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Development of a Plan for a Navigator Program

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Walden University
2017

Abstract

Development of a Plan for a Navigator Program

by

Linda K. Dunaway

MSN, University of Kentucky, 1987

BSN, University of Kentucky, 1984

ADN, Maysville Community College, 1979

Project Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Nursing Practice

Walden University

February 2017

Abstract

Following implementation of the Patient Protection and Affordable Care Act, hospitals

have seen a reduction in Medicare reimbursement for 30-day post-discharge readmissions

of acute myocardial infarction patient. The purpose of this project was to develop a plan

for a navigator program to improve a patient's health status post discharge and reduce

readmission rates. The Johns Hopkins nursing evidence-based practice model and

guidelines were used in determining the quality of obtained experimental and non-

experimental studies with or without meta-analysis and popular source articles. The

literature revealed the most successful programs involved providing best practices for a

navigator program allowed better patient education, discharge planning, safety and

quality of care, improved communication and post-discharge follow-up, and improved

facility finances to achieve positive results for the patient and the hospital. Watson's

caring theory was used as the theoretical framework since it incorporated the aspect of

caring to create a good working nurse-patient relationship. A navigator program training

module, job description, objectives, program forms, mission and goal statements, and a

health care team were developed and seen as crucial to the success of the program and its

evaluation process. Using navigator practices, based on evidence, formed the

infrastructure and management process for the facility and health care providers, thereby

increasing the quality of patient care. The resulting social change was positive, benefiting

the patient, family, the organization, and the region served. With implementation, this

project was anticipated to reduce 30-day readmissions and increased facility

reimbursement.

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Dedication

This quality improvement project is dedicated to my parents, Woodrow and Gladys Smith. Without their love, encouragement, and support, my obtaining this degree or any of my previous nursing degrees would not have been possible. My parents taught me the value of obtaining an education and using the knowledge gain to help others as well as myself. Both of my parents have passed on to be with the Lord, but I believe they are watching me with pleased hearts and smiling faces. I will always be grateful to them for how they raised me. If given the chance to choose parents for myself, without hesitation, I would choose the same parents, and enjoy every day spent with them all over again.

Acknowledgments

I want to thank everyone in my life that gave me encouragement, support, and love as I worked on obtaining this degree. First, my husband Russ, who put up with me as I studied in the evenings, on weekends, wrote papers, and worked full-time as a nursing educator. Thank you for everything and your continued love. We never did get to take that vacation; hopefully, it will not be long now. Second, to my son Mike and daughter-in-law Lori for their patience with me saying *no* to many activities so I could work on my schoolwork. Third, I want to thank my two grandsons, John and Nick, who really liked the fact that their grandma was back in school showing them it is never too late to go back and further one's education. The smiles on their faces and their happy dances were the best encouragement I received through this entire educational journey.

To Dr. Allison Terry, my mentor and instructor: Your advice and patience is what guided me through this journey. I could not have asked for a better mentor. For you, a special thank you, for everything. I will not forget all you have done to get me through this program.

Finally, to everyone else I met while working on this degree. Each person involved in my journey both known and unknown contributed to my learning as a student, nurse, and person. I am so grateful to have experienced this journey with every one of you. Thank you so much for such a terrific journey.

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Section 1: Nature of the Project

Introduction

The U.S. Department of Health and Human Services (2010) in Healthy People 2020 pointed out that the federal government uses goals and objectives as tools for strategic management not just at the federal level, but also at the community level, including their public and private sector partners. These goals and objectives provide the foundational health measures, which include general health status, looking at chronic disease prevalence and progress in physical, mental, and social health-related quality of life issues. Several topic areas were monitored, developed, tracked, and periodically reported to the federal government. One of these includes heart disease, which I address in this paper.

Many different titles exist, used throughout the literature for navigators who perform a job similar to the one described in this project. Some articles used the term *nurse navigator*, while others used *patient navigator*. In this project, I used the term, *navigator,* to represent a nurse, performing the job description and completing the program's objectives, within an acute care hospital setting.

This quality improvement (QI) project is a plan that dealt with the development of a navigator program for the Medicare population of patients with acute myocardial infarction (AMI), which have been frequently seen in hospital settings. This group of patients is among the highest that were readmitted to hospitals within 30 days post discharge. The Medicare Payment Advisory Commission ([MedPAC]; as cited by Krumholz et al., 2011) pointed out that AMI represents one of seven conditions that

account for nearly 30% of potentially preventable readmissions. These readmissions remain preventable in the 15-day window after initial hospital discharge, therefore, demonstrating a problem with either inpatient or outpatient care or both. According to Dunlay et al. (2012), readmission caused decreased patient outcomes, such as longer length of stay and complications from treatments. With the development of the navigator program, the outcome sought a decrease in the readmission of the patients within the 30-day period post discharge. The navigator and patient(s) accomplished this by meeting the program objectives, prior to discharge, which improved patient care outcomes, while lowering the cost to hospitals for these readmissions and allowing the hospital to save precious health care resources.

The problem of readmissions of Medicare AMI patients within the 30-day post discharge timeframe encouraged the development of a navigator program, as a means to help reduce the readmission rates. As part of this project plan, the facility or hospital established an interdisciplinary project team, which included the navigator (the Doctor of Nursing Practice [DNP] student), and three others, chosen by the facility with the Chief Nursing Officer, serving as an alternate team member. To make sure that each team member was up-to-date on the project plan, and if requested, hard copies of the information and literature used in the project were made available to each member.

Facility Background and Context

The QI project plan was developed to assist any facility or hospital interested in reducing its AMI 30-day readmission rate and improving the quality of patient care given to those served within their region. According to Olsen and Coleman (2001), QI is an

important issue for all hospitals in determining the causes of hospital readmissions because they are compelled to cut costs and reduce patients' length of stay, but must maintain and improve the quality of services and patient care. Olsen and Coleman (2001) pointed out that the Joint Commission on Accreditation of Health Care Organizations promotes continuous QI efforts and programs in facilities to ensure that there is a balance maintained between the two.

Birk (2012) suggested that health care providers have a powerful incentive to work harder on keeping patients from reentering the system within 30 days post discharge. Birk (2012) pointed out in 2013, the Centers for Medicare and Medicaid Services (CMS) were to begin reducing reimbursements to hospitals for excessive rehospitalizations related to three conditions, one being AMIs. This was a result of the Patient Protection and Affordable Care Act (PPACA), which enabled the CMS to reduce Medicare payments to hospitals based on their 30-day readmission rates (Birk, 2012). The navigator program was developed to help address the problem of hospitals' 30-day readmissions, improve patient care, and prevent reimbursement reductions.

Problem Identification

In the health promotion and disease prevention report issued by the Institute of Medicine (IOM, 2010), the authors noted under the third recommendation that nurses are to identify problems and areas of system waste, devise and implement improvement plans, track improvement over time, and make necessary adjustments so the goals can be reached. According to Lauzon et al. (2003) and von Kanel et al. (2011), patients can also experience depression and increased levels of posttraumatic stress symptoms that can

hinder recovery from the health problem of AMI. The Clinical Advisory Board of The Advisory Board Company (as cited in Cornett and Latimer, 2011) observed that a patient's support system might stay as important to the patient's outcome as the health care received while hospitalized. Cornett and Latimer (2011) suggested that when patients do not receive the recognized standard of health care and the caregivers discharge them, the conclusion usually results in readmission, within 30 days post discharge.

The AMI health problem continues to be a major issue that needs to be addressed both at the national and local levels in the Medicare population (Birk, 2012; Bradley et al., 2012; Krumholz et al., 2011). When the AMI health problem became addressed at the local level, it involved identifying condition changes. These changes included those that can make care safer and more effective, promote interventions that reduce complications of care given, assess patients more fully for discharge readiness, improve patient discharge instructions, reconcile medications prior to discharge, and provide better patient transition preparedness for the home or facility (Cornett & Latimer, 2011). Keeping these individuals out of the hospital represents a challenge for both nurses, physicians, and other health care providers.

The problem for this population that experienced an AMI was their readmission to a hospital within the 30-day post discharge timeframe. Medicare's reimbursement for these readmissions has been reduced, leaving some hospitals paying the additional cost of care. Clinically, Lauzon et al. (2003) and von Kanel et al. (2011) pointed out that patients can experience depression and posttraumatic stress as part of an AMI, which may further

decrease the patients' health status. Therefore, the first step was to evaluate whether a program to address this problem utilizing a navigator would be effective at improving the patients' health status and reduce the readmission rate. In this QI project, the problem identified was the high readmission rate within the 30-day post discharge timeframe for patients admitted with an AMI. In addition, improving a patient's health status post hospital discharge should help in the prevention of a readmission.

Project Purpose

In working to reduce 30-day readmissions of Medicare AMI patients, a navigator program plan was developed for any hospital to use and implement. This program would assist with providing pre- and post-discharge health care, health teaching, and additional resources as needed in an attempt to prevent the patient from being readmitted. Available evidence, as found in the literature, suggested using a nurse navigator to help guide the patient(s) through the health care system back home or to another facility (Cornett & Latimer, 2011) by seeing that the patient received evidence-based quality care to help prevent a readmission within the 30-day post discharge timeframe.

Project Goal, Outcome, and Objectives

For this QI project plan, the goal was to improve the AMI patients' health status post-discharge. The developed navigator program plan had the outcome as a reduction in the 30-day readmission rates of the AMI patients, which could be accomplished by using a navigator to improve the patient's health status prior to being discharged.

In order to fulfill the program plan's mission and achieve the program's goal (Appendix A), I developed the objectives listed below to guide the project plan and for purposes of evaluation.

According to the program development objectives evaluation (PDOE; Appendix B),

The program will

- Be considered for implementation by a hospital within the next 2 years;

- Include a navigator job description (Appendix C) that fits the individual hospital and patient's needs;

- Have nurse(s) in the education department(s) in the hospital(s) trained using the individualized navigator training module (Appendix D);

- Result in patients in direct contact with the navigator program being surveyed (Appendix E) to determine their satisfaction with their care;

- Include a program team consisting of five individuals such as the navigator(s), me (the DNP student), and three others chosen by the facility;

- Result in the program team evaluating the program objectives for completion, then making any needed changes for program improvement at 6-month and one-year intervals; and

- Result in the program team reviewing the data reports received from the CMS (2014) to determine if the best practice core measures (BPCMs; Appendix F) were met and the 30-day readmission rate for Medicare AMI patient(s) has decreased.

According to the navigator patient care evaluation objectives (NPCEO; Appendix G), the navigator will

- Obtain and review the AMI patient's baseline assessment information from the electronic medical record (EMR) on admission or as soon as possible;

- Ensure that the AMI BPCMs are met prior to the patient's discharge as applicable to the patient's care and, if they are not, seek the reason(s) why;

- See that patient needs are met and reassessed in a timely manner;

- Complete discharge teaching for patient, family, and/or caregiver; and

- Complete a post discharge follow-up telephone call within 2 days after patient discharge to identify and refer the patient(s) to resource(s) as needed.

According to the patient education care evaluation objectives (PECEO; Appendix H), the patient or caregiver will

- Verbalize the date of a follow-up appointment;

- Verbalize understanding of their discharge medication regimen;

- State from which pharmacy they will obtain their medications and the payment method used to purchase said medications;

- State where he/she will receive any needed rehabilitation care or where other resources will be obtained (such as dressing materials, etc.); and

- State when a health care provider should be called for a specific problem to determine if the problem is or is not related to the AMI diagnosis and obtain any needed resource(s) or treatment(s).

Significance to Practice

The QI project plan was developed based on the need of the facility or hospital with the intent to determine if the development/implementation of the navigator would lower the number of AMI patients in the project that were readmitted within the 30-day window post discharge. Because this would be the first time this position was implemented in a hospital and the first time a navigator project had been conducted on the potential effects, the significance for this project was based on the outcome of either reducing or not reducing the number of 30-day readmissions. The QI project plan was developed based on the need of the facility or hospital with the intent to determine if the development/implementation of the navigator would lower the number of AMI patients in the project that were readmitted within the 30-day window post discharge.

The information, as given above, has shown AMI as a serious health problem within the elderly patient population, taking a toll on Medicare and hospitals financially, while patients and families were left feeling physical and emotional distress. The literature indicated that quality patient care was not being given to this patient population for a variety of reasons, which included poor communication, early discharge, and poor understanding of condition and treatment (Cornett & Latimer, 2011; Lacker, 2011). Based on the identified readmission issue, action needed to be taken to resolve the problem at the local level. As shown in the CMS *Medicare Hospital Quality Chartbook 2014,* the national hospitals unplanned readmission rates distribution over the previous 3 years showed the maximum AMI at 21.7%. This value was the upper indicator of 30-day readmission rates for hospitals across the nation and conveyed performance and variation

outcomes by hospitals in the risk-standardized readmission rates. A hospital where the performance on the 30-day risk-standardized readmissions for AMI showed at or higher than the national distribution for 30-day readmissions could potentially benefit from the implementation of the navigator program in increased quality of patient care and increased Medicare reimbursements.

Evidence-Based Significance of the Project

Time has shown that navigators have been used significantly with cancer patients as identified in the literature (Case, 2010; Pedersen & Hack, 2010; Seek & Hogle, 2007; Shockney, 2010; Wells et al., 2008). However, few if any studies exist on using a navigator for Medicare patients who are readmitted during the first 30 days post hospital discharge for an AMI diagnosis. This was the underlying premise identified for this QI project.

