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Community Transitions of Care for Hospital Readmission Prevention

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UVM DNP Class of 2023

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Abstract

Background: Transitions of Care (TOC) occur whenever an individual moves from one healthcare setting to another. Older adults are higher utilizers of healthcare services, including inpatient and emergent visits, than the general population (Tian, 2016), and thus experience more TOCs. Due to risk of poor outcomes at discharge from the hospital, rehospitalizations are a concern. Standardized TOC protocols have been shown to be beneficial in reducing rehospitalizations for this vulnerable population.

Purpose: Use current best practices to design and implement TOC for a rural community organization to reduce unintended rehospitalizations for older adults.

Methods: Best practices in TOC were assessed, formalized, and informed the intervention.

Patients from three local hospitals were evaluated inpatient for TOC services. Registered nurses implemented TOC visits within 24 -72 hours post discharge, and completed a in-home care plan with need for additional followup. Clients were followed for 60 days following discharge for any unintended hospital events.

Results: 31 patients were referred for TOC. 21 were deemed appropriate referrals and 9 (42%) consented to the TOC visit. 2 patients (22%) of those who received TOC had an unintended hospital event within 60 days of discharge.

Conclusion: Implementation of TOC services post hospital discharge has a beneficial effect on reducing readmission and emergency visits for older adults in the short term

Keywords: transitions of care, older adults, rehospitalization

Introduction

Problem Description

Rehospitalization after a recent hospital discharge is a major detriment to patients, especially for older adults. There are multiple factors that can lead to rehospitalizations: hospital discharge prior to adequate stabilization of the patient; discharge to an environment that cannot appropriately support the patient and their care needs; and worsening of patient's health status due to poor supervision, inadequate care management upon discharge or issues beyond the control of the patient (Dinerstein, 2022). Transitions of care (TOC) are defined as “the movement of a patient from one setting of care to another. Settings of care may include hospitals, ambulatory primary care practices, ambulatory specialty care practices, long-term care facilities, home health, and rehabilitation facilities” (Chartbook, 2016, p.1).

For older adults, many of whom have multiple chronic conditions that require complex therapeutic interventions across multiple settings, high-quality TOC play a vital role in the prevention of rehospitalizations. Inadequate handoff from hospital to home for older adults has also been linked to adverse events, dissatisfaction with care, and high rates of rehospitalization (Naylor & Keating, 2008). Addressing readmission concerns is a concerted effort between many parts of the healthcare sphere including doctors, nurses, social workers, pharmacists, and community health workers, to provide effective discharge education in the hospital and TOC services provided by community resources.

Available Knowledge

TOC are both risky and necessary for patients to progress from an acute medical event to long-term medical management. Potential risks to patient well-being include infection, potential adverse events, fall risk, and accidental injury (Glans et al., 2020). In 2018 there were 3.8 million hospital readmissions that occurred within 30 days of discharge, 2.3 million (60%) of which

involved Medicare beneficiaries (Weiss & Jiang, 2021). Multiple comorbidities, recent prior discharges, medication changes, polypharmacy, age of the patient, and the length of time the patient spends in the hospital are all risk factors for rehospitalization (Glans et al., 2020). These readmissions can cost anywhere from \$10,900 to \$16,400 with or without insurance, with an average cost of \$15,200 (Weiss & Jiang, 2021).

In the United States, older adults are more than twice as likely to need hospitalization than middle-aged adults and nearly 70% of them require post-acute care services with home health or skilled nursing facility at discharge (Tian, 2016). When hospital staff are planning for patient discharge, considerations for medication management, functional and nutritional needs, equipment needs, and medical care management are required.

There is evidence that a multifaceted approach to transitional care is more beneficial to reducing readmission rates than singular focused approaches (Finlayson et al., 2018, Alper et al., 2021). In a meta-analysis and systematic review of 60 trials, Becker et al. (2021) found that effective patient and provider communication interventions had several benefits including reducing hospital readmissions, increasing patient satisfaction with care, and increasing treatment adherence. In relation to transitional care, communication between the patient and their discharge team may be shared with a community organization who can further support and encourage the patient following discharge. Altfeld et al. (2012) completed a randomized control trial that compared an enhanced discharge planning program (EDPP) and traditional discharge planning. EDPP included telephone calls, collaboration with other healthcare professionals, and supportive services for patients. Traditional discharge planning did not include any post-discharge care or phone calls. The researchers found that telephone calls in the post-discharge period could be beneficial for at risk older adults, by addressing unmet needs such as those who

required home health, needed medication reconciliation, or managing more subtle issues that may present during this time, such as mental status changes, caregiver burden, and poor coping. This suggests that multifaceted approaches to TOC like EDPP may help identify and address unmet needs and thus reduce rehospitalization rates. Home visits have also been shown to be beneficial for reducing readmission and improving transitions of care in addition to phone calls and telehealth video visits (Alper et al., 2021). Noel et al. (2019) found that while the use of telehealth in TOC may not have had a notable effect on ED visits or rehospitalization, it did suggest an improvement in patient involvement and motivation in their care following discharge.

