

# Improving Transitions of Care and Reducing Readmissions

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### Implications

- Hospital readmissions were reduced by supporting patients who were at high risk for readmission beginning from patient's discharge throughout the first weeks in their home.
- Patients actively engaging in their care felt more capable of managing their diseases.
- Care Coordinators and students collaborated to facilitate problem solving during transitions
  - Addressing medication and follow up appointment issues
  - Contacting providers for clarification on treatment plans
  - Common disease management topics included: weight tracking, diet, medications, constipation treatment and prevention
  - Fostering patient self-advocacy
- Students will take into their professional nursing careers lessons regarding the patient's discharge and their transition back into their homes and community.
- Students experience patient care from inpatient to outpatient setting.

### Outcomes

- 69 patients admitted into the program over 4 school semesters
- 64 of 69 patients did not readmit (93%)
- Unadjusted potential cost savings - \$880,036 (HRTC program to date)
  - 2012-2014 cost reference-median readmission costs at Gundersen Health System for Medicare payer source:
    - 2012: \$11,795
    - 2013: \$13,087
    - 2014: \$14,375

### Why was the program created?

- Care transitions for patients are often fraught with complications. A readmission can be a common symptom of a poor care transition.
- Nurses identified time constraints and patient related obstacles (inability for the patient to communicate, patient feeling too ill, etc.) as the many barriers to properly discharging patients. (7)
- Hospitals should develop models and concepts to improve patient outcomes upon discharge. Nurses can enhance discharge instruction by providing patient-centered care and including self-management techniques in discharge teaching. (8)

### Background

- Between 2003-2004, unplanned hospital readmissions incurred a nearly 17.4 billion dollar cost to the Medicare program with nearly 20% of the >11 million hospitalized patients discharged being readmitted (1) (5).
- The Patient Protection and Affordable Care ACT will fine hospitals through a Medicare reimbursement rate cut for high readmissions. (5)
- Patients with heart failure, myocardial infarction, and pneumonia are most likely to readmit within 30 days of hospital Discharge (4).
- Contributing factors to readmissions (6):
  1. Feeling unprepared for discharge
  2. Too weak to perform activities of daily living
  3. Trouble adhering to or accessing discharge medications and treatments
  4. Lack of social support
  5. Financial ability to get services and treatment needed, including transportation to appointments
- Enhanced partnerships between academia and hospital organizations can build and support creative ways to meet student's learning objectives, while providing cost effective support to patients and families (3).



### Methods

- Clinical partnership between 6 Care Coordination nurses and 6 student nurses in a 3 month public health practicum.
- Each week Clinical Nurse Leaders (CNL) (Masters prepared nurses) from the hospital units select 6 patients who are high risk to readmit based on organization criteria (LACE+).
- Care Coordination nurses with students collaborate to create, implement, and continuously revise an individualized patient transition plan.
- Focus is on the patient/family comprehension of diagnosis and discharge plan of care. This plan is implemented with the use of Teachback methodology within a Stages of Change framework partnering the use of motivational interviewing skills.
- Ideally students provide 2 home visits each week per patient (or meaningful contact at clinic appointment or via telephone) for three weeks or until the patient/family meet goals.
- An Ipad with a face-to-face calling application is used while the student is in the patient's home to allow a virtual presence with the Care Coordinator Preceptor during each home visit.
- Targeted Patients:
  - o Age 18+
  - o LACE+ Index Score of >10
  - o Multisystem Disease or Failure
  - o Cognitive Disorders/Mental Health (without student safety concerns)
  - o Lack of Social Support/Financial Difficulty
- Encounter Types: Inpatient Visit, Home Visit, Phone Call, Clinic Appointment
- Student-Patient Encounters include:
  - o Complete interaction sheet and home safety check
  - o Meet with patient and their family
  - o Review medications, diet changes, electrolyte/fluid chart and fitness changes
  - o Review upcoming appointments and develop a list of questions for providers
  - o Review weight and blood pressure chart or activity logs
  - o Arrange home health/cardiac rehab
  - o Learning resources and how to contact clinic staff, specialty departments, primary care provider, and telephone nurse advisor after hours.



### Testimonials

#### Patient Comments:

- “They were like two guardian angels holding our hands every step of the way, never letting go until they sensed we would be o.k. We are forever grateful.”
- “We were sent home wearing a defibrillator life vest and many new medicines. To say the least we were terrified. When we were offered this program where a student would come to our home once a week for three weeks on Tuesdays and call us on Thursdays and any concerns in between were only a phone call away. This service was a God send.”
- “Having the student come to our house was wonderful and very helpful. Especially in a rural area, having a healthcare professional visit is especially appreciated. Do not underestimate the value of a personal visit, plus the assurance of the tele-com connection to the hospital.”

#### Student Comments:

- “The high risk transitional care program was very beneficial to me as a nursing student, and I plan to use the knowledge that I gained through the program when I begin my nursing practice. Before partaking in this program, I had never thought about the patient's health literacy or their transportation needs to and from the hospital. I learned the importance as a bedside nurse of spending that extra five to ten minutes when the patient is being discharged to make sure that they fully understand their medications and lifestyle changes.”
- “Throughout this program I have gained confidence and knowledge that I will use in my future career. So, by the end of this practicum I felt very comfortable in my interactions with patients, their families and healthcare providers.”
- “I found medication errors, could answer questions about their diet and exercise, and found other programs for them to utilize-the patients were very appreciative of the program.”
- “I enjoy how this experience exposed me to various other professionals in the healthcare setting by attending clinic visits and working with the social workers. When I graduate I will feel more comfortable talking to other professionals. This is a great experience.”
- “It made me realize that patient care isn't just about taking care of someone in the hospital or clinic. It definitely put into perspective all the factors that go into transitioning care from hospital to home.”

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