Patient Navigation Implementation to Improve Health Outcomes after Stroke

Initiated by grant funding from Health Resources and Service Administration (HRSA)

Disclosures

No conflicts of interest

Funding Background

- $540,000 3-year grant from HRSA with the goal to improve access to care and health outcomes among patients recovering from stroke or TIA residing in rural Minnesota
- Funding used to establish patient navigation and initiate telehealth services, including equipment purchase for consortium partners
- Eligible patients reside in rural counties of Todd, Swift, Chippewa, Pope, Wadena and several rural zip codes of Stearns.
- Consortium consists of
  - 8 rural hospitals and clinics
  - 7 home care agencies
- Grant period May 1, 2015 – April 30, 2018
- Sustainment plan to maintain program is required by HRSA

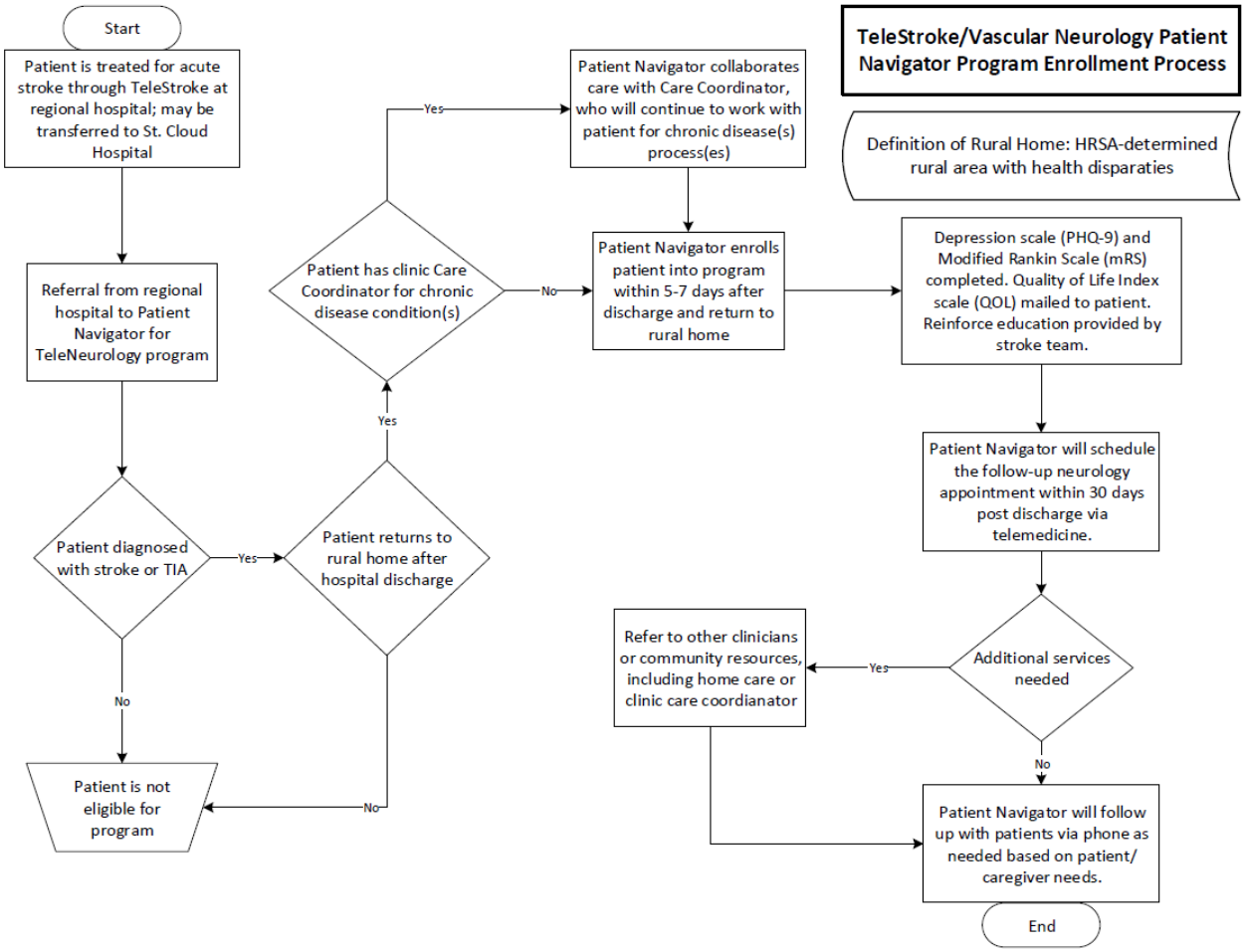
What is Patient Navigation?

