

Nurse Practitioner's Role in Reducing Readmissions / Rehospitalizations

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Abstract

Background: Hospital readmissions cost Medicare about \$26 billion annually, with about \$17 billion spent on avoidable hospital readmissions after discharge. Preventable hospital readmissions are a significant part of unnecessary medical spending. According to data from the Center for Health Information and Analysis (CHIA), the estimated annual cost of this problem for Medicare is \$26 billion annually and \$17 billion is considered avoidable. The good news is that strategies are being incorporated or put in place that specifically identifies the role of Nurse Practitioner in not only providing quality care but reducing the numbers of preventable readmissions. This study will reflect the importance of the Nurse Practitioner's role in reducing readmissions.

Methods: Key words were used to streamline the search on numerous databases. Examples are: Nurse Practitioner, Readmission, Rehospitalizations, Transition Care, Medicare, Home-based care. Some descriptive words such as: reduction, prevention, independent, co-management were also used. These key words were then used to navigate and search journals and sites such as PubMed and Google Scholar.

Each study gathered is classified in categories and topics and further analyzed and grouped into different sub-category. This study purposely did not limit the cases involving specific diseases or diagnoses namely, Congestive Heart Failure, Pneumonia, Sepsis. To insist on the exclusivity of the study on these three criteria will limit the research to only a few causes of readmissions. Including other diagnoses will not be overwhelming instead it will assist the validity and importance of the project.

Instruments

The Critical Appraisal Skills Programme (CASP) was used to appraise the individual studies. Basing on the three fundamental questions, it will ensure the validity and relatedness of the literatures to the research question. Within the various CASP Tools, the appropriate tool was used to each data to ensure the consistency and quality. Studies used will be reflected in the Literature Review Matrix.

Conclusion: Purposeful and active inclusion of Nurse Practitioner in caring for the patients who are discharged to their home or in the varied transition care facilities greatly affects the reduction and prevention of unnecessary readmission within the 30-day period since discharged.

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Introduction

Hospital readmissions and their preventability have been the subject of intense study, and their utility as a performance measure is often debated. There are various attempts in reducing avoidable hospital admissions to improve quality and reduce necessary costs. Policy makers have targeted readmissions stemming from poor quality of care during an initial hospital stay, readmissions also can occur when patients don't receive appropriate follow-up care or ongoing outpatient management of other conditions. (Sommers & Cunningham, 2011). There is significant attention given on how to reduce avoidable hospital readmissions thus help control health care costs. Readmissions in the first 30 days after a hospital discharge are relatively common and often unscheduled, affecting up to one-fifth of Medicare fee-for-service patients. (Sommers & Cunningham, 2011). A commentary echoes the same scenario stating that, "the Medicare Payment Advisory Commission estimated that 13.3% of 30-day hospital admissions were potentially preventable and cost an additional \$12 billion. (Axon & Williams, 2011). These issues are just stating the financial impact of readmissions. Congestion and over-crowding of Emergency Department as well as other Departments, constraint to depleted workforce.

The question is: how can a Nurse Practitioner help with this ongoing, lingering and worsening problem of readmissions? Can the Nurse Practitioner's involvement reduce the volume? It has been documented that NPs provide quality patient care with great disease management outcomes, as well as a discrepancy in the number of patients needing treatment and the number of physicians available to treat them (Chicoine & Selton, 2014). Research studies have demonstrated that NPs provide expert care, and reduce emergency department use, hospitalizations, and rehospitalizations, thereby reducing costs. (Neal-Boylan, Mager, & Kazer, 2012). Furthermore, it has been documented that NPs provide safe and effective care that is

comparable to that of physicians within homecare and other settings. (Chicoine & Selton, 2014)

