



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

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Region 15 RHP Meeting

El Paso First Healthplan, 1145 Westmoreland Drive

June 24, 2015

1:00pm

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)

Project Milestones and Metrics

P2.1: Number of People Trained as Patient Navigators

Goal: 1 Additional Patient Navigator hired and trained

DY 3: Met milestone, 1 person hired – start date 8/20/2014

DY 4 & 5: Excluded from milestones

P2.2: Develop Outreach Plan to enroll patients in Navigation Program

Goal: Complete Patient Outreach Plan

DY 3: Completed and submitted 8/7/14

DY 4 & 5: Excluded from milestones

Project Milestones and Metrics

P-10.1: (Customized) Report on types of services provided to high risk patients enrolled in the program

Goal: Complete report on those services provided to High Risk Patients

DY 3

Navigators use EMR form to document the services (started in 6/2014).

Total services from June – Sept 2014: **326**

Top 5 services: Care Coordination – High Risk Clinic, Care Coordination – PCP, System navigation – DME issues, Apnea monitoring, Phone calls – prior to High Risk clinic visit

Navigation Services – DY 4

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	June	Total
Total Services	292	160	202	230	288	153	218	135	108	1786

Top 5 services										
Care Coordination – High Risk Clinic	80	51	77	73	99	41	87	48	43	599
Phone calls - Each High Risk Clinic visit	44	20	17	25	38	11	34	22	13	224
Education - appropriate use of services	14	6	16	8	21	9	23	3	9	109
Other services	12	8	14	20	19	9	23	3	9	103
Care Coordination - PCP	25	9	8	15	14	5	8	3	2	89

Other services: Care Coordination – other issues, 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

P-8.1: Participate in semi-annual face- to-face meetings or seminars organized by the RHP

Goal: Participate in at least 2 face-to-face meetings /seminars

DY 3	1 st meeting: 7/30/2014	2 nd meeting: 9/24/2014
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DY 4	1 st meeting: 3/25/2015	2 nd meeting: 6/24/125
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I-10.2: Increase Number of Unique Patients served by Navigator Program

DY 3	Goal: 30 → 50 Patient enrolled Oct 2013 - Sept 2014: 53 (out of 72 patients recruited = 74%); 57% Medicaid
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DY 4	Goal: 55 Patient enrolled Oct 2014 – May 2015: 43 (out of 50 patients recruited = 86 %); 67.44% Medicaid
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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 ≤ 1500 grams).
- Communication and Symbolic Behavior Scales Developmental Profile (CSBS-DP) – performed during high risk clinic visit on target patients starting at 9 months chronologic age (started in June 2014).

	DY 3	DY 4
Total number of targeted patients who turned 12 months of measurement year	(13)	26
Total number of targeted patients who received developmental screening using CSBS-DP	(52)	65
Total number of targeted patients who received developmental screening using CSBS-DP (%)	(25%)	Goal 17% May 2015: 40%

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.

	DY 3	DY 4
Total patients Discharged < 34 weeks GA	31	52
Patients with documented receipt of transition record	99	67
Patients with documented receipt of transition record (%)	31%	Goal: 35% May 2015: 77.6%

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).

	DY 3	DY 4
Children discharged from EPCH NICU who turned 6 months of age during the measurement year		735
Number of patients who received SIDS counseling		1031
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.	May 2015: 71.3%

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 – May 2015)	121	2375	5%

Quality Improvement (PDSA)

- 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 2015**

1. Phone call reminders to parents of SCC appointment
 2. Family meetings prior to hospital discharge
 3. Hospital discharge welcome packet to SCC services
 4. Texas Tech Welcome to first High Risk Clinic Visit
 5. Follow up appointment scheduled prior to leaving exam room
 6. Scheduling High Risk Clinic visits at 1 hour intervals
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Quality Improvement (PDSA)

7. Follow-up phone calls 2 weeks after NICU discharge

- Provided continued reassurance to families that they have partners who can help them be successful as they assume care of their babies after NICU discharge
- Helped identify and anticipate patient needs minimizing delays in patient services

8. Provide assistance with preauthorization & referrals

- Preauthorization and referrals are processed in time reducing cancellation and rescheduling of visits
- Prediction: By continuing to provide this type of service to parents who find the task difficult and/or unpleasant will yield a higher percentage of compliance over a longer period of time.

9. Projection of the timing of developmental screen at 9-12 months chronologic age

- This tracking system allowed for some control of scheduled F/U appointments which increased the number as well as the percentages of developmental screen (CSBS-DP) performed

Quality Improvement (PDSA)

10. Tracking of Developmental Screening (CSBS-DP)

- Weekly meeting between the patient navigator performing the CSBS-DP and the data analyst reporting CSBS-DP are being conducted to audit each other's spreadsheet and compare results.
- This process eliminated the discrepancy in the actual number of CSBS-DP being performed and the number captured by the analyst and identified potential causes of discrepancy.

11. Parental education on prevention of RSV during RSV Season

- Screened and identified all candidates for Synagis administration
- Follow-up education and confirmation from parent to submit baby's information to Medicaid for medication authorization
- Provide one on one education about RSV season, and provided literature in their primary language

12. Providing incentives to parents for keeping the first appointment (Swift Card)

- An incentive card (\$20) is given to parents who live outside the city limits if they kept their first scheduled appointment (QPI).
- This incentive, to some extent has contributed to higher rate of compliance with follow-up appointment.

Projects

- Preemie Baby's Day Out – March 7, 2015, 2-5PM at Texas Tech
 - Provide opportunities for gathering of families to connect with one another for support as they share their stories and a time to honor them
 - Educational presentations on developmental care and interventions and appropriate use of services and community resources to assist families as they increase their ability and confidence to care for their infants after NICU discharge

Lessons Learned

- Open discussion

PREMIER
DAY OUT

PREMIER
DAY OUT





QUESTIONS?



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COMMENTS?