

# Good proposed solution research proposal example

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Amongst mentally ill patients at high risk for early readmission, does the utilization of a multi-component transition care plan as compared to usual care help to improve early readmission rates?

## **Abstract**

The early hospital readmission rate in a 30-bed psychiatric unit in California is 25%. This figure is higher than the 13% reported in the literature for high-income countries like the US (Vigod et al., 2013). Early readmissions are problematic as they are costly and disruptive to the personal and professional lives of patients and their family members. In addition, they are construed to be negative patient outcomes and negative indicators of quality of care (Vigod et al., 2013). Multiple factors contribute to the 'revolving door' phenomenon. These factors range from quality of care to the sociodemographic variables of patients (Lin et al., 2010). The factors identified as contributing to early readmissions in the psychiatric unit include premature discharge and inadequate discharge planning. Discharge planning is an important nursing process. High rates of early readmission in the unit thus have significance to nursing (Alghzawi, 2012). The proposed solution to the problem is a multifaceted transition care intervention. The components of this intervention include structured needs assessment, predictive modeling, patient/caregiver medication education, patient/family involvement, medication reconciliation, transition communication, and support for patients as they transition from inpatient to community/outpatient care. The efficacy of these components has been shown by research studies including randomized controlled trials. They are also supported by expert consensus. Rogers (2003 as cited in Kaminski,

2011) diffusion of innovations model is the theoretical framework selected for the study. It will guide the design of and implementation planning for the intervention. Authority to carry out the proposed project will be sought from the senior administration of the psychiatric unit that consists of a board of directors, administrator, and nursing director. Implementation of the project will require time, money, materials, and manpower. Dissemination of information on the need, goals, and design of the project will be done through posters, pamphlets, champion leaders, and a 1-day workshop. Evaluation of the efficacy of the intervention will entail collection of data on patient demographics, patient health care utilization, patient satisfaction with treatment, and quality of life. The variables to be assessed include patient demographics, patient readmission rates at 60 days post-discharge, medication adherence, patient quality of life, patient satisfaction with mental health services, and patient attendance of out-patient appointments. This data will be collected from a review of patient medical records and using the Wisconsin Quality of Life Index (W-QLI) Client Questionnaire. The data will be collected at baseline and 60 days post-discharge. To reach a wide and appropriate audience, the outcomes of the project will be disseminated in seminars, meetings, workshops, and through peer-reviewed journals.

## **Description of Current problem**

Early re-hospitalization, defined as readmission within 90 days of discharge, is a phenomenon that affects an estimated 25% of patients discharged from a 30-bed psychiatric unit in California. A retrospective clinical audit of patient's file managed at the unit over the past three years led to the

identification of this problem. The audit was prompted by anecdotal observations by private payers of the high costs incurred as a result of frequent hospitalization of their patients. A review of literature reveals that the problem of frequent hospitalization of mentally ill patients is not limited to the psychiatric unit alone and is in fact, a national and international concern. Data from Western countries like the US, UK, and Canada indicates that approximately 13% of psychiatric patients are re-hospitalized within 90 days of discharge from acute psychiatric units (Vigod et al., 2013). Further data suggests that 25% of patients discharged from psychiatric inpatient settings in the US are readmitted within 1 year of discharge (Viggiano, Pincus, & Crystal, 2012). Early readmissions are problematic as they are construed to represent negative patient outcomes (Vigod et al., 2013). This is because they are costly in terms of time, cost, and resources. They disrupt the professional lives of patients of patients and have been shown in one study to be responsible for the greatest loss in working years (Knudsen, Overland, Hotopf, & Mykletun, 2012). In addition, early rehospitalization was adopted by an international expert panel as a negative marker of quality of care (Vigod et al., 2013). Evidence drawn from empirical research also suggests that frequent hospitalizations reflect the quality of inpatient psychiatric care and continuity of mental health care services in outpatient and community settings (Viggiano, Pincus, & Crystal, 2012). The demarcation of frequent readmissions as a negative indicator of inpatient and outpatient quality of care has serious implications on the measurement of the quality of care rendered at the psychiatric unit. Inpatient psychiatric care is expensive as it accounts for an estimated 16% of all mental

healthcare expenditure in the US. The actual costs associated with preventable psychiatric readmissions are unknown, it is, however, estimated that avoidable re-hospitalizations of all diseases account for \$17.4 billion of Medicare expenses each year (Vigod et al., (2013). The high costs of inpatient psychiatric care and preventable readmissions have made prevention of early readmissions a target for policymakers.

As already described, the root causes of frequent admissions for mentally ill patients include poor quality inpatient care as well as poor coordination and support during the transition from inpatient to outpatient care. The transition period between different care contexts is the time during which mentally ill patients are most vulnerable. The distinct vulnerabilities of mentally ill patients make it essential for skillful coordination and planning of their care transitions (RARE Mental Health work Group, n. d.). The retrospective audit of patient's file traced the problem of early re-hospitalizations for patients treated at the psychiatric unit to poor discharge planning and coordination of after care. Although social problems like homelessness and unemployment have been shown to contribute to the phenomenon of early rehospitalizations (Lin et al., 2010), only a few patients with a history of frequent admissions at the facility were found to be homeless or jobless. The specific factors identified as contributing to early readmissions at the unit include premature discharge, poor planning for care transitions, poor medication reconciliation before discharge, and insufficient communication between staffs caring for patients at the unit and patients, their carers, and community care providers.

