Nurse Navigators: Improve Patient Transitions to Home, Cut Readmissions

By Heather Peiritsch MSN, RN and Katora Campbell MSN, RN-BC

Tuesday December 11, 2018
1:30pm-2:45pm

#IHIFORUM
Nothing to disclose

- Heather Peiritsch MSN, RN and Katora Campbell MSN, RN-BC today have no relevant financial or nonfinancial relationship(s) within the services described, reviewed, evaluated, or compared in this presentation.
Session Objectives

• 1. At the completion of this session, participants will be able to identify value of two nurse led models in reducing hospital readmissions.

• 2. At the completion of the session, participants will be able to identify the role of partnerships with post-acute community organizations.

• 3. At the completion of this session, participants will be able to describe the components of two nurse-led models that could be replicated in various hospitals or community settings.
Why Nurse A Navigation Program?

Heather Peiritsch MSN, RN
Abington Jefferson Health
Bundle Payment Program Manager
Heather.Peiritsch@jefferson.edu
Hospital Readmissions Reduction Program

Bundled Payments for Care Improvement (BPCI) Initiative

Bundled Payments for Care Improvement Advanced (BPCI-A)

2012

Risk adjusted readmissions within 30 days of discharge:
AMI, CABG, COPD, Elective THA/TKA, HF, PN

2012

Payments linked for multiple services beneficiaries receive during an episode of care.
Include financial and performance accountability

2018

New iteration of bundled payments, align incentives for reducing expenditures and improving quality of care. Qualifies as an APM.

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/HRRP/Hospital-Readmission-Reduction-Program.html

https://innovation.cms.gov/initiatives/bundled-payments/
The IHI Triple Aim

http://www.ihi.org/Engage/Initiatives/TripleAim
Abington’s Navigation Program Goals

**Cost**
- Readmission Reduction
- SNF placement and SNF LOS
  - Patients will go to the safest, lowest level of care as soon as medically stable

**Quality**
- Care Redesign
- Patient satisfaction and Engagement
  - Patients will have a great hospital experience

**Coordination**
- Acute and post-acute provider alignment
  - Patients will have excellent care coordination
# Abington Navigation Program Goals

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>Patients will go to the</td>
<td>Patients will have a</td>
<td>Patients will have</td>
</tr>
<tr>
<td>safest, lowest level of</td>
<td>great hospital experience</td>
<td>excellent care coordination</td>
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<tr>
<td>care as soon as medically</td>
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<tr>
<td>stable</td>
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</tbody>
</table>

- "Home First" focus
- Decrease SNF length of stay
- Reduction of Medicare expenditures

<p>| | | |</p>
<table>
<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>Educate inpatient teams</td>
<td>Nurse Navigator</td>
</tr>
<tr>
<td></td>
<td>about navigation program</td>
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<td></td>
<td>Redesign inpatient care to</td>
<td>Coordinate care with post</td>
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<tr>
<td></td>
<td>support initiatives</td>
<td>acute providers: preferred</td>
</tr>
<tr>
<td></td>
<td></td>
<td>providers and other</td>
</tr>
<tr>
<td></td>
<td></td>
<td>community providers</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Patient is at center of care</td>
<td>Reduction of readmissions</td>
</tr>
</tbody>
</table>


The Nurse Navigator

- Meets patient and/or family in the hospital
- Calls patients 24-72 hours after discharge
- Collaborates with multidisciplinary inpatient and outpatient teams
- Follows the patient 90 days after hospital discharge
The Nurse Navigator
Engages the patient/caregiver to develop strategies to guide positive change and self-responsibility for managing their disease process.

Goal Setting
Teach Back Technique
Motivational Interviewing
### Nurse Navigator

- Develops “Zone” management action plan
- Educates patient, caregiver and community partners
  - Signs and Symptoms
  - No added sodium diet
  - Daily weights
  - Who to call and when

