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 hospitaladmissionsafteremergencycareforheartfailure: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

are given high-risk drugs or those with poor health literacy should be especially aware of this.

-Stacy

Lee, Z. Y., Uitvlugt, E. B., & Karapinar-Çarkit, F. (2022). Medication-related readmissions: documentation of the medication involved and communication in the care continuum. *Frontiers in pharmacology*, *13(*824892), Pg1-P16. https://doi.org/10.3389/fphar.2022.824892

WorldHealthOrganization.(202).*Qualityofcare*.https://www.who.int/h ealth- topics/quality-of- care#tab=tab_3

- Dr. Turner and class,
- It is always important to have the right people on a task force when looking to implement a new tactic across a healthcare system. My task force would include
  case management, social work, primary care, quality, as well as representatives from the emergency department, urgent care and inpatient. I will have quality auditing charts of Centers for Medicare and Medicaid Services (CMS) patients who were readmitted within 30 days of discharge to identify if a transitional care management (TCM) appointment occurred within 7-10 days of discharge. I will utilize Premier Inc to extract data for baseline readmission rates and to re-evaluate if we are at goal after implementing our TCM appointment tactic. We would like to see a 10% decrease in 30-day readmission rates over the next 6 months which would bring us closer to the average readmission rate reported by CMS. We would utilize CMS for our benchmarking as most of our patient population utilizes them as a primary payor for healthcare services.
- Instead of making a phone call to the patient within 7 days of discharge, I would require that our social workers and case managers work with primary care to schedule a TCM appointment with the patient's primary care provider within 7-10 days of discharge for all CMS patients Transitional care management can help reduce readmissions through identifying medication discrepancies and changes in health status post discharge (Henriksen & Stuckey, 2018). The TCM appointment allows the team to lay eyes on the patient to ensure they are transitioning home in a safe and effective manner after a hospitalization; it also allows the team to make adjustments to the plan of care that could prevent readmission for the patient.
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- **P:** CMS patients readmitted within 30 days of discharge
- **I:** Transitional care management (TCM) appointment scheduled within 7-10 days after discharge
- **C:** Follow-up phone call 7 days after discharge
- **O:** Reduce readmission rate of CMS patients from 25% to 15%
- **T:** Over the next six months
-
-
- Betsy
-
- Henriksen, B., & Stuckey, N. (2018). Effects of transitional care management services from an interprofessional team on 30-day readmission rates among medicare beneficiaries. *Topics in Geriatric Rehabilitation, 34*(3), 182-184. https://doi.org/10.1097/TGR.0000000000000192
- ReplyReply to Comment
    - Collapse SubdiscussionStephanie Turner

Stephanie Turner

Oct 3, 2022Oct 3 at 1:46pm

Manage Discussion Entry

HI Betsy!

Of particular interest are the social determinates of health. These are key in discovering a cause for readmissions from an access perspective. Who might you need to engage in developing this part of the plan in order to capture the specific elements that you may need?

ReplyReply to Comment

- Collapse SubdiscussionBetsy Burton

Betsy Burton

Oct 4, 2022Oct 4 at 7:27am

Manage Discussion Entry

Hi Dr. Turner,

Social determinants of health are something we commonly see in our area. The robust support system the Social Workers and Case Managers have created here is quite impressive. From lining up transportation for patients prior to them discharging from the hospital so they have a way to their appointment to adjusting appointments to virtual for those who don't have anyone to watch their kids. We have even created a new program in our areas of high social determinants of health to bring Advance Practices Nurses to the patient's home to perform the visit. We serve a large uninsured and underinsured population, so we have many services that are offered to our patients free of charge to ensure they are getting the care they need without making sacrifices at home. By taking the time to listen to the barriers and needs of our patients, we are able to address some of their concerns. These concerns often prevent them from seeking care or prevent them from following up with their clinicians before they reach the point of needing the emergency room.

Betsy

ReplyReply to Comment

- Collapse SubdiscussionStephanie Turner

Stephanie Turner

Oct 4, 2022Oct 4 at 2:22pm

Manage Discussion Entry

Great response, Betsy! I love the idea of giving them transportation!

