Cross-Continuum Collaboration: Nurse Driven Interventions to Improve Care Transitions

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OBJECTIVES

- Recognize patient characteristics that place them at higher risk of readmission.
- Identify strategies to optimize care transitions.
- Identify one strategy you could implement to support older adults transitioning to post acute care.

Problem

- Communication between institutions occurs predominantly through discharge summaries.
- 1 or more medication discrepancy was identified in 71% of SNF admissions; CV agents, opioid, neuropsychiatric agents, hypoglycemic, antibiotic and anticoagulants accounted for >50% of these discrepancy.
- Only 23% of SNF patients had all discharge follow-up plans completed, in patients who had 3 to 8 follow-up instructions.
Care Transition Challenges

Hospital
- Timely or multiple discharge summaries
- Discrepancies between discharge documents
- Goals of Care information
- Schedule II hard script and accurate/current medication list
- Mechanism for communication with hospital team

SNF
- SNF discharge summary
- Accurate and complete Medication Administration Record (MAR)
- Timely follow-up scheduled with PCP

PCP
- Ownership of home health or other community agency referrals
- Communication link with inpatient and Skilled nursing providers
- Accurate medication list
- Accurate problem list with accompanying history

Health Optimization Program for Elders (HOPE)

HOPE is a transitional care model that provides:
- Inpatient NP geriatric consultation for adults age 55 and older
- 3-5 day post discharge follow up by NP

GOAL
To reduce avoidable readmissions and other adverse outcomes during and after transition from the acute inpatient care setting to the post acute care setting.

DukeWELL

- Provides care management, clinical pharmacy support and specialty advice to patients and providers.
- Serves a wide variety of high-risk patients that are eligible through Duke Health’s Accountable Care Organization.

GOAL
To improve quality of care and health outcomes for those patients with chronic illness while reducing unnecessary costs and hospital re-admissions.
HOPE and DukeWELL

A subset of HOPE patients were identified as high risk who would benefit from additional follow up beyond the five days provided by HOPE.

Collaboration to meet the needs of the high risk patients across the care continuum

DukeWELL supports high risk patients transitioning from Rehab to Home.

HOPE – DukeWELL Collaboration

HOPE Assessment and Actions

Acute Care

- Chart review/Patient Exam
- Patient/family discussion
- Recommendation to team/family
- Delirium
- Frequent falls
- Inadequate home
- Ongoing Goals of Care issues
- Caregiver Stressor

Refer to DukeWELL

Immediate collaborative follow up in SNF
HOPE-DukeWELL Assessment and Actions

Post Acute Care

DukeWELL

• Visit patient, advocate for their needs
• Coordinate care with SNF staff
• Serve as a communication hub for patient/Family
• Coordinate with home health, hospice, palliative care and PCP
• High risk medication review
• Assess participation in rehabilitation
• Communicate any outstanding symptoms
• Confirm follow up appointments and labs

Until discharged to home

3-5 days

DukeWELL Assessment and Actions

Ambulatory/PCP

Serve as communication hub for Pt/PCP, family or HPOA and community based agencies

Collaborate

Coordinate care with home health, hospice, palliative care

Ensure outstanding issues are addressed at initial PCP visit

Impact of Collaboration

Collaboration and REDcap Data

Readmission

September 2016 – June 2017
## Patient Demographics

<table>
<thead>
<tr>
<th>Category</th>
<th>HOPE (N:226)</th>
<th>HOPE Plus DukeWELL (N:30)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>79</td>
<td>82</td>
</tr>
<tr>
<td>Female</td>
<td>63.7%</td>
<td>67.9%</td>
</tr>
<tr>
<td>Race: White</td>
<td>72.1%</td>
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<tr>
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<tr>
<td>Race: Asian</td>
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<td>0.0%</td>
</tr>
<tr>
<td>Race: Other</td>
<td>2.7%</td>
<td>3.6%</td>
</tr>
</tbody>
</table>

## Readmission Rates

- 7 Day readmission: HOPE Plus DukeWELL (30%)
- 14 Day readmission: 14.3%
- 30 Day readmission: 0.0%

## Severity of Illness

- Average LOS: HOPE (21.26) vs. HOPE Plus DukeWELL (21.71)
- Case Mix Index: HOPE (6.48) vs. HOPE Plus DukeWELL (6.48)
**Discussion**

HOPE DukeWELL readmission rates are higher when compared to HOPE.

- DukeWELL patients are clinically complex as seen in the CMI and longer LOS

  AND

- Greater use of high risk medications and use of antipsychotics
Discussion

Patient and Family Engagement
- SNF Brochure
- Rehab Orientation

Cross-Continuum Team Collaboration
- Duke SNF Collaborative
- HOPE/DukeWELL Collaboration

Health Information Exchange and Shared Care Plans
- Medlink
- Discharge to Outside Facility Form

Our Team
- Michael Krol, MD
- Tyanna Thomas
- William English, MBA, MSHA
- Loretta Matters, MSN, RN
- Heidi White, MD, MHS, MEd, CMD

Thank you