

Decreasing Hospital Readmissions with Advanced Care Planning

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Abstract

Patients with progressive and terminal disease processes such as chronic kidney disease (CKD), congestive heart failure (CHF), and chronic obstructive pulmonary diseases (COPD), acute myocardial infarction (AMI), and coronary artery bypass graft surgery (CABG), are at a higher risk for hospital readmissions due to the progressive nature of the disease processes and the continuation of symptoms that worsen over time. Regardless of recent hospitalizations, once symptoms escalate, the common response for patients and families is to return to the hospital.

To reduce readmissions health care providers should address goals of care and advanced care planning prior to discharge. The palliative care patient navigator is typically the initial person on the interdisciplinary health care team to initiate this conversation. Patients who receive palliative care consults for patient-centered goals of care and advanced care planning conversations early in the disease process will have an increased understanding of symptomology and symptom management allowing them to utilize community-based resources and have more autonomy in the management of their care. As a result, return visits to the hospital are decreased, patients can remain at home to manage episodes of symptom exacerbation and improve the quality of life.

Methods

As a collaborative project between the quality and case management departments, this evidence-based process improvement project was designed to reduce 30-day readmission rates for high-risk patient populations. The Gunderson Lutheran Health system Advanced Disease Coordination Respecting Choices model was used to frame the development, implementation, and evaluation of the project. All inpatients readmitted to the hospital within 30-days of discharge were screened using the BOOST tool method within the electronic medical record (EMR). Patients with BOOST scores >15 demonstrate the highest risk for readmission. Those with a score >15 and who met inclusion criteria were triaged and seen by the Palliative Care

team for appropriateness of the Respecting Choices Advance Care Planning education and assistance completing health care goals and advanced directives. All patients who received goals of care and advance care plan conversations, were also referred to interdisciplinary teams for follow up and identified discharge needs. The goal of the program was to discharge patients with a specific plan for treatment with the necessary resources for symptom management at home to prevent frequent hospital readmissions.

Results

The evidence-based project was implemented over 30 days during the month of August 2023 with aggregate 30-day readmission data collected for September 2023 on October 1. Data collection and analysis began immediately with a comparative analysis of baseline data collected June 2023 and post implementation data from September 2023.

The goal of the project was to reduce the hospital readmission rates by 10% within 30 days of implementation. And to increase the amount of advanced care plans/advanced directives by 20%. The goal was surpassed by 15% reduction in hospital readmission rates within 30-days post project completion. The amount of advanced care plans/advanced directives was 9%.

Discussion

Comparative analysis pre and post implementation data revealed a 15% decrease in 30-day hospital readmissions. This information has been presented to stake holders proposing continuation of the process to address 30-day readmissions with advanced care planning.

Keywords: palliative care nurse navigators, advanced care planning, 30-day hospital readmissions, BOOST tool.

Decreasing Hospital Readmissions with Increased Advanced Care Planning

Patients with progressive and terminal disease processes such as, congestive heart failure (CHF), chronic obstructive pulmonary diseases, (COPD), chronic kidney disease (CKD), acute myocardial infarction (AMI), and coronary artery bypass graft surgeries (CABG), are at a higher risk for hospital readmissions within 30 days of discharge due to the progressive nature of the disease process as the severity and frequency of symptoms worsen over time to overwhelm the patient and caregiver. There are systematic processes in place to assist with decreasing episodes of symptom exacerbation. A proactive consultation with a palliative care nurse navigator to explore with the patient what their future wishes are regarding the progressive nature of the disease is an effective means proven to be effective in supporting the patient and family.

Palliative care nurse navigator programs are designed to help patients transition from in-patient hospital stays to community support and have been shown to significantly reduce 30-day re-admission rates and improve quality of life for chronic patients and caregivers. Palliative care is often confused with end of life or hospice care. However, the term palliate means to reduce the violence of a disease and to moderate the intensity of (Merriam Webster, 2022). The World Health Organization (WHO), defines palliative care as a team – based approach for patients facing the problems associated with a life-threatening illness with the goal of achieving the best possible quality of life for patients and their families (Ryan et.al, 2020).

The goal of the palliative care consult is to understand what the patient's perception of the disease process is and to establish patient-centered goals of care. In these initial conversations the patient is given information to assist them in understanding what quality of life looks for them personally and includes an advanced care planning packet to assist with legal considerations when declaring what those wishes are. If these conversations can occur early in

the disease process, quality of life can be improved, and hospital readmission rates are more likely to be reduced as a result.

Background

According to the National Priorities Partnership in conjunction with the National Quality Form, an estimated one million people in the United States die each year without palliative care services resulting in needless suffering and unnecessary financial burden to families and the healthcare organization (ACHE, 2017). Palliative care nurse navigators provide the education and support to help patients and their caregivers to establish goals of care and bridge the knowledge gap to effectively break the cycle of symptom exacerbation, emergency department (ED) admission, acute treatment, and discharge without addressing the underlying problem.

Over \$52.4 billion is spent annually for the care of patients readmitted for a previously treated condition. In 2018, there were a total of 3.8 million adult hospital readmissions within 30 days, with an average readmission rate of 14 percent and an average readmission cost of \$15,200 per case. Nationally, 30-day readmission rates have increased significantly and have remained elevated (Agency for Healthcare Research Quality, 2020). There are five diagnosis groups of patients that have consistently had the highest percentages of 30-day hospital readmission rates each month: chronic obstructive pulmonary diseases (COPD), chronic kidney disease (CKD), chronic heart failure (CHF), acute myocardial infarction (AMI), and coronary artery bypass grafting surgeries (CABG). Frequent readmissions have proven difficult for patients and their families but also results in increased hospital costs and Medicare penalties for the healthcare system. These diagnoses are considered progressive diseases, in that patients will have progressively worsening symptoms over time with increased frequency and severity of illness as the disease enters a stage of decline. These patient populations are treated for acute symptoms

and discharged from the hospital with no cure for the underlying disease process. Therefore, they are discharged with the same condition that brought them to the hospital initially. Inevitably symptoms will re-occur, and the cycle of hospital admission, treatment and discharge continues without return to previous baseline creating two problems; one the patients' quality of life is impaired and two, avoidable healthcare expenditures and financial penalties for the hospital with Medicare fines and decreased reimbursements. According to Gradwohl et.al, (2022), goals of care conversations increase the likelihood that patients with life threatening diseases agree to care that is congruent with their preferences and therefore reduce stress, anxiety and depression. The earlier goals of care are established the quality-of-care increases, overall costs are reduced, and hospital readmissions are fewer.

