What’s in the Secret Sauce? How Nurse Practitioner Managed Care Differs in Preventing Nursing Home Placement and Supporting Transitions in Care

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After this presentation participants will be able to:

• Describe the role of the NP within a NP led PACE program
• Identify NP interventions that support aging in their home and preventing nursing home placement
• Describe the roles of the NP and RN in the NP led Transitional Care Program
• Differentiate between Transitional Care Model (Naylor) and Coleman Transitional Care Model (Coleman) and how they were combined for this program
• Differentiate rehospitalization rates and lengths of stay before the start of the program and after
Opening of LIFE UPenn
What Makes Nurse Practitioners Unique

• Nurse Practitioners are nurses first
• Bridge the Communication gap between Medicine and other disciplines
• Care coordination part of NP education
• Biopsychosocial Model
Nurse Practitioner Led Model at LIFE UPenn

• A nursing perspective was not added to LIFE UPenn, a nursing perspective produced LIFE UPenn

• Penn Life’s practice model was built by primary nurses and Nurse Practitioners, who appreciate the full scope of nursing care and maximize nursing contributions made to LIFE members
Nurse Practitioner Led Model at LIFE UPenn

- NPs lead 5 interdisciplinary teams and panels of Members, providing both primary care and intensive care coordination (NP to Member ratio is 1:90)
- Life’s Medicare Waiver allows NPs to function at the full scope of practice (i.e. make all primary care visits except for those to a skilled nursing facility or hospital that specifically require a physicians visit)
Nurse Practitioner Led Model at LIFE UPenn

- Each interdisciplinary team and member panel includes a Baccalaureate prepared nurse who works closely with the NP
- Integration of an interdisciplinary mix of professional students from area colleges and universities enhances the highest level of Evidence Based Practice
LIFE Nursing Professional Model

• Owned and operated – Penn School of Nursing
• Chief Nursing Officer & Member Services
• Primary Care – Nurse Practitioners
• Geropsychiatric Nurses
• Transitional Care Nurse Practitioner
• Transitional Care RN
• Home Care Nurses
• Day Center Triage Nurses
Nursing Committees at LIFE led to Pathways to Excellence Designation

- Nursing Council
- Primary care
- Quality Assurance and Process Improvement
- Evidence Based Practice
  - Journal Club
- Palliative Care
Nurse Practitioner Led LIFE Program

17 years of successful NP model of care for multimorbid dual-eligible older adults

- Expert NP Clinicians
  - Pathways to Excellence
  - Holistic Care
  - Collaborative coordination of care
  - Transitional care

- Biopsychosocial Environmental focus
- Leadership in Education Mentorship of Students & Colleagues
- Change Agent & Quality Improvement
- International & National Recognized Model of Practice

- High Member Satisfaction

- Nursing
- Social Services
- Rehabilitation Services (PT/OT/Recreation)
- Physicians
- Transportation
- Pharmacy
- Nutrition
- Spiritual Care
- Consultants (Geropsychiatry, Eye, Dental Podiatry)

NPs Lead the Interdisciplinary team with low use of consultants

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Case 1

Mr. S, a new enrollee, is 58 y/o with multiple morbidities, including diabetes, hypertension, depression with anxiety, rapidly progressing kidney disease, left above the knee amputation with a prosthesis, and cocaine dependency with cocaine related complications. He has a history of homelessness, but has been living with his daughter for the past year, but sleeps on the couch. Mr. S must rely on Para Transit for medical appointments; otherwise, he is essentially housebound. The bathroom is upstairs; he must “bump” up the steps on his bottom to get there. Mr. S is fiercely independent, but is depressed about his current living situation and needs an “outlet” in order to cope with his many problems. He is joining the LIFE program to gain some control over his rapidly changing health status, to access social activities, and to receive assistance in placement in public housing.
The most urgent problems were identified by the NP and the following interdisciplinary plans initiated:

- **Severe advancing kidney disease**: Medical records were accessed and NP ordered relevant lab tests and recommended possible referral to the renal specialist.

- **Left leg amputation with prosthesis; right knee weakness.** Mr. S is able to stand and transfer, but cannot negotiate stairs. Plan of care coordinated with PT & OT; treatment goals established to improve function and mobility. Home care contacted with recommendation for 2 hours of home care / week.

- **Active cocaine dependency with moderate to severe depression/ anxiety**: Contacted LIFE geropsychiatric team for more planning and appropriate intervention for depression and drug treatment options. Request made to increase the number of days at LIFE for more contact and support.

- **Living in temporary housing with daughter.** PHA paper work completed same day as enrollment. Coordinated with social work to address safe permanent housing with wheelchair access.