The proposed solution to the problem of early rehospitalization of patients discharged from a 30-bed psychiatric unit in California is a multifaceted transition care plan. The multifaceted discharge plan will include usual care and the following components: predictive modeling, structured needs assessment, medication education for patients/caregivers, medication reconciliation, patient/family involvement, communication with community care providers, and support for patients during the transition from inpatient to community/outpatient care. The goal of hospitalization of mentally ill patients admitted due to deterioration of their psychiatric conditions is stabilization of their conditions. Evidence from the literature further suggests that the manner in which their transition to outpatient or community care is planned as well as the level of support they receive from care providers during this period influences patient community stays. The components of the multifaceted intervention are selected based on the best available evidence. This evidence consists of results from randomized trials, systematic reviews, and expert consensus.

For example, a controlled study by Schmidt-Kraepelin, Janssen, and Gaebel (2009) employed a multifaceted transition intervention to amongst other goals prevent readmissions of patients suffering from schizoaffective disorder and schizophrenia. The complex intervention was applied to 46 'high utilizing' patients post-discharge. The multifaceted intervention incorporated the following components: psychoeducation, integrated psychological therapy, social competence group therapy, sociotherapy, coping skills training, nursing care, social-worker care, help to family members, home visits, and an emergency call line that participants could

use for enquiries. These interventions were delivered by a project team drawn from the local hospital. The rehospitalization rates for participants in the intervention group decreased by almost 50% within 1 year. In contrast, the re-hospitalization rates for participants in the control arm of the study increased leading to a group difference of 23%. The component that influenced readmission rates most for the intervention group in this study was shown to be coping skills training. The study additionally found that patient satisfaction with therapy and cost effectiveness was improved in the intervention group even though quality of life remained constant.

A systematic review by Vigod et al. (2013) sought to assess the efficacy of interventions utilized during the transition from inpatient to outpatient care in mitigating early readmission. The review incorporated 15 studies with a total of 1 non-overlapping component which were further classified into pre-discharge, post-discharge, and bridging interventions. The study found that the interventions applied had absolute risk reductions of between 13.6 to 37.0% in statistically significant studies. The components found to be effective include pre-and post-discharge structured needs assessment, psychoeducation of patients, medication education/reconciliation, and communication between transition managers and in-patient/outpatient care providers.

Expert consensus on interventions to prevent frequent admission of mentally ill patients recognizes the fact that readmissions are complex as they are influenced by multiple variables. The experts have, however, based on analysis of available literature and state and national programs identified areas of focus for quality improvement activities. These components include

predictive modeling, patient/family engagement, medications management, comprehensive transition planning, transition support, and transition communication (Viggiano, Pincus, & Crystal, 2012).

Integration of research evidence into clinical practice is paramount in ensuring delivery of high-quality care (Alghzawi, 2012). Discharge planning for all patients admitted at the unit will be started on admission. Because discharge planning falls squarely in the domain of nursing, every patient will be assigned a primary nurse who will be responsible for planning as well as coordinating the patient's discharge with the patient/family and psychiatrist. Prospective modeling will help to identify patients at risk for early readmission. It will be based on a questionnaire that will be developed from existing knowledge on patients at high risk for early rehospitalization. A structured needs assessment will then be done for patients identified to be at high risk for early readmission. Psychoeducation for patients and their caregivers will be carried out to empower them and equip them with coping skills on how to deal with the patient's illness in an optimal way.

Patient/family involvement will entail authentic inclusion of patients and their caregivers in discharge and transition care planning as per their identified needs. Prior to discharge every patient/family will be educated about the client's medications such as mode of action, appropriate dosage, frequency of intake, and potential side/adverse effects. Medication reconciliation for all patients discharge medications will be done by a pharmacist prior to discharge. On transition communication, a copy of the client's discharge notes will be faxed to the outpatient/ community clinics where the various clients are followed up at discharge. Once discharged, patients will be



followed up via telephone by transition coaches. The transition coaches will consist of advanced practice psychiatric nurses who will contact patients via pre-paid cellular phones and their outpatient care providers. The transition coaches will offer support to the patients until they establish a therapeutic relationship with their outpatient care providers.