#### Controlling heart failure at home

**How do I feel today?**

<table>
<thead>
<tr>
<th>Green zone</th>
<th>Yellow zone</th>
<th>Red zone</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>You are in control.</strong></td>
<td><strong>Take action today.</strong></td>
<td><strong>Take action now!</strong></td>
</tr>
<tr>
<td>Call:</td>
<td>Call:</td>
<td></td>
</tr>
<tr>
<td><strong>Is my weight up?</strong>&lt;br&gt;My healthy weight:</td>
<td>No change in my weight.</td>
<td>My weight is up:&lt;br&gt;• 3 pounds overnight&lt;br&gt;• 5 pounds since last week</td>
</tr>
<tr>
<td><strong>Do I have swelling?</strong>&lt;br&gt;I do not have swelling.</td>
<td>I have swelling in my:&lt;br&gt;• Foot, ankle or shin&lt;br&gt;• Knee or thigh</td>
<td>I have swelling in my:&lt;br&gt;• Belly – feels bloated or pants are tighter&lt;br&gt;• Hands or face</td>
</tr>
<tr>
<td><strong>Am I short of breath?</strong>&lt;br&gt;I do not feel short of breath:&lt;br&gt;• Breathing is normal&lt;br&gt;• Sleep is normal</td>
<td>I feel short of breath or cough while:&lt;br&gt;• Walking or talking&lt;br&gt;• Eating&lt;br&gt;• Bathing or dressing&lt;br&gt; I need to use more pillows when I sleep.</td>
<td>I feel:&lt;br&gt;• Short of breath or wheeze at rest&lt;br&gt;• Less alert&lt;br&gt; I need to sleep sitting up to breathe.</td>
</tr>
<tr>
<td><strong>How is my energy level?</strong>&lt;br&gt;My energy level is normal.</td>
<td>I am too tired to do most of my normal activities.</td>
<td>I am so tired that I can hardly do any of my normal activities.</td>
</tr>
<tr>
<td><strong>My other signs of heart failure:</strong></td>
<td></td>
<td>Chest pain or pressure that does not go away.</td>
</tr>
</tbody>
</table>

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The Nurse Navigator

- Recommends patient to see a care provider within 7-14 days
- Performs thorough clinical assessment
- Clarifies discharge instructions and completes medication reconciliation
The Nurse Navigator

- Initiates referrals to community agencies and services
- Documents assessments and interventions in the EMR
- Tracks patient location and level of care
- Provides warm handover to next level of care upon discharge
Post Acute Community Partners
Benefits of a Post Acute Network

- Patient-centered care
- Development of new relationships amongst healthcare providers, homecare agencies and facilities
- Decreased variation in care practices
- Decreased 30 and 90-day readmission rates
- Increased education and quality of care
Networking a Pathway to Quality

Primary Care Physician
- Practice Care Managers
- Pharmacist
- Behavioral Health Specialist
- Social Work
- Zone Management Education
- Same day sick appointments
- Advanced Care Planning

Homecare
- Coordination of Care
- Zone Management Education
- Specialized teams
- Goals of Care
- Readmission Review
- Tele-monitoring

Patient

Skilled Nursing Facility
- Monthly leadership meetings
- Best Practice Guidelines
- Zone Management Education
- Weekly patient updates
Networking a Pathway to Quality

Skilled Nursing Facilities

Goals: Decrease utilization, Decrease length of stay

- Preferred Providers ➔ Medical Directors
  - Scorecard transparency of data analysis
  - High quality ratings, high volume
- Hospital nurse to SNF nurse handoff
- Weekly report – clinical, functional, disposition
- Timely readmission review and feedback
- On site continuing education
### SNF Facility - CMS Data April 2016

<table>
<thead>
<tr>
<th>Unit(s)</th>
<th>Desired Direction</th>
<th>As Of</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>Variance</th>
<th>PA Goal</th>
<th>National Avg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall Star Rating (out of 5)</td>
<td>▲ 7/26/2016</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Inspection</td>
<td>▲ 7/26/2016</td>
<td>4</td>
<td>4</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staffing</td>
<td>▲ 7/26/2016</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>5</td>
<td>4</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quality Measures</td>
<td>▲ 7/26/2016</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>5</td>
<td>3</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% improvement in function</td>
<td>▲ 7/26/2016</td>
<td>57%</td>
<td>66%</td>
<td>77%</td>
<td>73%</td>
<td>54%</td>
<td>74%</td>
<td>63%</td>
<td>64%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% hospitalized after a nursing home admission</td>
<td>▼ 7/26/2016</td>
<td>17%</td>
<td>27%</td>
<td>33%</td>
<td>30%</td>
<td>24%</td>
<td>17%</td>
<td>20%</td>
<td>21%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% who had an outpatient ED visit</td>
<td>▼ 7/26/2016</td>
<td>9%</td>
<td>9%</td>
<td>11%</td>
<td>12%</td>
<td>9%</td>
<td>11%</td>
<td>10%</td>
<td>12%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>% successfully discharged into the community</td>
<td>▲ 7/26/2016</td>
<td>67%</td>
<td>63%</td>
<td>69%</td>
<td>41%</td>
<td>58%</td>
<td>67%</td>
<td>55%</td>
<td>55%</td>
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</tbody>
</table>

