

# Design for change proposal to reduce readmission rates



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## Design for Change Proposal

An increasing problem in healthcare is the rate of readmission. A readmission is defined as an admission to a hospital within the 30-day period after being discharged from a hospital. There was an estimated \$17.4 billion dollars that was used to pay for unplanned 30-day readmissions in 2004 by Medicare (Nandan, Bohnen, Changm Yeh, Lee, Velmahos, & Kaagarni, 2017). There is an estimated cost of \$17.4 billion in readmission costs within the healthcare system for Medicare alone (Kripalani, Theobald, Anctil, & Vasilevskis, 2014). There high readmission rate costs pose many issues for healthcare organizations. For hospitals that have high 30-day readmission rates there has been regulations developed and put into effect. Many healthcare organizations attempt to keep the rates of hospital readmissions under control for not only patient safety concerns but also for reimbursement concerns. There is a significant change in the number of hospital readmissions for older adults who receive early discharge planning in comparison to those who don't (Fox, Persaud, Maimets, Brooks, O'Brian, & Trgunno, 2013). Early discharge planning had resulted in a decrease of readmissions by twenty-two percent as well as a decrease in length of hospital stay to nearly two-and-a-half days (Fox, Persaud, Maimets, Brooks, O'Brian, & Trgunno, 2013). There are ways in which the readmission rates can be reduced simply through education. There could be an education or continuing education program/model that teaches the importance of starting discharge planning upon admission with emphasis on the need for follow-up care after discharge. The education would include information explaining everything step by step and the follow-up process focusing on critical

admissions of patients 65 years and older. This education would be tailored towards those aged sixty-five and older admitted for critical reasons. The ultimate goal is to decrease the amount of 30-day readmissions within a six month period in comparison to the previous six month period for metrics.

### Change Model Overview

The ACE Star Model was created by the Academic Center for Evidence-Based Practice (ACE) to assist nursing students in passing the NCLEX. There is five points in the star. In the discovery research stage the information collection and research begins. In the evidence summary stage the information collected from the discovery research stage is summarized into a clear statement. In the translation to guidelines state the research is taken and made into practice guidelines that can be incorporated into algorithms or clinical protocols. The practice integration stage is where the algorithms and clinical protocols are put into place. The last stage, process outcome evaluation, is when the evaluation is made based upon the ability to impact patient health outcomes, patient and provider satisfaction, efficacy, efficiency, etc. In order, these five stages are: the discovery of new information, the summary of information and evidence collected, translation or transition of this information into being used in clinical practice, integrating this information in the clinical setting, and evaluating the effect that the changes have made on practice (Schaffer, Sandau, & Diedrick, 2012). The ACE Star Model gives this process the chance to show the process in full circle from beginning-to-end with the first step of discovering new information to the evaluation of this information in the clinical setting in order to ensure that the specific practice is beneficial to the nursing practice.

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## Define the Scope of the EBP

For critically ill/injured patients aged sixty-five and older, recovery happens with a step-down process from the intensive care unit (ICU) to another unit. The intensive care unit is where these patients will begin the most critical point of their healing journey and later move to a step-down unit to continue their healing process until they are able to be discharged. After discharge there is always that possibility that they will be back. According to Hospital Care Data, the unplanned hospital readmission rates for sixty-five years and older at my local hospital is COPD 24. 0% with the national average 20. 2% and heart failure 25. 1% with the national average 22. 0%. As stated in section 3025 of the Affordable Care Act (ACA), for the hospital organizations with high readmission rates there will be a decrease in payments made. Constant discussions come up regarding developing procedures to reduce readmissions within the 30-day period and increasing the healing process on discharge patients because of the changes that have been happening within hospital organizations and reimbursements.

## Stakeholders

The Chief Nursing Officer (CNO), ICU Director, and two day and night representatives from the ICU is included in the leaders team. Others that would also be included are the step down unit's Director and two representatives from day and night shift that are also from the step down unit.

## Determine Responsibility of Team Members

The team leader, who is the project coordinator, will work on and present the project in to the CNO for the approval. All areas of the project and discussion regarding the project including the contact of patients post-discharge (1 day, 3 days, and 12 days) will include the team leader. The ICU Director will help with the direction ensuring that all patients who are sixty-five and older being discharged from the ICU and step down unit are included. There will be daily logging on both the ICU and step down unit which will be handed in to the leader each day for reviewing. There will be representatives from each shift (day and night) in the ICU that will oversee and direct the education to other staff members. These representatives will need to ensure understanding and compliance on teach-back or return demonstration procedures using a teach-back toolkit, this way all staff members receive the same information and instructions. The step down unit, where discharge takes place, will also have representatives from each shift. These representatives will make sure that the education provided by the teach-back toolkit is being used for the patients by all of the nurses.

For comparison of metrics on this project, the previous six-month metrics of thirty-day readmission rates of patients who are sixty-five and older admitted to the ICU and discharged from the step down unit will be looked at. The comparison of these rates will be graphed and the CNO will be updated on all progress made within the project.