The Gunderson Lutheran Health System model has been identified as the standard for best practices in decreasing hospital readmissions through advance care planning. A study by the Centers for Medicaid and Medicare Healthcare Quality on The Gunderson Lutheran Health system model, titled "*Advanced Disease Coordination Respecting Choices*" was performed in 2010 and recognized by the Medicare Healthcare Quality review board as a high-quality healthcare improvement measure (CMS, 2010) highly effective in reducing hospital readmission rates. Findings of the CMS study asserted that 85% of patients who died in a 12-month span at Gunderson Lutheran Medical had advanced care planning in place. This care coordination focused on patients who were admitted with a prognosis of two years or less. There was an intradisciplinary team made up of physicians, care coordinators, social workers, pastoral care, palliative care nurses and hospice representatives. Patients with more progressive diseases and complications with frequent emergency department visits were targeted for consult. The model consists of three steps: 1) proactive discussion of basic advanced directives and advanced care

planning for a time when they will not be able to make decisions for themselves, 2) the patient and caregiver are educated about the disease process and typical course, and 3) the patient and caregiver are encouraged to verbalize their fears and concerns. The goal of the consult is to establish and document an informed patient-centered Physician Ordered Treatment of Life Sustaining Care (POTLSC) order that is placed in the patient's medical record to follow them throughout the disease process (CMS, 2010). As the recognized standard for best practice in advanced palliative care planning, the Gunderson Lutheran Health System, Respecting Choices advanced care plan (ACP), model will inform the development of this DNP quality improvement project with the aim of decreasing hospital readmissions through advance care planning.

The observed situational gap is an inevitable cycle of physical decline that without palliative care advanced care planning in place patients will continue to be readmitted and discharged until their decline has reached end of life and the conversation with the family is most often shifted to focus on withdrawal of care or home with hospice. To address this gap, this process improvement project will follow the Respecting Choices Advanced Care Plan (ACP), to establish a health care culture of person-centered care that honors patient's wishes for current and future health. It is a shared decision-making process that involves interaction between providers, patients, and families, to assist them in planning their future health care according to their vision of quality of life (Respectingchoices.org).

Problem Statement

Patients are not receiving proactive advanced care planning information early enough in the disease process for them to make informed decisions. They are discharged from the hospital without advanced planning for symptom management related to their progressive disease, or without adequate knowledge of available treatment options to maximize quality of life. As

patients with terminal illnesses near end of life, the use of medical resources to include hospital readmissions increases as acute exacerbations of the disease process becomes increasingly more frequent with increased severity over time. This cycle of mismanaged care will continue until the patient is no longer capable of making informed decisions for themselves. The opportunity for improved quality of life with symptom management at home and a dignified death are squandered.

Palliative and end-of-life care services and interventions have the potential to improve the quality, appropriateness and efficiency of care provided at the end-of-life from both the perspective of patients and their families as well as the health system. Especially since end-of-life care costs increase substantially for hospitals and patients (BMC Palliative Care, 2021) with an estimated 25% of Medicare dollars consumed annually by 5% of patients during the last 12 months of their lives (Duncan et. al, 2019). This DNP process improvement project was designed to address this situational gap in care practices through the implementation of a systematic evidence-based process. Implementation of the project began with early identification of patients with the highest risk for readmission, followed by proactive face to face goals of care conversations, and education with the advanced care planning. Patients received the Respecting Choices packet to support the education provided and to assist them in creating a discharge plan that would provide them with symptom management at home and follow them through end-of-life care.

Organizational “Gap” Analysis of Project Site

The Alabama Market Performance on Quality Safety Patient Experience (QSPE) measures is a valid and reliable tool used by the Hospital Inpatient Quality Reporting Program to assess hospital wide readmission scores. The Center for Medicare/Medicaid Services (CMS)

collects quality data from hospitals paid under the Inpatient Prospective Payment System, with the goal of driving quality improvement through measurement and transparency by publicly displaying data to help consumers make more informed decisions about their health care. This prospective payment system is also intended to encourage hospitals and clinicians to improve the quality and cost of inpatient care provided to all patients. Performance data for selected quality and efficiency measures are used to determine reimbursement incentives or disincentives when paying hospitals for care provided. These programs include the Hospital Value-Based Purchasing Program, Hospital-Acquired Condition Reduction Program, and Hospital Readmissions Reduction Program (Medicare.Gov).

Based on the Alabama Market Performance on QSPE Measures hospital wide readmission scores exceeded the 2022 market target of 0.813 with a score of 0.867 overall for the last quarter. The highest diagnosis was end stage renal disease with 2.75 compared to the target market of 0.813 followed by the second highest coronary artery bypass graft surgeries of 1.64 with a target market 0.738. HF and AMI were the lower of the five categories. Readmission rates have increased 14% over the last fiscal year with significant financial impact to the health care organization (NHRQ, 2022).

Review of the Literature

A literature review was conducted utilizing the Cumulative Index to Nursing and Allied Health Literature (CINAHL). Search terms were 30-day hospital readmissions, advanced care planning, palliative care, and patient navigator. The CINAHL Ultimate data base search generated 2,080 results. The inclusion and exclusion criteria were professional articles written between 2017 and 2022 and generated 333 articles. Articles were further refined to include studies that specifically addressed only interventions related to advanced care planning to reduce

readmission rates. Articles focused on diagnosis or patient populations other than CHF, COPD, CKD, AMI OR CABG were omitted. The final search generated 75 results.

Hospital Readmission Reduction Program

The Hospital Readmission Reduction Program (HRRP) was created by the Center for Medicare and Medicaid Systems (CMS), in 2012. This program was developed to reduce Medicare payments to hospitals with excess readmissions and improve quality of care. The CMS implemented a strategy of linking quality to payment that relies on financial penalties to improve inpatient care quality and reduce cost. Hospitals subject to the HRRP program receive reduced Medicare reimbursement through penalties and disincentives when readmission rates exceed compare group benchmarks. Penalties have increased by 1% each year since inception of the program and will cap at a 3% (CMS.gov, 2022).

The CMS considers high readmission rates as an indicator of inadequate quality of care. They are seeking to improve the patient and caregivers discharge experience through patient engagement, better communication, and care coordination of post-discharge care (CMS, 2021). Studies have demonstrated the positive effects that financial penalties have had on reducing preventable or excess readmissions for pneumonia (PN), acute myocardial infarction (AMI), and heart failure (HF). The current penalty of three percent in Medicare based payments have caused considerable financial difficulties for smaller and rural hospitals with milder setbacks for larger hospitals. Further studies are needed to determine if reduced readmissions are the result of quality improvement measures motivated by the financial effect of HRRP. These studies will be beneficial to policymakers, hospitals, patients and the overall quality of health care (Wu et.al, 2015, Yang et.al, 2017).

Tools for Measurement

Healthy People 2020 defined Health Related Quality of Life (HRQOL) survey, as a multi-dimensional measurement tool to evaluate the effectiveness of symptom management in improving quality of life for patients with progressive diseases. Health related quality of life is subjective and defined differently by everyone. In 1984 Dr Thomas Rector developed The Minnesota Living with Heart Failure Questionnaire (MLHFQ) and has been proven valid and reliable as a measurement (Rector, T. et.al, 1987). The questionnaire consists of 21 items specifically identified to measure the effect that symptoms associated with cardiac disease and related conditions have on the physical, mental, emotional and social factors affecting quality of life among patients living with heart failure (Barkley, 2018).