The research showing that NPs provide safe and equitable care comparable to physicians is evidenced by the increasing number of states that have granted independent practice to NPs including: Alaska, Arizona, Colorado, Connecticut, Hawaii, Idaho, Iowa, Kentucky, Vermont, Washington, and Wyoming. (Chicoine & Selton, 2014). It is at the federal level that limits, prohibits NPs from functioning independently in Home Health Care. Current federal laws that govern home health agencies do not allow nurse practitioners (NPs) to order care for homebound patients. Instead, all orders must be signed by a physician or Medicare reimbursement may be jeopardized. (Chicoine & Selton, 2014). What is happening is the role of NPs in homecare writing orders seems to be affected by the perception of a threat to the financial stability of private practice physicians, not the realities of homecare. (Wilson, Whitaker, & Whitford, 2012). More than 125 million people in the United States have a chronic illness and the incidence is increasing. Associated medical costs are expected to exceed US\$6 trillion by the year 2050. Increasingly, physicians are leaving or avoiding primary care in preference for specialty care and non-physicians are compensating by providing care to very sick patients. (Neal-Boylan et al., 2012).

The Home Health Care Planning Improvement Act of 2011 was introduced on January 31, 2011 to Congress, the goal being to ensure more timely access to home care services for Medicare beneficiaries. (H.R. S. 227, 2011). Unfortunately, as noble as its intentions, it was not enacted. So, while NPs could order long-term (nursing home) care for Medicare recipients, they could not order home care services nor certify patients for services. Based on these limitations pertaining to NPs, Medicare will not certify payment for services until a physician signs the orders. This factor can lead to delays in the start of home care services as well as requiring frail

and ill patients to make a second visit to a physician whom they may or may not know to get the needed services in place. (Neal-Boylan et al., 2012). Nurse Practitioners have the clinical expertise to determine what services may be needed such as skilled nursing, physical/occupational or speech therapy as well as medications, treatments, supplies, and visit frequencies. In addition, by having the NP order the services directly, communication is simplified while relaying information about the patient to the home care providers. The NP determines the need, makes the referral, and orders the plan of care directly. (Neal-Boylan et al., 2012). The concern of NPs having a full autonomy in Home Health Care is the cannibalization of private and primary care practice physicians.

It has been obvious that NPs have the ability, skills and knowledge in providing quality home health care intervention but are limited due to federal requirements. Patient's safety, unnecessary trip to emergency rooms and the implications of additional costs incurred by hospitals for each preventable visit are legitimate reasons to grant NPs the autonomy to function in Home Health Care setting.

This is the reason why my research will focus on the positive impact of Nurse Practitioners in preventing readmissions or rehospitalizations.

Review of Literature

Nurse Practitioner roles have been expanding due to evolving patient needs. They offer a cost-effective and quality health care. Among the myriad function being done by Nurse Practitioners, involvement in the planning and implementation of strategies in reducing readmissions and rehospitalization has been overlooked. Several systematic reviews have been gathered and reviewed to reflect the positive impact of involving and giving Nurse Practitioners appropriate autonomy. States with full practice of nurse practitioners have lower hospitalization rates in all examined groups and improved health outcomes in their communities. Results indicate that obstacles to full scope of APRN practice have the potential to negatively impact our nation's health (Oliver, Pennington, Revelle, & Rantz, 2014).

There is no clear consensus on how many of the readmissions may be preventable. Different studies have shown different results. But the common denominator is, there is a significant percentage of readmission that could have been prevented if adequate steps are made. There are extraneous factors that are hard to quantify, such as patient's compliance, severity of illness, availability of support from both family and PCP.

Medicare accounts one eighth of the federal budget. Among Medicare fee-for-service patients discharged from the hospital, 19.6% are re-hospitalized within 30 days (, 2011). The Medicare Payment advisory Commission has estimated that three quarters of such re-hospitalizations may be avoidable and annually account for \$12 billion in excess health care costs (, 2011). As a result of this re-admission rates and huge dollar or budget impact, there has been considerable interest in the development of strategies to reduce the avoidable re-admissions after hospital discharge. A well-structured home visits, follow-up calls have shown that it can

result in readmission reduction, there are other steps and strategies that each affected institution apply what best suits their unique demographics, budget and health problems being catered.

