TEXAS TECH UNIVERSITY
HEALTH SCIENCES CENTER™
Paul L. Foster School of Medicine

TEXAS HEALTH CARE

REGIONAL HEALTHCARE PARTNERSHIP REGION 15

Transformation and Quality Improvement Program – 1115 Waiver

Improving Care and Outcomes of High Risk Newborns after NICU Discharge using the Patient Care Navigation Program

March 30, 2016

Description of the Project

- Patient Care Navigation Program within the High Risk Clinic, a neonatal follow-up program at Texas Tech University Health Sciences Center (TTUHSC) El Paso - Department of Pediatrics

- Target infants born at ≤ 32 weeks gestational age and/or infants whose birth weight was < 1500 grams – a cohort of high-risk patients discharged from the El Paso Children's Hospital (EPCH) – Neonatal Intensive Care Unit (NICU)

Benefits to the Community

- Utilize health care workers, case workers, and other health care professionals as patient navigators.
- To provide enhanced social support and culturally competent care to vulnerable high risk patients.
- The navigators will help patients navigate the continuum of health care services, assuring timely site-appropriate coordinated services.

Navigation Services – DY 5

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Total
Total Services	151	207	177	135	215								**885**
Top 4 services													
Care Coordination – High Risk Clinic	61	93	64	62	86								366
Phone calls - Each High Risk Clinic visit	17	34	25	22	22								120
Care Coordination – other issues	20	25	9	8	22								84
Education - use of services	12	18	22	17	11								80

Other services:, Care Coordination – PCP, System navigation – DME issues, Apnea monitoring, care coordination for subspecialty ff-up, barriers to access, insurance services, phone calls – 2 weeks after NICU discharge, prescriptions, social services, home health, referrals to ECI and other rehab facility, triage medical problems, etc.

Project Milestones and Metrics

Goal: Participate in at least 2 face-to-face meetings /seminars		
DY 3	1st meeting: 7/30/2014	2nd meeting: 9/24/2014
DY 4	1st meeting: 3/25/2015	2nd meeting: 6/24/2015
DY5	1st meeting: 3/30/2016	

I-10.2: Increase Number of Unique Patients served by Navigator Program (Number of patients recruited to follow-up at high risk clinic and made it to their first scheduled appointment)

DY 3	Goal: 50 Oct 2013 - Sept 2014: 53 (out of 72 patients recruited = 74%) 57% Medicaid
DY 4	Goal: 55 Oct 2014 - Sept 2015: 66 (out of 74 patients recruited = 89.1 %) 60.61% Medicaid
DY 5	Goal: 60 Oct 2015 – Feb 2016 : **18** (out of 18 patients recruited= 100%) **55.56** % Medicaid (10 of 18)

Category 3 Measures

IT 8.21. Developmental screening in the first 3 years of life.

- Indicator: The percentage of children who had screening for risk of developmental, behavioral and social delays using a standardized screening tool documented by 12 months of age.
- Denominator: Target patients who turn 12 months of age between Jan – Dec of measurement year.
- Targeted patients: Premature infants enrolled in the program (≤ 32 weeks and or birth weight ≤ 1500grams).
- Communication and Symbolic Behavior Scales Developmental Profile (CSBS-DP) – performed during high risk clinic visit on target patients at 9-12 months chronologic age (started in June 2014).

Calendar Year	DY 3	DY 4	DY5
Total number of targeted patients who turned 12 months of measurement year	(52)	(63)	10
Total number of targeted patients who received developmental screening using CSBS-DP	(13)	(47)	6
Total number of targeted patients who received developmental screening using CSBS-DP (%)	(25%)	(74.6%)	60% To Date for 2016

Category 3 Measures

Communication and Symbolic Behavior Scales Developmental Profile (CSBS-DP) – performed during high risk clinic visit on target patients at 18-24 months chronologic age.		
Calendar Year	DY 4	DY5
Total number of targeted patients who turned 24 months of measurement year (Born in July –Dec 2013)	33	10
Total number of targeted patients who received developmental screening using CSBS-DP	13	7
Total number of targeted patients who received developmental screening using CSBS-DP (%)	39.4% July – Dec 2015	70% To Date for 2016

Category 3 Measures

IT 9.9. Transition record with specified elements received by discharged patients.

- Measure: Percentage of patients who received transition record at the time of discharge.
- Targeted condition – Premature infants < 34 weeks admitted and discharged at El Paso Children's Hospital – NICU must have documentation of receipt of transition record.
- Transition record entered as an event by residents/NNPs at discharge (started in June 2014). Tracking done monthly.