In a study conducted by Bilboa, Escobar et.al, The MLHFQ questionnaire was supported as a valid tool of measurement from the patients' perspective on how they rate their quality of life (Bilboa, Escobar et.al, 2016). This tool defined how patients relate symptom control to improved quality of life. Heart failure (HF) is characterized by high symptom burden, and frequent hospitalizations. Palliative care is recommended to maximize quality of life and symptom management. But other diseases with frequent readmission rates and severe symptoms also benefit from palliative care consults (Wu, 2018).

The BOOST tool (Better Outcomes for Older adults through Safe Transitions) is an evidence based multi-element care transition assessment model that was developed to reduce harm and improve transitions as patients move from one setting to another specifically from hospital to home. Key findings from studies on the BOOST method determined a reduction of 30-day rehospitalization rates. Accurate use of the BOOST tool is reliable in predicting 90 percent of readmissions (Earl et.al, 2020). As a proven and reliable tool, it will be used to identify which patients need goals of care meetings sooner and allow a more accurate triage

patient list in this DNP process improvement project.

Palliative Care

Palliative Care is a specialized medical care model for people living with a serious illness. This type of care is focused on providing relief from the symptoms and stress of the illness. The goal is to decrease symptom burden and improve quality of life for both the patient and the family (CAPC, 2022).

Palliative care is provided by an interdisciplinary team of specially trained doctors, nurses and other specialists who work collaboratively with the patient's primary care physicians and other doctors to provide an extra layer of support. Palliative care is based on the needs of the patient, not on the patient's prognosis. It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment (CAPC, 2022). More to the point, delayed palliative care interventions say a 12% mortality rate increase for consults that occurred day seven and later (Barkley et. al, and Wilson, 2014).

According to findings from a comparative, retrospective and observational study on the effects of advance care planning conducted in LaCrosse County, Wisconsin, early advanced care planning achieved a high rate of consistency between advanced care plans and treatment decisions. The collaboration began in 1993 and has been studied as part 1 and part 2 to evaluate the consistency of data findings. Part 1 analyzed data on patients who died between 2007-2008. And part 2 analyzed data on patients who died between 1995-1996. Findings from both part 1 and part 2 demonstrated higher percentages of patients who had advanced directives in the presence of chronic and terminal disease at the time of their death experienced death in their home, hospice or long-term care facilities rather than acute care hospitals (Hammes et.al, 2010).

Advanced Care Planning

Advance care planning is the informed process of preparing for future decisions with respect to medical care should you become seriously ill or unable to communicate your wishes concerning treatment options. Having meaningful conversations proactively with patients regarding the trajectory of their disease process and what their wishes are in respect to comfort, and quality of life is the most important part of advance care planning. Many people also choose to put their preferences in writing by completing legal documents called advance directives (NIH.gov,2023). Of all the articles included in the final review, findings in all 24 studies demonstrated a direct correlation with early interventions, readmissions, and mortality rates (CAPC, 2022). Specifically, the earlier the intervention of palliative symptom management and advanced care planning in patients with progressive diseases, the lower the hospital readmissions and inpatient mortality rates (CAPC, 2022). According to the literature, there was a 12% mortality rate increase for consults occurring at day seven and later (Barkley et.al, and Wilson, 2014). Once patients understood the disease process and treatment options, they were able to make informed decisions. A discharge plan that preserves quality of life without frequent hospital readmissions can be created. According to the literature, data on advanced directives (AD's) is relevant to this DNP project because of the direct correlational relationship between increased advanced directives and informed patients who have identified treatment options at end-of-life and reduced hospital readmission rates.

The Gunderson Model Respecting Choices (RC) model was first studied in 1998 as the first LaCrosse Advance Directive Study (LADS I). LADS I was a retrospective study that reviewed medical records and death certificates of 540 adult decedents in LaCrosse County from March 1995-April 1996. Findings from LADS I revealed that at the time of death 86% of all adult decedents had an AD. Ninety-five of the ADs were in the patient's medical record at the

healthcare organization providing care at the time of death. In 98% of the cases the patients' instructions regarding cardiopulmonary resuscitation (CPR) and hospitalization in the AD were consistent with the treatments provided near time of death (Hammes et.al, 2010). These findings are significant as they also suggest that at the time of death 96% of decedents had an advanced care plan. The advanced care plan outlined specific treatment options with specific instructions such as no CPR and no hospitalizations. Therefore, patients were not being readmitted for symptom management (Hammes et.al, 2010). These advanced care plans were written with sufficient clarity that clinicians could refer to them for treatment decisions. The plan was available to the healthcare professionals taking care of the patient near time of death and they were almost always consistent with treatment. This system made access to patients' end of life treatment decisions accessible. Referring to the advanced care plan is an excellent component when discussing goals of care and treatment options. It is especially beneficial for caregivers and healthcare providers if the patient is no longer capable of making decisions for themselves and the family is struggling with decision making. A comparative analysis of data from Part I and Part II found an increase in the prevalence and documentation of AD's. The Respecting Choices model has been replicated in other large healthcare organizations across the United States with percentages of AD's increased from 86%-90% and the documentation of AD's in the electronic health record (HER) increased from 95.2% to 99.4%. (CAPC, 2022).

Palliative Care Patient Navigator

A nurse navigator is a healthcare professional who “navigates” the patient through the treatment process. Nurse navigators provide aid and support and can follow the patient from the start of the treatment process through to the end-of-life care. They also serve as an advocate during interdisciplinary team meetings with other departments to ensure that the discharge plan

stays congruent with the patient's wishes.

The first nurse navigator role was created by Dr Harold Freeman in 1990, in response to the American Cancer Society's *Report to the Nation on Cancer in the Poor*. This report highlighted health disparities of the poor stating that poor people were more likely to die from cancer. It claimed that poorer Americans had more barriers to timely care, including limited finances, distrust, emotional barriers and poor communication. Dr Freeman created a community-based model for patient navigation that addressed the often-fragmented path of chronic disease and created a seamless journey from diagnosis, treatment, rehabilitation, survivorship to end of life care (Freeman, 2011).

Palliative care teams focus on quality of life. They treat people suffering from the symptoms and stress of serious illnesses. The goal of palliative care is to provide symptom management and maximize the quality of life for patients and their families. Symptoms may include pain, depression, shortness of breath, fatigue, constipation, nausea, loss of appetite, difficult sleeping, and anxiety. The Palliative care purpose is to assist the patient to gain the strength to carry on with daily life. In short, palliative care will help improve quality of life (GetPalliativeCare.org). So, to merge the two into one, the palliative nurse navigator is a nurse who provides symptom management and assists the patient through the processes of treatment to end of life. Therefore, having proactive goals of care conversations, determining their treatment goals and providing information about advanced directives is providing them with care to improve their quality of life.

Early Intervention and Readmissions

A two-year retrospective control study was conducted to evaluate the impact of palliative care consultation on hospital charges, hospital and intensive care unit length of stay, readmission

rates, and rates of hospital-acquired conditions (Glasgow et.al, 2021). Researchers collected data from all adult patients admitted to a two-hospital healthcare system over a two- year period from April 1, 2015- March 31, 2017, with the purpose of understanding how palliative care consultations impacted the rates of patient readmissions in a value-based purchasing model. Findings suggested that hospitals operating under the value-based purchasing model are at risk for three percent penalties on Medicare reimbursements based on readmission rates. Further, by determining prognosis and patient goals, palliative care consultations were shown to reduce 30-day hospital readmission rates. Recommendations from the study suggested that hospital systems may want to invest in larger palliative care programs as part of their efforts to reduce hospital readmissions (Glasgow et. al, 2019).

