Patient Navigator Program
Focus MI

June 4th, 2019
Smart Tactics for Data Collection
Webinar #2

AMERICAN COLLEGE of CARDIOLOGY

Agenda

Time	Topic	Presenter
12:00 pm EST	**Welcome and Introductions**	Dr. Ty Gluckman
	Patient Navigator Program: Focus MI "Smart Tactics for Data Collection"	
12:02	Benefits of Real Time Data Abstraction: Tactics Utilized	**Randy Cash, RN, CCCT** Transitional RN Aurora BayCare Medical Center
12:17	Developing Tools to Improve Workflow and Effectiveness	**Amanda Francis, RN, BSN** Acute MI Nurse Navigator Indiana University Health Methodist Hospital
12:32	A Team Based Approach for Data Collection	**Eleanor Rawls, MSN APRN ACCNS-AG CCRN** Heart & Vascular Services Quality Programs Manager, CNS **Betsy Gaskin-McClaine** Executive Director Patient Navigation & Transition Wake Med Raleigh
12:47	**Q&A**	All
12:57	**Wrap-up & Next Steps**	Dr. Ty Gluckman

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Benefits of Real Time Data Abstraction

Tactics Utilized

Aurora BayCare Medical Center

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Aurora BayCare Medical Center

- Advocate Aurora
- Located in Green Bay, WI
- 167 bed Hospital
- Teaching Hospital
- Patient Navigator Program
- Patient Navigator Program: Focus MI Diplomat Hospital

Our Process

- Data Abstractor-Julie Manny, RN CPHQ
  - Identifies all CHF/AMI patient admits
  - Adds these patients to a shared patient list within EPIC
  - Reviews chart to ensure all metrics are being met
  - Identifies potential fallouts and sends message within EPIC to:
    - Physician
    - Transitional Care Coordinator
    - If attending is a Hospitalist will alert Hospitalist Coordinator
  - Correlates all data to discuss at AMI/CHF committee meetings
    - Fallouts
    - Readmissions
    - Case reviews
    - Quality Data

Our Process

- Randy Cash, RN, CCCTM – Transitional RN
  - Moves patient on shared list into treatment team list
  - Assists in ensuring metrics are being met
  - Ensures best practices are being followed by speaking with Physician, attending rounds.
    - Care Plan
    - Diet
    - Wgts
    - Education
    - Follow up
  - Conducts follow up calls
    - 3 days of discharged
    - Once a week for one month

Aurora BayCare Medical Center

AMI Worksheet

Patient Name: _____ DOB: _____ MRN: _____

Arrival Date/Time: _____ Admit: _____ D/C Disposition: _____

Admit MD: _____ DC MD: _____

STEMI: Yes No Entered in Navigator log: Yes No AMI Order Set Used Yes No

DATA POINT	RESPONSE	DATA POINT	RESPONSE
Date/Time of Onset of Symptoms		Referring Facility Departure	
Did patient activate EMS		Date/Time Arrival to ABMC ED	
EMS Agency Name		ABMC ECG Time	
EMS Arrival		ABMC ED Door in/Door Out Time	
EMS ECG		Date/Time Arrival to ABMC CCL	
EMS Departure		Device Time	
Transfer/Name referring facility*		D2B Time (minutes)	
Referring Facility Arrival (D1)		D2D2B Time (minutes)	
Referring Facility ECG		FMC to Device Time (minutes)	

Eval LV Function: EF Yes No NC _____

Aspirin DC: Yes No NC

Beta Blocker: Yes No NC

Statin: Yes No NC

ACE/ARB LVSD Yes No NC

Aldosterone Antagonist: Yes No NC

Education: Yes No NC

AVS to Patient: Yes No NC

DC Summary Routed: Yes No NC

Community Res: Yes No NA

Med Rec Admit: Yes No NA

Med Rec D/C: Yes No NA 3 Day Call:

NOTES: _____

Aurora BayCare Medical Center

Results

- Improved aldosterone blocking agents for LVSD at discharge for AMI patients from 17% to 75%
- Improved Medication reconciliation from 71% to 94.7%
- Improved compliance with follow up appointment scheduled at discharge from 73% to 96.7%
- Improved compliance with routing of discharge summary to PCP for AMI and CHF patients from 81% to 96.2%
- Improved compliance with providing information on community resources for high risk AMI and CHF patient from 75% to 100%.

Results

- STEMI performance Composite 97%
- NSTEMI Performance Composite 94% to 96%
- Overall Defect Free Care 77% to 98%
- Cardiac Rehab referral rates from 83% to 96%
- Reduction in CHF readmission
  - Final quarter 2018 6.5%
- Increase in Cardiology Consult for New Onset CHF patients 49% to 97% in 2018

Indiana University Health Methodist Hospital

Amanda Francis, RN, BSN
Acute MI Nurse Navigator

Indiana University Health

Indiana University Health Methodist Hospital

- 735 bed academic hospital in Indianapolis, Indiana
- Major referral center for entire state of Indiana and beyond
- 103,000 annual ED visits
- ~400 annual acute MIs

National Distinction of Excellence HeartCARE Center 2018

Patient Navigator Program
Focus MI

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Developing Tools to Improve Workflow and Effectiveness

- Real-time screening tool to identify acute coronary syndrome patients quickly and efficiently
- Assessment worksheet to aid the nurse navigator in identifying barriers, needs, and high-risk patients
- Intervention tracking tool to capture the impact of the program beyond the reported metrics

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Developing a Patient Tracking Tool

