Telephone talks with nurse can reduce hospital re-admissions, study finds

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Weekly telephone contact with a nurse substantially reduced hospital re-admissions for high-risk patients, according to results of a University of Wisconsin School of Medicine and Public Health study.

The findings, published in the December issue of *Health Affairs*, also determined that health care costs were decreased by approximately $1,225 for each patient enrolled in the program, when compared to similar patients who were not enrolled.

The study measured the efficacy of Coordinated Transitional Care (C-TraC), a program used by 605 patients discharged over an 18-month period from the William S. Middleton Memorial Veterans Hospital.

High-risk patients were defined in one of three categories: having dementia or some other impairment in memory, over 65 years old and living alone, or over 65 years old with a previous hospitalization in the last year. Patients in the program were one-third less likely to be readmitted than similar patients who were not in the program.

According to Dr. Amy Kind, lead investigator and assistant professor of medicine (geriatrics) at the UW School of Medicine and Public Health, patients in C-TraC were phoned by a nurse case manager 48 to 72 hours after discharge. The nurse met with each patient before discharge to make arrangements for the phone calls and with each patient's hospital providers to help ensure that the patient's transition home was as smooth as possible.

"The nurse engages the patient in an open-ended discussion," she said. "They spend a lot of time talking about medications, follow-up, and the appropriate response to any signs and symptoms that the patient's medical condition could be worsening."

Kind said most of these discussions involved the proper use of medications.

"Many patients, within two days of discharge, were not taking their medications properly," she said. "They may not have understood what they should have been doing, or became confused about their medications when they arrived home. Our nurse can help them work through those issues and make sure they are doing things as they should."

Kind said the patients got weekly phone calls for up to four weeks or until they were transitioned to a primary-care provider. That provider was updated at each step of the process and immediately informed if problems were detected.

"Our role is not to complicate the process, but to more seamlessly bridge the patient's journey from the hospital to the home and to primary care," she said.

The study was funded by a grant from the VA. Kind estimates the program saved the hospital $741,125 in health care costs over its first 18 months of operation.

"This means more money for the VA to provide medical care to veterans in need," she said.

Kind said C-TraC was very popular and only five patients of more than 600 approached declined to participate.

"Patients don't mind a phone call," she said. "Also, since most traditional transitional care programs use home visits and most of our patients live beyond the reach of a home visit, transitional care wasn't even an option for them until C-TraC."

Kind said 75 percent of the patients lived outside the Dane County, Wisconsin area, and the nurse made phone calls to patients as far away as South Dakota and Florida.

"Because it is phone-based and our nurse doesn't spend a lot of time traveling, we can communicate with many more patients per month than in traditional home visit-based transitional care," she said.

Kind believes C-TraC could eventually be used in other clinical settings, and become a useful tool in lowering the cost burden on the health care system while minimizing re-hospitalizations of patients with high-risk health conditions, but notes that the program does need additional testing.

"This model requires a relatively small amount of resources to operate and may represent a viable alternative for hospitals seeking to offer improved transitional care as encouraged by the Affordable Care Act," she said. "It provides an option to hospitals that previously could not effectively access transitional care services, especially those in rural areas or other areas challenged by a wide geographic distribution of patients, or those with constrained resources."

Provided by University of Wisconsin-Madison

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