Key strategies that were identified as a result of this study were promotion of early identification of at-risk patients, educating physicians and other health care providers in addition to patients and their families about the differences of palliative care and hospice. And creating a liaison role in palliative care to resource for symptom management after discharge. There was also a positive correlation between high-risk patients who transition to palliative care or hospice after discharge who reported an increase in health-related quality of life and fewer readmissions, suggesting that advanced care planning was the difference in outcomes (Glasgow et.al, 2019).

Evidence-based Practice: Verification of Chosen Option

The Gunderson Respecting Choices Model, adopted by The Agency for Healthcare Research and Quality (AHRQ) in 1993 and endorsed by the Institute of Medicine as a structural framework to improve advanced care planning (ACP) conversations and advanced directive (AD) completion rates (CAPC, 2022) has proven to be widely accepted and successful in aiding patients in creating their advanced directive in a brief easy to understand format without the need

for lawyers or legal assistance. The Respecting Choices model has been replicated in other large healthcare organizations across the United States. (CAPC, 2022) and provided the framework for this DNP process improvement project to answer the PICOT question: (P) will patients with progressive diseases such as CHF, COPD, and CHF improve symptom management at home without being frequently admitted to the hospital; (I) patient navigators within the palliative care department will discuss goals of care and provide access with information regarding advanced care planning; (C) comparing 30-day readmission rates before implementation and 30 days after implementation will indicate if this project was beneficial for symptom management at home and decreased readmissions; (O) the compared readmission rates reflected a 15% decrease in 30-day readmission rates which indicates these patients were able to manage symptoms at home without being readmitted to the hospital; (T) implementation was conducted for 30 days with pre and post readmission data collected and analyzed to assess efficacy of the program. This evidence-based process improvement project implemented a palliative care patient nurse navigator program aimed at understanding the patient's perception of the disease process and establishing patient-centered goals of care, treatment options, and advanced directives. In the initial conversations with the patient there were given information to assist them in understanding what quality of life looks like for them personally and included an advanced care planning packet to assist with legal considerations when declaring what those wishes are.

Theoretical Framework or Evidence-based Practice Model

The Respecting Choices model started in LaCross, Wisconsin in 1991 as a community-wide initiative to integrate advanced care planning (ACP) at Gunderson Medical System. The Respecting Choices Model has been proven valid and reliable in supporting patients when establishing patient-centered goals and ADs. This widely adopted model provides a

comprehensive approach to advance care planning that involves in-depth conversations between patients, family members, and healthcare providers. The Respecting Choices model is proven to improve patient and family satisfaction with care and reduce hospital readmissions (Wilson, 2020). Respecting choices is also a model intended to normalize end-of-life care communications because it is based on what the patient's wishes are, and not what the family or physicians assume it to be. The goals of care conversation start and end with what the patient's wishes.

The program features ACP as an ongoing process; shifting focus from completion of documents to facilitating discussion about values and goals to encompass what the patient and family see as quality of life and reasonable end of life goals. The ACP ultimately ensures that advance directives are available in patients' charts and serve as a resource for families and health care providers when the patient becomes unable to speak for themselves (Mackenzie et.al, 2018). The Respecting Choices Advanced Care Packet is a six-page easy to understand guide that asks necessary questions regarding code status, determining health care proxies and specific life sustaining measures. The patient simply initials a yes or no response to the questions. The proxy must sign stating they are aware and then two witnesses sign agreeing the patient has made their decision known in their presence. A copy is given to the patient, and one is placed on the chart. The physician is notified, and code status is then changed. This is also the opportunity to discuss what aggressive versus comfort measures means to them personally. Asking opened ended questions regarding what quality and comfort look like to them is the next step in determining what discharge needs are present and then making appropriate consults to case management for palliative, hospice or home health care.

Goals, Objectives and Expected Outcomes

The goals of this DNP process improvement project were twofold; reduce 30-day hospital readmissions by 10% and increase the completion rate of advanced directives by 20% within 30 days of implementation. Palliative care patient navigators were scheduled 0700-1500, seven days a week. Aggregate hospital readmission rates were compared month by month on a concurrent basis and compared to baseline data collected June 2023. Thirty-day re-admission baseline data was collected in aggregate form the month of June 2023 and compared to 30-day re-admission data collected September 2023 to reflect data 30 days post implementation of the project. The palliative care department tracked and recorded all patients meeting inclusion criteria daily to identify those who had completed their advanced directive.

Objectives:

1. Review and document aggregate readmission data for end of June 2023. Baseline data one month prior to implementation.
2. Educational in-services one week prior to implementation to educate palliative care patient navigators on the implementation of Gunderson Respecting Choices processes and informational packet.
3. The BOOST tool used daily to triage patients for a Palliative care nurse navigator consult. This process occurs electronically in the electronic medical record.
4. Palliative care nurse navigator consult list circulated to nurse navigators by 0900 each day.
5. All patients identified for Palliative care nurse navigator consults seen within 24 hours of admission.
6. Huddle meetings with palliative care nurse navigators at the beginning of each business day.
7. Debrief palliative care nurse navigators at the end of each business day.

Methods (Plan)

This is an evidence-based process improvement project that followed a continuous quality improvement (CQI) design guided by the Agency for Healthcare Research and Quality (AHRQ, 2020) quality improvement model; Plan, Do, Study, Act (PDSA) for continuous improvement. This model for process improvement and CQI has been endorsed by the 2018 National Palliative Care Standards (2023) for the implementation of quality and process improvement initiatives in palliative care. The plan stage included problem recognition of potential facilitators and barriers, and preparations for change to leverage strengths and mitigate barriers optimizing success of the project. The Do stage involved the implementation and concurrent monitoring of change. The study stage focused on the examination and analysis of data because of the process improvement project and change to processes. The act stage involved the interpretation and translation of study results and the development of recommendations for refining, normalizing, institutionalizing, and sustaining the change. During the plan stage, patients in the five higher diagnoses percentage groups of hospital readmissions (CHF, COPD, CKD, AMI, CABG) were triaged and prioritized for palliative care nurse navigator consults for goals of care conversations based on BOOST score of five or more. The patient data was placed into an EMR readmission data base using the BOOST tool. This prioritized which patients needed early palliative care consults for goals of care and advanced care planning. The patient navigator in the palliative care department met with the patient and or their families to discuss goals of care and advanced care planning. Then appropriate discharge plan consults were made. At the beginning of October 2023 data was analyzed to compare readmission rates for the month of June 2023 to the month of September 2023. The goals were to have a five percent decrease in hospital readmissions and a ten percent increase in advance care plan completion.

