Avera McKennan's Nurse Navigator Program uses MEDITECH's EHR to Steer ED to $475,000 Annual Cost Savings

Avera McKennan Hospital & University Health Center, a HIMSS Analytics Stage 7 hospital and four-time designated Magnet facility, is a 545-bed tertiary hospital located in Sioux Falls, SD. The hospital is the flagship of Avera Health, a 32-hospital system spanning five states: South Dakota, North Dakota, Iowa, Minnesota, and Nebraska. Avera McKennan operates a Level 2 trauma center with 30,000 visits annually.

Executive Summary

Nurses in Avera McKennan's Emergency Department identified a segment of their patient population frequently utilizing the ED for non-emergent situations. This is a problem faced by EDs across the United States, with potentially avoidable visits estimated to be over 50 percent or about 67 million visits.[1] Avera nurses are taking this challenge head on by implementing a nurse-driven care manager program.

The ED nurse navigator program focuses on patients considered "super utilizers" by providing personalized care management that extends beyond the ED. Fully automated in MEDITECH, the software makes it easy to track and monitor these patients and provides a standardized toolkit to roll out to other hospitals in the Avera system.

The program results are impressive:

78% decrease in ED visits by program participants

$475,000 decrease in cost of care for program participants in 2015

13.7% decrease in overall non-emergent ED visits in 2015

68% patient follow-up compliance, well above the Magnet hospital compliance average of 25%-40%

Key satisfier with ED physicians and front line staff

1 Weinick R, Billings J, Thorpe J, Ambulatory care sensitive emergency department visits: a national perspective, Abstr AcademyHealth Meet, 2003;20(abstr no. 8):525-526.

Opportunity Identified

A health care ministry rooted in the Gospel, Avera Health's core values of compassion, hospitality, and stewardship permeate the organization and empower staff to identify ways to improve care and address patient needs. Front-line nurses in Avera McKennan's Emergency Department put these core values into action by identifying an opportunity to improve the management of at-risk patients who use the ED as a clinic or healthcare provider rather than for emergent situations. Not only does this drain the ED of valuable resources, it is a high-cost setting for the patient to receive the ongoing care and support needed.

Leadership along with a multidisciplinary team created an ED nurse navigator program. The team looked at this challenging situation through the lens of patient-centered care and set out to identify specific interventions to address the complex medical and psychosocial needs of these patients.

Design and Implementation

The project started with the team mining a year's worth of ED visit data to analyze patients who are "super utilizers" of the ED and identify contributing factors. The data revealed several characteristics common to this patient population:

In addition to the patients remaining in a cycle of crisis, the hospital was not reimbursed for these visits. The average cost associated was over $900 per ED visit.

The team determined that hiring a registered nurse to take on the role of ED nurse navigator offered a holistic approach to addressing these patients' needs.

The ED nurse navigator takes the lead in coordinating patient care across care transitions. This includes creating a personalized health care plan outlining the patient's medical and psychosocial health problems. The navigator collaborates with the patient and caregiver to facilitate ongoing care. They review each problem identified in the care plan and educate the patient on when it's appropriate to see the PCP versus when to use the Emergency Department. The nurse navigator arranges follow up appointments with PCPs and/or medical referrals, and sends appointment reminders to assist the patient in being compliant.

Another key responsibility of the nurse navigator is networking with community agencies offering outpatient services that can help

address financial or psychosocial issues. Bridging this gap from when the patient departs the ED and returns to the community is critical to breaking the cycle of non-emergent ED visits.

In September 2014, Avera McKennan launched the ED nurse navigator program with a focus on improving quality of care and decreasing costs. The program goals included:

