

A HEART CARE NAVIGATION TEAM IMPROVES ACUTE MYOCARDIAL INFARCTION CARE AND OUTCOMES

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BACKGROUND

In 2017, a Heart Care Navigation Team was implemented to optimize acute myocardial infarction (AMI) care transitions in order to improve compliance with guideline-based care, reduce mortality and minimize avoidable readmissions.

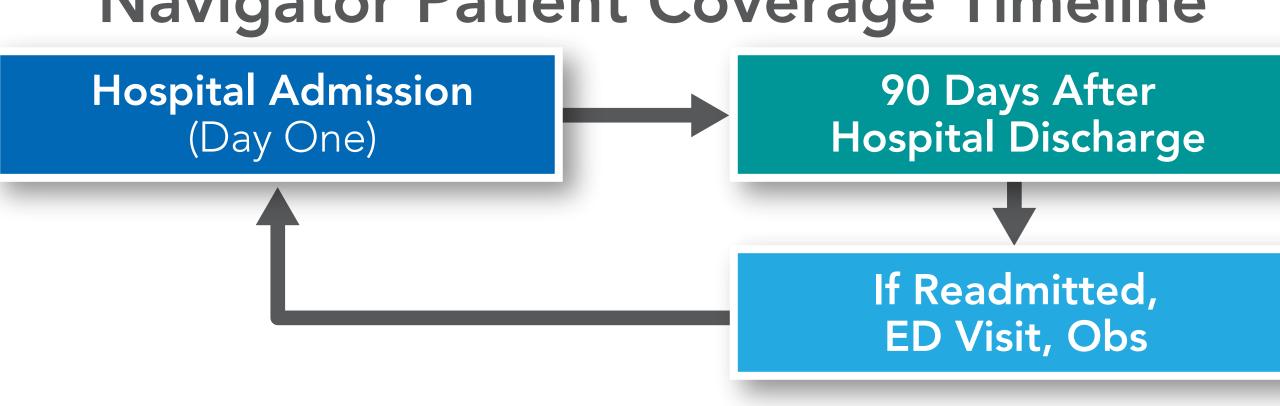
METHODS

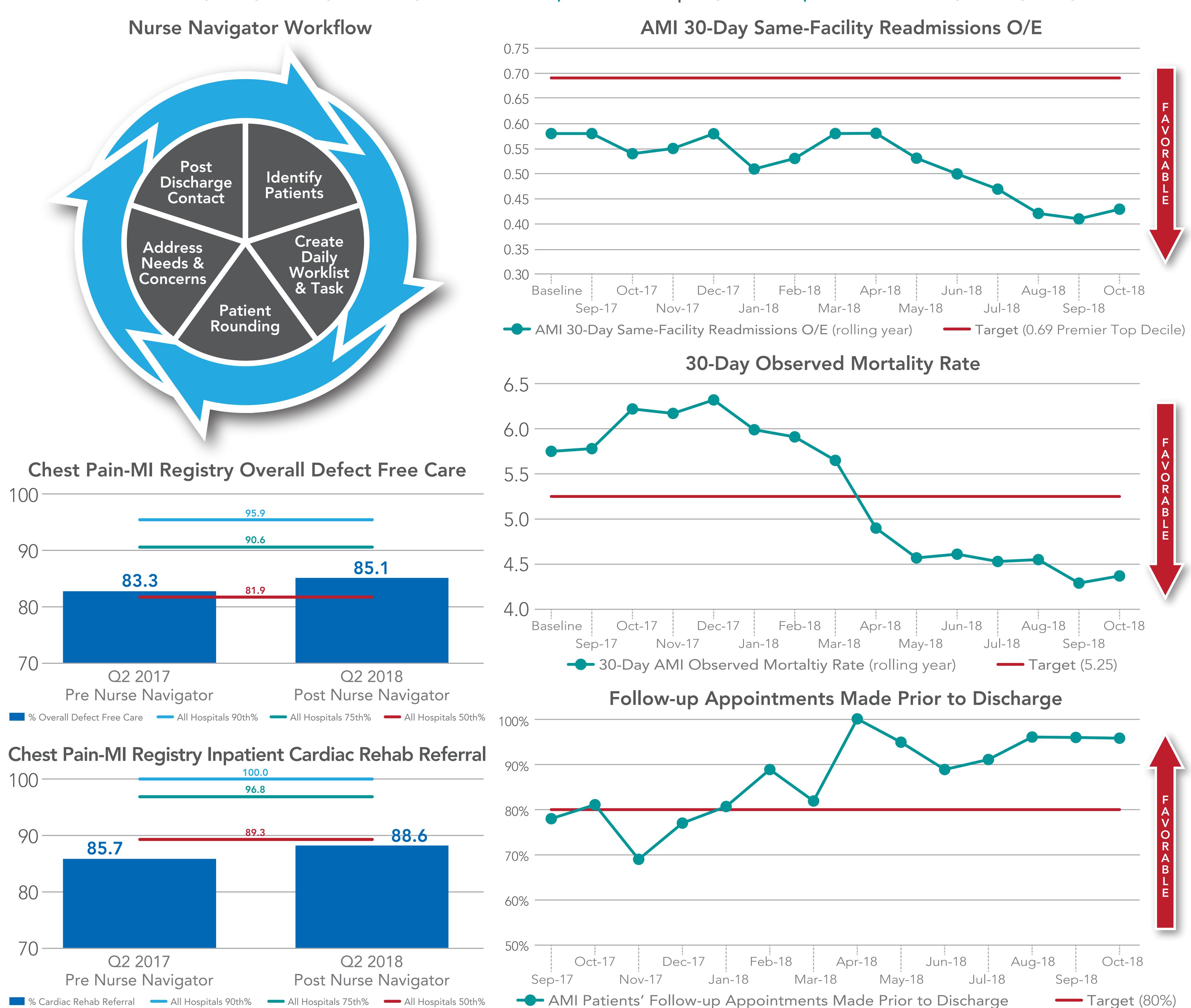
One health advocate and two full-time AMI nurse navigators were hired in the summer of 2017. Using the Plan, Do, Study, Act methodology, the team's workflow evolved to

- (1) enhance the discharging process without adding additional burden to the existing clinical staff, and
- (2) provide AMI patients with direct access to a clinical resource during and after the hospital stay.

During the inpatient encounter, the nurse navigator focuses on education, care coordination, and quality improvement. The team assists with timely access to followup care, promotes self-management, and addresses patients' questions or concerns for a period of 90 days following hospital discharge. During this 90-day post discharge period the duration of care can reset if the patient has an additional inpatient encounter. This program is limited to weekdays during business hours.

Navigator Patient Coverage Timeline







RESULTS

