Healthcare Transformation: Emerging Roles for Nurses
Presented by: Jayne Mitchell, ANP-BC, CHFN
Date: May 20, 2014

Evolution of Nursing

Projected changes in the model for healthcare delivery in Oregon
Payment Penalties:

Medicare Provisions in PPACA Readmissions

1. A risk-adjustment model which includes age, gender, race, poverty level, chronic conditions or diagnosis, and comorbidities that patients had when they arrived at the hospital that will begin to impact their payments for Medicare inpatients during 2015.
2. Hospitals with "excessive readmission rates" before program start will receive a reduction in Medicare payments.

Why do patients readmit?

The top five reasons:

- Patients may not fully understanding what’s wrong with them
- Patients may be confused over which medications to take and when
- Hospitals don’t provide patients or doctors with important information or test results
- Patients do not schedule a follow up appointment with their doctor
- Family members lack proper knowledge to provide adequate care

Scope of the problem- nationally

- Heart failure is a disease of epidemic proportions. Approximately 4.6 million Americans are currently living with heart failure.
- Approximately 1 million hospitalized a year
- Average rate for 30 day all cause readmission on Hospital Compare is 24.7%
- 12 billion dollars spent per year on 30 day readmissions alone
From: Diagnoses and Timing of 30-Day Readmissions After Hospitalization for Heart Failure, Acute Myocardial Infarction, or Pneumonia


Scope of the problem - locally

- OHSU has about 400 patients a year who are seen for primary heart failure
- OHSU Hospital Compare rate 26.1% for all cause readmissions
- Approximately 40% of our patients come from out of area
- OHSU cost for readmissions?

Heart Failure at OHSU
OHSU Patients Discharged with Heart Failure Primary Diagnosis
30-day Related and All Cause Readmission to OHSU UHC data

- FY 2010 n=343
  - Related: 17%
  - All Cause: 31%
- FY 2011 n=365
  - Related: 13%
  - All Cause: 28%
- FY 2012 n=381
  - Related: 11%
  - All Cause: 19%
- FY 2013 n=382
  - Related: 8%
  - All Cause: 17%
Why are transitions important?

- Right thing to do for the patient
- The Patient Protection and Affordable Health Care Act (law March 23, 2010)
- Triple Aim
  - Population health
  - Experience of care
  - Per capita cost

HF survival: poor regardless of EF

Increased hospitalizations equals poor prognosis
Transition of care

- The movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehab facility) to another.

Centers for Medicare and Medicaid Services

What are the issues that effect transitions?

- Sick patients
- Geography
- Electronic records that act as silos
- Health literacy issues
- The two week follow up fallacy
  "follow up with your PCP in 2-4 weeks"
- Optimizing Evidence Based Practice

What can nurses do?
The Transitional Care Model

Translating Research into Practice and Policy

Mary D. Naylor, PhD, RN, FAAN
Marian S. Ware Professor in Gerontology
Director, NewCourtland Center for Transitions and Health
University of Pennsylvania School of Nursing

Context: Acute Care Episode

Trajectory 1 (T1) Relatively healthy adult with onset of new chronic illness
Trajectory 2 (T2) Adult with multiple chronic conditions
Trajectory 3 (T3) Adults at end of life

Population At Risk Acute Phase Post Acute/Rehab Phase
Secondary Prevention

Adapted from the National Quality Forum (NQF) steering committee on Measurement Framework: Evaluating Efficiency Across Patient-Focused Episodes of Care. The committee’s report presents the NQF-endorsed measurement framework for assessing efficiency and ultimately value, associated with the care over the course of an episode of illness and sets forth a vision to guide ongoing and future efforts.

Different Goals of Evidence-Based Interventions

- Address gaps in care and promote effective “hand-offs”
- Address “root causes” of poor outcomes with focus on longer-term value
Transitional Care Model (TCM)

- Screening
- Maintaining Relationship
- Engaging Elder & Caregiver
- Coordinating Care
- Managing Symptoms
- Ensuring Continuity
- Educating
- Collaborating

Unique Features

Care is delivered and coordinated
...by same advanced practice nurse
...in hospitals, SNFs, and homes
...seven days per week
...using evidence-based protocol
...with focus on long term outcomes

![Caregiver image]


How can Case Managers help?

