Implementation of Telephone Follow-Up Post Discharge in Cardiac Surgery Patients

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Problem Statement

Readmission

- The definition of readmission is an unplanned return to the hospital shortly after being discharged from a recent hospitalization

Coronary artery bypass graft (CABG**) surgery**

- **CABG surgery** patients are of particular interest due to **high readmission rates** and **mean hospital charges**
- **Readmission rates** for (CABG) surgery range from **8.1–21.1%**
- The annual cost to Medicare for potentially **preventable** CABG readmission is **$151 million**

Project Purpose

The **purpose of this quality improvement project** is to implement telephone follow-up (TFU) post discharge to improve transition of care and readmission rates in post-cardiac surgical patients.

Nursing Theory

Application of **Maslow's hierarchy of needs** along with emphasis on **improving patients' self-care capacity,** both must be prioritized during the hospital stay and after they are discharged home, in order to **reduce the incidence of readmission.**

Methods

Quantitative Experimental Design

Sampling Inclusion
- Isolated CABG procedure
- Age 50 and older
- English Speaking
- Alert and Oriented
- Discharged Home
- Telephone Access

Intervention
- **Delivery**: The intervention consisted of a telephone follow-up post-discharge at 48-72 hours and 30 days that was a part of the AHRQ Red Toolkit
- **Components**: Health status, medication reconciliation, case management needs, follow-up appointments, and plans for what to do if a problem arises

Outcome Measures
- Readmission rates
- transition of care: primary care provider appointments, patient knowledge for self-management, and patient satisfaction.

Data Collection
- Self-reporting survey via phone interviews
- Medical record review

Results

Patient Demographics

Of the 30 participants, 27 (90%) were male, 3 (10%) were female.
- Age: M=67.37, SD= 8.342, BMI: M= 30.84, SD= 5.687

Medical Record Review Results 01/01/19-03/31/2020

	Jan-Dec 2019 1 year	July-Dec 2019 6 month	Oct-Dec 2019 3 month	Jan-March 2020 DNP Project
Number of CABG (A)	449	221	105	30
Number of CABG Patients Readmitted in 30 days (B)	43	27	11	1
CABG 30-day readmission rate (A÷B)	9.6%	12.2%	10.5%	3.3%

Transition of Care/Self-Reporting Outcomes

	Yes	No
Completed/Scheduled Appointment with Primary Care Provider	28 (93.3%)	2 (6.7%)
Knowledge for Self-Management		
1) Patients who correctly identified the reason for their hospital visit	30 (100%)	0 (0%)
2) Patients who were able to report signs and symptoms and what to watch out for after being discharged home	29 (96.67%)	1 (3.33%)
3) Patients who were able to correctly identify and report how to take their medications	28 (93.3%)	2 (6.7%)
Patient Satisfaction with TFU	30 (100%)	0 (0%)

Discussion

- **Readmission rates improved by 7.2% after the implementation of a telephone follow-up post discharge.**
- **Attention to primary care provider appointments and follow-up (93.3%), knowledge for self-management (100%, 96.67%, 93.3%), patient satisfaction (100%), as well as utilization of hospital discharge summaries to deliver education post-discharge was completed with each individual patient to achieve successful patient outcomes.**

Implications for Advanced Practice Nursing

- APRN's can translate research into evidence-based practice and drive change within an organization with aims of improving patient outcomes.
- The project experience was rewarding and attributed advanced leadership skills and clinical expertise and signified the purpose and reputation of being a DNP-prepared nurse practitioner.

Sustainability

- Given the success, the site where the QI project was implemented is interested in continuing the intervention.

References

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Implementation of Telephone Follow-Up Positively Impacted Readmission Rates and Transition of Care Outcomes Among this Patient Population

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