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Implementing Change to Decrease the Re-admission Rate for Clients of a Care Transition Program

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Prospectus Elements 1-10: Implementing Change to Decrease the Re-admission Rate for Clients of a Care Transition Program

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Clinical Leadership Theme

The clinical nurse leader (CNL) is a "nurse who would provide direct clinical leadership at the point of care, working to ensure that care delivery is safe, evidence-based and targeted toward optimal quality outcomes for the cohort of clients served by the CNL" (Reid & Dennison, 2011, p. 1). The CNL acts as an implementer of change (AACN, 2013). The clinical leadership theme for this project is "care environment manager" (AACN, 2013, p. 41). The clinical nurse leader (CNL) functions as a "team manager", "information manager", and "systems analyst/risk anticipator" (AACN, 2013, p. 38). The transformational leadership model was used during this change project, which is based on "motivating followers, participatory leadership, moral agency, [and] recognition of staff" (Finkelman, 2011, p. 12).

The global aim statement is that we aim to improve the follow-up phone call process to decrease readmission rates for clients in a care transition program. The process begins with assessing the microsystem to determine what the re-admission rate of the care transition program is, and to compare this value with national data. The process ends with implementing an intervention to decrease re-hospitalization, thereby increasing patient safety. By working on the process, we expect to decrease re-admission rates, increase patient safety and satisfaction. It is important to work on this now because patients who are readmitted have decreased safety and quality of life, and because there is a high financial burden on hospitals and Medicare.

Statement of the Problem

This care transition program aids with the transition from hospital to home for adult clients over the age of 18. The care transition program aims to decrease readmission rates for

their clients to a 5% readmission rate. The rate of readmission in the United States is at a critical level (CMS, 2016). Centers for Medicare & Medicaid Services (CMS) defines "readmission as an admission to a subsection (d) hospital within 30 days of a discharge from the same or another subsection (d) hospital" (2016). As part of the Affordable Care Act, the Hospital Readmissions Reduction Program was created, which "requires CMS to reduce payments to IPPS hospitals with excess readmissions" (CMS, 2016). Hospitals are being penalized for excessive readmissions. In addition to the financial burden of readmissions, quality of life is decreased with readmission.

Project Overview

This project took place at a care transition program funded by a county program. The aim of the care transition program is to decrease readmission rates for its clients. The microsystem is composed of public health nurses, volunteers, student interns, supervisors, and an administrative assistant. This care transition program aids with medication management and reconciliation, transit to appointments, social company, and assistance with compliance with the discharge plan. This care transition program is based on Coleman's care transition model of the four pillars of "managing medications, maintaining personal health records and sharing them with providers as needed, having a follow-up appointment with the primary care physician and/or specialist, and knowing the 'red-flags' for their condition – indications that it is worsening- and how to respond" (p. 2). The primary diagnoses for the clients of this care transition program vary. According to a chart audit, the most common primary diagnoses include accidents and unintentional injury, diseases of the heart, chronic pain, diabetes, and disease of the gastrointestinal system. The most common co-morbidities include mental health

diagnoses, chronic pain, substance abuse, and social issues which include incarceration, being conserved, limited English, and social isolation.

This care transition program has already demonstrated success in reduction of re-admission rates since its inception. Chart audits indicate that 6% of the care transition clients in 2011 were re-hospitalized within 30 days, as compared to the national rate of 19% (Gerhardt, Yemane, Hickman, Oelschlaeger, Rollins, and Brennan, 2013). Gerhardt et al. (2013) reported that the national rate in 2012 was 18.4 percent (2013). The aim statement for this change project is to improve patient safety by decreasing readmission rates by implementing an initial follow-up phone call within one day of discharge in 75% of the care transition clients by April 30, 2016. The purpose of this change project is to implement a change to further decrease readmission in this care transition program's clients to increase safety and improve quality of life.

Rationale

An assessment of the microsystem was performed to determine the need for this project. Quantifiable data was obtained through an audit of client charts from 2014 and 2015. In 2014 and 2015, the care transition program worked with 65 clients each year for both years. Chart audits of clients of the care transition program in 2015 indicate that the rate was 8.9% for clients last year. Data from 2014 indicates that the rate was 9.2%. A copy of the data from 2014 and 2015 can be found in Appendix A. The findings from the chart audits were presented to the nurses during the weekly meeting. The nurses were unaware that the rate in 2015 and 2014 was 8.9% and 9.2%, which is an increase from previously reported data. After reading the data compiled during this assessment phase, the nurses stated that they wanted to further decrease the readmission rate.

