Patient Navigator Program

Webinar 5
November 9, 2016

Quality Improvement for Institutions

How this webinar is organized

Time	Topic
12:00pm	Welcome and Introductions
12:05pm	Overall Defect Free Care and Cardiac Rehab
12:20pm	Q&A
12:22pm	Heart Failure and Palliative Care Huddle
12:37pm	Q&A
12:39pm	Community Involvement
12:54pm	Q&A
12:56pm	Wrap-up and Next Steps

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University of Colorado Hospital

Kim Marshall, BSN, RN, CPHQ, AACC

Jessica Nensel, DNP, APRN, ACNS-BC

UCHealth

Overall Defect Free Care for the AMI patient population

Baseline Overall Defect
Free Care for ACC PNP :
65%

The proverbial low hanging fruit-
Improve Cardiac Rehab Referrals

Order Sets Prepopulated for Cardiac Rehab

BUT

Utilization showed poor performance

Look at Troponin list ?
Viewed as insufficient

The solution we chose at UCH

Solution 1: Multidisciplinary rounds for Cardiology Service- Have Cardiac Rehab attend

Solution 2: Create Smart phrase for Cardiac Rehab to use for documentation when see patients in house and include domumentation in Education tab of Epic

WE PUT THE FACE TO FACE COMMUNICATION
BACK INTO THE EQUATION

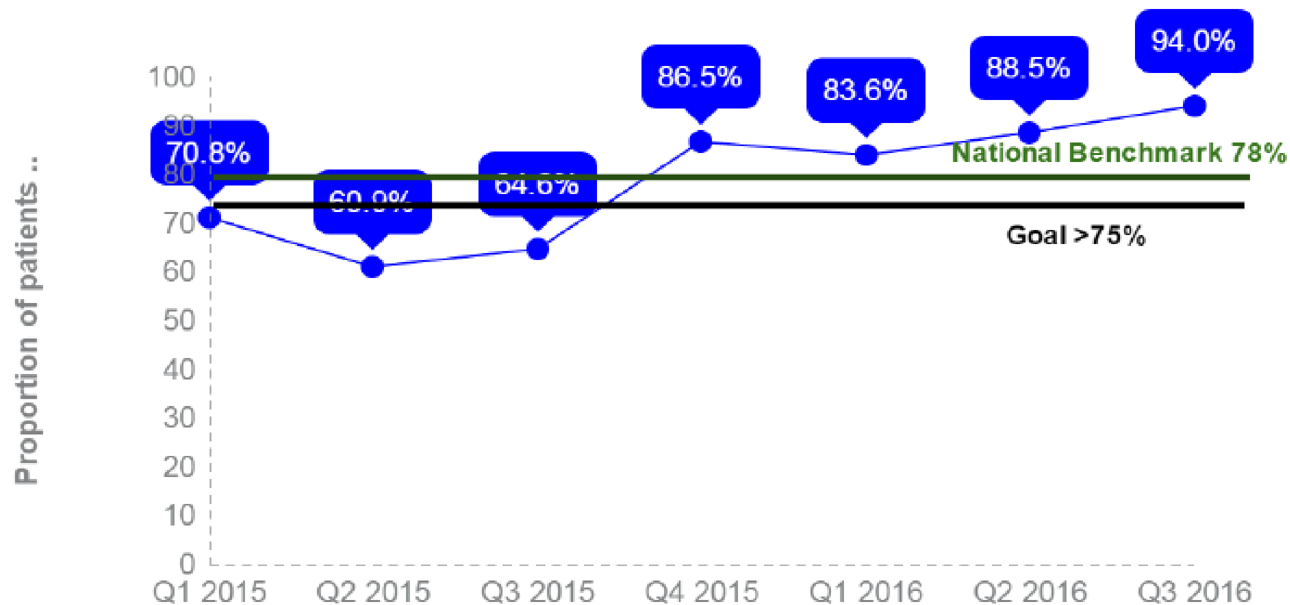
Overall Defect Free Care: Q3 2016 94.7%, R4Q 88.2%

