BRIDGING THE GAP IN CARE TO PREVENT 30 DAY HOSPITAL READMISSIONS

Rose L. Darbouze RN, MSN, CCM

Nova Southeastern University

Background

In the United States 30 day hospital readmissions is a national concern; this problem is significant because it is costly and is a poor indication of the quality of our healthcare delivery. Patients face many challenges after hospitalization; concerted efforts are needed to improve care during the health and illness transition phase.

Objectives

❖To examine the ramification of lack of care coordination post hospital discharge on 30 day hospital readmissions in a primary care practice.

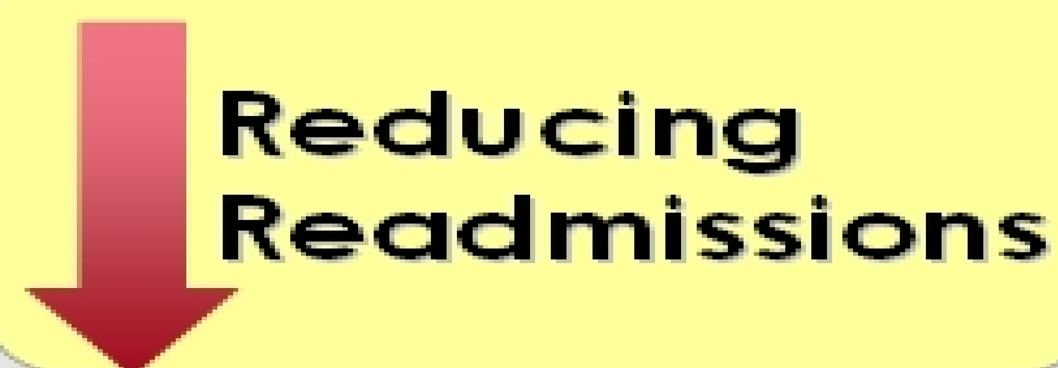
❖To investigate how the practice is addressing transitional care post hospital discharge.

❖To develop a clinical pathway and implement protocol to address post discharge transitional care.

Problem Statement

The clinical problem is the lack of timely and efficient post discharge follow up with primary care physicians for care coordination may be a causative factor in patients

readmission within 30 days of hospital discharge.



Methodology

Design

The proposed project will be a descriptive study.

Methods of data collection

❖Review of clinic policies and procedures

❖Review of de-identified data

Setting

The setting for this project is a large primary care physician practice that serves a diverse adult population.

Participants

Participants will be the practice staff.

Purpose

❖Heighten awareness on the importance of post hospital discharge transitional care.

❖Create and implement a post discharge follow-up protocol in a primary care setting to reduce the prevalence of 30 day readmissions in the diabetic and hypertensive population in the practice

Framework

The theoretical frameworks selected by the researcher for this capstone project are:

❖The Transition Theory by Dr. Afaf Ibrahim Meleis to heighten the staff awareness on health and illness transition

❖The Care Transition Program by Dr. Eric Coleman to create a pathway based on best practices in transitional care

❖Kurt Lewin Change Theory to promote transitional care changes in the practice that will be long lasting.

Literature Review

❖In researching the literature many studies addressed the different aspects of the dilemma of 30-day hospital readmissions. However studies addressing 30 day readmission from the perspective of primary care practices was scarce. A retrospective observational study of adult primary care physicians at the University of California San Francisco (UCSF) was conducted between July 1, 2009 and June 30, 2012 findings suggested that primary care providers played a vital role in managing population health and keeping discharge patients out of the hospital; hence decreasing healthcare spending (Tang, Maselli,

Implications

Nursing Practice

The findings from this project will raise awareness and incorporate best practices in transitional care

Healthcare Delivery

The findings from this project may possibly affect health care delivery in the primary care setting.

Healthcare Policy

The findings from this project have the potential to influence healthcare policy by making transitional care a standard practice

Healthcare Outcomes

The findings may improve patient outcomes post discharge.

Results

A sample size of 80 de-identified data was analyzed. It included 40 de-identified records pre-protocol intervention and 40 post discharge intervention protocol. Data was categorized into two groups Diabetic and hypertensive groups and into two categories those who had follow up post discharge intervention and those who did not. A Chi-square Fisher Exact test was conducted in SPSS and based on the results there was no significant statistical difference between the pre and post intervention groups.. However, Based on the numbers less people were admitted post protocol intervention.

Recommendations

More studies are needed with larger sampling size looking at the causative factors.

Reference

Tang, N., Maselli, J.H., Gonzales, R. (2014). Variations in 30-day hospital readmission rates across primary care clinics within a tertiary referral center. *Journal of Hospital Medicine* 9 (11) 688-694.

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