According to Woods and Magyary (2010), a growing body of evidence exists, suggesting a therapeutic alliance, partnership building, and effective communication with patients were significant predictors of positive outcomes. This fit well with the introduction of a navigator whose intent was to help a patient or patients by checking the core measure form(s) to determine if the entire list of CMS quality indicators for AMI best care practices had been met during the patient's stay prior to being discharged. The navigator was to demonstrate good communication skills with patients, families, health care providers, and all others involved in the patient's care, facilitating coordination of services across the care continuum, providing organized and knowledgeable nursing interventions for AMI health care and treatments, assessing patient's needs and

addressing them in a timely manner, completing discharge teaching by using the *teach back method*, completing a post discharge telephone call to answer questions, and identifying needed resources to improve continuity of care preventing readmission of the patient (Birk, 2012; Bradley et al., 2012; Case, 2010; Harrison, Hara, Pope, Young, & Rula, 2011; Seek & Hogle, 2007; Smith, 2010; Van de Steeg, Langelaan, Ijkema, & Wagner, 2012). In addition, the navigator was to understand the navigator's role in patient care, the program's purpose, objectives, intended outcome, and evaluation process prior to program implementation.

Implications for Social Change in Practice

In developing a program plan or project plan, its mission statement should reflect the mission statement of the organization where it was implemented. An effective mission statement was "focused on what lies ahead for its clients or consumers if the agency is successful in addressing their problems and meeting their needs" (Kettner, Moroney, & Martin, 2013, p. 131), therefore, providing a positive social change. The mission statement of this project plan was "To develop a Navigator Program to improve the patient(s) health status post-discharge thereby reducing the 30-day readmission rates in the Medicare population experiencing acute myocardial infarctions in a quality safe caring manner" (see Appendix A). The intent of this project plan was to provide a positive health status change for the Medicare patients and families, reducing the 30-day readmissions and the added patient and family stress, plus the cost the hospital would incur for these readmissions. If the project plan were implemented and successful, it

would have made a needed change that would benefit patients, families, the organization, and the region served, making the project a quality endeavor.

Ethically it was important that the program plan be developed for future implementation and consideration by a hospital whose CMS rate indicated a major problem with 30-day readmissions in the Medicare population. Although Medicare readmissions typically resulted from multiple factors, the MedPAC (as cited by Cornett & Latimer, 2011) suggested that "hospital readmissions are sometimes indicators of poor care or missed opportunities to better coordinate care" (p. 5). The American Nurses Association Code of Ethics provided guidelines and expectations for nurses to follow in making ethical decisions (Taylor, Lillis, & LeMone, 1997). The code reflected universal moral principles such as respect for persons; autonomy; beneficence; nonmaleficence; veracity; confidentiality; fidelity, and justice-providing guidance for conduct in carrying out nursing's responsibilities to give high-quality nursing care (Taylor et al., 1997). In addition, I made sure to obtain Institutional Review Board (IRB) approval (# 08-22-13-0304703) to protect the university and myself.

Definitions of Terms

Centers for Medicare and Medicaid Services (CMS). The CMS is part of the U.S. Department of Health and Human Services that administers health care programs including Medicare, which is the health insurance program for senior (CMS, n.d.).

CMS best practice core measures (BPCMs). The percentages of eligible patients that received care represented by the measure and used by hospitals to improve patient care. There are 26 core measure health problems, with AMI being one. The core measure

data are reported to the CMS and a report is sent back to the facility. If the CMS core measures were met and the facility benchmark was met, the facility would receive higher reimbursements from Medicare (Nix, 2009).

Institutional Review Board (IRB). Body charged with reviewing data collection plans and procedure to ensure compliance with human subject protection that is respectful, just, fair, and does no harm (Hodges & Videto, 2011).

Joint Commission on Accreditation of Health Care Organizations. Independent, not-for-profit group in the United States (U.S.) that accredits hospitals, and other health care-related organizations, as a condition for Medicare reimbursement (Rouse, 2010).

Measurement management system. System used by the CMS to calculate, store, and retrieve data for reports (Joint Commission on Accreditation of Health Care Organizations, 2011).

Medicare beneficiary. A person 65 years or older receiving health care under the Medicare system (Watkins, Hall, & Kring, 2012).

Navigator. Doll et al. (as cited by Pedersen & Hack, 2011) defined this as "one who provides information and emotional support, and link patients to other support service, facilitates decision-making and practical assistance, and develops community support. The role is supportive rather than psychotherapeutic" (p. 202).

Project/program. Interchangeable terms to describe this proposal.

Quality improvement (QI). Focused on improving processes that are defective or not functioning at an optimal level to improve the quality of the process and its outcome (Kelly, 2011).

Quality management. The unit that collected, completed, and sent required data to the appropriate sources, such as the CMS, to explain and continuously improve their organization, allowing the delivery of quality, safe patient care achieving improved health outcomes (Kelly, 2011).

Risk-standardized readmission rates. A statistical analysis used for a "comparison of a particular Hospital's performance given its case mix to an average hospital's performance with the same case mix" (CMS, 2014, p. 17). A lower ratio rate indicates an expected lower readmission rate and better quality of care; whereas, a higher ratio indicates an expected higher readmission rate and worse quality of care (CMS, 2014).

Navigator Job Description

This QI project plan was using data provided by the CMS, and because of this, it was assumed that the data were accurate. Viewing the CMS data allowed me to identify this project's 30-day readmission problem among Medicare beneficiaries. Another assumption made was that the CMS diagnosis codes were accurate and a hospital's data coder had accurately put the information into the CMS reports. The last assumption being made was that hospital health care providers were correctly diagnosing Medicare patients with AMI on admission and discharge from a hospital's acute care setting, and then again when the patient(s) was readmitted within the 30-day post discharge timeframe.

Based on the CMS information that helped identify the readmission problem along with information found in the literature search, I identified the need for a navigator to assist in lowering the readmission rate. For the navigator to function and help with

reducing readmissions, the following points demonstrate the navigator's job description (Appendix C):

- The navigator is a graduate of a Bachelor of Science in Nursing (BSN) registered nurse (RN) program or higher, but an Associate's Degree in Nursing (ADN) RN graduate is acceptable when a BSN or higher graduate is not available and is a member of the facility's education department.

- The navigator understands the role of the navigator and the program's purpose, objectives, and intended outcome prior to the program's implementation through an individualized navigator training session given by the education department.

- The navigator is to have good communication skills with the patient, family, and/or caregivers and can collaborate well with multiple physicians, ancillary support services, and exceeds in customer service.

- The navigator is able to facilitate coordination of care giver services across the continuum of care, which allows for a timely patient discharge.

- The navigator is organized and knowledgeable regarding nursing interventions for AMI health care and treatments. The navigator is able to reassess patients' needs and addressed those needs in a timely manner and functions as the patient's advocate throughout the hospital stay and for 2 days after discharge

- The navigator provides any needed emotional support and obtains further support resources as needed.

- The navigator is to complete discharge teaching by simplifying information taught and assess a patient, family and/or care giver's understanding of the information using the teach back method.

- The navigator completes a post discharge follow-up telephone call within 2-days after the patient is discharged to identify and refer the patient(s) to resources as needed to improve continuity of care and prevent patient readmission (Birk, 2012; Bradley et al., 2012; Case, 2010; Harrison et al., 2011; Seek & Hogle, 2007; Smith, 2010; Van de Steeg et al., 2012).

- The navigator ensures the AMI BPCMs on the BPCM form (Appendix F) are met prior to discharge, (allowing for improved patient health pre and post discharge) as applicable to the patient's care, and, if they do not, seek the reason(s) why.

- The navigator is assigned a maximum of five patients to care for during any one period.

- The navigator is to review the patient's electronic medical record (EMR) to obtain needed information appropriate to patient's care.

- The navigator is to conduct the initial patient assessment and structured interview on admission.

- The navigator is to spend time with each patient and not be hurried, make two daily visits or more if needed to assess and re-assess the patient, and address any questions or concerns.

- The navigator is to develop a detailed plan of care that all nursing staff can follow.

- The navigator is to provide the discharge teaching at least 3 days prior to discharge and address any questions or concerns.

- The navigator is to complete all required paperwork.

- The navigator is to document all information in the EMR and on the appropriate program forms.

- The navigator is a member of the program team and reviews/evaluates the program objective's data at the recommended periods of 6-month and 1-year intervals and helps make any needed revisions to improve the program.

- The navigator is to keep track of the completion of the program's PECEO (Appendix H) through completion of the PECEO form throughout each of the AMI patient's care stay, the NPCEO form (Appendix G), and the BPCMs AMI form (Appendix F).

- The navigator is part of the education department and will be given at least 4 hours of in-class instruction and 6 to 8 weeks of on-the-job guided performance by a member of the education department, to provide program information and to allow for integration of the program's job description, including the program objectives. Evaluation of the navigator's job performance will take place based on the facility's already in place hiring policy and procedures. The facility is at liberty to use the Navigator Program

Patient Survey (NPPS) as part of the evaluation process of the navigator's job

performance.

Project Problems/Limitations to Avoid

Listed here are a few examples of the identified problems of this proposed QI

project plan when implementation strays from the navigator program's proposal;

however, not all have been identified, so this is not an all-inclusive list:

- The project used only one BSN-RN who was the navigator for two or more
  acute care units within a hospital's Medicare population with a diagnosis of
  AMI.

- The project relied on the hospital data being calculated by the CMS for the 30-
  day readmission rate where the hospital does not have the ability to calculate
  its own data rate.

- The navigator did not have any direct patient contact and relied on the staff
  nurses to complete the core measure forms, patient education, and provide the
  needed emotional support. This was contrary to what the literature indicated
  regarding what the navigator was supposed to do as described in Lee et al.
  (2011), Pedersen and Hack (2011), and Swanson and Koch (2010).

- The navigator did not follow the job description as outlined earlier, nor was
  there any orientation or education provided by the education department using
  an individualized navigator training module.

In providing for a better-implemented and successful program plan, the limitations/problems identified should be avoided along with any other limitations/problems identified by a facility choosing to implement the program.

Summary

This QI project plan was developed for a hospital or health care facility to determine the effectiveness of the navigator program where the navigator had fulfilled the job description. Part of the job description included checking for completion of the CMS core measure forms showing that the CMS best practices were used to provide quality care to improve the patient(s) health status post discharge. If the job description was followed, it could lead to reducing the 30-day readmission rates for Medicare patients with the diagnosis of AMI. A hospital that chose to use this plan would have had a high rate of 30-day readmissions for AMI based on the national rate and would be seeking a method to reduce the readmission rate. When reviewed, the use of a navigator appearing in the nursing literature had been mostly for cancer patients, which represented a lack of information on the use of a navigator for the Medicare population with a diagnosis of AMI. With no direct information found in the literature to guide the QI project plan in using a navigator to reduce readmission rates in the Medicare population, the literature needs to be continually searched for this information to help improve the overall program and its implementation.

There were some examples of limitations/problems identified that needed to be avoided. One major limitation was the navigator not having contact with the patient(s) or families. Without that contact, the chance of the navigator program being successful was

nonexistent. Another major consideration was the first-time use of a navigator by a

hospital to address the problem of 30-day readmits; therefore, it would most likely need

to go through a trial-and-error period to see what worked and this would have required

more time. If the navigator program plan had worked to improve the health status of the

patient(s) post discharge and reduce readmission(s), this would certainly have been a

positive social outcome for the patient(s), hospital, and the service region.

Section 2: Review of Literature and Theoretical and Conceptual Framework

Introduction

This QI project plan was developed for any facility having an AMI 30-day readmission problem that wanted to reduce their readmission rate. Prior to determining to use this QI plan, a facility should have completed a self-assessment to determine if the facility could benefit from the proposed project plan. Searching the literature to find information on the use of a navigator became important in order see what had worked or not worked in past navigator projects. Using a guiding theory also helped in assuring that the patient(s) remained the center of the project and the care that was given. This project plan used Watson's (2006, 2009; Watson & Smith, 2002) caring theory.

Facility Background

The QI navigator project plan was developed to assist any facility or hospital interested in reducing its AMI 30-day readmission rate and improving the quality of patient care given to those served by their region, while at the same time preventing reimbursement reductions. According to Olsen and Coleman (2001), in determining the causes of hospital readmissions, QI represents an important issue for all hospitals because they are compelled to cut costs and reduce patients' length of stay, but must maintain and improve the quality of services and patient care. They pointed out the Joint Commission on Accreditation of Health Care Organizations promotes continuous QI efforts and programs in facilities to ensure that there is a balance maintained between the two (Olsen and Coleman (2001).

Literature Review

Implementation of a navigator program, which is a form of case management for the population of Medicare patients with AMI, was to begin, at a time to be determined, in an acute care hospital with the intent to reduce the 30-day readmission rates for this patient population. With regard to the problem of readmissions, Cornett and Latimer (2011) provided information on the issue of patient 30-day readmissions. This included the readmission's relationship to meeting required quality and usage metrics and the new reduction in payment for excessive readmissions of AMI patients. MedPAC (as cited in Cornett & Latimer, 2011) suggested the readmissions could be related to poor quality of care given during the hospital stay. Crowther (2012) pointed out that the CMS saw 30-day readmissions as a worsening problem among hospitals and suggested that patients needed to be educated in self-management techniques prior to discharge as a means of reducing the readmission rates. Lacker (2011) suggested that to reduce the 30-day readmission rates of Medicare beneficiaries, effective communications techniques should be used along with a strong transition plan, prompt post discharge communication, and better follow-up care could reduce readmission rates.

Cornett and Latimer (2011) pointed out that the Readmission Measures Overview at www.qualitynet.org showed AMI as a common readmission among the Medicare population and was related to substantial mortality and morbidity across the U.S. in hospitals and that these readmissions were often preventable. Krumholz et al. (2011) pointed out that for the AMI Medicare group, readmissions could be influenced by the quality of care, which involved potential complications of inpatient care or outpatient

care where hospitals and physicians had no incentive to focus on improving the transition from inpatient to outpatient status, along with the use of ineffective disease management programs.