## **Implementation Plan**

Roger's (2003 as cited in Kaminski, 2011) diffusion of innovations model will guide the design and implementation plan of the proposed intervention. The model outlines a 5-step model process through which adoption of new practices takes place. These are knowledge, persuasion, decision, implementation, and confirmation. The model also delineates attributes of innovations that influence the rate at which their adoption takes place. These characteristics include relative advantage, trialability, complexity, compatibility, and observability (Kaminski, 2011). Once approval for the proposed multifaceted transition intervention is obtained from the unit's senior management, sensitization on the need for the change amongst all health staffs at the facility will be done through a powerpoint presentation at the unit's weekly continuous medical education meeting. Pamphlets detailing the problem, gaps in care that contribute to the problem, and proposed solution will also be distributed to all health care professionals working at the psychiatric unit. Once sensitization is done, health professionals from the various discipline i. e. pharmacy, medicine, and nursing will be invited to nominate two champion leaders for the proposed change through secret ballot. Individuals with the most nominations will be incorporated into the

project team. The project team will be given the responsibility of spearheading the implementation of the change. This team will consist of two psychiatrists, the nurses' in-charge of the two units, two pharmacists, two advanced practice psychiatry nurses, and two registered nurses. A 1-day workshop will be organized for training nurses and other health care staffs on the various components of the multifaceted interventions, individual responsibilities as well as the use of the questionnaire for identifying high utilizing patients. Continued support will be offered to the staffs through on-job training by members of the project team. The unit's administrator and nursing director will officiate the 1-day workshop which will also serve as a launch for the proposed change project. Prior to the official launch of the proposed intervention, it will be piloted amongst 5 patients over a period of 3 months and modified depending on the findings of the pilot study. Piloting will help to identify areas of unclear role responsibilities as well as gaps in the intervention. It is expected that the intervention will become fully integrated into the normal workflow at the unit by end of the third month.

## **Evaluation Plan**

Assessments of coordination interventions for care utilize 5 types of measures: measures of the process of care delivery, patient outcomes, cost outcomes, perceptions of patient/family of coordination, and mechanism measures. The end goals of improvements in coordination of care are patient and cost outcomes measures such as morbidity, mortality, functional status, and costs. Assessment of these outcomes is vital in evaluations of interventions aimed at enhancing coordination of care. Care delivery

processes usually reflect the occurrence of the recommended care activities. These are expected to come from appropriate coordination of work. Measures of processes of care delivery are designed to determine whether care practices for instance patient follow-up visits occurred as per the recommendations of relevant guidelines. Patient perceptions of coordination and coordination mechanisms are related more to care coordination (American Nurses Association, 2013).

In the case of the proposed transition of care intervention, early readmissions are deemed to be negative indicators of in-patient quality of care especially discharge planning. They also reflect the sufficiency of transitional services like provider support through home visits or telephone follow ups. Lastly, they are indicators of the efficacy of outpatient mental health services (Vigod et al., 2013). The effectiveness of the proposed multifaceted intervention will thus be evaluated through analysis of data that is able to measure the quality of inpatient, bridging, and outpatient services. Data that will be collected for analysis will include patient demographics, patient health care utilization, patient satisfaction with treatment, and quality of life. The available evidence suggests that patient demographics like joblessness, homelessness, and being single have a bearing on readmission rates of mentally ill patients (Vigod et al., 2013). Consequently, it is essential to collect and analyze data on patient demographics to determine whether they will have an impact on patient readmissions after implementation of the proposed transition care intervention.

Health care utilization will be assessed through analysis of data on patient readmission rates at 60 days post-discharge and patient compliance with

medication and outpatient follow up. Adherence with outpatient follow-up will be assessed through review of patient medical records on attendance of outpatient appointments. Adherence with medications will be assessed through patient self-reports 60 days after discharge. Data on the number of readmissions of a patient within 60 days post-discharge will be extracted from patient records with informed consent from the client/caregivers. The Health Insurance Portability and Accountability Act (HIPAA) privacy rule gives clients rights regarding their health information. These rights include the right to know who has access to their medical information. HIPAA also requires the removal of all personal identifying information from medical data when the same is used for quality improvement or research purposes (Bova, Drexler, & Sullivan-Bolyai, 2012). To comply with HIPAA regulations, therefore, informed client for the use of personal information for this quality improvement intervention will be sought from clients or their caregivers where applicable before discharge. All personal identifying information will also be removed from the data during analysis to protect the privacy of patient information.

Quality of life and satisfaction with mental health services will be measured using a pre-and post-intervention design using the Wisconsin Quality of Life Index (W-QLI) Client Questionnaire. Quality of life is a subjective measure that differs depending on the population studied. For instance, healthcare providers, caregivers, and patients can have varied perspectives of a patient's quality of life. Quality of life is conceptualized as a multi-faceted construct that is made up of several independent domains that include psychological well-being, physical health, functional roles, social

relationships, and a subjective sense of life satisfaction (Becker, Shaw, & Reib, 2010). The W-QLI is selected as the measure for quality of life of clients for this project because it is a multi-dimensional measurement tool that comprehensively reflects the individual goals and priorities of mentally ill patients. The questionnaire has 9 domains: general life satisfaction, activities and occupations, psychological well-being, physical health, social relations and support, economics, activities of daily living, symptoms, and goal attainment. Every domain is weighted individually depending on its relative importance to a patient. The internal consistency of the 9 domains ranges from .68 to .93 cronbach alpha (Becker, Shaw, & Reib, 2010). In addition to measuring quality of life of clients, W-QLI also measures client adherence to prescribed medications. Therefore, it will also be used to assess client adherence to discharge medications. The W-QLI questionnaire can be used to assess a patient's status at a particular time as well as a tool for monitoring and evaluating patient outcomes (Becker, Shaw, & Reid, 2010). The W-QLI questionnaire will be administered to patients at discharge and 60 days after discharge. Improvement of patient scores pre-and post-intervention on measures of quality of life and adherence to medications will demonstrate the efficacy of the multi-dimensional transition care intervention and vice-versa. Analysis of the collected data will be done using the SPSS software as the data collected will be quantitative in nature.

