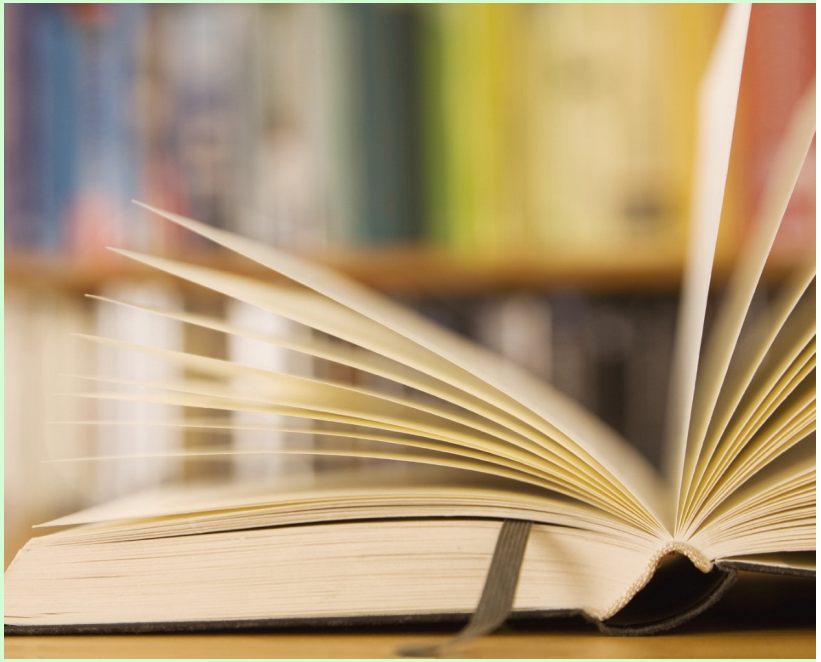
"HOW TO BE A BETTER DNP IN 3 DAYS"

THE DNP IN CHRONIC DISEASE MANAGEMENT



insight

A DNP Scholarship Team

DR Praba Koomson, Dr Analiza Baldonado, Dr Nisha Nair

8th Annual DNP Conference 2015

Our background

Meet The insight Scholarship Team

President

- Dr Praba Koomson **c**urrently works for a large northern California Health Care System of 21 hospitals, Home Health, Hospice and Private Duty. She is a Regional Program Director for a Centers for Medicare & Medicaid (CMMI) grant – funded innovations program in Advanced Illness Management, and palliative care.

Chief Executive Officer

- Dr Analiza Baldonado currently works for different health provider organizations and specializes in innovations development. She is passionate about publishing and scholarship in practice, and a member of the review board of an open access journal.

Chief Administrative Officer

- Dr Nisha Nair currently works as a specialist for a large hospital in Northern California. She provides clinical leadership for her team, and leads practice innovations in maternal and child health.

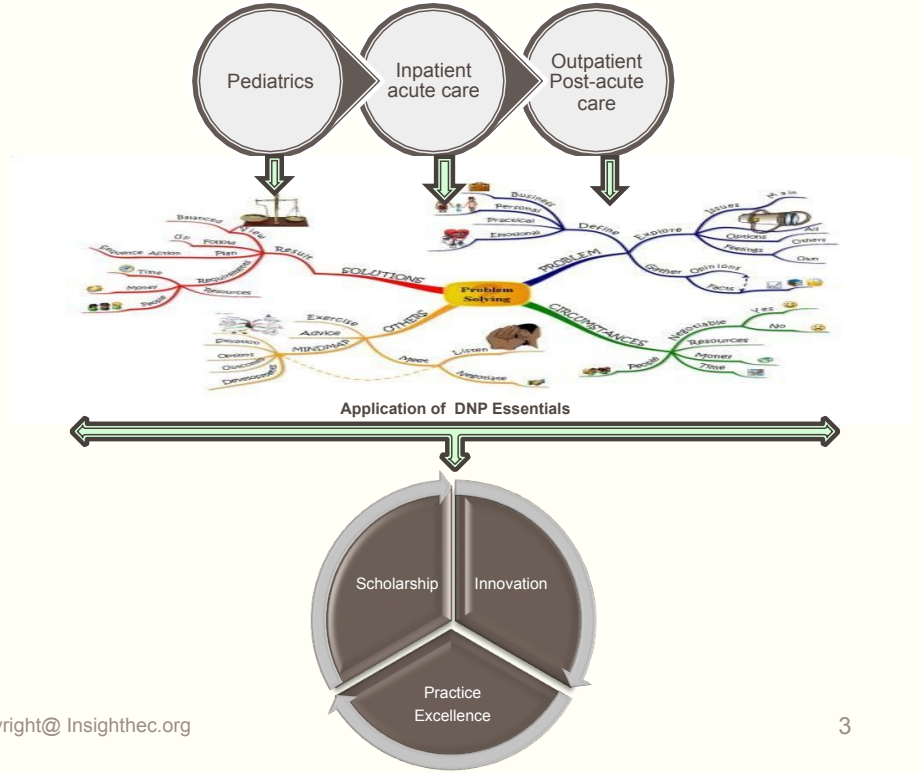
(First Cohort of the Norcal DNP Program 2014 - Alumina of San Jose State University & Fresno State University)