This review is not disease specific. Though some studies focus on specific health issues such as Heart failure, COPD and Pneumonia among others, the intention of this review is to reflect the general dilemma affecting the healthcare system with readmissions if no appropriate steps are taken.

Varied Methods

A study done by Mount Sinai Visiting Doctors Program (MSVD) between January 1, 2012 and July 2013 comparing pre-enrollment and post-enrollment hospitalization and 30-day readmission rates of home-bound patients active in the Nurse Practitioner Co-Management Program shows after enrollment in co-management, patients have lower annual hospitalization rates and fewer patients have 30-day readmissions (5.8% vs. 17.2%) (Jones, et al., 2016).

A nurse practitioner that does home visits has a positive impact, sometime more than 50% reduction rate. Patients receiving home visits had an acute care return rate of 28.2% (Smith, Pan, & Novelli, 2016). To further validate the positive effect of involving Nurse Practitioner in reducing the readmission rates, a study shows that the NPs collaborated with physicians, a key component for success, according to the authors. By integrating medicine, nursing, individualized care, and therapeutic interventions, the program achieved a readmission rate of 8% for the 30 days post-discharge, a far cry from the 26% readmission rate in the 12 months before the program was implemented (Kutzleb, et al., 2015).

Strategies to reduce Readmission Prior to relegating all readmissions to the negative list, steps should be implemented. First is to identify the root cause of hospital readmission. Factors such as

inadequate care coordination, lackluster transition management results to preventable readmission (Reardon, 2015). The writer also opined that Optimizing the Transitions of Care and Improvement with patient engagement and education are very crucial to the reduction of unnecessary rehospitalization.

Understanding Readmission. There are currently a lot of strategies implemented as what previously stated, it is important to understand the reason behind readmission. First, although it may be reasonable to hold hospitals accountable for problems that patients experience during the first week after discharge, readmissions occurring after that may increasingly reflect patient self-management, outpatient care, community resources, or the development of new problems that go beyond the control of the discharging hospital (Joynt & Jha, 2013). Those factors are beyond the discharging hospital's control. Second, it is unclear what proportion of readmissions are truly preventable, as estimates range from 5% to 79%, with a median of 27% (van Walvaren, Bennett, Jennings, Austin, & Forster, 2011). Numbers vary because of certain factors like age, diagnoses, economic status and even cultural background greatly affect the data. Third, hospital readmission rates are not meaningfully related to other performance measures that are accepted to be valid reflections of hospital quality (Stefan, et al., 2013). Associating all readmissions rate to quality of care to each hospital is not a safe and lead to false gauge of performance measure. It is very important to correctly identify the discharging diagnosis versus the admitting diagnosis if it is consistent or a new health problem developed. Lastly, academic institutions and hospitals in socioeconomically disadvantaged areas are disproportionately affected by the new readmission penalties (Joynt & Jha, Characteristics of hospital receiving penalties under the Hospital Readmissions Reduction Program, 2013).

Literature Reviewed

Author (Year Published) Country	Variables DV IV	Study Design	Sample Size	Sample Characteristics	Methods	Results	Conclusions, limitations. Level of evidence
(Warren, Lemieux, & Bittner, 2019)	DV: co-morbidities and multiple diagnoses IV: Elderly patients	Meta-analysis of randomized trials	8,000 including partners hospitals	Elderly patients at high risk of hospital readmission	Interviews. questionnaires	Readmission rate decreased to 12.5% an 11% decline	Added interventions decrease future hospitalizations Level II
(Peacock, Siegel, Harmer, Alejos, & Freeman, 2018)	IV: neuroscience patients DV: history of malignancy	Survey, Questionnaires, Data Collection	340 consecutive patients	Patients in neuroscience critical care unit	Chart Review	65.8% considered “low-risk” were readmitted within 30 days	N=279 pts only included, specific patient population only. Should create unique readmission scores Level IV
(Baldwin, Zook, & Sanford, 2018)	IV:NP added to the Posthospital Interprofessional Care Team DV: generic diagnosis	Case Controlled	75 patients	Medicare and private pay patients	Questionnaire	Readmission rates: Medicare patient: 17.3% Private pay: 8.6%	Discharge Clinic can be a model to be implemented to advance the bridge for acute and ambulatory care patients Level III
(Breathett, et al., 2018)	IV: Education and tablet intervention DV: Heart Failure patients	Randomized survey	122 patients	Heart Failure patients	Survey	13.2% treatment 26.7 (controlled)	NP education and tablet lowered 30-day readmission Level III

