

A Quality Improvement Initiative to Engage Older Adults in the Discharge Process Using the IDEAL Discharge Protocol

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Background

In the United States, avoidable readmissions continue to be a significant challenge for hospitals (Silow-Carroll, Edwards, Lashbrook, 2011). High readmissions have resulted in \$280 million in assessed penalties for sixty-five percent of the 3,400 hospitals participating in the Hospital Readmission Reduction Program (Hume & Tomsik, 2014). Despite the efforts made to decrease readmissions rates, hospitals have not found the solution to reduce readmission rates. These readmissions are costly for organizations and adversely impact patient outcomes. There are factors impacting readmissions that may be out of a hospital's control. However, organizations can control the quality of care delivered to patients and ensure the care is safe. Implementing multiple transitional care interventions have proven to be successful in reducing readmissions.

Readmissions are a significant issue for the elderly and across the country. In particular, readmission significantly impacts older adults related to the likelihood of existing comorbidities and social barriers impacting their ability to manage post-discharge. Additionally, data show that older adults are more likely to have challenges with understanding newly prescribed medications after discharge and therefore are less compliant with medications (Hume & Tomsik, 2014). Older adults are also less likely to follow-up with their primary care physician after discharge (Howard-Anderson et al., 2016). Evidence shows engaging patients and families in a collaborative discharge process is a key foundational element needed to improve patient outcomes and reduce avoidable readmission rates. This quality improvement initiative engaged patients and families in an evidence-based discharge protocol to reduce avoidable readmission and improve medication compliance.

Methods

Theoretical Framework: The Design, Measure, Analyze, Design, Verify (DMADV) Six Sigma methodology was used to create a new process for the organization.

Design: A quality improvement initiative used to design a new discharge process to reduce avoidable readmissions.

Setting: The IDEAL Discharge Protocol pilot occurred on one medical-surgical unit at a 180-bed acute care facility in Silver Spring, Maryland. The Protocol focused on implementing a structured collaborative process that utilized a discharge checklist to track the care team's engagement efforts to include patients and their families in a collaborative care process focused on discussion, education, and post-discharge follow-up.

Sample Size: The QI initiative identified 44 participants for the IDEAL Discharge Protocol.

Measurement: The following measures were used to evaluate the success of the implementation of the IDEAL discharge protocol. 1) Adherence to the IDEAL process, 2) Readmission rate, 3) Medication compliance, 4) Scheduled follow-up appointments, 5) Percentage of IDEAL patients from piloted unit readmitted within 30 days post-discharge.

Analysis: SPSS and control charts were used to analyze and track data trends in 1) The number of IDEAL patients readmitted within 30 days of discharge, 2) The number of follow-up calls placed to IDEAL patients after discharge, 3) The number of scheduled follow-up appointments with primary care providers for IDEAL patients, 4) The number of patients readmitted within 30 days after participating in the intervention.

Results



Forty-four participants engaged in the study. A 4 percent decrease in the pilot unit readmission rate was observed. Before implementation, the readmission rate was 17 percent. After implementation, the readmission rate was 13 percent. Post-discharge follow-up resulted in the completion of 52.2 percent follow-up calls and 45.5 percent follow-up appointments scheduled. Of the 44 participants engaged in the intervention, two were readmitted, resulting in a 4.5 readmission rate for the study participants. Medication compliance was assessed and found to be 93.3 percent and 100 percent of participants received education while engaged in the study.

Objectives

PURPOSE

The purpose of this study was to implement an evidence-based discharge protocol on a medical surgical unit to engage high-risk older adults and their families in a collaborative discharge process to reduce avoidable readmissions over a three-month period.

AIM

- Engage all eligible older adults on pilot unit at risk for readmission in the IDEAL interventions to mitigate their risk for readmission within 3 months of implementation.
- Increase patient and family education practices through the IDEAL process around medications and red flags related to discharge by 100 percent within 3 months of implementation.
- Reduce readmission rates of patients engaged in the IDEAL discharge protocol to less than 5 percent within 3 months of implementation

Limitations

There were limitations that impacted this quality improvement initiative. There was an increase in the COVID-19 patients at the organization where the pilot was implemented, therefore, there was a smaller sample size than anticipated.

The pilot was implemented on one Medical Surgical unit and focused on a specific population older adults 65 years or older. The result were specific to this population and may not be generalizable across a different population.

Medication compliance was assessed for participants during the eight-week implementation; however, pre-implementation data was not available. Further study will be needed to evaluate the impact the IDEAL Discharge Protocol has on medication compliance.

Conclusions

The results indicate that over the course of eight weeks the participants and their families were engaged in a multi-disciplinary collaborative process to prepare them for a successful discharge.

No one singular event had the most influence on reducing readmission but instead it was the combination of multiple activities to reduce readmission rates that proved to be the most successful. The IDEAL Discharge Process combined with other existing measures aided in improving the discharge process to better equip patients with the tools to successful transition home after discharge and return to their preadmission state.

References

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