Problem Statement

Presently, an area agency on aging in a rural Northeastern state with the goal of helping older adults age in place, has not been able to provide TOC services for their patients in several years. Completion of TOC visits was hindered by staffing shortages, financing, and the COVID-19 pandemic. The organization is now committed to once again implementing these services for their patients and has been approved for a grant to help bring TOC back under their umbrella of services. The organization's goal is to have registered nurses (RN) develop and initiate an updated TOC protocol which will ideally include a home visit, post-discharge planning and follow up.

Rationale

The Transitional Care Model (TCM) is a nursing focused model that aims at "improving the care of high-risk, high-cost, and high-volume patient groups" (Meleis, 2010, p. 459). Older adults who are chronically ill are one of these patient groups. When the healthcare needs of older adults, especially those with multiple chronic conditions, are unmet or poorly managed, they are at risk for more negative health and financial consequences (Hirschman et al., 2015). Nurses are

uniquely qualified to improve TOC because they work directly with patients as they transition throughout the health system, from inpatient units to community settings and in long-term care. Due to the often deep and personal connections developed between nurses and patients, they are also well attuned to identify barriers or concerns in the transition and address them (Camicia & Lutz, 2016).

Specific Aims

The project was focused on the older adult patient population deemed most at risk for rehospitalization from October 2022 – January 2023. The primary aim of this quality improvement project was to enhance TOC services within a rural agency on aging. This was achieved through two aims:

1. Developing and implementing a best practice TOC protocol for the RN who would be providing the services.
2. Reduce readmission rates through the use of TOC services.

Project benchmarks included providing 100% of referred patients with TOC services with at least 50% of those patients not requiring an unintended hospitalization for 60 days following discharge.

Methods

Context

Vermont is home to an estimated 528,803 adults, with approximately 133,173 (20.6%) of that population over the age of 65 years of age (US Census Bureau, 2020). The project site is an aging in place organization that assists patients who are 65 years of age or older and those 18 or older with a disability. Services include Meals on Wheels, in-home care, and assistance obtaining community resources. The organization also assists with insurance to help patients understand

their options with Medicare and provides medication reconciliation services for recently discharged patients. The organization utilizes an electronic notification system which sends an alert when a patient is seen at the hospital as well as when they are discharged or admitted from the emergency department.

The organization was already in the process of obtaining a grant for expansion of TOC services in Spring 2022. Stakeholders identified a lack of proper staffing, financial limitations for funding TOC, as well as the COVID-19 pandemic as barriers to reinstating this valuable service. The RN and Director of Care and Service Coordination (DCSC) received support for this expansion in services from three local hospitals case management teams. The organization aimed to utilize this grant to not only update their TOC services, but also add on new nursing staff to expand the organization's TOC reach.

Intervention

Review of previous transitional care practices were assessed for utilization in collaboration with RN site mentor and DCSC. The Doctor of Nursing Practice (DNP) student conducted a literature review to assess current best practices to direct creation of an improved TOC workflow. The main interdisciplinary team consisted of a DNP student, two RN as well as the DCSC. Additional healthcare staff including case managers from three local hospitals, and case managers from the organization also provided referrals, but were not involved in the creation of the updated TOC guidelines.

Multiple TOC guidelines and best practice were explored and evaluated for feasibility for the organization. TOC protocols were evaluated based on the intended population, financial costs, and applicability of the TOC guidelines to current workflow. The DNP student researched multiple TOC guidelines and best practice as well as relevant literature, which was relayed to

the RN site mentor and DCSC for consideration, utilizing their prior experience in TOC.

Additional research by the DNP student explored and identified diagnosis of interest for patient events. These diagnosis included: hypertension, fall with injury, COVID-19, chest pain, weakness, congestive heart failure (CHF) and chronic obstructive pulmonary disease (COPD).

