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.

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 SP 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

<table>
<thead>
<tr>
<th></th>
<th>Pre-CAREs Intervention</th>
<th>During CAREs Intervention</th>
<th>Percent Change</th>
<th>Significance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average # of Readmissions (Intervention Group)</td>
<td>0.85</td>
<td>0.59</td>
<td>30%</td>
<td>P&lt;.001</td>
</tr>
<tr>
<td>Average # of Readmissions (Control Group)</td>
<td>0.82</td>
<td>0.94</td>
<td>15%</td>
<td>P&lt;.001</td>
</tr>
<tr>
<td>Average Cost of Care (Intervention Group)</td>
<td>540,361</td>
<td>528,685</td>
<td>31%</td>
<td>P&lt;.001</td>
</tr>
<tr>
<td>Transition Skills (Average score per participant)</td>
<td>6.42</td>
<td>7.21</td>
<td>36%</td>
<td>P&lt;.0001</td>
</tr>
<tr>
<td>Quality of Life Scores (Average Staff days per participant)</td>
<td>47.69</td>
<td>20.77</td>
<td>230%</td>
<td>P&lt;.0001</td>
</tr>
</tbody>
</table>

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.

REFERENCES


