Improving discharge process key to reducing avoidable rehospitalizations, study finds

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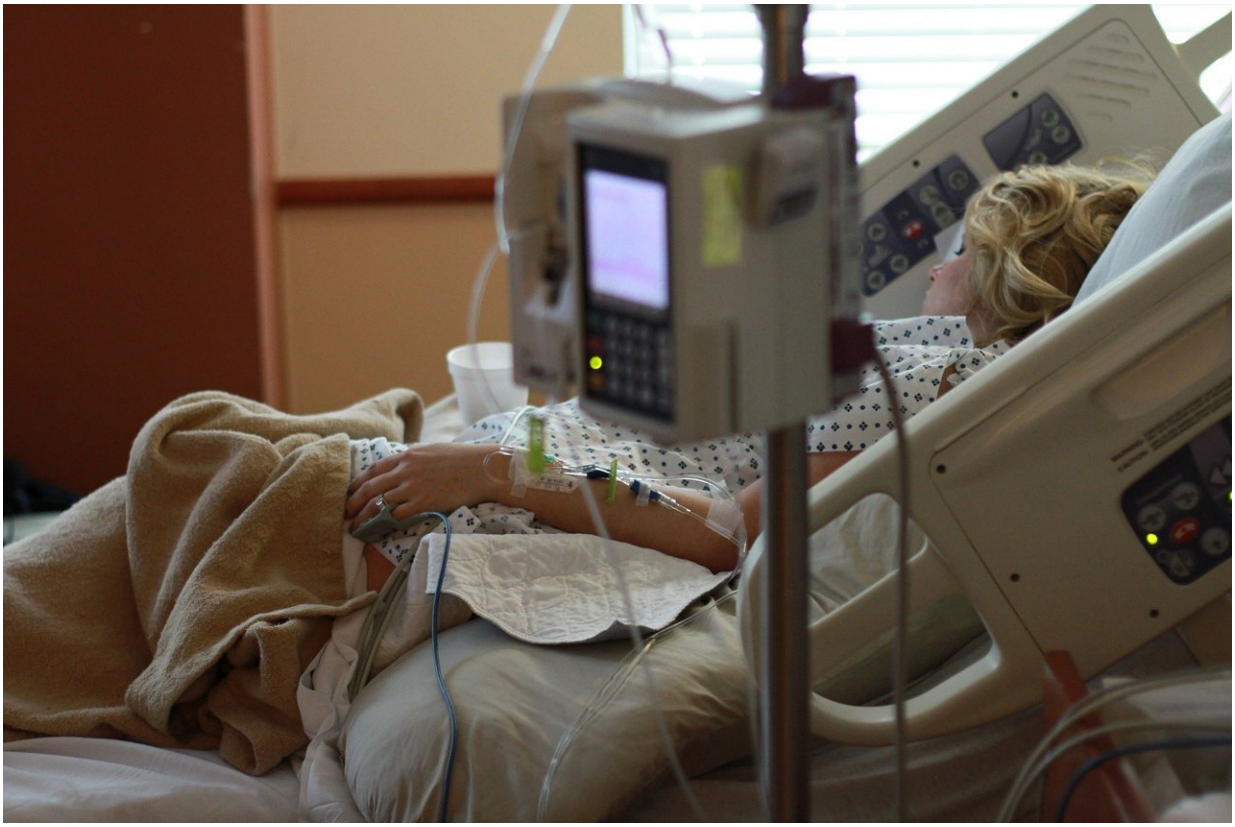

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Throughout her career, Lori Popejoy provided hands-on clinical care in a variety of health care settings, from hospitals and nursing homes to community centers and home health care agencies. She became

interested in the area of care coordination, as patients who are not properly cared for after being discharged from the hospital often end up being readmitted in a sicker, more vulnerable state of health.

Now an associate professor in the University of Missouri Sinclair School of Nursing, Popejoy and her research team conducted a study to determine the most effective way patients can be discharged from nursing homes utilizing the Re-Engineered Discharge program, a program originally designed to help hospitals discharge patients to their homes more effectively and safely.

To track its effectiveness, she implemented the program into mid-Missouri nursing homes with two different strategies: one nursing home team received all of the training in a one-day workshop upfront, while the other group received the training more gradually over the course of a few months. She found that while both strategies successfully improved the quality of care after patients were discharged from nursing homes, the group receiving the training more gradually saw greater buy-in from the nursing home team and implemented the intervention program better, which resulted in lower patient rehospitalization rates.

"Discharge plans always vary from patient to patient depending on their condition, and the plan is often developed by a health care team involving physicians, nurses, therapists, family members and the patients themselves," Popejoy said. "Figuring out who the primary family care provider will be to support patients when they go home is critical to ensure the appropriate services are in place and everyone is on the same page."

Identifying the correct medications patients need to continue to take and ensuring home health care services are both set up and arriving at the appropriate times are common issues that arise post-discharge that the program is designed to help address.

"Follow up phone calls have traditionally revolved around patient satisfaction, but we have found the more important question is finding out if the discharge plan is being implemented as it was designed," Popejoy said. "Ensuring that appointments are scheduled, services have started, and medications are correct and available will help ensure the discharge process goes as smoothly as possible, ultimately resulting in improved patient care and better health outcomes."

Although the study focused on nursing homes in mid-Missouri, the program can be implemented in nursing homes nationwide to help reduce avoidable rehospitalizations.

"This program can hopefully be utilized to improve the discharge outcomes for more nursing home residents," Popejoy said. "If we can keep people recovering at home and avoid sending them back to the hospital, the better off they will be overall."

More information: Lori L. Popejoy et al, Testing Re-Engineered Discharge Program Implementation Strategies in SNFs, *Clinical Nursing Research* (2020). DOI: 10.1177/1054773820982612

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