Improving ED RNs' Safety During AMA Discharge: A Quality Improvement Project

Kelly L. Witbeck

ABSTRACT

Emergency Department nurses at Legacy Salmon Creek Hospital were experiencing violent patient encounters during AMA discharges. Further investigation revealed no policy nor procedure to assist nurses during this potentially volatile process. Type II violence, or workplace violence, like AMA discharge is also a phenomenon that is prevalent in the ED setting. Two phenomena present in one high risk setting where nurses are not equipped with proper practice guidance increases the nurses' risk for Type II violence encounters. When nurses are not provided the appropriate education and training that provides them with the knowledge of their roles and responsibilities their safety is put at risk. Project objectives were to improve safety of ED RNs during AMA discharge with an overall goal to decrease rates of Type II violence during AMA discharge. Following the IHI Framework for Improving Joy in Work, continuous PSDA cycles were used to develop and partially implement an AMA discharge practice guideline, AMA discharge algorithm, risk factor assessment and education intervention to decrease Type II violence during AMA discharge. A mixed methods approach was planned, although no outcome data was collected due to several delays effecting the project timeline, and the onset of the global COVID-19 pandemic. However, the QI project provided essential progress towards improvement of safety during AMA discharge. Stakeholder management and commitment to physical and psychological safety is required of all institutions and health systems. Future implications for results showed a need for additional continuous intervention implementation and highlighted the importance in selecting key stakeholders in order to successfully implement project interventions.

1. **A Program Evaluation of a Southwest Washington National Alliance on Mental Illness: STRivE Program**

Gareth J. Penta, BSN, RN

Abstract

Background: An increasing body of evidence provides data showing that interventions directed at strengthening interpersonal skills yield decreased homelessness, increased utilization of medical and mental health care, decreased social isolation, and increased rate of recovery. The purpose of this program evaluation is to assess if the National Alliance on Mental Illness (NAMI) Southwest Washington STRivE Program is effective in achieving these goals.

Local Problem: Care and resources for those with MI and SUD in Clark County, WA are insufficient. This at-risk population has a heightened propensity for homelessness, social isolation, and low rates of treatment for medical and mental health comorbidities.

Methods: A program evaluation using quantitative and qualitative methods was conducted to assess if the SW WA NAMI STRivE program is meeting its goals.

Intervention(s): The Center for Disease Control (CDC) model for program evaluation was used to identify variables of the STRivE program that improve outcomes for individuals with mental illness and or substance use disorder through education to enhance interpersonal skills. At the conclusion of the evaluation, findings were disseminated to SW WA NAMI leadership.

Measures: Quantitative measures assessed changes in employment, housing, and substance use status, and on the utilization of STRivE courses. Qualitative measures identified recurring themes, which were helpful in assessing for changes in participants' behavior, perceptions, skills, and attitude.

Analysis: Quantitative and qualitative data were collated and analyzed at the end of the 10-week STRivE course cycle to identify if the program was meeting its goals.

2. An Evaluation of a Transition of a Care Intervention at a Federally Qualified Health Center: A Program Evaluation

Fidel Hernandez Jr BSN, RN

Abstract

Background: A Federally Qualified Health Center (FQHC) in Washington State has implemented a Transitions of Care (TOC) program to improve patient outcomes, reduce hospital readmissions, and diversify revenue streams.

Local Problem: The FQHC identified in 2017 that only 25% of its patient population was scheduled for primary care provider appointment within seven days of discharge and was failing to meet CMS criteria for transition of care. The organization implemented a Transition of Care (TOC) program in June of 2018 to improve this number and meet CMS criteria. The effectiveness of the TOC program has not been evaluated.

Methods: This DNP project used quantitative and qualitative methods to assess the performance of the TOC program.

Intervention(s): A program evaluation using the Lean Six Sigma framework was used to identify the factors contributing to not meeting TOC program goals. Upon conclusion of the evaluation, evidence-based recommendations were made to leadership about options to implement to improve outcomes.

Measures: Quantitative measures tracked the frequency goals are met. Qualitative measures identified the processes that hinder the completion of goals within the specified timeframe. CMS criteria for an effective and reimbursable TOC service are the focus of all measures.

Analysis: Quantitative data was aggregated and analyzed monthly to provide baseline data. Qualitative data was reviewed at the end to identify wasteful processes.

Results: Quantitative data indicates that outcomes necessary for reimbursement are not being met. Each county evaluated would be reimbursed for less than 25% of the patients it attempted to engage for TOC services. Qualitative data indicates that the barriers to meeting outcomes are communication, provider availability, and lack of patient participation.