A SWOT analysis "guides you to identify your organizations strengths and weaknesses (S-W), as well as broader opportunities and threats (O-T)" (Renault, 2016, para. 3). A copy of the SWOT analysis can be found in Appendix B. Strengths of the microsystem include there is buy-in for the change, multidisciplinary teamwork, and proven past success of the care transition program. When the nurses presented with the data, they recognized the need for change. Weaknesses include that there are only two public health nurses with large caseloads. Another weakness is that the nurses work business hours, as opposed to working weekends and 24 hours a day. The capacity of the nurses was a limiting factor. Opportunities include that the program is recognized within the community for having success, minimal costs to maintain the program due to federal funds and funding streams, and hospitals being motivated to work with the care transition program due to being penalized by Medicare for readmissions. A major threat includes late or incomplete referrals and paperwork from the hospitals, resulting in a delay of care and initiation of services.

A process map was utilized to assess the steps of the care transition program services. A copy of the process map can be found in Appendix C. By assessing the steps of the care transition program, potential delays can be determined. Potential delays can occur when the hospital sends the initial referral paperwork, the nurses initiate contact with the client, scheduling and performing home visit, and assigning a volunteer to work with the client. These potential delays indicate a need for change to streamline the process of delivering effective care to clients. This project will address the time in which nurses initiate contact with the client following their discharge.

A fishbone diagram was utilized to determine the causes for readmission. A copy of the fishbone diagram can be found in Appendix D. Possible causes include professionals, process,

referrals, and patients. Contributing factors to the professionals cause include that there is limited staff with large caseloads. Contributing factors to referrals included incomplete or untimely referrals and high acuity clients being referred. Contributing factors to process include that the standard practice is that a follow-up phone call to initiate services occurs within two to three days. Contributing factors to patients include high acuity clients with multiple co-morbidities being referred and that clients may be non-compliant in their health care.

Further assessment of the microsystem comprised of reviewing the clients who were re-admitted. Through an assessment of the clients who were readmitted to the hospital within 30 days in 2014 and 2015, it was determined that 6 of the 9 clients had their initial phone call after one day of discharge, supporting that a change is necessary with this process. Through the analysis and assessment of the microsystem, it was determined that a step that needed change was the process in which the initial follow-up phone call after discharge was made. Current practice of this care transition program is to initiate the first follow-up phone call within three days. The intervention of this change program to initiate the follow-up phone call within one day of discharge is based on research by Melton, Foreman, Scott, McGinnis, and Cousins (2012), which states that the patients who received a follow-up phone call within one day had a "22% relative reduction in all-cause readmissions" in comparison to those who received a follow-up call within two days (2012, p. 838).

Analysis of the costs further indicates a positive outcome through an implementation of change. The business costs to implement this change project is minimal, as what is planned to be change is already being done. The change project will be to implement a call and start of the care transition services within a day of discharge for clients. Current practice is to call a client within three days of discharge. The change will be to expedite the call to one day as opposed to

three days. Research has indicated that a follow-up within one day of discharge results in decreased re-admission rates (Melton, Foreman, Scott, McGinnis, & Cousins, 2012). As nurses are already making these initial phones calls to clients, this change project does not increase the work of the nurses. This means that there is no extra cost associated with this change.

According to the State of California Office of Statewide Health Planning & Development (2015), the cost of an emergency room visit is $1,800 and a medical/surgical bed is $6,381.72 per night at the local hospital. Per the National Hospital Discharge Survey (2015), the average length of an inpatient stay is 4.8 days. Using this data, the approximate cost of hospitalization is $32,432.25. Due to the Medicare penalty for readmission, this number demonstrates the savings per client who is not readmitted due to their services. Reduction of readmissions is pivotal in decreasing costs. A copy of the savings per care transition program client who is not readmitted can be found in Appendix E.