- Identify suspected acute myocardial infarction patients early to allow for visits each day during their hospitalizations
- No preexisting tools in our electronic medical record system to accurately screen patients
- Resources:
  - Level One STEMI activation paging system
  - Cardiology rounding lists
  - Cardiac unit lists
  - Cath lab schedule

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Nurse Navigator Tracking Tool and Rounding List

	Last Name	First Name	Age	MRN	FIN	Action	Pt #	DC Date	Phone #	VM	Visited?	Cardiac Rehab	Dx	Notes
Week of 5/27/2019														
	######	######	57	######	######			5/30/2019	N/A	N	N/A	N/A	Demand Ischemia	2/2 hypertensive urgency
	######	######	63	######	######			5/28/2019	######	Y	Amanda	IU West Hospital	STEMI	95% mLAD with thrombus
	######	######	43	######	######			5/31/2019	######	Y	Amanda	Kentucky One Louisville	STEMI	PCI to 100% LAD, pap rupture, ECMO, s/p MVR
	######	######	74	######	######			DC Today?	######	Y	Amanda	IU Bedord Hospital	NSTEMI	PCI to SVG-R1, DES x 2
	######	######	27	######	######			5/29/2019	N/A	N	N/A	N/A	Demand Ischemia	2/2 heart failure, congenital patient (s/p
	######	######	66	######	######			5/30/2019	N/A	N	N/A	N/A	Demand Ischemia	2/2 CHF exacerbation
	######	######	79	######	######				N/A	N	N/A	N/A	Demand Ischemia	2/2 ESRD/hypertensive urgency
	######	######	64	######	######									NSTEMI? Planned LHC tomorrow - WATCH!
	######	######	45	######	######				######	Y	Amanda	IU West Hospital	STEMI	Inferior MI, VT/VF arrest, neuro recovery after
	######	######	67	######	######			5/31/2019	N/A	N	N/A	N/A	Demand Ischemia	2/2 afib RVR
	######	######	68	######	######				N/A	N	N/A	N/A	Demand Ischemia	2/2 new onset HF
	######	######	63	######	######			6/1/2019	N/A	N	N/A	N/A	Demand Ischemia	2/2 COPD, flu
	######	######	53	######	######			DC Today?	######	Y	Amanda	St. Vincent	STEMI	100% pRCA, DES x1

Patient Worksheet

- Aids the nurse navigator with bedside visits
- Assists in screening for high-risk patients, barriers to care, and patient needs

AMI Patient Worksheet

Name: (Patient Label)

DOB:

Room: 4301
Age: 57
Admit Date: 5/29/2019
Team/Attending: Team A, Dr. Smith
Admitting Dx: STEMI
MOA: Private Vehicle (EMS) Transfer from:
HPI: EMS STEMI activation

Chest Pain:
Onset: woke up with CP
Location: midsternal
Quality: pressure
Radiation: to left arm
Score: 10/10
Worse with: n/a
Better with: SL NTG
(N/V)
Diaphoresis
(SOB)

PMH:
Cardiac: CAD MI CABG PPM/ICD Afib (HTN) HLD HFpEF HFrED CHF Last EF:
Pulm: COPD Asthma OSA/CPAP Home O2
Neuro: CVA TIA
Endocrine: (DM) Thyroid
Psych: Anxiety Depression
Renal: CKD ESRD
Other:

EKG: (EMS) NSR @ 94bpm, ST elevation in II, III, aVF, with recip. depression
LHC/PCI: **Date:** 5/29
Attending: Dr. Smith
Results:
100% pRCA – aspiration thrombectomy and DES x1, normal LVEDP
Echo: **Date:** 5/30
EF: 57%, no RWMA

Social Hx: **Tobacco:** cigarettes ½ PPD **ETOH:** "occasional/social" **IDR:** denies **Occupation** **current** **retired** **disabled** **not working** FedEx distribution center, lifts heavy boxes **Family Hx:** CAD, HTN, DM	**Allergies:** PCN **Pertinent Home Meds:** Ibuprofen PRN Multivitamin Novolog
Labs: Troponin: peaked at 7.02, down trended Total cholesterol: 212 Triglyceride: 189 HDL: 50 LDL: 124 HgbA1c: 10.2 Others: BMI: 28.2	**MAR:** **Gtts:** Aspirin: 81mg nitro – off P2y12: ticagrelor 90mg Statin: atorvastatin 80mg BB: (none d/t bradycardia) ACEI: (none, may need) ARB: Aldost: Other: nicotine patch
Access: Insurance: Medicare Medicaid Commercial None Drug coverage: yes no Cardiologist: none – prefers to see Dr. Smith OPCR Location: IU West location – referral completed **Living Situation:** Home: Indy, West Side Family Support: married, reports good support Barriers: needs education, DM management **Folder/resources provided:** yes	Other Problems – This Admission: Bradycardia – HR low 50s Interventions -Suspected medication noncompliance – reports he can afford Rx's, says he is compliant -Request DM education consult -Pt requesting dietician visit – consult placed -Pt wants to see Dr. Smith for follow-up – clinic notified -Pt interested in smoking cessation aid – requested provider to discuss options, community resources provided

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Intervention Tracking Tool

- We wanted to show this role had an impact on patients that reached beyond the metrics we were tracking
- Interventions by the nurse navigator outside of the daily workflow of visiting and educating patients while inpatient and calling patients for follow-up
- We had staff support, but we needed hospital administration buy-in
- This contributed to the approval of a permanent hospital-funded position and the continuation of the program

