Week 6: Quality Management and Control

Zanderville Healthcare Systems, a regional, acute care facility in the foothills of the Appalachians is committed to delivering quality healthcare to its local and neighboring communities. The population it serves is diverse by gender and ethnicity. The primary payer for healthcare services is CMS. Over the past six months the acute care facility has experienced a 25 % increase in readmissions from this payer group within the first 30 days of discharge. The economic impact on the health system has been negative and patients' satisfaction with their hospital experience has declined. Senior leadership has charged you, the nurse executive, to convene an ad-hoc task force to perform an outcomes audit and propose an intervention. Currently patients receive a follow-up telephone call about 7 days following discharge. You decide to use an evidence-based practice approach and have the following information for the "working" PICOT:

P: CMS patients readmitted within 30 days of discharge

I: What will we do differently to impact the improved

outcome (State what this is)

C: Follow-up phone call 7 days after discharge

O: Reduce readmission rate of CMS patients from to_____....

T: Over next six months

If this were happening in your organization, discuss:

Whom will you include in your task force?

Bedside nurses, discharge coordinators, transition liaison, quality control. These individuals are key in incorporating new strategies into the plan of care for patients, ensuring successful outcomes in the audits.

What outcomes measures will you audit?

Knowing readmissions are typically related to chronic health conditions, audits would be performed on patients with exacerbations of COPD, DM, and CVD.

Where will you obtain the data to determine your baseline and goal regarding the percentage of readmissions within 30 days of discharge?

Of the 25% increase, data would be researched to discover if particular patients are returning. Another interesting piece of data may be to determine if individuals were readmitted more for certain disease processes versus others (example a high percentage of the 25% increase were patients with CVD). If tracing can pinpoint this fact, further investigation into what can be done departmentally to better aid these

patients is warranted. Also, knowing which patients have support systems in place outside of the facility would be a key factor in the success of managing their ailment.

What specific outcome do you want to achieve?

I would hope to determine where the facility's shortcomings have been and develop an action plan to decrease the number of readmissions; therefore, increasing profits for the institution.

What standard or benchmark will you use for the outcome? What does your organization use as a benchmark for readmissions within 30 days of discharge?

HARRP (Hospital Readmission Reduction Program) is an incentive program for hospitals to keep readmission rates low. This benchmark is used by many facilities that accept Medicare, including the organization where I work. Because this benchmark specifically measures readmission outcomes, this is the preferred method for evaluating my intervention. CMS sends reports annually for review and modification if the hospital discovers any discrepancies in the data. Funds are then dispersed accordingly.

Describe the intervention you will use to achieve your goal?

Many facilities are moving towards hospitalist care. This is a relatively new role. Formerly, patient's primary physician would care for them while they were in the hospital setting. Many patients with chronic illnesses have a report with their primary physician and may not feel comfortable being cared for by a hospitalist. This lack of trust may result in the patient not providing all necessary information to provide the best possible care. Primary physicians may not even be aware that their patient has been hospitalized until their follow- up visits. Therefore, early follow- up appointments can be the missing link to decreasing readmissions. On the other hand, there are also many patients who do not have a primary care doctor for various reasons. This lapse in care is yet another reason for possible early readmissions. These patients need thorough education and can often be referred to sliding scale clinics. Again, swift follow- up appointments for care management outside of the facility can be beneficial. Less than half of the patients in this studied group who presented to/ were discharged from the emergency room with acute HF symptoms obtained follow-up care within a week of their discharge. In comparison to those who followed up 8+ days after discharge, patients who obtained follow-up care as soon as possible (within 7 days) experienced lower rates of subsequent hospitalization and mortality due to cardiovascular problems. Findings confirm that setting up early follow-up consultations for patients following an ER visit is the key to improving outcomes.

Then, restate the completed PICOT using the information you have collected related to the intervention and outcomes.

P: CMS patients readmitted within 30 days of discharge

I: Schedule hospital follow- up appointments for within 5 days of discharge

C: Follow-up phone call 7 days after discharge

O: Reduce readmission rate of CMS patients from 25% t 0%

T: Over next six months

-Stacy

Atzema, C.L., Austin, P.C., Yu, B., Schull, M.J., Jackevicius, C.C., Ivers, N.M., Rochon, P.A., Lee, D.S. (2018). Effectofearlyphysicianfollow-uponmortalityandsubsequent hospitaladmissionsafteremergencycarefor heartfailure:aretrospectivecohortstudy. *CMAJ,190*(50), Pg1468-Pg1477. https://www.mendeley.com/catalogue/5c9b4c1d-b7a4-39c6-934e-af6b37266c50/

According to the WHO (2022), people are becoming more conscious of the necessity for efficient, safe, and person-centered healthcare. Health care must be provided in a timely, coordinated, efficient, and equitable manner. Quality of care refers to the likelihood that treatments made by health-care professionals will have favorable results. Many adverse incidents that happen after discharge are brought on by problems with transition of care, resulting in decreased quality of care. Transition of care refers to the process of transferring a patient's care from one setting to another. One area where a lapse in quality of care can be evident is when a break down occurs regarding communication and education on discharge medications. Most of the patient's care is taken on by them after discharge. To ascertain the patients' ability to care for themselves, accurate discharge assessments are necessary. When a patient leaves the hospital and is unable to understand medication instructions or the treatment plan, they can be in a vulnerable position. Patient understanding is imperative prior to discharge. Lee et al (2022) tell readers, a patient evaluation of the reason for the readmission should be done in order to more accurately identify a medication-related readmission. Medication information should be included consistently in discharge statements. A thorough method for evaluating, tracking, and identifying medication errors and readmissions linked to medication might improve patient safety and healthcare quality. In order to avoid future MRRs with the same medicine, patients must be informed of the cause of their readmission. To get the best results from pharmacotherapy, patients and healthcare professionals must agree on the function of medicine. According to the study, 58% of readmissions included information about how the readmission was connected to medications. Patients are frequently prescribed new prescriptions during hospital stays or have home medications adjusted. When a medication is used as prescribed, an adverse drug response could occur. Serious complications can result from an unfavorable medication response. Inadequate medication reconciliation might result in unintentional medication errors. This is a break down in transition of care. Patients who