This change project focuses on initialing the follow-up phone call of potential care transition program clients within one day of discharge. An analysis of the microsystem has confirmed that this change project is necessary and will be beneficial to the clients of this care transition program.

Methodology

Through the utilization of Kotter's Eight Steps of Change, initial follow-up phone calls will be made within one day of discharge in 75% of clients by April 30, 2016. Kotter's theory is comprised of eight steps that must be taken in order to guide change (Kotter, 2007). In Kotter's theory, the first step is having others recognize the need and to "establish a sense of urgency" (Kotter, 2007, p. 99). A sense of urgency was created by presenting the nurses with the data indicating that the readmission rates had increased from 2011. Subsequent steps included

recruiting a team of influential leaders, creating and communicating the vision, and removing obstacles (Kotter, 2007). This change project was discussed with the supervisors of the care transition program to determine any barriers or concerns. During weekly meetings, the vision of the change project was shared and supporting research articles were presented to the nurses through discussions.

In addition to providing information to the nurses, the administrative assistant was included in the education and weekly meetings. The role of the administrative assistant is to receive the referrals, follow-up on any missing documentation, and open the case files for the nurses. The administrative assistant will aid with streamlining the process of the initial phone call by opening the case files for the nurses as soon as the referrals are received. If there are missing files, the administrative assistant will contact the hospitals concurrently. Previously, the cases were not opened until all the paperwork was received, resulting in a delay of care.

In creating the action plan, the next step is to devise short-term attainable goals, followed by planning for long-term improvement. The final step of Kotter's theory is to ensure that the changes made become part of the culture of the microsystem. Follow-up phone calls within one day of discharge will be implemented through Kotter's theory and these eight steps.

Once the change has been implemented, the role of the CNL is to assess and determine any barriers to the change. Any barriers or issues will be addressed during the weekly meetings. Following the implementation, the effectiveness of the change project will be evaluated. This will be performed through an audit of current care transition program clients between the months of March and April 2016. The evaluation will assess if the clients were contacted within one day of discharge. The goal is that the nurses will initiate this phone call in 75% of clients.

A long-term goal of this change project is to decrease readmission rates to 5% of the care transition program clients. As the services last between four to six weeks, it is not possible to assess the readmission rate during the length of this current change project. It is predicted that through the implementation of this change, the readmission rate will decrease to 5%. Further evaluation is necessary in April 2017 to determine the long-term effectiveness of this change project.

Data Source/Literature Review

Information for this change project was gathered through chart audits from 2014 to 2015. This is appropriate for this project because it provides information for comparison. Prior to the implementation of the one day post-discharge phone call, the phone call was made within three days. The readmission rate of 2014 and 2015 is used to compare the rate of the three day phone call in comparison to the one day phone call.

A PICO search statement was developed to aid in finding literature to support the change project. The patient/population statement was adults who are eighteen and older who have been discharged from the hospital. The intervention statement was transitional care from hospital to home provided by the care transition program, providing assistance with medical reconciliation, transportation, assistance with paperwork, and connection to resources. The comparison statement was if no transitional care was provided. The outcome statement was a decrease of re-admission rates for all clients of the care transition program. Using these statements, a search to find literature to support the change was performed.

This project is necessary to decrease the amount of readmission in order to increase patient safety. Clients who are not readmitted are more satisfied than those who are. According to Gu, Gai, and Hay (2008), those who are satisfied with their care are more like to be compliant

with their medication. This results in increased safety for those who are not readmitted. In addition this project is necessary as high rates of readmission results in penalties to hospitals. The Readmission Reduction Program (HRRP) of the Center for Medicare & Medicaid Services penalizes the hospitals in which there are high rates of re-hospitalizations of patients within 30 days of discharge (CMS, 2016). These hospitals will receive reduced payments for "excess readmissions" (CMS, 2016). All clients who have been discharged from the hospital are served by this care transition program, including those with the measured diagnoses of chronic obstructive pulmonary disease, heart attack, heart failure, pneumonia, cerebrovascular accident, coronary artery bypass graft surgery, and hip and knee replacements (CMS, 2016).

According to Jencks, Williams, and Coleman (2009), the estimated "cost to Medicare of unplanned rehospitalization in 2004 was $17.4 billion". This care transition program provides care coordination for its clients. Hernandez et al. (2010) states that "care coordination is important in preventing readmission".