ReplyReply to Comment

- Collapse SubdiscussionShirelle Minor

Shirelle Minor

Oct 6, 2022Oct 6 at 3:08pm

Manage Discussion Entry

Hello Betsy,

The hospital readmission rate is an essential measure for determining the effectiveness of a patient's care. When a patient has a high readmission rate, it may indicate that the patient's healthcare concerns were not adequately addressed during previous admissions. It also has an impact on healthcare organizations' bottom lines through low HCAHP scores and denied reimbursements from healthcare insurance policies such as Medicare. So you are absolutely correct in that you will require the right people on your task force as well as a new strategy across a healthcare system. Also, your statement that you would leave it up to transitional care management to schedule a

7-10 day appointment to check on the patients sounds fantastic. The only question is how much this will cost the patient and whether or not the insurance company will cover this visit. I'm aware of it in the postpartum unit where I currently work. For our discharge, the nurse leader rounds on the patients before they leave and gives them their business cards, instructing them to call if they have any questions or concerns. They are also told that someone will contact them in one to two days.

ReplyReply to Comment

- Collapse SubdiscussionEmily Graham

Emily Graham

Oct 7, 2022Oct 7 at 3:29pm

Manage Discussion Entry

Betsy,

I really enjoyed reading your post in the discussion this week. You are right, it is so important to have the right people placed on a task force when attempting to implement a change. The people you listed for your task force, in my opinion, are all imperative to implementing the change effectively. The transitional care management (TCM) appointment initiative would be a great tactic to implement to try to decrease readmission rates to facilities. Utilizing a case manager and social worker would be very beneficial as far as ensuring patients have the resources necessary and in place to make it to those appointments. I think utilizing that approach could be very beneficial to decreasing the rate of re-admissions to the hospital with all the proper tools and resources in place. Does the facility you are employed now utilize this type of approach or some form of it for readmission rates?

ReplyReply to Comment

- Collapse SubdiscussionNicole Altman

Nicole Altman

Oct 3, 2022Oct 3 at 2:17pm

Manage Discussion Entry

Dr. T and class,

P: CMS patients readmitted within 30 days of

discharge I: Assisting in making follow up appointments

C: Follow-up phone call 7 days after discharge

O: Reduce readmission rate of CMS patients from 25% to 15%

T: Over next six months

I would want to include doctors, nurses, and case managers on this task force to reduce the readmission rate. Case managers especially are quickly able to identify barriers to care that patients experience in the community. Since Zanderville Healthcare System is in a rural area serving a diverse community, having a representative from a clinic in the area on the task force would also be beneficial. With this added value to the team, we can establish a connection for patients who may not have a primary care provider or have the financial means to cover co-pays. They can also assist in getting patients follow up appointments soon after their discharge date. Post-discharge follow-up within 7 days of discharge was associated with a substantially lower risk of readmission (Anderson et al., 2018).

Outcome measures I would audit are percentage of follow up appointments made and percentage of follow up appointments attended. Once patients are discharged it is often their responsibility to make follow up appointments with the appropriate providers. If this percentage is low, health care providers and case managers can try to assist. Currently in my own practice I advise patients I am discharging to start calling for follow up appointments while waiting for doctors, discharge orders, paperwork, etc. Once the appointments are made, either by the patients or by hospital personnel, it is still that patient's responsibility to arrange for transportation to the appointment. If this emerges as a barrier, then perhaps the case management team can assist in making those arrangements to the first appointment or making that connection between the patient and means of transportation.

I will obtain the data to determine the baseline and goal regarding the percentage of readmissions within 30 days of discharge from the electronic health record. You can see the patients last date of admission and if that is within 30 days, we can have a member of the task force meet with the patient to determine the reasoning behind their admission. During this meeting we will inquire about their compliance with follow up appointments.

