Abstract

BACKGROUND: Hospital readmissions impact patient outcomes and are costly to the healthcare system. The 2018 30-day readmission rate for Medicare enrollees 65 years and older at a national level is 14.9%. Nearly 20% of Medicare beneficiaries are readmitted within 30 days of discharge. Avoidable reasons for readmissions include confusion about medication prescriptions, miscommunication from acute care to primary care providers, inadequate instruction to patients and families on how to provide proper care.

LOCAL PROBLEM: Readmission rates vary by region and healthcare system. The 2018 30-day readmission rate for Virginia is 14.8%. The healthcare system where this project was implemented has a 2018 readmission rate of 14.5%. The overall goal of the healthcare system is a reduction in 30-day readmissions.

METHODS: This Quality Improvement Pilot project explored the impact of the implementation of a discharge navigator on 30-day unplanned readmissions for high risk readmissions in a 238 bed community hospital located in central Virginia. Cost avoidance related to prevented readmissions was calculated using a national average cost of heart failure readmissions per readmission. High risk readmissions were identified according to inclusion criteria of 65 years and older, HOSPITAL score of 5 or greater, English as the primary language, discharged to home without a home health agency, more than one comorbidity and consultation by case management, care coordinators and or social services. Once the participants were identified and consented, a discharge assessment tool was given to the participant and family to fill out on a document called the "discharge ticket".   Data collection included tracking participants for readmission within 30-days.

INTERVENTIONS: The intervention for the identified patients was to conduct 30-60 minute education sessions with a post discharge phone call within 24- 48 hours. The initial session with the participant and family reviewed the discharge assessment tool. Each session incorporated education, support and resources for day to day disease management at home. These sessions continued as needed until discharge.

RESULTS: Twenty-five patients were identified as high risk for readmissions. Fifteen consented to participate in this project. Fourteen out of the fifteen participants had the diagnosis of heart failure. Eight participants returned to the original hospital. Five participants returned to the original hospital and one participant returned to a different hospital. Two out of the eight participants did not meet readmission criteria set forth by Centers for Medicare and Medicaid Services. The national average conservative cost for a heart failure readmission is $9,051. Using this national cost estimate, the potential cost avoidance for this pilot study was $81,459 for nine non readmitted participants.

CONCLUSIONS/IMPLICATIONS: The pilot study results provided insight into the potential benefits between the role of the discharge navigator and patients at high risk for 30-day readmissions. This pilot study revealed recommendations for the next project that included evaluation of the inclusion criteria that excluded patients that would benefit from this support. Next steps include implementing the project again in 2019 with the same design excluding the inclusion criteria and a comparison to top quartile statistics for readmissions with like hospitals.