### BUNDLE STATISTICS

<table>
<thead>
<tr>
<th>Unit(s)</th>
<th>Desired Direction</th>
<th>As Of</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>D</th>
<th>D</th>
<th>Variance</th>
<th>Benchmark</th>
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<tbody>
<tr>
<td>HF Patients</td>
<td></td>
<td>7/15/2016</td>
<td>9.00</td>
<td>2.00</td>
<td>0.00</td>
<td>0.00</td>
<td>13.00</td>
<td>12.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF Readmission</td>
<td>▼ 7/15/2016</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>7%</td>
<td>9%</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HF LOS (episode)</td>
<td></td>
<td>7/15/2016</td>
<td>23.00</td>
<td>21.00</td>
<td>0.00</td>
<td>0.00</td>
<td>18.00</td>
<td>14.00</td>
<td>14 days</td>
<td></td>
</tr>
<tr>
<td>HF LOS (occurrences)</td>
<td></td>
<td>7/15/2016</td>
<td>23.00</td>
<td>21.00</td>
<td>0.00</td>
<td>0.00</td>
<td>17.00</td>
<td>12.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke Patients</td>
<td></td>
<td>7/15/2016</td>
<td>8.00</td>
<td>6.00</td>
<td>4.00</td>
<td>0.00</td>
<td>10.00</td>
<td>8.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke Readmission</td>
<td>▼ 7/15/2016</td>
<td>5%</td>
<td>0.00</td>
<td>5%</td>
<td>0.00</td>
<td>5%</td>
<td>3%</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stroke LOS (episode)</td>
<td></td>
<td>7/15/2016</td>
<td>24.00</td>
<td>24.00</td>
<td>17.00</td>
<td>0.00</td>
<td>25.00</td>
<td>21.00</td>
<td>21 days</td>
<td></td>
</tr>
<tr>
<td>Stroke LOS (occurrences)</td>
<td></td>
<td>7/15/2016</td>
<td>18.00</td>
<td>24.00</td>
<td>13.00</td>
<td>0.00</td>
<td>21.00</td>
<td>19.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Point Value (out of 24 points)</td>
<td></td>
<td>7/15/2016</td>
<td>16</td>
<td>17</td>
<td>12</td>
<td>11</td>
<td>11</td>
<td>17</td>
<td></td>
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</tr>
</tbody>
</table>
Outcomes
Continuing Education

Forging Partnerships in the Continuum of Care Symposium (2016, 2017 & 2018)