This project was based on research articles that stated that readmission rates were decreased with a follow-up phone call. Harrison, Hara, Pope, Young, and Rula (2011) stated that post-discharge follow-up phone call decreases the rate of re-admission. Jackson, Shahsahebi, Wedlake and Dubard (2015) stated that high-risk patients with multiple co-morbidities who have had a "follow-up within seven days was associated with meaningful reductions in readmission risk". Those individuals who received a follow-up call within 14 days of discharge also demonstrated a reduction in re-admission, although not as significant as those who received a call within seven days (Jackson et al, 2015). Furthermore, Melton et al. (2012) state that the patients who received a follow-up phone call within one day had a "22% relative reduction in all-

cause readmissions" in comparison to those who received a follow-up call within two days (p. 838).

Timeline

This change project began in January 2016 and will conclude in April 2016. The implementation of change will occur over the course of four months. A copy of the Gantt chart depicting the timeline can be found in Appendix F. The project began with an assessment of the microsystem with spanned from January until March 2016. The assessment of the microsystem included chart audits of clients from 2011, 2014, and 2015. The public health nurses, supervisors, and an administrative assistant were interviewed to determine any concerns and change needed in the microsystem. Leaders were recruited to aid with the implementation. During February and March 2016, education was provided to nurses regarding the importance of implementing the one-day post-discharge follow-up phone call. Education was also provided at this time to the administrative assistant regarding streamlining the process of opening the charts. The intervention to make the initial phone call with prospective clients within one day of discharge was implemented in mid-March. Following implementation, feedback was elicited from the nurses to determine any concerns or barriers to the intervention. The set goal will be that 75% of the care transition program clients are contacted within one day of discharge by April 30, 2016.

Expected Results

The expected long-term result is that there will be a decrease in hospital readmissions amongst the care transition program clients. As these results will not be evident until outside of the timeframe of this change project, my expected result is that 75% of clients will be contacted within one day of discharge. There is buy-in from the nurses, as they stated that they would like

to decrease readmission. As such, I expect that my aim is attainable. The results will be reported to the nurses in the microsystem via tables indicating the percentage of clients that were contacted within one day. Possible conclusions that can arise from this study may be that there are outside factors that prevent this change from occurring. Nurses have voiced concerns that there are many external barriers to implementing this change, including the timeliness of referrals. The time issue will be addressed by the administrative assistant opening the client charts for the nurses to begin services concurrently with requesting additional information from the hospitals. Previously, the administrative assistant waited until all information was received from the hospital prior to opening cases. By performing these tasks concurrently, time will be saved. Further evaluation is necessary to determine if these expected results are impacted by these external barriers.

Nursing Relevance

By decreasing the readmission rate by implementing a one day post-discharge follow up phone call, this project has the potential to make significant contributions to nursing. This care transition program was amongst the first care transition programs in the nation when it was founded. It has been a pioneer in care transition and decreasing readmission rates. Using the information gathered in this study, this care transition program can improve other care transition programs. This would contribute greatly to clients who have been discharged from the hospital, resulting in decreased readmissions and increased safety and quality of life. Patient safety programs, such as this care transition program, exhibit the nursing ethical principle of beneficence, which is the "core principle of doing good and patient advocacy" (Phang, 2014, para. 4). This care transition program's aim is to best serve its clients and increase their quality of life.

Summary Report

At a current readmission rate of 8.9% in 2015, this care transition program has already demonstrated success in decreasing readmissions in the community. The national readmission rate in 2012 was 18.4% (Gerhardt et al., 2013). The aim of this change project was to improve patient safety by further decreasing readmission rates through initiating a follow-up phone call within one day of discharge in 75% of care transition clients by April 30, 2016. Current practice was for clients to be contacted within three days of discharge. The long-term aim of this change project is to decrease readmission rates. This goal cannot be measured until April 30, 2017, as these clients have not finished their care transition program services. In addition, a majority of these clients are still within the 30-day window that Medicare considers a readmission if re-hospitalized during this time frame (CMS, 2016).

