The Case for Intake RNs/Nurse Navigators in Hospital at Home

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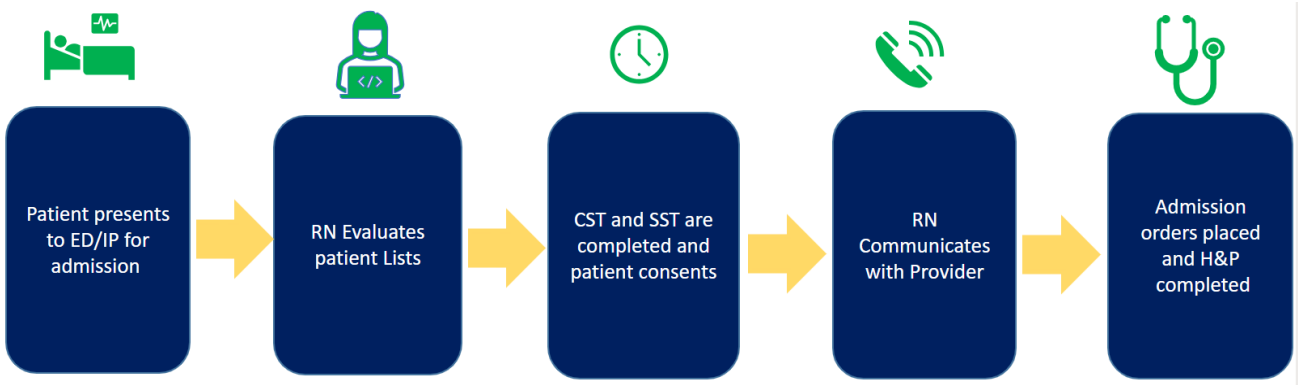
INTRODUCTION: As the US Hospital at Home movement evolves to permanency, we are implored to increase value to both payors and patients. Multiple studies demonstrate that Hospital at Home (HaH) care can become less expensive than traditional bricks and mortar care while demonstrating equivalent if not better outcomes for our patients when appropriately scaled[1,2]. Utilizing clinicians at the top of their licensure is an opportunity to increase value and improve clinician satisfaction. Patient intake and increasing patient admission volume is a top priority for HaH programs and is where many stumble to get out of the starting blocks. Electronic patient identification algorithms are useful and effective to pare down the number of potentially eligible patients to those who are most suitable for Hospital at Home. However, due to the lack of sophisticated Electronic Health Record (EHR) filters and discreet field documentation coupled with the ever-changing social situations of our patients and the delay in re-charting in busy emergency rooms, it is necessary to dedicate personnel to identify the most suitable patients through chart review, facilitate clinical and social screenings, and to secure consent from patients/caregivers and attending providers to admit into the HAH model[3]. One solution is to lean heavily on command center hospitalists and intake Advanced Practice Providers (APPs). At sites with lower potential patient volumes, this can result in increased costs and bottlenecks in the patient intake processes at other sites as providers juggle performing in-home visits with performing admission history and physicals with the identification and intake clinical screenings for potential patients[4]. We would like to present the practice innovation of the use of intake RNs collaborating with providers to be considered across the HaH landscape to augment this work.

Solution: RN Driven Patient Identification



RECOMMENDATIONS FOR IMPLEMENTATION: Research on these positions should be conducted to drive HaH into the value landscape. This type of practice innovation pays dividends far beyond the positive cost of care implications as it offers a potential to expand nursing career opportunities, increase the percentage of time spent at top of scope therefore improving clinician satisfaction, improves patient movement, and overall efficiency. We encourage programs who consider RN driven potential patient identification to be mindful of the essential collaboration of the entire care team and the tools required for efficient identification of potential patients. Additionally, ensuring there is enough time to train and support RNs via physician oversight must also be considered.

Successes/Learnings/Opportunities	Considerations
With adequate oversight and partnership, RNs can safely complete CST and SST lifting the burden off practicing providers	Require close partnership and oversight to adequately train on patient selection- anticipate 6 months to reach proficiency.
With adequate back-up, RNs can be empowered to assist with change management in the push/pull patient identification process	Must be empowered and supported to allow for perception of authority as it pertains to change management- must come from high level and engaged customer leaders.
RNs are the right peer resource to connect with CCMs, Charge RNs, CNLs at facilities to assist with patient identification and cultural change management.	RNs cannot perform in person required H&P for ED admissions. For facilities with high volume ED admission opportunity, consider APP Intake role to support ED throughput for HAH admissions.
Improves flow and expedites patient movement out of B&M.	Continue researching the role for evolution, RN engagement, and timing of clinical support enhancement (APP addition).
Positions RNs as developer of care plan and drives engagement at the time of admission throughout their hospitalization with top of license work	
Less expensive than utilizing a provider to perform non-billable work.	

CONCLUSION: Nursing is essential to the HaH movement in the delineated responsibility of executing the care plan for patients while also facilitating the care delivered within the HaH care model. The development of intake RNs/nurse navigators can steer HaH programs even further onto the journey towards value while providing a myriad of benefits to programs, payors, and ultimately patients.

References
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