IMPACT OF NURSE-LED PERSONALIZED CARE PLANS IN HOME HEALTH

PRACTICE PROBLEM

- Unplanned hospitalization rates among Medicare beneficiaries ranges from 17-28% (Arundel et al, 2018).
- Unplanned hospitalization rates led CMS to enforce penalties on healthcare entities who do not meet quality requirements with positive outcomes, through the QRP program (CMS, 2023).
- Skilled treatment in the home decreases acute care hospital readmission rates with certain interventions (Weerahandi et al, 2020).
- Home health care provides education & skilled care at various appropriate levels, reducing cost & utilization of Medicare benefits (Howard et al, 2019).
- Final Total Performance Score-Adjusted Payment Percentage Applied to CMS Payments for CY2025: -4.073% (0 achievement, improvement, or care points for readmission rates) at site.

Project Aim: Decrease 30-day hospital readmission rates of home health patients

PRACTICE QUESTION

In geriatric patients discharged from the hospital with ordered home health, will a nurse-led personalized care plan utilizing a structured 11-step process at the first home health visit compared to the current generic care plan, decrease the 30-day readmission rate over 14 weeks?

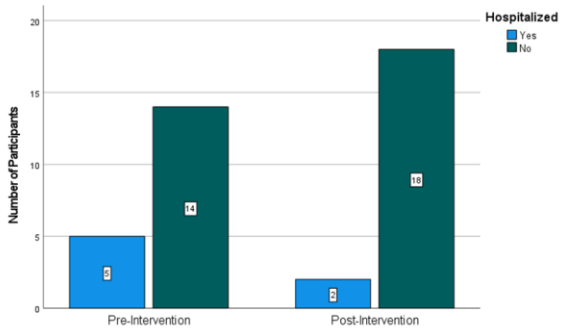
METHODOLOGY

- **Translational Science Model:** Knowledge to Action Model.
- **Setting:** Home health care, Tennessee.
- **Population:** Geriatric patients with recent acute care hospital stay, transitioning to home health services; 20 participants.
- **Inclusion Criteria:** Medicare beneficiaries admitted to home health service from a healthcare facility, after an acute care stay.
- **Exclusion Criteria:** Patients admitted to home health from the community & non-Medicare payors.
- **Intervention:** Structured nurse-led care plans at start of care (Zolnorri et al, 2021, Randi et al, 2013).
- **Formative Evaluation:** Review of all SOC assessments submitted to EMR.
- **Summative Evaluation:** Identification of the pre- & post-implementation rates.
- **Outcome:** Decreased 30-day hospital readmissions.
- **Data Collection:** 30-day readmission data collected preintervention & 30-days post intervention.
- **Instrument or Data Source:** EMR & SHP analytical software systems**.**
- **Data Analysis: C**omparison, chai squared statistical analysis.
- **Timeframe:** 14 weeks

Casey Walthall, DNP, MSN, RN

RESULTS

- Nurse-led plans of care decreased readmissions in home health patients through the 11-step Project Re-Engineered Discharge model, tailored to home health, & a clinical support tool serving as a resource for clinicians for the 11-step process.
- A comparison of the acute care hospitalization rate before the intervention and post intervention 30 days after the home health start of care answered the practice question by reducing the acute care hospitalization readmissions rate.
- Preintervention ACH of 26.3% reduced to post intervention ACH 10%.
- No statistical relevance could be found, due to small sample size.
- Additional implementation should be considered in the future for re-evaluation of the statistical analysis for relevance.
- *The Number of Hospitalizations in the Pre- and Post-Intervention*



IMPLICATIONS

- Patient 30-day readmissions decreased, increased quality of care, and improved health outcomes.
- Nursing practice will increase the quality of care delivered through a structured plan of care development process increasing quality of nursing care.
- The organization will have improved patient and provider satisfaction, improved quality ratings, increased reimbursement, and an enhanced market share in the community.

CONCLUSIONS

The focused intervention decreased 30-day hospital readmission rates by more than 50% in patients who received a nurse-led personalized care plan.

REFERENCES

Arundel, C., Sheriff, H., Bearden, D. M., Morgan, C. J., Heidenreich, P. A., Fonarow, G. C., Butler, J., Allman, R. M., & Ahmed, A. (2018). Discharge home health services referral and 30-day all-cause readmission in older adults with heart failure. Archives of Medical Science 14(5), 995-1002. https://doi.org/10.5114/aoms.2018.77562

Centers for Medicare and Medicaid Services. (2023). Home health quality reporting program. https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits

Howard, J., Clouser, J. M., Brock, J., Davis, T., Jack, B., Levine, C., Mays, G. P., Mittman, B., Nguyen, H., Sorra, J., Stromberg, A., Du, G., Dai, C., Adu, A., Vundi, N., & Williams, M. V. (2022). Effects of different transitional care strategies on outcomes after hospital discharge-Trust matters, too. Joint Commission Journal on Quality and Patient Safety, 48(1), 40-52. https://doi.org/10.1016/j.jcjq.2021.09.012

https://www.bu.edu/fammed/projectred/publications/projectredlowershosptialreadmissions.pdf

Randi E. Berkowitz, Zachary Fang, Benjamin K.I. Helfand, Richard N. Jones, Robert Schreiber, Michael K. Paasche-Orlow. (2013). Project Reengineered Discharge (RED) lowers hospital readmissions of patients discharged from a skilled nursing facility. JAMDA. 1-5. https://www.bu.edu/fammed/projectred/publications/projectredlowershosptialreadmissions.pdf

Weerahandi, H., Bao, H., Herrin, J., Kumar, D., & Ross, J. (2020). Home health care after skilled nursing facility discharge following heart failure hospitalization. Journal of the American Geriatrics Society, 18(1), 96-102. DOIN:10.1111/jgs.16179

Zolnoori, M., McDonald, M. V., Barrón, Y., Cato, K., Sockolow, P., Sridharan, S., Onorato, N., Bowles, K., & Topaz, M. (2021). Improving patient prioritization during hospital-homecare transition: Protocol for a mixed methods study of a clinical decision support tool implementation. JMIR Research Protocols, 10(1), e20184–e20184. https://doi.org/10.2196/20184

NAHQ