Early Follow Up Post AMI Discharge and the Impact on Readmission Rate; Experience from the Patient Navigator Program Focus MI

Hurst Hall, MD; Therese Vallina, MPH, BSN, RN; Janet Burkhard, MBA; Cheryl Kaplan, MBA, MHA, RN; Anne McCormack, BSN, RN; Sarah McCoy, BFA; Angela McKune, BSN, RN; Susan Neill-Fogus, BSN, RN; Laura Pattee, BSN, RN-BC; Chadell Rayford, MPH; Carmen Sandlin, RN; Carolyn Swann, MBA, RN; Deshonna Taylor, MSN, RN; William Tharpe, PharmD; Amber Ulate, MSN, MHA, RN

The University of Texas Southwestern Medical Center, Dallas, Texas

Background

As early post-discharge provider follow-up has been promoted as a method of reducing 30-day readmission rates1,2, we concentrated on the importance of the 7 day follow up appointment and continued risk-specific interventions that were implemented in Phase I of the PNP initiative in an attempt to decrease our 30 and 90 day readmission rate for AMI patients.

Methods

A multi-disciplinary approach was implemented prior to discharge to include the cardiologist, transition nurse, in-patient pharmacist and patient navigator.

- AMI patients receive inpatient education by our transition nurse (Monday- Friday)
- Pharmacists provide medication counseling at discharge and coordinate with patient navigators in ensuring medications received from outpatient pharmacy or routed to patient’s local pharmacy (Pharmacists available 7 days a week; weekends until 3:30pm)
- The transition nurse and patient navigator are available during hospital rounds to assess the patient’s discharge needs.
- The patient navigator is responsible for scheduling the follow up appointment with a cardiologist mid-level provider to accommodate a 7 day appointment prior to discharge from the hospital.
- A follow-up telephone call is made by the transition nurse within 72 hours of discharge to assess the patient’s understanding of the discharge instructions, ensure they had filled any new prescriptions and to give a reminder for the upcoming appointment.

Epic My Chart messages (secure messaging portal allowing intercommunication between patient and their physician/clinic staff) as well as automated reminders are also sent to patients to remind them of their upcoming appointment.

A nurse from the Clinical Heart Center makes a follow up phone call at 30 days and 90 days post-discharge.

Results

- The transition nurse and patient navigator are responsible for assessing the patient’s readmission risk for AMI patients.
- The patient navigator is responsible for the 72 hour, 30 and 90 day follow up telephone call made by the transition nurse within 72 hours after discharge, completing a follow-up appointment within 7 days and subsequent follow-up visit within 30 days are most impactful in reducing AMI readmission rates.
- Future investigation will include continued focus on increasing 7 day follow up appointment completion rate, identifying which risk factors are more predictive of readmission and evaluating impact on 90 day readmissions.
- Emphasis will continue on the 72 hour, 30 and 90 day follow up phone calls to encourage patient’s adherence to the medical regimen, solicit feedback and information beneficial to enhancing the transition of care experience.
- Forthcoming changes to the NCDR Chest Pain-MI Registry™ may expand our patient population and the impact is yet to be realized.

Conclusion

- Early results suggest that a combination approach of follow-up call within 72 hours after discharge, completing a follow-up appointment within 7 days and subsequent follow-up visit within 30 days are most impactful in reducing AMI readmission rates.

References


Disclosures and Contact

Authors do not have any disclosures.

Hurst Hall, MD: Hurst.Hall@UTSouthwestern.edu
Therese Vallina, MPH, BSN, RN: Therese.Vallina@UTSouthwestern.edu