What do you think should be some of the things that we should do next? - Optimize Order Sets

AMI

Increase our Overall Defect Free Care to be greater than 75%

Overall Defect Free Care: The proportion of patients that receive "perfect care" based upon their eligibility for each performance measure. All performance measure must be met in order to be included in the numerator



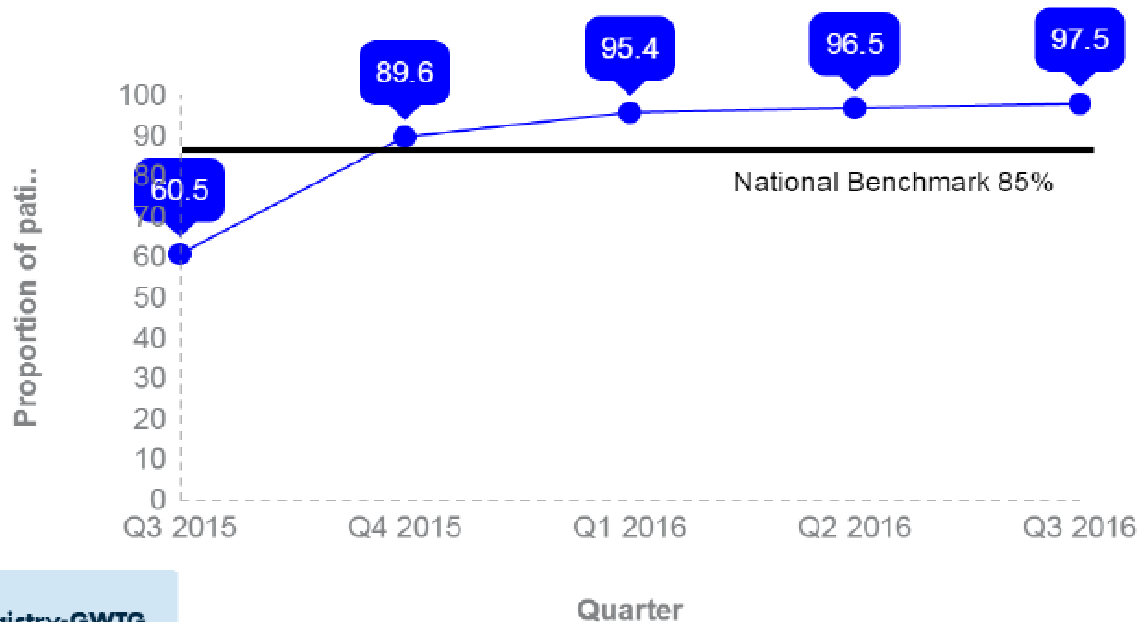
Source: ACTION Registry-GWTG

UCHealth

AMI

Increase patient self-care regimen evidenced by an inpatient cardiac rehab consult documented by 5%

30 patient audit per quarter.
Baseline data was 37%.   Q2 2016 was 63%, a 26% increase



