Preventing Readmissions with Nurse Navigation

Heather Peiritsch MSN RN
Abington Hospital - Jefferson Health, Abington, PA.

Abington Jefferson Health
HOME OF SIDNEY KIMMEL MEDICAL COLLEGE

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

Abstract

Effective October 1, 2012, the Affordable Care Act added a section establishing the Hospital Readmissions Reduction Program (HRRP). This is defined as a readmission to a hospital within 30 days of discharge from the same or different hospital. The initial diagnoses that were targeted were acute myocardial infarction, heart failure and pneumonia. Beginning in 2015 the program expanded to include chronic pulmonary disease and elective total hip arthroplasty and total knee arthroplasty. In 2017, patients admitted with coronary artery bypass graft are now included in the readmission penalty. In April 2015 Abington Hospital voluntarily became involved in the Bundle Payment Care Initiative for major joint replacements with and without complications. The program goals were to reduce readmissions, reduce skilled nursing facility placement and reduce skilled nursing facility length of stay. In July 2015, Abington entered the bundle for bilateral joint replacements and in October 2015 the hospital expanded to heart failure and stroke. The benchmark metrics that were given by Centers for Medicare & Medicaid Services (CMS) was data from 2009-2012. Internal target goals for the organization were set below the benchmark data. For the above goals achievement was below the baseline with the exception of stroke by 0.3 percent during FY17. In April 2016, the nurse navigation program expanded to cover patients under Medicare and IBC coverage with a diagnosis of COPD, MI, and CABG for 30 days. Benchmark data for these diagnosis was taken from Crimson Continuum of Care An Advisory Board Company Software Tool.

The Nurse Navigation Program presents opportunities to reduce readmission by increasing use of hospice and palliative care and by clinical monitoring and navigation throughout the 30 or 90-day period following discharge. Improved clinical outcomes, patient engagement and sustained financial value are the hallmark of the Nurse Navigation Program. This program supports the transformation of Abington Health from a volume-based fee for service institution to an organization capable of managing the health and wellness of select populations.

Role of the Nurse Navigator

- Monitors the patient beginning with the index hospital admission to hospital discharge and continuing for 30 or 90 days post acute.
- Communicates and rounds with multidisciplinary inpatient hospital teams daily.
- Collaborates and communicates with post acute community partners weekly and as needed
- Performs telephonic clinical assessment, medication reconciliation, follow up appointments, and community referrals.
- Performance of real time readmission review.

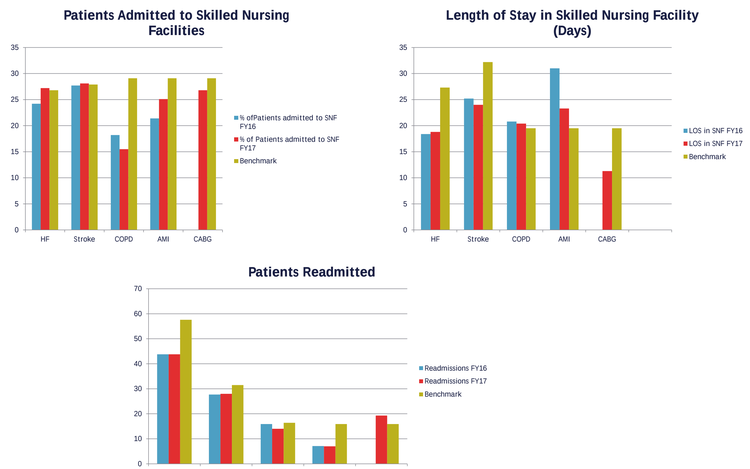
Collaboration with Post Acute Partners

- March 2015 four skilled nursing facility (SNF) providers and one homecare agency were established as preferred providers for Abington Hospital.
- Facility and homecare personnel were educated by clinical experts to standardize care.
- Reoccurring multidisciplinary monthly meetings were created for SNF's to discuss clinical issues, length of stay, readmissions, and high utilization patients.
- Unblinded score cards were created to display the CMS quality metrics for the facilities as well as the readmission rate and length of stay for navigated patients.
- August 2016, a second group of SNFs were selected to meet monthly.
- Meetings with SNF Medical Directors occurred to discuss enhanced communication at the caregiver level.
- Point persons were established with community partners for follow up patient assessment.
- Outcomes to date are: creation of clinical guidelines and protocols, increased multidisciplinary communication and readmission review, two symposiums hosted by Abington Hospital for post acute community partners and a SNF skills lab hosted by the navigation department at Abington Hospital.

Readmission Reduction

- Clinical expertise of the nurse navigator strengthens the patient focus and allows for high level critical thinking to be utilized.
- Intermediary advocating for patients within the post acute continuum.
- Relationship building with patients and post acute partners.
- Minimum of weekly communication and follow up to discuss early changes in condition.

Results & Outcomes



Conclusion

A Nurse Navigation Program positively impacted the decrease of SNF admissions allowing patients to rehabilitate in their own homes, demonstrated a decrease in SNF length of stay and a decrease in hospital readmissions.

References

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

Disclosures

None. Contacts: Heather.Peiritsch@jefferson.edu