Recommendations: It is recommended that further analysis of qualitative data is necessary to extrapolate what is working and eliminate what is not. Program evaluations focused on each specific county individually will provide improvement on data collection and qualitative data analysis.

3. Interprofessional Dedicated Education Unit as a Strategy to Reduce Communication Related Errors: A Program Evaluation

Angie Bailey, MN, BSN, RN

Abstract

At least thirty percent of medical errors can be correlated with communication breakdowns among healthcare providers and the increasingly complex care of patients is dependent upon critical communication and multiple handoffs between members of the healthcare team. The clinical agency has begun expanding the interprofessional dedicated education unit (IPDEU) model to include additional disciplines with the intent of improving patient outcomes. No evaluation has been completed on the initial pilot implementation.

The RE-AIM model was used to conduct a comprehensive evaluation, gauge readiness for expansion of the model, and provide evidence-based recommendations. Patient and staff outcomes were examined and compared between a baseline period and the pilot timeframe.

There was no statistically significant variation in average length of stay, readmission rates or patient harm events between the baseline and pilot timeframes. Press Ganey HCAHPS survey results show a statistically significant decrease in discharge information scores, however, the change can be attributed to a system wide policy change. Staff engagement scores remained very high throughout the pilot timeframe. Surveys show staff value working with interprofessional students and support are ready to embrace development opportunities to support their work in the IPDEU model. There is a need for ongoing program evaluation and quality improvement efforts

to assess and optimize the IPDEU model. The exploration of IPDEU projects is useful as it could lead to improved patient and staff outcomes. Further study of similar models is warranted as is the development of IPDEU opportunities in the ambulatory setting.

4. Tobacco Use Screening in Outpatient Wound Care: A Quality Improvement Project

Jessica Shuell BSN, RN

Abstract

The PeaceHealth Southwest Wound Healing and Hyperbaric Oxygen Center has a substantial number of patients documented to be users of tobacco products. Tobacco use significantly delays wound healing and reduces the therapeutic effects of hyperbaric oxygen treatments. Suboptimal caregiver screening rates of tobacco use and readiness to quit is a known problem at the wound clinic. Gaps in knowledge pertaining to workflow use and cessation counseling contribute to decreased caregiver adherence. The risk of not improving screening rates includes potential loss of federal grant funding and adverse patient outcomes. Evidence supports the value of nurses offering motivational support to improve sustained tobacco cessation. The 5 A's mnemonic is an evidence-based brief intervention that is nationally endorsed to improve tobacco cessation. Utilizing the Knowledge to Action framework and Kotter's 8-Steps of Change supported the development and implementation of an education-driven quality improvement project. This quality improvement project aligns with the Institute of Medicine's domains of health care quality by providing patient-centered, timely, efficient, and equitable tobacco screening and intervention, which optimizes wound healing and health outcomes. A task force was assembled to develop an educational intervention that was evidence-based and mitigated barriers. Delivery of the educational content during a nurse staff meeting demonstrated a 32% increase in learning pre/post testing. Eight weeks of manual chart reviews were collected pre and post the date of the educational intervention. There was an increase in screening and counseling of new patients of 11% and 8% respectively during the post-intervention phase. The impact of the educational intervention on the observed increase in screening and counseling cannot be inferred. Semi-structured interview theme codes helped inform the quantitative results. Strengths of this quality improvement project included improved caregiver communication, increased use of patient educational instructions, and visual aid utilization. The quality improvement model falls outside of the realms of formal research limiting the generalizability of these findings. Recommendations to institutional stakeholders are to enlist the provider group to develop a workflow in the electronic health record that contains the components known evidence-based practice. Future research is needed to inform meaningful practice changes in tobacco use screening in the setting of outpatient wound care.

5. Anti-Inflammatory Diet: A Quality Improvement Practice Change for aNutritional Intervention for Chronic Pain Patients

Elizabeth Spokoiny MN, RN-BC

Abstract

Background: Chronic non cancer pain remains a leading cause of disability in the United States with associated costs of $560 billion annually. The National Pain Strategy calls for multimodal treatment paradigms for chronic pain. Diet and nutrition are part of a complex relationship with the experience of chronic pain. Low-grade chronic inflammation is now known to be a driver of most chronic degenerative diseases.

