Advanced Practice Registered Nurse Led Transitional Care Program to Prevent Hospital Readmissions

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PURPOSE
Reduce or prevent readmissions among heart failure (HF) patients and increase quality of life (QOL), self-care behavior (SCB) and satisfaction through an advanced practice registered nurse (APRN) led transitional care program (TCP) in collaboration with an Accountable Care Organization (ACO)

BACKGROUND & SIGNIFICANCE
HF is a major reason for readmissions and healthcare costs
- 30-day readmission rate with HF - 24.8%1
- ~ 35% of readmissions after a HF hospitalization2
- Inappropriate level of care for safe transition from hospital to home increases readmission, escalates healthcare costs, reduces quality of life
- Negative impact on QOL, self-management, and functional status

ACO in the southwest US identified a need to improve hospitalization & readmission rates

Evidence suggests that APRN-led home visit + telephonic follow-up are cost effective and reduce readmissions among HF patients

RESULTS
Demographics
- N=7: Mean age 79 (SD 6.74) years
- Female -71%; Male- 29%; Caucasian and retired (100%)
- Married - 57%; Single/widowed- 43%
- Mean number of chronic conditions = 2 (SD 0.577)
- Mean number of Rx =11 (SD 1.38)
- ED visit/ hospitalization in the prior 6 months: ER Visit (SD=1.55); Hosp. (SD=1.11)

Analysis/Results:
- Friedman Test: QOL, self-care management and satisfaction (χ² = 30.35, p<.000)
- No readmissions at 30 days post discharge
- QOL – Pre-Intervention Mean 49 (SD 13.29); Post-Intervention Mean 30 (SD 10.19) (Graph 1 & 2)
- Self-care behavior – Pre-Intervention Mean 25 (SD 5.56); Post-Intervention Mean 14 (SD 2.14) (Graph 3 & 4)
- Satisfaction – 100% of patients were satisfied with the TCP; Satisfaction score Mean 24 (SD 0.38) Median score 24; Range 23 to 24

METHODS
Ethics: ASU IRB - Expedited Review
Setting: ACO family practice clinic in a metropolitan area
Participants: 7 patients with HF recently discharged or at risk of readmission

Intervention
- Weekly home visit for 12 weeks
- Weekly phone call

Outcome Measures:
- Number of hospital readmissions at 30 days post discharge
- QOL – “Minnesota Living with HF Questionnaire”
- Self-care behaviors - “European HF Self-Care Behavior Scale”
- Satisfaction - Satisfaction survey

CONCLUSION
Outcomes: APRN led TCP had a positive effect on reducing readmissions; improved patient outcomes
Feasibility: TCPs can be conducted in/ through private practices
Impacts
- Increased awareness/ utilization of transitional care interventions
- Improved patient use of alternate care (PCP, urgent care) instead of emergency room (ER) to reduce health care cost
- Doctoral project in partnership with ACO can improve the quality of care and promote sustainable change in the organization and population

Limitations and Implications
- Small participant numbers – narrow inclusion criteria and lack of patient interest
- Medicare only pays for transitional care services once in 30 days
- Some patients did not require 12 home visits
- Home delivery pharmacy underutilized

Future Research, Project Design & Sustainability
- Project design for flexible number of visits based on assessment needs
- Quality of services can be improved with coordination & communication.
- Payment reform/ Innovative billing for sustainability of the TCPs
- System workflow design with multidisciplinary team approach for cost effectiveness and replication throughout ACO

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