Hasan et al. (2009) and Krumholz et al. (2011) used an observational cohort study and a hierarchical logistic regression model respectively to determine their results. All concluded that Medicare patients were more likely to be readmitted within the first 30 days post discharge for the identified diagnoses of AMI. Hasan et al. (2009) and Krumholz et al. (2011) identified models that showed a high potential for identifying those at risk for being readmitted during the first 30 days post discharge. A study by Schmeida and Savrin (2012) indicated that Medicare patients were more likely to be readmitted and that case management interventions could be used to prevent these readmissions. Aspenson and Hazaray (2012) pointed out that AMI Medicare patient discharge activities were a good predictor for hospital readmissions within the 30-day post discharge period if not carried out appropriately. This involved patient education related to their discharge plan, execution of the plan, and care coordination after discharge. Aspenson and Hazaray (2012) suggested that hospitals look closely at these three reasons to prevent avoidable readmissions and protect patient safety, as well as the facilities financial status.

A study by Bradley et al. (2012) dealt with practices implemented by hospitals to reduce 30-day readmissions post discharge for AMI patients. They used a web-based survey in a cross-sectional study of hospitals participating in a hospital-to-home QI initiative that looked at hospital practices in the areas of QI resources and performance

monitoring, medication management, and discharge and follow-up processes. They found the hospitals had written objectives on preventing readmissions of AMI patients, but the way they met the objectives varied greatly. However, most hospitals reported they did not have a comprehensive set of recommended practices; there was a lack of key practice implementation in medication management, discharge, and follow-up processes (Bradley et al., 2012). These findings suggested that further continued improvement was needed in the areas of communication and care coordination in an attempt to decrease 30-day readmission rates (Bradley et al., 2012).

According to Olsen and Coleman (2001), the use of a continuous QI plan was important in determining the causes of readmissions. They conducted a 6-month retrospective study in a military hospital in Maryland using hospital records to determine factors related to unscheduled readmission that could be addressed by hospital management. The results showed a need to emphasize the importance of data accuracy and integrity during the hospital stay, determining high-risk readmission patients during the admission assessment, improve the patient education program during the hospital stay and after through mailing information, and using follow-up telephone calls within 2 weeks of discharge (Olsen & Coleman, 2001).

Boulding, Blickman, Manary, Schulman, and Staelin (2011) used an observational analysis on patients 18 years and older using Hospital Compare data on clinical performance, patient satisfaction, and 30-day readmission rates for AMI and two other conditions. The investigators performed a hospital level multivariable logistic regression analysis on each condition to determine if hospital 30-day readmissions had a

relationship to reported patient satisfaction with inpatient care (Boulding et al., 2011). It determined that, for AMI patients, the higher the satisfaction scores reported for overall patient care and discharge planning the lower the risk of a 30-day readmission post discharge. The findings suggested that providing patient-centered information on discharge after adjusting for the quality of care given did play an important part in reducing readmission rates (Boulding et al., 2011). Even though patients knew little about evidenced-based practice, they were able to assess other care aspects that lead to better health outcomes for themselves (Boulding et al., 2011).

According to McHugh and Ma (2013), the PPACA increased the financial accountability of hospitals for preventable readmission, which caused a response by hospitals to find ways to reduce the readmissions. Their study looked at the association of 30-day readmissions of Medicare AMI patients (and two other conditions) to nurses' education, work environment, and staffing levels. A cross-sectional survey of RNs in California, Pennsylvania, and New Jersey was completed along with patient data obtained from index admissions based on CMSs databases and state databases (McHugh & Ma, 2013). The relationship between the nursing factors and 30-day preventable readmissions were estimated using a robust logistic regression technique. Results showed that, with each additional patient given a nurse above the average workload that added patient became associated with a higher risk of an AMI patient being readmitted (McHugh & Ma, 2013). The odds of an AMI patient being readmitted were decreased when the nurses' work environment was considered good by the nurse, who in turn created a better patient care environment. Nurses' education level did not significantly

relate to patient readmission rates (McHugh & Ma, 2013). Therefore, preventable readmissions could be decreased by improving nurses' work environments and decreasing the staffing ratios of nurses to patients (McHugh & Ma, 2013).

Looking at care coordination or case management, Lee et al. (2011), Swanson and Kock (2010), Thygesen, Pedersen, Kragstrup, Wagner, and Mogensen (2011), Case (2010), and Robinson and Watters (2010) identified that a lack of communication and care coordination for cancer patients hindered their care and the patients did not receive the quality of care they needed. With the implementation of a navigator for these patients, the patients' satisfaction with care and overall care was better. The first three studies were qualitative in nature and used interviews and/or chart reviews to obtain their data (Lee et al., 2011; Swanson & Koch, 2010; Thygesen et al., 2011). The other two were informative articles that suggested the use of a patient navigator could create quality patient care through better communication techniques and nurse-patient relationships to ensure a patient's safe passage through the health care maze (Case, 2010; Robinson & Watters, 2010). According to Pedersen and Hack (2011), a patient navigation model could have helped patients and families navigate the potential obstacles they faced when trying to get through a hospital's cancer care system. Pedersen and Hack (2011) also pointed out that the role of a patient navigator included removing barriers to health care, thereby improving patient outcomes and the overall quality of health care delivery. In this process, nurses would gain insight into performing patient navigation and be able to identify gaps that needed navigation services. Shockney (2010) suggested that interest in

the use of patient navigators as a way to maintain care continuity and to provide increased patient-centered care.

Paskett, Harrop, and Wells (2011) pointed out there are several things known about cancer patient navigation that apply to health care providers in community practice. Patient navigation programs and those that practice in them have diverse backgrounds and seem to be driven by the needs of the local community. Because of this, any health care organization, thinking of implementing a cancer patient navigation practice, should assess the needs of the population served and develop their program interventions based on those needs. Paskett et al. (2011) also suggested that further study needs to be done in the areas of program sustainability, reimbursement methods, methods for competency-based patient navigator training, and program monitoring and evaluation.

According to Melinyshyn and Wintonic (2006), using nurse navigators for surgical patients with breast abnormalities provided the patient and families with supportive compassionate care and education that helped reduce the stress and anxiety the diagnosis had caused. The nurse navigator received referrals from a multidisciplinary team for individuals with high levels of anxiety, which often only involved simply listening caringly to the patient express fears of what may come due to a cancer diagnosis (Melinyshyn & Wintonic, 2006). In addition, the nurse navigator was up-to-date on evidence-based practice measures across the breast abnormalities' continuum of health care providing supportive care leading to a goal of a positive patient outcome (Melinyshyn & Wintonic, 2006).

Thygesen et al. (2011) used a qualitative longitudinal study with a phenomenological-hermeneutical approach on cancer patients who were offered additional help from nurse navigators during their treatment care. The timeframe began with their referral and lasted until 2 months after discharge from the hospital. Using a semi-structured interview technique, patients reported a bond had developed with the nurse navigator, and they benefited from the navigator's help and presence, but felt rejected once the contact with the nurse navigator ended (Thygesen et al., 2011). The authors determined that nurse navigators can help patients through the system of cancer care, but they must be aware of and work to prevent the hurt feelings patients can experience once their services were withdrawn (Thygesen et al., 2011).

Health care providers, according to Birk (2012), have been given a strong incentive to keep patients from being readmitted within 30-days of discharge. The author noted that during the federal fiscal year in 2013, the CMS was to start decreasing reimbursements to hospitals for excessive readmissions related to three major problems one of which was AMIs. In trying to reduce readmissions, Birk (2012) pointed out that one hospital's efforts stemmed from wanting to provide a better quality of care to its patients that included making care safer, effective, efficient, equitable, timely, and patient-centered. Birk (2012) noted one senior hospital leader found that some of their chronically ill Medicare patients benefited from the added support of a nurse navigator. Those patients received the help of a nurse navigator at the time of discharge when it was determined that the traditional nursing model did not meet the patient's care needs.

With nurse navigators being used most frequently with cancer patients, Thygesen et al. (2012) studied the issue of which patients benefited most from the use of a nurse navigator early on in their journey dealing with the diagnosis of cancer. A longitudinal study based in phenomenology and hermeneutics, using a semi-structured patient interview was conducted with women who had gynecological cancer. It was determined that not all patients could benefit from the use of a nurse navigator. The factor of trust or distrust in their physician prior to meeting the nurse navigator played a part in whether a patient would accept additional support from the navigator. However, patients who chose to use nurse navigators that lacked trust in their physician did develop a trusting relationship with the nurse navigator and felt reassured by the nurse navigator's support. Thygesen et al. (2012) suggested that health care professionals especially physicians should work harder at establishing a trusting relationship with their patients, since patients who trusted their providers were more likely to accept extra help when needed. Identifying patients who could benefit from the added nurse navigator support remained unanswered and open for continued study and debate (Thygesen et al., 2012).

Wells et al. (2008) pointed out that patient navigation programs had been used as an intervention with cancer patients to reduce cancer disparities; however, no consensus agrees on what the navigator's job description should entail, their qualifications, nor on a definition for the term, patient navigator. Efficiency and cost effectiveness of patient navigation programs was also investigated. The investigators used a qualitative synthesis of several articles obtained from PubMed and other data sources and found when using patient navigators there had been some improvement in getting patients' care in a timely

manner, along with screenings, which included diagnostic follow-up care and treatment. Wells et al. (2008) suggested that defining patient navigation depended on where it remained in use and the circumstances surrounding the care given. Due to limitations found in the articles, the ability to generalize the findings on program efficiency could not be completed, and no program cost could be found (Wells et al., 2008). The recommendation given by the authors dealt with an in-depth evaluation of future patient navigation programs to determine their cost and effectiveness better (Wells et al., 2008).

Evidence-Based Practice

The literature review section of this project has a total of 24 articles. In addition, each article was reviewed for its ability to provide nursing and this project with evidence-based-practice (EBP) information. In using EBP, the intent was to center the care on the patient to provide the best care and outcomes possible. While EBP is patient-centered, it also supports and informs a facility's educational, clinical, and administrative decision making. EBP enhances the efficiency of care given to patients, allowing for a decrease in expense, effort, and time (Dearholt & Dang, 2012). For this project, the Johns Hopkins Nursing Evidence-Based Practice (JHNEBP) model was chosen and used to evaluate each article.

Looking at the JHNEBP model, the focus was on three areas, which were vital to the practice of nursing and this project: research, practice, and education. The core of the model is evidence, and researchers can use this core for either non-research or research sources. Although, research is the highest level, non-research evidence also demonstrates important information that influences patient care. When translating research and non-

research information into practice, factors must be considered, such as the patient population, setting, question being considered and its condition, type of non-research or research being studied, the findings' relevance to a clinical setting, and any risks/benefits when implementing the results (Dearholt & Dang, 2012). In considering the patient as the center of care, the health care provider must look at the patient's beliefs, preferences, and values as these guide the patient's compliance with any treatment, no matter what EBP findings are chosen for implementation (Dearholt & Dang, 2012).

Using the JHNEBP model, each of the 24 articles were divided into 12 non-research (Appendix I) and 12 research (Appendix J) articles. Moreover, these were individually evaluated for the evidence level, quality of information that each contained, and its relevance to this project and EBP. The evidence and quality guidelines used were found in the JHNEBP model (Dearholt & Dang, 2012, pp. 232-233, 244). In the non-research quality guide, Levels 4 and 5 were used to evaluate the 12 articles using a rating of A to C in each level, with A being high quality, B being good quality, and C being low quality or major flaws (see Appendix I). In evaluating the 12 research articles, the quality guide Levels of 1, 2, 3, 4, and 5 were used, using a rating of A to C in each level, with A being high quality, B being good quality, and C being low quality or major flaws (see Appendix J).

In evaluating the 12 non-research articles and applying quality evidence ratings, the appraisal showed Level 4(1): A = 8%, B = 0%, and C = 92%; Level 5(2): A = 8.3%, B = 33.3%, and C = 58.3%; and Level 5(3): A = 8%, B = 67%, and C = 25%. Looking at the 12 research articles and applying quality evidence ratings, the appraisal showed

Levels 1 and 2 as 0%; Level 3: A = 33.3%, B = 33.3%, and C = 33.3%; Level 4: A =

25%, B = 41.6%, and C = 33.3%; Level 5: A = 41.6%, B = 50%, and C = 8.3%; Level 5:

A = 16.6%, B = 75%, and C = 8.3%. Based on the information contained within each

article and its usefulness to this project, the DNP student (me) concluded that all article

ratings were acceptable in determining quality of the articles; therefore, all articles were

used. Although this project has not been implemented, a facility looking to use the project

received advice on establishing an EBP team. This was done to allow for a discussion of

the literature review articles, the navigator information, and the usefulness to the facility

in implementing a navigator program to reduce 30-day readmission rates for the

Medicare population.

      Limitations of this review included using only the DNP student (me) to evaluate

the articles, thereby providing just one health care provider's opinion, which might not

have proved correct. Second, it did not allow for any discussion to help determine an

article's rating. Finally, as identified above, an established EBP team was needed to

review the articles, allowing discussions to take place within the team and making

decisions regarding the article's quality, the usefulness of the information, and any

changes to be made in the health care practices at a facility.

Guiding Theory for the QI Project

      In planning this QI project or program for improving care to the AMI Medicare

population, the nursing theory used was Watson's (2006) caring theory, which not only

focused on the patient, but also the nurse and the ability to be caring and compassionate,

which then provided the patient with the needed healing care throughout their hospital

stay (Cara, 2003). The use of Watson's (2006) caring theory as a framework to guide the navigator's role was an important part of this project as navigators are to be caring individuals. According to Wilcox and Bruce (2010), a navigator provides advocacy for the patient(s) when needed to help reduce the patient's anxiety about finding their way through the complex health care system. This project was directed at providing the needed care, which would in turn help reduce the 30-day post discharge readmissions.