Each morning the Palliative Care manager or charge nurse generated a patient list of

those readmitted within a 24-hour period based their EMR BOOST score and assigned patient consults according to the patient navigators on duty for the day. Patients meeting inclusion criteria were visited at the bedside by the palliative care nurse navigator within 24 hours of admission. Initially upon meeting the patient at the bedside, patients were asked to verbally participate in the MLHFQ screening tool. The MLHFQ has been proven valid and reliable and is an effective way to determine how the patient views health related quality of life and at what level they are currently existing. This initial assessment flowed into the next phase of the consultation. Palliative care nurse navigators used the Respecting Choices Advanced Care Planning model to guide goals of care conversations and help patients establish what they saw as quality of life for them.

The Respecting Choices Advanced Care Planning Packets guided the conversation as it was shared with the patient and caregiver and explained in detail. The packet was given to the patient during the consultation visit. This initial consultation laid the foundation for informed decision-making and the patient was able to expound on the treatment options they identified as their vision for quality of life and how to make informed decisions regarding aggressive treatment with home health care, or rehabilitation, palliative care for symptom management, or hospice with full comfort measures only, and what would be the best option for them and their family. The palliative care nurse navigator followed each day to address lingering questions and provide ongoing support. The DNP student as project facilitator met with the palliative care nurse navigators at the beginning and end of each shift to identify potential barriers and facilitators of the project.

In the study stage, the DNP student was the project facilitator and ensured that all patients meeting inclusion criteria met with a palliative care nurse navigator, received their Respecting

Choices packet, and had follow-up visits as necessary. The DNP student also collected readmission data each month for month-to-month concurrent comparative analysis of readmissions for those patients who received palliative care nurse navigator consults in the previous 30-days were re-admitted and if so, re-assessed their needs to determine what could be done differently to meet those needs and make necessary referrals.

In the act stage, baseline data was collected by the DNP student from June 2023 and compared to September 2023 readmission rates. These findings were presented to the case management and palliative care departments with recommendations for expanding and continuing the project as it was successful in reducing readmission rates as anticipated. The success of this process improvement project for these patients in the higher percentages of readmissions, CHF, CKD, COPD, AMI, CABG, were the focus this project and will potentially be adopted as part of the palliative care daily assessment protocol.

Project Design

This evidence-based DNP process improvement project was a single cohort, non-randomized, prospective design with aggregate data review and analysis of readmission rates. Readmission data was analyzed to determine which diagnosis groups had the highest readmission rates and triaged to determine which patients needed goals of care and advance care planning using a quantitative method. The DNP student compared readmission rates for the patients who completed advanced care planning with a discharge plan for symptom management rather than returning to the hospital seeking aggressive treatment as compared to those who did not. A total number of patient consults per day was documented and compared to the number of advanced care plans documented in the EMR.

Baseline data was collected from June 2023 hospital readmission data and compared to

the September 2023 hospital readmission data. As anticipated the comparison demonstrated a decrease in 30-day hospital readmissions rates after the interventions occurred.

Project Site and Population

The process improvement program was implemented in a progressive 328-bed faith-based acute care hospital that serves the adjacent four counties. It is a charity, non-profit based mission hospital who ranks higher nationally as compared to other hospitals in their service area for charity care and proportions of uninsured patients in the community. According to patient demographics, the representation of black patients is between 45%-75% lower than the community. Black residents have 30% more frequent hospitalizations. Over a five-year period, the rate of preventable hospitalizations for both black and non-black residents have shown worsening health disparities (U.S. New & World Report, 2023) as indicated by the 10%-30% higher rate of hospitalizations among black residents than non-black residents. They ranked higher in renal care and orthopedic surgeries scores, and lower in preventable hospitalizations and re-admissions (U.S. New & World Report, 2022).

The project was conducted in the palliative care department of this 328 bed, faith-based, non-profit acute care hospital. The palliative care department is made up of a department manager, two full time RNs, and one part time and two flexible weekend RN's. The manager is a certified Palliative Care Hospice Nurse and certified Patient Care Navigator. The DNP student is the project facilitator where she typically works weekends as a patient navigator. During the implementation of the project, she participated Monday through Friday and as needed in the introductory phase during weekends, to oversee the implementation of the project.

The Case Management and Quality Improvement departments are made up of case management RN's and social workers. These teams worked collaboratively with palliative care

navigators once the goals of care discussions and discharge referrals were made.

Interdepartmental, interdisciplinary communication was a vital part of ensuring patient discharge goals were met. The target patient population was adult-geriatric and in at least one diagnosis group of CHF, COPD, CKD, AMI or CABG and a BOOST score of five or greater. They were categorized as currently admitted within a 30-day or less discharge timeframe.

Inclusion Criteria

Any male or female patient over 40 years old, with a BOOST score of 5 or greater, readmitted within the last 30 days of discharge, with at least one of the diagnoses of CHF, COPD, CKD, AMI or CABG.

Exclusion Criteria

Under the age of 40, not readmitted within the last 30 days with one of the diagnoses of CHF, COPD, CKD, AMI or CABG.

The resources and facilitators for the project were the unit manager, hospital administrator, chief nursing officer, the physicians, and the palliative care team. The nurse navigators were the palliative care nurses who were currently on staff. The Respecting Choices Advanced Care Planning Packets were used at this facility by request if patients requested more information about advanced directives prior to the implementation of the project. The palliative care manager had access to data required for the project based on management access to files and QSPE reports. Aggregate data collected by the DNP student as PI for the project collected and documented in a spread sheet within the management scorecard that the department manager utilized for departmental data files. The BOOST tool is included in the EMR readmission report and the MLHFQ tool is included in the Respecting Choices packet.

Measurement Instruments

The BOOST (Better Outcomes for Older adults through Safe Transitions) model was developed with the intention of improving transitions across the continuum of care. This model is beneficial for high risk and older adult populations with frequent hospitalizations who move frequently across health care settings and experience high rates of post discharge complications readmissions morbidity and mortality (Earl et.al, 2020)

BOOST was created in 2008 by the Society of Hospital Medicine to improve care for patients as they transition from hospital to home. The objective was to reduce 30-day readmission rates, decrease medication errors and improve provider workflow. A study by Williams et.al, in 2016 reviewed the BOOST patient risk assessment tool via retrospective chart reviews and determined the tool was successful in predicting 90 percent of readmissions for patients 65 years of age and older for two or more risk factors and 99 percent effective with one factor. The actual tool is an eight-category checklist with points per category. The higher the points the greater the risk for readmission. This was done through a chart review each day.

The Minnesota Living with Heart Failure Questionnaire (MLHFQ) tool is the most widely used questionnaire in CHF patients and is also useful determining patient viewed health related quality of life with other progressive diseases as well. It is one of the most widely used forms and has been tested in reliability and validity. This is a simple and easily understood instrument that assists the patient in measuring and identifying quality of life needs. The goal of the tool is to assist the patient with evaluating how well they view their health-related quality of life. After identifying their needs, the goals of care and advanced care planning conversations are more relevant to the patient and their family.

The tool consists of 21 items and the score is 0-105. The two areas are physical and emotional health. The higher the score is, the worse health related quality of life. Within this

questionnaire, each item is scored in a 6-point Likert Scale (0 to 5). Because this is a patient reported questionnaire there is no room for bias or misinterpreted results (Bilbao, 2016).

