Home Health Nurses Perception of Collaboration With NP in Transitions of Care Management

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Problem Description: Vulnerable, homebound older adults are highly susceptible to unplanned 30-day hospital readmissions, which is costly for the health care system. As a result, health care expenditures for this population continue to rise. Transitional care affects all patients discharged which ideally should begin before discharge and continues through post-hospital discharge and follow up in community-based care. Case management is part of the transition care team. There are many barriers that can lead to fragmented care during this transition period leading to readmission. The elderly population have multiple chronic conditions that need comprehensive care coordination between the medical provider (the nurse practitioner), the home health nurse and other professionals (physical therapist, occupational therapist, social workers, and others) within the home health agency.

Purpose: The purpose of this quality improvement pilot project is to implement medical house calls as a component of transitional care management (TCM) and measure perception (awareness/satisfaction/importance) of the home health nurse towards the transitional care management collaboration with a medical house call provider.

Interventions: Medicare beneficiaries, 65 years and older, discharged from skilled nursing facilities (SNFs) to home are identified by convenience sampling through referral and offered a home visit by a NP in collaboration with a home health agency in providing transitional care management.

Methods: The perception (awareness/satisfaction/importance) of the home health nurses engaged in the collaborative care with the medical house call NP of a transitional care management patient is measured using Hsieh's (2006) modified Client Satisfaction to Improve Case Management (CSAT-CM).

Evaluation: Statistical instruments will be used to measure significance. The main statistical method used in data analysis is descriptive statistics, using indexes, the mean and standard deviation.

Implications: The results of the quality improvement project is used towards developing transitional care management programs in collaboration with home health nurses with the ultimately aim of translating evidence into practice while addressing the need of a vulnerable population group: the homebound older adult.

Title:

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Keywords:

home health care, interprofessional collaboration and transitional care

References:

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Abstract Summary:

Preventing hospital readmission during transitions of care from higher level of care to home requires interprofessional collaboration. The perception of home health nurses is measured to explore home health nurses awareness/satisfaction/importance of transitional care medical house call by a nurse practitioner.

Content Outline:

Problem Description: Vulnerable, homebound older adults are highly susceptible to unplanned 30-day hospital readmissions, which is costly for the health care system. As a result, health care expenditures for this population continue to rise. Transitional care affects all patients discharged from a higher level of care (such as hospital or skilled nursing facility to home) which ideally should begin at admission and continues through post-hospital discharge and follow up in community-based care. Collaboration and case management is part of transitional care management. There are many barriers that can lead to fragmented care during this transition period leading to ER/hospital readmission. The elderly population has multiple chronic conditions that need comprehensive interprofessional care coordination between the medical provider (the nurse practitioner), the home health nurse, and other professionals (physical therapist, occupational therapist, social workers, and others) within the home health agency.

Purpose: The purpose of this quality improvement pilot project is to implement medical house calls as a component of transitional care management (TCM) and measure perception (awareness/satisfaction/importance) of the home health nurse towards the transitional care management collaboration with a nurse practitioner (NP).

Interventions: Medicare beneficiaries, 65 years and older, discharged from skilled nursing facilities (SNFs) to home are identified by convenience sampling through referral and offered a home visit by a NP in collaboration with a home health agency in providing transitional care management.

Methods: The perception (awareness/satisfaction/importance) of the home health nurses engaged in the collaborative care with the medical house call NP of a transitional care management patient is measured using Hsieh's (2006) modified Client Satisfaction to Improve Case Management (CSAT-CM).

Evaluation: Statistical instruments will be used to measure significance. The main statistical method used in data analysis is descriptive statistics, using indexes the mean and standard deviation.

Implications: The results of the quality improvement project is used towards developing transitional care management programs in collaboration with home health nurses with the ultimate aim of translating evidence into practice in addressing the need of a vulnerable population group: the homebound older adult.

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