According to Watson (2006), the caring theory

Involves making explicit that human caring and relationship-centered caring is a foundational ethic for healing practices; it honors the unity of the whole human being, while also attending to creating a healing environment. Caring-healing modalities and nursing arts are reintegrated as essentials to ensure attention to quality of life, inner healing experiences, subjective meaning, and caring practices, which affect patient outcomes and system successes alike. (p. 89)

As the caring theory was integrated into patient care, Watson (2006) suggested there would be caring moments involving the humanity of the nurse creating a healing environment for the patient. In creating this environment, the nurse was to connect with the spirit of the patient by listening, making one's presence felt, and expressing emotions as one human being to another. Creating a caring environment would not only provide the patient with a better opportunity for healing, but it reflected the humanity within us and began the devoted commitment to the care and healing of the patient (Watson, 2006).

Interestingly, the caring theory has gained recognition as a philosophical-ethical-epistemic field of study where a whole field of caring science has been developed as a

separate discipline. Caring knowledge has become a trans-disciplinary field not only used in nursing. The use of the caring theory by other fields has given a view of caring that encompasses a humanitarian, human science orientation worldview (Watson & Smith, 2002). By moving into other fields, it allowed nursing to bring other disciplines into the program planning of care for the patient. In addition, this theory was used to inform this project as it progressed, so as not to lose sight of the patient through the QI process.

<div align="center">**Summary**</div>

This QI project plan was developed for hospitals having a problem with their AMI 30-day readmission rate. With the implementation of the PPACA, hospitals with high readmission rates have seen a reduction in their Medicare reimbursement funding. This has given hospitals a reason to seek a means to reduce their readmission rates. The navigator program was developed as a way to help hospitals in their struggle to get their rates in line with the CMS requirements.

I used the literature review to show that nurse navigators worked with a variety of patients, but mostly with patients who have a diagnosis of cancer. Therefore, it does leave a gap in the literature for information observing the Medicare patient, 65 years and older, with a diagnosis of AMI who has reentered admission to the acute care setting within the 30-day post discharge timeframe. It remains apparent from the literature, that using a navigator has shown effective results in working with patients to enhance communications, continuity of care, and decrease the patient's stress level. This QI project plan was developed to use a Navigator to reduce readmissions and enhance communications between the patient(s) and their health care providers. Watson's (2006)

caring theory was used to bring the caring aspects of nursing into the care of the

Medicare population, which then created a healing environment.

In addition, this project used the Johns Hopkins Nursing Evidence-Based Practice

model to evaluate the literature review articles for quality in providing evidence-based

practice. The DNP student (me) determined that all the articles were of a quality, which

made these useable. This was based on the information contained within each article and

the importance of that information to the development of this project.

Section 3: Methodology

Introduction

The design used for this QI project plan was one where 17 program objectives were developed and divided as follows: seven objectives related to putting the program in place, five related to patient education objectives, and five related to navigator patient care objectives. In addition to the objectives, there were preexisting. CMS BPCMs for AMI included in the project plan. Three separate objectives forms and one AMI core measure form were developed for this program. The first form was for the PDOE with seven objectives (Appendix B), which was completed and evaluated once at the time the program was implemented except for Objective 4, regarding the NPPS (Appendix E). This survey was given to the patient or caregiver during the inpatient stay to complete prior to discharge for feedback on care given. Two weeks after discharge, a new survey copy was sent to all AMI patient(s) or caregiver(s) to be completed and mailed back to the facility's navigator in the postage paid envelope. The inpatient surveys and returned surveys were included in the program's evaluation at the 6-month and 1-year timeframes by the program team to understand how the patient(s) viewed the navigator program and care received from the navigator. Where applicable, the NPPS results were also made a part of the facility's human resources and nursing department's performance evaluation protocol for a new navigator hire or position change to a navigator.

The second form included the PECEO form, consisting of five objectives (Appendix H) that dealt with the education of the patient or caregiver by the navigator. Form 3 was the NPCEO form (Appendix G), which contained 5 objectives used to

address the care provided for the patient by the navigator. Last was the fourth form containing the CMS BPCMs (Appendix F); these were used as part of the program's criteria to provide patient(s) with best practice quality health care and used by the CMS as a hospital quality measure. These three program forms were completed throughout the patient's in-hospital stay, with the last objective on the NPCEO regarding the follow-up phone call completed in the first 2 days post patient discharge. Completion of the two objective forms and the core measure form were not only to help accomplish the program's goal and mission, but they functioned as evaluation criteria for the program along with the PDOE, which was evaluated when the program was implemented.

The PECEO and NPCEO objectives along with the BPCMs were evaluated on each AMI Medicare patient by the program team after the program had been in place for 6 months, then again at the 1-year mark. The PECEO and NPCEO objectives were reviewed to determine if they were met or not met. In addition, at each of these timeframes, the program team reviewed the latest facility report received from the CMS, which contained the BPCMs to determine how the hospital's average percent on each core measure compared to other hospitals in the state's average and then to the national average percent on each core measure. The percentages were based on 100% being the highest score, indicating excellence in patient care. As the percentages dropped down the care given by a hospital was considered poorer care. In addition, the hospital's CMS averaged percent rate for 30-day readmissions for Medicare AMI patient(s) was reviewed and compared to the U.S. average percent rate and the state's average percent rate. The

percentages used for this purpose were the lower number percentages, indicating the better the hospital was doing on preventing 30-day readmissions.

Once the review of the CMSs hospital report for the AMI 30-day readmission rate was completed, it was then compared to the previous hospital's CMS quarterly rate to determine if the rate had decreased or not for the hospital. The AMI BPCM results for the hospital were reviewed by the team to determine how the hospital rated as a percentage on each core measure as compared to the state and national averages. Then the hospital's percentages were compared to the previous CMS quarter's rates to determine if improvements were made or not on each core measure.

The program team then reviewed the program's objectives (not including the CMS reports) to make any needed revisions to improve the quality of patient care. Any suggested changes to the PDOE form were put in writing and sent to the Chief Nursing Officer (CNO) for consideration and action. Approval to change any objective(s) on this form was needed by the CNO to prevent fragmentation and keep the program organized. However, if revision(s) to the objectives were needed on the PECEO and NPCEO forms, the team was allowed to put these in place, the objectives forms were changed, and the evaluation process resumed as stated in the program design with the revised forms being used. In addition, the program team was allowed to review the returned patient surveys or NPPS forms for content as to how the patient(s) evaluated the navigator program's benefit to their health care during their stay and the short period after discharge. The program team did not have the ability to make changes to the NPPS form or make direct suggestions to the navigator on job performance improvements. Instead, the program

team was to put in writing any suggestion(s) for navigator performance improvements and any NPPS revision(s) seen as needed. This information was sent to the CNO for his/her consideration and action. If the revisions were approved, the NPPS was revised and put into use as soon as possible. Any job performance improvements were discussed between the CNO, the navigator, and the nursing education department.

Project Population

The Medicare population, all of those 65 years and older who had a diagnosis of AMI admitted to a hospital's acute care units, were the target population considered in this project. According to Cornett and Latimer (2011), AMI is a common readmission among the Medicare population. The hospital's claim numbers for the Medicare AMI population with CMS core measures, the hospital developed into the CMS and reported an AMI aggregate percent number on each core measure, indicating how well or how poorly it was met. Therefore, no names or identifying numbers were given on any patient. From the AMI admissions claims data turned in to the CMS, the number of Medicare AMI patients who enter readmission can also be measured and reported back to the hospital as a 30-day readmit aggregate percent with no specific patient identified.

Data Analysis and Synthesis

Planned Project Data Collection

Data collection for the identified problem was accomplished by the program team obtaining from the navigator all the NPCEO forms, the PECEO forms, the program's CMS BPCMs forms, the one-time evaluation of the PDOE form, and the NPPS forms. The PDOE form is collected once at the implementation of the program and only as

needed after this initial time. Lastly, the latest hospital's AMI 30-day readmissions and AMI-core measures data forms from the CMS were obtained by the navigator for the program team from the quality management department. In the quality management department, the CMS data were put in an understandable form that made it easier for the hospital's administration, other departments, and the navigator program team to see where the hospital ranked within the state and nationally on this particular health care issue.

The data forms were collected at the 6-month and 1-year timeframes once the program plan was implemented. The CMS data were used to determine the effectiveness of the navigator program along with the completed program's PECEO, NPCEO, PDOE, and NPPS forms. The navigator was responsible for obtaining the CMS reports, as well as all the completed program's forms. Furthermore, approval was obtained through Walden University's IRB (# 08-22-13-0304703) as this project plan was developed by a DNP student (me). In addition, approval must be obtained from the facility's IRB to collect and use their data to facilitate and evaluate the navigator program.

Planned Program Data Evaluation

The hospital's AMI Medicare aggregate claims data reports were calculated and analyzed by the CMS with the hospital and the navigator's program goal of reducing the 30-day hospital readmission rate. According to the Joint Commission on Accreditation of Health Care Organizations (2011), the

> CMS recognizes the need for quality measures of the highest caliber, maintained
>
> throughout their life cycle to ensure they retain the highest level of scientific

soundness, importance, feasibility, and usability. Using a standardized process with broadly recognized criteria, the Measurement Management System Ensures that CMS will have a coherent, transparent system for measuring quality of care delivered to its beneficiaries. (p. 6)

Readmission rates were calculated by the CMS, using Medicare claims data for admitted AMI beneficiaries who reside in a hospital's service region. The 30-day readmission rate was calculated as the percentage of beneficiaries who were hospitalized in a hospital, which is a short-term acute care hospital (STAC) and subsequently admitted to the same hospital within 30-days of discharge from the first admission (index admission) with the same diagnosis of AMI. Index admissions were excluded from consideration if they had a discharge status of transfer to another STAC hospital. Claims data were used to determine the post-acute care (PAC) setting of the patient after hospital discharge (Markley, Sabharwal, Wang, Bigbee, & Whitmire, 2012).

Aggregate quarterly Medicare AMI 30-day readmissions and AMI core measure claims data reports were received by a hospital from the Centers for Medicare and Medicaid Services. For a review of this AMI, the hospital received readmissions and core measures data, and quality management put it into an easily understood form. The program team had the ability to determine if the Navigator program remained effective in reducing the AMI 30-day readmission rate by improving the health status of the patient(s) prior to discharge.

This QI project plan looked at whether a navigator program was able to reduce the 30-day post discharge readmission rates by improving the AMI Medicare populations'

health status prior to discharge and after by a follow-up telephone call to the patient or caregiver. To decrease the 30-day readmissions, the navigator fulfilled the program objectives (Appendix B), tracked the BPCMs (Appendix F), determined if they were met and if not, then the navigator identified the reason a measure(s) was not met, and what was done (if anything) to correct the situation. Any reason(s) given for not meeting a measure was discussed at the next program team meeting with the intent to find a solution.

The program team evaluated each program objective for completion and determined its status of either met or not met on each AMI patient form. Team members also reviewed the AMI BPCM program forms, filled out on each AMI patient, for completion, and determined the status of the core measures used by the hospital, as either met or not met. The completed forms that were met showed that best practice care was given by the hospital for each patient indicating that quality care was given during their hospital stay and in the period required by the CMS. In having met the program objectives and the CMS core measures, it was determined that the navigator program had met the patient's needs, which resulted in decreasing the AMI 30-day post discharge readmissions rate, as reported by the CMS for Medicare AMI patients at this hospital. From this overall program evaluation, it was determined that the Navigator program was working effectively and the program's goal was being met.

As stated earlier, the program development objectives (Appendix B) were completed and evaluated when the program was first implemented. However, these objectives were evaluated again at the 6-month and 1-year intervals along with the other

10 program objectives and the core measures. This was done in order to keep the program's evaluation plan consistent, which allowed for better problem identification over the 6-month and 1-year period.

In the evaluation process, the program team reviewed the patient care surveys and included the results, as an additional program indicator of the care received, and the amount the Navigator and the program worked with the patient, the patient's family and/or patient's caregiver, and other needed health care providers. The patient survey results were used by the navigator to improve his or her nursing care, communications skills, and job performance as needed. In addition, the patient survey results and comments were considered by the program team when decisions were made on changing or revising the Navigator program. This represented in an attempt to improve the program and the overall care given to AMI patients.

Process Evaluation

In addition to the program data collection and planned data evaluation as described above, the program used a process evaluation that looked at the program's implementation. The program team conducted the process review based on the three objectives sets and the navigator's job description for the 6-month and 1-year time frames. It is important that the implementation of the program be reviewed to determine if the program followed the objectives and the job description. This assessment helps the program stay true to the overall goal of reducing the AMI Medicare 30-day readmission issue identified by the facility. An implementation assessment allows the facility to determine where the program worked well, where the program failed to work, what was

done to correct the failure, and if the program ran as planned. At this time, the PDOE

form was begun and completed by the program team as each program objective was met.

Process Evaluation Steps

Stakeholders

Groups involved in the navigator program that was affected by the program's

success or failure included:

- Medicare patients 65 years old and up

- Navigators

- Program team

- Physicians

- Pharmacists

- Other health care professionals as identified

- Administration

The Medicare patients were the receivers of the navigator program's care while

the other groups as health care providers were either on the program team or invited to

the team meetings to learn about the program and the data being collected. The health

care providers were asked to be active participants and provide input to help in the

program's implementation and success.

It is essential to the program's success that all participants have input into the

implementation and provide feedback to improve the delivery of program services. The

health care providers and facility administrators involved in the program are considered

the experts and utilizing their knowledge through the team meetings was stressed. Input

from these individuals helped strengthen the program's implementation and evaluation process. Feedback from the target population was very valuable. It was obtained through the NPPS forms completed by participants within two weeks of their discharge and returned.

Target Population

The target population was Medicare patients 65 years old and up admitted to the hospital with the diagnoses of AMI. This group of patients would ideally be first-time admissions with the intent to prevent a 30-day readmission once discharged. However, in providing quality safe health care, the target population included Medicare AMI patients that have a history of a 30-day readmission to prevent another 30-day readmission. All AMI patients were either admitted through the emergency department or admitted directly from a primary care clinic or physician's office. A hospital policy was developed pointing out all Medicare patients 65 years old and up diagnosed with an AMI are to be referred and admitted to the navigator program for individual assistance in preventing a 30-day readmission. After a patient had been admitted to the program; a navigator was assigned to provide the patient, family or caregiver with additional individualized health care services.