## **Dissemination plan**

Rogers (2003 as cited in Kaminski, 2011) in his diffusion of innovations model posited that adoption of innovations is an uncertainty reducing

process that involves 5 stages. The 5 stages are knowledge, persuasion, decision, implementation, and adoption. In the first stage, individuals are exposed to an innovation but do not have complete information. In the second stage, individuals develop interest in a new idea and seek more information. In the third stage, individuals apply the innovation to their situations mentally then decide whether try or not try the idea. The fourth stage entails full utilization of the novel idea. The fifth stage is where there is continued use of an idea. Rogers also stated that there are 5 groups of adopters in an organization, innovators, early adopters, early majority, late majority, and laggards. The different groups have different levels of readiness for change in a descending order and varied needs. Diffusion of an innovation occurs effectively when the needs of the different groups are considered and catered for. Utilization of peer networks to communicate a new idea helps to enhance the efficacy of the communication process. Peers act as opinion leaders and influence others to adopt a change through peer to peer communication, networking, and role modeling (Kaminski, 2011). The dissemination strategies for the proposed change will be guided by this model.

Initial dissemination of information about the proposed multifaceted transition care intervention will take place over a period of 4 weeks. The initial dissemination will target nurses, psychiatrists, pharmacists, and social workers. The information to be disseminated will include the need, goals, design, and evaluation strategies of the proposed change. Also to be communicated are the roles and responsibilities with regards to client care of individuals drawn from the different disciplines. The dissemination of this

information will be achieved through posters, pamphlets, champion leaders, and oral presentation. The posters and pamphlets will be distributed one week before the 1-day workshop to create awareness. Once the representatives of the various disciplines are selected, they will be required to champion the proposed change amongst their colleagues. The oral presentation will be done using power point presentation at a 1-day workshop that will be organized specifically for the purpose of educating the staffs about the proposed intervention.

The findings of the data analysis pre-and post-intervention will be presented to the nursing director, unit administrator, and board of director using power point presentations. A two-hour feedback meeting will be organized for nurses and other staffs working in the unit four months after the commencement of the project. A power point presentation detailing the outcomes of the intervention will be done during the feedback meeting. In addition, the findings of the intervention will be submitted for publishing in peer-reviewed journals. Publishing in peer-reviewed journals has been selected as a means of dissemination because it will ensure that the findings of this intervention study reach a wide and appropriate audience. This audience includes mental health nurses, registered nurses, advanced practice nurses, psychiatrists, and other mental health professionals. The findings of this study will also be presented in seminars and workshops with relevant stakeholders such as mental health nurses, governmental agencies, and private payers.

## Review of Literature

In-patient hospital services constitute a small fraction of the range of services available for patients with mental illnesses. They are often sought when psychiatric conditions become severe. Hospital admissions are an important way of stabilizing patients whose psychiatric conditions are deteriorating, of re-initiating discontinued medication regimens, and of assisting individuals' transition to outpatient and/or community-based services (Halter & Varcarolis, 2015). Repeated admissions in a psychiatric unit, a phenomenon termed the 'revolving door syndrome', are a substantial problem. Data from western countries like the USA, UK, and Canada indicate that an estimated 13% of psychiatric patients are re-hospitalized shortly after been discharged from acute psychiatric units (Vigod et al., 2013). The data further suggests that 40- 50% of patients' discharged from a psychiatric hospital as well as those with a history of frequent psychiatric admissions are re-hospitalized within 1 year. Overall, the psychiatric readmission rates reported in the literature vary from 10% within 1-month of discharge to the highs of 86% within 7-year intervals (Lin et al., 2010).

Early re-hospitalizations, defined as readmission within 90 days of discharge, often represent a negative clinical outcome like relapse for patients (Vigod et al., 2013). Re-hospitalizations are additionally disruptive to the personal and professional lives of patients and families. For instance, a Norwegian study by Knudsen, Overland, Hotopf, & Mykletun (2012) found that mental disorders as compared to other conditions accounted for the most loss in working years (33. 8%). Frequent re-hospitalizations also cause patients and healthcare providers to feel demoralized and/or have a sense of failure.



Inpatient care for psychiatric patients is additionally expensive with regards to cost, time, and resources (Funke, 2013). On account of the high cost of inpatient psychiatric treatment, reduction of the hospital bed days for psychiatric patients is an important priority economic issue for providers, insurers, and policy-makers (Vigod et al., 2013).