Introducing *insight*: A DNP Scholarship Team

From *The Doctor of Nursing Practice Essentials...*

- Organizational and Systems Leadership for Quality Improvement and Systems Thinking
- Scientific Underpinnings for Practice
- Clinical Scholarship and Analytical Methods for Evidence-Based Practice
- Information Systems/Technology and Patient Care Technology for the Improvement and Transformation of Health Care
- Health Care Policy for Advocacy in Health Care
- Inter-professional Collaboration for Improving Patient and Population Health Outcomes
- Clinical Prevention and Population Health for Improving the Nation's Health
- Advanced Nursing Practice

…to a DNP Scholarship Team- *shared scholarship, shared insight*



Introducing *insight*: A DNP Scholarship Team

What areas of interest are we currently involved in?

- Scholarship collaboration activities with groups and individuals
- Offer a platform for collaboration and discourse
- Participate/lead in the development of practice innovations
- Supporting application of research and evidence base to practice settings
- Publishing research
- Providing mentoring

How can you contact us?

- Website – share your comments and insights online via our Blog
- Email –info@insighthec.org
- Call us at (925 322 5786)

Purpose and Objectives of this presentation

Purpose

To demonstrate the impact of DNP-led practice exemplars on innovations in chronic disease management by a DNP scholarship Team.

Objectives

By the end of this presentation the participant will be able to:

- Identify a DNP scholarship team approach to utilizing the DNP Practice Essentials to facilitate shared learning and translation into innovations practice.
- Describe one exemplar of a practice innovation translation from conceptual framework to practice implementation.
- Describe one approach to developing a scholarship team.

Innovation 1

An Integrated Behavioral Health Care Model for Standard Home Health (IBHC Model)

What *insights* do we have about this patient care gap?

Millions of Americans **live with various types of mental illness and mental health problems, such as social anxiety, obsessive compulsive disorder, drug addiction, and personality disorders.** Treatment options include medication and psychotherapy.

According to the National Council on Aging (NCOA), **approximately one in four older adult Americans suffers from a mental health disorder. This population is expected to double to 15 million by 2030.** There is an increase in untreated behavioral health issues in the older population

Care for older people remains fragmented and as such integrated management of behavioral health issues must be infused into chronic disease management especially in the primary care setting.

Depression affects approximately **3-7% of older adults**
~Anxiety disorders affect 11% of the general older adult population.
~In 2007, the rate of suicide among older adults was approximately 14.3 per 100,000 with older men having the highest suicide rates of any age group among the general population.

In addition **substance abuse** rates for this very population are also on the rise. According to SAMHSA and NCOA, **one in five older adults may be affected by combined difficulties with alcohol and medication misuse.**

Background

Scholarship and the Evidence Base

- The cost of depression in healthcare has been well documented—among the five conditions (mood disorders, diabetes, heart disease, hypertension, and asthma) that account for 49% of total healthcare costs. There is a robust body of research about the incidence of depression in the population seeking healthcare services and the interventions that result in improved healthcare outcomes.

- Clinically significant depression in late life has been shown to run concomitantly with physical health conditions including ischemic heart disease, diabetes, stroke, cancer, chronic lung disease, arthritis, Alzheimer's disease, and Parkinson's disease.