- **Meet with IDT one week after enrollment to discuss progress and continue active communication with all disciplines to support member and improve current health & living status.**
Follow-up on Case 1

- Own apartment
- Not using drugs
- Seeks geropsych group routinely
- Regular center attendance
- Actively participates in his care
- Primary care streamlined
- Tight coordination with Renal now on track to start dialysis
Case 2

• Mrs B is a 66 y/o established enrollee. S/P fall developed epidural abcess L5-L7 which thrombosed causing cord ischemia and subsequent lower extrem paraplegia.

• During hospital and rehab course she developed a Large stage 4 sacral decub w/ subsequent osteomylitis of sacrum precipitating coccygectomy. Afterwards she developed an anal fistula w/ subsequent expl. lap and colostomy diversion.

• She is now in chronic urinary retention with a foley catheter and has a J tube in place for daily tube feedings. She is receiving IV antibiotics for UTI and has a PICC line in place.

• She also has wound vac in place for the sacral decubitus ulcer. Mrs. B has been in the LTAC for nearly a year and she and her family are asking for her to go home.
Case 2 contd.

• Mrs B was placed in one of our SAL (supportive apartment living) apartments with round the clock caregiver support. Several meetings with the IDT and family to plan an arrange her discharge.

• Her Care plan included the following interventions:
  – Paraplegia as a result of thrombosed ischemia L5-L7- wheelchair bound. hoyer transfers. PT working on upper body strengthening.
  – Stage 4 sacral decub- wound vac- arrange for dressing changes mon, wed and fridays. protein supplements. ascorbic acid/ zinc. ensure. clinitron bed until wound is healed.
  – ostomy- as a result of anal fistula and subsequent coccyx osteomyilits. functioning well. change bags and wafers as needed
  – neurogenic bladder- member has residuals of 700-800 cc. unable to cath member TID. opted for foley until wound is healed. once wound is healed, consider BID caths. change catheter q 2-3 weeks.
  – J-Tube- J-Tube fell out the first night. she does not want the J-tube replaced, member and her dtr feel she is capable of taking adequate nutrition by mouth and member is willing to take protein supplements by mouth TID. discussion w/ Dr, member and dtrs, , the plan is to keep tube out. Encourage PO intake. Dietary to follow closely
Case 2 contd.

• Her Care plan also included the following interventions:

  – UTI/ PICC- IV antibiotics x 1 week- home infusion nurse to manage until course of therapy has finished
  – Depression- currently being treated w/ mirtazipine. mood is much improved, she is adjusting to the center and home again, less anxious spending more time doing activities and less time in clinic. Continue to be followed by Behavioral wellness
  – severe carpal tunnel disorder bilat hands- sign. atrophy weakness both hands. no pain. adaptive equipment for eating. Arrange for evaluation for power mobility device to enable member to more mobile and independent
  – Member initially will be daily attendance until she feels she has stabilized
Case 2 concluded

- Mrs. B lived in her apartment for 3 years after her discharge from the LTAC. She vowed to never have another hospitalization or procedure again. She developed end stage renal disease and staying true to her vow opted out of hemodialysis. She died peacefully in her apartment with her daughters in attendance.
Transitions of Care

• According to the Joint Commission, transitions of care refers to any patient movement between HC practitioners, settings and home

• Example of ineffective transitions of care:
  – Taken from one of the vignettes from the 1st Joint Commission paper
  – 78 yo woman s/p fall placed on several new medications [from Hot Topics in Healthcare, see References]
Models for Transitions of Care

• Naylor’s Transitional Care Model
  – Uses advanced practice nurses to oversee transitions; customized care plans; home visits for an average of 2 months after discharge

• Coleman’s Care Transitions Intervention
  – Specially trained coaches [RN, SW] to educate & facilitate continuity; home visits for about 1 month

☐ BOTH MODELS VISIT IN HOSPITAL AS WELL
THE BLEND at LIFE UPenn

• Naylor and Coleman
  – NP in the role of Care Transitions Coordinator
  – RN in the role of Care Transitions Nurse
  – Members are seen in various settings including hospital, hospice, LTAC, acute and subacute rehab
  – Members are often brought to the center to be assessed by team during transitions
  – In some cases, team members visit member at home post discharge.
  – HC nurse conducts home visit to assess meds, function and environment
  – Med reconciliation is done between settings and at time of discharge to home
  – Family meetings with member, if able, arranged to discuss goals of care
OUR GOALS

– Effective Communication to all parties involved
– Comprehensive member and family education especially with medications
– Accountability for coordination across settings
– PACE [LIFE] PCP involvement during transitions
– Timely follow up with PCP, IDT and specialists as needed
– Care plan revised/updated as needed
Developing a Transitional Care Program

- Transitional Care Nurse
- Transitional Care Committee
- Home care department for visits and DME
- Med room and pharmacy
- Involvement of the IDT
- Policies, procedures, forms
- Documentation in the EMR
Effective Transitions of Care

• Ensuring coordination of services and continuity of care

• Advocating for our members
  – Ex: member who was obtunded & the hospital was going to d/c to NH that day

Medication Reconciliation

Ability to order medications and other treatment modalities

Strong communication skills

Reinforcing teaching

Goals of care discussions
Hospital Admissions, Re-admissions and LOS

- Statistics recorded in excel spreadsheet
  - Member, facility, ER, Location, Transport, Diagnosis, Admission, Discharge to; all cause re-admission within 30 days
  - Re-admission rate <15%; 3\textsuperscript{rd} Q 2015: 8.2%
Final Thoughts on Transitions Monitoring

• Med reconciliation at the skilled facility
  – Ex: member whose levothyroxine fell off the med list while inpatient....... 