Budget

The navigator program was established as part of the nursing department and placed within the nursing education services section with services being offered every day. The program was included in the overall nursing department's budget with additional funding allowed for program implementation. The budget included

- two navigator positions for $110,000;

- a research officer for $40,000 cost shared half $20,000 by the nursing
   department and half $20,000 by the quality management department;

- office equipment for $5,000;

- office supplies, including postage and stamps for $8,000; and

- miscellaneous requirements for $5,000.

The budget totaled $148,000 for the first year startup of the program. Based on the facility's target population numbers, the facility was able to hire two navigators with a Doctor of Nursing Practice degree, which exceeded the expectation of a BSN. Neither of the hires had experience in nursing navigation and went through the required navigator orientation and training session taught by a nurse in the education department. The navigator program training module outline included in the program was used for the training after first being individualized to meet the needs of the facility.

The budget items listed can be revised and based on a facilities resources, may be reduced or increased for the next fiscal budget. The one item that should not be reduced is the navigator's salary as this could create an inability to hire qualified personnel. It was important when planning this program that the budget developed covered all potential expenses needed to ensure the program's goal could be achieved.

Navigator Assignment

Each navigator was assigned a maximum of five patients to care for during their hospital stay. This number allowed the navigator to

- review the patient's EMR;

- conduct the initial patient assessment and structured interview on admission,

- spend time with each patient and not be hurried, make two daily visits to the patient's room or more if needed, to assess and re-assess the patient, and address any questions or concerns;

- coordinate care with the physicians, and when needed pharmacy, physical therapy, occupational therapy, dietary services, social services, nursing staff, any other providers as needed;

- develop a detailed plan of care that all nursing staff could follow;

- begin the discharge teaching, at least, three days before discharge, and address any questions or concerns;

- complete all required paperwork;

- make a follow-up phone call two days after discharge; and

- documented all information in the EMR and on the appropriate program forms.

Because this is a new program, there was no way to determine if the number of assigned patients was to many or few or that the workload, including paperwork, was an overload or not. Each navigator will need to allocate their working hours so that the program objectives are met including each patient's care needs. With the implementation of the program, the workload of each navigator can be reviewed and revised as needed to provide quality patient care.

Program Patient Admission

When a patient was admitted to the navigator program, the navigator began the process of reviewing the patient's EMR and interviewing the patient, family or caregiver to determine as much information as possible about the issue that led to the referral or admission to the program. At this time, the navigotor filled out the NPCEO and BPCMs for AMI forms. During the interview, the navigator program was explained to the patient, family or caregiver. It included making sure all involved had a clear understanding of the clinical picture, treatments, and possible patient outcomes. In addition, the navigator program and role of the navigator were explained, and a phone number and instruction card was given on how to get in touch with the navigator day or night during the hospital stay. Patients were informed that the navigator would visit them in their room at least twice a day or more often if needed. It provided time for the patient's health status, any other issues, and treatments to be evaluated or re-evaluated and for questions and concerns to be addressed.

This portion of the admission and continued care process can be quite time consuming on the navigator's part. Allowing time with the patient was evaluated by each navigator based on the number of patients assigned and the ease of obtaining patient information. It is important the patient, family, or caregiver does not feel rushed or get the feeling the navigator is rushed in completing the interviews or visits. Providing the patient, family, or caregiver with an attitude of caring is part of the program's foundation and is to be adhered to throughout the patient's hospital stay.

At least three days before discharge:

- The patient, family, or caregiver was given the npps to complete;

- The navigator began the discharge teaching process following the hospital discharge protocol for an ami patient;

- The navigator met with the physician at least 3 days before the discharge date to obtain the needed information on medications, follow-up appointment, and any other resources needed, including rehabilitation or home care;

- Rehabilitation or home care needed by the patient was located within the community and the information obtained in written form as a handout;

- All handout information was obtained from the education department along with printouts of the patient medication information;

- The discharge information was collected, and then two days before discharge, the navigator began the discharge teaching with the patient, famil,y or caregiver, using the teach-back technique, and began completing the peceo form;

- The teaching was conducted by the navigator using the handout material, along with answering any questions or concerns;

- All ami education material, including medication handouts and community resources needed were given to the patient, family, or caregiver to read over;

- The navigator returned the next day to re-assess the knowledge retained by the patient, family, or caregiver, allowing for further questions and concerns to be addressed;

- On the day of discharge, the navigator gave the follow-up appointment card and addressed any other issues and concerns the patient, family, or caregiver had;

- The navigator informed patient, family, or caregiver of the npps that would be sent in 2 weeks after discharge to be completed and returned; and

- The in-hospital npps form was collected, and the peceo, the npceo, and bpcms for ami forms were completed by the navigator.

Data Collection and Analysis

Quantitative data collected on each patient on admission to the program included the age 65 years old and up, gender, ethnicity, marital status, diagnosis, hospital admission unit, and if this was the first AMI admission or an AMI 30-day readmission. All Medicare patients admitted to the hospital with a diagnosis of AMI were tracked by the navigator using the hospital's EMR system and daily census, to determine if they were admitted to the navigator program as the hospital policy states. If a patient was not admitted to the program, the navigator sought the reason or grounds for non-admission, which included contacting the physician to determine any problems or concerns and see if the doctor was aware of the hospital policy.

Additional quantitative data collection began once the navigator interviewed the patient, family or caregiver, and during services offered through discharge, and follow-up. Quantitative data was placed on the appropriate forms and included the NPCEO, PECEO, BPCM for AMI, NPPS completed by the patient, family or caregiver during a

hospital stay and the NPPS completed by the patient, family or caregiver two weeks after discharge.

All forms were kept in the navigator's office to provide an organized system and were given to the research officer in the QI department on the last Monday of each month for data input into the computer system program. The navigator program used a descriptive statistical method to analyze the data obtained during the program to determine program use throughout the hospital and see if services needed to be altered in any way.

In analyzing the data, the research officer used the Statistical Packages for the Social Sciences (SPSS) being utilized by the facility, which allowed for a cost reduction for the program. In order to categorize the information, the data were given specific codes allowing for better organization and data interpretation. Areas identified as ineffective at the six-month time frame were revised to address the issues and then re-evaluated at the one-year time frame.

Reporting Results

Once the process data has been analyzed, the program team gained results that characterize the efficiency or inefficiency of the program. This information was then used to write a report that summarized all the steps and stated process efficiency or inefficiency and provided the reasons for the results. The process evaluation reports were given at the six months and one-year meetings as handouts to those in attendance. However, meetings could have been scheduled as needed through the first year of the program's implementation to provide stakeholders with up to date information on the

program and to obtain their feedback. A review of the handout in summary form was given along with a powerpoint presentation, with stakeholders being asked for their feedback. A discussion, question, and answer session were held. It was important that all the stakeholders' questions were addressed in the meetings. Addressing these questions allowed for a better understanding of the program's specific needs and where, if needed, the program could improve the delivery of health care services for the target population.

Any recommendations, changes or program challenges generated at the meetings from the data report or from stakeholders were placed in the meeting minutes and discussed as revisions to the program. The evaluation process itself was reviewed by the stakeholders and suggested revisions to the process were considered, and changes made as appropriate to improve the overall assessment process and to improve the data collection throughout the program. After the program had been in operation for one year, the hospital administration and health care providers evaluated the program to determine if it was self-sustaining without revisions, needed further revisions and continued for six more months, or should be discontinued because it was not sustainable or useful to the facility.

Summary

The design for this project plan was one that used a set of 17 developed objectives, along with AMI BPCMs for Medicare patients, which were evaluated over a 6-month and 1-year period. Data collection was accomplished by the navigator obtaining the CMS AMI readmission rates and core measures data through the quality management department. This QI project looked at reducing the 30-day post-discharge readmission

results as reported by the CMS on AMI readmission(s) of the Medicare patient population within this facility. The navigator program's 17 objectives provided the framework for the project's evaluation, which included the AMI BPCMs and the patient care surveys. Evaluation results from all the objectives were used to determine if the navigator program provided the necessary care intended to reduce the 30-day readmission rate for AMI Medicare patients.

A process evaluation was included in the navigator program and was used to determine if the program was functioning effectively and implemented according to the program plan. Team meetings with stakeholders excluding the target population were held at the 6-month and 1-year timeframes. Analyzed program data reports were provided for each person to review the program's progress. During the meetings, discussions were held and recommendations for any needed revision(s) were given and incorporated as feasible to improve the functioning of the navigator program.

With the development of the navigator program/project plan for use by a hospital, the hope was that some answers to the 30-day AMI readmission problem would be found and addressed. In addition, by having used the navigator program's job description, objectives, and the evaluation process the quality of care was increased for Medicare AMI patient(s) and the readmissions were reduced.

Section 4: Findings, Discussion, and Implications

Introduction

The intent of the navigator QI program plan is to work toward reducing the 30-day readmissions rates of Medicare AMI patients. At this time, the program is developed, but not implemented. Its implementation is at the discretion of any acute care facility that chooses to use it to help reduce their readmission rates. If a facility is having problems with their readmission rate, this program is one way to reduce the rate while improving the health care given to this patient population.

Summary of QI Findings

Although the navigator program has not yet been fully implemented by a facility, the findings are obtainable through the program's evaluation process of determining if the program's objectives are being met or not met. The CMS aggregate numbers reports for AMI readmissions for the 6-month and 1-year periods post navigator program implementation when compared to the CMS reports pre navigator program implementation should show the readmission rate is below the facility's previous rates. An example of this is as follows: *the facility's readmission rate, pre navigator program demonstrates at 24%, and the post navigator program the rate demonstrates at 22%.* Finding the rate 2% below the previous rate indicates the navigator program is producing successful results for the facility and needs to be continued. The facility can choose to make changes in the navigator program over time as the evaluation data may suggest or indicate. This ability improves the quality of patient care, ultimately increasing the amount of reimbursement received.

In evaluating the navigator program, the program team should go through each of the 17 objectives at the 6-month and 1-year timeframes based on the program plan. Because evaluating these objectives will take time, scheduling meetings should be based on facility need and more than one meeting may be necessary; therefore, the facility and the individuals on the team must take this time into account when evaluation timeframes are reached. Meeting time schedules are left up to the facility, but team members may need to be scheduled release time in order to attend the meeting(s) to accomplish this important part of the program plan. The objectives can remain evaluated at additional timeframes based on a facility's need. For example, if the census of AMI Medicare patients runs high, then more frequent team meetings may be required with the opposite being true: if the census runs small, a facility may only want to meet at the program's set evaluation times of 6 months and 1 year.

Discussion of Findings in the Context of the Literature

This project/program has not been implemented, but the previously published researchers described many navigator programs that were successfully implemented with problems such as cancer, but not directed towards reducing 30-day readmissions for AMIs within the Medicare population. In a study by Thygesen et al. (2011), the use of a nurse navigator provided benefits through the nurse navigator being able to give one-on-one help. The cancer patients and the nurse navigator developed a mutual connection involving an experience of trustworthiness. The nurse navigator offered attention and help over a period of time, which helped reduce the patients' stress and anxiety levels.

There were challenges once the patient was released from acute care. Challenges became a break of mutual connection and a lack of help from the nurse navigator.

A study by Thygesen et al. (2012) indicated that a trust or distrust attitude toward a physician by the cancer patient prior to meeting a nurse navigator influenced the patient in choosing a nurse navigator's help or not. The patients that did accept the nurse navigator's help when offered found that they were able to develop a trusting relationship despite their feelings toward the physician. Shockney (2010) pointed out that using nurse navigators allows for the development of a real collaboration between the oncologists, nurse navigator, patient, and family. Good collaboration establishes the needed patient-centered care allowing for a positive outcome for the patient.

From the literature, it became evident that using a navigator can help a patient in several different ways, such as providing support, guidance, stress reduction, and continuity of care. Wilcox and Bruce (2010) pointed out that using a navigator increases the access time to care for cancer diagnosis and treatment. A navigator assist patients and families in coping with the diagnosis, and decreasing complications from treatment while increasing the patient's quality of life. In using a nurse navigator, the problem involves the point at which the navigator is no longer available to the patient. Without a navigator, the patient had feelings of hurt and rejection. In an effort to alleviate this, there needs to be a specific end time set with the patient and family at the time the nurse navigator begins to provide additional care for the patient.

Study Implications

Implications for Practice

QI projects such as the implementation of a navigator program to reduce 30-day readmissions of Medicare AMI patients have the ability to improve and positively affect patient care based on the information found in the literature. Though the majority of the literature findings for using a navigator have been with cancer patients, it is a worthwhile project to implement with AMI Medicare patients. There continues to be a gap in the nursing literature for using a navigator with the Medicare AMI patients to reduce 30-day readmissions, so this QI project/program can begin to address that gap in care. McHugh and Ma (2013) noted that the PPACA has increased hospitals' financial accountability for 30-day AMI readmissions that are preventable. This has helped hospitals become more aware of implementing strategies to reduce these readmissions.

This QI project is built upon Watson's (2006, 2009; Watson & Smith, 2002) caring theory, which encourages the formation of a healing environment for the patient. The navigator develops this environment from the moment he or she begins the relationship with the patient. Watson (2009) noted that nursing is a journey of caring and healing meant to offer compassionate and informed care to patients (Watson, 2009). Caring and healing are the underlying premise of the navigator in helping patients through a difficult and stressful time in their lives. The elder patient with a diagnosis of AMI is quite vulnerable in the health care system and needs the healing environment that the navigator can create both pre and post discharge to help prevent a 30-day readmission.