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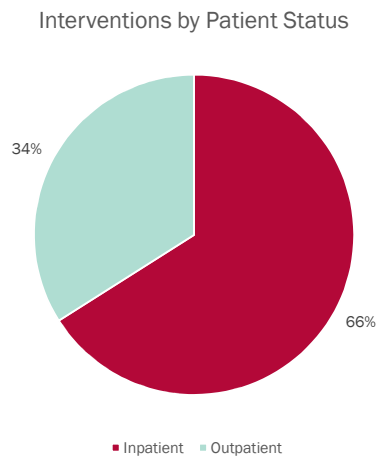
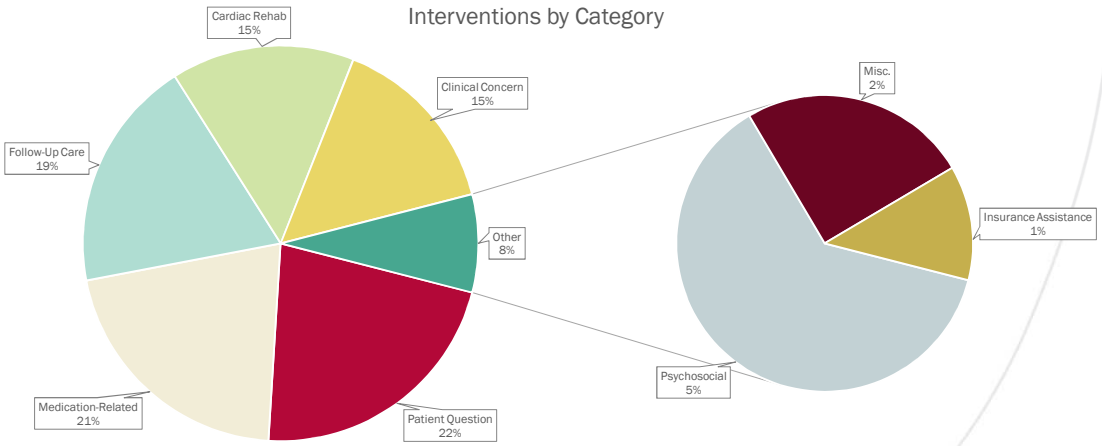
Example of Intervention Tracking Tool

Date	Last Name	First Name	MRN	Patient Status	Category	Primary Intervention	Notes
5/20/2019	########	########	########	Outpatient	Cardiac Rehab	Cardiac rehab referral completed	Pt states OPCR at outside hospital never contacted her to enroll, assisted with referral and ensured pt got an appt for initial visit
5/20/2019	########	########	########	Outpatient	Patient Question	Contacted provider	Patient wants to know when she will be cleared to return to work, CDL - drives SEMI
5/21/2019	########	########	########	Inpatient	Psychosocial	Contacted social worker	FMLA help, SW consulted to assist
5/21/2019	########	########	########	Inpatient	Cardiac Rehab	Cardiac rehab referral completed	No order in Cerner
5/21/2019	########	########	########	Outpatient	Follow-up	Advised patient	Help with transferring medical records, connected with HIM, confirmed records were transferred
5/21/2019	########	########	########	Inpatient	Follow-up	Contacted clinic	No cardiology f/u appt, appt made
5/22/2019	########	########	########	Inpatient	Clinical Concern	Contaced physical therapy	Coordinated physical therapy to take place before HD, pt does not feel like participating after HD, had been refusing to get out of bed
5/22/2019	########	########	########	Outpatient	Patient Question	Advised patient	Patient cannot start OPCR for 3 weeks, wants to confrim activity restrictions before OPCR starts
5/22/2019	########	########	########	Outpatient	Medication	Contacted provider	Pt wanting to titrate BP meds, adivsed pt of MD response
5/23/2019	########	########	########	Inpatient	Medication	Contacted provider	Pt uninsured, request switch to generic antiplatelet, swithced to clopidogrel, GoodRx coupon provided
5/23/2019	########	########	########	Inpatient	Follow-up	Contacted social worker	Assist with low cost health care, pcp
5/23/2019	########	########	########	Inpatient	Medication	Contacted case management	Assist with paying for medication at discharge
5/23/2019	########	########	########	Inpatient	Cardiac Rehab	Cardiac rehab referral completed	Had not been ordered for STEMI pt

Data Obtained Through Intervention Tracking



Data Obtained Through Intervention Tracking



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Patient Navigator Program
Focus MI
Diplomat Hospital

WakeMed

A Team Based Approach to Data Collection

Webinar: Smart Tactics for Data Collection
June 4, 2019

Rebecca Jones, AMI Quality Data Specialist
Eleanor Rawls, Manager Heart & Vascular Programs
Mary Krizay, Director Quality Analytics
Betsy Gaskins McClaine, Executive Director Patient Navigation & Transition

WakeMed
Exceptional People. Exceptional Care.