The organization opted to create their own TOC guidelines, following best evidence from research shared by the DNP student. An in-home client care plan was filled out during the initial TOC visit. This involved taking the patient discharge paperwork and organizing it for ease of use. At this visit, the TOC RN completed a medication reconciliation and an action plan if relevant to the patients diagnosis at discharge. At the conclusion of this first visit, the patient and TOC RN established the need and modality for further communication, either via phone calls or in person visits. Once the initial visit was completed, the patient was monitored for 60 days for an unintended hospital event, defined as either an emergency department visit or emergent hospital admission related to the previous hospital admission.

At the completion of the patient's monitoring period (60 days) an anonymous voluntary patient satisfaction survey, which was created by the DNP student with feedback from the TOC RN and DCSC, was mailed to all patients who received a TOC visit.

Study of the intervention

TOC referral for home visits following discharge began on October 1, 2022. During this time the organizations current notification system would alert the TOC RN when a patient was emergently admitted to the hospital, their diagnosis at admission, and a potential discharge date. In addition, case managers from 3 local area hospitals who had been notified of the new TOC offering, could send in referrals for patients who were not already involved in the organization's other programs, but could benefit from a TOC visit following discharge.

Monthly meetings between the DNP student and site mentor/TOC RN were utilized to discuss progress of the intervention, including number of referrals, number of visits, as well as discussing what parts of the intervention could use an improvement, utilizing the FADE model. Subjective data from the patients was analyzed using the 60-day post survey to gather valuable insights and comments for future improvement

Utilizing the Focus, Analyze, Develop, Execute (FADE) model for quality improvement was applied to the development of the intervention and TOC workflow (Methods of Quality Improvement, n.d). It's cyclic nature allows for regular reassessment of practice in order to drive further improvement both during measure creation and following initiation of the measure, which is vital for improvement of healthcare processes.

Over the summer, several informal meetings were held between the DNP student, RN site mentor and DCSC to discuss intervention creation and realistic expectations of the intervention and goals for implementation. Monthly meetings began in October 2022 following initiation of the new protocol between the DNP student and TOC RN/site mentor. During these meetings, current intervention numbers, including number of referrals, number of patients who consented or didn't consent were shared. Additional information discussed included a FADE review of the intervention including what seemed to work well and what could be improved upon in the next month. This led to modifications with the intervention such as the addition of the TOC RN meeting appropriate referrals at the bedside prior to their intended discharge date with the goal of improving consent for a visit, which began in January 2023 and the addition of weekly meeting with hospital case managers to help encourage appropriate referrals to the organization, which began in February 2023.

The patient satisfaction survey was designed to be anonymous and provided an opportunity for patients to share their feedback and experiences about the TOC visits to inform future improvements. The organization sent the survey in the mail to help encourage completion of the patient satisfaction survey in the comfort of the patient's home.

Measures

Definition of Terms

Home Client Care Plan: To be completed in collaboration with the TOC RN and patient within 24-48 hours of discharge. Completed with every patient who received a TOC visit from the organization.

Patient Action Plan: completed by the TOC nurse at the initial visit to aid the patient with medical self-management following a recent discharge from the hospital.

Patient satisfaction survey: This was a 6 item anonymous, open- ended questionnaire created by the DNP student and mailed to patients t0 days after their initial TOC visit.

Analysis

Results for post-intervention rehospitalizations were analyzed with Microsoft 365 Excel (Microsoft Corporation. 2018) Number of referrals for TOC visits, number of appropriate patients, number of consenting patients and number of declined patients were assessed for frequency of potential referrals vs. actual visits, then compiled to included percentages of referrals completed compared to those who were deemed appropriate. The patient satisfaction survey using frequencies and open-ended feedback was analyzed for common themes related to patient perspectives of the intervention.

Ethical Considerations

The proposed activity did not meet the federal regulatory definition of research requiring IRB review and approval. Therefore, this research does not require IRB review and approval. Patient participation in the TOC visits was completely voluntary.

Results

Figure 1 details the overall process of initiating transition of care services and the TOC process following discharge. From October 1, 2022 to February 28, 2023, a total of 31 TOC visit referrals were submitted to the organization, with 21 patients (70%) deemed appropriate to receive a TOC visit (see Figure 2). Within month referral distribution is found in Table 1. Of these 21 referrals a total of 9 TOC visits were completed. Of the remaining 12 referrals; 2 patients declined or did not respond to the organization to set up the TOC visit, 9 were discharged with home health services or to long term care, and 1 potential referral was deceased. Two (22%) patients who received TOC had unintended hospital events, with one of these patients requiring a rehospitalization (see Figure 3). Post hospital discharge diagnoses are found in Figure 4. As of February 28, 2023, there have been no responses to the anonymous patient survey.

