A quality improvement pilot on NP-led Transitional Care Medical House Call Visits Reduce ER/Hospital Unplanned Readmissions of Homebound Seniors

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The Sigma Theta Tau International
27th International Nursing Research Congress
Cape Town, South Africa
July 21-25, 2016
Disclosure

- Ron Billano Ordonia, MSN, FNP is the primary care provider (PCP) at Senior Care Clinic House Calls in Sacramento and Placer Counties, Northern California, USA.

- The presentation is supported in part by the University of California, Davis Medical Center (UCDMC), Sacramento, California, USA.
Disclosure

• This has been a quality improvement project pilot study in collaboration with a local home health agency in the process of addressing readmission rates reduction.

• The data gathered in this quality improvement project was meant to determine logistical requirements in the development of a sustainable transitional care medical house call program.
Objectives

• Acquaint attendees with data collected over a period of one-year for a NP-led medical house call program for homebound seniors.

• Explore potential for further studies on the subject and its implications to other initiatives such as the hospital readmission reduction by Medicare.
Purpose

• The purpose of data gathering was to assess trends of house calls made by the nurse practitioner in a house calls private practice from its inception in 2014 onwards.

• Furthermore, the project aimed at determining logistical requirements for a transitional care medical house call program.
Literature Review

- A curious 21st century phenomenon: physicians (and nurse practitioners) reviving the house call
  

- Washington Hospital Center's Medical House Call Program has been offering elderly residents of the poorest area of the D.C., medical treatment in their own homes.

  (Kroll, NP, University of Texas at Tyler, 2012; Ph.D. v. 86)
Literature Review

- Stress burden older adults >65: hospitalization
  - 48% inpatient hospitalization days
  - Delirium sets in
  - Dementia worsens
  - Functional decline, polypharmacy, and patient/provider (dis) satisfaction of care

(Ahmed & Pearce, 2010; ; Mramor, Hagman, Ford, Oman, & Cumbler, 2015)
Literature Review

• In October 2012, the Center for Medicare and Medicaid Services (CMS) began reducing Medicare payments for Inpatient Prospective Payment System (IPPS) hospitals with excess readmissions

Literature Review

• Medical House Calls
  • ER visits reduced by 30%
  • Admissions reduced by 10%
  • In most cases, the medical care is
    • more effective, less costly
    • more accessible for both the family and the health care system.

(De Jonge E; Taler G, 2002; Bader, P, 2014)
Method

• Retrospective and simple analysis of cases seen.
• Data obtained using the electronic health record (EHR) used by the practice.
• Patients assigned to local home health agency.
• Logistical needs.
Subject Population

- Elderly Medicare beneficiaries who are homebound enrolled in a Nurse Practitioner (NP) house call practice.

- Program receiving a medical visit in their own homes or communities within seven days of discharge from hospital or skilled nursing facility (SNF) who are under home care.
Results

- 58 referrals

- 25 patients (43%) were visited in their homes for a medical visit

  - 1 was readmitted (4%) due to rapid decline in condition

- 33 patients refused visit (57%)
Results

• Benchmark: Medicare.gov Home Health Compare (2013)

  • Measure A: How often home health patients had to be admitted to the hospital?
    • 13.5%

  • Measure B: How often patients receiving home health care needed any urgent, unplanned care in the hospital emergency room without being admitted to the hospital?
    • 14.2%

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Results

- Readmission was 1 case (4%), during the pilot study period, among patients seen
- 9.58% point reduction as compared against benchmark.

“Sir, I'll need to see more than a birthday card to prove you're sixty five.”

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Learning from the pilot

- Factors that Predispose, Reinforce or Enable Behaviors
  - medication reconciliation
  - scores for hospitalization risk
  - fall risk
Learning from the pilot

- Factors that Predispose, Reinforce or Enable Behaviors
  - nutritional risk
  - adequacy of discharge patient education
  - post-discharge continuity checks.
Learning from the pilot

- Complementary intervention
  - home health or home care agency providing nursing visits and nursing oversight.
Implications for Practice

• The United States is currently faced with the challenge of how and where to care for its aging population. Nurse practitioner (NP) home-based care is a potential solution to meet this challenge. Current research indicates that care provision by advanced practice nurses reduces cost, decreases length of stay and readmission to hospitals, and improves patient quality of life. Advanced practice nurses are able to fill the provider gap for aged patients.

(Kroll, NP, University of Texas at Tyler, 2012; Ph.D. v, 86).
Implications for Practice

• There is a resurgence of medical house call services by a combination of physicians and emerging practices by nurse practitioners. House calls by a Nurse Practitioner (NP) opens up opportunities to address access to care.

• Further exploration at how this practice model can lessen ER visits or hospital readmissions is recommended.
Implications for Practice

- Further studies:
  - A transitional care medical house call program is currently under development as part of a Doctor of Nursing Practice (DNP) scholarly project that will develop a protocol from existing transitional care models to help reduce 30-day unplanned emergency room/hospital readmissions.
  - Target completion April 2018
Thank you for your attention!