Readmissions rates are considered to be indicators of quality of in-patient as well as out-patient/community care. Generally, re-hospitalizations that occur close to the time of discharge are deemed as valuable indicators strongly linked to the quality of in-patient care in hospitals. Readmissions that occur long-after hospital discharge are, on the other hand, influenced by quality of inpatient care as well as psychiatric services and aftercare provided in outpatient and community settings (Lin et al., 2010). Consequently, early psychiatric re-hospitalization was adopted as a negative indicator of quality of care internationally (Hermann et al., 2006 as cited in Vigod et al., 2013). As a result, governments are setting benchmarks for decreasing early psychiatric readmission. A key issue explored in targeting this problem is the fact that early psychiatric re-hospitalization may reflect the quality of inpatient care and level of continuity of care with respect to services offered in other areas of a mental health system (Vigod et al., 2013). In specific, it can depict the ability of a mental health system to offer coordinated care and support to patients as they transition from hospitals to ambulatory care. For example, hospital rehospitalization rates for psychiatric conditions have been associated with sufficiency of discharge planning as well as transitional services. They have also been linked to availability and access to outpatient and community treatment services (Vigod et al., 2013).

In mental health, the transition between care settings is the time during which patients and their caregivers are most vulnerable. This period carries many risks such as symptom relapse, suicidal attempts, and rehospitalization. The unique vulnerabilities of these patients enhance the need for careful coordination of transitions and aftercare (Viggiano, Pincus, & Crystal, 2012). Discharge planning is an important process in the field of nursing. It is considered to be a methodology, discipline, function, movement, and solution. It can be defined as a comprehensive, collaborative, and dynamic process that should be commenced at admission and whose purpose is to prepare a plan of care and support clients and caregivers exiting from a psychiatric unit (Alghzawi, 2012). Financial pressures have led to changes in mental health systems that emphasize on deinstitutionalization of mentally ill patients. This has occurred in the context of limited outpatient resources as well as complex and fragmented community care systems (Tomita & Herman, 2012). Consequently, there is a need for creative discharge planning as well as development of support structures for patients discharged from psychiatric units in the community. Integration of evidence derived from research into clinical nursing practice is in this case necessary for the delivery of high-quality transition care. The “ revolving door” phenomenon has been extensively studied by a significant number of studies. These studies seek to understand the reasons behind high rehospitalization rates of psychiatric patients. Findings from these studies suggest that the association between the use of psychiatric services and treatment outcome is complex and is influenced by a number of factors. Other than the quality of care, rehospitalization rates have been

found to be linked to condition-related factors such as the severity of mental disorders, earlier onset of mental conditions, and longer duration of illness. Other factors linked to readmission rates include co-morbid drug or alcohol problems, dual diagnosis, poor functioning at discharge, prior history of frequent hospitalizations, and poor adherence to treatments.

Sociodemographic factors like homelessness, unemployment, and being unmarried or involved with the criminal justice system have also been linked with increased use of inpatient mental health services (Lin et al., 2010).

Some researchers have also attributed the increased rates of readmissions to changes in the mental health system. Over the last decades, the bed-capacity of psychiatric hospitals has reduced and been complemented by day or outpatient services (Babalola et al., 2014). This has been prompted by a paradigm shift that has shifted emphasis of managed of mental illnesses to community services resulting in reduced lengths of in-patient stay for psychiatric patients. The contention that shortened length of hospital stay leads to increased readmissions is not supported by research. A recent meta-analytic review by Babalola et al. (2014) established that short inpatient stays for psychiatric patients were not associated with a higher readmission risk. Notably, the studies reviewed by the Babalola et al. (2014) study are considered to be low evidence trials. A study by Zhang, Harvey, & Andrew (2011) also investigated the factors that influence length of stay and predict readmission risk at an acute psychiatric inpatient unit. The study established that 10 variables were linked to length of stay. Accommodation problems, residing in an area that lacked community services, behavioral manifestations of disease, and seclusion during index admission predicted

longer inpatient stays. The authors of the study concluded that length of stay is determined by multiple factors.

Based on the literature reviewed above, the key factors in reducing the chances of subsequent psychiatric hospitalizations are four-pronged. These include rendering adequate and appropriate inpatient care to address sufficiently the acute presenting problem and to stabilize a patient's psychiatric status. The second and third prongs entail ensuring a sufficient discharge plan and provision of adequate support services during the transition from inpatient to outpatient settings (Agency for Healthcare Research and Quality, 2014). The latter incorporates discharge services, psychoeducation, bridge visits, follow up calls, and short-term case management. The final prong is continuing sufficient outpatient and community services to allow a client to stay in the community (Agency for Healthcare Research and Quality, 2014).

The efficacy of the various transition care interventions for general medical patients and psychiatric patients like psychoeducation and bridge visits has been evaluated in studies. Notably, the number of studies that have examined interventions to lower the risk for readmission amongst mentally ill populations, unlike those of the general medical patients, is limited. Peer support uses individuals with a history of mental illness. On account of their experience, peers act as role-models and can restore hope through positive disclosure. They also provide emotional support, information about a disease, and support based on assessment. They perform a variety of tasks such as case management, counseling, disease self-management, coaching, advocacy, outreach, and befriending (Lloyd-Evans et al., 2014).