Strategic Plan

PATIENT & FAMILY

Mission
To improve the health and well-being of our community with outstanding and compassionate care to all

Vision
To be the preferred partner for quality care and health through collaboration and transformation of care delivery

Values
Foster trust and transparency * Quality experiences
Financial stewardship * Leadership in safety, innovation and education
Empower & partner with health care team * Partner with others who value our culture

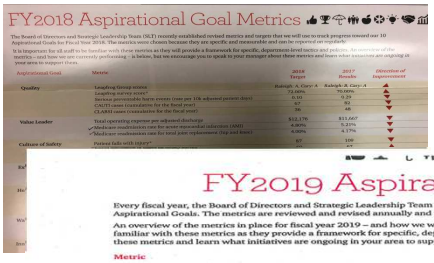
ASPIRATIONAL GOALS

VALUE LEADER	QUALITY	CULTURE OF SAFETY	EXTRAORDINARY TEAM	HEALTHY COMMUNITY
Quality / Cost	Top 10 in US	For patients, families, community & health care team	Recruit, retain and develop	Healthiest capital county in US

WAKE WAY	INNOVATION	PREFERRED PARTNER	FINANCIAL HEALTH	HIGHEST ETHICS & STANDARDS
Every-time behaviors	Transformation of care and health improvement	With physicians and others for best value		In all we do

THE WAKE WAY TO EXCELLENCE

Focus MI: Aspirational Goals


FY2018 Aspirational Goal Metrics

FY2019 Aspirational Goal Metrics

Every fiscal year, the Board of Directors and Strategic Leadership Team (SLT) establish metrics and targets that we will use to track progress toward our 10 Aspirational Goals. The metrics are reviewed and revised annually and results are reported regularly.

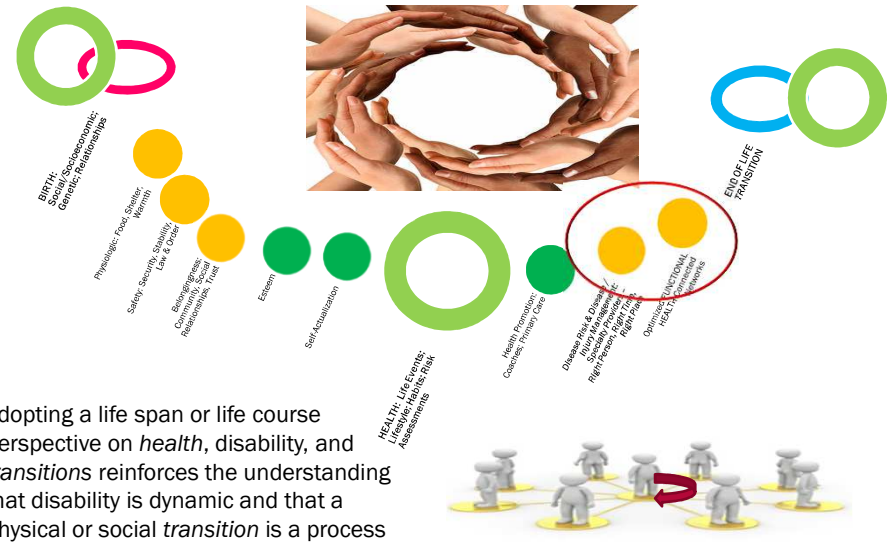
An overview of the metrics in place for fiscal year 2019 – and how we were performing at the end of fiscal year 2018 – is below. It is important for all staff to be familiar with these metrics as they provide a framework for specific, department-level tactics and policies. We encourage you to speak to your manager about these metrics and learn what initiatives are ongoing in your area to support them.

Metric	2019 Target	2018 Results	Direction of Improvement
Quality			
LeapFrog Grades	Raleigh A; Cary A	Raleigh A; Cary C	
LeapFrog Survey Scores	75.00%	77.00%	
Serious preventable harm events (rate per 10K adjusted patient days)	0.10	0.12	
CAUTI cases (cumulative for the fiscal year)	66	87	
CLABSI cases (cumulative for the fiscal year)	39	35	
C-Diff infection (cumulative for the fiscal year)*	137	146	
Value Leader			
Total operating expense per adjusted discharge	$13,427	$11,924	
Medicare readmission rate for acute myocardial infarction (AMI)	8.00%	7.16%	
Medicare readmission rate for total joint replacement (hip & knee)	3.50%	4.00%	
Culture of Safety			
Patient falls with injury	96	120	
Overall perception of safety on AHRQ Survey	70.00%	68.00%	
Lost work days due to workplace injury	66	57	
Extraordinary Team			
Employer of Choice percentile ranking on employee engagement survey	93.50%	92.70%	
Employer of Choice percentile ranking on physician engagement survey	90.00%	88.10%	
Staff turnover rate	11.50%	11.89%	
Healthy Community			
Annual savings tied to Community Case Management program	$1,500,000	$1,753,000	
Percent of deliveries via C-section	21.00%	19.30%	
MyChart activation by patients	35.00%	30.70%	
Healthy Planet populations	8	7	
Community outreach activities*	80	63	

Overview: HVS Clinical Programs Focus

- Strong collaborative relationships..focused on health promotion / disease prevention, risk factor reduction, and integrated care (pre, peri and post hospitalization) of patients and families dealing with acute and chronic heart & vascular diseases across the lifespan:
  - Chest Pain / CAD - ACS / AMI
  - Heart Failure
  - Structural Heart Disorders
  - Rhythm Disorders
  - Neurovascular Disorders / TIA - Stroke Program
  - Peripheral Vascular Disorders
  - Pulmonary Disorders
- Cutting edge technology, comprehensive services, excellent outcomes, a core of highly qualified, experienced and dedicated team of physicians, clinical professionals, support team members and community partners
- **Partnerships** with patients, families, providers, payors, WakeMed colleagues and community partners to promote health, maximize functional quality of life, and minimize hospital readmissions through coordinated care with expert navigation for cardiac patients to ensure they are receiving the *best care in the right way at the right time in the right place with the right resources.*