Data Collection Procedures

Plan: data was generated from the admissions and discharge data through the quality improvement departments admission and readmission aggregate data report. Patients were grouped by diagnosis and admission status. A BOOST tool for indicating which patients are at highest risk for readmission was used through an EMR BOOST Tool that electronically collects high readmission risk data and triages the patients in priority to be seen. This was collected daily to include any re-admissions since the previous census.

Do: Based on the daily BOOST assessment, patients receiving a score of 5 or greater were identified as high risk for readmission. This data created a consult list of patients who met inclusion criteria for the Palliative Care Nurse Navigator Consult. The unit manager and DNP student made consult assignments for the palliative care nurse navigators based on the BOOST assessment. Each Nurse Navigator was assigned up to eight new consults each day. The patients who scored a five or higher were met at the bedside. Palliative Nurse Navigators utilized the MLHFQ screening tool with the patients on the initial visit to determine if they were at the health related and functional quality of life they desired. The MLHFQ tool is a 6-point Likert Scale scoring system with 21 items combining emotional and physical questions. The score is 0-105 with 0-45 considered poor, and above 45 rating in the good category. This led to questions regarding goals of care, symptom management and advanced care planning. The Respecting Choices packet was explained and left with the patients. If possible, family members were included in this process. The medical treatment team was then updated, and referrals were made to case management for discharge needs.

Study: the palliative care department manager-maintained data on an Excel spreadsheet in a secure password protected HIPPA compliant server and the Quality Departments hospital readmission care collaboration scorecard that collects and compares data regarding length of stays, palliative consults, conversions from inpatient hospice or comfort care. All data was stored in a secure management file in a HIPPA compliant server in password protected dual authentication desk top computer in a secure locked office. Aggregate data only was collected, no personal patient identifying information was collected or documented.

Act: Aggregate data was compared concurrently month-to-month and summatively at the end of the project comparing June 2023 to September 2023. Findings demonstrated improved hospital readmission rates by at least 15 % at the end of 30 days. After successful implementation of the project the goal of decreasing 30-day readmission rates and the DNP project was presented to stakeholders and recommended to become policy for the palliative care department nursing protocol.

Data Analysis

The EMR readmission data base analyzed data to evaluate readmissions. Understanding readmission patterns is critical to designing an effective readmission reduction strategy. This straightforward analysis highlighted high-leverage opportunities to reduce readmissions for the hospital overall. This tool was modified for hospital's particular data analysis needs (AHRQ, 2022).

The data collected based on the Quality Safety Patient Experience (QSPE) Alabama Market Performance Measures, provided baseline data from June 2023. Healthcare performance measurements were aggregated, quantified and analyzed data on a healthcare-related activity. Their purpose was to identify opportunities for reducing costs, improving quality of care and

increasing efficiency of care delivery. The EMR Discern Reporting Portal included patient identifiers and admitting diagnosis for current encounters. Those patients were then submitted into the EMR Readmission BOOST tool for specific patient triage organization. These patients were assigned to the patient navigators in the palliative care department.

The QSPE data also included data the unit manager of palliative care had access to which contained the department metrics from mortality rates, readmission rates, length of stay and patient conversions from inpatient to hospice and comfort care. It resulted in percentages and is comparative to previous monthly data.

Results

Hospital 30-day readmissions are one of the key measures used for evaluating the quality of inpatient care. Although in most cases readmissions are necessary, a significant portion may be preventable, particularly in patients with progressive diseases. Various strategies have been implemented at both the national and state levels to reduce readmissions, particularly through improved discharge planning and care coordination. Hospitals and health systems are incentivized by linking payment with certain key readmission measures. The patient navigators within the palliative care department are consulted to initiate goals of care conversations with patients and their families to assist with discharge planning and care coordination. The patient navigators follow the Gunderson Medical Health Center model Respecting Choices to assist patients with advanced care planning during goals of care meetings. At this facility the highest category of patients readmitted within 30 days are CHF, COPD, CKD, AMI, and CABG. The readmissions with these disease processes were the target patients to discuss advanced care planning. Aggregate data for 30-day readmissions was collected from the Cerner electronic medical record (EMR) 30-day readmission tool in June of 2023 for (the five highest DRG's patient population) with a re-admission rate of 148 patients. This data served as baseline data to measure the efficacy Decreasing 30-Day Hospital Readmissions by increasing Advanced Care Planning. Implementation of the project ran from July 24,2023 to August 28, 2023, with post implementation aggregate data collected

from the Cerner electronic medical record (EMR) 30- day readmission tool for the month of September 2023. Thirty-day readmission data for the five highest diagnosis categories were queried and broken down into percentages as follows: 30% COPD, 20% ESRD, 20% CHF, 15% AMI, 15% CABG. The population of most interest were the three highest with COPD, ESRD and CHF. Using the Discern Analytics program within Cerner the comparative readmission data was collected. Out of 126 readmissions in the month of August, 50 met criteria for advanced care planning. There were 19 advanced care plans completed during the implementation phase which is 15% of the patients who were interviewed. Aggregate data for post implementation 30-day readmission rates was 126 patients. Compared to pre-implementation benchmark data from the month of June 2023 with 30-day hospital readmissions at 148 patients the implementation of an evidenced based Decreasing 30-Day Hospital Readmissions by Increased Advanced Care Planning demonstrated a 15% reduction in 30-day hospital readmissions overall.

Interpretation/Discussion

The demonstrated decrease in readmissions after 30 days of increasing advanced care planning indicates that Decreasing Advanced Care Planning by Increasing Advanced Care Planning project was an effective means to support patients with end-of-life decisions and improve symptom management at home without frequent hospital re-admissions. The Gunderson Medical Center Respecting Choices model was effective as a framework to guide the development and implementation of this evidence-based project as it supported the nurse navigator, allowing in depth conversations between the patient navigator, patient and family members. This model provided normalized patient-centered end-of-life care conversations based on patient's wishes and not what patient's family and physicians assumed it would be. This allowed patients to establish patient centered goals and advanced directives (AD). Based on the findings of this project demonstrating a 15% reduction in 30-day readmission rates for this patient population it is evident that an evidence-based patient-centered end -of- life care program will have a positive impact on decreasing 30-day readmission rates for high-risk patients. Limitations Given the timeline of project

implementation 30 days was not adequate time to make the outcome what it potentially could be, and it is estimated that the following 30 days could possibly show even more improvement in readmissions. The BOOST tool within the EMR system was used to triage those at highest risk for readmission so they could be seen before discharge. The number of readmissions within the high risk DRG categories exceeded staffing capabilities and workload precluding the nurse navigator's ability to individually counsel all patients meeting inclusion criteria. Patients who did not have the cognitive ability to engage in advanced care planning conversations and counseling and those patients who did not have a family member readily available were excluded from the project. Patients who chose to pursue aggressive treatment and returning to the hospital when symptoms reoccurred declined to participate and were excluded from the project but still received patient education regarding advanced directives and their disease process. The Respecting Choices packet was provided for all patients and families meeting inclusion criteria for their review.