(Dizon & Reinking, 2017)	IV: Enrollment to the TOC DV: Generic diagnosis	Cross-sectional study	441-bed capacity, over 4 years	Hospital wide	Survey, Case Study	During planning: 11.8% (2011) During implementation: 12% (2012) During intervention: 11.4% (2013) Pre-study: 13.7%	Having clinical staff involved in TOC program is important to reduce readmissions Level III
(Mora, Dorrejo, Carreon, & Butt, 2017)	IV: phone calls post DC, home visits, hand off information to PCP DV: No specific diagnosis	Literature Review	June 2016 – March 2017	Chronically ill 65 and above	Synthesis Meta-analysis, Non-Randomized studies	Data not provided. Summary states: decreased hospital readmission rates	No data provided. Level I
(Condon, Lycan, Duncan, & Bushnell, 2016)	IV: Enrolment to the Transitional Stroke Program DV: Stroke / TIA	Controlled study	510 patients	Stroke or Transient Ischemic attack patients	Case Study	48% reduction with TSC visit	TSC visit did not impact 90-day readmission. Level II
(White & Hill, 2014)	IV: Care Coordination DV: Heart Failure patients	Controlled study	291 diagnostic-related patients	Inpatient Medical-surgical unit	Case Study	Decreased from 23.1% to 12.9%	Collaboration between disciplines improved continuity of care and compliance. Level II
(David, Britting, & Dalton, 2015)	IV: NP inclusion To med team DV: HF and MI with ST and non-ST elevation	Controlled study	185 patients	ST or non-ST segment elevation MI or HF admitted to cardiovascular ICU	Case Study	Decreased approximately 50% with NP on-board	Addition of NP to medical teams had positive impact on 30-day readmission rates Level II
(Hall, et al., 2014)	IV: NP home visits DV: CABG DC patients	Controlled Study	401 CABG patients	169- enrolled 232- controlled Between May 1, 2010 – Aug 31, 2011	Case Study	Decreased from 11.54% to 3.85%	Significantly reduced 30-day readmission rate Level II

Discussion and Conclusion

Data is piling up since the last decade that shows not only the significance but the importance of including the Nurse Practitioner during the discharge process, follow and visit to patient's home to reduce the readmission or rehospitalization of patients. Not only to heart failure patients (Breathett, et al., 2018) especially patients who have diagnosis of stroke or TIA (Transient Ischemic Attack) (Condon, Lycan, Duncan, & Bushnell, 2016). When they did the initiative of coordinating with a nurse Practitioner, not only it did decrease the length of stay but decrease the readmission rate as well (White & Hill, 2014). When Medicare tried to zero in on cases to include in the 30-day period of readmission the case of Heart Failure, hospitals that were penalized or does not want to be penalized implemented the inclusion of NP to the care. Even for cardiac surgery patients (Hall, et al., 2014), it prevented the unnecessary readmission of coronary artery bypass graft patients.

The mere inclusion of the NP alone is not a silver bullet that will solve the revolving door issue of readmission but rather incorporating to the various program or models that the hospital adopts. A community-based care Transition program model (Warren, Lemieux, & Bittner, 2019) that already shows solid results. Not forgetting the importance of home visits, care coordination and other Transition of Care models (Dizon & Reinking, 2017) which includes home visits (Hall, et al., 2014).