The methods used to implement this change project were consistent with the planned methods. Education was provided to those in the microsystem regarding the importance of implementing this change. This increased the buy-in from the nurses, to ensure that they would participate in this project. Weekly meetings were held with the nurses to discuss any concerns or barrier to this change. In addition, education was provided to the administrative assistant on techniques to streamline the process of opening charts sooner. Previously, the protocol was for the administrative assistant to open the charts after all the paperwork was received. The administrative assistant was educated on opening the charts for the nurses to begin the follow-up call, while concurrently contacting the hospital for additional information. During the evaluation phase, the nurses reported that process was effective in streamlining the charts. This negated the wait time to begin services for a client after discharge.

Twenty-one clients accepted services from the care transition program. During the "study" phase of the PDSA cycle in which results of the intervention are evaluated, the chart analysis indicated that 71.4% of clients that accepted services were called within one day of discharge (AHRQ, 2013). A copy of this table can be found in Appendix G. This result does not meet the stated aim of 75%. These results indicate that there are possible improvements to be made.

An analysis was done of the reasons why clients did not receive a follow-up phone call within one day of discharge. This table can be found in Appendix H. Initial concerns from the nurses were that services were delayed due to incomplete referrals without discharge paperwork. With one client, the skilled nursing facility did not provide the care transition program with information on how to contact the patient. This was an example of one of the anticipated reasons for delay of care. Following the evaluation of the outcome, it was evident that there were other factors to delay of the follow-up phone call then incomplete referrals and charts.

Through an analysis of the data of those who were not contacted within one day of discharge, four of those six clients were not contacted because the client was discharged on Friday. Due to the fact that the program is open during business hours, there was no nurse to begin services for these clients until the following Monday. This program does not have the capacity to serve clients on the weekend. This threat was anticipated during the SWOT analysis, that the limited capacity and business hours would be a threat. A copy of the SWOT analysis can be found in Appendix B. In another situation, the referral was not made until after the client was already discharged. This is another example of an external factor that delayed the initiation of services.

The change intervention in this project was determined by an analysis of the microsystem, including multiple interviews of the nurses. The nurse believed that the reason why there was a delay in the follow-up phone call was because of incomplete referrals. Upon evaluation of the change, it was determined that there were other additional external factors that influence this process. Moving forward, to further improve the program and decrease the readmission rate, the microsystem would benefit from further PDSA cycles to address changes necessary to address the other reasons for a delayed follow-up phone call after one day of discharge (AHRQ, 2013). Future change projects will focus on methods to increase the timeliness of the referrals. Multidisciplinary team collaboration will be facilitated by the CNL in the role of "team management collaboration with other health professional team members" (AACN, 2013, p. 36). The multidisciplinary team will be comprised of the care transition program team, as well as case managers and social workers from local hospitals. This will increase the timeliness of the referrals to increase the percentage of follow-up calls made within the first day of discharge.

The goals of this change project were in line with the goals of the microsystem. There was buy-in from those in the microsystem, which was comprised of public health nurses, supervisors, volunteers, student interns, and an administrative assistant. As such, there was cooperation with this change project. The nurses have been invested in the change because they all share the same goal of decreasing readmissions. The buy-in from the nurses increases the sustainability of the one day follow up call. Standardization will also occur through repetition as the nurses have been implanting this change for the past two months.

Kotter's Eight Steps of Change was used to implement this intervention. In creating the action plan, a step was to devise short-term attainable goals, followed by planning for long-term

improvement (Kotter, 2007). Although the goal was not fully reached, the outcome was close to the short-term goal. By attaining short-term goals, nurses are more motivated to continue the change. Nurses were impressed by their ability to perform the initial phone call within one day of discharge in 71.4% of the clients who accepted services. Closely reaching the short-term goal continues to motivate the nurses and they are more likely to buy-in to the continuing change. The final step of Kotter's theory is to ensure that the changes made become part of the culture of the microsystem and is sustainable (Kotter, 2007). The aim of this final step is to ensure the continued success of the change through appointment of effective leaders and that positive outcomes are sustained through continued promotion of the change (Kotter, 2007). A leader in the microsystem, a senior public health nurse, has been a champion for the change, which ensures its sustainability. Through continued support and promotion of the change, it is anticipated that this change intervention will be sustained. Through sustaining this change intervention, it is anticipated that the long-term goal of 75% of the clients contacted within one day of discharge to decrease the readmission rate to 5% by April 30, 2017 will be successful.