- Promoting Safe Patient Handoffs
- Increased Communication leads to Positive Patient Outcomes
- Zone Education
- Utilizing Home Tele-monitoring
- Enhancing Communication with the ER
- Patient Satisfaction Strategies
- Skills for Identification and Care Planning for End of Life
- Disease Specific Best Practices and Teachings
| 1 | **Patient Name:** _______________________________  | **DOB:**__/__/____  |
|   | **Facility Name:** ___________________  | **Nurse leader cell phone#:** __________   |
|   | **Covering Provider cell phone #:** ___________________ |
| 2 | **Reason for Transfer / Consultation Question:** |
|   | - [ ] Fall / Injury:  | - [ ] Witnessed  | - [ ] Unwitnessed  | - [ ] Head trauma-known or possible  | - [ ] No head trauma  |
|   | - [ ] Localized pain  | - [ ] Suspected fracture: ____________________  |
|   | - [ ] X-ray done  | - [ ] Y  | - [ ] N  | - [ ] Blood thinners  | - [ ] Y  | - [ ] N  |
|   | - [ ] Change in baseline mental status:  | - [ ] Y  | - [ ] N  , if yes, last time known to be well: ____________________  |
|   | - [ ] Indicate baseline mental status: ____________________  |
|   | - [ ] Sign and Symptoms that patient has:  | - [ ] Resp. distress / hypoxia  | - [ ] Altered mental status  |
|   | - [ ] Hypotension  | - [ ] Hypertension  | - [ ] Chest pain  | - [ ] Shortness of Breath  |
|   | - [ ] Weight gain  | - [ ] High or Low Temperature  | - [ ] cough  | - [ ] diarrhea  |
|   | - [ ] Adverse drug event:  | - [ ] Rash  | Other symptoms: ____________________  |
|   | - [ ] Other: ____________________  |
|   | **Transfer to ETC at the request of:**  | - [ ] Patient  | - [ ] Family  | - [ ] Physician  | - [ ] Other  |
|   | **READMISSION ALERT?** (Last hospital DC < 30 days)  | - [ ] YES  | - [ ] NO  , If yes, hospital name ____________________  |
| 3 | **Document Checklist** (ensure all sent with Pt)  | **Nursing Facility Capabilities:**  |
|   | - [ ] Code Status / POLST  | - [ ] IVF  | - [ ] IV Antibiotics  | - [ ] Laboratory Testing  |
|   | - [ ] Current meds (with route, schedule, last dose)  | - [ ] Lovenox  | - [ ] IV Diuretics  | - [ ] Other  |
|   | - [ ] Key progress notes / labs / radiology  | *see opposite side for more extensive list  |
|   | - [ ] MD/NP can see tomorrow?  |
| 4 | **Abington ETC Completes**  |
|   | **ETC Provider please call covering Facility Provider with your questions or concerns**  |
|   | **ETC Diagnosis:**  |
|   | **Suggested treatment Plan:**  |
|   | **Perceived Need at Nursing Facility:**  |
|   | - [ ] IVF  | - [ ] IV Antibiotics  | - [ ] Laboratory Testing  |
|   | - [ ] Lovenox  | - [ ] IV Diuretics  | - [ ] Other:  |
|   | **Facility Physician/Provider to see patient tomorrow?**  | - [ ] Yes  | - [ ] No  |
|   | **ETC Physician:** ____________________  |
|   | **Facility Transfer Checklist (AH ETC Completes)**  |
|   | - [ ] Facility Confirms able to execute plan  |
|   | - [ ] TIMING Facility Confirms able to accept patient  | A) immediately  | B) 4-6 hrs  | c) 6-12 hrs  |
|   | *Options B and C - patient will not be readmitted back to the SNF  |
Facility: ______________________________________

Please fill out the below portion with the options: immediately, # of minutes, # hours or # days to indicate how long it will take for you to get the necessary people/supplies/medications to care for a returning patient.

<table>
<thead>
<tr>
<th>Capabilities</th>
<th>Expected time frame</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Frequency of Prescribing Care Provider</strong></td>
<td></td>
</tr>
<tr>
<td>(e.g., MD/NP/PA) in the Building</td>
<td></td>
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<tr>
<td><strong>Diagnostic Testing:</strong></td>
<td></td>
</tr>
<tr>
<td>Turn around for stat labs</td>
<td></td>
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<tr>
<td>Turn around for xray</td>
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<tr>
<td>EKG</td>
<td></td>
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<tr>
<td>Bladder Ultrasound</td>
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<tr>
<td>Venous Doppler</td>
<td></td>
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<tr>
<td>Swallow Studies</td>
<td></td>
</tr>
<tr>
<td><strong>Therapies on Site:</strong></td>
<td></td>
</tr>
<tr>
<td>OT, PT, ST, RT</td>
<td></td>
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<tr>
<td><strong>Nursing Services:</strong></td>
<td></td>
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<tr>
<td>Frequent vital signs (q 2 hours)</td>
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<tr>
<td>Strict I&amp; O monitoring</td>
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<tr>
<td>Daily weights</td>
<td></td>
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<tr>
<td>Accuchecks</td>
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<tr>
<td>Oxygen</td>
<td></td>
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<tr>
<td>Nebulizer treatments</td>
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<tr>
<td>BiPAP, CPAP capabilities</td>
<td></td>
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<tr>
<td>Incentive Spirometry</td>
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<tr>
<td><strong>Interventions:</strong></td>
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<tr>
<td>IV fluids</td>
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<tr>
<td>IV antibiotics</td>
<td></td>
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<tr>
<td>IV push medications</td>
<td></td>
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<tr>
<td>PICC insertion</td>
<td></td>
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<tr>
<td>PICC management</td>
<td></td>
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<tr>
<td>TPN</td>
<td></td>
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<tr>
<td>Isolation</td>
<td></td>
</tr>
<tr>
<td>Surgical drain management</td>
<td></td>
</tr>
<tr>
<td>Tracheostomy management</td>
<td></td>
</tr>
<tr>
<td>Analgesic pumps</td>
<td></td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy Services:</strong></td>
<td></td>
</tr>
<tr>
<td>New medications filled</td>
<td></td>
</tr>
<tr>
<td>Narcotic medications filled</td>
<td></td>
</tr>
</tbody>
</table>
Jefferson Health  SNF Heart Failure/COPD Educational Session

Outline of Program

Purpose: to implement a set of tools to optimize the care of residents with heart failure (HF) and COPD and to improve outcomes and prevent hospital readmission.

