Title:
Enhanced Patient and Caregiver Engagement Drive Utilization and Quality Outcomes in an Advanced Practice Nurse-Led
Care Transitions Intervention with Super Utilizers

Megan McNamara Williams
School of Nursing, Thomas Jefferson University, Philadelphia, PA, USA

Session Title:
Rising Stars of Nursing Invited Posters - Group 2
Slot (superslotted):
RSG STR 2: Friday, September 26, 2014: 10:00 AM-10:30 AM
Slot (superslotted):
RSG STR 2: Friday, September 26, 2014: 11:45 AM-1:00 PM
Slot (superslotted):
RSG STR 2: Friday, September 26, 2014: 3:00 PM-3:30 PM

Keywords:
Advanced Practice Nurse and Transitional Care

References:
Brooten, D., Naylor, M., York, R., Brown, L., Munro, B., Hollingsworth, A. & Youngblut, J. (2002). Lessons learned from testing the quality cost model of advanced practice nursing (APN) transitional care. Journal of Nursing Scholarship, 34(4), 369-375. Center for Disease Control and Prevention (1993). Health Related Quality of Life (HRQOL-4). National Center for Chronic Disease Prevention and Health Promotion, Division of Population Health. Coleman, E., Mahoney, E., & Parry, C. (2005). Assessing the Quality of Preparation for Post-Hospital Care from the Patient's Perspective: The Care Transitions Measure. Medical Care, 43(3), 246-255. Gillespie, J., Mollica, R., Horvath, J., & Williams, C. (May, 2005). Coordinating care in the fee-for-service system for Medicaid beneficiaries with chronic conditions (Contract No. HHS-100-03-0025). Washington, DC: US. Department of Health and Human Services. Naylor, M., Brooten, D., Campbell, R., Maislin, G., McCauley, K., & Schwartz, J. (2004). Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial. Journal of the American Geriatrics Society, 52(5), 675-684. doi: 10.1111/j.1532-5414.2004.52202.x Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §2702, 124 Stat. 119, 318-319 (2010). Project BOOST Team (2008). The Society of Hospital Medicine Care Transitions Implementation Guide: Project BOOST: Better Outcomes for Older adults through Safe Transitions. Society of Hospital Medicine website, Care Transitions Quality Improvement Resource Room http://www.hospitalmedicine.org

Learning Activity:

LEARNING OBJECTIVES	EXPANDED CONTENT OUTLINE	TIME ALLOTTED	FACULTY/SPEAKER	TEACHING/LEARNING METHOD	EVALUATION/FEEDBACK
Example Critique selected	**Example** Definitions of	**Example** 20 minutes	**Example** Name, Credentials	**Example** Lecture PowerPoint	**Example** Group discussion: What does cultural

	definition of the term, "curriculum"	"curriculum" Course of study Arrangements of instructional materials The subject matter that is taught Cultural "training" Planned engagement of learners			presentation Participant feedback	training mean to you?
	The learner will be able to describe the 90 day APRN-led transitional care program implemented with high utilizers.	Strusture, methods and implementation of program	1 hour	Megan Williams, DNP, FNP-C	Poster presentation	Peer Review
	The learner will be able to describe the impact of the 90 day APRN-led transitional care program on participant healthutilization, and	Specific outcome measures include readmission rates, cost of care, transition skills and quality of life.	1 hour	Megan Williams, DNP, FNP-C	Poster presentation	Peer Review

	transition skills and quality of life.					

Abstract Text:

Background Care transitions across the health care continuum have been the focus of numerous efforts of health care systems throughout the United States in the last few decades. Poorly managed transitions can result in poor health outcomes and have tremendous financial implications for both patients and healthcare systems. In an effort to address poor transitions in care and minimize waste in the health care system, several approaches to the provision of transitional care have been tested and are still currently underway. Congruent with the triple aim, improving the experience of care, improving the health of populations, and reducing per capita costs of health care, health care facilities, clinicians and patients have been working together to establish effective programming and interventions to improve transitions in care, reduce health care ending and optimize the quality and safety of care provided to patients across the care continuum. Current shortcomings in the U.S. health care system have a profound impact on the chronically ill, who experience repeated changes in health status accompanied by numerous transitions between providers and care settings. The common thread among all of the successful transitional care models has been the presence of nurses, as clinical leaders or care managers. Advanced Practice Nurses possess the clinical and interpersonal skills, in-depth knowledge of systems and how to work within them to affect positive patient outcomes and keep patients well during vulnerable transitions in care.

Objectives To explore the impact of a 90 day Advanced Practice Nurse-led transitional care program, specifically the incorporation of health coaching and the resulting impact on readmissions, cost of care, patient transition skills and quality of life.

Results The intervention population (n = 142, M= 0.59 re-admissions, SD= 0.84) demonstrated a 30% overall reduction in re-admissions compared to the pre-program re-admission population (M= 0.85 re-admissions, SD= 0.47, t (1,136) = -3.82, p= < .001[O1] . The intervention resulted in over a three-fold increase in average transition skills scores, t (1, 136) = 19.20, p < .00001 and 2.5 fold improvement in quality of life among intervention participants t (1, 136) = -11.99, p< .00001). The resulting impact on cost of care was a total reduction in cost of $1,534,330, with an average of $12,276 reduction per participant, t (1, 141) = 3.79, p < .001).

Conclusion As the health care industry moves forward in pursuit of the best way to provide care for patients across the entire continuum of care, the focus should be on optimizing both utilization and quality of life for the most vulnerable populations through the provision of Advanced Practice Nurse- led transitional care emphasizing health coaching and patient and caregiver engagement. Incorporation of models of care, based in the nursing paradigm, augmented by interdisciplinary collaboration and emphasizing patient engagement through health coaching should be a focus for future research and serve as the basis for transitional care programs nationwide.