- RN Case Management
- Assessment of patient's abilities after their stroke
- Assistance in obtaining additional help/support
  - Support group
  - Respite
  - Transportation
  - Food/housing
- Assistance in scheduling appointments
- Review of medications, making sure patient is taking
- Education, including reinforcement of stroke education from hospitalization

Patient Eligibility for Grant Program

- Referral comes from patient's local ED
- Patient Navigator verifies stroke or TIA diagnosis
- Patient must reside in HRSA-determined rural area
- When patient meets both criteria above, Patient Navigator calls patient within 5-7 days after discharge from hospital or rehab unit

Patient Navigator Workflow



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Program Assessment Tools

- Enrollment Tool
- Modified Rankin Scale (mRS) – level of disability
- Quality of Life – Stroke version
- PHQ-9
- Survey

- Telehealth option for follow up stroke appointment

Enrollment Tool

- Designed to capture data for Primary Stroke Center while reducing the number of phone calls to the patient/family
- Patient's health-related goal
- Verify patient knows follow up appointments and referrals
  - Date/time
  - Therapy or home care referrals
- Medications
  - Prescription filled and patient is taking as directed
- Education – stroke symptoms, risk factors & lifestyle changes
- Review any additional support needed

Modified Rankin Scale

- Measures the degree of disability
- Can be completed in person or over the phone by asking specific ability questions
- Scores:
  - 0: no symptoms at all
  - 1: no significant disability despite symptoms; able to carry out all usual duties and activities
  - 2: slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance
  - 3: moderate disability; requiring some help, but able to walk without assistance
  - 4: moderately severe disability; unable to walk without assistance and unable to attend to own bodily needs without assistance
  - 5: severe disability; bedridden, incontinent and requiring constant nursing care and attention
  - 6: dead
- Course can be found at http://rankinscale.org. Certification good for 2 years.

Quality of Life – Stroke Version

- Ferrans and Powers Quality of Life Index
- Scores in the following areas of a patient's life:
  - Quality of life overall
  - Quality of life in health and functioning
  - Quality of life in psychological/spiritual
  - Quality of life in social and economic
  - Quality of life in family

PHQ-9 and Survey

- PHQ-9 is a tool used to screen, diagnose, monitor and measure the severity of depression.
- Post-stroke depression affects more than a third of stroke survivors and can slow down stroke recovery.

- Survey used to evaluate the telehealth appointment as part of the program.

Telehealth Appointment Option

- Telehealth offered to patients as an option for their follow-up with the stroke care team
- Patients may choose face-to-face or telehealth
- If telehealth is chosen, patient navigator will assist with scheduling the appointment

Patient Contact

- Initial completed within 5-7 days of returning home (may be from hospital or rehab)
- Follow-up within a few days if patient/caregiver expresses desire to have post-stroke follow-up via telehealth to schedule appointment
- First 6 months – minimum is monthly
- After 6 months may drop to quarterly
- Grant does not allow for discharge from program
- Sustainment is in the works – we will review these processes and develop sustainable algorithms.