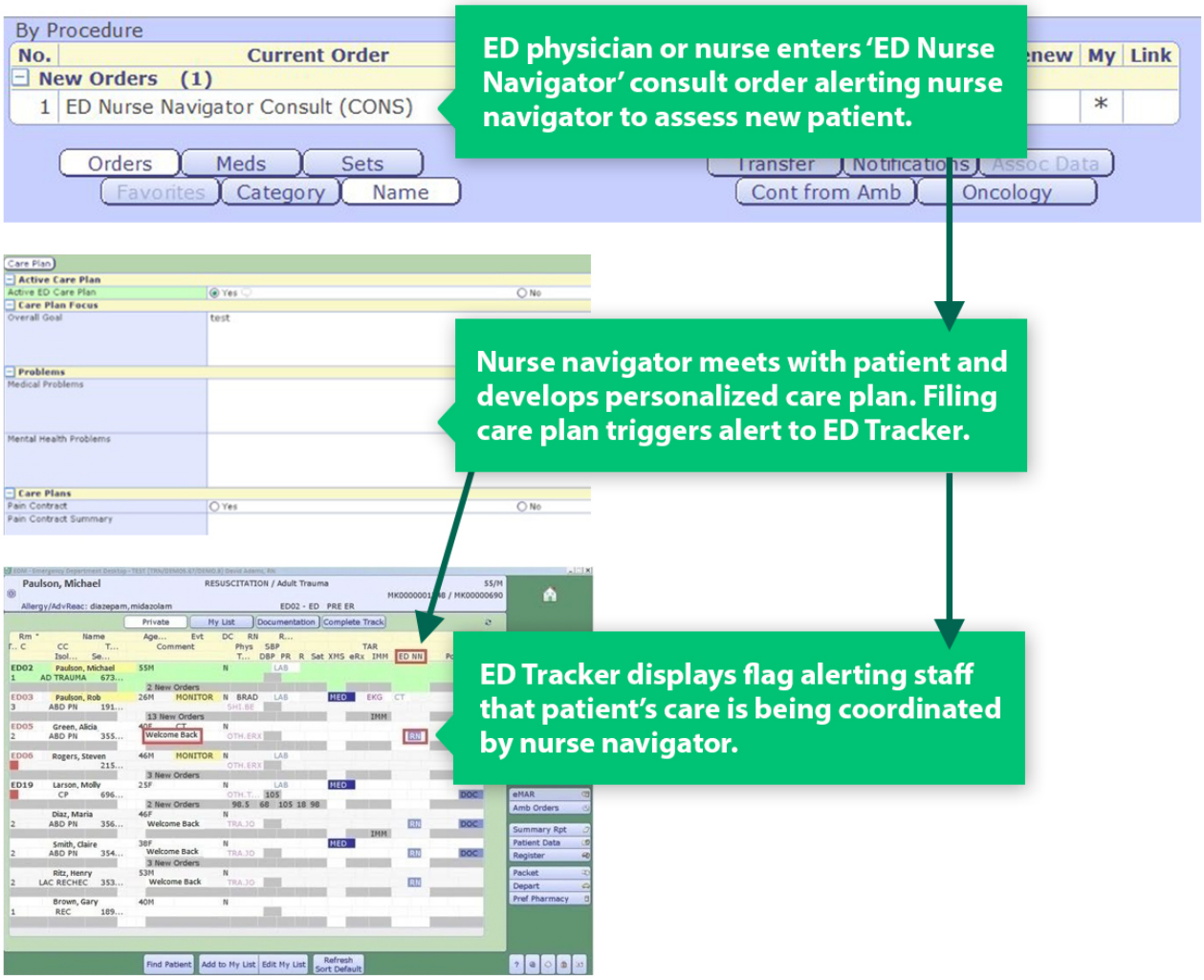
- Improving ED patients' transitions of care
- Reducing non-emergent ED patient visits
- Encouraging appropriate use of the ED
- Improving ED collaboration with community agencies throughout the area
- Coordinating care for chronic medical/mental health issues
- Promoting medical compliance
- Preventing inappropriate use of controlled medications (i.e. narcotics).

How MEDITECH's EHR Drives Program Success

Avera McKennan initially implemented their ED nurse navigator program using paper to track enrollment, care coordination, and care plan documentation. After working through the process on paper, they enlisted Avera's Information Technology (IT) team to automate the documentation in MEDITECH.

IT maximized MEDITECH's integration, documentation, and clinical decision support tools to capture all the data electronically, and embed alerts within the registration and documentation process to improve communication and continuity of care within the ED. Avera McKennan's fully automated process begins the moment a potential participant presents at the ED.

