

Post-discharge telephone calls may reduce hospital readmissions

July 22 2014, by Sara Saldi



(Medical Xpress)—It's an all too familiar story: a patient—specifically a patient with chronic disease—goes into the hospital to get well and is discharged only to be readmitted within 30 days. Medicare spends \$15 billion a year on readmissions alone.

It turns out that better communication to patients and their physicians about follow-up care might be one way to prevent a return to the hospital or emergency room.

The Agency for Healthcare Research and Quality (AHRQ) has awarded the University at Buffalo School of Nursing a grant of \$298,934 over a two-year period to create a pilot project whose goal is to work with [primary care](#) physician's offices, their patients and families to see that patients get follow-up care very soon after leaving the hospital.

Sharon Hewner, PhD, RN, assistant professor of nursing and author of the grant is a specialist in population [health](#) analysis, health services research, and informatics.

Hewner says that there has been a lack of timely communication between the hospital and community setting.

"Our project will use the electronic health record to exchange health information across settings in real time," she says, "and provide decision support to nurse care coordinators in primary care offices to proactively prevent re-hospitalization."

As part of the study, Hewner says they will use the "Care Transitions Dashboard" to incorporate an alert message about a hospital discharge from the regional health information organization, HEALTHeLINK, with information from the electronic health record at Elmwood Health Center, an affiliate of People Inc.

The "dashboard" will help guide the nurse care coordinator in developing an individualized plan of care specifically to prevent re-hospitalization through its structured assessment of social factors such as health literacy, home environment, and financial resource issues that may increase the complexity of care after leaving the hospital.

According to Hewner, most post-discharge intervention studies focus on a single disease, such as heart failure, and not a variety of chronic health problems or patients with a number of interdependent health issues.

"Our study will try to improve the identification of patients who are at-risk for being readmitted by using the COMPLEXedex™, a hierarchical algorithm which divides the population into healthy, at-risk, chronic and complex cohorts based on nine prevalent chronic conditions," says Hewner.

Health outcomes such as readmissions and emergency department visits in the 90 days after discharge will be compared with another primary care practice using data from the New York State Medicaid Data Warehouse.

U. S. Representative for New York's 26th district, Brian Higgins, said that he applauds efforts to improve health care delivery in fiscally smart ways in Western New York.

"Through this federally-supported project, the UB School of Nursing is creating a model for proactive post hospitalization [health care delivery](#)," says Higgins. "Their leadership, community coordination and electronic medical record integration aim to lower long term costs and improve health care outcomes."

Hewner says the study design is significant because it promotes a low-cost, targeted intervention—a [health care](#) coordinator using telephone outreach to patients guided by an organized assessment—to ensure that the care is more patient-centered and takes into account that this may be a time when the patient is vulnerable and therefore likely to misinterpret instructions and be too preoccupied, or ill, to arrange follow-up with a primary care health provider on their own.

"We will also study how to implement a system of two-way communication, alerting the primary care clinic immediately about their patient's hospital discharge and transmitting the results of the back to the hospital and other providers," says Hewner.

"Our working hypothesis is that timely notification in the form of discharge alerts and system-wide understanding of the patient's condition and their social and medical complexity will reduce follow-up time and encourage better patient outcomes."

Hewner says that the intended outcome of the study would be to develop an automated system, the Care Transitions Dashboard, to notify the primary care practice of real-time discharge and for post-discharge follow-up to happen ideally with 72 hours of discharge.

"The project lays the groundwork for future research focused on sustaining the improvement through securing reimbursement for outreach, evaluating the most cost-effective interventions, and customizing outreach for different populations," she says.

Provided by University at Buffalo

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