Recommendation

The Affordable Care Act contains provisions that indirectly improve the care transitions. It implemented both incentives and penalties under the program Hospital Readmissions Reduction Program (HRRP). The penalty is a percentage of total Medicare payments to the hospital; the maximum penalty has been set at 1% for 2013, 2% for 2014 and 3% for 2015 (www.cms.gov, 2018). With the advent of Medicare penalties, tempting as it is, it would be unwise to categorize all readmissions on the negative column. It is not healthy nor productive to set unrealistic expectations without identifying the cause and providing a solution to the problem. Reducing readmission or rehospitalization is a noble objective provided there is a safety net put in place, such as addressing the need for a creation of Transition of Care to oversee the phone call, home visits and hand off communication to the PCP.

Inclusion of Nurse Practitioner in the planning, implementation, intervention and evaluation of discharged patients overwhelmingly shows reduces the readmission rates as previously cited multiple times in this study.

Challenges / Obstacles

One glaring example is seen in the Home Health setting. Currently, at the federal level, Medicare recognizes NPs as independent practitioners. They can order outpatient physical, speech, and occupational therapies; certify patients for services in post-acute care and skilled nursing facilities; and are included in Medicare's definition of "attending physicians" for hospice patients (Neal-Boylan, Mager, & Kazer, 2012). Yet Medicare does not allow NPs to sign orders certifying patients for home health services nor NPs can officially sign a face to face evaluation, but a physician must still certify the evaluation to sign the order according to CMS Medicare Benefit Policy Manual Chapter 7 – Home Health services. There will be tangible delays in care

and can lead to worse outcomes, increased emergency room visits and increased cost as well (Brassard, 2012).

Limitations

Health Care is a complicated topic. There are myriad of factors that you must weave through in order to achieve your goal. As long as human factor is considered, it is primed for debates, squabbles, endless meetings and not to mention the budget. Surveys, and research and studies will be conducted and have been conducting and still conducting about the importance of incorporating Nurse Practitioner in every facet of health care issue, it is still a fact that committees must convene and vote, oftentimes not what is best for the common people but for the chosen few. Program should be encouraged in each individual hospital or entity and should not wait from the state, much more federal level to make a change. The revolving door of unnecessary and/or preventable readmissions/rehospitalizations if not totally eradicated, with the involvement of Nurse Practitioner should be reduced.

References

- (2011). *Interventions to Reduce 30-Day Rehospitalization: A Systematic Review* [Peer commentary on the journal article "Improving Patient Care" by L. O. Hansen, R. S. Young, K. Hinami, A. Leung, & M. V. Williams]. *American College of Physicians*, 520-528. Retrieved from <https://www.ncbi.nlm.nih.gov/pubmed/22007045>
- Axon, R. N., & Williams, M. V. (2011). Hospital Readmission as an Accountability Measure [Special issue]. *The JAMA Network*, 305(5). <http://dx.doi.org/doi:10.1001>
- Baldwin, S., Zook, S., & Sanford, J. (2018, September/October). Implementing Posthospital Interprofessional Care Team Visits to Improve Care Transitions and Decrease Hospital Readmission Rates. *Professional Case Management*, 23(5), 264-271.
doi:10.1097/NCM.0000000000000284
- Binstock, R. H., & Cluff, L. E. (2000). *Home Care Advances*. R. H. Binstock & L. E. Cluff (Eds.). Retrieved from catalog.nyam.org
- Boccuti, C., & Casillas, G. (2017). Aiming for Fewer Hospital U-turns: The Medicare Hospital Readmission Reduction Program [Special issue]. *The Henry J. Kaiser Family Foundation*. Retrieved from <http://www.kff.org/medicare/issue-brief/aiming-for-fewer-hospital-u-turns-the-medicare-hospital-readmission-reduction-program/>
- Brassard, A. (2012). Removing Barriers to Advanced Practice Registered Nurse Care: Home Health and Hospice Services. [AARP Public Policy Institute]. *INSIGHT on the Issues*, 66. Retrieved from http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/removing-barriers-advanced-practice-registered-nurse-home-health-hospice-insight-july-2012-AARP-ppi-health.pdf

Breathett, K., Maffett, S., Foraker, R., Sturdivant, R., Moon, K., Hasan, A., . . . Abraham, W.

