



Criteria for AAN Edge Runners

- Nominations support the innovative work of nurses and demonstrate the holistic and integrated philosophy underlying nursing care.
- The nomination demonstrates how an innovative solution (intervention or model of care) remedied a problem in the delivery of health care or an unmet health need of a population. (Please include a description of the problem, population served, the specific outcomes expected/desired, and the implemented solution.)
- Although single demonstrations are acceptable, data that substantiate the success and impact of the project must be included with the nomination. (Please describe the clinical outcomes, financial outcomes, and evidence of improved access to care. Include mention of any randomized clinical trials or other research that demonstrate the impact of the innovation.)
- There is evidence that the original work has been replicated or has the promise of leading to replications in other settings.
- Nominees need not be Fellows in the American Academy of Nursing.

Making Transitional Care More Effective & Efficient *APNs Ensure Smooth Transition From Hospital to Home, Cutting Re-Hospitalization Rates for Geriatric Patients*

The Challenge:

High rates of poor post-discharge outcomes that put elderly patients back in the hospital soon after their release following earlier treatment. Up to one-third of those hospitalizations are considered preventable.

The Goal:

Improve post-discharge outcomes – lowering rates of re-hospitalization and thereby reducing health care costs.

An Innovative Solution:

Focus on transitional care lead by master's-prepared advanced practice nurses (APNs) in conjunction with the patient's entire healthcare team, targeting high risk patients at risk for poor post-discharge outcomes.

Where To Learn More

What It Is

- An evidence-based innovative model of hospital-to-home care in which APNs work to ensure a smooth transition from hospital care to home care.

What It Does

- Assures that APNs: establish a relationship with patients and their families soon after hospital admission; design the discharge plan in collaboration with the patient, the patient's physician, and family members; and implement the plan in the patient's home following discharge, substituting for traditional skilled nursing follow-up.
- Reduces the incidence of poor communication among providers and health care agencies, inadequate patient and caregiver education and poor quality of care; enhances access to quality care.

How It Stands Out

- Findings from three clinical trials funded by the National Institute of Nursing Research consistently demonstrate that the APN Transitional Care Model improves quality of care and substantially decreases health care costs.
 - Compared to standard care there are longer intervals before initial rehospitalizations, fewer re-hospitalizations overall, shorter hospital stays and better patient satisfaction.
 - Following a four-year trial with a group of elderly patients hospitalized with heart failure, the APN Care Model cut hospitalization costs by more than \$500,000, compared with a group receiving standard care – for an average savings of approximately \$5,000 per Medicare patient.

With the support of the Commonwealth Fund, Jacob and Valeria Langeloth Foundation, the John A. Hartford Foundation, Inc., the Gordon & Betty Moore Foundation, and the California HealthCare Foundation., efforts are underway to test the “real world” application of this model in collaboration with Aetna, Inc., and Kaiser Permanente.

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Veterans Integrated Service Network 8 Patient Safety Center of Inquiry: *Preventing Adverse Events Associated With Mobility and Immobility*

The Challenge:

Mobility problems are a major threat to patient health.

The Goal:

Promote safe use of technology to prevent adverse events associated with mobility or immobility, and also promote a culture of safety to support clinicians in providing safe patient care and safe working environments.

An Innovative Solution:

The Veterans Integrated Service Network (VISN) 8 Patient Safety Center of Inquiry (PSCI) at the James A. Haley Veterans Health Administration Medical Center in Tampa, FL.

What It Is

- A facility that promotes patient health and well being by preventing adverse events associated with mobility and immobility targeting two vulnerable populations: those living with disability and frail elderly. Center research foci include patient falls, safe patient handling, hospital bed/wheelchair safety, wandering and pressure ulcers.

What It Does

- Specializes in designing and testing evidence-based clinical tools (e.g. algorithms, protocols, policy templates, resource guides, patient and staff education materials) to facilitate safety and reduce adverse events.
- Nurses significantly impact patient safety and create safer work environments by combining technology solutions with evidence-based practices.

How It Stands Out

- Has developed more than 120 implementation tools to enhance patient and staff safety, which have been tested at the local, regional, and national levels. Of these tools, 96 already are active.
- Places a strong value on building a new generation of researchers and practitioners in patient safety. Successful track record in recruiting 80% of researchers and practitioners in patient safety into VA service once their training at the center is completed.
- Now funded as a site for the VA Patient Safety Fellowship Program, which includes funding for two interdisciplinary trainees each year.

Where To Learn More

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- Key Outcomes:
 - Patient Falls – Using the consensus validation process from the National Institutes of Health, developed a research agenda to target provider-level safety defenses to prevent falls and fall-related injuries. Through a \$3.2 million VHA initiative, developed provider tools to decrease variations in practice including standardized interdisciplinary fall risk assessment and fall prevention protocols, a fall incident reporting system, and provider feedback systems. The innovations to prevent falls were implemented at 12 VA Hospitals in Florida and California. Outpatient clinics have been established for veterans at high risk for falls.
 - Bedrail Entrapment – Nurse researchers found that although rates of injury related to hospital bed systems are rare, the injuries, potential disabilities and deaths are preventable. The BedSAFE program developed through that research has transformed the practice across professional and support staff.
 - Safe Patient Handling and Movement – The health care industry has come to understand that manually lifting and transferring physically dependent patients is a high-risk activity for the health care worker or family caregiver, and for the patient. Three federally funded studies at the Tampa VA led to development of a Patient Care Ergonomics Guidebook that is considering a national performance measure for implementation. The facility spearheaded national VHA efforts to develop resources on safe patient handling and movement.
 - As a result of these efforts, ceiling-mounted lifts were imported from Europe and tested at the Tampa VA. Using six interventions, including new technology, results included a 31% reduction in incidence of injuries, an 88% reduction in modified duty days, and 18% decrease in lost work days, significant improvement in nursing job satisfaction, and high acceptance from patients, staff, and administrators. The cost to implement the program on 25 high-risk units was \$850,000. Annualized over a 10-year period (life of equipment), the cost savings are projected at \$1.25 million.