Identifying and Monitoring Patients for the Nurse Navigator Program



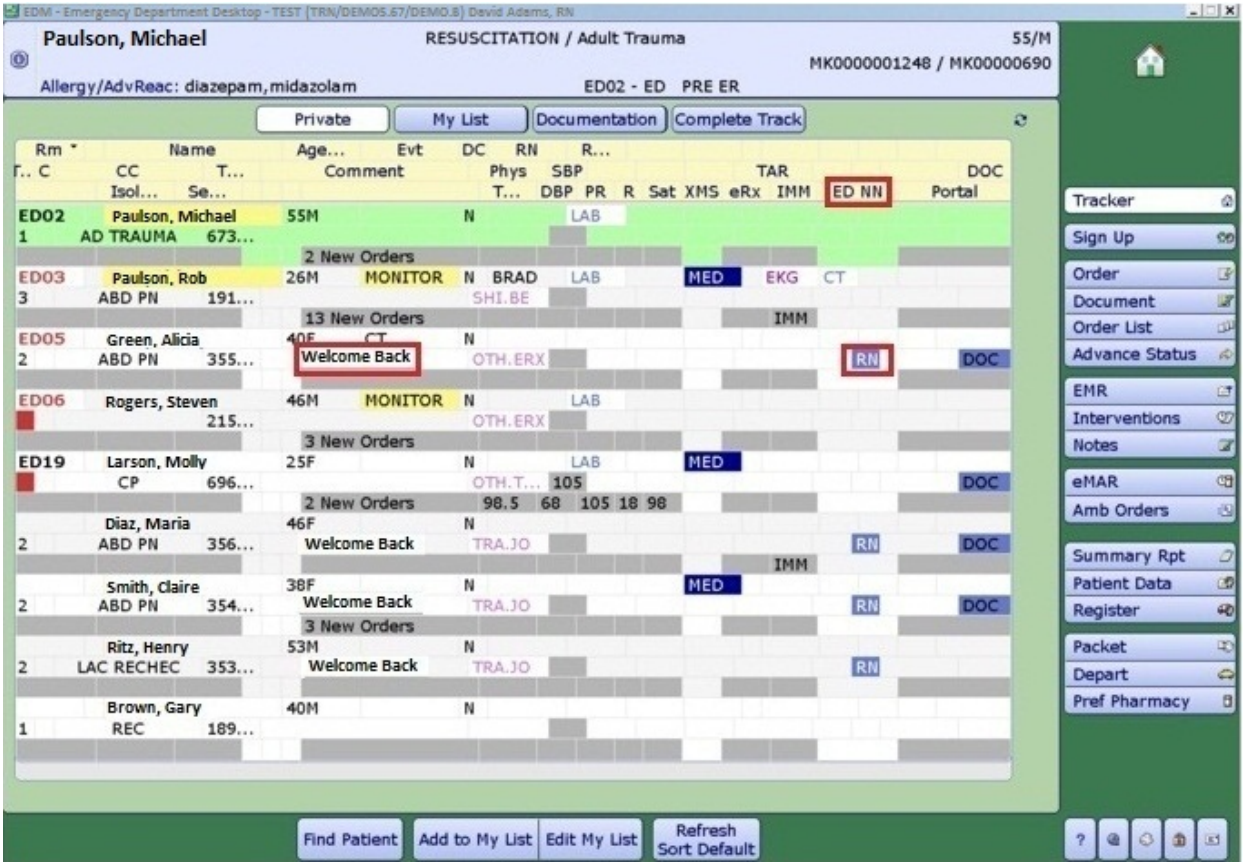
When an ED physician or nurse identifies a patient that may meet the criteria for an ED Care Plan, the clinician proceeds to enter an “ED Nurse Navigator” consult order. The order alerts the nurse navigator of a new patient with qualifying needs to assess and determine if an ED Care Plan is appropriate.

Care plans are typically used in the inpatient setting; however, using a version of this tool for program participants is effective in providing much needed continuity of care. This plan outlines the patient’s medical and mental health problems - as well as interventions agreed upon by the patient’s PCP/health care team, the ED nurse navigator, and referral ED provider - and involves notification to the patient of enrollment.

Once the “ED Care Plan” is implemented, an alert triggers a flag on the ED Tracker. This communicates to all ED staff that the patient’s care is being coordinated by the nurse navigator.

The ED Care Plan remains with the patient and is pushed to future visits. The next time the patient arrives at the ED and is registered, an alert automatically triggers to the ED Tracker. The receiving nurse is able to view the patient’s care plan in the EMR and get a quick picture of how their medical and psychosocial issues are being managed. Staff throughout the ED can quickly glance at the tracker and see that the nurse navigator is coordinating the patient’s care.

