# The Use of Readmission Risk Stratification Tool to Guide Post-Discharge Interventions

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## INTRODUCTION

Readmissions, especially those related to patients 65 and older with heart failure and pneumonia, represent a challenge to healthcare facilities to identify effective methods of intervention based on risk while maximizing resources.

## PURPOSE

To determine if the interventions implemented based on risk of readmission reduced 30-day hospital readmissions for patients 65 years and older discharged to home with primary diagnosis of heart failure or pneumonia.

## METHOD

- **Care coordinators, social workers, nurses and physicians** identify the patient
- **APRN** assesses patient and performs risk stratification
- **APRN** consents the patient for participation
- **Variances from remote monitoring managed by RN**
- **Social Worker** connects patient to community resources
- **Pharmacist** does medication reconciliation, medication management, simplification of medications

## RESULTS

<table>
<thead>
<tr>
<th><strong>Enrolled in Program</strong></th>
<th><strong>June 14, 2012 to December 31, 2012</strong></th>
<th><strong>N=220</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>High Risk</strong></td>
<td><strong>Intermediate Risk</strong></td>
<td><strong>Total</strong></td>
</tr>
<tr>
<td>Heart Failure</td>
<td>114</td>
<td>17</td>
</tr>
<tr>
<td>Pneumonia</td>
<td>78</td>
<td>11</td>
</tr>
</tbody>
</table>

## INTERVENTIONS BASED ON RISK FOR READMISSION

<table>
<thead>
<tr>
<th><strong>Low Risk</strong></th>
<th><strong>Intermediate Risk</strong></th>
<th><strong>High Risk</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Remote Monitoring</td>
<td>Remote Monitoring plus RN call at days 3, 7, 21 post discharge</td>
<td>Remote Monitoring plus APRN home visit for 90 days</td>
</tr>
</tbody>
</table>

## PATIENT CHARACTERISTICS

- **Average age**: 80 years old
- **Average Number of Co-morbidities**: 4
- **Average Number of Prescriptions**: 14
- **Frailty Risk is high**

## CONCLUSION

The risk tool was not able to discern low risk patients. Despite intensive interventions for the intermediate and high risk patients, the readmission rate for patients with heart failure is higher than baseline. In addition to clinical, data about the patient’s environment outside the hospital must be included.

## REFERENCES