8:00am: Registration

8:30-8:45: Preadmission- process for how the Admissions Coordinator will determine from the hospital care coordinators whether HF/COPD diagnosis is present

8:45-10:00: Admission
  Nurse to Nurse report
  HF/COPD Admission Order Sets
  HF/COPD Consent to treatment

10:00-10:15: Break

10:15-12:00: Interval care
  HF/COPD nurse education
  HF/COPD CNA education
  (Includes Stoplight tool education)

12:00-12:30: Lunch

12:30-1:30: Readmission Prevention
  SBAR tool for a change in condition
  SNF-ETC consent tool
  In house initiatives for prevention

1:30-2:30: Discharge planning
  Standardized process for making PCP f/u appointment within 7 days of SNF discharge
  Communication with home care team and PCP
  Educational materials given to patients at time of discharge

2:30-2:45: Break

2:45-4:00: Case Studies
Preferred Provider Length of Stay

- Data retrieved from McKesson Homecare database

- Line chart showing preferred provider length of stay from FY16 Q2 to FY18 Q4, with 90-day benchmark.

- Two lines representing HF Length of stay (blue) and Stroke Length of stay (brown).

- The chart indicates fluctuations in length of stay over time.
90 day readmission rate

Data retrieved from McKesson Homecare database
# Heart Failure Bundle Dashboard

**DRG 291, 292, 293**

<table>
<thead>
<tr>
<th>GOAL</th>
<th>CMS Baseline 2009-2012</th>
<th>October 1 2015-September 30 2018</th>
<th>Change From Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the number of heart failure bundle patients admitted to SNFs</td>
<td>26.8%</td>
<td>24.8%</td>
<td>2%</td>
</tr>
<tr>
<td>Reduce SNF days for Stroke bundle patients:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Providers:</td>
<td>26.05 days</td>
<td>21.85 days</td>
<td>4.2 days</td>
</tr>
<tr>
<td>Non Preferred Providers:</td>
<td>28.01</td>
<td>28.12</td>
<td>-0.11 days</td>
</tr>
<tr>
<td>Reduce HF Bundle 90 day Readmissions</td>
<td>57.6%</td>
<td>44.2%</td>
<td>13.4%</td>
</tr>
</tbody>
</table>

Data retrieved from McKesson Homecare database
### Stroke Bundle Dashboard
**DRG 61, 62, 63, 64, 65, 66**

<table>
<thead>
<tr>
<th>GOAL</th>
<th>CMS Baseline 2009-2012</th>
<th>October 1 2015-September 30 2018</th>
<th>Change From Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the number of Stroke bundle patients admitted to SNFs</td>
<td>27.9%</td>
<td>27.4%</td>
<td>0.5%</td>
</tr>
<tr>
<td>Reduce SNF days for Stroke bundle patients:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preferred Providers:</td>
<td>35.50 days</td>
<td>25.03 days</td>
<td>10.47 days</td>
</tr>
<tr>
<td>Non Preferred Providers:</td>
<td>33.61 days</td>
<td>29.95</td>
<td>3.66 days</td>
</tr>
<tr>
<td>Reduce Stroke Bundle 90 day Readmissions</td>
<td>31.5%</td>
<td>26.8%</td>
<td>4.7%</td>
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</tbody>
</table>

Data retrieved from McKesson Homecare database
Data retrieved from McKesson Homecare database
Excess Readmission Ratio

- AMI
- HF
- CABG
- COPD

<table>
<thead>
<tr>
<th>Month</th>
<th>AMI</th>
<th>HF</th>
<th>CABG</th>
<th>COPD</th>
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</thead>
<tbody>
<tr>
<td>Jun-13</td>
<td>1.0766</td>
<td>1.0910</td>
<td>1.0766</td>
<td>0.9841</td>
</tr>
<tr>
<td>Jun-14</td>
<td>1.1193</td>
<td>1.1160</td>
<td>1.1193</td>
<td>1.0125</td>
</tr>
<tr>
<td>Jun-15</td>
<td>1.0875</td>
<td>1.1399</td>
<td>1.0875</td>
<td>1.0084</td>
</tr>
<tr>
<td>Jun-16</td>
<td>1.0778</td>
<td>1.0893</td>
<td>1.0778</td>
<td>1.0882</td>
</tr>
<tr>
<td>Jun-17</td>
<td>1.0089</td>
<td>1.0089</td>
<td>1.0089</td>
<td>0.9601</td>
</tr>
</tbody>
</table>