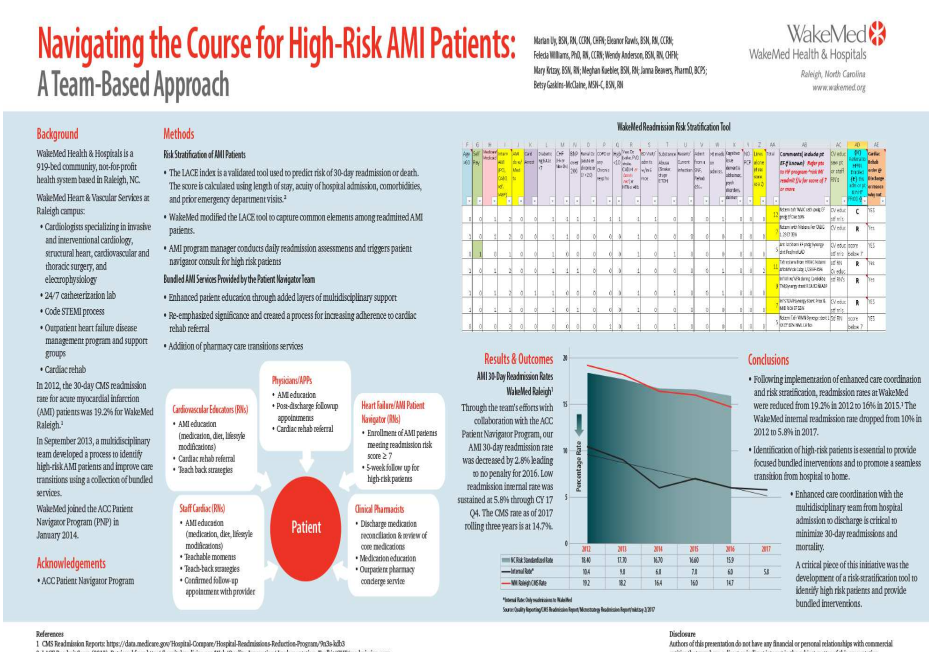
Navigating Health Transitions



Adopting a life span or life course perspective on *health*, disability, and *transitions* reinforces the understanding that disability is dynamic and that a physical or social *transition* is a process rather than a point in a person's life.

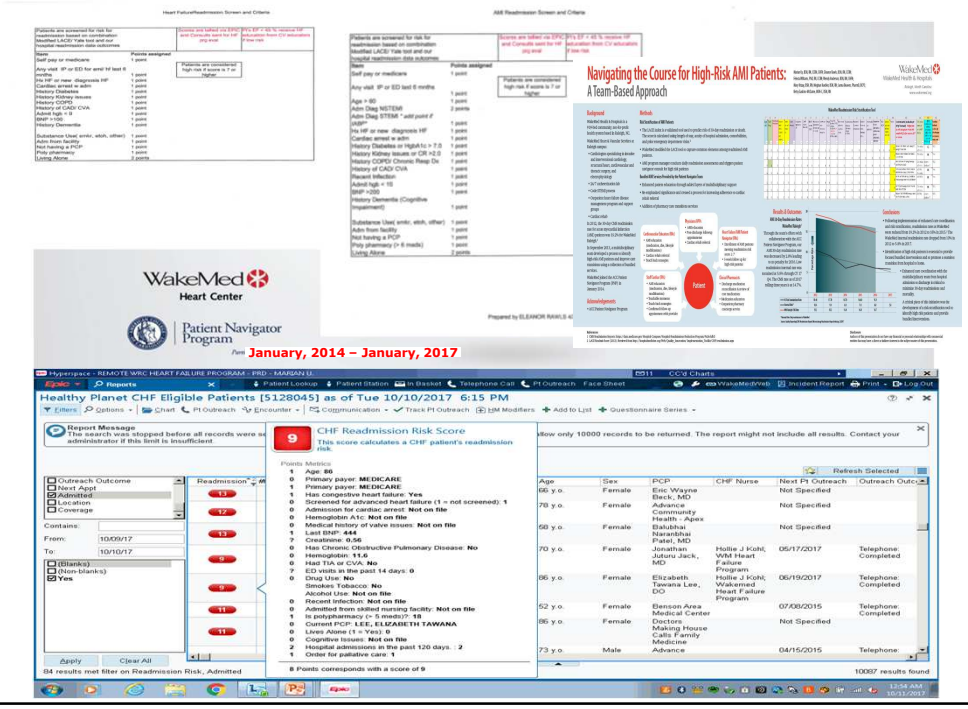
bgm51319


NAVIGATING HEART PATIENTS TO BETTER HEALTH
WakeMed Heart Center
Patient Navigator Program
Participating Hospital
January, 2014 – January, 2017
WakeMed Heart Failure Program
• Developed in 1999 as a pilot program under Duke Endowment
• Chronic disease management program - "virtual"
• Goal: improve care for high risk HF patients and reduce avoidable cost of readmission and frequent ED visits
• Nurse-led under supervision of cardiologists.
• First hospital in North Carolina to be accredited for HF by Society of Cardiovascular Patient Care (now ACC) since 2012
Patient Navigator Program Services
• Focused access & follow up with highly-trained specialty RN top of license health coach 24/7
• Navigation follow-up (48-hour discharge call; scheduled protocol calls/triage)- for 90 days to provide ongoing:
- Connect and facilitate referrals for primary care, specialty care and advanced therapies
- Medication review, education and adherence to evidence-based guidelines, protocol-driven titration of medications
- Ongoing patient-family education, engagement and support networks that empower patients and families in management of lifestyle and disease, including cardiac rehabilitation programs, and living well resources – cooking & eating, rest & sleeping, mobility & movement, spiritual resource support, and tools / resources to support healthy body systems – immune, lungs, GI, heart, brain, skin, endocrine, kidneys
- Collaborate with Home Health/Telehealth for assessments & monitoring resources
- Collaborate with EMS Services, Community Case Management and Community Health Resource programs / agencies to engage & support access to social health resources
- Partner with Mended Hearts Program and facilitate support group connections / meetings
- Partner with Transition LifeCare for Palliative and Hospice Care
- Provide health tools as needed (weight scale, pill boxes, BP cuffs)
• Provide education to PAC partners: HH, Personal Care, Skilled Nursing, Rehab Facilities
• Partner with community health providers to provide public education, expand community based health resources / networks – transportation, shelter, healthy meals, primary care