Source: ACTION Registry-GWTG

Q&A

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

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Q&A

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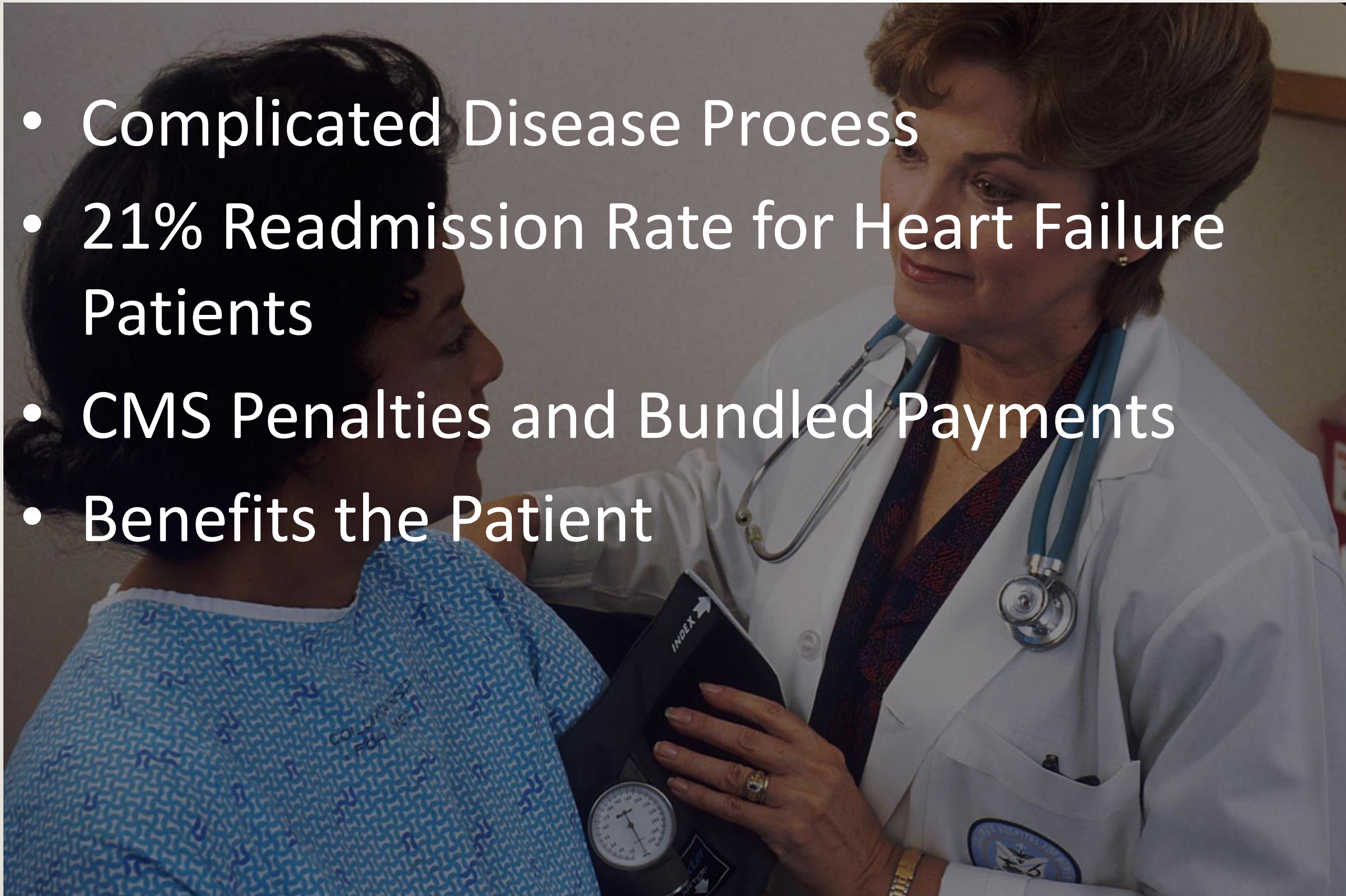
Heart Failure and Palliative Care Huddle

November 9, 2016

Randy Cox, MPH
Quality Consultant, Heart & Vascular

Compelling Reasons



- Complicated Disease Process
- 21% Readmission Rate for Heart Failure Patients
- CMS Penalties and Bundled Payments
- Benefits the Patient