October 1, 2015 – September 30, 2016	DY 3	DY 4	DY 5 Oct2015-Feb2016
Total patients Discharged < 34 weeks GA	99	99	37
Patients with documented receipt of transition record	31	76	29
Patients with documented receipt of transition record (%)	31%	76.7 % Goal: 35%	78.38%

Category 3 Measures – P4R

IT 8.25. Sudden Infant Death Syndrome Counseling

- Measure: Percentage of children 6 months of age who had documented Sudden Infant Death Syndrome (SIDS) counseling.
- Numerator: Children who had documented SIDS counseling within 4 weeks of birth or by first pediatric visit, whichever comes first.
- Denominator: Children who turned 6 months of age during the measurement year.
- Targeted facility. All infants discharged from the El Paso Children's Hospital – NICU.
- SIDS counseling incorporated in discharge teaching on all infants discharged from the El Paso Children's Hospital – NICU.
- SIDS counseling is entered as an event in Site of Care by residents/NNPs for documentation (tracking started in June 2014).

October 1, 2015 – September 30, 2016	DY 3	DY 4	DY 5 Oct2015-Feb2016
Children discharged from EPCH NICU who turned 6 months of age during the measurement year	514	1035	411
Number of patients who received SIDS counseling	0	737	270
Number of patients who received SIDS counseling (%)	Baseline of 0% None of those patients who received SIDS counseling from June – Sept 2014 had turned 6 months.	71.2%	65.69%

P4R Measure attached to IT 8.25.

Tracking of deliveries at UMC with BW <2500g			
Year/Month	Number of deliveries BW <2500 g	Total deliveries (live births) at UMC	%
2014			
Total	271	2741	10%
2015			
Total (Oct 2014 – Sept 2015)	240	3572	6.72%
2016			
Total (Oct 2015 – Feb 2016)	**114**	**1480**	**7.70%**

Quality Improvement (PDSA)

- Overall Goals
  - Promoting compliance with ff-up appointment at High Risk Clinic Neonatal Follow-up program
  - Increase retention of patients enrolled in the program until discharge
  - Improve services
  - Increase parent satisfaction

Quality Improvement (PDSA)

- **Presented in March 2016**

❖ <u>Assess benefits of pediatric physical therapists during Special Care Clinic visits.</u>
Promote optimal developmental skills based on patient's corrected age for milestone.

❖ <u>Enhance awareness to community providers of Special Care Clinic services</u>.
Educate on SCC services available to community. Increase referrals and increase current patient population seen.

❖ <u>Bayley 3 Evaluations at the prior to the completion of Special Care clinic visits.</u>
The purpose of this evaluation is to follow up outcomes from ongoing outpatient rehabilitative services from hospital discharge to current and identify progress baby has made in 5 developmental areas, towards meeting milestones and preparation for school entrance and parent's understanding of progress and projection of future needs/services.

Quality Improvement (PDSA)

- **Presented in March 2016**

❖ PDSA: **Welcome Packet Received**
A follow- up to an earlier PDSA done "Welcome SCC Packet" where a packet with clinic information and services provided is given to families being discharged from NICU to help provide guidance and assistance to promote the well-being of the baby.

❖ PDSA: **Compliance with 1 year Immunizations**
First time testing to determine our populations compliance with immunizations up to 12 months of age compared to National and State level, and if not up-to-date can we promote compliance by verify appointments and/or scheduling visits with their PCP.

❖ PDSA: **Assisting with Nutritional Services**
First time testing; by providing literature and education (Nutritional Services) to determine if their is a positive effect on the patients growth and development.

❖ PDSA; **Patients receiving ECI service**
To track and monitor our families receiving services in a timely manner.

Quality Improvement (PDSA)

13. Mini iPad Give away for keeping the 1st scheduled appointment at High Risk Clinic

- Patients who made it to their first scheduled appointment are included in the raffle for mini iPad

• DY 3 show-up rate to first appointment (prior to all QI initiatives including mini iPad raffle):	53 out of 72 NICU discharges (74%)
• DY 4 show-up rate to first appointment after QI initiatives and mini iPad raffles	66 out of 74 NICU discharges (89.1%)
▪ 1st drawing (10/1/14 to 12/15/14	12 out of 13 (92.3%)
▪ 2nd drawing (12/16/14 to 6/15/15)	34 out of 38 (89.5%)
▪ 3rd drawing (6/17/15 to 12/7/15)	24 out of 27 (88.8%)
▪ 4th drawing (12/08/15 to 5/30/16)	PENDING

Challenges for DY 5

- **May have difficulty meeting QPI if we have to increase goal (current goal 60)**
- **Number of patients recruited dependent on EPCH NICU discharges**

- **Possible solutions**
  - **Success depends on our navigators and how efficiently we run the clinic**
  - **Creative projects/incentives to retain patients in the program**

OTHER SOLUTIONS

- Expand the criteria for enrollment in the Patient Navigator Program to include additional NICU graduates who are at risk for adverse outcomes as a consequence of their various diagnoses (*e.g.* infants with major congenital or chromosomal anomalies)

- Expand the coverage by enrolling high-risk infants discharged from other NICU facilities in the region referred to Special Care Clinic

Additional Challenges for DY 5

- **Potential problem with tracking data (those derived from Site of Care) when we change to Cerner documentation. Difficulty securing information and sharing information.**

QUESTIONS?

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COMMENTS?