The effectiveness of peer support is contentious. For instance, two meta-analytic reviews conducted in the same year (2014) arrived at different conclusions on the efficacy of peer support. The first review was conducted by Fuhr et al. (2014) and critiqued 14 studies from high-income countries. The authors found that peer-delivered interventions were shown in some trials to have small positive impacts on hope and quality of life. The second meta-analytic review was conducted by Lloyd-Evans et al. (2014). The latter study incorporated 18 trials. Significant variations in the trials included limited the performance of analysis in this study. The authors reported that based on the little analysis conducted, there was little to no evidence to suggest peer support has positive effects on admissions, satisfaction with services, or overall symptoms. A 2011 study by Sledge et al., on the other hand, examined the effectiveness and feasibility of utilizing peer support to lower recurrent psychiatric admissions. The study used a randomized design whereby 74 patients were assigned to either usual care (n= 36) or a peer-mentor and usual care (n= 38) after discharge. Participants were evaluated at 9 months. Participants who had been assigned to the intervention group (peer mentor plus usual care) had significantly lesser readmissions and hospital days ( $.89 \pm 1.35$  vs  $1.53 \pm 1.54$ ;  $p = .042$  and  $0.08 \pm 17.31$  vs  $19.08 \pm 21.63$  days;  $p < .03$  respectively). In spite of the fact that the study had several limitations like small sample size, the authors concluded that peer mentors is a promising approach to reducing frequent psychiatric admissions.

On the issue of discharge planning, a cross-sectional retrospective clinical file audit by Zhang, Harvey, and Andrew (2011) investigated predictors of

the risk of rehospitalization at an acute inpatient unit for the mentally ill. The authors reviewed 226 randomly selected admission episodes over a 12-month period that included 178 patients. They concluded that good clinical practice in the community post-discharge helps to lower the risk of re-hospitalizations. Steffen, Costers, Beker, & Puschner (2009) evaluated the effectiveness of discharge planning interventions in improving patient outcomes and reducing readmissions in mental health. Their study was a meta-analysis and systematic review that incorporated a total of 11 studies. Of these, 6 were randomized controlled trials, 3 controlled trials, and 2 cohort studies. Although the discharge planning interventions used varied substantially, most involved preparations for discharge during an inpatient stay. The authors concluded that discharge planning interventions help to reduce re-hospitalizations of patients with psychiatric conditions. A systematic review by Shepperd et al. (2013) reviewed 24 randomised controlled trials that compared routine discharge plan with individualized discharge plan. The studies reviewed included a total of 8098 patients who consisted of a mix of psychiatric and medical/surgical patients. The study established that hospital readmissions were significantly reduced for patients in the individualized discharge planning arm of the study (RR 0.82, 95% CI 0.73 to 0.92, 12 trials). Patients in this group also reported increased satisfaction.

Regarding the intervention of medication reconciliation, Shaw, Mackie, and Sharkie (2011) evaluated the effect of pharmacy discharge planning on the medication problems experienced by discharged mental health patients. In the study, 97 patients identified from 3 acute-admission psychiatric units

were allocated randomly to an intervention or control group. Participants in the intervention group received a baseline assessment of pharmaceutical needs, information about their medications, and pharmacy discharge plan that was sent to their community pharmacy. Domiciliary visits were also conducted for the intervention group at 1, 4, and 12-weeks post-discharge. Knowledge of medications as well as medication problems experienced was assessed during each visit. The control group did not receive any additional pharmaceutical care. The authors of the study reported that lesser medication problems and a trend for lesser re-hospitalizations noted in the intervention group although it was not significant statistically ( $p= 0.065$ ).

On the evidence of multifaceted transition interventions, a controlled study by Schmidt-Kraepelin, Janssen, and Gaebel (2009) sought to prevent readmissions, optimize satisfaction with treatment, and improve quality of life of patients suffering from schizoaffective disorder and schizophrenia. The study employed a complex intervention to 46 'high utilizing' patients post-discharge. These interventions included psychoeducation, integrated psychological therapy, social competence group therapy, sociotherapy, coping skills training, nursing care, social-worker care, help to family members, home visits, and an emergency call line that participants could use for enquiries. The interventions were delivered by a project team drawn from the local hospital. The readmission rate for the intervention group reduced by almost 50% within 12 months. The re-hospitalization rates increased in the control group leading to a group difference of 23%.

Participation in the coping skills training was shown to be the intervention that favorably influenced the readmission rates for the intervention group.

The study additionally found that patient satisfaction with therapy and cost effectiveness was improved in the intervention group with quality of life remaining constant.

Transition care that includes psychotherapy has been shown to be effective in reducing recidivism amongst patients with borderline personality disorder and schizophrenia. The findings from these studies additionally suggest that the use of pharmacotherapy alone does not adequately address some of the symptoms of mental illnesses such as the social impairment associated with borderline personality disorder. The first of the two studies was by Amianto et al. (2011). It sought to evaluate the efficacy of addition of Sequential Brief Adlerian Psychodynamic Psychotherapy (SB-APP), a form of psychotherapy to supervised team management (STM) in the treatment of borderline personality disorder as compared to STM only in a group of heavy mental health service users with borderline personality disorder. The study employed a randomized trial design whereby participants were randomized to each arm of the study. Supervised team management consists of medications, unstructured psychological support, rehabilitative interventions, and mental health service training. The study found that STM was effective in improving the global function and symptoms of patients and reducing rehospitalizations. Addition of SB-APP, psychotherapy targeted at a patient's personality, however, was more effective than STM alone.

