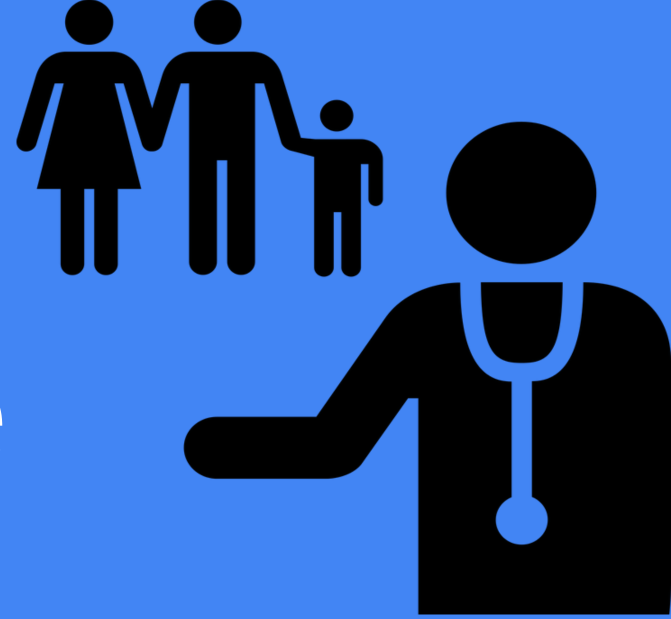
Partners in Care



Dedicated to Providing Cost Effective Quality Care

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Introduction

Purpose:

To provide community-based nursing intervention developed by our team which offers a comprehensive, integrated, and tightly managed system of care coordination, disease management, and preventive services. Provided by community-based nurse care managers working collaboratively with primary care providers to improve the health and reduce all-cause mortality in chronically ill older adults.

Coburn, K., Marcantonio, S., Lazansky, R., Keller, M., Davis, N., Coburn, K. D., & ... Davis, N. (2012). Effect of a community-based nursing intervention on mortality in chronically ill older adults: a randomized controlled trial. *Plos Medicine*, *9*(7), e1001265. doi:10.1371/journal.pmed.1001265

Mission Statement:

Client-centered, holistic quality care delivered to your door.

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Philosophy:

Evidence-based preventive and care management interventions delivered longitudinally by nurse care managers in collaboration with local health care and social service providers

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3 Clinical Objectives

Initial Client Assessment & Disease Management (Objective one)

Nurse care manager developed an individualized plan for each participant. Three factors were used to establish priorities for this plan:

(1) the participant's self-articulated primary concerns and unmet needs,

(2) findings from risk assessments and evaluations (initial and repeated),

3) the participant's motivational readiness.

Preventative Services (Objective two)

1-Education

2-Symptom monitoring

3-Medication reconciliation and counseling for adherence

4-Help identifying, arranging, and monitoring community health and social service referrals.

5-Group interventions such as curriculum-based education

6-Structured lifestyle and behavior change programs for weight loss

7-Weight loss maintenance

8-Exercise classes for improving strength and increasing physical activity; and a balance and mobility program for fall prevention were also provided directly to participants by the nurse care managers.

Collaborative Care (Objective three)

A network of primary care practices was developed physician-hospital organizations, independent physicians associations, and individual practices. The basic requirements of practices agreeing to participate include:

(1) responding to communications about their patients initiated by the nurse care managers on an as needed basis,

(2) making the office medical records available to the nurse care managers and chart auditors

(3) assisting in case-finding potentially eligible individuals on their patient panels, using billing system reports or extracts, or other mutually agreed to processes.

Services of Health Care Offered:

- Community based nurse led care management.
- Primary care services focused on early screening and preventative services consisting of in-person visits, group sessions, and telephone contacts. In-person encounters occurred in the participants’ homes, physicians’ offices, hospitals, community centers, libraries, and faith-based organizations.
- Education.
- Symptom monitoring
- Medication reconciliation and counseling for adherence.
- Help identifying, arranging, and monitoring community health and social service referrals.
- Once enrolled into the program, intervention participants received services until they died, moved out of the area, requested disenrollment, had a change in insurance coverage making them ineligible for the demonstration, or were placed in a care environment in which the nurse care manager felt they were unable to significantly add to the effectiveness of care (e.g., hospice placement).

Providers of Care

We are dedicated to providing comprehensive, integrated, and tightly managed system of care coordination, disease management, and preventive services.