Alert Triggers at Patient’s Next ED Visit



Collaboration with Ambulatory Clinics

The ED nurse navigator routinely collaborates with ambulatory clinic coordinators to manage the patient across the care continuum. While on the phone discussing a patient’s care, both clinicians are simultaneously accessing and viewing the patient’s ED care plan in the EHR, making it easier to review patient problems and discuss potential interventions. One area where this is particularly effective is managing patients with drug-seeking behaviors. This collaborative effort is further enhanced by holding monthly meetings to discuss patient care plans.

The Power of Electronic Data Leads to Positive Results

The ED nurse navigator program is a great example of the power of electronic data making a real difference in patients' lives. This can be seen on an individual level as well as with the population as a whole.

Susan's Story - ED visits per month cut by 50%

Susan, a 34-year-old female with a complex medical and mental health history that includes migraines, chronic abdominal pain, depression, anxiety, history of suicide attempts, and drug-seeking behaviors, presented at the ED nine times in one month. She was referred to the ED nurse navigator who worked with Susan to develop a care plan. The navigator connected Susan to specialty services in the community, collaborated with her primary care team to improve her continuity of care, and introduced her to AveraChart, the hospital's patient portal system powered by MEDITECH. As a result of these efforts, Susan's monthly visits to the ED were cut in half.

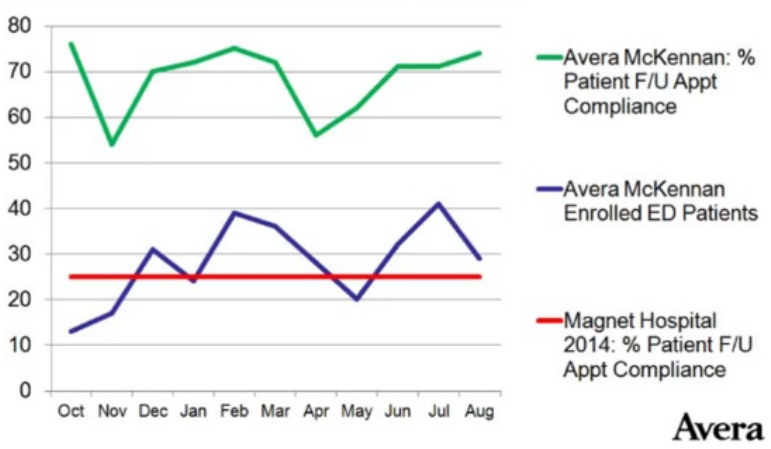
A Bird's Eye View of Patient Population

As a Stage 7 hospital, Avera McKennan knows the importance of paying attention to their data. MEDITECH's EHR enables the ED nurse navigator to get a bird's eye view of what's happening with the program's patient population and observe emerging trends. For example, the ED nurse navigator identified a high recidivism rate for patients who are homeless and chronically inebriated, creating a revolving door to the ED. The nurse navigator reached out to community partners to collaborate and discuss better ways to engage this population. Monitoring the data allows for this kind of responsiveness to patient needs.

What does the data show?

From December 2014 through December 2015, Avera McKennan saw a decreased rate of recidivism, increased care savings, and improved care continuity.

Successful patient engagement efforts led to 68% patient follow-up compliance, well above the Magnet Hospital average of 25-40%.



Other program results include:

- A 78% decrease in ED visits by patients in the nurse navigator program, despite an increase in enrollment over the same time period
- Annual care cost savings of $475,000
- 13.7% decrease in overall non-emergent ED visits for 2015
- Key satisfier with ED physicians and frontline staff, who recognize the positive impact the program has on managing this patient population.

Future Plans

With the success of Avera McKennan's ED nurse navigator program, Avera Health is moving forward with implementing at other hospitals across the system. The initiative is easily replicated using tools already available within MEDITECH to automate a standardized nurse navigator toolkit. As the program expands, Avera will continue to use the data to further refine the program.

The ED nurse navigator program is a great example of one way Avera Health is using MEDITECH to improve outcomes and drive change. Using robust tools inherent in their system, Avera is identifying, tracking, documenting, and analyzing patient data to provide patients with the best care, in the most appropriate setting.