- Many behavioral health integration initiatives have focused particularly on depression because of the broad scope of the problem (more than 19 million Americans each year are diagnosed and treated for some type of depression) and the degree to which it is under-recognized and under-treated in primary care settings **(30-40% of depression cases is not identified. About 10% only of cases may be recognized and placed on treatment with benzodiazepines therapy.**

Making the case for Value Add

- As such, care for patients in the home setting benefit most from enhanced focus on common behavioral health conditions that impact the health and well-being of the patient in addition to such clinical conditions as may warrant a referral for home based skilled care interventions.

Innovation Design

Program Vision

- To deliver comprehensively coordinated behavioral health care to patients receiving home health service to enhance clinical outcomes and improve quality of life for patients receiving services from Vista Rehab Home Health

Program Philosophy

- All patients deserve to receive comprehensively delivered skilled interventions and care that addresses all aspects of their physical and psychosocial needs in order to optimize their quality of life. Such care will be delivered in a manner that respects patient's choices, values and preferences.

IBHC Program Goals are as follows:

- To coordinate care between all providers to insure a near seamless delivery of comprehensive behavioral health care, layered on chronic disease management for the patient transitioning along the healthcare continuum.
- To reduce avoidable readmissions - enhance the patient and caregiver experience of care, improve quality of life
- Reduce cost

Since treating mental health issues in the primary care setting can be a challenge for providers, the IBHC model offers additional support to providers for effective management of complex patient status, as well as insuring patients receive the right level of care, in the right setting applicable to their needs.

A Model for Success – Implementation, Scalability, Replication

The IBHC Model design principles

Principle 1
Clinical Excellence

- Clinical Diagnosis for Home Health
- IBHC Diagnosis
- POC Development
- Integrated Physicians
- Specialist Care

- Protocol Guided Care
- Workforce Development
- Coordination Outreach

Principle 2
Execution Excellence

- Case Management
- Interdisciplinary Collaboration
- Documentation
- Patient Caregiver - Engagement

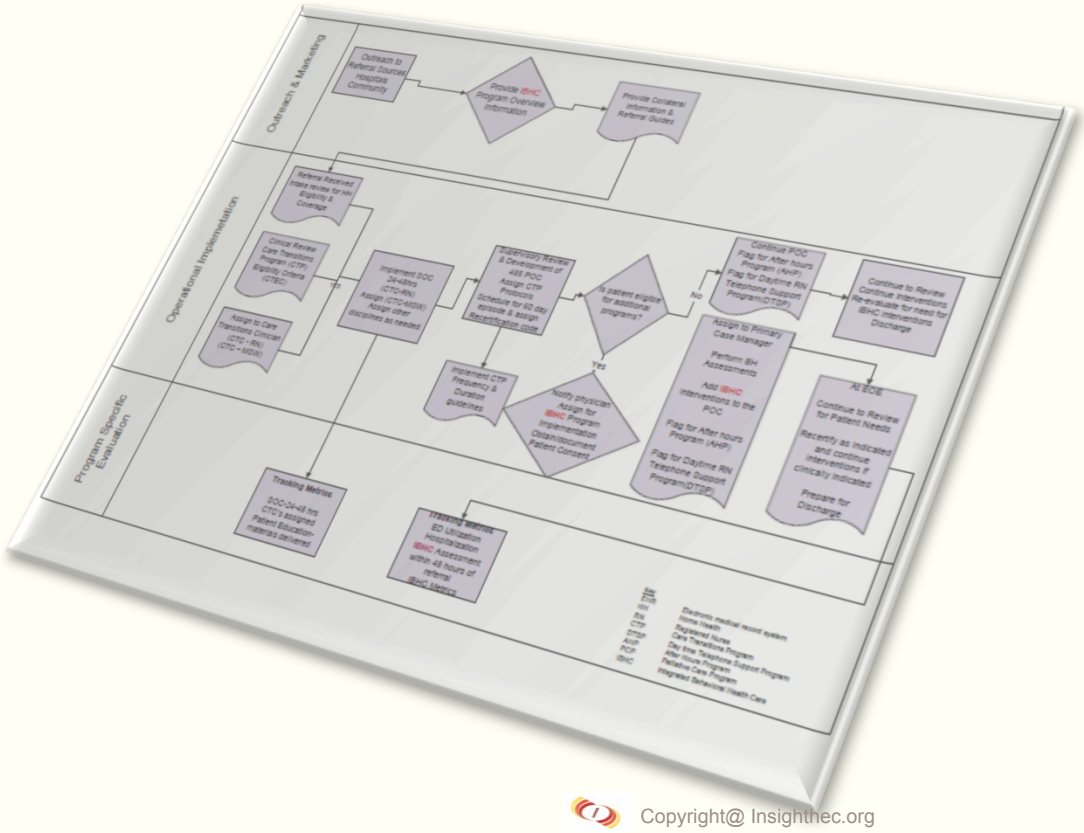
- *Process Measures
- *Outcome Measures
- *Utilization Metrics - ED/ Hospital Utilization
- *Stakeholder Satisfaction

