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

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ABSTRACT

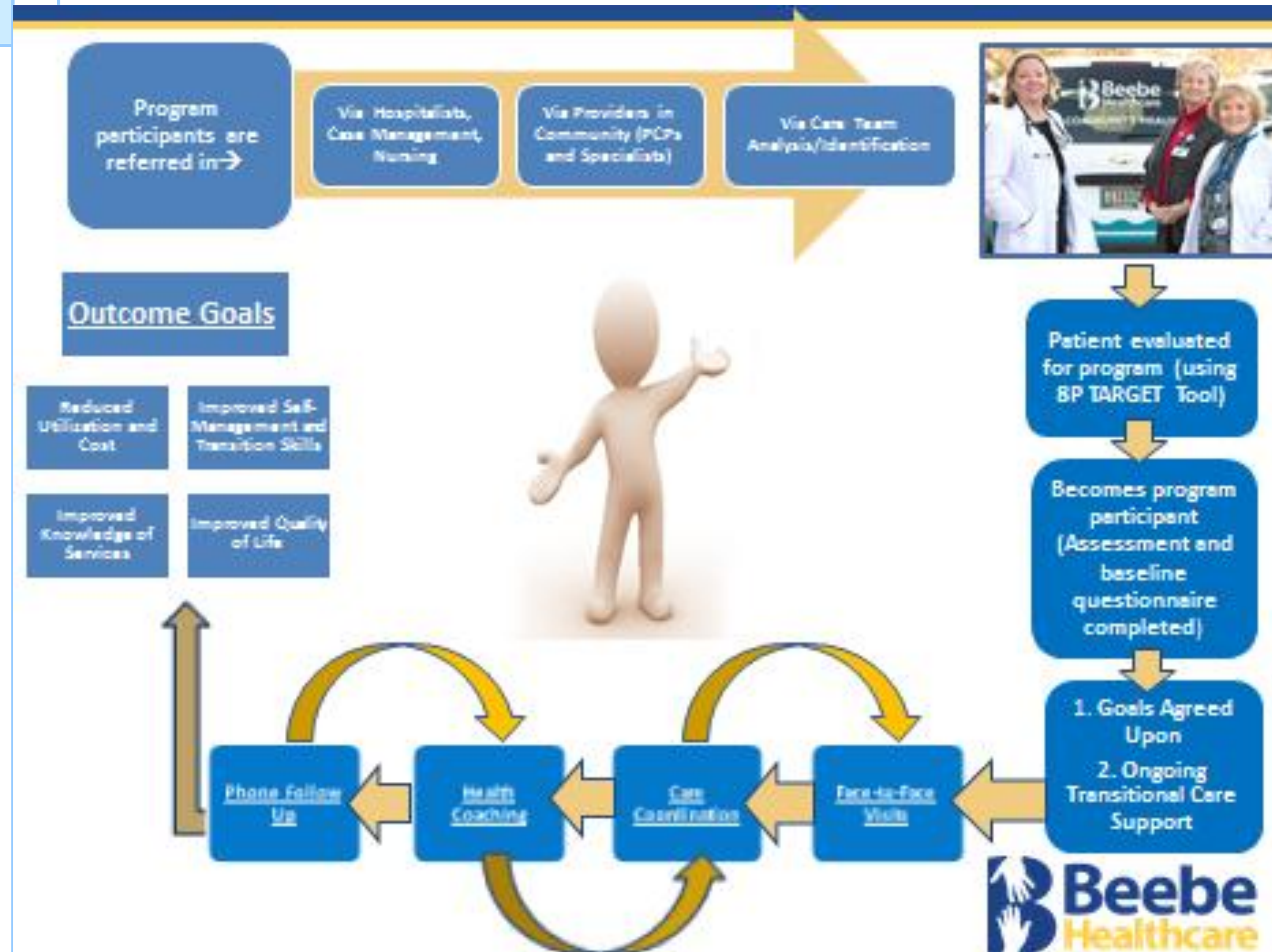
The purpose of this project, Beebe CAREs, was to incorporate health coaching and a multidisciplinary approach into traditional Advanced Practice Nurse-led transitional care. The CAREs intervention (Care coordination, Access to care, Referral to community based resources and Empowerment of patients and caregivers) aimed to achieve a sustainable impact on participants, resulting in reduced hospitalization, and improved transition skills and quality of life. APRNs 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. 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.

Background

- By 2020, over 157 million Americans will be living with one or more chronic diseases, leading to greater risk for hospitalization, emergency room visits and expanding healthcare costs (Gillespie et al., 2005).
- APRNs possess a unique and powerful skill set that is particularly well suited to providing comprehensive care for complex patients such as those transitioning out of the hospital setting.(Naylor et al., 2004).
- The APRN holistic and patient-centric approach facilitates identification of vulnerable patients and development of high acuity interventions that encompass both clinical and social components of care which is central to the successful transition of patients across the health care continuum (Brooten et al., 2002).

METHODS

- Quasi-experimental, pre-test post-test design
- The CAREs Team, comprised of a nurse practitioner, social worker and registered nurse trained in health coaching implement a 90 day team-based transitional care intervention
- Program eligibility is based upon recent inpatient hospitalization at the site hospital two or more times in the previous six months and the presence of five or more readmission risk factors based on the adapted 8P BOOST Target Tool
- The dependent variables measured for each participant in the study are number of inpatient readmissions, transitions skills score and quality of life score
  - Care Transitions Measure -15 (CTM-15)
  - CDC Health related Quality of Life
  - Utilization (Re-admissions, Length of stay and cost of care)



RESULTS

Reducing Utilization and Improving Outcomes

	Pre-CAREs Intervention	During CAREs Intervention	Percent Change	Significance
Average # of Readmissions (Intervention Group)	0.85	0.59	↓ 30%	P< .001
Average # of Readmissions (Control Group)	0.82	0.94	↑ 15%	P< .001
Average Cost of Care (Intervention Group)	$40,361	$28,085	↓ 31%	p< .001
Transition Skills (Average score per participant)	6.42	23.21	↑ 362%	P< .00001
Quality of Life Score (Average 'bad' days per participant)	47.69	20.77	↑ 230%	P< .00001

CONCLUSION

The changes associated with health care reform as laid out in the Affordable Care Act (2010), are daunting to most and still quite vague in a number of areas, however, we have noted a change in the culture, patient-centered approach to care, and outcomes with the implementation of the CAREs program. It has enabled the health care system to re-design care and demonstrate sound cost savings and improve the quality of life for patients. It will serve to springboard a multitude of initiatives across the entire health care system and has inspired confidence in our ability to effectively embrace the changes associated with healthcare reform led by APRNs.

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