Comprehensive Evaluation of the NP-led Coordinated Care Program in Post-Acute Care

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Background

• Four primary care nurse practitioners (NPs) link the hospital health system and their geriatricians to six different post-acute care facilities. The NP works directly within the post-acute care facility to provide comprehensive geriatric care every day of the week.

• These NPs track hospital readmission rates as a core measure of their NP-led Coordinated Care Program in post-acute care.

• However, there is no comprehensive outcomes assessment plan for the effectiveness and quality of NP care in post-acute care.

• In order for NPs to become innovators in care delivery, an evaluation of their role in generating quality outcomes of care is now demanded by major federal and state regulatory agencies (Kapu & Kleinpell, 2012; Kleinpell, 2013).

Setting

• This project evaluates one NP working in a 232-bed Medicare and Medicaid for-profit nursing facility located in west suburban Chicago, IL area.

• This facility provides both short and long-term care, skilled nursing care, sub-acute rehabilitation services, and hospice and palliative care programs.

• This facility served as a model for a future NP outcomes assessment plan for all of the facilities.

Purpose

• Evaluate the effectiveness of the NP-led Coordinated Care Program in the post-acute care setting.

• Identify NP-specific indicators for outcome tracking and reporting using Institute of Medicine's (IOM) Triple Aim Framework.

• Comprehensively evaluate and analyze the impact of the nurse practitioner role on health-related outcomes and metrics in the post-acute care setting.

Methods

Steps taken to identify NP-specific indicators for outcome tracking:

- Performed an extensive literature review of NP outcomes of care
- Conducted a manual chart audit of all resident encounter notes
- Interviewed practice experts
- Directly observed the NP role
- Created an outcomes criteria tool used for selecting outcomes of interest
- Gathered input from the NPs, primary stakeholders, and health system administration

Approved Outcomes:

- 30-day All-Cause Readmissions
- All-Cause Unplanned Hospitalizations
- ED Transfers
- Advanced Care Plan
- Multidisciplinary Team Satisfaction and Team Vitality
- Outpatient referrals or consultations made by the NP

Methods (continued)

• The Information Systems (IS) team of analysts generated data reports from the EMR database on the selected outcomes for analysis and evaluation.

• Initially, the IS team data found it difficult to collect data on the selected NP outcomes after careful analysis using the SPSS statistics software.

• Manual chart audits of 167 residents in the post-acute care facility in a six-month time period were conducted to generate data on these outcomes and to help formulate an ongoing outcomes assessment plan from the EMR.

• The IS team, statistician, primary stakeholders, and the NPs helped analyze the process for gathering outcomes data to provide recommendations for future outcomes assessment plan and reporting.

Results

• Among both short-term and long-term residents, the total ER visit rate was 14.3%, the total 30-day readmission rate was 13.3%, and the total unplanned hospitalization rate was 36.7% in a 6-month period. There were 0 observation stays.

• There were a total of 120 (71.9%) referrals or consultations to specialty services made by the NP for acute and chronic care management of disease in a 6-month period among both short-term and long-term residents.

Short-Term Resident Results

• **Short-term resident ER visits** for the NP were well below benchmarks at 5.1% compared to 11% at the post-acute care facility, 12% in IL, and 11.9% nationally (See Figure 1).

• **Short-term resident readmissions** were also well below benchmarks at 11.2% for the NP (See Figure 1).

CMS Short-Term Resident Benchmarks

	NP	Post-Acute Care Facility	Illinois	USA
ER VISITS	5.1%	11%	12%	11.9%
READMISSIONS	11.2%	22.9%	22.5%	21.1%

Advance Care Planning

• There were 24.2% advance care planning discussions documented in the EMR among long-term residents, which includes completion of advance directives and/or goals of care.

• Developed and launched an EMR Advance Care Planning (ACP) Activity for the entire health system, including inpatient and ambulatory care settings. This activity facilitates ACP discussions, documentation, and communication among care transitions.

• Created a system-wide standardized ACP note template with smartdata elements that is able to directly track and generate ACP outcome reports via EPIC over time. The note template meets all requirements for ACP billing and coding.

• Dissemination and widespread education on the ACP activity and template to promote its use.

Results (continued)

Advance Care Planning Note Template

Diagnosis or condition that led to ACP discussion: (***)

Code Status: (drop down list, options to select: Full Code, DNR, DNI, Special Code Status

Who was present (include names if possible): (***)

Summary of discussion: (***) The patient, family members, and/or surrogate decision maker understand explanation of advance care planning and that participation is voluntary.

Explanation and Discussion of Advance Directives? (Yes/No)

Yes-
Option to select:
a) Advance care plan documented
b) Surrogate decision maker documented
c) Plan was discussed but the patient did not wish to have an advance directive or advance care plan
d) Plan was discussed but patient was not able to name a surrogate decision maker
e) Plan was discussed but patient was not able to provide an advance care plan

(Can select more than one)

Outcome of the discussion/Decisions: (***)

(Examples of outcomes: increasing presence of palliative care, DNR/code status change, hospice referral, any decisions made about care)

Were any legal forms completed and signed? (Yes/No, drop down menu for "Yes": HCPOA, POLST, Living Will, Declaration for Mental Health Treatment)

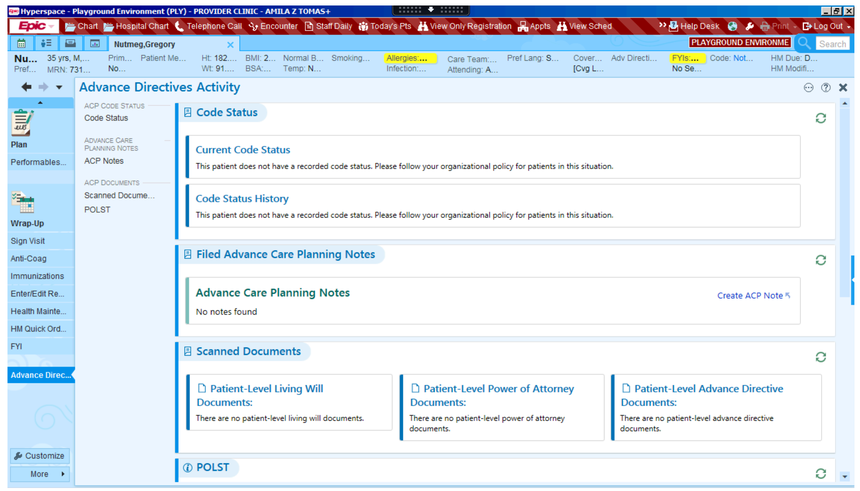
(Can select more than one)

Patient/Family Goals of Care: (***)

Goals of Care determined by: (drop down list, options to select: patient, legal surrogate decision maker, legal guardian, or other)

Future care planning needs: (***)

Time spent in the face-to-face encounter: (***)



Applicability to NP Practice

• This project serves as a useful model for identifying and tracking data on NP-specific indicators in the post-acute care setting.

• Nationally, hospitals and healthcare institutions lack a systematic process for documenting NP outcomes within their electronic medical records.

• There is a strong need for nursing informatics in healthcare to demonstrate the value of NPs to the health care system.

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