- Encourage the patient to become an expert with self care
- Address health literacy issues
- Polpharmacy
- Patient engagement
- Optimizing follow up

Self-Care
The process of making decisions about symptoms when they are recognized

Heart Failure and self-management

Self-Care of Heart Failure Model

- Self-Care Maintenance
- Self-Care Management
- Symptom monitoring and treatment adherence
- Symptom Recognition
- Symptom Evaluation
- Treatment Implementation
- Treatment Evaluation
- Self-Care Confidence


Self-Care
The process of making decisions about symptoms when they are recognized
Why focus on Self-Care?

- Better self care results in improved outcomes: reduced health care cost, length of stay for HF by as much as a 39-56%.

Nursing role in self-care

- Provide education
  - Include behavioral strategies if needed
  - Help patient plan how they will succeed with the task
  - Goal setting
  - Include caregivers
- Self care maintenance
  - Actions follow advice of providers
- Self-care management
  - Decision making and behaviors engaged in response to physiologic symptoms

Self-Care

- Quality of life
- Risk of hospitalization
- Sense of control
Heart Failure and self management: moving the patient from novice to expert

- Experts: Experienced and skilled, positive attitudes, including confidence, functionally compromised
- Inconsistent: Lack of vigilance, cognitive decline, lack of family engagement
- Novices: Higher functional status, poor attitudes, low confidence, daytime sleepiness, depression

Source: Nat Rev Cardiovasc Med © 2011 Nature Publishing Group

Keeping it basic??

You have cardiomyopathy!!
you may experience dyspnea
on exertion or orthopnea

Basic Heart Failure Daily Education
RN’s assess every day, patients given scales if needed
whiteboard used

Developed by:
Cecil G. Sheps Center for Health Services Research
UNC at Chapel Hill

Feinberg School of Medicine
Northwestern University

UCSF
Hfeducationalmaterial@schsr.unc.edu
NIH Grant, NHLBI
Enhanced teaching and learning

Utilizing “Teach Back”

- Example: “I want to be sure that I did a good job of teaching you today about how to stay safe after you go home. Could you please tell me in your own words the reasons you should call the doctor?”
- Return demonstration or show back

Triple aim
Follow up appointments

• Early follow-up *
  – Associated with reduced readmissions
  – Poorly implemented nationally
  – Frontloading (60% of visits within first 2 weeks) was effective in reducing 30 day readmissions**

• Goal:
  – Call within 48-72 hours-review meds, apt reminder
  – Within one week of hospital discharge pt has face to face with provider
  – Advance Practice Nurse/ PCP/ Cardiology teamwork
  – Follow for critical transitional period

*Hermandez WF, et al. JAMA. 2010;303(17):1716-1722

Disease trajectory

Figure 1: Schematic Depiction of Comprehensive Heart Failure Care
Figure Illustration by Rob Howell
Heart Failure at OHSU: Tiered Intervention Based on Needs

HOT SPOT

Heart Transplant?
Ventricular Assist Device?
Inotrope Therapy?
Palliative Care?

In-home monitoring?

Unknown?

Patients already engaged in care

Heart failure at OHSU: tiered intervention based on needs

Hot spot

New Yorker Article “Hot Spotters” by Atul Gawande.

- Jeff Brenner, MD evaluated “super utilizers” of the health care system.
- One percent of the hundred thousand people account for thirty percent of cost.
- Fragmented care with multiple ER and hospital visits.
- Development of Multidisciplinary teams with long term follow up.
- Improved care.
- Significant cost savings.

http://www.newyorker.com/reporting/2011/01/24/110124fa_fact_gawande#ixzz2M1eHtToi
Beth...

- **Medical issues**
  - Repeated hospitalizations for heart failure, varicoses with "blowouts" and chronic anemia
  - Weight fluctuates with 20 pound fluctuations.
  - 19 medications and 2 inhalers (all in a shoe box).
  - 4 pharmacies due to multiple hospitalizations and limited transportation (bus line)

- **Social issues**
  - Apartment up 20 steep steps. Government subsidized housing.
  - Ate out frequently.
  - Pizza box on counter, soup in cupboards, food boxes - cheese and cans.

- **Health literacy issues**
  - Confusing discharge information frequent medicine changes.
  - First grade literacy level.