The second study by Karow et al. (2012) compared the 12-month cost-effectiveness of therapeutic assertive treatment (ACT) with routine care in schizophrenia. Participants in the study were randomized to either arm of the study depending on their catchment area. The study established that ACT



was linked with significantly lesser inpatient but more outpatient costs than standard care although the reductions in costs were not significant. The authors concluded that ACT resulted in improved patient outcomes with lessened need for inpatient care.

A systematic review by Vigod et al. (2013) sought to evaluate the efficacy of interventions utilized during the transition from inpatient to outpatient care in mitigating early readmission. The review incorporated 15 studies with a total of 1 non-overlapping component which were further classified into pre-discharge, post-discharge, and bridging interventions. The study found that the interventions applied had absolute risk reductions of between 13.6 to 37.0% in statistically significant studies. The components found to be effective include pre-and post-discharge structured needs assessment, psychoeducation of patients, medication education/reconciliation, and communication between transition managers and in-patient/outpatient care providers.

Regarding expert consensus on interventions to prevent frequent hospitalization of mentally ill patients, experts are of the view that the issue at hand is complex as it is influenced by multiple variables. Experts have, based on analysis of literature, state and national programs, identified areas and components of focus for quality improvement activities on the issue of transition from inpatient to outpatient transition care for this patient population. These components include predictive modeling, patient/family engagement, medications management, comprehensive transition planning, transition support, and transition communication (Viggiano, Pincus, & Crystal, 2012).

## Conclusion

In summary, this paper has addressed a proposed project to reduce the readmission rates at a 30-bed psychiatric unit in California. The early readmission rate at the unit (25%) is markedly higher than the 13% rate seen in high-income countries such as the US. Early rehospitalizations are an issue of concern for a number of reasons; they are expensive in terms of time, cost, and resources. In addition, they often represent negative patient outcomes and have been denoted as negative markers of quality of care. The etiology of frequent rehospitalization is multi-factorial. Contributing factors include quality of inpatient and outpatient care, severity of the psychiatric condition, and sociodemographic variables of patients. Premature discharge and inadequate discharge planning are some of the factors that have been noted to contribute to early readmissions at the psychiatric unit. Discharge planning is a vital nursing process. The problem of early recidivism at the unit thus has significance to nursing. This paper proposes a multifaceted transition care intervention as the solution to this problem. The components of this intervention will entail predictive modeling, structured needs assessment, patient/family involvement, medication education to patients/caregivers, medication reconciliation, transition communication, and healthcare provider support for patients as they transition from inpatient to community/outpatient care. These components are supported by research findings (randomized and observational studies) as well as expert consensus. The theoretical framework to inform the planning and implementation of the proposed project is Rogers (2003 as cited in Kaminski, 2011) diffusion of innovations. Permission to carry out the proposed project will be sought from

the administration of the psychiatric unit. Implementation of the project will require time, money, materials, and manpower. Once commenced, it is expected that the intervention will become incorporated into the normal workflow of staffs at the facility. Sensitization of staffs at the facility on the need, objectives, and design of the project will be achieved through the use of posters, pamphlets, champion leaders, and a 1-day workshop. Evaluation of the efficacy of the multi-faceted intervention will involve collection of data on patient demographics, health services utilization patterns, satisfaction with health services, and quality of life. The following variables will be assessed patient demographics, readmission rates 60 days after discharge, medication adherence, quality of life, satisfaction with mental health services, and attendance of out-patient appointments. The above data will be collected through a review of patient medical records and the Wisconsin Quality of Life Index (W-QLI) Client Questionnaire. The outcomes of the project will be shared in seminars, workshops, meetings, and via peer-reviewed journals.

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#### Appendix 1: Pamphlet

##### Problem

High rates of early readmissions (within 90 days of discharge) for patients discharged from the psychiatric unit (25%) as compared to the national average of 13% for the same time period.

##### Significance

High rates of readmissions:

Are negative indicators of quality of inpatient and transition care.

Impact negatively on the personal and professional lives of patients and their significant others.

Contribute to an acute shortage of beds at the unit.

Increase the workload at the facility.

Contribute to demoralization and job dissatisfaction amongst staffs.

Increase the cost of treatment for patients.

##### Factors that Contribute to High Rates of Readmissions

A review of literature shows that the etiology of frequent readmissions is multifactorial. Factors that contribute to this phenomenon include:

Poor discharge planning

Lack of patient/family engagement in the discharge process

Premature discharge

Failure to reconcile patient medications before discharge

Lack of support for patients during the transition from inpatient to outpatient

settings

Poor communication with community health care providers

Sociodemographic variables like joblessness, being unmarried, and homeless

Solution to the Problem

Evidence from an array of studies and expert consensus suggests that the following strategies help to prevent early readmissions amongst mentally ill patients:

Patient/family engagement in the discharge process

Patient/family education on patient's medications

Medication reconciliation before discharge

Communication with community health care providers upon a patient's discharge

Provision of support for patient's during the transition from hospital to community settings through telephone follow ups or home visits.