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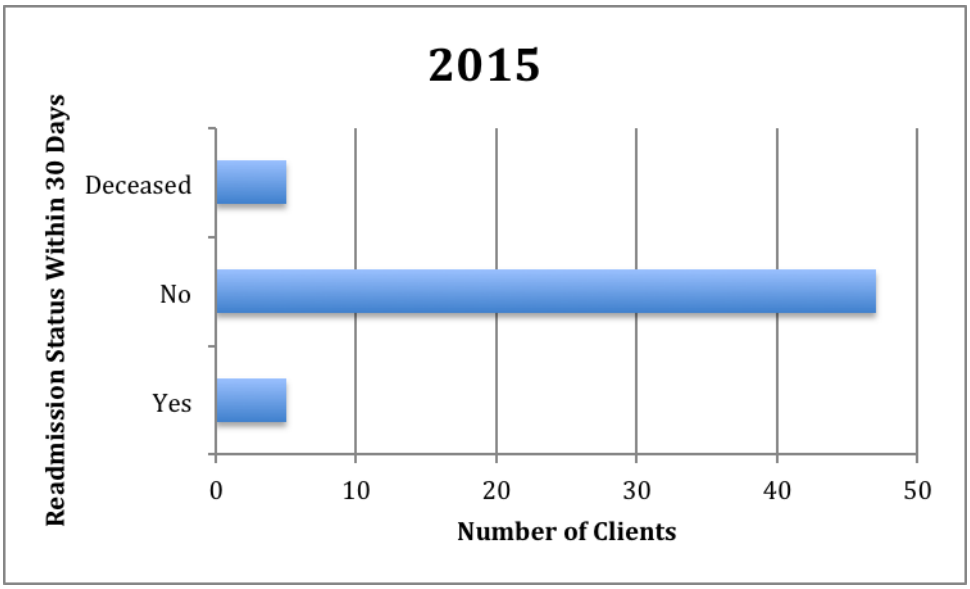
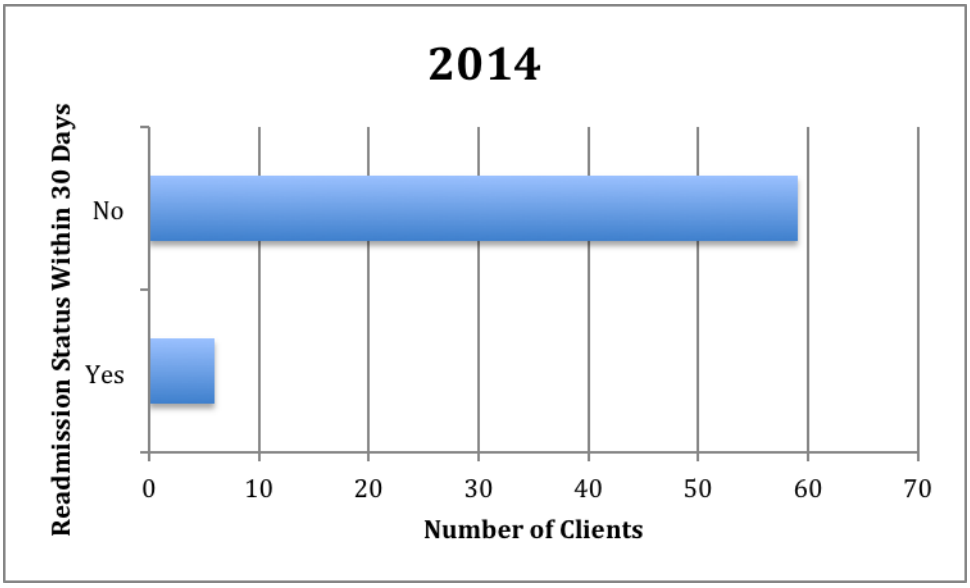
Appendix A

