Health Care Policy: The Role of Nurses in Achieving Quality Outcomes for Heart Failure Patients

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Disclosures

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Objectives

• Discuss nursing’s role in the changing healthcare delivery system as it relates to the interdisciplinary team and excellence in care delivery across the continuum

• Discuss the role of nursing in preventing avoidable hospital readmissions
What is Health Policy?

- Refers to decisions, plans, and actions undertaken to achieve specific health care goals within a society

- An explicit health policy can:
  1. Define a vision for the future - help to establish targets and points of reference for the short and medium term
  2. Outline priorities and the expected roles of different groups
  3. Build consensus and inform people

Health Policy - Readmissions

- Policy makers constantly searching for ways to improve quality of patient care and lower Medicare program spending
- Medicare Hospital Readmissions Reduction Program (HRRP) established in the Affordable Care Act (ACA)
  - Financial incentive to lower readmission rates
- ACA gives secretary of the DHS the discretion to expand to additional high-volume or high-expenditure conditions to the extent practical

Impact of Hospitalizations

- Hospitalizations account for nearly 1/3 of the total $2 trillion spent on health care in the US
- Most are necessary and appropriate
- About 20 percent of US hospitalizations are rehospitalizations within 30 days of discharge
- Medicare Payment Advisory Committee (MedPAC), up to 76 percent of 30 day rehospitalizations within 30 days of discharge are avoidable
Impact of Readmissions

Care transitions occur when a patient moves from one health care provider or setting to another. Nearly one in five Medicare patients discharged from a hospital - approximately 2.8 million seniors - are readmitted within 30 days, at a cost of over $26 billion every year.


Readmissions- Not Just $!

- Indicator of the (or lack of) care coordination amongst providers and across the continuum of service
- Stimulates hospitals to reach beyond their walls into the community and build collaborative relationships
- Stimulates the development of integrated care systems
- Is a precursor to bundled payments and shared risk models of reimbursement
- Hospitals are a costly, and at times, even dangerous venue for care

Shi et al., 2008 Commonwealth Fund pub. no. 1155
Crisis = Opportunity

“When written in Chinese, the word 'crisis' is composed of two characters. One represents danger and the other represents opportunity.”

John F. Kennedy

Readmissions are a Crisis

- An opportunity for teams to develop and grow - with nurses at the center!
- Success is a step toward reducing the fragmentation of care
- If we succeed:
  - Patients will do better!
  - Will create precedent for changing health care that will hold promise for helping to save it


Power of Design

“Design is thinking made visual”

Florence Nightingale
Nightingale Ward

St. Thomas Hospital:
- beds well apart
- interspersed by windows
- specialist heaters mid-ward created up-currents of hot air to remove stale air and increase the circulation of fresh air

Inventions by Nurses

Neonatal phototherapy- 1950’s

Disposable baby bottles - 1946
Inventions by Nurses

Crash Cart - 1960's

Ostomy bag - 1953

In 1954, Elise Sarensen designed a revolutionary ostomy bag for her sister, who had colon cancer.

Key Resources

- The Future of Nursing: Leading Change, Advancing Health; 2010, Institute of Medicine; www.iom.edu/nursing

- The Value Of Nursing Care Coordination: A White Paper of the American Nurses Association; June 2012, American Nurses Association; CNPE Health Policy Workgroup

- Nurse Role Exploration Project: The Affordable Care Act and New Nursing Roles; October 2014, Nurse Leader; Berg & Dickow
**Keys to Success**

- **Recommendation 2:** Expand opportunities for nurses to lead and diffuse collaborative improvement efforts.
  - Health care organizations should support and help nurses in taking the lead in developing and adopting innovative, patient-centered care models.
  - IOM - The Future of Nursing, 2010

- “The RN’s ability to create a relationship in which people are enabled to hear and respond to the care advice being offered is key to the success of this role.”
  - ANA – The Value of Nursing Care Coordination, 2012

**Inventions by Nurses**

**Reducing Hospital Readmissions - 2010**

**Multidisciplinary Team**

- Pharmacists, Respiratory Therapists
- Social Workers, Case Managers
- Palliative Care, Hospice
- Physicians, Nurses, Physical Therapists
- Care Transition Coordinators, Navigators
- Home Health, Advanced Illness Management, Skilled Nursing Liaisons
- Patient!
### Middle of the Team

- Pharmacists, Respiratory Therapists
- Social Workers, Case Managers
- Palliative Care, Hospice
- Physicians, **Nurses**, Physical Therapists
- Care Transition Coordinators, Navigators
- Home Health, Advanced Illness Management, Skilled Nursing Liaisons
- Patient!


### APRN Models: Naylor

- APRN Transitional Care Model
  - University of Pennsylvania
  - APRN optimizes identified high risk patient's health during hospitalization and designs plan for follow-up care
  - Provides visiting nursing
  - Available 7 days a week by phone
  - Improves patient satisfaction, reduces rehospitalizations, decreases costs

Naylor et al; Journal of the American Geriatrics Society; 52(5); 2004

### APRN Models: Coleman

- Care Transitions Coaching; 4 week process
  - University of Colorado Health Sciences Center
  - APRN teaches patient/caregiver skills to assume more active role during care transitions
  - Lowered all-cause readmissions and hospital costs
  - Four Key Elements
    - Medication Self Management
    - Patient-Centered Health Record
    - PCP/Specialist Follow-Up
    - Red Flags

Coleman, Archives Internal Medicine, 166; 2006
Improving Outcomes

- **Transitional Care Programs Improve Outcomes for Heart Failure Patients: An Integrative Review (n=20)**
- Transitional care programs for individuals with HF can increase patient's quality of life and decrease number of readmissions and overall cost of care
- Most successful interventions were home visits alone or in combination with telephone calls

Stamp et al; 2014; JCN: 29; 2; P14054

### Transitional Care Programs

![Diagram of transitional care programs]

Naylor et al; Journal of the American Geriatrics Society; 52(5); 2004

Gaps During Transitions

- Poor communication
- Incomplete transfer of information
- Inadequate education of older adults and their family caregivers
- Limited access to essential services
- Absence of a single point person to ensure continuity of care
- Language/health literacy issues and cultural differences

Nyble et al; Journal of the American Geriatrics Society; 52(5); 2004
Working with Patients

- Active Listening
- Shared decision making
- Motivational interviewing
- Patient centered goals
- Goals of Care
- Teach back
- Availability
- Follow Up
- Novice ➔ Expert

Working with Systems

- Get a seat at the table....even if you have to invite yourself (easier to do if you have an advanced degree)
- Don’t settle for “no”....reframe the idea/proposal
- Find your allies....they may be people you would never expect (PT, pharmacists, doctors, volunteers, patients)
- When offered an opportunity, find a way to say yes...this will open doors you didn’t know were there
- Show them the importance of the voice of the nurse....they won’t regret it
Opportunities for Nurses

- Disease Telemangement Program
- Intensive Outpatient Care Program
  - Using care coordinators to manage chronic disease; in home visits
- Transitional Care Coordinators
- Skilled Nursing Facilities
- Consulting
- Health Policy, Advocacy, Legislation!
- Clinical Nurse Specialists
- Clinical Nurse Leaders
- Masters in Case Management
- Nurse Practitioners

Remaining Relevant

People who say it cannot be done should not interrupt those who are doing it.

George Bernard Shaw

What Will You Design?