Development and Implementation of a Standardized Transition of Care Process for Stroke Readmissions

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An estimated 795,000 individuals in the United States (US) suffer a new or recurrent stroke each year (Centers for Disease Control and Prevention [CDC], 2017). According to Benjamin, Blaha, Chiuve, & Subcommittee (2017), stroke is a leading cause of disability and costs the US 34 billion dollars each year. The Centers for Medicare and Medicaid Services (CMS) data reports approximately 14% of stroke survivors are readmitted to the hospital within a 30-day period after discharge (Lichtman, Leifheit-Limson, Jones, Wang, & Goldstein, 2013). Hospitals face financial losses for high readmission rates as a result of penalties assessed by CMS (Castellucci, 2017). Identified causes for stroke readmissions include unresolved issues at the time of discharge, poor post-discharge care, and chronic comorbidities related to the disease process (Lichtman et al., 2013). The period of transition from acute rehabilitation to home for stroke survivors is critical in preventing hospital readmissions. Formalized and structured transitions of care protocols including interventions such as follow-up calls within 48-hours of discharge and in person follow up care with a healthcare provider within two weeks can decrease readmission rates significantly (Condon, Lycan, Duncan & Bushnell, 2016).