In addition, although this QI project was developed to use objectives to determine the success of the navigator program/project and the implementation time has been left to the health care facility. Approval to develop the project was obtained from Walden University's IRB, providing the ethical basis to move the project forward. Although this project was developed to be implemented in an acute care hospital with AMI patients, it is possible with some revisions that it could be implemented for other CMS identified conditions, such as pneumonia or heart failure. The navigator program easily allows for any facility having a 30-day readmission problem with one or more of the CMS Medicare identified conditions to use this program.

Implications for the Future

Current literature has not shown any data on using a navigator with the Medicare AMI population experiencing 30-day readmissions. Because of this, it would be important for this project to be implemented in the future and evaluated to determine its effect on reducing 30-day readmissions of this group of patients. Because this is a QI project and not a research project, this program could be replicated in different acute care facilities either as a QI project or changed into a research project. As a research project, it could identify the different issues or variables that might influence the overall outcome of reducing 30-day readmissions employing a navigator. According to Shockney (2010), before implementing a patient navigator program, the facility should perform an analysis of the care delivery process as seen through the eyes of the patients. This would enable the facility to identify any barriers to care the patient may experience, as well as the patient navigator. Once the program/project has been implemented, it becomes important

to disseminate the findings (both positive and negative) to the health care community at large. This allows for further investigation into the use of a navigator to reduce 30-day readmissions. Shockney (2010) pointed out that measuring the effectiveness of a navigation program is important in establishing the value of the program not only for the facility, but also for other facilities that may decide to implement such a program.

Implications for Social Change

In developing a program plan or project plan, the mission statement should reflect the mission statement of the organization where implementation is to occur. An effective mission statement needs to "focus on what lies ahead for its clients or consumers if the agency is successful in addressing their problems and meeting their needs" (Kettner et al., 2013, p. 131), providing a positive social change. The mission statement of this project plan is "To develop a Navigator Program to improve the patient(s) health status post-discharge thereby reducing the 30-day readmission rates in the Medicare population experiencing acute myocardial infarctions in a quality safe caring manner" (Appendix A). The intent of this project plan is to provide a positive health status change for the Medicare patients and families, reducing the 30-day readmissions and the added patient and family stress, plus the cost the hospital would incur for these readmissions. If the project plan remained successful, it would make a needed change that would benefit patients, families, the organization, and the service region, making the project a quality endeavor.

Project Strengths, Limitations, and Recommendations

Strengths

The strength of this plan or project lies in its ability to address the problem of 30-day readmissions for the Medicare population experiencing an AMI, which is lacking presently in the nursing literature. By putting forth a program to address this problem, it also addresses the needs of an acute care facility to obtain the needed reimbursement from the CMS for the care given to this population. A second strength is the ability of the plan or project to be changed to address any of the health issues considered reimbursement problems by the CMS. Examples of this are pneumonia, heart failure, and hip/knee arthroplasty just to name a few from the CMS *Medicare Hospital Quality Chartbook 2014*. The third strength is the program can be easily revised to address other CMS identified 30-day readmission health problems. Finally, the navigator program can be generalized to other health areas and patient populations. A facility can accomplish this by using the program's framework and revising the content to address the health area and health problem.

Limitations

Listed here are a few examples of the identified problems of this proposed QI project plan when implementation strays from the navigator program's proposal. Not all have been identified, so this is not an all-inclusive list:

- The project only had one BSN-RN who was the navigator for two or more acute care units within a hospital's Medicare population with a diagnosis of AMI.

- The project relied on the hospital data being calculated by the CMS for the 30-day readmission rate, where the hospital had the ability to calculate its' own data rate.

- The navigator did not have any direct patient contact and relied on the staff nurses to complete the core measure forms, patient education, and provide the needed emotional support. This was contrary to what the literature stated regarding what the navigator was supposed to do, as described by Lee et al. (2011), Pedersen and Hack (2011), and Swanson and Koch (2010).

- The navigator did not follow the job description, as outlined in the program, and was not provided a program orientation or any education by the education department using an individualized program navigator-training module.

- The program/project did not have administrative support or support of the interdisciplinary team, such as physicians, nurses, social workers, pharmacy, and others.

Recommendation/Remediation of Limitations

In providing for a better implementation and successful program plan, the limitations/problems should be avoided along with any other limitations/problems identified by a facility choosing to implement the program. A facility should be able to calculate their own 30-day readmission rates allowing for more frequent data information than every quarter as provided by the CMS. This would give better feedback to the navigator and facility on the effectiveness of the program in reducing the 30-day readmissions and identify where the program is weak and corrections are needed. Making

sure the navigator is in direct contact and working with the patients and families is imperative as identified by Lee et al. (2011), Pedersen and Hack (2011), and Swanson and Koch (2010), as part of what the navigator's job responsibilities. The navigator should understand the program by attending an orientation and education session(s) through the facility's education department using an individual training module developed by the facility using the navigator program's as an example. According to Wilcox and Bruce (2010) to have a successful navigator program, the program needs administration support, interdisciplinary teamwork, and enhanced communication to build relationships within the health care team, which will enhance patient care as all work together to meet the individual patient and family's need(s).

<div align="center">**Analysis of Self**</div>

As a Nurse Scholar and Practitioner

During the process of developing this QI project, the knowledge I acquired in using the research process was invaluable. Researching the literature for information on Medicare 30-day readmissions allowed me to gain a great deal of insights and information that I can share with a facility that chooses to implement the program. The basics of initiating a navigator program within an institution to reduce AMI 30-day readmission rates are within its writing, and implementation is the next logical step in order to determine the program's effectiveness. DNP-prepared nurses are well versed in leadership and the nursing research process. With these skills, they could initiate, implement, and evaluate the program and make program adjustments based on the evaluation findings. This program includes CMS evidence-based practice (EBP) changes

required to reduce AMI 30-day readmissions. Making these changes may be a challenge for nurses and others due to the established culture of a facility, which dislikes making changes.

In today's world, making EBP changes or putting research information into nursing practice will be of importance to nurses and facilities. Evidence based practice implementation provides quality safe patient care, decreases 30-day readmission rates, and allows the needed facility reimbursement from the CMS for Medicare patient(s). Helping nursing staff and others, change will require accurate, up-to-date research information, along with change agent and leadership skills. A DNP practitioner should have these skills ready to apply to the program implementation and support the nursing staff and facility as they work through EBP changes. I believe that my knowledge and skills provide me with the ability to implement EBP changes, the navigator program, or any QI project within my employment facility.

As a Project Developer

Researching the literature for information on navigator use and implementation was a learning endeavor in dividing out the information that was pertinent to the development of this project. There were no studies directed toward the use of a navigator with Medicare patients to reduce 30-day readmissions. However, I was able to apply data or information from other studies to the project's development. This program's writing allows changes to address any of the CMS identified 30-day readmission problems, therefore, making it easy for any facility to adapt it to their identified problem or problems.

It is important that a facility implement this project. According to Jencks, Williams, and Coleman (2009) nearly one-fifth of Medicare beneficiaries were rehospitalized within 30-days after discharge costing Medicare billions of dollars. The MedPAC (2013) Report to the Congress pointed out the PPACA has directed the CMS to institute the hospital readmissions reduction program (HRRP). In the HRRP reimbursement penalties for hospitals with higher than normal readmissions, rates were assigned beginning in 2013. Brown et al. (2014) suggested that to reduce AMI 30-day readmission rates should involve better discharge planning and care coordination. However, other methods should be taken into account including looking at reducing the overall admission rates for a facility. This project provides the navigator program framework to reduce 30-day AMI readmission rates that will serve a facility in providing quality safe patient care and increasing CMS reimbursement for care given to Medicare patients.

Future Professional Development

Plans for future professional development include the continued study of the CMS 30-day readmissions for AMI and other Medicare 30-day readmission problems for changes in the reimbursement process. Any changes would be used to update the navigator program keeping a facility following the federal health care law and CMS requirements. Networking with facilities using other navigation models to determine what methods are effectively being used that could be incorporated into this navigation program to enhance its functional ability in reducing readmission rates would be needed. Leadership is one aspect essential in implementing this project. The ability to implement

this project in a facility is truly a professional development endeavor in planning, organization, and leadership. This project or program should be part of an organization's strategic planning process since its goal and mission will require long-term evaluation to determine its effectiveness. In this process, there will be identification and management of problems that arise some will be expected others will be new. Following the program as outlined in this paper is highly advised as it forms the organization or structure for a well-planned implementation.

Summary and Conclusions

The project intent is to reduce 30-day readmissions of Medicare AMI patients through the implementation of a navigator program. Using a navigator should help provide quality safe health care for this patient population as indicated through the literature review. Keeping AMI patients from being readmitted should allow a facility to obtain the needed CMS reimbursement for care given. Components to implement the program are within this project and if followed should provide positive results. Facilities choosing to implement the program need to include it in their strategic planning process to allow time for evaluation and revisions as needed.

Section 5: Scholarly Product

Introduction

This QI project is a plan that deals with the development of a navigator program for the Medicare population of patients with an AMI frequently seen in the hospital setting. This group of patients is among the highest that are re-admitted to hospitals within 30 days post discharge. The MedPAC (2013) pointed out that AMI is one of the seven conditions that account for nearly 30 percent of potentially preventable readmissions. These readmissions are avoidable in the 15-day window after initial hospital discharge, therefore, demonstrating a problem with either inpatient or outpatient care or both. According to Dunlay et al. (2012), readmission causes decreased patient outcomes, such as longer length of stays and complications from treatments. With the development of the navigator program, the outcome sought is a decrease in the readmission of the patients within the 30-day period post discharge. Readmission decreases can be accomplished by the navigator and patient(s) meeting the program objectives prior to discharge and after, thereby, improving patient care outcomes while lowering the cost to hospitals for these re-admissions. Decreasing readmissions allows the hospital to save precious health care resources creating a more stable business environment.

Purpose of the Project

In working to reduce 30-day readmissions of Medicare AMI patients, a navigator program plan was developed for implementation by any acute care facility. This program would assist with providing pre and post discharge healthcare, health

teaching, and additional resources as needed in an attempt to prevent the patient from being readmitted. The literature, suggest using a nurse navigator to help guide the patient(s) through the health care system back home or to another facility (Cornett & Latimer, 2011). A nurse navigator can see that the patient receives evidence-based quality care to help prevent a readmission within the 30-day post discharge timeframe.

Project Outcome

The goal for this QI project plan is to improve the AMI patients' health status, post discharge. In order to achieve this goal, the objectives or outcomes listed below were developed to guide the project plan creating healthy patient(s) outcomes.

The following points represented the program objectives or outcomes:

- Be considered for implementation by a hospital within the next 2 years;

- Include a navigator job description (Appendix C) developed that fits the individual hospital and patient's needs;

- Have a nurse(s) in the education department(s) in the hospital(s) trained using the individualized navigator training module (Appendix D);

- Result in patients in direct contact with the navigator program being surveyed (Appendix E) to determine their satisfaction with their care;

- Include a program team consisting of five individuals, such as the navigator(s), me (the DNP student), and three others chosen by the facility;

- Result in the program team evaluating the program objectives for completion then, making any needed changes for program improvement at 6-months and 1-year intervals; and

- Result in the program team reviewing the data reports received from the CMS to determine if the BPCMs were met and the 30-day readmission rate for Medicare AMI patient(s) has decreased.

The navigator did

- Obtain and review the AMI patient's baseline assessment information from the EMR on admission or as soon as possible;

- Ensure that the AMI BPCMs core measures were met prior to the patient's discharge, as applicable to the patient's care and, if these were not, seek the reason(s) why;

- See that patient(s) needs were met and reassessed in a timely manner;

- Complete discharge teaching for patient and/or caregiver; and

- Complete a post discharge follow-up telephone call within 2 days after patient discharge to identify and refer the patient(s) to resource(s) as needed.

The patient or caregiver did

- Verbalize the date of a follow-up appointment;

- Verbalize understanding of their discharge medication regimen;

- State from which pharmacy they obtained their medications and the payment method used to purchase these medications;

- State where he/she received any needed rehabilitation care or where other resources were obtained, such as dressing materials and so on; and

- State when a health care provider should be called for a specific problem to determine if the problem was or was not related to the AMI diagnosis and obtain any needed resource(s) or treatment(s).

Literature Review

Implementation of a navigator program, which represents a form of case management, for the population of AMI Medicare patients can be useful in an acute care hospital with the intent to reduce the 30-day readmission rates. Looking at the problem of readmissions, an article by Cornett and Latimer (2011) provided information on the issue of patient 30-readmissions. Cornett and Latimer (2011) provided information on the issue of patient 30-day readmissions. This included the readmission's relationship to required quality and usage metrics and the new reduction in payment for excessive readmission of AMI patients. MedPAC (2013) suggested the readmissions could be related to poor quality of care given during the hospital stay. Crowther (2012) pointed out that the CMS saw 30-day readmission as a worsening problem among hospitals. A suggestion is that patients need to be educated in self-management techniques prior to discharge as a means of reducing the readmission rates. Lacker (2011) suggested that to reduce the 30-day readmission rates of Medicare beneficiaries effective communications techniques are needed. Add to this a strong transition plan, prompt post discharge communication, and better follow-up care provides the potential to reduce readmission rates.

Pedersen and Hack (2010) found that "the role of a patient navigator included removing barriers to health care, improved patient outcomes, and improving the overall quality of health care delivery" (p. 55). According to Melinyshyn and Wintonic (2006)

the use of a nurse navigator with patients diagnosed with breast cancer was important in providing expert evidenced-based practice care for patients, providing support, and ensuring continuity of care. Paskett et al. (2011) indicate the use of patient navigators must be efficient, disseminated, used widely in many institutions, have reimbursement and training mechanisms, with continual monitoring and reevaluation. Wells et al. (2008) indicates that using patient navigators shows overall evidence for some degree of effectiveness with helping cancer patients participate in cancer screenings and adherence to diagnostic follow-up care.