(2018, August). Pilot Randomized Controlled Trial to Reduce Readmission for Heart Failure Using Novel Tablet and Nurse Practitioner Education. *The American Journal of Medicine*, 131(8), 974-978. doi:10.1016/j.amjmed.2018.02.017

Chicoine, V., & ASelton, P. (2014, December 17). Nurse practitioner role in home healthcare: Challenges and opportunities [Review of the book , by]. *Clinical Nursing Studies*, 3(1), 100. <http://dx.doi.org/DOI: 10.5430/cns.v3n1p100>

Condon, C., Lycan, S., Duncan, P., & Bushnell, C. (2016, June). Reducing Readmissions After Stroke With a Structured Nurse Practitioner/Registered Nurse Transitional Stroke Program. *Stroke*, 47(6), 1599-604. doi:10.1161/STROKEAHA.115.012524

Crary, D. (2011, November 21). Aging in Place: a Little Help Can Go a Long Way. . Retrieved from <http://www.aarp.org>

David, D., Britting, L., & Dalton, J. (2015, May-June). Cardiac acute care nurse practitioner and 30-day readmission. *The Journal of Cardiovascular Nursing*, 30(3), 248-55. doi:10.1097/JCN.0000000000000147

Dizon, M., & Reinking, C. (2017, December). Reducing Readmissions: Nurse-Driven Interventions in the Transition of Care From the Hospital. *Worldviews on Evidence-based nursing*, 14(6), 432-439. doi:10.1111/wvn.12260

G. Jones, Masha & V. DeCherrie, Linda & S. Meah, Yasmin & R. Hernandez, Cameron & J. Lee, Eric & M. Skovran, David & Soriano, Theresa & Ornstein, Katherine. (2016). Using Nurse Practitioner Co-Management to Reduce Hospitalizations and Readmissions Within a Home-Based Primary Care Program. *Journal for Healthcare Quality*. 39. 1. 10.1097/JHQ.0000000000000059.

- Ellis, B. H., Shannon, E. D., Cox, J. K., Aiken, L., & Fowler, B. M. (2004). *Chronic Conditions: Result of the Medicare Health Outcomes Survey, 1998-2000* (). Retrieved from <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/04summerpg75.pdf>
- Hall, M., Esposito, R., Pekmezaris, R., Lesser, M., Moravick, D., Jahn, L., . . . Hartman, A. (2014, May). Cardiac surgery nurse practitioner home visits prevent coronary artery bypass graft readmissions. *The Annals of Thoracic Surgery*, *97*(5), 1488-5. doi:10.1016/j.athoracsur.2013.12.049
- Home Health Care Planning Improvement Act of 2011, H.R. S. 227 , 112 Cong. (2011).
- Hospital Readmission Reduction. (2017). Retrieved from <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>
- Jones, M. G., DeCherrie, L. V., Meah, Y. S., Hernandez, C. R., Lee, E. J., Skovran, D. M., . . . Ornstein, K. (2016, September). Using Nurse Practitioner CO-Management to Reduce Hospitalizations and Readmissions Within a Home-Based Primary Care Program. *Journal for Healthcare Quality*, *39*(5). doi:10.1097/JHQ0000000000000059
- Joynt, K., & Jha, A. (2013, March 28). A path forward on Medicare readmissions. *The New England Journal of Medicine*, *368*(13), 1175-7. doi:10.1056/NEJMp1300122
- Joynt, K., & Jha, A. (2013, January 23). Characteristics of hospitals receiving penalties under the Hospital Readmissions Reduction Program. *Journal of the American Medical Association*, *309*(4), 342-3. doi:10.1001/jama.2012.94856
- Kutzleb et al. (2015). Nurse practitioner care model: Meeting the health care challenges with a collaborative team. *Nursing Economic\$, 33*(6), 297-304.

