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

A DNP Scholarly Project Proposal by:

Anquinette Cray, MSN, FNP-C
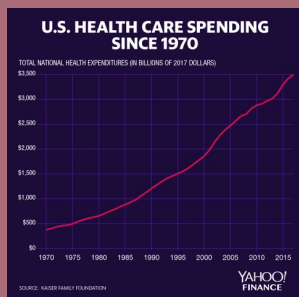DNP Student, Grand Canyon University, USA

Ron Ordona, DNP, FNP-BC
Medical House Call Provider/Mentor

Senior Care Clinic — HOUSE CALLS

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 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.

U.S. HEALTH CARE SPENDING SINCE 1970
TOTAL NATIONAL HEALTH EXPENDITURES (IN BILLIONS OF 2017 DOLLARS)

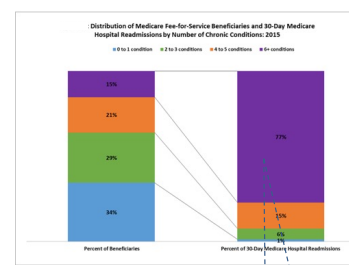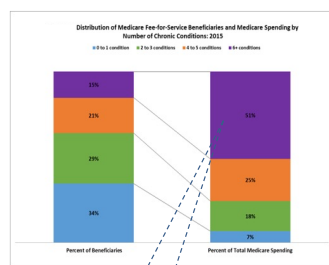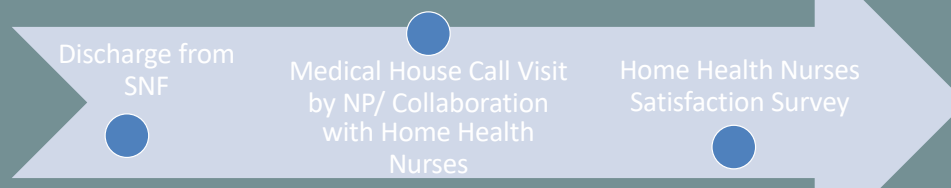SOURCE: KAISER FAMILY FOUNDATION
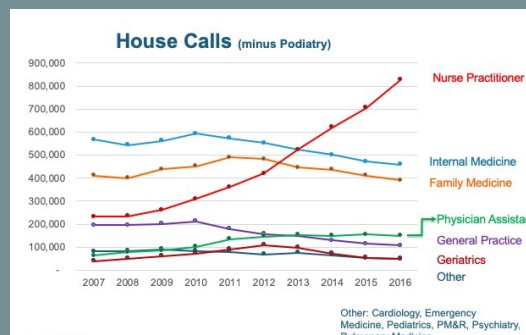YAHOO! FINANCE

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 modified Hsieh's (2006) Client Satisfaction to Improve Case Management (CSAT-CM) survey.

Discharge from SNF → Medical House Call Visit by NP/ Collaboration with Home Health Nurses → Home Health Nurses Satisfaction Survey

Distribution of Medicare Fee-for-Service Beneficiaries and Medicare Spending by Number of Chronic Conditions: 2015

Distribution of Medicare Fee-for-Service Beneficiaries and 30-Day Medicare Hospital Readmissions by Number of Chronic Conditions: 2015

Graphics from Wolff-Baker & Ordona (2019). *Journal of Gerontological Nursing.* 2019;45(6):9-14 https://doi.org/10.3928/00989134-20190422-01

House Calls (minus Podiatry)

Nurse Practitioner
Internal Medicine
Family Medicine
Physician Assistant
General Practice
Geriatrics
Other

Other: Cardiology, Emergency Medicine, Pediatrics, PM&R, Psychiatry, Pulmonary Medicine

51% of US Medicare spending is for patients with >6 chronic conditions.

A staggering 77% of US Medicare beneficiaries with >6 chronic conditions are readmitted to the hospital.

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.

References:

Gahayan, G. Z., Sarkisian, C. A., Lian, L., & Sun, B. C. (2015). Predictors of admission after emergency department discharge in older adults. *Journal of American Geriatrics Society, 63,* 39-45. http://dx.doi.org/10.1111/jgs.13185

Hamar, B., Rula, E. Y., Wells, A. R., Coberley, C., Pope, J. E., & Varga, D. (2016). Impact of a scalable care transitions program for readmission avoidance [Magazine]. *American Journal of Managed Care,* 28-34. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/26799122

Stall, N., Nowaczynski, M., & Sinha, S. K. (2014). Systematic review of outcomes from home-based primary care programs for homebound older adults. *Journal of American Geriatrics Society,* 2243-2435. http://dx.doi.org/10.1111/jgs.13088

Towne, Jr., S. D., Ory, M. G., & Smith, M. L. (2014). Cost of fall-related hospitalizations among older adults: Environmental comparisons from 2011 Texas hospital inpatient discharge data. *Population Health Management, 17,* 351-356. http://dx.doi.org/10.1089/pop.2014.0002

Wang, H., Robinson, R. D., Johnson, C., Zenarosa, N. R., Jayswal, R. D., Keithley, J., & Delaney, K. A. (2014). Using the LACE Index to predict hospital readmissions in congestive heart failure patients. *BMC Cardiovascular Disorders, 14*(97), 1-8. http://dx.doi.org/10.1186/1471-226l-14-97