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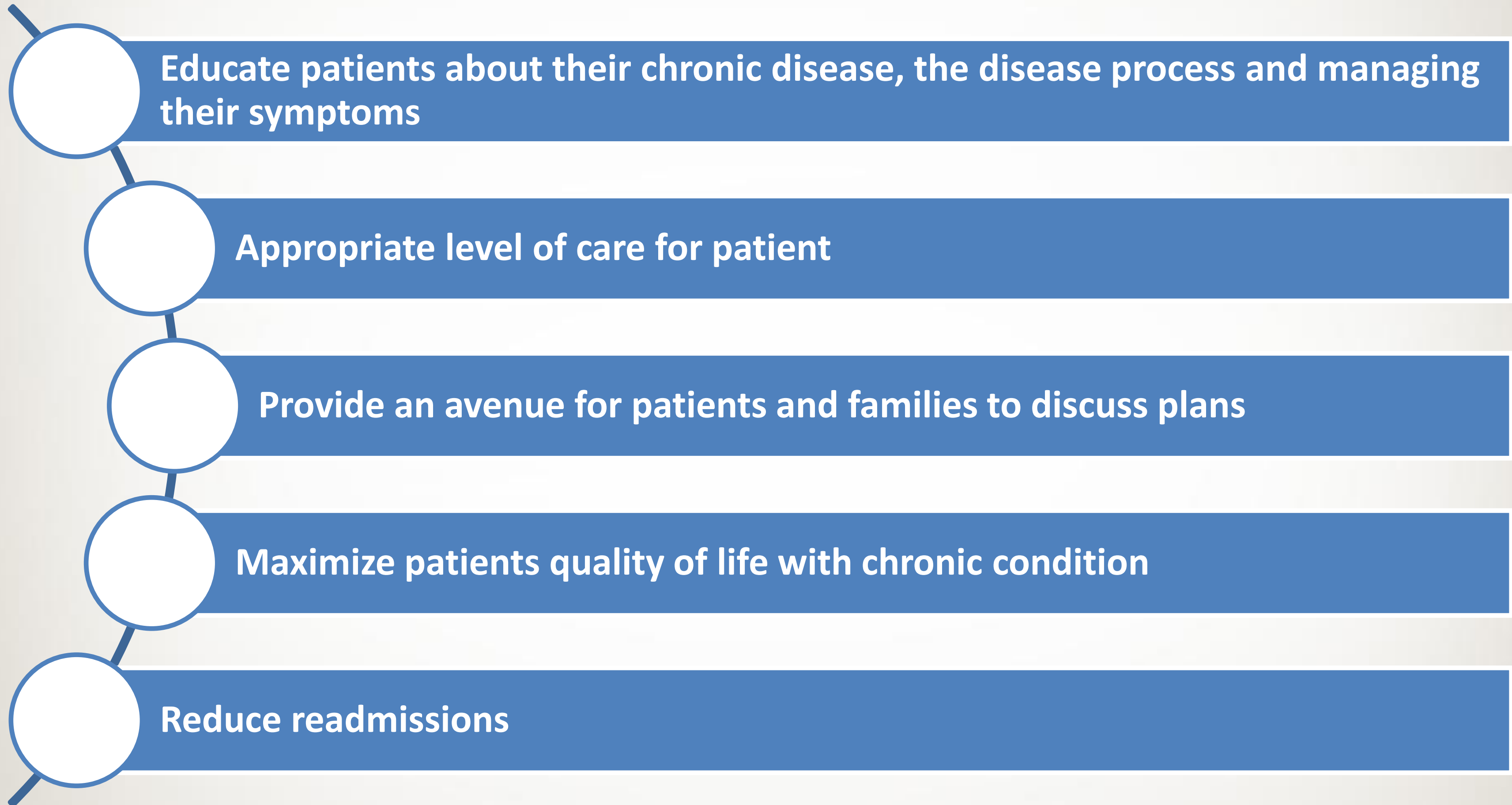
Purpose



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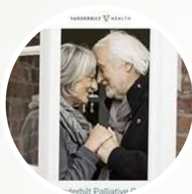
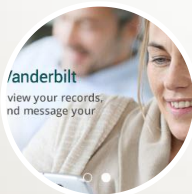
Palliative Care Program