Comparing the excess readmission ratios for different conditions over the years from June 2013 to June 2017, it shows that the AMI condition had the highest ratio in June 2014, while COPD had the lowest ratio in June 2017.
HHRP Penalty for Abington Hospital - Jefferson Health

April 2015 - Start of Nurse Navigation Program
Great Saves—Learning Opportunities
Stroke Readmission Prevention

**Situation**
- 9/7/18: Patient having headaches in the middle of the night.
- Last CT 8/21/18 showed improvement; saw Neurologist on 8/24 with plan to f/u in 30 days.
- On oxycodone for his chronic back pain, states his headache during the day is a "3" and not constant

**Background**
- Original IP Admission dates: 8/10/18-8/13/18
- 49 yo on Medicare due to back injury.
- Coded into the stroke bundle as a “Non-traumatic bleed”
Great Saves—Learning Opportunities
Stroke Readmission Prevention

- **Assessment**
  - Pt asked nurse navigator "if I have to live with these headaches and should I get a second opinion" also stated “I do not want to bother the doctors.”
  - Nurse navigator stated the doctor should be made aware and offered to call the office for him. Pt agreeable.
  - Office nurse stated patient should go to ER.

- **Recommendation**
  - Nurse navigator instructed patient to go to ETC for a CT scan, he needed coaxing, agreed to go, then called back an hour later saying "I feel good and really don't think I need to go to the ER”.
  - Support provided again, explained doctor wanted to see if there was a change on the CT scan
  - Patient agreed to go to the ER.
Great Saves—Learning Opportunities
Stroke Readmission Prevention

- **Result:**
  - ✓ ETC = +CT
    - ✓**** CT with increase in mixed density left subdural hematoma with *increase in mass effect* and *mid-line shift c/w recurrent bleeding* within the prior subdural hematoma.
  - ✓ Admitted and went to the OR for burr hole evacuation and then to Neuro ICU.
  - ✓ Discharged 9/11/18 to home
  - ✓ Pt grateful……praised the nurse navigator for all her patience and care. Stated he would not be here today if it weren’t for her persistence.
Faith Community Nurse Transitional Care Research Project

Katora Campbell, MSN, DrPH, RN-BC
Director Westberg Institute
Connecting care from hospital to home
Early detection of actual or potential issues
Support of collaboration and communication
Accessible health professional
Faith Community Nurse Transitional Care Research Project

Issue: Need to improve transitional care

Goals:
- Reduce readmission rates
- Demonstrate the FCN role and Congregational Care Team in transitional care
- To align the resources of the hospital and faith community to transition patients to the home setting
Faith Community Nurse Transitional Care Research Project

- IRB approval for Quasi-experimental research study
- Development of literature review, resources, and curriculum
- FCN Transitional Care Training & Module
- Transitional Care Ministry Groups Orientation
- Data collection
  - Hospital (quantitative data)
  - FCNs documentation (NICs)
- Publish results
Requirements of Research Partners

- Commit to 2-year period
- One or more paid, full-time faith community nurse
- Agreement between hospital and faith community
- Faith Community agrees to form Transitional Care Ministry Groups
- Hospital and FCN assist project staff in establishing data sharing methods and measures
- Establish inpatient procedure for referral to FCN
Key Partnerships

Transitional Care Post-Discharge Patients

Faith Community

Westberg Institute for Faith Community Nursing (Church Health)
- Evaluation and Outcome measures
- Data collection and Documentation Tools
- Transition Care Plan tool and Orientation
- Care Team Orientation

Hospital/Healthcare
Patient Centered Care, FCN is the Bridge

HOSPITAL
- Discharge Planners
- Case Managers
- Faith Community Nurse

PATIENT
- Admitted
- Faith Community Nurse
- Transitional Care Ministry Groups
- Primary Care
- Community Resources

TRANSITIONAL CARE
- Faith Community Nurse
- Discharged
Faith Community Nurse (FCN) Transitional Care Model  
(Ziebarth & Campbell, 2015)