Guiding Theory

In planning this QI project or program for improving care to the AMI Medicare population, the nursing theory used was Watson's (2006) caring theory. This theory not only focused on the patient, but also the nurse. It gives the ability to be caring and compassionate providing the patient with the needed healing care throughout their hospital stay (Cara, 2003). The use of Watson's (2006) caring theory, as a framework to guide the navigator's role, remained an important part of this project. Navigators are to be caring and provide advocacy for the patient(s) when needed to help reduce the patient's anxiety about finding their way through the health care system. The goal is directed at providing the needed care, which would in turn help reduce the 30-day post discharge readmissions.

Implications for Practice

Quality improvement projects, such as the implementation of a navigator program to reduce 30-day readmissions of Medicare AMI patients, have the ability to improve and

positively affect patient care based on the information found in the literature. Though the majority of the research findings for using a navigator have been with cancer patients, it is a worthwhile project to implement with AMI Medicare patients. A gap continues to exist in the nursing literature for using a navigator with the Medicare AMI patients to reduce 30-day readmissions, so this QI project/program can begin to address that gap in care. McHugh and Ma (2013) noted that the Affordable Care Act (ACA) has increased hospitals' financial accountability for 30-day AMI readmissions that are preventable. Financial accountability has helped hospitals become more aware of implementing strategies to reduce these readmissions.

Recommendations

In providing for a better implementation and successful program plan, a facility choosing to implement the program should be aware of any limitations/problems that might occur. A facility should be able to calculate their 30-day readmission rates allowing for more frequent data information than every quarter as provided by the CMS. This data would give better feedback to the navigator and facility on the effectiveness of the program in reducing the 30-day readmissions and identify where the program is weak and corrections are needed. Making sure the navigator's job responsibilities bring them in direct contact working with the patients and families is imperative (Lee et al., 2011; Pedersen & Hack, 2011; Swanson & Koch, 2010). The navigator should understand the program by attending an orientation and education session(s) through the facility's education department using an individual training module developed by the facility using the navigator program. According to Wilcox and Bruce (2010) to have a successful

navigator program, the program needs administration support, interdisciplinary teamwork, and enhanced communication. These aspects help build relationships within the health care team, which will enhance patient care as all work together to meet the individual patient and family's need(s).

Dissemination Plans

Dissemination of my QI project involved two presentations, one to the local hospital and a second one to a regional medical center. A power point presentation was given to the CNO, case manager, and unit managers of the local hospital. The regional medical center's power point presentation was delivered to the nursing management committee. Future presentations may be planned for a third hospital and a Kentucky or national professional nursing association's conference. It is important that the program be promoted so that facilities become aware of its development and the benefits the program has to offer the Medicare population and a facility. Finally, getting the program published in a peer review journal would get the program out to the wider health care community.

Summary

This QI project plan was developed for hospitals having a problem with their AMI 30-day readmission rate. With the implementation of the PPACA (also known as the ACA) hospitals with high readmission rates have seen a reduction in their Medicare reimbursement funding. A reduction in reimbursement has given hospitals a reason to seek a means to reduce their readmission rates. The navigator program is a way to help hospitals in their struggle to get their rates in line with the CMS requirements. It is apparent from the literature, that using a navigator has been shown to produce results that

improve patient communications, provide needed support, and increase continuity of

care. I used the Watson's (2006) caring theory to bring the caring aspects of nursing into

the care of the Medicare population, which then created a healing environment allowing a

positive outcome for the patient, family, or caregiver.

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Appendix A: QI Project Mission Statement, Goal, and Objectives

Mission Statement: To develop a navigator program to improve the patient(s) health status post discharge thereby reducing the 30-day readmission rates in the Medicare population experiencing acute myocardial infarctions in a quality safe caring manner'.
Project Goal: To improve the Medicare AMI patients' health status post-discharge preventing a 30-day readmission.
Objectives

The Program will:
- Be considered for implementation by a hospital within the next 2 years;

- Include a navigator job description that fits the individual hospital and patient's needs;

- Have a nurse(s) in the education department(s) in the hospital(s) trained using the individualized navigator training module;

- Result in patients in direct contact with the navigator program being surveyed to determine their satisfaction with their care;

- Include a program team consisting of five individuals such as the navigator(s), me (the DNP student), and three others chosen by the facility;

- Result in the program team evaluating the program objectives for completion then, making any needed changes for the program improvement at 6-months and 1-year intervals; and

- Result in the program team

- Ensure that the AMI BPCMs are met prior to the patient's discharge as applicable to the patient's care and if not seek the reason(s) why;

- See that the patient(s) needs are met and reassessed in a timely manner;

- Complete discharge teaching for patient, family, and/or caregiver; and

- Complete a post-discharge follow-up telephone call within 2 days after patient discharge to identify and refer the patient(s) to resource(s) as needed.

The Patient or Caregiver will:
- Verbalize the date of a follow-up appointment;

- Verbalize understanding of their discharge medication regimen;

- State from which pharmacy they will obtain their medications and the payment method used to purchase said medications;

- State where he/she will receive any needed rehabilitation care or

reviewing the data reports received from the CMS to determine if the (BPCMs) were met and the 30-day readmission rates for Medicare AMI patient(s) has decreased.

The Navigator will:

- obtain and review the AMI patient's baseline assessment information from the electronic medical record (EMR) on admission or as soon as possible;

where other resources will be obtained (such as dressing materials, etc.); and

- State when a healthcare provider should be called for a specific problem to determine if the problem is or is not related to the AMI diagnosis and obtain any needed resource(s) or treatment(s).

Appendix B: PDOE

Program team will answer questions completely. Date of evaluation _____

The program will

- Be considered for implementation by a hospital within the next two years.

  Date implemented_____.

- Include a navigator job description that fits the individual hospital and patient's needs that the navigator will follow. Completed:

  Yes/Date_____   No/Date_____

- Have nurse(s) in the education department(s) in the hospital(s) trained using an individualized navigator training module.

  Completed: Yes/Date_____ No/Date_____

- Results in patients having direct contact with the navigator program surveyed to determine their satisfaction with their care.

  Implemented: Yes/Date_____ No/Date_____

  If using survey, document results of survey using a blank survey to tally responses both numerically and written at 6- months and 1- year intervals. Attach both survey result forms for each timeframe. Use information in making changes to the program for improvement and continuation or for discontinuation of program.

- Include a program team consisting of five individuals, such as the navigator(s), and the DNP student and three others chosen by the facility to evaluate the navigator program. Team consist of

  _____,

  _____,

  _____, _____, and

  _____.

- Result in the program team evaluating the program objectives for completion then, making any needed changes for program improvement at 6- months and 1- year intervals. 6-month evaluation date

  _____. List changes if any that are to be made with implementation date:

  _____

  _____

  1-year evaluation date _____.

  List changes if any that are to be made with implementation date:

  _____

  _____

- Result in the program team reviewing the data reports received from the CMS to determine if the BPCMs for AMI were met and the 30-day readmission rate for Medicare AMI patients has decreased.

Date of BPCMs for AMI and CMS 30-day readmission reports obtained

for 6-month evaluation:

_____.

Review of the report for the BPCMs. Attach a copy of the report for future

reference. List BPCMs not met that need further work on.

_____

_____

_____

30-day readmission rate at the 6-month evaluation:

_____.

Date of CMS 30-day readmission report obtained for the 1- year

evaluation:

_____.

Review of the report for the 1- year CMS-30 day readmissions. Attach a

copy of the report for future reference. The 30-day readmission rate at the

1- year evaluation _____. Program working or not

working _____.

List any changes needed for program improvement. _____

_____

_____

_____

Final recommendation for program at this time:

Continue program:

Yes _____.

Discontinue program:

Yes _____.

State reason(s) for ending the program:

_____

_____

_____

_____.

Appendix C: Navigator Job Description

The navigator's job description is a document that can be altered as the facility determines to provide a facility, implementing the navigator Program, with safe quality health care for their AMI Medicare patient(s).

Each of the following should be followed to provide a quality navigator program:

- The navigator is a BSN-RN program or higher graduate, but an ADN-RN graduate is acceptable when a BSN or higher graduate is not available and is a member of the facility's Education Department.

- The navigator understands the role of the Navigator and the Program's purpose, objectives, and intended outcome prior to the Program's future implementation through a one to two day, eight hours per day, individualized Navigator training module given by the Education Department.

- The navigator is to have good communication skills with the patient, family, and/or caregivers and can collaborate well with multiple physicians, ancillary support services, and exceeds in customer service.

- The navigator is able to facilitate coordination of caregiver services across the continuum of care, which allows for a timely patient discharge.

- The navigator is organized and knowledgeable regarding nursing interventions for AMI healthcare and treatments.

- The navigator is able to reassess patient's needs and addressed those needs in a timely manner and functions as the patient's advocate throughout the hospital stay and for 2 days after discharge.

- The navigator provides any needed emotional support and obtains further support resources as needed.

- The navigator is to complete discharge teaching by simplifying information taught and assess the patients', families, and/or care givers understanding of the information using the 'teach back method'.

- The navigator completes a post-discharge follow-up telephone call within two days after patient discharge to identify and refer the patient(s) to resources as needed to improve continuity of care and prevent patient readmission (Birk, 2012; Bradley et al., 2012; Case, 2010; Harrison et al., 2011; Seek & Hogle, 2007; Smith, 2010; Van de Steeg et al., 2012).

- The navigator ensures the AMI BPCMs on the BPCM form (Appendix F) are met prior to discharge, (allowing for improved patient health pre-and post-discharge).

- The navigator is assigned a maximum of five patients to care for during any one period.

- The navigator is to review the patient's electronic medical record (EMR) to obtain needed information appropriate to patient's care.

- The navigator is to conduct the initial patient assessment and structured interview on admission.

- The navigator is to spend time with each patient and not be hurried, make two daily visits or more if needed to assess and re-assess the patient, and address any questions or concerns.

- The navigator is to develop a detailed plan of care that all nursing staff can follow.

- The navigator is to provide the discharge teaching at least 3 days prior to discharge and address any questions or concerns.

- The navigator is to complete all required paperwork.

- The navigator is to document all information in the EMR and on the appropriate program forms.

- The navigator is a member of the program team and reviews/evaluates the program objective's data at the recommended periods of six months and 1-year intervals and helps make any needed revisions to improve the Program.

- The navigator is to keep track of the completion of the program's PECEO (Appendix H) through completion of the PECEO form throughout each of the AMI patient's care stay, the NPCEO form (Appendix G), and the BPCMs AMI form (Appendix F).

- The navigator is part of the education department and will be given at least six to eight weeks of on the job-guided performance by a member of the education department, to allow for integration of the program's job description, including the program objectives. Evaluation of the navigator's job performance will take place based on the facility's already in place hiring policy and procedure. The facility is at liberty to use the Navigator Program Patient Survey (NPPS) as part of the evaluation process of the navigator's job performance.

Signatures below show reading of, understand of, and approval for implementation of the

Navigator job description.

_____

_____   _____

Navigator Signature, Date   Chief Nursing Officer Signature, Date

_____   _____

Facility Administrator/President Signature Chief Medical Staff Officer Signature

Date: _____   Date: _____

Appendix D: Navigator Program Training Module Outline

Navigator Program Training Module Outline

Linda K. Dunaway RN., MSN

To Be Individualized by the Facility Implementing the Program

Content

Agenda – Determined and Written by Facility

Development of a Plan for a Navigator Program (Copy)

Program Development Objectives Evaluation Form-PDOE (Copy)

Navigator Job Description (Copy)

Navigator Program Patient Survey-NPPS (Copy)

Best Practice Core Measure's for AMI-BPCMs for AMI (Copy)

Navigator Patient Care Evaluation Objective's-NPCEO (Copy)

Patient Education Care Evaluation Objectives-PECEO (Copy)

Resource List – Determined and Written by Facility

Navigator Program Training Module

Module Description

This training module is designed to provide the navigator with the information needed to deliver quality patient care to Medicare AMI patients and decrease the 30-day readmission rate of this patient population. With the decrease in readmission rates the patient's health status will be improved pre and post discharge, and the facility will have an improved Medicare reimbursement rate.

Guiding Theory

The nursing theory this program is developed around is Jean Watson's caring theory, which not only focuses on the patient, but also the nurse and the ability to be caring and compassionate, which then provides the patient with the needed healing care throughout their hospital stay (Cara, 2003).

Teaching Personnel

An individual from the nursing education department will conduct the training session.

Required Information

A copy of the navigator program's plan entitled 'Development of a Plan for a Discharge Navigator Program' to be covered during the training session.

Timeframe

The timeframe for the session will vary, but should last approximately four hours in classroom time. A clinical portion involving a nurse educator preceptor for the navigator is required lasting a total of six weeks.

Module Outline

I.   Overview of the 'Development of a Plan for a Navigator Program'
II.   QI Project Mission Statement, Goal, and Objectives (Appendix A)
III.   Program Development Objectives Evaluation-PDOE (Appendix B)
IV.   Navigator Job Description (Appendix C)
V.   Navigator Program Patient Survey-NPPS (Appendix E)
VI.   Best Practice Core Measure's for AMI-BPCMs for AMI (Appendix F)
VII. Navigator Patient Care Evaluation Objective's-NPCEO (Appendix G)
VIII. Patient Education Care Evaluation Objectives-PECEO (Appendix H)
IX.   Resource List (To be determined by Facility)

Teaching Methods

Review of Program Plan
Questions and Answers
Discussion
Computer-Assisted Instruction

Clinical/Preceptor

Assignment

Over a 6-week period, the navigator will work with a nurse educator for two weeks of on the job training. During this time, applying the information contained in the course outline and any other information or actions as required providing patients with best practice high quality safe patient care. After two weeks, the navigator will spend four weeks of self-directed navigator patient care seeking assistance from the nurse educator as needed. Forms are to be filled out as appropriate during the 6-week assignment, including any needed electronic medical records (EMR)/electronic medication administration record (EMAR) documentation.