Cost Benefit Analysis/Budget

There was no additional cost for this project. The time required for this project was spent using staff that were already budgeted for this department. There was no external funding for this project. There is data provided at the end of 2023 to reflect the amount of money saved because of the project with reduced hospital readmissions and increased discharges to community based palliative care or hospice.

Timeline

Once IRB approval was obtained, the process improvement project commenced with one week of staff educational in-services. Four in-service opportunities, one-hour each across five days. Simultaneously, as education was underway, June 2023 baseline 30-day readmission aggregate data was collected from Quality Performing Measures and securely stored within the palliative care unit managers desk top computer. The first Monday following the first full week

after IRB approval a consult list was generated from the EMR through the Discern Reporting Portal using the EMR Readmission BOOST tool. This list was generated each morning before 0900 and distributed to the Palliative Care Nurse Navigators by the DNP student. Beginning shift huddles were held to discuss the patient load and any information relevant and beneficial for an optimum patient interaction. The unit manager and the DNP student divided the patient load for the day amongst the patient navigator staff. Post shift debrief included a summary of which patients seen during the day, the outcomes of the consult, and any consults or referrals initiated for discharge planning. At the beginning of the month the 30-day readmission data was generated from the Hospital Inpatient Quality Reporting Program to assess hospital wide readmission scores and concurrently compared to previous 30-day readmission score. Post implementation data collection for September began on October 1, 2023. The baseline data collected from June 2023 was used for comparative analysis. Educational in-services for palliative care staff were provided throughout implementation of the project to keep them abreast of the phases of the project and to reduce potential barriers. Data from the hospital readmissions report and EMR BOOST tools were reviewed weekly to determine which patients were to be included in the project and seen by the palliative care nurse navigator. There were patient navigators available seven days a week to maintain consistency for the project.

At the beginning of each month the readmission analysis tool generated admission and readmission data. This aggregate data reporting tool was used concurrently to determine how well the project was advancing. The project continued through the month of August 2023 with data collection October 1, 2023, followed by data analysis.

Ethical Considerations/Protection of Human Subjects

The University of Alabama (UA) Institutional Review Board (IRB) approval was

obtained prior to initiating the project. No individual patients were identified, no patient identifiers were collected or documented. All data collected was aggregate 30-day readmission data. All inpatient information used in this project is protected by the Health Insurance Portability and Accountability Act of 1996 (HIPPA) which guarantees, protects the privacy of patients' health information. All standards of care for practice for this facility were carefully followed. All information collected as a result of evaluating the impact of this project did not contain any patient identifiers. All data collected is stored electronically on UA box with any hard copies of data acquired stored securely and destroyed following completion of this project.

Conclusion

This project focused on decreasing 30-day hospital readmission rates by increasing advanced care planning in patients at highest risk for readmission. Thirty-day hospital readmissions are problematic not just for the patient, but financially for the hospital due to CMS penalties and lack of payments. Progressive diseases such as CHF, CKD, COPD, AMI and CABG are the highest patient populations for 30-day readmissions. Since these are progressive diseases, the symptoms will continue to worsen as the patient declines and the patients' baseline is never regained. Without symptom management at home the patient is without a plan in place other than returning to the Emergency Department and admitted again. The implementation of an evidence based advanced care planning program following the Gunderson Medical Health Center model Respecting Choices using patient navigators to assist patients with advanced care planning and goals of care meetings has proven effective in in improving patient outcomes.

When summarizing and comparing pre and post readmission rates in relation to the project timeline the implementation of Decreasing 30-Day Hospital Readmissions by Increasing Advanced Care Planning has been shown that 15% of patients were finding symptom relief and management without hospital readmission and the original goal of 5% was surpassed. Additionally, 15% of the patients

interviewed completed an advanced directive. This surpassed the estimated goal of 10%. The number of patients and families who received awareness of treatment options and education about their disease process cannot be measured but is also considered valuable. This is an implementation that needs to be continued in effort to ensure patients are aware of healthcare options and receive symptom management as they choose. Often it takes more than one conversation and interaction with the patient and their family members before they are prepared to make end of life care decisions. It would be most beneficial if healthcare providers would institute this measure in the clinic or hospital setting since typically patients want medical information from their provider before they will make these types of decisions.

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Appendices/ Tables

Table 1

Inclusion and Exclusion Criteria for Literature Review

Inclusion Criteria	Rationale	Exclusion Criteria
30 Day Readmissions Rates	What studies have been done that were successful in reducing rates	Older than 2017
Advanced Care Planning	Model of ACP in Hospitals	Professional Journal Articles
Palliative Care Nurse Nurse Navigator	Role of PCN in Hospital readmissions Are nurse navigators useful in decreasing readmissions	No other dx involved than CHF, COPD, CKD, AMI, CABG

Table 2

Proposed Timeline of Project

Date	Task to Accomplish
May 8- June, 2023	Facility and UA IRB approval
June 1-3, 2023	Project notification to nursing staff and education of intervention
June 4, 2023-July 6, 2023	Initiate Intervention
July 7, 2023	Data analysis
July 12, 2023	Compare aggregate data
July 14, 2023	Initiate QSPE Scorecard Evaluate Data and Efficiency of Project
September 2023	Begin DNP proposal part II and share data with shareholders
October 2023	Dissemination of Data