Discussion

Of the patients referred and eligible for TOC services only 29% (n = 9) of patients agreed to a TOC visit after discharge, falling short of the goal of 100% of referred patients receiving a TOC. Figure 2 shows the breakdown of referrals, including total number of referrals and number of consents from October 2022 to February 2023. The second benchmark that at least 50% of those where eligible for a TOC visit did not experiencing an unintended hospital event within the 30 and 60 day time frame was successful with 7 (77%) patients avoiding an unexpected hospital

event. Two patients (25%) who received a TOC visit presented to the hospital less than 30 days after discharge, one patient required only an ED visit, and one patient required a rehospitalization. Figure 3 displays the events for the consenting patients during the course of the project. Of these two events, one event was precipitated by a health emergency related to their initial hospitalization diagnosis. The other patient's event was not related to their initial diagnosis. Figure 4 displays the breakdown of the most common hospitalization diagnosis for those who consented to a TOC visit, with COPD and diabetes mellitus (DM) being the most common diagnosis of consenting patients.

Communication with the organization was a major strength of this project, with regular contact between the DNP student and site mentor. The organization was motivated to create this new protocol, thus increasing the likelihood of success. During monthly discussions with the TOC RN/site mentor there was limited communication between the organization and participating hospitals, especially in the first few months of offering visits. This occasionally led to lack of patient visit within the 24-to-48-hour timeframe. This included a patient receiving a TOC visit despite being set up to receive home health services or a patient would be discharged and would not respond to the organization for their TOC visit. This was discovered during the first month of the intervention, with subsequent months involving additional education to the participating hospitals on who should be referred to the organization for TOC.

Feedback from patients could not be analyzed due to a lack of survey responses. Potential lack of response could have been due to utilizing a mailed survey vs. an online or phone survey. Patients may not have been interested in completing the survey at the conclusion of their 60 days. Patients who opted to decline the TOC visits were not followed after discharge and comparison

between unintended hospital events for those who did consent to the TOC visit vs. those who declined the TOC visit could not be evaluated.

Interpretation

There was limited completion of TOC visits during the 5-month collection period. While not every eligible patient received a TOC visit, 7 patients (77%) who consented, did not have an emergency department visit or unexpected hospitalization within 60 days of discharge, while 2 patients (22%) did experience an unintended hospital event and rehospitalization. These findings appear to correlate with similar results from Altfeld et al. (2012) which suggested that TOC benefits at risk older adults and help identify concerns that may not have been present at discharge. Presumed barriers to patients consenting to the intervention included lack of knowledge about the service and what it entailed, concern for COVID-19, and/or having a stranger in the home.

Limitations

Several limitations were identified during the intervention. A small group (n=30) of individuals were identified as being appropriate for a TOC visit with an even smaller group consenting to receive a TOC visit (n=9). Referrals and communication between the organization and local hospitals was limited at times. During the implementation period various modalities to improve communication were discussed and trialed, however the effect of these modalities is unknown at this time. Only two nurses were available for TOC visits, limiting reach and the number of visits that could be completed on any given day. In addition, the large geography of the intervention setting restricted the number of visits that can be reasonably completed in a day. Finally, not all referred patients consented to a TOC visit, which may be attributed to patients not

receiving more information about the service until just prior to discharge or disinterest in the protocol.

Conclusions

Transitions of care are valuable interventions to help mitigate the risk of rehospitalization for older adults. Formalizing transition of care within an agency of aging was successful in reducing short term 60-day rehospitalizations. Identified barriers and areas for improvement were needed for inpatient coordination of TOC services to avoid a patient from receiving multiple TOC services (or none) upon discharge. Future goals for TOC could consider expanding TOC services to other agencies of aging in the area, incorporation of diagnosis informed TOC services that directly address the needs for patients with the most common diagnosis. Future analysis should include assessment of mortality for 90 days following a patient's discharge and a patient's rehospitalization status to align with Medicare goals in the prevention of readmissions. Overall, this DNP project further supports current best practice and provides a foundation for future rehospitalization prevention for older adults.