Principle 3
Patient Experience

- Patient Engagement
- Crisis Planning
- Coaching for safety
- Medication Management
- Individual Goals and advance Care Planning
- MD Follow up

- Patient satisfaction
- Patient Outcomes -Quality of Life Measures

Outcomes and Proof of Concept



Outcomes - Quantitative

- Quarter 1 post implementation 64% increase in referrals
- Baseline mandatory assessments for Home Health Platform 100% for enrolled patients
- Medication reconciliation-Pharmacist review 100% for enrolled Population
- Ed utilization – 36% reduction
- Hospitalization 27%
- New contracts with service purchasers -4

Outcomes – Qualitative

- Staff satisfaction – reported increased satisfaction
- Patient/Caregiver satisfaction – Survey- improvement 30 percentage points

Innovation 2

Pilot Study: Avoiding Readmissions of Heart Failure Patients Across Transitions of Care

What *insights* do we have about this patient population and the gaps in care?

The DNP has an expanded role in Chronic Disease management as the skill set of the DNP practitioner demonstrates they are

~Equipped with scientific underpinnings for practice

~Develop and evaluate new practice approaches

~A major problem facing the U.S. healthcare system is avoidable hospital readmissions. Patients with Heart Failure (HF) face variety of barriers to health care and are at higher risk for readmissions

~Patients with complex medical issues are major drivers of health care costs due to high utilization of Emergency Department (ED) and inpatient hospital resources

Development and Implementation of a pilot study based on:

"Home telehealth-appropriate & cost-effective way to manage patients at home with implementation of disease management technologies & health informatics"

Background

Scholarship and the Evidence Base

The Doctor of Nursing Practice Essentials - *Clinical Scholarship and Analytical Methods for Evidence-Based Practice*

- **Fact -** a major problem facing the U.S. healthcare system is avoidable hospital readmissions. Patients with Heart Failure (HF) face variety of barriers to health care and are at higher risk for readmissions

DNP Intervention: Develop an innovative pilot project to address identified practice gap.

Outcome: Published Innovation Pilot Project

Reference : Baldonado, A., Rodriguez, L., Renfro, D., Barrett-Sheridan, S., McElrath, M., & Chardos, J. (2013). A Home Telehealth Heart Failure Management Program for Veterans through Care Transitions. Dimensions of Critical Care Nursing, (DCCN) 32(4), 116-119

- Published in Europe PubMed
- Listed in Europe DefMed Bulletin (Defense Medical Library Service)

(This Innovation Pilot Study has been the **most downloaded and emailed article** in Dimensions of Critical Care Nursing Journal)

Background

Scholarship and the Evidence Base

The Doctor of Nursing Practice Essentials:- *Clinical Prevention and Population Health for Improving the Nation's Health*

- **Fact**: The Affordable Care Act (ACA) is changing the healthcare environment to address the cost and quality of healthcare

DNP Intervention: Design innovative teaching frameworks in academia and in clinical settings.

Outcome: Published Innovation

Reference: Baldonado, A., Dutra, D., Abriam-Yago, K. (2014). Model for Heart Failure Education. Dimensions of Critical Care Nursing, 33(5), 280-284.

- One of the most popular articles of DCCN
- Article included in the curricula of East Carolina University, College of Nursing

Background

Scholarship and the Evidence Base

The Doctor of Nursing Practice Essentials:- *Interprofessional Collaboration for Improving Patient and Population Health Outcomes*

- **Fact:** Patients with complex medical issues are major drivers of health care costs due to high utilization of Emergency Department (ED) and inpatient hospital resources

DNP Intervention: Design innovative teaching frameworks in academia and in clinical settings.

