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). This Doctor of Nursing (DNP) project will focus on decreasing stroke survivor hospitalization readmission rates by implementation of a transitions of care protocol for the stroke survivor transitioning from the acute rehabilitation setting to the community. A protocol will be developed and implemented through collaboration of the multidisciplinary team and stakeholders, education of individuals involved in the transitions process, and leadership endeavors to create organizational change.

Background

Strokes affect many individuals in the US and financially impact the healthcare system. According to the CDC (2017), a stroke occurs in the US every 40 seconds. Strokes can result in

death or costly disability and chronic healthcare needs. In 2014, stroke was named the fifth leading cause of death in the US (Kochanek, Murphy, Xu, & Tejada-Vera, 2016). According to the American Stroke Association [ASA] (2017) one in four stroke survivors will suffer another stroke. Risk factors that lead to an initial stroke or secondary stroke include high blood pressure, high cholesterol, heart disease, diabetes, sickle cell disease, previous stroke, family history of stroke and smoking (CDC, 2017).

The residual effects of stroke can lead to permanent disability which result in a substantial financial impact. This financial impact is both personal, for the stroke survivor and expands to the community and government. The financial burden for this population varies greatly depending on the age of the stroke survivor, but can include a loss of wages, insurance costs, prescription drug costs, long-term care costs, and costs related to routine assistance due to disability (Taylor et al., 1996).

Hospitals face financial losses due to the readmission rates of stroke survivors. According to Vahidy et al. (2017), 12% of ischemic stroke survivors are readmitted within 30 days of discharge. Poston, Dumas, & Edlund (2014) one-fourth of stroke readmissions were related to lack of coordinated care and less than 5% of the readmitted patients had any post-care follow-up. In 2009, the Medicare Payment Advisory Commission (MedPAC) found that an estimated cost of up to $12 million dollars per year in avoidable readmissions were attributed to stroke related discharges (Jencks, Williams, and Coleman, 2009). As a result, MedPAC recommended to Congress that hospital readmission rates be reported and penalties should be assessed for excessive readmission rates (Jencks, et al., 2009). As these penalties were about to take effect, hospitals placed priority on initiatives to improve stroke readmission rates. The CMS Hospital Readmission Reduction Program was mandated in 2012 through the Affordable Care

Act and instituted the first penalties, up to 3% of total Medicare payment, to hospitals with excessive readmission rates (Castellucci, 2017). To this day, it is estimated that 75% of all hospitals in the US continue to be penalized per year (Castellucci, 2017).

The high incidence and residual effects from a stroke lead to increased readmission rates which negatively impact the healthcare system. The following DNP project aims to decrease hospital readmissions of the stroke survivor through development of an improved transitions of care process for the stroke survivor being discharged from a rehabilitation center to the community.

The transition of a patient to home should be a process. Abrashkin, Cho, Torgalkar, and Markoff (2012) describe this transition of care period as a complex and potentially compromising part of the patient's overall care. The implementation of a multi-disciplinary transition of care team approach when discharging a patient to home can increase patient outcomes and reduce readmissions (Abrashkin et al, 2012). Maygers, Lawrence, Woolford, Llinas, and Marsh (2015) discuss the implementation of structured post-discharge follow-up process for stroke patients which resulted in decreased readmission rates, which reinforces the idea that transition of care of the stroke patient from acute rehabilitation to home must be a continuous process.