Relief from pain and other physical symptoms

Improve quality of life

Friend and family support



Assist with difficult medical decision making

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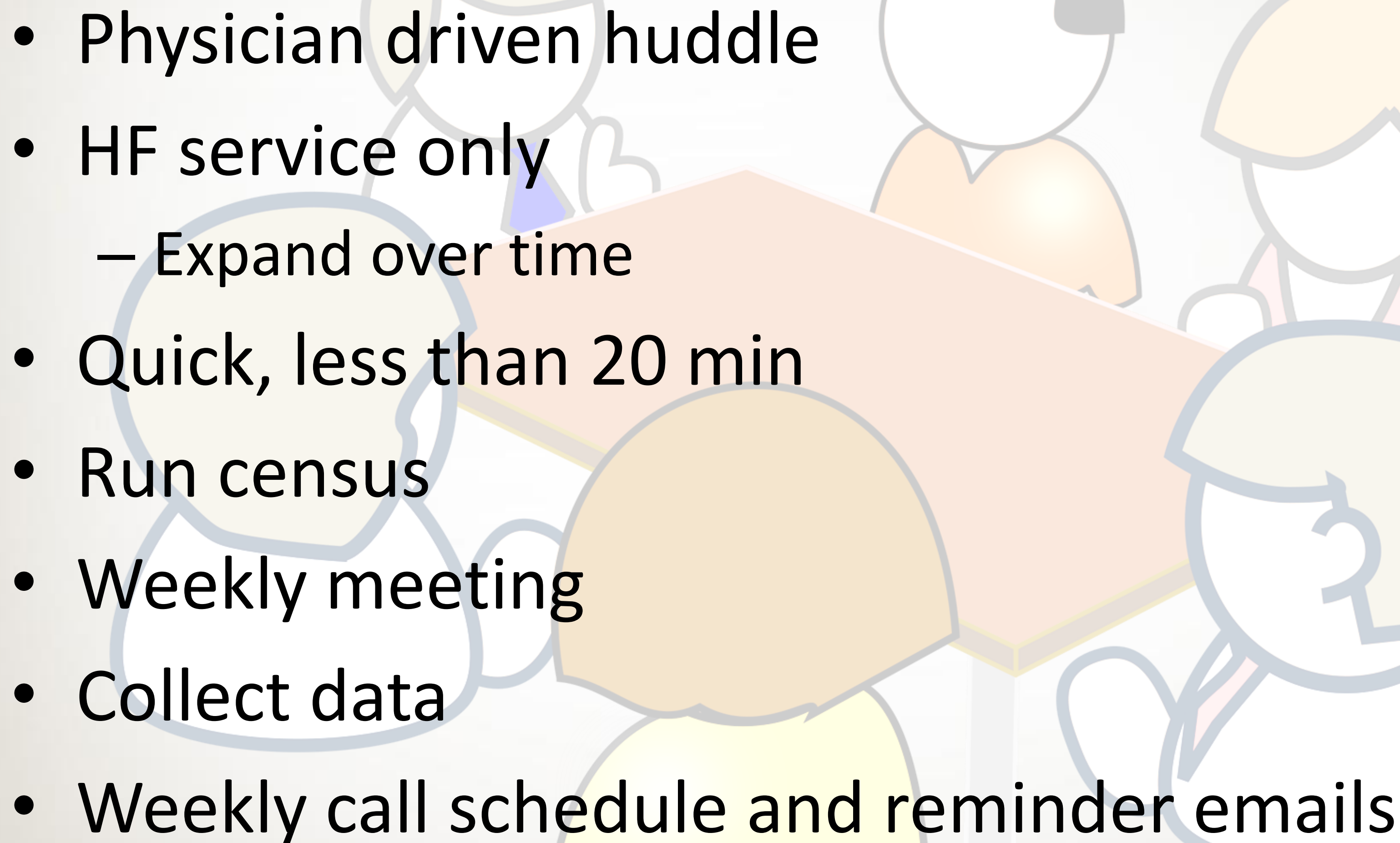
Structure