Peer mento

Appendix 2: Wisconsin Quality of Life

Wisconsin Quality of Life Associates

Directions: We are interested in your views and feelings. The questions in this booklet ask for your opinions about the quality of your life. When you answer each question please indicate the response which most closely reflects your opinion.

You are the person who knows best how you feel about these questions. If you would like someone to help you in filling out this questionnaire, and a friend or family member is not available, please contact a staff member to



assist you.

Note: If this form was filled out by someone other than you, please

Indicate who helped:

Relationship to you: \_\_\_\_\_

Background Information

What is your date of birth? \_\_\_\_/\_\_\_\_/\_\_\_\_

You are?  Male  Female

What is your highest school grade completed:

What is your current relationship/marital status?

How many times have you been married? \_\_\_\_

What is the source of your income? (Check all that apply)

What is your racial/ethnic background? (Check all that apply)

During the past four weeks, you lived: (Check all that apply)

Who would you like to live with? (Check all that apply)

During the past four weeks, you lived primarily: (Check one)

Where would you like to live? (Choose one)

Satisfaction Level

We have asked how satisfied you are with different parts of your life. Now we would like to know how important each of these aspects of your life are.

Activities and Occupations

During the past four weeks, you have: (Check one)

been working/studying or doing housework in your usual manner

been working/studying or doing housework but less often

stopped working/studying or doing housework

About how many hours a week do you work or go to school? Hours per week

= \_\_\_\_\_

What is your main activity? (Check one).

How satisfied or dissatisfied are you with the main activity that you do?

(Check one)

Do you feel that you are engaged in activities: (Choose one)

What would you like to have as your main activity?

Psychological Well-being

Now we would like to know how you feel about things in your life. For each of the following questions, check the boxes that best describe how you have felt in the past four weeks.

In the past four weeks, would you say that your mental health has been:

Symptoms/Outlook

During the past four weeks, you have: (Check one)

generally felt calm and positive in outlook

been having some periods of anxiety or depression

generally been confused, frightened, anxious or depressed

There are many aspects of emotional distress including feelings of depression, anxiety, hearing voices, etc. In the past four weeks, how much distress have these symptoms caused you?: (Check one)

Physical Health

In the past four weeks, you would best describe your physical health as:

How do you feel about your physical health? (Check one)

How important to you is your physical health? (Check one)

Are you currently taking psychiatric medications? ( ) Yes ( ) No (If no, go to next page)

If you are currently taking psychiatric medications, do you take them as prescribed? (Check one)

If you are currently taking psychiatric medications, do you have side effects from them?

If you take medications for mental health problems, do you feel the medication helps control your symptoms?

How do you feel about taking your psychiatric medications?

#### Alcohol & Other Drugs

Over the past four weeks, have you drunk any alcohol?  Yes  No

If yes, on how many days have you had any alcohol to drink over the past four weeks? \_\_\_\_\_ (number of days)

What do you think about your alcohol use? (Check one)

Over the past four weeks, have you used any street drugs (cocaine, marijuana, heroin, speed, LSD, etc.)?

Yes  No

If yes, on how many days have you had any alcohol to drink over the past four weeks? \_\_\_\_\_ (number of days)

What do you think about your drug use? (Check one)

#### Social Relations / Support

##### Importance Level

During the past four weeks, you have (check one):

been having good relationships with others and receiving support from family and friends

been receiving only moderate support from family and friends

had infrequent support from family and friends or only when absolutely

necessary

Money

Are you paid for working or attending school?  Yes  No

How do you feel about the amount of money you have?

How satisfied are you about the amount of control you have over your money?

How important to you is money?

How important is it to you to have control over your money?

How often does lack of money keep you from doing what you want to do?

Activities of Daily Living

Below are activities that you may have participated in recently. Please check YES or NO to indicate whether you have done the activity in the past four weeks.

During the past four weeks you:

have been able to do most things on your own (such as shopping, getting around town, etc.)

have needed some help in getting things done

have had trouble getting tasks done, even with help

In the past four weeks, how often have you had any problems with personal grooming (e. g. taking showers, brushing your teeth)?

Goal Attainment

What do you hope to accomplish as a result of your mental health treatment? Please write below up to 3 goals:

Goal 1:

How important is this goal?

Goal 2:

How important is this goal?

Goal 3:

How important is this goal?

Goal Attainment

Please write below your agreed upon goals: Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Goal 1:

How important is this goal?

Goal 2:

How important is this goal?

Goal 3:

How important is this goal?

Other

Below are activities that you may have participated in recently. Please check Yes or No to indicate whether you have done the activity in the past four weeks.

Please check the box below to indicate how you feel about your quality of life during the past four weeks. Lowest quality means things are as bad as they could be. Highest quality means things are the best they could be.

If your quality of life is less than you hope for, how hopeful are you that you will eventually achieve your desired quality of life? (Check one)

How much control do you feel you have over the important areas of your life? (Check one)

Is there anything else you would like us to know?

This is the end of the questionnaire. Thank you for giving your opinion and

sharing your responses with us. If you have any questions about this questionnaire, please call or write