**Referral to FCN**
- Hospital staff makes referral to FCN

**1st visit**  
Hospital by FCN

**Discharge planning by FCN**
- FCN earns trust
- Hospital staff makes referral to FCN

**Discharged**

**2nd visit**  
Home by FCN within 72 hrs.

**3rd visit**  
To Physician by Patient & FCN

**Faith Community (FC) Volunteer Group**

**Transition To Self Care**

**Pre-discharge**
- First Visit
  - Open record & develop care plan
  - Transitional Care Program Brochure
  - “Taking Care of Yourself” booklet
  - Introduction to staff as a team member
- Discharge assessment and planning
  - Patient’s Assets
  - Medical needs
  - Non-medical needs
  - Meeting with discharge planner or care manager
  - Physician Introduction letter

**Post-discharge**
- Extra Hospital Visit (if needed)
  - Second hospital visit with patient
  - Or follow-up with discharge planner / case manager
- Second Visit
  - Assessment
    - Safety
    - Spiritual
    - Sociological
    - Physical Psycho-
  - Medication review
  - Screenings (vitals)
  - Disease education
  - Clinic visits scheduled
  - Resources & Referrals
  - Refer to Visitation Guidelines

- Initial Physician Visit with Patient, Caregiver, and FCN
  - Refer to “Visitation Guidelines” booklet

- Faith Community
  - Provide social supports (Meals, Cards, Visitation, and Transportation)
  - Refer to “Tools for Developing and Sustaining a Volunteer Ministry” booklet

- Based on assessment and care plan, FCN will plan contacts such as phone checks or added home visits, with goal to transition to self-care or caregiver within 60 days

**Transitional Care**
Faith Community Nurse Roles

Post-Discharge Care

- Spiritual care and socialization
- Medication review
- Assessments and disease surveillance
- Acute and chronic disease(s) education
- Coordination of physician/clinic visits
- Coordination of resources and referrals
- Coordination of Transitional Care Ministry Groups
- Advocacy and self efficacy
Transitional Care Ministry Groups

- Non medical support as needed
- Transportation
- Meals
- Social support
- Home visits
- Phone and mail contact
- Other as needed
Faith Community Nurse Interventions

Transitional Care
6 Key Interventions

- Medication Review
- Self-Care Education
- Spiritual Care
- Resource Coordination
- Critical Contacts
- Care Coordination
FCN Interventions in Transition Care

Transition from hospital to home

- Inpatient Settings
- Self-care Education
- Spiritual Care
- Critical Contacts
- Care Coordination
- Resource Coordination
- Home Settings
- Medication Review
Who is at risk for Readmission?

- 5 or more medications
- Poor participation in self-care
- One or more chronic diseases
- No support or assistance in the home
- Problems in cognitive or functional abilities
- Previous readmissions
Medication Review

- Reconciliation of medications
- Patient and caregiver education
- Provider communications

"NO, I HAVE NO MEDICAL HISTORY BUT HERE ARE MY MEDICATIONS."
Self-Care Education

- Evidence-based tools:
- Disease specific self care
  - Signs & symptoms of change in condition
  - Self-management
  - Who/When to call for assistance and information
Spiritual Care

- Promote positive outlook on self-care and health status
- Support Self-efficacy and empowerment

"I suggest you roll up in a tight little ball until the danger is passed."
Critical Contacts

4 Types of contact with patients:

1) Hospital Visits
2) Home Visits
3) Primary Care Provider Visits
4) Phone contacts

HIPPPA and Patient Privacy

"I haven't been feeling well, so I checked with my medical doctor, 'Dr. Google.' It seems that I have a fractured uterus."
Care Coordination

- Supports the care continuum across transitioning settings
- Advocacy

"MY INSURANCE DOES NOT COVER SCREENING SO THE DOCTOR GAVE ME A REFERRAL TO THE AIRPORT FOR FREE MAMMOGRAM X-RAY AND CHEST PAT DOWN."
Resource Coordination

Non-medical support

Extended Caregiver support
- Family, friends
- Community programs

Faith Community support ministries
- Transportation
- Food/meals
- Social support
Advantages for Faith Communities

- Provide one or more caring programs that can have a tremendous impact on the health and well-being of those served
- Outreach efforts well aligned to serve those with unique need in their community that are often overlooked
- Opportunity to demonstrate the church’s mission and vision in community
Care beyond 6 transitional interventions