- **Support**
  - Robert significant other stayed with her and helped with meds.
  - Friend Debbie from community agency.

Beth...

- **Medical issues**
  - Multiple patient care conferences with Beth and Robert next 2 years. Consensus of Cardiology, Family Practice, Palliative care and Beth and Robert.
  - Pills filled weekly at Family Practice clinic by pharmacist.
  - Cardiology NP and Family Practice alternated visits every other week.
  - NP home visits and Family Practice home visits as needed.
  - RN from CareOregon home visits every week.
  - RN from Palliative Care home visits every week.

- **Social issues**
  - CareOregon agreed to pay for Meals on Wheels - low sodium meals once a day.

- **Health literacy issues**
  - All team members reiterated weights and fluid restriction at home visits and office visits.

- **Support**
  - Robert and friend Debbie were included in all conferences and visits. Team members.
Beth ...

Tremendous Support with Diverse Team members:

- Family Practice
  - Christine Allen, MD, Richmond Clinic
  - Megan Bell, PharmD, Richmond Clinic
  - Lori Witter, PharmD, Richmond Clinic

- Cardiology
  - Connie Barber, ANP, Cardiology
  - James Bruce, MD, UF Gainesville, FL; OHSU Advanced Heart Failure
  - Susan Rogowsky, MD, Cardiology

- CareOregon
  - Peggy Parker, RN Cardiology
  - Jane Webster, RN, Portland Adventist Palliative Care

- Patient, Family and Friends
  - Beth
  - Robert, significant other
  - Debbie

- Readmissions reduced dramatically due to the support.
- Admitted 5 more times in the next 2 years.
- Died at home in her sleep while on hospice services, Robert with her.

Heart failure at OHSU: tiered intervention based on needs

Acute Care Telemedicine

- Program began 2007
  - PICU to Sacred Heart, Eugene

- Expansion in 2010
  - Service lines
    - Stroke, PICU, NICU
    - Genetics, Trauma
    - Neuros, Psychiatry
  - 17 sites
    - based on local needs
TeleHealth – Across the Continuum of Care

Other uses: Language interpretation

Remote patient monitoring and heart failure meta analysis

<table>
<thead>
<tr>
<th>Authors</th>
<th>Journal</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clark, Inglis, McAlister, Dleland, and Stewart</td>
<td>BMJ (2007)</td>
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<tr>
<td>Klersy, De Silvestri, Gabutti, Regoli and Auricchio</td>
<td>JACC (2009)</td>
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<td>Inglis, Clark, McAlister, et al</td>
<td>Cochrane Report (2010)</td>
<td>Structured telephone support and telemonitoring effective in reducing risk of all cause mortality</td>
</tr>
<tr>
<td>Clark, Shah, Sharma</td>
<td>J Telemed Telecare (2011)</td>
<td>Telemonitoring in conjunction with home visit can be effective to improve QOL</td>
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Remote patient monitoring and heart failure results of recent large trials

<table>
<thead>
<tr>
<th>Trial</th>
<th>NYHA Class</th>
<th>Length of follow up</th>
<th>Results</th>
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<tbody>
<tr>
<td>Tele-HF (n=600)</td>
<td>I-III</td>
<td>6 months</td>
<td>No significant change</td>
</tr>
<tr>
<td>TIM-HF (n=718)</td>
<td>II-III</td>
<td>27 months</td>
<td>No significant change</td>
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<tr>
<td>SMARTHeart (n=428)</td>
<td>I-IV</td>
<td>90 days</td>
<td>No significant change</td>
</tr>
<tr>
<td>CHAMPION (n=270)</td>
<td>III</td>
<td>15 months</td>
<td>Reduction in hospitalizations by 30%</td>
</tr>
<tr>
<td>SPAM-CHF II (n=188)</td>
<td>I-IV</td>
<td>90 days</td>
<td>Short-term reductions in heart failure hospitalization were associated with use of in-home monitoring system</td>
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Using Evidence Based Practices

Current OHSU performance:

OHSU performance measures:
Summary

- Healthcare is changing dramatically with a focus on optimizing evidence based care and transitions
- Engaging the patient and family to promote self care supports the triple aim
- Nurses are key to promoting transitional care to patients with chronic illnesses

Thank you!
Questions???