



Reducing Readmissions: A Win for All

Judy Dillon, MSN, MA, RN, Kathy Morrison, MSN, RN, CNRN
Penn State Hershey Medical Center

Stroke Center



Good People. Great Medicine.[™]
PennStateHershey.org



Abstract

Decreasing hospital readmissions is now a major goal of the federal government, insurance agencies, and other regulatory agencies. Our stroke program follow-up involves appointments at 30-days, 90-days and one year; however many readmissions occur before the first appointment. To address this concern, high risk stroke and TIA patients discharged home now receive a phone call three to seven days following discharge. High risk is defined by: emergent admission in past six months, inability to “teach back” care information, five or more new medications, newly prescribed Warfarin, no caregiver at home, poorly controlled diabetes, or poorly controlled hypertension. We intended to demonstrate that early follow-up with high risk patients will reduce our current 30-day readmission rate of 6.7% , and improve patient satisfaction – a win for all.

Methods

The inpatient care coordinator identifies at-risk patients during their acute care hospitalization, and notifies the stroke clinic nurse by email, including the reason that they qualify for the call. The stroke clinic nurse makes the call within 3-5 days post discharge. They take any necessary action, and document the process on a powerform in the electronic medical record.

Results

This initiative was instituted in July 2011. During the second half of 2011, eleven patients were identified by the inpatient care coordinator, and called by the stroke clinic nurse. Qualifying criteria were as follows:

- Eight were for new warfarin therapy
- 1 was for non-compliant history
- 1 was for new diabetes diagnosis
- 1 was for an unscheduled admission during the previous 6 months

None of these eleven patients had a readmission during the 30-day or 90-day period post discharge.

Early phone calls: 2 nd half 2011 = 11 cases	
8 cases	New warfarin therapy
1 case	Non-compliant history
1 case	New diabetes diagnosis/therapy
1 case	unscheduled admission during previous 6 months



Discussion

This initiative was instituted in addition to our current process of clinic visit / phone call follow-up at 30-days, 90-days and 1-year for ischemic stroke and TIA patients which was started in 2009. The readmission rates for 2011 – including elective readmissions – are significantly less than for 2010.

Readmissions	30 day		90 day	
	2010	2011	2010	2011
TIA	10.9%	2.7%	16%	10.8%
Ischemic	6.7%	6.3%	13.1%	5.5%

However, this data represents only 80% of the discharged patients, as 20% had no follow-up information as a result of being unable to reach them. We anticipated the volume of early phone calls to be @ 2-3/month based on historical data from our database; eleven cases in 6 months is consistent with that. The improvement in readmission cannot be definitively attributed to the early phone call initiative, but more likely is a result of the structured program that is in place. The engagement of the inpatient care coordinator is new with the early phone call initiative, and has resulted in additional observations/communications to the clinic nurse about specific patient concerns for follow –up.

Conclusions

In the past, hospital readmission has been related to decreased patient satisfaction and increased cost of healthcare. Under the new Patient Protection and Affordable Care Act, hospitals will now be penalized for high readmission rates, making it all the more important to find strategies to limit readmission. Nationally, rates have been reported between 6.5% and 24.3%. Our outcomes suggest that a structured follow-up program that includes early phone calls for high-risk patients can impact the readmission rate.

References

Fonarow, Gregg C., Smith, Eric E., Reeves, Mathew J., Pan, Wenqin, Olson, Dai Wai. 2010. Hospital-Level variation in Mortality and Rehospitalization for Medicare beneficiaries With Acute Ischemic stroke. *Stroke*. Epub Dec. 16, 2010.

Svendsen, M., Ehlers, L., Andersen, G. & Johnsen, S. 2009. Quality of care and length of hospital stay among patients with stroke. *Medical Care*; 47: 575-582.

Kripalani, S., Jackson, A., Schnipper, J. & Coleman, E. 2008. Promoting effective transitions of care at hospital discharge: A review of key issues for hospitalists. *Journal of Hospital Medicine*; 2:314-323.

Contact Information
jdillon@hmc.psu.edu
kmorrison1@hmc.psu.edu