The specific outcome I want to achieve is higher compliance with follow up appointments. I believe this will reduce the readmission rate. Follow up appointments are important because patients can ask questions that arise after discharge, get prescriptions refilled, have their progress monitored, and if there is an issue with their health at home the consulting physician can intervene. When patients do not follow up and their condition in deteriorating, there is no one to offer medical advice on interventions that can be done at home, leading to further deterioration and the need for readmission. For example, a patient who was admitted to the hospital with CHF exacerbation gets discharged home and is instructed to follow up with their primary care doctor and their cardiologist. The patient stops taking their Lasix at home after a week because they are inconvenienced by the frequent need to urinate, and while spending the weekend with family they are encouraged by many family members to drink water because they are concerned the patient is dehydrated. Now family members are

noticing the patient is experiencing SOB and their legs have become swollen overnight. Had this patient seen his/her cardiologist or PCP, they may have mentioned the urinary frequency and been tested for a UTI, told to take their Lasix at night or maybe split into two doses throughout the day, but most importantly educated on its importance and the need for a fluid restriction.

To evaluate the outcome, I would use internal benchmarking to compare readmission rates. I would compare the readmission rate from the last six months prior to the team being implemented to the next six months with the team assisting with discharge planning. My organization uses an electronic health system that flags charts of patients who had been admitted in the last 30 days as a benchmark. This triggers nurses, doctors, and case managers working with the patient to identity barriers to care and address them. To achieve my goal of less CMS readmission I would put together a team of doctors, nurses, case managers and members in the community to assist with coordinating follow up appointments and transportation when needed.

Among CMS patients readmitted within 30 days of discharge (P), will be assisting in making follow up appointments (I), as opposed to a follow-up phone call 7 days after discharge (C), reduce readmission rate of CMS patients from 25% to 15% (O), over the next six months (T)?

Reference:
Anderson A, Mills CW, Willits J, Lisk C, Maksut JL, Khau MT. (2018). Follow-up post- discharge and readmission disparities among medicare fee-for-service beneficiaries. *Journal of general internal medicine 09*;37(12):3020-8.

ReplyReply to Comment

- Collapse SubdiscussionStephanie Turner

Stephanie Turner

Oct 4, 2022Oct 4 at 2:21pm

Manage Discussion Entry

Hi Nicole!

From a hospital perspective, would an audit tool that addresses quality during the admission process be something valuable?

ReplyReply to Comment

- Collapse SubdiscussionNicole Altman

Nicole Altman

Oct 5, 2022Oct 5 at 6:12am

Manage Discussion Entry

Dr. Turner,

From a hospital perspective I think an audit tool would definitely be valuable in this scenario. I don't believe the readmissions are caused in the admission process but rather the discharge process. However if there could be an audit tool implemented during the re-admission process, that scanned over discharge instructions, follow up appointments, medications prescribed at discharge, etc I think this would help find the root of the problem. In my original post I mentioned having the team visit with patients who have been readmitted to get an idea of what went wrong post discharge, but having an audit tool would ensure that every case gets reviewed while saving time and money for the hospital.

Thank you,

Nicole

ReplyReply to Comment

- Collapse SubdiscussionStephanie Turner

Stephanie Turner

Oct 5, 2022Oct 5 at 1:56pm

Manage Discussion Entry

HI Nicole! I agree - an audit tool would indeed save money!

ReplyReply to Comment

- Collapse SubdiscussionJoella Larsen

Joella Larsen

Oct 9, 2022Oct 9 at 5:28pm

Manage Discussion Entry

Nicole ,

Your idea of creating an interdisciplinary team I believe will be beneficial for many aspects of the patients care, another resource could be a health coach post discharge. The hospital I work at utilize them and they can assist with transportation to appointments, making sure medications have been filled, and answering questions for the patient. Another way the hospital I work at try to fight readmissions is with a clinical nurse specialist order set flagged when a readmission shows in the emergency department. During the week each clinical nurse specialist has a role in one of the admission diagnosis such as COPD,CHF, and Sepsis. When patient is readmitted within thirty days with one of those diagnosis (along with others) an alert is set for power chart to create a readmitted within thirty days in their orders and a clinical nurse

specialist consult is automatically sent. We have seen some success with avoidance of readmission but rather treatment of fluid overload in ED medication refill and next day follow up with PCP's or specialist. Do you think with an audit tool would take into consideration what the patient perceives as the reason for readmit? Sometimes what patients are readmitted for they don't fully understand what caused it.

JoElla

ReplyReply to Comment

- Collapse SubdiscussionStacy Pee

Stacy Pee

Oct 3, 2022Oct 3 at 3:01pm

Manage Discussion Entry

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:

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If this were happening in your organization, discuss:

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