Value-Based Care: Readmission Reduction, Polypharmacy Reduction, and Cost Containment

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**Purpose:** A quality improvement project looked into Home-Based Primary Care (HBPC) contributions towards value-based care. Review of literature showed that staggering Medicare spending on beneficiaries with multiple chronic conditions, is threatening the long-term viability of the US healthcare system, if not addressed. Costs of poorly coordinated or delayed care for the vulnerable homebound older adult with multiple co-morbidities continue to rise; measured financially, as well as, in diminished quality of life (QOL) and patient dis-satisfaction. Studies show that HBPC practices are an effective way to meet needs of frail elders who find it difficult, if not impossible, to leave home to seek medical care.

**Methods:** A quality improvement project (QIP) using descriptive methods conducted literature review for the evidence, translation of the evidence found into practice and testing the evidence, to determine if the evidence supports clinical outcome improvement initiatives. The QIP was conducted during the implementation of a Transitional Care Management (TCM) house call practice improvement initiative.

**Results:** The 30-day unplanned readmission rate was at par compared to benchmarks. There was a statistically significant reduction in polypharmacy. The overall satisfaction with TCM house calls were measured using a modified client satisfaction case management (CSAT-CM) survey and showed patient/family/caregiver, as well as, home health nurses, overall satisfaction with care delivery.

**Conclusion:** There is a resurgence in HBPC practices propelled in large part by Nurse Practitioners (NPs) who provided over 825,000 HBPC visits per year in a 2016 data. HBPC teams are multi-disciplinary and are patient-focused. HBPC home visits offer many types of Medicare-covered services including Evaluation and Management (E/M), Chronic Care Management (CCM), Transitional Care Management (TCM), the Medicare Annual Wellness Visit (AWV), and Advance Care Planning (ACP). Home and community-based care, in the advent of value-based care, provides opportunities for the Nursing profession to significantly contribute to the improvement of the healthcare system in the US. Furthermore, HBPC and Value-Based Care provides avenue for collaboration among the members of the health care team, including doctors, advanced practice nurses, home health nurses (RNs and LPNs), physical and occupational therapists, social workers, pharmacists, and others, with the end goal of better clinical outcomes and improved patient satisfaction with the healthcare delivery.

**Title:**  
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Abstract Summary:
Value-Based Care is the future of healthcare in the US. Nurse Practitioners in Home Based Primary Care (HBPC) help address prevention of unplanned 30-day readmission, reduction in polypharmacy and overall cost-containment for the US Medicare system. The resurgence of house calls is contributing to quality of care and patient satisfaction.

References:
• Buerhaus, P., Perloff, J., Clarke, S., O'Reilly-Jacob, M., Zolotusky, M., & Desroches, C. (2018). Quality of primary care provided to Medicare beneficiaries by nurse practitioners and physicians. Medical Care, 56(6), 484-490. http://dx.doi.org/10.1097

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Author Summary: Ron Ordona, DNP, FNP-BC is a house call nurse practitioner focused in the care of older adults in a primary care practice. His doctoral project was Transitional Care Medical House Call quality improvement pilot project. Dr. Ordona is actively involved in the care of older adults in long-term care community setting.