## Evidence

Increase mortality has been proven with higher readmission rates. One in five Medicare patients nationally gets readmitted within the thirty-day period

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after discharge which costs \$26 billion annually and more than \$17 billion in what could be preventable expenses (Hitch, Parlier, Reed, Gavin, Fagan, Wilson, 2016). The question was: why was this occurring and how could the readmissions have been prevented? A significant amount of patients aged sixty-five and older are covered by Medicare and these same patients saw a big difference in in-patient care, length-of-stay, and in-hospital survival depending on the payment type (Loop, Van Dyke, Chen, Brown, Durant, Safford, & Levitan, 2016). Action was taken and Medicare created guidelines due to the circumstances that created and unknown survival rate because of reimbursement to be sure that this age group would receive the proper care. The teach-back and return demonstration methods are both effective in making sure the patient is understanding of their personal need prior to discharge. The teach-back method includes materials such as videos, powerpoints, pamphlets, or flip chart presentations. The patient's family is also included in the education as well as others included such as the pharmacy tech for explanations of new medications. The teach-back method allows the RN to demonstrate the full process and continue the teaching and demonstration in the clinical field with guided design and delivery of a unique learning activity. This learning activity gives the patient an opportunity to apply the information that they have learned and teach or demonstrate it back (Mangold, 2016). The patients who are discharged benefit from this method because it brings their daily living needs to reality.

The project leader is who ensures that the patients are being seen in a timely manner by the primary physician(s) and that the patient to be discharged or their family members questions or concerns are answered. The

patients who are classified as higher risk for readmission will be scheduled to see a physician within seven days after discharge and the patients who are classified as being a lower risk to be seen within fourteen days after discharge (Hitch, Parlier, Reed, Gavin, Fagan, & Wilson, 2016). The leader is to also make sure to their best ability that there is follow ups on the patients, thus decreasing the chances of recurrent readmissions.

### Summarize the Evidence

The evidence supports changes in the way that patients aged sixty-five-years and older before discharge. Solutions to reduce readmission rates are implemented to benefit the organization and provide the best patient care. Using the teach-back and return demonstration method as well as routine following upon patients can potentially reduce the readmission rates on the critically ill patients who have been discharged.

### Develop Recommendations for Change Based on Evidence

Constant reviewing of the supplies needed for the teach-back/return demonstration toolkit. The outline of the method and materials needed for the method that will be provided should be sent to the CNO for the approval. The nursing representatives for each shift on each unit should be taught the technique within a two week period. There will be two classes set for each week for three weeks to ensure that all of the nursing staff is up to date on the education. The patients who are discharged from the step-down unit will be given teach-back information and education and then followed up with by the project leader. For a six-month period all of the discharges will be reviewed and made into a metric graph for the CNO to look over monthly.

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After the six-month period, the CNO and the project leader will review the results that are graphed and determine implementation needed as well as possible go-live dates for other areas within the hospital.

## Translation

## Action Plan

The timeline of this project is six-months. Throughout the six-month period the progress of this teach-back method will be graphed so that the results each month are easily recognizable as positive or negative. After the method has been implemented for six months, the results will then be graphed together and compared to the previous six months in order to see any changes between the two time periods. After the results have been reviewed, further revisions will be made if needed.

## Process, Outcomes Evaluation and Reporting

The desired outcome will be a reduction in the readmission rates for critically ill patients aged sixty-five and older. The change(s) in readmission rates will be measured using a metric graph and reviewed monthly. There will be a final graph which shows the full six months of data and compared to the previous six months before the start of the project.

## Identify Next Steps

The review after the six-month period of the project will provide information on what needs to be implemented and if there are any changes that may be needed to ensure further success. The directors for each unit (ICU and step-



down) will hold a meeting with the CNO as well as the project leader to review the findings. Aside from reviewing the findings they will also discuss the process in which they will be purchasing materials needed and leaders for the unit that will be doing the teaching. Doing this will ensure that the project becomes part of the standard for care with all patients and the discharge process. The project leader will work closely with the units to ensure consistency.

### Disseminate Findings

The final results of this project may be inserted in the hospital's newsletter to provide detailed information for the staff. The hospital's website will also include information regarding the process of discharging and the after-care that will be provided. This information will help build confidence for patients who choose to come to this hospital. The positive findings can also be reported to the American Nurses Association and possibly published in the Nursing Journal to provide information for other organizations to make the readmission rate reduced nationally.

### Conclusion

Mortality increases and a decrease in organizational reimbursement come as a result of an increased readmission rate for critical care patients aged sixty-five and older. A priority would be finding a solution to ensure patient safety. The five points of the ACE Star Model are: discovery research, evidence summary, translation to guidelines, practice integration, and process outcome evaluation. All areas of the project research and implementation is covered within this model. The teach-back/return demonstration method is <https://assignbuster.com/design-for-change-proposal-to-reduce-readmission-rates/>

on that can reduce the overall rate for readmissions as well as the higher rate for mortality which comes as a result. Discharged patients will have the correct and needed understanding of information regarding their health and the process. The patients also will feel a sense of support and caring after discharge. This sense of importance will increase the encouragement and motivation for healing instead of declining health. All staff must be consistent with the teach-back method which is why a yearly review of the project with updates and implementation may be utilized. The most current level of evidence-based practice will be provided to ensure the highest level of patient care resulting in a higher quality of life are the goals of this project. The staff will give one-hundred-percent to each patient to increase the quality of care because every patient matters.

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