Outcome: Practice Change

- Primary care teams can identify high risk patients BEFORE the first hospitalization and improve outcomes and costs
- Embedded Pro-Active Outpatient Case Management/Care Coordination process linking ED and inpatient care

Expanding DNP Practice

Key Strategies

- Develop specialist services for consultation: Chronic Disease Management, Palliative Care Models, Home-based Services, Quality, Regulations and Compliance.
- Extensive marketing of specialist care services to in-patient healthcare provider organizations in utilization management, patient population management, reimbursement service alignment with focus on lean methodologies.
- Target health care provider development activities: (new home health agency start-up, avoiding readmissions models, health care organization service line improvements).
- Target International Markets for human resource recruitment activities (Nursing recruitment & cross cultural education).
- Target International Markets for consulting in new service line developments.

Innovation 3

Risk Assessment Strategy for Late Preterm Infants

What *insights* do we have about this patient population and the gaps in care?

The DNP has an expanded role in management of challenging patient populations and has the skill set to demonstrate

~Systems thinking, Healthcare organizations, and the Advanced Practice Nurse Leader role
~Develop and evaluate new practice approaches

The DNP possesses the skill set to **~Develop Innovations in practice grounded on the evidence-base and to infuse the evidence into achieving excellence in practice**

The DNP has an expanded role in the development, support and implementation of **~Healthcare Policy for Advocacy in Healthcare**

Development and Implementation of a pilot study based on:

"Late preterm infants often develop complications post discharge from hospital which is largely unaddressed effectively. There is a high risk of avoidable readmissions related to caregiver lack of knowledge and skill in caring for this vulnerable patient population"

Background

Scholarship and the Evidence Base

The Doctor of Nursing Practice Essentials:- *Healthcare Policy for Advocacy in Healthcare*

- **Fact:** Evidence to guide safe discharge for late preterm infants (34-36 weeks' gestation) is lacking. Previous studies have demonstrated the increased risk of neonatal readmission for these infants compared with those born at term (> or =37 weeks' gestation)

DNP Intervention: Design innovative educational interventions to promote caregiver engagement and self support in post-discharge care of late preterm infants

Outcome 1: Practice Change for large Regional Hospital

Outcome 2: Published Innovation

- Clinical care teams can identify high risk infants prior to discharge, and implement focused caregiver coaching interventions to prevent avoidable readmissions and improve outcomes, quality of life and costs

- Embedded Pro-Active Outpatient Case Management/Care Coordination process linking ED and inpatient care

Key Strategies

Provision of health literate information to the mother /caregiver of the late preterm child and implementation of “teach back” to ascertain competency in basic post discharge care to include

- The anticipated pattern of urine and stool frequency for the breastfeeding or formula-fed neonate (both verbal and written instruction provided)
- Care of the umbilical cord, skin, and newborn genital care
- Infection Control and hand hygiene, specifically to diminish the risk of infection
- Instruction in equipment needed to care for the newborn (proper use of a thermometer to assess axillary temperature)
- Proper assessment, instruction, provision and demonstration of appropriate manner to clothe the newborn.
- How to identify common signs and symptoms of emerging common illness in the late preterm infant (hyperbilirubinemia, sepsis, and dehydration, failure to progress, assessment for jaundice)
- Instruction on safe sleeping practices and an optimal sleeping environment, to include correct positioning of the infant
- Instruction of newborn safety issues
- How to manage emergencies and complications in the late preterm infant

References

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- Melnyk, B. M., Fineout-Overholt, E., Stillwell, S. B., & Williamson, K. (2009). Transforming healthcare quality through innovations in evidence-based practice. Interdisciplinary Shared Governance: Integrating Practice, Transforming Health Care, 167.
- Schmidt, N. A., & Brown, J. M. (2014). Evidence-based practice for nurses. Jones & Bartlett Publishers.
- Bryant-Lukosius, D., DiCenso, A., Browne, G., & Pinelli, J. (2004). Advanced practice nursing roles: development, implementation and evaluation. Journal of Advanced Nursing, 48(5), 519-529.

(Reference handouts provided)

WHAT QUESTIONS DO YOU HAVE?

insight

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