Problem: The University of Washington Center for Pain Relief (UWCPR), a tertiary pain clinic, serves chronic pain patients in the Northwest. Treatment paradigms do not routinely emphasize nutrition despite compelling evidence that nutritional strategies are efficacious, safe, and cost-effective for non-cancer pain.

Aims. The overreaching goal of the project was to implement an anti-inflammatory (AI) nutritional treatment modality for chronic pain patients that would become routine practice for clinic physicians.

Interventions: All clinic physicians were educated on AI and trained to use motivational interviewing techniques to introduce AI to patients. The targeted physician education increased physician knowledge and confidence on AI principles. Physician practices were expanded by the now routine prescribing of AI as an adjunct non-drug treatment. Physicians were provided with evidenced based resources for patients.

Findings. Eighty-eight percent of clinic physicians increased their knowledge of AI for chronic pain and are 50% more likely or extremely likely to use evidenced based resources with patients.

Implications to practice. The program may serve to facilitate more integrative focused clinic programming emphasizing non-drug options amidst the opioid crisis aligning with the National Pain Strategy. Pain patients may have improved symptom control with the tenets of AI

6. A Program Evaluation of Skin Assessment in a Progressive Care Unit

Kim-Tien Pham, BSN, RN

Abstract

Hospital-acquired pressure ulcers (HAPUs) have been a major problem in hospitals for many decades. The negative emotional, financial, physical, and spiritual impacts of a pressure ulcer (PU), as well as associated treatment costs ranging from $10,000 to $86,000 per PU, demonstrates the importance of preventing HAPUs. Although prevention of HAPUs through skin risk assessments and preventive strategies have been a top priority, HAPU eradication still remains challenging. The problem is that a recent skin audit in the Progressive Care Unit (PCU) revealed troubling results. A program evaluation (PE) utilizing the Centers for Disease Control and Prevention (CDC) PE model was implemented to assess the knowledge and satisfaction of the staff and to evaluate the effectiveness of the current skin assessment program (SAP) in the PCU. Program outcome results demonstrated that the percentage of accurate, completed PCU skin assessments at admission or transfer decreased during the evaluation period. Levels of staff knowledge and satisfaction with the skin assessment program were found to be sufficient to carry

out the assessments. These program evaluation results indicate that further action is needed to establish an effective skin assessment program in the PCU.

7. Reducing 30-Day All-Cause Readmission of Heart Failure: A Quality Improvement Project

Kaelin Vince-Cruz BSN, RN DNP Student

Abstract

Background: In 2012, President Obama implemented a financial reimbursement program for hospitals to reduce 30-day all-cause readmissions for diagnoses such as heart failure (HF). However, about 27% of hospitalizations for HF are still readmitted within 30 days of a hospital discharge.

Local Problem: St. Francis Hospital in Federal Way, WA struggled to consistently maintain their monthly goal for 30-day all-cause readmission of HF (RHF) at no more than 15.4%.

Method: Two cycles of the Plan-Do-Study-Act (PDSA) method occurred and focused on a discharge checklist (DC) for HF and staff satisfaction on the nursing process change.

Intervention: The project started with educating staff on a DC to reduce 30-day all-cause readmission of heart failure (RHF). A voluntary survey occurred at 45 and 90 days post intervention to measure staff satisfaction on the nursing process change. The intervention occurred from August 28th, 2019 through November 30th, 2019.

Results: Initially, 16 DC were collected, however only 12 were fully completed and underwent data analysis. There were 4/12 (31%) 30-day all cause RHF, leaving 8/12 (62%) of patients with non-30-day all-cause RHF. There were two non-30-day all-cause RHF who passed away. Overall, staff agreed that the DC had potential to reduce 30-day all-cause RHF and was easy to implement into their nursing practice.

Conclusion: The use of a DC for patients with HF on the third medical unit was successful on 30-day al-cause RHF. Additionally, staff embraced the nursing process change. Further information is needed to support the findings of this QI project.

8. Implementing and Evaluating a Quality Improvement Project to Reduce Unnecessary Diagnostic Imaging in Urgent Care

Jill Lawton MSN, BSN, ARNP, RN

Abstract

Acute knee injury in young adults and children is one of the most common injuries seen in emergency departments (ED). Despite low fracture rates, usually associated with only blunt force trauma, plain knee radiographs are one of the most common tests ordered for any type of knee

injury (Elshaug et al., 2017). Currently, there are clinical decision rules (CDR) in place to guide the ordering of knee films for complaints of acute knee pain. However, results of a needs assessment indicated the nursing staff at Kaiser Longview Urgent Care (UC), the primary site for the current project, are unaware of the CDR and protocol. Interviews with the clinic providers revealed that while the providers were aware of the CDR, they were unaware that it was Kaiser policy and were not using them. The purpose of the current project was to address this practice to knowledge gap and implement evidence-based guidelines, the Ottawa Knee Rules (OKR), in triage at the Kaiser Longview Urgent Care. The change in practice was instituted over a four-month period, and data were collected pre- and post-intervention. The intervention showed a decrease in the number of knee films ordered in the UC over the project period.