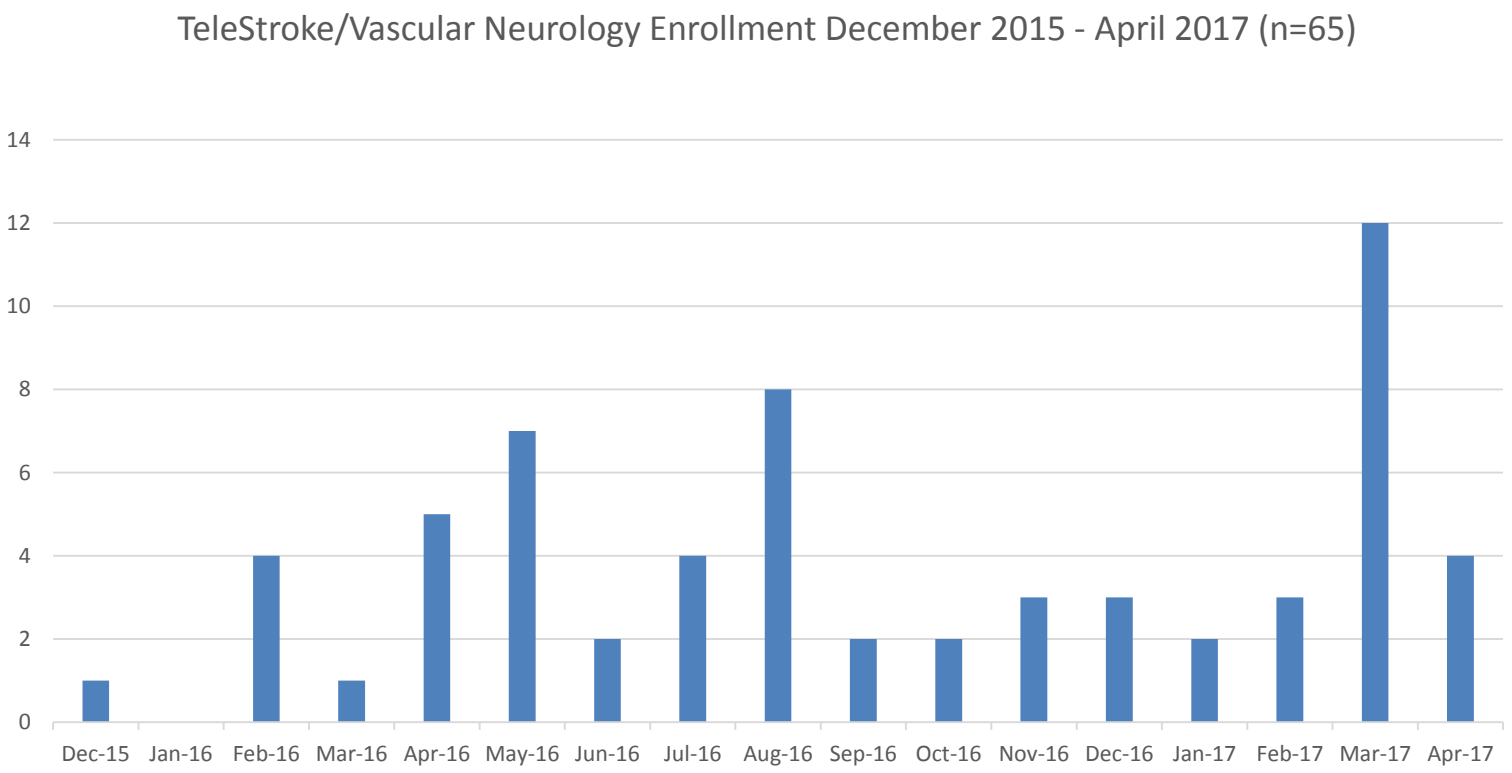
Objectives of Program

- 80% of the patients who visited with the patient navigator will receive a telehealth visit within 30 days after discharge
  - 80% will complete a follow up neurology visit within 30 days after discharge
- Degree of disability will be reduced by 50% within 3 and 6 months of discharge
- Improve the quality of life among patients by 30% within 6 months of discharge
- Provide positive experience for patients in the program with all services including telehealth
- All-cause readmissions will be less than 9%

Current Program Measurements

- 74% of enrolled patients completed neurology follow-up visit
  - 60% completed within 30 days of hospital discharge
- Reduction of degree of disability by average of 56%
- Improvement of QOL by average of 41%
- 77% patients surveyed agree the quality of care via telemedicine is as good as a face-to-face visit
- 5% had secondary stroke within 90 days
- 9% were re-hospitalized within 30 days

Monthly Enrollment Numbers



Questions?

Thank you!