30 Day Readmission Data for 2014 and 2015



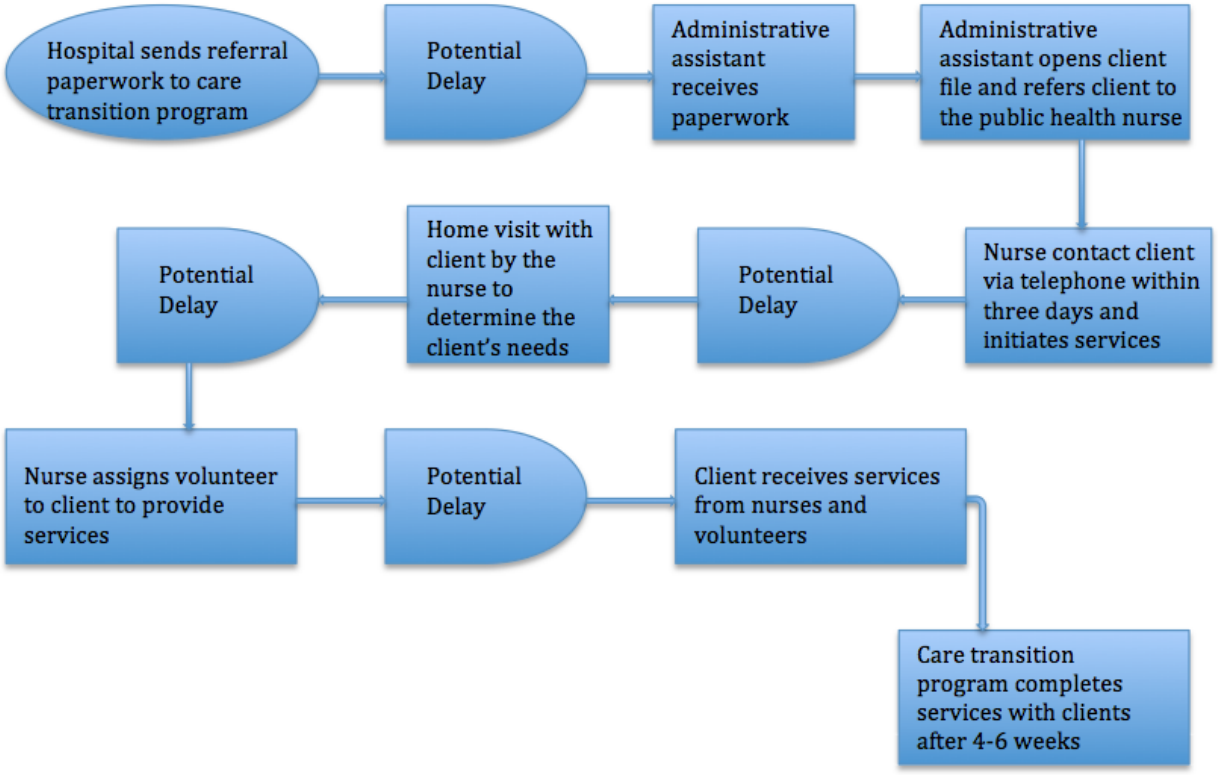


Appendix B

SWOT Analysis

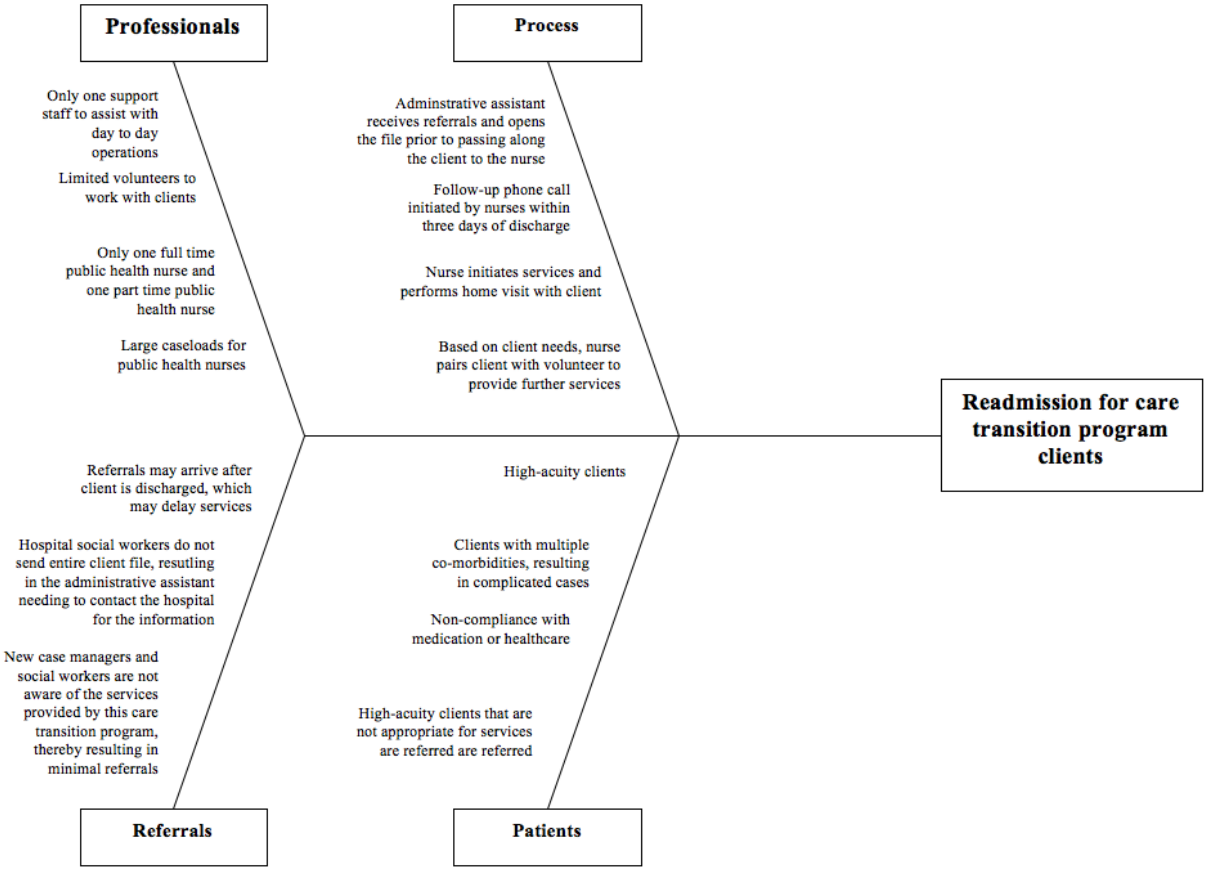
Appendix C

Process Map – Flow Chart



Appendix D

Root Cause Analysis – Fishbone Diagram



Appendix E

Savings Per Client Who is Not Readmitted Due to Care Transition Program Service

Potential Costs for Re-admission	Average Cost	Savings by Preventing Readmission
Emergency room Visit	1,800	1,800.00
Stay on Medical/Surgical Unit per night (Average length of stay = 4.8 nights)	6,381.72	30,632.26
Savings Per Client		**32,432.26**

Appendix F

Timeline

	January 2016	February 2016	March 2016	April 2016
Diagnosing problem - assessment of the microsystem: chart review				
Diagnosing problem - assessment of the microsystem: discussion with public health nurses, supervisors, and administrative assistant regarding any concerns or barriers to providing care to clients				
Create urgency and recognize need for change				
Recruit leaders, including public health nurses and supervisors, in the microsystem to aid with the change implementation				
During weekly meetings, share the vision with public health nurses re: importance of initiating contact with potential clients within one day of discharge to decrease readmission rates				
During weekly meetings, share the vision with administrative assistant re: importance of initiating contact with potential clients within one day of discharge to decrease readmission rates				
During weekly meetings provide education to public health nurses regarding the change project				
Begin implementation of calling prospective clients within one day of hospital discharge				
During weekly huddle, address any concerns or barriers to nurses making phone call within one day of discharge				
Continued education and promotion of the change to providing a follow-up phone call within one day of discharge				
Evaluation of effectiveness of change project by evaluating the percentage of clients called within their first day of discharge				
Set goal of 75% of care transition program clients being contacted within their first day of discharge				

Appendix G

Clients Called Within One Day of Discharge

YES	**15**	**71.43%**
NO	6	28.57%

Appendix H

Reasons Why the Client Did Not Receive a Follow-up Phone Call One Day After Discharge

Reason	Number of Clients
Friday discharge and referral	4
Missing discharge paperwork	1
Referral received after discharge	1