Other Information

Funding

No source of funding from the educational institution was used to complete this QI study.

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rivate%20insured%20stays](#)

List of Tables

Table 1

Breakdown of Transition of Care Referrals to the Facility by Month

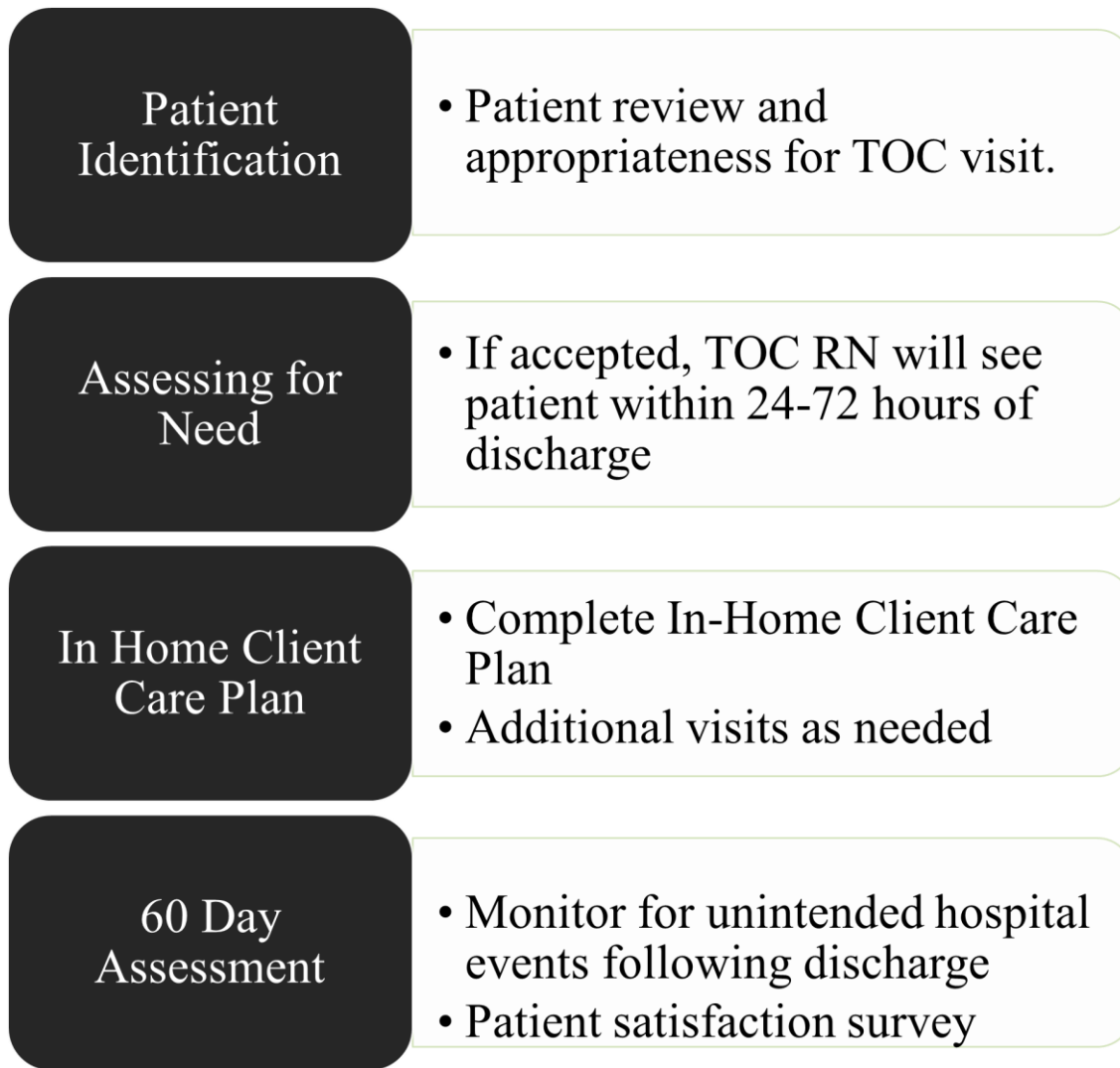
Month	Referrals Initiated (n)	Met criteria (n)	Consented to TOC (n)	Declined TOC (n)	Engaged in TOC services (%)	Post Hospital Discharge Events (n)
Oct	5	4	3	1	74	0
Nov	6	3	1	2	33	0
Dec	5	5	1	4	20	1
Jan	4	4	1	2	25	3
Feb	11	5	3	2	60	0

Note. Percentage of referrals are calculated using the number of those who met criteria to Transition of care (TOC) services and number of those who consented to a TOC visit.

