Discharge Phone Call?



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How to define Value of Post Discharge Phone Call?

- HCAHPS improvements for Pts who receive a Follow Up Phone Call:

	DC Call = YES	DC Call = NO
Above 50th Percentile	8	0
Above 75th Percentile	5	0

Q&A

Patient Navigator Program

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

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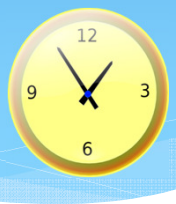
Newark Beth Israel Medical Center
Newark, NJ

Rapid Rounds



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Barnabas Health

Rapid Rounding Objectives

- Reduce LOS
- Identify high risk for readmission patients
- Ensure pathway compliance
- Expedite testing and consults
- Escalate case management/social issues
- Highlight focused on other areas that need to be addressed (Foley catheters, lines, VTE prophylaxis etc.)

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Barnabas Health

Interdisciplinary Team members

- Primary RN
- Nurse Manager
- Case Management
- Social Worker
- Physical Therapy
- Transition of Care team
- Administration
- Cardiac Echo manager
- Nurse Practitioners

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Barnabas Health

Team Planning

PLAN FOR THE DAY

(Primary Nurse)

- **Patient's LACE score**
- What is keeping the patient in the hospital today?
- What tests/procedures/consults is the patient open for?
- New symptoms?
- IV Fluids/IV Medication?
- What is the Medical Plan of Care?
- Foley Catheter: Day __?
- Central Line Day ____?
- VTE Prophalaxis
- Physical/Occupational therapy order?

PLAN FOR THE STAY

(Case Management)

- **How long has the patient been here?**
- **Average length of stay per diagnosis?**
- **Expected discharge date?**

- Delays present?
- Is the patient getting the appropriate level of care?
- Family involvement/concerns

PLAN FOR THE PAY

(Case Management)

- **Authorized days**
- **Preauthorization pending**
- **Tx not covered i.e MRI back for HF admission**
- What type of insurance does this patient have?
- What are the finanical barriers to discharge?

PLAN FOR THE WAY

(Social Work)

- **D/C plan**
  - **Home with services**
  - **Post acute facility**
  - DME
- Patient/Family concerns
- Patient barriers
- Will the patient be eligible for rehab based on payor status?

PLAN FOR THE DELAY

(Interdisciplinary)

- **Factors contributing to possible readmission in near future?**
- Do any tests/procedures need to be escalated?
- Are there gaps in care?

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Focused Rounding Checklist

Focused Rounding

- LACE Score:
- Plan for the day:
- What is keeping the patient in the hospital/medical plan of care?
- What tests/procedures/consults is the patient open for?
- New symptoms?

- IV fluids/IV medication?
- Foley Catheter: Day _____
- Central Line: Day _____
- VTE Prophylaxis
- Physical/Occupational therapy order?
- Cardiac Rehab evaluation?

Case Management:

- Length of Stay
- Anticipated Discharge Date

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Rapid Rounds

- Process is in pilot phase
- Currently done on 2 units
- Initiated March 21, 2016
- Initially, process took one hour per unit to complete
- After one month time reduced to 30 minutes per unit
- Escalation of delays are reviewed daily regarding status
- Daily follow through of pending issues
- **Plan to roll out house-wide if successful**

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Barnabas Health

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 5: Wednesday, August 10 from 12-1pmET

Cohort 2:

- Community Call 4: Wednesday, June 29, from 12-1pmET
- 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

pnp@lists.acc.org

cvquality.acc.org/patientnavigator

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