A Nurse-Led Collaborative Linking Medical Center with Community Partners Transforms Patient Care and Reduces Readmissions

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AIM

- Institute a collaborative partnership between one academic medical center and local skilled nursing facilities (SNF) and home health agencies (HHA) to create a community standard for heart failure (HF) patient care based on the evidence
- Align quality care practices across the continuum, share metrics, identify care gaps and develop improved processes for patient care

BACKGROUND

- Heart failure (HF) is the leading cause of hospitalization among adults ≥ 65 years, with highest readmission rates occurring within 30 days of discharge.[1] Costs for heart failure (HF) patient care in the US are expected to increase to $53 billion by 2030.[2] Total economic burden that includes direct and indirect costs of care is projected to reach $70 billion in the next 16 years, at which time 1 out of every 33 Americans will have HF.[2]
- Nationwide, medical centers are instituting evidence-based strategies to improve HF patient transitions from hospital back to the community and reduce 30-day all-cause readmissions.
- Patients discharging to skilled nursing facilities or home with home care services are generally recognized as more vulnerable and at heightened risk for rehospitalization

METHODS

- HF nurse specialists led monthly multidisciplinary meetings with local SNF and HHA participants. In these meetings, the collaborative refined interventions for patient care transitions, for example: patient handover, patient education and medication safety strategies
- Two heart failure patient volunteers participate regularly in the monthly forum and provided frank input from patient perspective
- Aging Adult Services and local outside medical clinic also participate
- Medical center process and outcome metrics are routinely reviewed
- Medical center-developed educational tools are shared with the collaborative
- HF nurse specialists provided outreach support with on-site training of SNF staff on guideline-based HF patient care and promoting self-management skills
- Community facilities share their innovations on improving patient transitions and patient and caregiver education
- Readmissions cases analyzed to identify and address gaps in care
- Data drill-down by specific facility facilitated more focused collaboration for solutions

HF DASHBOARD

Execution and impact of staff workflows and interventions are tracked by a web-based, interactive HF dashboard, which displays 30- and 90-day rehospitalizations as well as balancing measures of ED encounters and observation stays within 90 days post-discharge. Patient-specific data uploaded within 48 hours of discharge.

The dashboard permits 8virtually real-time analysis of patient information in multiple ways, e.g. by payor, care unit, disposition, etc. and facilitates rapid assessment of workflow effectiveness.

RESULTS

Exemplar of collaborative work on communication

- Collaborative workshop redesigned acute→ subacute → home health handover for patients transitioning from hospital to SNF or home with HHA services
  - Define & communicate the main point of contact for care issues post-discharge
  - Develop structured patient handovers, patient education and transition follow-up strategies for each phase in the care continuum
  - Nurse-to-nurse interfacility "warm handover" reinstituted
  - Algorithmic communication flow among all care providers

Contents of Initial Referral Packet
Face sheet
(Demographics, Emergency Contact, Encounter Detail, Referring Physician, Primary Physician, Guarantor, Insurance)
Code status
Pt. weight
Pt. demographics
LOS/admit date
Allergies
Immunization record
Current Orders with in the last 24 hours
Rehab Engineering notes
Dialysis record
OR notes
H&P
Rehab Notes with the last 48hrs (PT,OT & speech)
CM notes for the last 48 hrs
Progress notes for the last 24 hrs
Consult note for the last 72hrs
At-a-glance

Contents of Final Referral Packet
Face sheet
(Demographics, Emergency Contact, Encounter Detail, Referring Physician, Primary Physician, Guarantor, Insurance)
Immunization record
OR notes
H&P
Last 48 hrs Progress Notes
Current medication list
MAR
TB test
PICC information
D/C summary
Rehab notes
Consults notes
CM notes
SW notes
Last 48 hrs of labs, radiology, test
Last 48 hrs of vitals

Additional printed information sent with all patients going to SNFs
Nursing Interagency Form
MAR
Form #2353 (Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or "prolonged use of a device")
Nursing-Pressure Ulcer Discharge Form (15-2739), if applicable
Physician Interagency Form / Discharge Report – with triplicate attached, if applicable
Triplicate prescriptions for narcotics, if applicable
Discharge Summary
EKG (for cardiac patients)
POLST (if available)

RESULTS

- Comparing baseline 1 year data to 1 year post implementation of our intervention bundle, total 30-day HF readmissions to our center declined from 20% to 13% (by 32%), while 90-day rehospitalizations improved from 30% to 24%.
- 30-day rehospitalizations for SNF patients improved more dramatically, from 18% to 9% (50% reduction) and from 24% to 19% (21% reduction) for those going home with home health services following the index admission.
- Smaller improvements were seen in 90-day readmission rates for patients returning to hospital from SNF (from 29% to 25%) and for those who had discharged home with home health services (from 32% to 28%).

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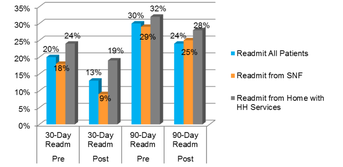
Primary Diagnosis HF Readmissions by Index Admission Disposition – Pre- & Post Collaboration



CONCLUSION

- Incorporating community partners into care transition planning is essential for successful patient outcomes, particularly in light of new bundled payment models
- Building relationships with community partners is critical to success in reducing readmissions and sustaining improved patient outcomes. Nurses are well-positioned to plan and lead such collaborative work.
- Quality care across the continuum demands everyone be "on the same page", delivering consistent messages to patients/families on self-management skills, medication safety, etc. and communicating optimally at care transitions

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