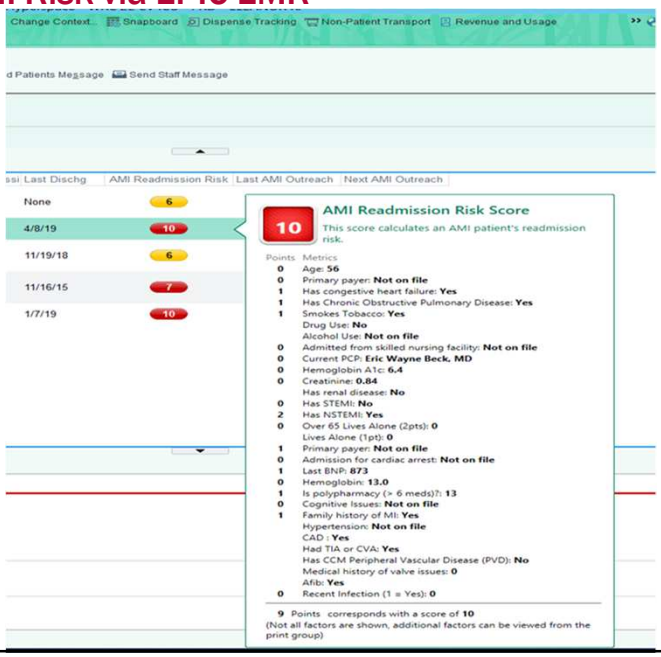

Navigating the Course for High-Risk AMI Patients:
A Team-Based Approach
Marian Uy, BSN, RN, CCRN, CHFN; Eleanor Rawls, BSN, RN, CCRN;
Felecia Williams, PhD, RN, CCRN; Wendy Anderson, BSN, RN, CHFN;
Mary Krizay, BSN, RN; Meghan Kuebler, BSN, RN; Janna Beavers, PharmD, BCPS;
Betsy Gaskins-McClaine, MSN-C, BSN, RN
WakeMed
WakeMed Health & Hospitals
Raleigh, North Carolina
www.wakemed.org
Background
WakeMed Health & Hospitals is a 919-bed community, not-for-profit health system based in Raleigh, NC.
WakeMed Heart & Vascular Services at Raleigh campus:
• Cardiologists specializing in invasive and interventional cardiology, structural heart, cardiovascular and thoracic surgery, and electrophysiology
• 24/7 catheterization lab
• Code STEMI process
• Outpatient heart failure disease management program and support groups
• Cardiac rehab
In 2012, the 30-day CMS readmission rate for acute myocardial infarction (AMI) patients was 19.2% for WakeMed Raleigh.[1]
In September 2013, a multidisciplinary team developed a process to identify high-risk AMI patients and improve care transitions using a collection of bundled services.
WakeMed joined the ACC Patient Navigator Program (PNP) in January 2014.
Acknowledgements
• ACC Patient Navigator Program
Methods
Risk Stratification of AMI Patients
• The LACE index is a validated tool used to predict risk of 30-day readmission or death. The score is calculated using length of stay, acuity of hospital admission, comorbidities, and prior emergency department visits.[2]
• WakeMed modified the LACE tool to capture common elements among readmitted AMI patients.
• AMI program manager conducts daily readmission assessments and triggers patient navigator consult for high risk patients
Bundled AMI Services Provided by the Patient Navigator Team
• Enhanced patient education through added layers of multidisciplinary support
• Re-emphasized significance and created a process for increasing adherence to cardiac rehab referral
• Addition of pharmacy care transitions services
Physicians/APPs
• AMI education
• Post-discharge followup appointments
• Cardiac rehab referral
Cardiovascular Educators (RNs)
• AMI education (medication, diet, lifestyle modifications)
• Cardiac rehab referral
• Teach back strategies
Heart Failure/AMI Patient Navigator (RNs)
• Enrollment of AMI patients meeting readmission risk score ≥ 7
• 5-week follow up for high-risk patients
Patient
Staff Cardiac (RNs)
• AMI education (medication, diet, lifestyle modifications)
• Teachable moments
• Teach-back strategies
• Confirmed follow-up appointment with provider
Clinical Pharmacists
• Discharge medication reconciliation & review of core medications
• Medication education
• Outpatient pharmacy concierge service
WakeMed Readmission Risk Stratification Tool
Results & Outcomes
AMI 30-Day Readmission Rates
WakeMed Raleigh[1]
Through the team's efforts with collaboration with the ACC Patient Navigator Program, our AMI 30-day readmission rate was decreased by 2.8% leading to no penalty for 2016. Low readmission internal rate was sustained at 5.8% through CY 17 Q4. The CMS rate as of 2017 rolling three years is at 14.7%.
Percentage Rate
20
15
10
5
0
2012 2013 2014 2015 2016 2017
NC Risk Standardized Rate 18.40 17.70 16.70 16.60 15.9
Internal Rate* 10.4 9.0 6.0 7.0 6.0 5.8
WM Raleigh CMS Rate 19.2 18.2 16.4 16.0 14.7
*Internal Rate: Only readmissions to WakeMed
Source: Quality Reporting/CMS Readmission Report/Microstrategy Readmission Report/mkrizay 2/2017
Conclusions
• Following implementation of enhanced care coordination and risk stratification, readmission rates at WakeMed were reduced from 19.2% in 2012 to 16% in 2015.[1] The WakeMed internal readmission rate dropped from 10% in 2012 to 5.8% in 2017.
• Identification of high-risk patients is essential to provide focused bundled interventions and to promote a seamless transition from hospital to home.
• Enhanced care coordination with the multidisciplinary team from hospital admission to discharge is critical to minimize 30-day readmissions and mortality.
A critical piece of this initiative was the development of a risk-stratification tool to identify high risk patients and provide bundled interventions.
References
1 CMS Readmission Reports: https://data.medicare.gov/Hospital-Compare/Hospital-Readmissions-Reduction-Program/9n3s-kdb3
2 LACE Readmit Score (2013). Retrieved from http://hospitalmedicine.org/Web/Quality_Innovation/ Implementation_Toolkit/CHF/readmission.aspx
Disclosure
Authors of this presentation do not have any financial or personal relationships with commercial entities that may have a direct or indirect interest in the subject matter of this presentation.

