Title: Reducing Hospital Readmissions in the Homeless Population

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PROBLEM STATEMENT

Homelessness can occur at any age and affect anyone at any time. 26 (25.4%) of 64 clients discharged from a local hospital were readmitted to the hospital within a 30-day window. Currently, clients entering the recuperative care program (RCP) from the hospital are arriving without discharge paperwork (84%), prescribed medication (73%), and/or hospital wristband/form of identification (68%). This leads to clients returning to the hospital within hours or days.

PROJECT PURPOSE

- The overarching aim of this evidenced based, quality improvement (QI) project is to reduce the incidence of avoidable readmissions to the hospital in people experiencing homelessness.
- The overarching purpose of this project is to (1)Achieve health stability and recovery following hospital discharge from the RCP (2)Implement a comprehensive discharge referral protocol that includes completion of the JustHealth Recuperative Care Pilot Referral Form by RCP personnel to utilize when admitting clients to the RCP and (3) to establish a mechanism for clients to obtain prescribed medication upon admission to the RCP
- This project will be designed to answer the clinical research question: In homeless adult clients entering a recuperative care program (RCP), will the implementation of a discharge referral protocol, versus current practice, reduce less than 30-day readmission rates in three months?

MODEL/NURSING THEORY

- **Dorothea Orems' Self-Care Deficit Model**

This model is based on the belief that an individual will perform their own self-care to maximize their overall health and wellbeing by ensuring clients have received education on their illness, injury, or disease processes, have access to necessary resources and supplies, support of the client in their self-management of care during the recovery process, and adhering to the proposed treatment plan.

METHODS

- **Subjects (Participants)**

Single adults (over age 18), who are experiencing homelessness, and have been discharged from a local hospital

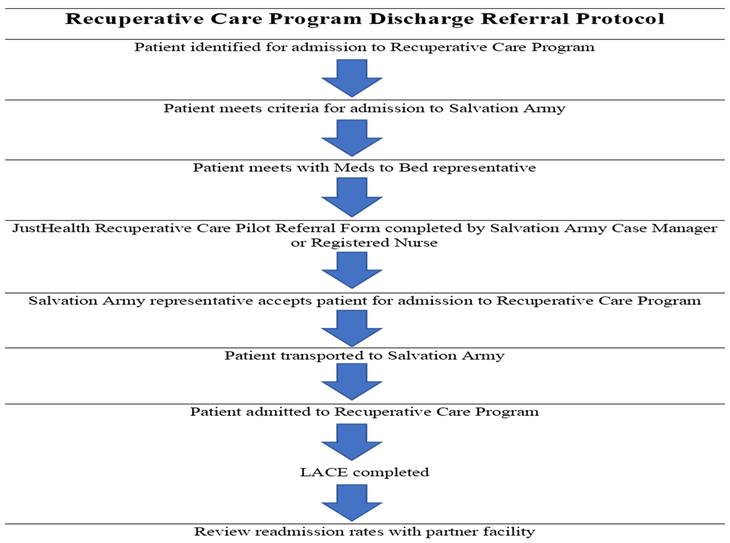
- **Setting**

Local adult homeless shelter that has an RCP

- **Instruments/Tools**

JustHealth Recuperative Care Pilot Referral Form and LACE Index (length of stay. type of admission [acuity], comorbidities, and number of ED visits)..

INTERVENTION AND DATA COLLECTION



RESULTS

This project was unable to be implemented. Therefore, available intake data was analyzed.

Table 1

Clinical Intake Data

Clients arriving with	April 2022 (baseline) (n = 26)		September 2022 (n = 27)		October 2022 (n = 21)		November 2022 (n = 24)		% Change from April to November 2022
	n	%	n	%	n	%	n	%	
Discharge paperwork	4	15	7	26	9	43	12	50	+35
Prescription medications	5	19	7	26	13	62	16	67	+48
Wristband/ identification	8	31	12	44	19	90	18	75	+44

DISCUSSION

Despite the inability to implement the project as planned, all three intake measures improved from baseline in April 2022 to November 2022.

1. Clients arriving with prescription medication demonstrated the greatest improvement (48%) from baseline in April 2022 to November 2022.
2. Clients arriving with discharge paperwork and discharge medications each demonstrated sustained improvement (35% - 48%) from baseline in April 2022 to November 2022.

Assessment data supports an improvement in multiple measures identified at the point of client intake. Concurrent organizational changes and social contamination related to ongoing needs assessment discussions and planning may have contributed to these improvements despite an inability to implement the project as planned.

Challenges to implementation included sub-optimal communication across organizations, difficulty in accessing and retrieving data, and limited organizational resources to support QI processes. The inability to implement the project as planned impacted data collection and analysis which serves as a limitation.

To support implementation in the future, it is recommended that the RCP dedicate time and adequate resources for QI. Analysis of necessary structures and processes to support improvements is also recommended through a more comprehensive needs assessment. Necessary resources to consider include time for staff development, more robust internal data management systems, and electronic access to patient information/data to support transitions in care.

IMPLICATIONS FOR ADVANCE PRACTICE NURSING

Advanced Practice Registered Nurses (APRNs) are well-positioned to lead change and address barriers to improve overall patient outcomes by reducing preventable hospital readmissions in vulnerable populations.

While this evidenced based, quality improvement project was unable to be implemented as planned, it provides a framework by using the Recuperative Care Program Discharge Referral Protocol. This protocol was created to enable a more targeted discharge decision while making and paving the way for future efforts in readmission reduction.

REFERENCES

UNIVERSITY of SOUTH FLORIDA