Patients appropriate for heart care navigation were identified based on the criterion: principle diagnosis of AMI. During Aug17-July18 approximately 680 patients were found to be appropriate for navigation care. Comparing pre- to post- Heart Care Navigation Team implementation (i.e., July16–June17 vs. Aug17–July18), our internal data showed a reduction in AMI 30-day same-facility readmissions observed/expected ratios (0.58 vs 0.42) and well below the Premier Top Decile [0.69], a reduction in AMI 30-day observed mortality rate (5.75% vs. 4.57%), and an increase in AMI patients' follow-up appointments made prior to hospital discharge (78% vs 96%). Data from the Chest Pain—MI Registry showed an increase in overall defect free care (83.3% vs 85.1%) and an increase in cardiac rehab referrals (85.7% vs 88.6%).

CONCLUSIONS

Results indicate successful impact of the Heart Care Navigation Team at the System's quaternary facility. There remains opportunity to improve defect free care, particularly referral to cardiac rehabilitation. Similar programs were implemented at two additional tertiary care facilities within the System, both of which have yielded similarly positive results. Strengths of the program include a one-on-one relationship between patient and Heart Care Navigator team through the care transitions and a strong collaborative relationship between the team and providers.

CLINICAL IMPLICATION

A well-designed Heart Care Navigation team appears to improve guideline-based care and patient outcomes.