Transition from hospital to home

- Spiritual Care
- Medication Review
- Self-Care Education
- Resource Coordination
- Critical Contacts
- Care Coordination
- Self-Care Education
- Transition from hospital to home
- Care Coordination
Study Locations

Memorial Hospital
Jasper Indiana
- No randomization
- Quantitative study:
  - FCN vs. Usual care
- Qualitative study
- Eligibility: readmission history
- 1 FCN, 2 churches
- September 2015 started
- Final October 2016

Baptist Hospital
Desoto, Mississippi
- Randomized
- 2 quantitative studies:
  - FCN vs. BOOST
  - FCN vs. Retrospective Group
- Qualitative study
- Eligibility: readmission history
- 1 FCN, 4 churches
- March 2016 started
- Final: February 2018
Faith Community Nursing Transitional Care Study
Qualitative Approach

Deborah Ziebarth, PhD, MSN-Ed, RN-BC, Herzing University

- Describe nursing interventions used by FCNs during transitional care, Nursing Intervention Classification (NIC)
- Identify most frequent nursing interventions implemented by FCNs during transitional care
- Compare interventions performed by FCNs during transitional care to previous evidence-based literature on transitional care.

- Mixed method descriptive approach
  - Qualitative analysis - describe transitional care interventions
  - Quantitative design - count categories of interventions
Faith Community Nursing Transitional Care Study

Qualitative Approach

- **1556** total interventions documented
- FCNs provided similar interventions as those found in literature that were identified as important for transitional care that reduces readmissions.
- Insight into the variety of evidence-based “priority” transitional care interventions provided by FCNs.
- FCNs’ provide additional emotional & spiritual support interventions in transitional care, which may further help reduce readmissions.
FCN care aligns with interventions that reduce readmissions found in research literature.

<table>
<thead>
<tr>
<th>Transitional Care Interventions in Research literature</th>
<th>FCN Interventions while providing Transitional Care</th>
<th>Description of interventions*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Follow-up phone calls</strong></td>
<td>Telephone Consultation</td>
<td>Eliciting patient's concerns, listening, and providing support, information, or teaching in response to patient's stated concerns, over the telephone.</td>
</tr>
<tr>
<td></td>
<td>Telephone Follow-up</td>
<td>Evaluating patient's response and determining potential for problems as a result of previous treatment, examination, or testing, over the telephone.</td>
</tr>
<tr>
<td><strong>Home visits</strong></td>
<td>Listening visits</td>
<td>Empathic listening to genuinely understanding an individual's situation and work collaboratively over a number of home visits to identify and generate solutions to reduce depressive symptoms.</td>
</tr>
<tr>
<td></td>
<td>Active listening</td>
<td>Attending closely to and attaching significance to a patient's verbal and nonverbal messages.</td>
</tr>
<tr>
<td><strong>Medication reconciliation</strong></td>
<td>Medication Management</td>
<td>Facilitation of safe and effective use of prescription and over-the-counter drugs.</td>
</tr>
</tbody>
</table>
Faith Community Nursing Transitional Care Study
Quantitative Approach

SangNam Ahn, MPH, PhD, Data Analyst, University of Memphis

- Compare participant socio-demographic characteristics and primary/secondary diagnoses between treatment and comparison groups
- Evaluate the effectiveness of FCN on reducing LOS in six months after discharge
- Measure the effectiveness of FCN on the number of ER or inpatient visits in six months after discharge

Design: Pre- & multiple post-test design to estimate treatment effects in an Indiana hospital
Faith Community Nursing Transitional Care Study

Quantitative Preliminary Analysis

A Propensity Score Matching Analysis

Two-groups:
- FCN [n=33, mean age = 73.5±12.9]
- Usual care [UC, n=316, mean age = 75.5±10.0]

Significant differences in LOS
- FCN (4.2 days ±4.9) verses UC group (11.0 days ±11.7)

Other analysis:
- Differences in ER visits
- Likely to readmit
Faith Community Nursing Transitional Care

Importance of Studies

- Limited knowledge about transitional care as implemented by FCNs.

- Hospitals are examining innovative and efficient methods of decreasing avoidable readmissions.

- Results can provide the underpinnings for FCN transitional care interventions.

- Patients cared for by FCNs can experience whole-person interventions leading to readmission avoidance.

- Findings will help further disseminate FCN practice in diverse healthcare settings to reduce costly ER visits and hospital readmission.
Questions?

References


