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Don’t drop the ball, make the Call! Does follow up communication decrease number of 30-day re-admissions of patients living with heart failure?

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Abstract

Reducing hospital readmission for heart failure patients is a major focus for health care organization to improve quality and reduce cost, following centre for Medicare and Medicaid rule to lower reimbursement to hospitals with increased readmissions for heart attack, heart failure & pneumonia. This is a quantitative non-experimental comparative study of 2 groups of heart failure patients where a control group received standard discharge teachings and an intervention group received standard discharge teachings and a discharge follow up call or e-mail 72 hours post discharge from the hospital. This study established statistically significant relationship between discharge follow-up and heart failure patients 30 day readmission by describing correlation and causation based on objective measurement and observation (Hammer & Collinson, 2006). A non-probability convenience sample of 100 patients who were admitted to a heart failure unit were randomly selected to be in the control group where they received standard discharge instructions, and the intervention group received standard discharge instructions and discharge follow-up call or email 72 hours post discharge from the hospital. Data was analysed using IBM SPSS version 23.0. Descriptive statistics was used to describe the characteristics of the patients and the Chi-square, a non -parametric test was used to analyse the variables that were measured on a categorical level (Kim & Mallory, 2014). The study showed there were 6 patients re-admitted 30 days post discharge out of the control group, while only 3 out of the intervention group were re-admitted. The study also revealed gender has no statistical significance in both groups’ hospital readmission. Despite the difference of only 1.3% in readmissions between the two groups, this could mean a $1.5 million-dollar savings in Medicare reimbursement for the hospital. A meta-analysis of interventions for older heart failure patients found that comprehensive discharge follow-up reduces heart failure readmissions and improves outcomes without increasing costs (Phillips, CO, et al.).

Biography

Monette Mabolo completed her DNP from American Sentinel University in Denver, CO and her master’s in nursing from Duke University. She has been a nurse for over 40 years in various capacities from emergency department, medical-surgical and critical care. She is currently the department director of a 30-bed heart failure unit at Moses Cone Memorial Hospital in Greensboro, NC. She has presented at numerous conferences both internationally and in the U.S.

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