• Monitoring the BIG diagnoses: COPD, CHF
  – Especially for re-admission rates 

• Following up on ER only visits
  – Transitional Care Nurse
Transitional Care Registered Nurse

• Make contact in person or by phone with member or family caregiver 24 to 48 hours following discharge from hospital or SNF (Front loading contact)
  – Medication reconciliation
  – Primary care appointments
  – Member Education
  – Social and Care issues
  – Safety
  – Center attendance
Medication Reconciliation

• Goal is to avoid medication adverse events and rehospitalization
• Initially done by Transition Care NP post hospital or SNF for medication changes
• Once home the RN follows up with medication changes
  – If meds have been stopped home care nurses are notified to retrieve old medications and assess status of current medications
  – Home care nurse makes the changes to their medications to facilitate increased adherance
Primary Care Appointments

- Goal is to have the member seen in primary care within the week following discharge
  - Communicate with member or family the need to come to Center to see Primary Care Team
  - Arrange transportation
  - If not able to come to the center Transitional RN communicates with Primary Care RN to follow-up and stay in contact with the member
  - If needed send home care nurse for follow-up visit
Member Education

• Goal is to begin education with member and or the family caregiver why they went to the hospital
  – Review signs and symptoms
  – Anticipatory Guidance to prevent future hospitalizations
  – Individualized Education surrounding diet and fluid intake targeted towards condition that sent them to the hospital
  – How do they perceive their own health has their decisions around end of life care changed
  – Remind the member about the on call nurse and how to contact the on call nurse
Social and Care Issues

• Goal is early identification of increase care needs and potential social issues that may impact care
  – Members often describe their care needs during first contact following hospitalization without prompting
  – Ask about how things are going at home
  – Family report they are overwhelmed and need assistance
  – Alert the team of identified needs and team to follow up with home care assessment/family meeting/social work referral
Safety

- Goal is to review safety precautions for ambulation, toileting, bathing and medications to avoid adverse events and rehospitalization
  - If changes have occurred in their functional status, safety precautions are reviewed and referral to team for home safety evaluation for equipment if not completed prior to discharge
  - Review medications for adherence and medication delivery system changes, safety of medications with family members in the home
Center Attendance

• Goal is to resume center attendance as soon as possible
  – Review with member the need to resume center attendance
  – Follow-up with transportation to resume center attendance
  – Assess need to have IDT to evaluate the need to increase center attendance due to medical necessity, often short-term post discharge
Emergency Room Visits

• Transitional Care Nurse follows up on all ER visits when the member was not admitted
  – Review on call coverage for members available 24 hours a day
  – Review phone number with member
    • Magnet
    • Bracelet
  – Review how to contact team when have health concerns
  – Review can make an appointment with team
  – Review symptom management
Transitional Care Checklist

Done with member ________________  Caregiver ________________

Date ________________  Time ________________

1. Tell me why you were in the hospital?
   □ Accident  □ ER  □ Long-time diagnosis
   □ Inpatient  □ Pain

2. How is your appetite? Fluid intake? (What are you eating/drinking?)
   □ Good  □ Good
   □ Fair  □ Fair
   □ Poor  □ Poor

3. Are you due back at LIFE to see your NP or RN?
   □ Yes  □ No

4. How do you feel about your overall health at this point? (Review recent hospitalizations if indicated)
   □ Good  □ Fair  □ Poor

5. Review on-call procedure.

6. Is there anything else you think you need?

RN ________________

Recommendations/Concerns:

Labs  RN Education  Center Attendance
Hospice  Hospice  None
PT  Medication Reconciliation/Review
OT  Social Issues
Transportation:
WHO YA GONNA CALL??
MAGNETIC PHONE REMINDER

STOP
If you need HELP
Call a LIFE Nurse First

215.573.7200

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Care to change the world.
QUESTIONS?
REFERENCES


REFERENCES


• Hot Topics in Health Care: Transitions of Care: The need for a more effective approach to continuing patient care; The Joint Commission
REFERENCES

• Hot Topics in Healthcare, Issue 2: Transitions of Care: The need for collaboration across entire care continuum; The Joint Commission