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

Agenda

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<tr>
<th>Time</th>
<th>Topic</th>
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<tr>
<td>12:00 pm EST</td>
<td>Welcome and Introductions</td>
<td>Dr. Ty Gluckman</td>
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| 12:02   | Benefits of Real Time Data Abstraction: Tactics Utilized             | Randy Cash, RN, CCCT  
            | Transition 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                                                                                      |
Benefits of Real Time Data Abstraction

Tactics Utilized
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
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

- 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
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

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
## Nurse Navigator Tracking Tool and Rounding List

| A | B | C | D | E | F | G | H | I | J | K | L | M | N | O |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | Last Name | First Name | Age | MIN | FIN | Action | PRF | DC Date | Phone/VM | Visited? | Cardiac Rehab | Sk | Notes |
| 2 | Week of 5/2/2019 | | | | | | | | | | | | | |
| 3 | | | | | | | | | | | | | | |
| 4 | | | | | | | | | | | | | | |
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### 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**

<table>
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<th>Name: (Patient Label)</th>
<th>DOB:</th>
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| Room: 4301 | | |
| Age: 93 | | |
| Admit Date: 5/2/2019 | | |
| Team/Attending: Team A, Dr. Smith | | |
| MD: Private Vehicle | | |
| HPI: EMS STEMI, acute MI | | |

| PMH: CAD MI CABG PPM/LCD Afib | | |
| Head HLP HfEd HfEd CHF Last EF: | | |
| PTN: COPD Asthma OSA/COPAP Home O2 | | |
| Neuro: CVa TIA | | |
| Endocrine: DM Thyroid | | |
| Psych: Anxiety Depression | | |
| Renal: CKD ESRD | | |

**Code: STEMI**

| Chest Pain | Onset: wake up with CF | |
| Quality: pressure | |
| Radiation: to left arm | Score: 10/10 |
| Worse with: NA | Better with: SL NTG |

**ERG:**

- (EMS) Nitrates 4 x 2, ST elevation in II, III, AVL, with chest pain, depression
- LHC/PIC: Date: 5/2/19

**Attending:** Dr. Smith

**Results:**

- 100% SYCA – aspiration thrombolysis
- DES x1, normal LVEDP
- Ech: 59%, no TROMA
- Date: 5/30
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.
Example of Intervention Tracking Tool

Data Obtained Through Intervention Tracking

Interventions by Patient Status

- 34% Outpatient
- 66% Inpatient

Inpatient

Outpatient
Data Obtained Through Intervention Tracking

Interventions by Category

- Cardiac Rehab: 15%
- Clinical Concern: 23%
- Follow-Up Care: 19%
- Patient Question: 22%
- Psychosocial: 5%
- Medication-Related: 21%
- Other: 8%
- Insurance Assistance: 1%
- Other: 2%
- Clinical Concern: 12%

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
Focus MI: Aspirational Goals

FY2018 Aspirational Goal Metrics

FY2019 Aspirational Goal Metrics

- Quality
- Safety
- Finance
- Culture
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.
EPIC Healthy Planet

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

AMI Risk via EPIC EMR

Navigator Diplomat Questions

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

Education & Community Resource

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
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;
Thank you

Questions?

Please Submit your questions for the moderated question & answer session.
Learning Network - Listserv

Join the Patient Navigator Community:
patientnavigatorfocusmi@lists.acc.org

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
Don’t Forget!

DATA CHALLENGE
LET THE DATA WORK FOR YOU!