EPIC Healthy Planet

- Population Registry
- Risk Scores – from spreadsheet to EMR
- Navigator Documentation & Reports



AMI Risk via EPIC EMR



Navigator Diplomat Questions

PROCESS MEASURES – HOSPITAL SELF-REPORTED (Patient Navigator Program: Focus MI Metric #4-8)

Questions #4-5 will be Self-Reported by the hospital and collected from the data abstraction of all AMI patients.

4-1a Record the number of AMI patients that are identified prior to discharge. (Numerator)*

4-1b Record the number of patients with a principal diagnosis of AMI. (Denominator)*

5a-1 Record the number of AMI patients that were assessed for risk of readmission prior to discharge. (Numerator)*

5a-2 Record the number of patients with a principal diagnosis of AMI. (Denominator)*

5b-1 Record the number of patients with a principal diagnosis of AMI who were risk assessed for risk of readmission and an intervention(s) were deployed. (Numerator)*

5b-2 Record the number of patients with a principal diagnosis of AMI who were risk assessed for risk of readmission. (Denominator)*

Utilize Hospital Business Intelligence Tool & Cross Reference with Final list for NCDR Primary MI patients

Also utilize Patient Risk Tool to assess number of patients assessed. Until Nov 2018.

All Patients now risk assessed in EPIC EMR

Admission and Discharge Med Rec

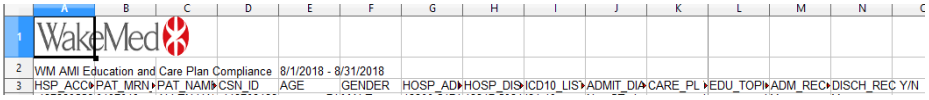
6a-1 Record the number of AMI patient charts with accurate medication reconciliation documentation on admission. (Numerator)*

6a-2 Record the number of patients with a principal diagnosis of AMI. (Denominator)*

7-1a Record the number of AMI patient discharge summaries or transition of care summary available to the follow-up clinician within 72 hours of patient's discharge. (Numerator)*

7-1b Record the number of patients with a principal diagnosis of AMI. (Denominator)*

Solution: Requested an EMR report with Admission and Discharge Med Rec Compliance



	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O
1	WakeMed														
2	WM AMI Education and Care Plan Compliance				8/1/2018 - 8/31/2018										
3	HSP_ACC	PAT_MRN	PAT_NAM	CSN_ID	AGE	GENDER	HOSP_AD	HOSP_DIS	ICD10_LIS	ADMIT_DIA	CARE_PL	EDU_TOPI	ADM_REC	DISCH_REC	Y/N

Education & Community Resource

8a-1 Record the number AMI patients/caregivers that were provided with specific education and documentation on their treatment regimen (self-care plan). (Numerator)*

8a-2 Record the number of patients with a principal diagnosis of AMI. (Denominator)*

8b-1 Record the number of AMI patients/caregivers that are provided with documentation of prescribed medications, changes to medications and instructions on when and how they should be taken. (Numerator)*

8b-2 Record the number of patients with a principal diagnosis of AMI. (Denominator)*

