Nurse Transition Coach Model: Innovative, Evidence-based, and Cost Effective Solutions to Reduce Hospital Readmissions

Leslie Becker RN, BS
Jennifer Smith RN, MSN, MBA
Leslie Frain MSN, RN
Jan Machanis MSN, RN
Kathy Benjamin MSN, RN
Donna McNally MSN, BSN, RN
Susan Morby MSN, RN, NE-BC
Randy Parker PhD, RN, NEA-BC
Introduction

Four culturally and socio-economically diverse community hospitals in the United States implemented a Nurse Transition Coach Model (NTCM) that significantly reduced readmission rates in patients with congestive heart failure (CHF) from 2011 through 2013.
Background

- In 2003-2004 Medicare fee-for-service data identified 30-day readmission rates for heart failure to be 26.9%

- Reduction in hospital readmission rates have been identified by Congress and President Obama as a source to reduce Medicare spending

- Health care costs impose an increased burden on the Federal budget

- On March 23, 2010 comprehensive healthcare reform legislation was signed into law by President Obama; Patient Protection and Affordable Care Act

Patient Protection and Affordable Care Act

- **Provisions**
  - Reduce preventable readmissions by reducing Medicare payments to hospitals with high preventable readmission rates
  - Demonstration projects to test reform of Medicare payment system
  - Demonstration projects to test improvements to patient care for people with chronic illness across the continuum

- 2012 hospitals were penalized up to 1% of every Medicare payment

- 2013 hospitals were penalized up to 2% of every Medicare payment

- 2017 Medicare may penalize providers and hospitals 8% if they fail to substantially reduce readmission rates

Objectives

- To improve care of patients vulnerable for readmission across the continuum

- Reduction of preventable CHF readmissions at our facilities from 25-17% in 2011, to 11% in 2013, by developing a NTCM utilizing evidence based practice

- Avoid loss of revenue from Medicare penalties
Definition

Readmission

- Readmit to same or different hospital
- Planned or unplanned surgical or medical procedure
- Within a specified time frame 30 days
Factors Associated with Readmissions

- Handoff of medical care information during transition to the next level of care and the primary care physician
- Patient education about diagnosis and the discharge planning which begins on admission
- Follow-up from hospital to next level of care: home, SNF, sub-acute
- Medication reconciliation and realistic plan for obtaining; resulting in medication errors
- Comprehension of a plan if condition worsens (notify PCP, TC, HHC)
- Discharge summary
- Discharge instructions: diet, activity level, follow up appointment with primary care physician, daily weights, plan is symptoms worsen, medication education
Method

- Establish discharge planning stakeholders committee
- Research service delivery models
- Develop a transitional discharge model
- Implement the discharge model
- Evaluate, improve, and evolve into

The Nurse Transition Coach Model
Conclusion: “No single intervention implemented alone was regularly associated with reduced risk for 30-day rehospitalization.”

Promising Approaches to Reduce Readmissions

- Improved Transitions Out of the Hospital
  - Project Red
  - Boost
  - IHI’s Transforming Care at the Bedside
  - Hospital to Home “H2H” (ACC/IHI)
More Promising Approaches

- **Supplemental Transitional Care after Discharge from the Hospital**
  - Care Transitions Intervention (Coleman)
  - Transitional Care Intervention (Naylor)

- **Alternative or Intensive Care Management for High Risk Patients**
  - Proactive palliative care for patients with advanced illness
  - Evercare Model
  - Heart failure clinics
  - PACE Program; programs for dual eligibles
  - Intensive care management from primary care or health plan
Nurse Transition Coach Model

- Ground in Jean Watson’s theory of human caring emphasizing rapport and trust building with patient’s and their families

- Establish a care continuum hand off with bi-directional communication to insure shared accountability for collaborative decision making
  - Multidisciplinary rounds
  - Patient/caregiver follow-up within 48 hours of discharge and weekly for 30 days
  - Hand off to complex care managers after 30 days
  - Homecare case-manager weekly report
  - SNF or sub-acute weekly report

- Process Improvement
  - Bedside post readmission meeting with transition coach, CNO, CMO, case management
  - Readmission Review Weekly Meeting and root cause analysis of all readmissions
  - Monthly Readmit Care Meeting with community care, home care, social work, case management, quality, transition coaches
Nurse Transition Coach Model, A Patient Centered Approach

- Upon Admission we establish a mutually responsible relationship with patient and family; patient centered and specific

- Assess the patient’s understanding, goals, and needs (transportation, caregivers, money for medications....)

- Individualize each patient’s care and liberate resources needed

There is no single answer for our patients, they are all different, with their own story and circumstance, their own vision of quality of life.

The transition coach is their teammate, coach, facilitator, organizer, planner, teacher, and partner, always available to help with even their most fundamental need of respect, trust, and consistency. The transition coach is the voice that is always available inpatient and outpatient.
Successful Innovative Strategies to Prevent Hospital Readmissions

- Receives a starter pack of discharge medications regardless of ability to pay
- Discharged with a follow-up appointment with 72 hours
- Given access to affordable transportation for physician visits (i.e., $2:00 a ride)
- Referred to homecare and seen with 24-48 hours of discharge with recommended visit frequencies
- Bedside report/debriefing for each readmission at 8:00a.m. with the Readmit Care Team
- Primary care physician intervene at readmission to treat and discharge in observation status
Results/Outcomes
Cost Savings: $294,429

2011-2013 Readmission Rates

<table>
<thead>
<tr>
<th>Hospital</th>
<th>2011</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital A</td>
<td>17</td>
<td>8</td>
</tr>
<tr>
<td>Hospital B</td>
<td>25</td>
<td>9</td>
</tr>
<tr>
<td>Hospital C</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Hospital D</td>
<td>20</td>
<td>16</td>
</tr>
</tbody>
</table>
Future Directions

- Broaden the NTCM to a larger population, expand to all patients
- Expand to all payers
- Risk stratification tool
- Tele-health
- Meaningful use
- Leveraging technology
References