The team consists of:

- Community-based nurse care managers
- Primary Care Providers
- Case Managers for Medicare and Medicaid Services
- Dieticians
- Health Quality Partners (HQP)
- Occupational & Physical Therapists
- Psychiatrists
- UAP

Community Served:

Adults aged 65 and over, residing in the tri-state area, with one or more eligible chronic conditions:

- ❑ Coronary Artery Disease
- ❑ Heart Failure
- ❑ Diabetes
- ❑ Asthma
- ❑ Hypertension
- ❑ Hyperlipidemia

Community served: fauziya

Specific & Unique Needs of Community:

- Education
- Weight loss management
- Social Services
- Medication reconciliation
- Counseling

Community Engagement

- ❖ Free public health screenings
- ❖ Community outreach with local organizations
- ❖ Planning local workshops in the community focusing on primary prevention and disease management
- ❖ Networking and meeting with trusted primary care providers whom have established rapport with the community

Improvements to Public Health

- ❖ Enhanced quality care & cost reduction in care for chronically ill older adults
- ❖ Increased education & awareness on several chronic conditions (coronary artery disease, heart failure, diabetes, asthma, hypertension, hyperlipidemia)
- ❖ Increase in disease management, prevention, and risk reduction practices
- ❖ Subsequent decrease in hospital readmissions & mortality rates for target population

Communication

Methods for staff-staff communication:

- ❖ Use of electronic records for easily accessible information available to all relevant staff
- ❖ Nurse care managers & PCP's will be provided work email/phone
- ❖ Weekly meetings/discussions mandatory for all providers

Staff-Patient communication:

- ❖ Telephone calls
- ❖ Mail
- ❖ Provide contact information of all staff to clients

Cost reduction for services:

Reduce the cost, and maintain quality, by focusing on:

- **Value based care**
- **Patient outcomes**

"Value-based care is a payment methodology that shifts the focus from the number and type of services delivered to one that rewards quality, safety, efficiency and lower costs." –Sherman 2013

“Value in health care should be based on the achievement of the desired outcomes, rather than the volume of services delivered or the number of checklists completed.” –Porter O’Grady

Cost reduction for services (cont.)

Care Coordination emphasizing wellness and chronic disease management.

Having nurses make weekly or biweekly home visits to make sure the patients are getting what they NEED.

Increase the time spent with the patient in their homes, instead of waiting until the patient is in the hospital.

Highly structured and organized community nurse interventions may include:

- Fall prevention
- Exercise
- Eating habits/diet teaching
- Encouragement
- Reminders (eg. medication)
- Helping patient to follow through on care plans to prevent them from going back to the hospital

Our Aim:

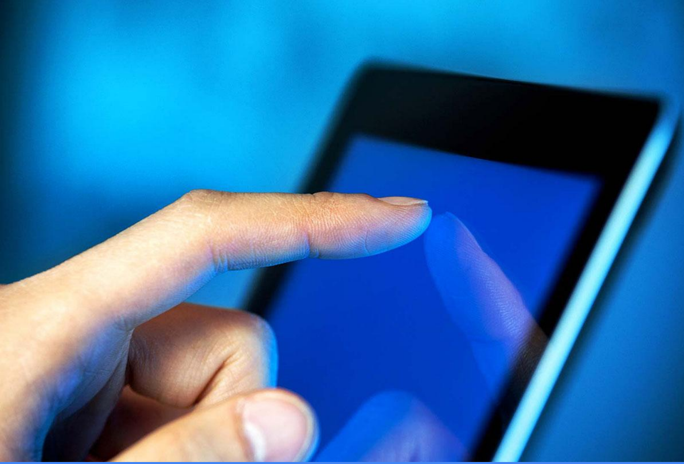
Chronically ill patients will have:

- Fewer hospitalizations
- Fewer emergency room visits
- Decrease in Medicare expenditures

Adjustments will be made in the services rendered according to patient outcomes.

Technology will influence and be utilized to:

- Collect data
- Reduce errors
- Help the interdisciplinary team network more conveniently
- Report patient status



Technology will influence and be utilized to (cont):

- Easily and quickly retrieve patient’s health history, past procedures/ treatments, medications etc
- Measure the effectiveness of the care provided.
- Create statistics for research purposes to improve care

Quality Indicators

- Developed by the Agency for Healthcare Research and Quality (AHRQ)
- Prevention Quality Indicators (PQI): used to evaluate care delivered in the community setting and how much early intervention decreases complications and reduces the need for hospitalization

AHRQ - Quality Indicators. (2015, September). Retrieved April 30, 2017, from https://www.qualityindicators.ahrq.gov

Prevention Quality Indicators

- PQI 01: Diabetes, short-term complications admission rate
- PQI 03: Diabetes, long-term complications admission rate
- PQI 05: COPD or asthma in older adults admission rate
- PQI 07: Hypertension admission rate
- PQI 08: Heart failure admission rate
- PQI 13: Angina without procedure admission rate
- PQI 14: Uncontrolled diabetes admission rate
- PQI 90: Prevention Quality Overall Composite
- PQI 91: Prevention Quality Acute Composite
- PQI 92: Prevention Quality Chronic Composite

AHRQ - Quality Indicators. (2015, September). Retrieved April 30, 2017, from https://www.qualityindicators.ahrq.gov

Defining Success

Goals

- ❖ Satisfy participants' needs
- ❖ Provide preventative services
- ❖ Reduce costs
- ❖ Decrease mortality rates

Evaluation

- ❖ Survey participants to discover how well they feel their needs have been met.
- ❖ Review data on hospital admissions and ED visits compared to community-based care.
- ❖ Analyze expenditures before and after the implementation of this program.
- ❖ Compare mortality rates and causes before and after the implementation of the program.

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AHRQ - Quality Indicators. (2015, September). Retrieved April 30, 2017, from https://www.qualityindicators.ahrq.gov

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