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Figure 1

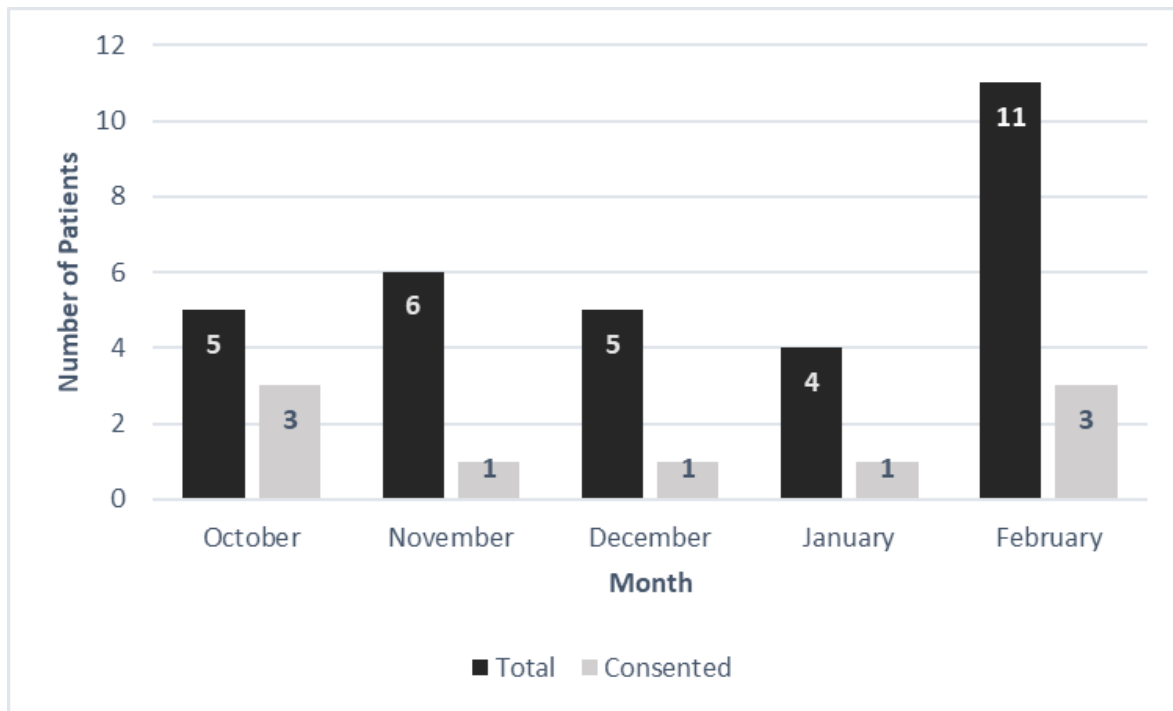
TOC Referral Process



Note. Protocol that TOC nurses followed from referral to discharge and home visit.

