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Geriatric Transitional Care and Readmissions Review

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ABSTRACT

Geriatric patients are a highly vulnerable population and are at increased risk for hospital admission and readmission. A university hospital implemented the Geriatric Transitional Care program, aimed at improving quality of care and reducing 30-day hospital readmission rates. Enrolled patients received telephone calls, and, if there was high risk for readmission, home visits from a nurse practitioner. Twenty-six (6.6%) inpatient-to-inpatient readmissions occurred, which was a 48% reduction from the hospital-wide readmission rate. Causes of readmissions fell into 6 categories. Transitional care can reduce frequency, serve as a point of contact, and monitor discharge follow-up.

Keywords: 30 days, care coordination, discharge, geriatrics, nurse, nurse practitioner, readmissions, transitional care, transitions

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BACKGROUND

Geriatric patients are a highly vulnerable population for hospital admission and readmission due to frailty, polypharmacy, comorbidities, cognition, and functional decline. Currently, 20% of Medicare patients are readmitted to the hospital within 30 days,[1] costing over $17 billion annually. Many of these rehospitalizations can be prevented, and the current literature suggests breakdown has occurred at both the patient and system levels to cause these rehospitalizations. Aging patients also are discharged from the hospital "quicker and sicker."[2] As a result, more patients are responsible for their care as they transition between health-care settings. This places an increasing burden on patients and their families to manage their care in the home setting, along with juggling appointments, medications, and recommendations made by multiple health-care providers. The lack of care coordination and communication after hospital discharge and increasing rates of hospital readmissions have led to a more in-depth look at quality of care and outcomes.

Transitional care is gaining more attention due to the Affordable Care Act, which was passed into law in 2010, and its implementation of financial penalties for hospitals with excessive readmission rates. The Hospital Readmissions Reduction Program was initiated in October 2012 as a subsection of the Affordable Care Act to address readmissions specifically.[3] The program allows the Centers for Medicare and Medicaid Services to reduce payments for readmissions of patients diagnosed with acute myocardial infarction, heart failure, and pneumonia. A readmission can be defined as an unplanned admission to a hospital within 30 days of discharge from the same or another hospital regardless of the admitting diagnosis.

Transitional care is a growing area of health care designed to address the needs of patients as they transfer between care settings or are discharged home from the hospital, with the goal of reducing hospital readmissions and ultimately improving the quality of patient care. It helps to remedy gaps in communication and coordination of care, identify patient goals of care, ensure timely patient follow-up, provide education and support, and serve as a point of contact for patients and families.

To serve the growing health-care needs of its geriatric population and reduce hospital readmissions, one midwestern university hospital implemented the Geriatric Transitional Care (GTC) program, aimed at improving quality of care and reducing 30-day hospital readmission rates. The GTC program is a hybrid approach of Dr. Eric Coleman's Care Transitions

Program[4] and Dr Mary Naylor's Transitional Care Model.[5] Patients are enrolled into the program and followed for 30 days after discharge. The program includes components of Coleman's program, such as self-management skills and education about hospital diagnosis, review of red flags, who to contact, and ensuring follow-up is scheduled and attended. It also includes components of Naylor's model, using a multidisciplinary approach to patient care with nurse practitioner home visits, follow-up telephone calls by a registered nurse, and social work services as needed. It strives to engage patients and caregivers as active participants in their care and is a point of contact for care coordination and communication. Between April 2012 and October 2013, 391 patients were enrolled in the program and each patient received telephone calls from a registered nurse for post-hospitalization follow-up. If a patient was considered high risk for readmission, home visits from a nurse practitioner were also initiated.

OBJECTIVE

A quality improvement retrospective health record review was conducted of patients enrolled in the GTC program. The objective of the review was to determine the cause of readmissions in patients participating in GTC and evaluate processes and outcomes to identify potential areas of improvement. This study addresses instances in which both the index admission and readmission were inpatient stays.

METHODS

Patients were identified through case finding using the hospital's computerized medical charting system. To be enrolled in the GTC program, patients had to be hospitalized on medicine services, aged $\geq$65 years, have a working telephone, and discharged home or to an assisted living facility. Patients were assessed during their hospitalization by the registered nurse and/or nurse practitioner. Each patient was stratified using a risk tool to determine if they were at moderate or high risk for readmission (Table 1). Patients determined to be at moderate risk for readmission received a telephone follow-up call within 72 hours of discharge by the registered nurse and then as needed up to 30 days. Patients considered to be at high risk for readmission had a home visit within 48 hours of hospital discharge from the nurse practitioner and phone calls thereafter as needed up to 30 days.

Table 1. Geriatric Transitional Care Program Risk Assessment Tool to Determine Whether the Patient Received a Home Visit From a Nurse Practitioner

High Risk for Readmission	Score
High-risk medications: anticoagulants, benzodiazepines, loop diuretics, antipsychotic, opiates, digoxin, insulin	
Two or more hospitalizations in past 6 months	
Lives alone or has inadequate support	
3 or more chronic diseases	
2 or more falls in past year or fall in past year with injury	
Low self-health rating, such as fair or poor	
Patient with CHF, COPD, PNA	
Rehospitalization in 30 days	
Hospitalization >4 days	
Returned home after discharge from SNF, LTAC in past 6 months	
Clinical judgment	
Total score: 4/11 = high risk	

CHF = congestive heart failure; COPD = chronic obstructive pulmonary disease; LTAC = long term acute care; PNA = pneumonia; SNF = skilled nursing facility.

The tool for high risk for readmission was developed by the team and grounded in previous research. The tool went through several iterations to fit the needs of the transitional care team and the hospital's population. The tool includes both objective and subjective measures. Clinical judgment could surpass all other criteria and place patients at high risk for readmission, as determined by the team. Patients would receive 1 point for each of the criteria they met on the tool. Zero to 3 points would place a patient at moderate risk for readmission and $\geq$4 points would place a patient at high risk for readmission and constitute a home visit by the nurse practitioner.

The high-risk tool was measured by face validity, as this was a quality improvement program. It was

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