- Medicare Claims Processing Manual Transmittal. (2004). Retrieved from <http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittal/downloads/R304CP.pdf>
- Mora, K., Dorrejo, X., Carreon, K., & Butt, S. (2017, December). Nurse practitioner-led transitional care interventions: An integrative review. *Journal of the American Association of Nurse Practitioners*, 29(12). doi:10.1002/2327-6924.12509
- Neal-Boylan, L., Mager, D. R., & Kazer, M. W. (2012). Nurse Practitioners in Home Health Care: An Update. *Home Health Care Management & Practice*, 24, 193-197. <http://dx.doi.org/10.1177/1084822312436682>
- Oliver, G. M., Pennington, L., Revelle, S., & Rantz, M. (2014, November-December). Impact of nurse practitioners on health outcomes of Medicare and Medicaid patients. *Nursing Outlook*, 62(6), 440-447. doi:10.1016
- Peacock, S., Siegel, J., Harmer, E., Alejos, D., & Freeman, W. (2018, November 27). Evaluation of Hospital-wide Readmission Risk Calculator to Predict 30-Day Readmission in Neurocritical Care Patients. *Journal of neuroscience nursing : journal of the American Association of Neuroscience Nurses*. doi:10.1097/JNN.0000000000000410
- Pereira, A. G., Kleinman, K. P., & Pearson, S. D. (Eds.). (2003). Leaving the Practice: Effects of Primary Care Physician Departure on Patient Care [Special issue]. *JAMA Internal Medicine*, 163(22) <http://dx.doi.org/10.1001>
- Pho, K. (Ed.). (2013). How I would end the war between nurse practitioners and doctors. Retrieved from <http://www.kevinmd.com/blog/2013/05/war-nurse-practitioners-doctors.html>

Preventable Readmissions Cost CMS \$17 Billion. (n.d.). Retrieved from <https://revcycleintelligence.com>

Reardon, S. (2015, January 13). 3 Strategies to Reduce Hospital Readmission Rates, Costs. *Revcycle Intelligence*.

Smith, J., Pan, D., & Novelli, M. (2016, May). A Nurse Practitioner-Led Intervention to Reduce Hospital Readmissions. *The Journal for Nurse Practitioners*, 12(5), 311-316.
doi:10.1016/j.nurpa.2015.11.020

Sommers, A., & Cunningham, P. J. (2011). *Physician Visits After Hospital Discharge: Implications for Reducing Readmissions*. Retrieved from National Institute for Health Care Reform: http://nihcr.org/wp-content/uploads/2016/07/Reducing_Readmissions.pdf

Stefan, M., Pekow, P., Nsa, W., Priya, A., Miller, L., Bratzler, D., . . . Lindenauer, P. (2013, March). Hospital performance measures and 30-day readmission rates. *Journal of general internal medicine*, 28(3), 377-85. doi:10.1007/s11606-012-2229-8

The Future of Nursing: Leading change, Advancing Health [Report]. (2010). Retrieved from [nationalacademies.org: http://www.nationalacademies.org/hmd/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx](http://www.nationalacademies.org/hmd/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx)

van Walvaren, C., Bennett, C., Jennings, A., Austin, P., & Forster, A. (2011, April 19). Proportion of hospital readmissions deemed avoidable: a systematic review. *Canadian Medical Association Journal = journal de l'Association medicale canadienne*, 183(7), E391-402. doi:10.1503/cmaj.101860