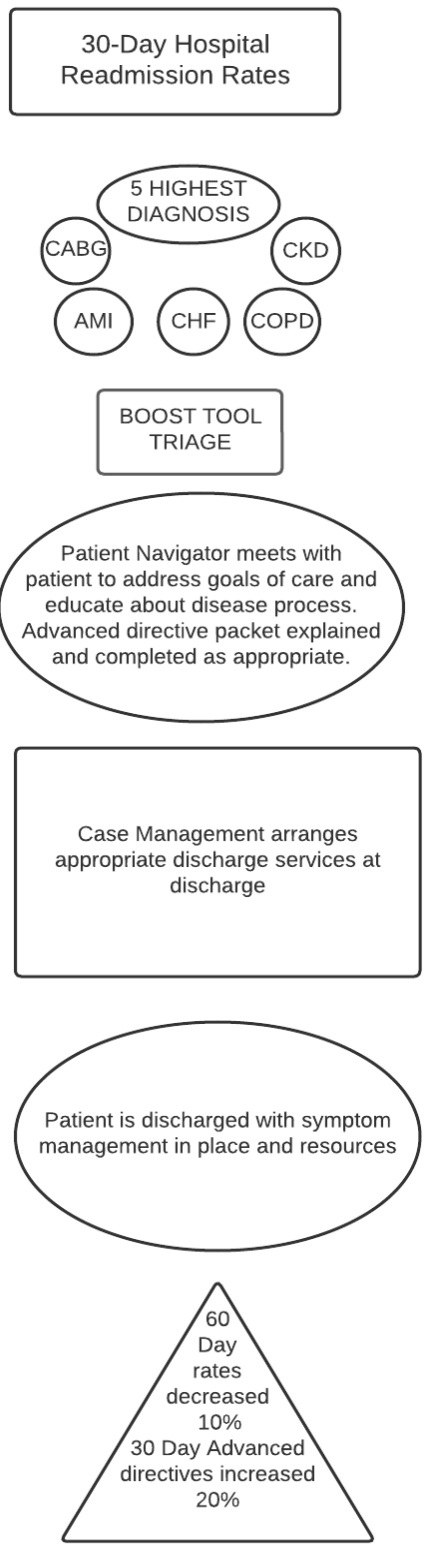


Figure 1

Appendix A



Tool for Addressing Risk

A Geriatric Evaluation for Transitions

Risk Assessment: 8P Screening Tool (Check all that apply.)	Risk Specific Intervention	Signature of individual responsible for insuring intervention administered
Problem medications (anticoagulants, insulin, oral hypoglycemic agents, aspirin & clopidogrel dual therapy, digoxin, narcotics) <input type="checkbox"/>	<input type="checkbox"/> Medication specific education using Teach Back provided to patient and caregiver <input type="checkbox"/> Monitoring plan developed and communicated to patient and aftercare providers, where relevant (e.g. warfarin, digoxin and insulin) <input type="checkbox"/> Specific strategies for managing adverse drug events reviewed with patient/caregiver <input type="checkbox"/> Follow-up phone call at 72 hours to assess adherence and complications	
Psychological (depression screen positive or h/o depression diagnosis) <input type="checkbox"/>	<input type="checkbox"/> Assessment of need for psychiatric aftercare if not in place <input type="checkbox"/> Communication with aftercare providers, highlighting this issue if new <input type="checkbox"/> Involvement/awareness of support network insured	
Principal diagnosis (cancer, stroke, DM, COPD, heart failure) <input type="checkbox"/>	<input type="checkbox"/> Review of national discharge guidelines, where available <input type="checkbox"/> Disease specific education using Teach Back with patient/caregiver <input type="checkbox"/> Action plan reviewed with patient/caregivers regarding what to do and who to contact in the event of worsening or new symptoms <input type="checkbox"/> Discuss goals of care and chronic illness model discussed with patient/caregiver	
Polypharmacy (≥5 more routine meds) <input type="checkbox"/>	<input type="checkbox"/> Elimination of unnecessary medications <input type="checkbox"/> Simplification of medication scheduling to improve adherence <input type="checkbox"/> Follow-up phone call at 72 hours to assess adherence and complications	
Poor health literacy (inability to do Teach Back) <input type="checkbox"/>	<input type="checkbox"/> Committed caregiver involved in planning/administration of all general and risk specific interventions <input type="checkbox"/> Aftercare plan education using Teach Back provided to patient and caregiver <input type="checkbox"/> Link to community resources for additional patient/caregiver support <input type="checkbox"/> Follow-up phone call at 72 hours to assess adherence and complications	

<p>Patient support (absence of caregiver to assist with discharge and home care)</p> <input type="checkbox"/>	<input type="checkbox"/> Follow-up phone call at 72 hours to assess condition, adherence and complications <input type="checkbox"/> Follow-up appointment with aftercare medical provider within 7 days <input type="checkbox"/> Involvement of home care providers of services with clear communications of discharge plan to those providers	
<p>Prior hospitalization (non-elective; in last 6 months)</p> <input type="checkbox"/>	<input type="checkbox"/> Review reasons for re-hospitalization in context of prior hospitalization <input type="checkbox"/> Follow-up phone call at 72 hours to assess condition, adherence and complications <input type="checkbox"/> Follow-up appointment with aftercare medical provider within 7 days	
<p>Palliative care (Would you be surprised if this patient died in the next year? Does this patient have an advanced or progressive serious illness?) Yes to either:</p> <input type="checkbox"/>	<input type="checkbox"/> Assess need for palliative care services <input type="checkbox"/> Identify goals of care and therapeutic options <input type="checkbox"/> Communicate prognosis with patient/family/caregiver <input type="checkbox"/> Assess and address bothersome symptoms <input type="checkbox"/> Identify services or benefits available to patients based on advanced disease status <input type="checkbox"/> Discuss with patient/family/caregiver role of palliative care services and benefits and services available	

General Assessment of Preparedness (GAP)

Prior to discharge, evaluate the following areas with the patient/caregiver(s). Communicate concerns identified as appropriate to principal care providers.
 A = beginning upon Admission; P = Prior to discharge; D = at Discharge

Logistical Issues

Psychosocial Issues

- | | |
|---|--|
| <p>1. Functional status assessment completed (P) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>Access (e.g. keys) to home insured (P) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>prepared for patient's arrival (P) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/>
 (e.g. medical equipment, safety evaluation, food)</p> <p>4. Financial resources for care needs assessed (P) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>5. Ability to obtain medications confirmed (P) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>6. Responsible party for insuring med adherence YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>8. Transportation home arranged (D) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> | <p>1. Substance abuse/dependence evaluated (A) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>2. Abuse/neglect presence assessed (A) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>3. Home prepared for patient's arrival (P) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>3. Cognitive status assessed (A) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>4. Advanced care planning documented (A) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>5. Support circle for patient identified (P) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>6. Contact information for home care services YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> <p>obtained and provided to patient (D) identified/prepared, if not patient (P)</p> <p>7. Transportation to initial follow-up arranged (D) YES <input type="checkbox"/> NO <input type="checkbox"/> N/A <input type="checkbox"/></p> |
|---|--|
- Confirmed by: _____
 _____/____/____ Signature Print Name Date

Appendix C

MINNESOTA LIVING WITH HEART FAILURE® QUESTIONNAIRE

The following questions ask how much your heart failure (heart condition) affected your life during the past month (4 weeks). After each question, circle the 0, 1, 2, 3, 4 or 5 to show how much your life was affected. If a question does not apply to you, circle the 0 after that question.

Did your heart failure prevent you from living as you wanted during the past month (4 weeks) by -	No	Very Little				Very Much
1. causing swelling in your ankles or legs?	0	1	2	3	4	5
2. making you sit or lie down to rest during the day?	0	1	2	3	4	5
3. making your walking about or climbing stairs difficult?	0	1	2	3	4	5
4. making your working around the house or yard difficult?	0	1	2	3	4	5
5. making your going places away from home difficult?	0	1	2	3	4	5
6. making your sleeping well at night difficult?	0	1	2	3	4	5
7. making your relating to or doing things with your friends or family difficult?	0	1	2	3	4	5
8. making your working to earn a living difficult?	0	1	2	3	4	5
9. making your recreational pastimes, sports or hobbies difficult?	0	1	2	3	4	5
10. making your sexual activities difficult?	0	1	2	3	4	5
11. making you eat less of the foods you like?	0	1	2	3	4	5
12. making you short of breath?	0	1	2	3	4	5
13. making you tired, fatigued, or low on energy?	0	1	2	3	4	5
14. making you stay in a hospital?	0	1	2	3	4	5
15. costing you money for medical care?	0	1	2	3	4	5
16. giving you side effects from treatments?	0	1	2	3	4	5
17. making you feel you are a burden to your family or friends?	0	1	2	3	4	5
18. making you feel a loss of self-control in your life?	0	1	2	3	4	5
19. making you worry?	0	1	2	3	4	5
20. making it difficult for you to concentrate or remember things?	0	1	2	3	4	5
21. making you feel depressed?	0	1	2	3	4	5