Figure 2

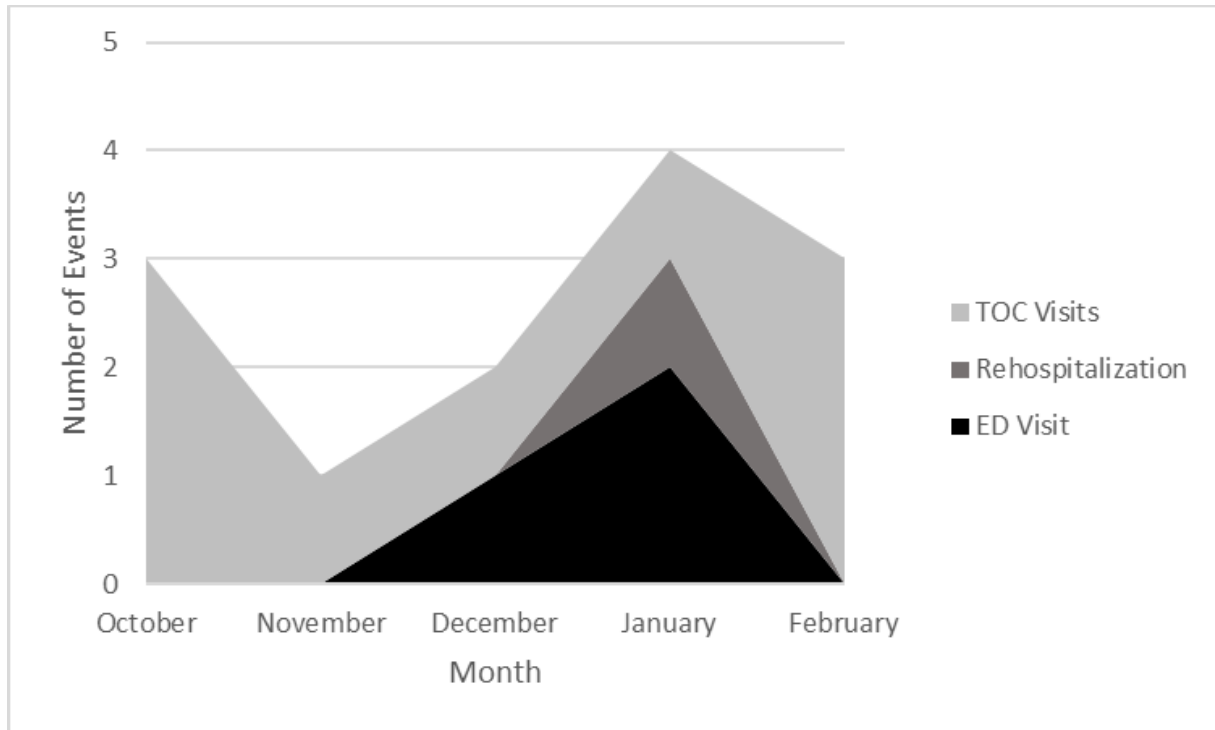
Monthly breakdown of TOC referrals and consenting patients.



Note. Figure represents eligible patients for the entire intervention $N = 31$ and number of consenting patients $n = 9$.

Figure 3

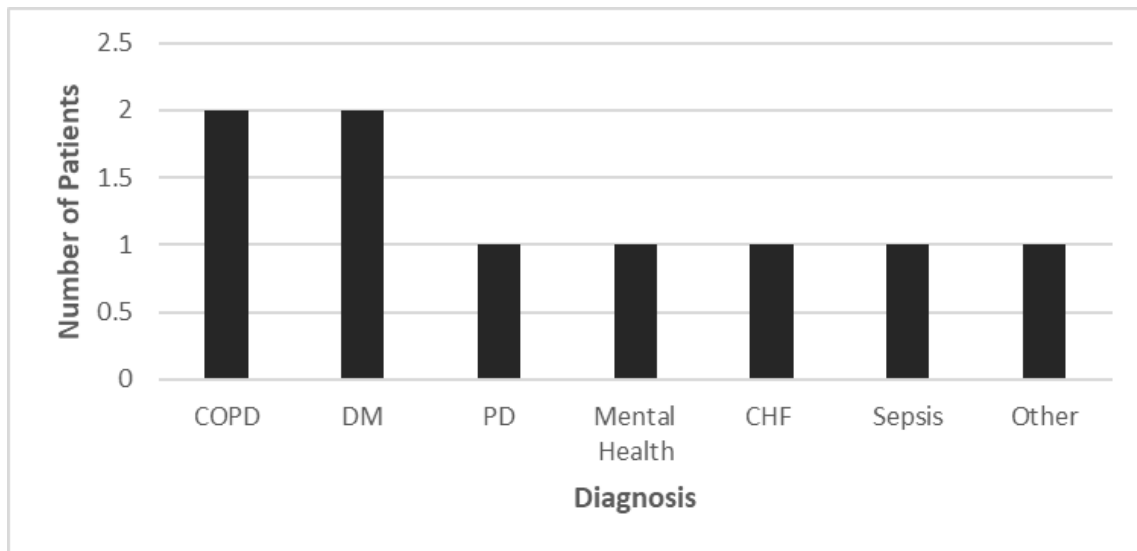
Number of unintended patient events within 60 days of discharge



Note. Figure represents number of completed TOC visits and unintended events (i.e., emergency department (ED) or rehospitalization) during the intervention period.

Figure 4

Discharge diagnosis of consenting TOC patients.



Note. Legend: chronic obstructive pulmonary disease (COPD), diabetes mellitus (DM), Parkinson’s disease (PD), congestive heart failure (CHF). Other classifies a patient with multiple discharge diagnosis’.