- Warren, C., Lemieux, A., & Bittner, P. (2019, January-February). Excellence in Population Health: A Successful Community-Based Care Transitions Program Model. *Professional Case Management*, 24(1), 39-45. doi:10.1097/NCM.0000000000000303
- White, S., & Hill, A. (2014, November-December). A heart failure initiative to reduce the length of stay and readmission rates. *Professional Case Management*, 19(6), 276-84. doi:10.1097/NCM.0000000000000059
- Wilson, A., Whitaker, N., & Whitford, D. (2012). Rising to the Challenge of Health Care Reform with Entrepreneurial and Intrapreneurial Nursing Initiatives [Special issue]. *Online Journal of Issues in Nursing*, 17(2). <http://dx.doi.org/10.3912>
- Whittemore, R. (2005). Analysis of integration in nursing science and practice. *Journal of nursing scholarship: an official publication of Sigma Theta Tau International Honor Society of Nursing*, 37(3), 261-7. doi:www.ncbi.nlm.nih.gov/pubmed



Nurse Practitioners role in the reduction of hospital readmission

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INTRODUCTION

Significant attention given on how to reduce avoidable hospital readmissions thus help control health care costs. Readmissions in the first 30 days after a hospital discharge are relatively common and unscheduled, affecting up to one-fifth of Medicare fee-for-service patients (Sommers & Cunningham, 2011). Medicare Payment Advisory Commission estimated that 13.3% of 30-day admissions were potentially preventable and cost an additional \$12 billion (Axon & Williams, 2011).

It has been documented that NPs provide quality patient care with great disease management outcome, as well as a discrepancy in the number of patients needing treatment and the number of physicians available to treat them (Chicoine & Selton, 2014). Research studies have demonstrated that NPs provide expert care, and reduce emergency department use, hospitalizations, and rehospitalizations, thereby reducing costs (Neal-Boylan, Mager & Kazer, 2012).

PROJECT PURPOSE

The purpose of this project is to reinforce the recognized facts about the importance of including NPs in decreasing preventable 30-day readmissions.

Decreasing 30-day hospital readmissions by involving Nurse Practitioner

METHODS

Problem Identification **Data Analysis**
Presentation **Data Evaluation**
Literature search

Basing on these steps (Whittemore 2005), this integrative review will be organized, succinct, and current. Various sources were utilized that reflects current and causal factors leading to unnecessary 30-day readmissions.

Data not limited to specific causes or diagnoses, such as Congestive Heart Failure, Pneumonia and Diabetes. General data of readmissions gathered to reflect the overall effect of NP inclusion.

SOURCES

Google Scholar
PubMed
Evidenced-based journals

KEY WORDS

Nurse Practitioner Medicare
30-day Readmission Home-based Care
Transition Care
Readmissions/Rehospitalizations

INSTRUMENTS

Critical Appraisal Skills Programme (CASP) used to appraise the project to ensure consistency, validity and relevance to the research question.

Studies will be reflected on the Literature Review Matrix.

EXPECTED OUTCOMES

Reinforcing the undeniable positive effect of NP inclusion in Home Health Care in reducing preventable readmissions will urge congress to allow independent practice for Nurse Practitioners.

Ultimately, more NPs will be incorporated in the Home Health Care setting, Transition of Care, Bridge Care to name a few.

RECOMMENDATION

Purposeful, systematic and strategic inclusion of NP in the planning, implementation, intervention and evaluation of care management during, after and immediately after discharge of patient which includes but not limited to phone calls, home visits and hand off communication to PCP.

REFERENCES

- Chicoine, V., & Selton, P., (2014). Nurse practitioner role in home healthcare: Challenges and opportunities [Review of the book by]. Clinical Nursing Studies
- Neal-Boylan, L., et al., (2012) Nurse Practitioners in Home Health Care: An Update. Home Health Care Management and Practice.
- Sommers, A., & Cunningham, P. J. (2011). Physicians Visits After Hospital Discharge: Implications for Reducing Readmissions
- Whittemore R. (2005) Analysis of integration in nursing science and practice. Journal of Nursing Scholarship 37, 261-267