- Physician driven huddle
- HF service only
  - Expand over time
- Quick, less than 20 min
- Run census
- Weekly meeting
- Collect data
- Weekly call schedule and reminder emails

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Data

	Total Count 9 weeks	Average/Huddle
Number of Patients Discussed	97	10.8
Inpatient PC Referrals	28	2.3
Outpatient PC Referrals	9	1
Type of Referral: • Primary • Specialty	 20 9	 1.4 1
Patients Already being Followed by Palliative Care	21	2.3
Time Spent at Huddle	161 min	18 min

Moving Forward

Learnings

- Primary PC Care vs Specialty
- Leadership support
- Moved day to allow for more time to catch pts before discharge

Next Steps

- Need for PC MD education
- Need for Bedside nurse education
- Include other disciplines

Q&A

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Trident Healthy Heart Collaboration:

A Dynamic Partnership

PRESENTED BY:

ALLISON WALTERS, RN, ASST. VP CARDIOVASCULAR SERVICES, AND

MARGARET GEORGIA, RN, DIRECTOR CASE MANAGEMENT

What is the Trident Healthy Heart Collaboration**?**

OUR
Mission Statement:

The Trident Healthy Heart Collaboration is a dynamic partnership that spans the healthcare continuum from hospital to home. We provide a strategic team-approach to caring for adults with congestive heart failure (CHF). While living with CHF can be challenging, we believe that proper coordination of care provides patients with the tools needed to manage their health more easily and cost-effectively. Our vision is to improve CHF population health literacy and overall wellness by focusing on the needs of one patient at a time.

Our Team:

- Trident Health System
- Trident Heart Failure Clinic
- Trident Care Assure
- Trident Palliative Care
- Heartland of Hanahan Nursing and Rehab
- Heartland Advanced Disease Management
- Heartland Hospice
- Agape Palliative Care
- Agape Hospice Services
- Amedisys Home Health Services
- Amedisys Hospice Services
- Palmetto Primary and Specialty Care Physicians

Our Goals:

- Decreasing hospital stay
- Helping patients understand their condition and how to manage it
- Providing the most appropriate medical support after discharge
- Helping prevent urgent visits to the doctor or emergency room
- Decreasing avoidable returns to the hospital
- Helping patients reach the highest level of overall wellness

Our Strategies:

- Identifying patients who will benefit from care coordination
- Assessing patients for the appropriate level of care
- Following designated care pathways to maintain consistency in healthcare practices
- Teaching patients about their condition and how Listening to patient concerns and focusing on individual goals of care
- Communicating closely with partners to identify changes in condition or needs of patients
- Evaluating the progress of our patients to determine efficacy of care to manage symptoms and prevent setbacks

What Role Do I Play?

- Each partner in the collaboration plays a unique role
  - Providing direct patient care by nurses and providers (MD,NP, PA)
  - Counseling patients and families about how to deal with chronic disease
  - Teaching patients and families about CHF and how to prevent exacerbations
  - Coordination of care and communication between all providers and agencies

Outcome Metrics

- Inpatient LOS
- NYHA Classification
- Palliative Care or ADM Consults
- Disposition
- Readmissions
- Near Misses
- Clinical Indicators
- Patient Satisfaction
- Quality of Life

Tools

- Standardized education booklet to be used by all members of collaborative
- Clinical Pathway (Inpatient, SNF, Home Health)
- Minnesota Living with Heart Failure Survey
- Patient Satisfaction Survey

In Summary:

Trident Healthy Heart Collaborative objective is to assist patient's with their transition from hospital to home with a group of providers and care givers that each have the same goal in mind –

TO HELP PREVENT EXACERBATION AND REHOSPITALIZATION.

Q&A

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Reminders

- **Q3 2016 Data Deadline- Nov. 30**
- **NCDR Abstracts Due online by Jan. 13**

http://cvquality.acc.org/en/NCDR-Home/Annual-Conference/Posters.aspx

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Thank You!

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pnp@lists.acc.org

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