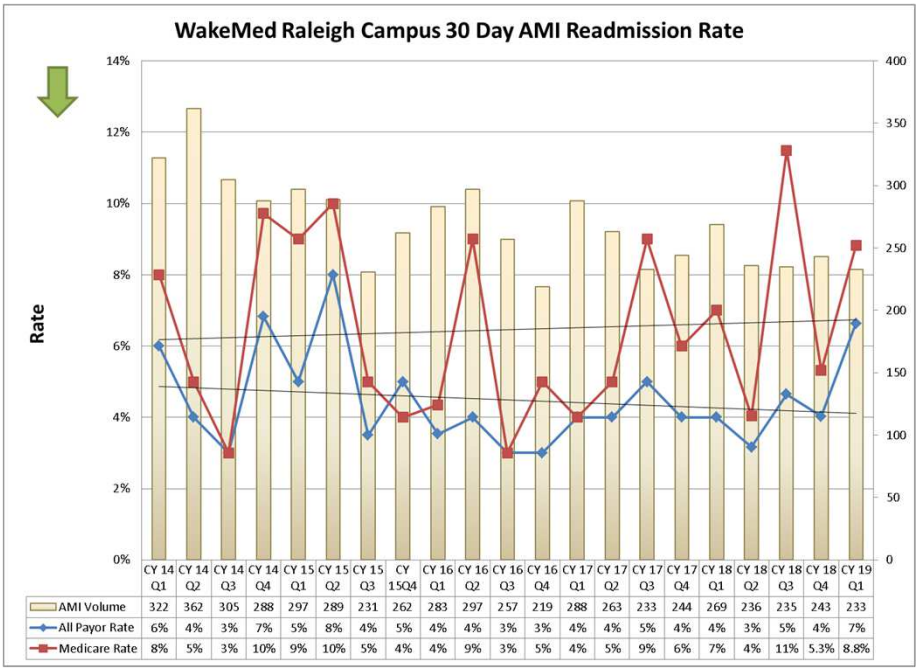
The following criteria apply to question #8c ***High risk patient criteria for receiving community resources:*** *Requiring nursing home or extended care placement/services; 80+ years old with multiple diagnoses and/or living alone; Status post trauma, new chronic diagnosis with significant lifestyle implications (CVA, HF, COPD, ESRD); Experiencing difficulty coping or family dysfunction that may hinder post discharge care; Impaired cognitive ability with no identified family/caregiver support; Issues with mental health or chemical dependency; Significant financial hardships ;Admitted from an assisted living/skilled nursing or extended care facility; Receiving home health care services at the time of admission; Terminal illness/chronic or intractable pain/candidate for hospice referral.*

8c-1 Record the number of high risk AMI patients/caregivers that receive community resources. (Numerator)*

8c-2 Record the number of patients with a principal diagnosis of AMI and meet the criteria for high risk. (Denominator)*

EMR EPIC built out our MI Care Plan and Patient education into a report format with specific yes no answers to the Self Care and Medication components. *(see previous slide)*

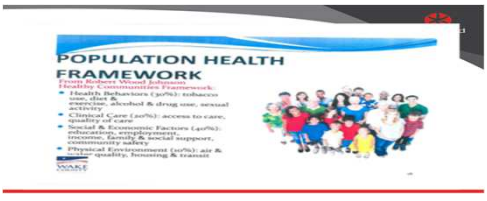
Community Resources are tracked using Patient Nurse Navigator Spreadsheet

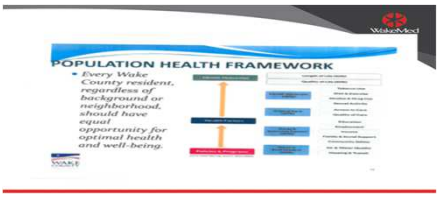


	CY 14 Q1	CY 14 Q2	CY 14 Q3	CY 14 Q4	CY 15 Q1	CY 15 Q2	CY 15 Q3	CY 15Q4	CY 16 Q1	CY 16 Q2	CY 16 Q3	CY 16 Q4	CY 17 Q1	CY 17 Q2	CY 17 Q3	CY 17 Q4	CY 18 Q1	CY 18 Q2	CY 18 Q3	CY 18 Q4	CY 19 Q1
AMI Volume	322	362	305	288	297	289	231	262	283	297	257	219	288	263	233	244	269	236	235	243	233
All Payor Rate	6%	4%	3%	7%	5%	8%	4%	5%	4%	4%	3%	3%	4%	4%	5%	4%	4%	3%	5%	4%	7%
Medicare Rate	8%	5%	3%	10%	9%	10%	5%	4%	4%	9%	3%	5%	4%	5%	9%	6%	7%	4%	11%	5.3%	8.8%

Focus MI Extended Goals

- Targeted Follow up Populations:
  - High Risk Zipcodes for engagement with CCM, ACO-WKCC, Transitional Care / Home Care Follow up
  - Patients with History of COPD / Lung Disease, Infections / Immune Issues, HF & CV Surgery
  - Primary Care Relationships
- Cardiac Rehab – continue to strengthen post referral communication between rehab & Patient Navigation team
- Community Resource Engagement: EMS, Mended Hearts, Church Community; Transportation Resources, Shelter / Housing Resources
- Living Well Community Health Initiatives / Partnerships – Eating / Cooking; Mobility / Activity; Relationship Health;





Questions?

Please Submit your questions for the moderated question & answer session.

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Patient Navigator Program
Focus MI

Learning Network - Listserv

Join the Patient Navigator Community:

patientnavigatorfocusmi@lists.acc.org

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Patient Navigator Program
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Save the Dates!
National Webinar Series 2019

Webinar 3: Tuesday, September 24th, 2019 12:00-1:00pm EST

Webinar 4: Wednesday, December 11th, 2019 12:00-1:00pm EST

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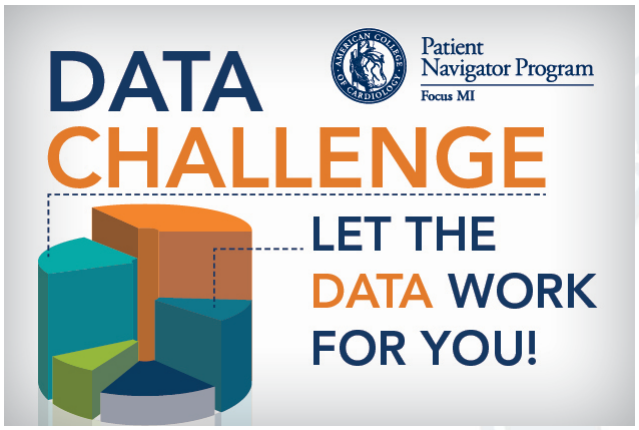
Don't Forget!



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