Evaluation Policy

Afterward six weeks, the navigator will be evaluated by the facility's nursing administration using already established new staff hiring or position change policies/procedures. If determined satisfactory he/she will then assume the position and continue to follow the facilities applicable personnel policies and procedures, in addition, to the navigator program requirements learned and practice throughout the training period.

Reference

Cara, C. (2003). A pragmatic view of Jean Watson's caring theory. *International Journal*

for Human Caring, 7(3), 51-61. Retrieved from https://iafhc.wildapricot.org/page-

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Appendix E: NPPS

Name_____

Date_____

We would greatly appreciate your feedback on how satisfied you are/were with your health care as a patient in the navigator program and how you see your overall personal health at this time. This survey will only take approximately 5-10 minutes and your responses will help us to understand how you see your overall health and how we can improve the health care given to patients while in the navigator program.

Thank you for helping us to improve the health care we give to our patients! Once completed, please put the survey in the enclosed pre-stamped envelope and drop in the mail. Again, thank you for helping us!

Please circle the best response that describes how you feel at this time about the questions, using the scale of:

1-Excellent 2-Better 3-Good   4-Fair   5-Poor   6-Not Applicable

Your overall personal health at this time, is?	1 2 3 4 5 6
During your hospital stay has/did the navigator see that your health care needs are/were met in a timely manner?	1 2 3 4 5 6
During your hospital stay has/did the navigator re-assess your health care needs to see that changes were made in a timely manner?	1 2 3 4 5 6
How was the discharge teaching provided by the navigator?	1 2 3 4 5 6
Were you able to understand the information taught?	1 2 3 4 5 6
Were you able to ask questions and get helpful answers?	1 2 3 4 5 6
How helpful is/was the navigator in seeing you received the health care you needed and wanted while in the program?	1 2 3 4 5 6
How is/was your experience as a patient in the program?	1 2 3 4 5 6
How helpful was the follow-up phone call in seeing that you had everything needed to help you continue to recover at home?	1 2 3 4 5 6
If you were asked about the care given to	1 2 3 4 5 6

you while in the program, how would you describe it?	

Please feel free to give us **any comments** you would like about your experience during or after being a patient in the navigator program. The program's intent is to provide quality safe health care to all Medicare patients experiencing a heart attack. Your feedback is important!

_____

_____

_____

(If needed, please continue on the back of this form).

Appendix F: BPCMs for AMI

Patient name: _____

Date: _____

Appropriateness of Care for Acute Myocardial Infarction (AMI) (Composite AMI 1-10)

AMI – 1   Aspirin at Arrival   _____

AMI – 2   Aspirin at Discharge   _____

AMI – 3   ACEI or ARB for LVSD   _____

AMI - 4   Adult smoking cessation advice   _____

AMI – 5   Beta-blocker at discharge   _____

AMI - 7   Time to thrombolysis <30 minutes mean _____

AMI -7a   Fibrinolytic Therapy within 30 Minutes of Hospital _____
       Arrival

AMI – 8a   Primary PCI Received w/I 90 minutes of arrival _____

AMI – 9   Inpatient Mortality   _____

AMI – 10   Statin prescribed at discharge   _____

Joint Commission on Accreditation of Health Care Organizations. (n.d.). *Acute myocardial infarction core measure set.* Retrieved from http://www.jointcommission.org/assets/1/6/Acute%20Myocardial%20Infarction.pdf (Interchangeable with CMS-AMI core measures)

To be used by the navigator to determine if the BPCMs have been implemented for this AMI patient. Information may be obtained from the patient's electronic medical record (EMR).

Navigator needs to inform the appropriate healthcare provider of any measure not implemented to either get the measure implemented or obtain the reason measure was not implemented. (Use back of form if necessary to document information)

Measure(s) not implemented _____ and reason_____.

Appendix G: NPCEO

Patient name: _____ Date: _____

Answer as appropriate and/or write response to questions fully. Use back of form as necessary for documentation.

The Navigator will

- Obtain and review the AMI patient's baseline assessment information from the Electronic Medical Record (EMR) on admission or as soon as possible;

  Date information obtained _____

- Ensure that the AMI BPCMs are met prior to the patient's discharge; See BPCM form and document measures completed with date of completion. _____

- See that the patient(s) needs are met and reassessed in a timely manner; Need(s) identified and date_____

  Need(s) intervention(s) and date completed_____

  _____

- Complete discharge teaching for patient, family, and/or caregiver. List discharge information

  taught_____

  _____

- Complete a post discharge follow-up telephone call within two days after

  patient is discharged to identify and refer the patient(s) to resources as

  needed.

  Discharge date_____ Call date: _____
  Needs identified_____
  Intervention(s) _____

Appendix H: PECEO

Patient or Caregiver's name: _____

Date _____

The patient or caregiver will

- Verbalize the date of a follow-up appointment.

  Yes _____ Date is _____ patient/caregiver gave date as

  _____.

  No _____ navigator reviewed correct date with patient/caregiver. Return

  date for follow-up reviewed _____. Repeat process if needed

  until date is stated correctly. Document each follow-up until information

  given correctly. Document in the EMR.

  Make sure patient/caregiver has appointment card.

- Verbalize understanding of their discharge medication regimen.

  List each home medication's name, dose, route, frequency, and what it is

  for.

  Make sure patient/caregiver has a written copy of this information.

  Teach patient/caregiver this information and document date taught

  _____. Return date for follow-up

  _____.

  Document patient/caregiver understanding of medication. Correct any

  misunderstanding of medications on the EMR and interventions taken.

- State from which pharmacy they will obtain their medications and the payment method used to purchase said medications.

  Name of pharmacy medications will be obtained from and payment method used.

  _____

  Document information as appropriate in EMR.

- State where he/she will receive any needed rehabilitation care or where other resources will be obtained (such as dressing materials, etc.).

  Name of rehabilitation care facility and/or store for needed supplies

  _____

- State when a healthcare provider should be called for a specific problem to determine if the problem is or is not related to the AMI diagnosis and obtain any needed resources or treatment(s).

  Patient/caregiver identifies signs and symptoms needing immediate attention such as:

  List:

  _____

  _____

  _____

  _____

Make sure that all teaching information required by the facility has been gone over with the patient/caregiver prior to discharge and then goes home with patient/caregiver. List booklets or other information in whatever form given to patient/caregiver to take home. Document in EMR as appropriate.

_____

_____

_____

Appendix I: Evidence Based Practice Article Evaluations

Ratings Based on One Nurse's Opinion for Non-Research Articles

(1) Quality Rating for Clinical Practice Guidelines, Consensus or Position Statement (Level 4 quality) A=High B=Good C=Low or major flaws	(2) Quality Rating for Organizational Experience (Level 5 quality) A=High B=Good C=Low or major flaws	(3) Quality Rating for Literature Review, Expert Opinion, Community Standard, Clinician Experience, Consumer Preference (Level 5 quality) A=High B=Good C=Low or major flaws
See Reference Section for complete article references. Chart and Ratings were adapted from the Johns Hopkins Nursing Evidence-Based Practice: Model and Guidelines (2012), Second Edition, p. 244. For complete Chart and Ratings see the book page 244.		
Pedersen, A. E., & Hack, T. F. (2011). The British Columbia patient navigation model: A critical analysis. Rating: (1) = C, (2) = B, (3) = B		
Cornett, B. S., & Latimer, T. M. (2011). Managing hospital readmissions: An overview of the issues. Rating: (1) = C, (2) = B, (3) = B		
Birk, S. (2012). Reducing hospital readmissions. Rating: (1) = C, (2) = C, (3) = C		
Melinyshyn, S., & Wintonic, A. (2006). The role of the nurse navigator in the breast assessment program at Hotel Dieu Hospital. Rating: (1) = C, (2) = C, (3) = B		
Paskett, E. D., Harrop, J. P., & Wells, K. J. (2011). Patient navigation: An update on the state of the science. Rating: (1) = A, (2) = A, (3) = A		
Shockney, L. D. (2010). Evolution of patient navigation.		

Rating: (1) = C,   (2) = C,   (3) = B
Pederesen, A., & Hack, T. F. (2010). Pilots of oncology health care: A concept analysis of the patient navigator role. Rating: (1) = C,   (2) = B,   (3) = B
Robinson K. L., & Watters, S. (2010). Bridging the communication gap through implementation of a patient navigator program. Rating: (1) = C,   (2) = C,   (3) = B
Case, M. A. (2010). Oncology nurse navigator: Ensuring safe passage. Rating: (1) = C,   (2) = B,   (3) = B
Aspenson, M., & Hazaray, S. (2012). The clock is ticking on readmission penalties. Rating: (1) = C,   (2) = C,   (3) = C
Lacker, C. (2011). Decreasing 30-day readmission rates: Strategies for nurses from the trenches. Rating: (1) = C,   (2) = C,   (3) = B
Crowther, M. (2012). Heart failure readmissions: Can hospital care make a difference? Rating: (1) = C,   (2) = C,   (3) = C

Appendix J: Evidence Based Practice Article Evaluations

Ratings Based on One Nurse's Opinion for Research Articles

| Evidence Level (1), Experimental study, RCT, Systematic review of RCTs, with or without meta-analysis

Quality Guides

A= High B=Good C=Low or major flaws | Evidence Level (2), Quasi-experimental Study, Systematic review of RCTs, with or without meta-analysis

Quality Guides

A=High B=Good C=Low or major flaws | Evidence Level (3), Non-experimental study, Systematic review of a combination of RCTs and quasi-experimental and non-experimental with or without a meta-synthesis

Quality Guides

A=High B=Good C=Low or major flaws | Evidence Level (4), opinion of respected authorities and/or nationally recognized expert/panel based on scientific evidence Includes: Clinical practice guidelines, and consensus panels

Quality Guides

A=High B=Good C=Low or major flaws | Evidence Level (5), Based on experiential and non-research evidence. Includes: Literature reviews, quality improvement, program or financial evaluation, case reports, opinion of nationally recognized experts based on experiential evidence

Quality Guides

Organizational Experience:

A=High B=Good C=Low or major flaws

Literature Review…Consumer Preference:

A=High B=Good C=Low or major flaws |
|---|---|---|---|---|
| See Reference Section for complete article references.

Chart and Quality Guides were adapted from the Johns Hopkins Nursing Evidence-Based Practice: Model and Guidelines (2012), Second Edition, p 232-233. For complete Chart and Quality Guides see pages 232-233. | | | | |

Olsen, J., & Coleman, J. R. (2001). Using continuous quality improvement techniques to determine the causes of hospital readmission.

Quality Guide: (1) = N/A,   (2) = N/A,   (3) = C,   (4) = C,   (5) = B/B

Wells, J. K., Battaglia, T. A., Dudley, D. J., Garcia, R., Greene, A., Calhoun, E., …Raich, P. C. (2008). Patient navigation: State of the art, or is it science?

Quality Guide: (1) = N/A,   (2) = N/A,   (3) = B,   (4) = A,   (5) = A/A

Thygesen, M. K., Pedersen, B. D., Kragstrup, J., Wagner, L., & Mogensen, O. (2012). Gynecological cancer patients' differentiated use of help from a nurse navigator: A qualitative study.

Quality Guide: (1) = N/A,   (2) = N/A,   (3) = A,   (4) = B,   (5) = B/B

Thygesen, M. K., Pedersen, B. D., Kragstrup, J., Wagner, L., & Mogensen, O. (2011). Benefits and challenges perceived by patients with cancer when offered a nurse navigator.

Quality Guide: (1) = N/A,   (2) = N/A,   (3) = C,   (4) = B,   (5) = B/B

Swanson, J., & Koch, L. (2010). The role of the oncology nurse navigator in distress management of adult in patients with cancer: A retrospective study.

Quality Guide: (1) = N/A,   (2) = N/A,   (3) = B,   (4) = B,   (5) = A/B

Lee, T., Ko, I., Lee, I., Kim, E., Shin, M., Rah, S., … Chang, H. (2011). Effects of nurse navigators on health outcomes of cancer patients.

Quality Guide: (1) = N/A,   (2) = N/A,   (3) = A,   (4) = A,   (5) = A/A

McHugh, M. D., & Ma, C. (2013). Hospital nursing and 30-day readmission among Medicare patients with Heart failure, acute myocardial, and pneumonia.

Quality Guide: (1) = N/A,   (2) = N/A,   (3) = C,   (4) = A,   (5) = B/B

Boulding, W., Blickman, S. W., Manary, M. P., Schulman, K. A., & Staelin, R. (2011). Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days.

Quality Guide: (1) = N/A,   (2) = N/A,   (3) = C,   (4) = C,   (5) = C/B

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Bradley, E. H., Curry, L., Horwitz, L. I., Sipsma, H., Thompson, J. W., Elma, MA., …
Krumholz, H. M. (2012). Contemporary evidence about hospital strategies for reducing
30-day readmissions.

Quality Guide: (1) = N/A,   (2) = N/A,   (3) = A,   (4) = B,   (5) = B/B

Schmeida, M., & Savrin, R. A. (2012). Heart failure rehospitalization of the Medicare
FFS patient.

Quality Guide: (1) = N/A,   (2) = N/A,   (3) = A,   (4) = C,   (5) = B/B

Hasan, O., Meltzer, D. O., Shaykevich, S. A., Bell, C. M., Kaboli, P. J., Auerbach, A. D.,
… Schnipper, J. L. (2009). Hospital readmission in general medicine patients: A
prediction model.

Quality Guide: (1) = N/A,   (2) = N/A,   (3) = B,   (4) = C,   (5) = A/C

Krumholz, H. M., Lin, Z., Drye, E. E., Desai, M. M., Han, L. F., Rapp, M. T., …
Normand, S. T. (2001). An administrative claims measure suitable for profiling hospital
performance based on 30-day all-cause readmission rates among patients with acute
myocardial infarction.

Quality Guide: (1) = N/A,   (2) = N/A,   (3) = B,   (4) = B,   (5) = A/B