9. Reducing High Healthcare Utilization Among Individuals Affected by Negative Social Determinants of Health: A Program Evaluation.

Samwel Mbua BSN, RN, CCRN, DNP-FNP candidate,

Abstract

High healthcare utilization (HHU) is a problem that substantially contributes to increased healthcare expenditures. HHU results when individuals faced with negative social determinants of health (SDoH) such as homelessness, mental illness, and disease comorbidity overuse emergency room and hospital services for avoidable reasons. HHU is a major healthcare problem in Highline Medical Center (HMC). In 2017 at HMC, 55 individuals faced by homelessness and disease comorbidity accounted for 511 ER visits in a period of six months, resulting in $856,833 of uncompensated care. In 2014, *Health Connections* was established at HMC to reduce HHU. Until 2018, *Health Connections* utilized a metric scoring based on length of hospital stay, acuity, comorbidity, and ER visit also known as (LACE) to enroll patients who have a score of ten or greater. In 2018, *Health Connections* expanded services and integrated additional screening tool known as Predictive Risk Intelligence System (PRISM). This program evaluation assessed the effectiveness of the expanded *Health Connections* services.

10. Robotic Companion Animal Therapy: A Quality Improvement Project in a Veterans Affairs Hospice Unit

Diep Nguyen RN, FNP- DNP Student

Abstract

The increased utilization of hospice care for veterans in recent years has motivated the Veteran Health Administration (VHA) to focus on the expansion of its hospice services to include improving end-of-life care. Nationally, the IOM reported the widespread dissatisfaction in end of life care (IOM, 1997 and 2014). The Puget Sound VHA, the Community Living Center (CLC) has a lower family perception of quality of end-of-life care when compared to the in-patient hospice and palliative care units (Ersek et al., 2015). This project aims were to address the concerns of the VA Puget Sound leadership by improving the physical and psychosocial symptoms and the well-being of the hospice patient. Guided by the Health-Related Quality of Life (HRQoL) and using the Robotic Companion Animal Therapy (RCAT) intervention, this intervention was implemented for veterans on the hospice service at the CLC of the VA Puget Sound hospital and will be evaluated using quantitative and qualitative methodologies.

11. Improving Diabetes Self-Management in Older Russian/Slavic Immigrants: A Quality Improvement Project

Olga P. Tsytsyna, FNP-DNP Student, BSN, RN-BC

Abstract

Diabetes mellitus type II is a worldwide pandemic that affects about 382 million people due to high-calorie, low-nutrient diet and sedentary lifestyles. Immigrant populations are at increased risk for developing diabetes and its related comorbidities given the acculturation to American nutrition selections and physical inactivity (Parr & Elmendorf, 2015), social and religious values, language barriers, and low health literacy (Razum & Steinberg, 2016; Smith-Miller, Berry, Dewalt, & Miller, 2016).

The purpose for the DNP project was to develop and implement a culturally appropriate diabetes self-management program for elder Russian population at Sunrise Family Medical Clinic, Happy Valley, OR. Using Orem's Self Care model, the goal of the program was to develop individually focused self-management skills with emphasis on diet modification, medication adherence, physical activity, and glycemic control. The expected outcomes: decreased HgA1C by 10-12% and increased patients' performance within a 3-month time frame.

12. Enhancing the depression screening in cancer patients: A Quality Improvement Project

Grace Mwangi, DNP-FNP student, RN-BSN

Abstract

Depression affects more than 300 million people worldwide. In patients with cancer, the reported prevalence is approximately 25% of cancer patients. Inadequate screening and treatment of depression can lead to delayed or no treatment, causing reduced quality of life and survival. Despite the high prevalence and considerable impact of depression in the oncology outpatient care setting, identification had been suboptimal. At Seattle Integrative Cancer Center (SICC), there were no set guidelines for depression screening and management, this quality improvement project aims to implement the current standard guidelines by the American Society of Clinical Oncology (ASCO) screening and management of depression in adults with cancer. The goal was to increase the efficacy of screening, interventions, referral, follow-up and treatment for depression, to 80% screening percentage. The second objective was to increase the cancer patient retention rate to remain in cancer treatment by at least 5% within 60 days. The use of a new depression protocol for cancer patients with depression at SICC was successful. Additionally, staff embraced the nursing process change. Further information is needed to support the findings of this QI project.

13. Implementing Code Sepsis in Acute Care at Northwest Hospital: A Quality Improvement Project

Tera Giles:

Abstract

Sepsis is considered a medical emergency requiring immediate medical treatment. Sepsis has a high mortality rate, with a third of all in-hospital deaths being a result of sepsis (CDC, 2016). Patients that become septic while in the hospital have a mortality rate of 25.5% (Rhee et al., 2017). Recently published international sepsis guidelines call upon hospitals to be actively screening for sepsis on all acutely ill patients (Rhodes et al., 2017). Northwest Hospital (NWH) in Seattle, Washington has an active Sepsis Quality Improvement committee. The existing code sepsis program is utilized in the emergency department (ED) where high levels of Centers for Medicare and Medicaid Services (CMS) compliance are met. Acute care units at NWH perform below the national average for CMS sepsis compliance. This quality improvement project evaluated the implementation of an inpatient code sepsis program at NWH. The intervention yielded mixed results. Self-assessed nursing knowledge about sepsis identification and intervention improved after educational session, staff nurses responded favorably to satisfaction questions about the intervention, but nursing usage of the code sepsis intervention was inconsistent. In spite of mixed results, the intervention was useful in moving the hospital towards international best practice guidelines.

19. **Initiating A Falls Prevention Screening Program: A Quality Improvement Project**

Jessica Small:

Abstract

Background: Falls in the elderly are devastating. The aftermath of a fall impacts the healthcare industry as a whole, the family, the community, and the elder who experienced the fall. Falls can be prevented in elder homes and around the community. Facilities that provide primary care to elderly should have a process in place to identify those at greater risk of falling and follow steps to help prevent falls.
Local Problem: The Chehalis Tribal Wellness Center is a rural family clinic. It did not have a process in place to screen elders, age 60 and older, for risk of fall. There was also no area in the current electronic health record to quickly find this assessment or risk status.
Methods: A literature review was conducted in CINHAL, Cochrane, and Medline. The search terms used were “falls prevention screening” and “falls prevention”. The search was limited to full text and peer reviewed articles. Articles were included if they had included participants age 60 years or older and had a fall prior to the study. Articles excluded if the fall was in a hospital or long-term care facility, and not community prevention based.
Intervention(s): The interventions were specific to the goal of increasing screening in the elder population. The interventions were evidence based and followed the Center for Disease Control and Prevention’s Stop Elderly Accidents, Deaths, and Injuries program. The interventions were focused on medication reviews, physical exams, education, and referrals to the Chehalis Tribal Wellness Centers’ falls prevention team. The interventions included medical staff education on falls prevention, how to complete a screening, and how to place a referral to the stay active and independent for life (SAIL) class and the falls prevention team (FPT).

20. **Evaluating a Team-Based Approach to Lowering Hemoglobin A1c in the Diabetic Population in a Primary Care Setting**

Moira Kapeen:

Abstract

Background: Diabetes mellitus is among the most costly and predominant chronic diseases in the United States; it is estimated that 1.5 million people are diagnosed with it each year. Diabetes impacts the quality of life of individuals who suffer from it and causes a significant economic strain to both patients and society at large.
Local Problem: Diabetes is a significant chronic issue in King County, Washington. The most recent data in 2014 indicate that approximately 110,000 adult residents eighteen-years-old and above in King County have a diagnosis of diabetes. In addition, Kaiser Permanente estimates that there are an additional 35,000 patients diagnosed with diabetes and 10,000 patients with undiagnosed diabetes.
Methods: Patients were admitted to the chronic disease management (CDM) Program, and registered nurses (RNs) and clinical pharmacists monitor and facilitate treatment plans. Patients are engaged every two weeks via telehealth to assess progress. The CDM team huddles every 30 days to discuss the progress of patients. Also, the RNs reassess the patients every 90 days for appropriateness for continued enrollment in CDM, assessing engagement; identify opportunities for intensifying therapy; and obtaining repeat HbA1c.
Results: The change in Hemoglobin A1c (HbA1c) performance results was significant, 85% of the enrolled patients had their HbA1c decrease to less than 8% during the six months they were enrolled in the program. The staff surveys were supportive of the benefits provided by the CDM programs.
Conclusion: This program evaluation found that the team-based approach in conjunction with lifestyle modification and glycemic lowering drugs was beneficial in lowering HbA1c in the diabetic population.

21. **Olympia Bupe Clinic, Implications for Treatment within Marginalized Populations: A Program Evaluation**

Kim Miker:

Abstract

The United States is currently experiencing an opioid epidemic. In 2017, over 47,000 people died from opioid overdoses in the US. In order to address this epidemic, innovative ways to tackle the problem will need to be explored. Locally, Washington State's Governor Jay Inslee, authorized the formation of a taskforce to examine the epidemic at the state level. Three objectives were identified: *primary prevention, treatment enhancement and management,* and *user health and overdose prevention*. This DNP project will evaluate the progress of a clinic located in Thurston County, which providesMedication Assisted Treatment (MAT) for Substance Use Disorder (SUD). This is in alignment with the state's second objective: *treatment enhancement and management*. A program evaluation will be conducted at the Olympia Bupe Clinic (OBC). They offer MAT, using a progressive approach, low barrier harm reduction methods, in order to expand access to historically disenfranchised populations. Using a mixed-methods approach, consisting of interviews, surveys and clinical benchmarks, this

evaluation will offer an assessment of progress from all key stakeholders. Future projects and clinic offerings will benefit from this evaluation, in that the results from this analysis may offer insight to gaps in care and opportunities for growth.

22. Surgical Site Infection in Total Hip Arthroplasty: A Program Evaluation

Melissa Lee:

Abstract

Background: According to current literature within multiple databases (e.g. PubMed, Medline, and Cinahl), surgical site infections (SSI) are one of the leading adverse events following total hip arthroplasty (THA), and an economic burden for healthcare institutions. Policy initiatives and bundled payments have led to many organizations prioritizing measures to address this growing problem as the number of these elective procedures has increased exponentially.
Local Problem: A large hospital in the Portland metro area is a total joint center that performs several thousand THAs annually; and has noted an upward trend in SSIs as they have increased their surgical volume. Thus far, a root cause has not been identified and reducing the rate of SSI has become a top priority of the institution
Methods: A total of 1,727 patients underwent THA between January 2018 and October 2019. This program evaluation aims to examine the incidence of SSI and readmission, in both the inpatient and outpatient THA cohorts, as well as identifying common themes and potential risk factors. The relevant aggregate data was extracted via settings by internal analysts from the EHR for evaluation.
Results: The rates for SSI in the outpatient cohort was unchanged between 2018 and 2019 (0.8%) as the volume increased from 119 to 266, and the number of readmissions increased from zero to five (0.0% vs. 2.0%). However, the inpatient number of SSI's increased from five to ten (0.6% vs. 2.0%), and the corresponding number of admissions were 22 to 21 (2.6% vs. 4.1%); while the total number of inpatient procedures decreased from 835 to 509.
Conclusion: The increased rates of SSI and readmission appear to be a larger problem for inpatients who likely are higher risk. Ongoing efforts at patient optimization could include a nutritional risk screening, which is often overlooked, and is not current practice at this facility.

23. Outpatient Total Knee Replacement Arthroplasty: A Program Evaluation

Pam Martin:

Abstract

Background: The ever-increasing cost of medical care and bundled insurance reimbursements have resulted in immense changes to the care of surgical patients. Advancements, in surgical technique, pain control and rehabilitation have allowed clients to undergo outpatient total knee arthroplasties without an increased rate of postoperative complications.
Local Problem: In 2018, a medical center in the Pacific Northwest began offering outpatient total knee arthroplasties. The goal was to perform 30% of these procedures in the outpatient setting without increased complications.

Methods: The Premier Integrated Care Pathway for Total Joint Arthroplasty was applied to this medical center's surgical program. This process improved patient flow and decreased waste, which allowed patients to undergo outpatient surgery through the Home Recovery Program.
Interventions: The Centers for Disease Control and Prevention Framework for Program Evaluation in Public Health was utilized during the transition to assess progress. The rates of outpatient surgery, surgical site infections, thromboembolisms and 30-day readmission rates from April 2018 to October 2019 were analyzed.
Results: The hospital facility was able to increase the rate of outpatient total knee arthroplasties to 50% over a 19-month period. This was accomplished without a perceived increase in the rate of 30-day complications.