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Does Transitional Care Can Decrease Readmission in Stroke Patients?

Yurike Septianingrum[1], Siti Nurjanah[2], Nursalam Nursalam[2]

[1,2] Doctoral of Nursing, Faculty of Nursing, Universitas Airlangga
Jl. Dr. Ir. H. Soekarno, Mulyorejo, Kec. Mulyorejo, Surabaya, East Java, Indonesia 60115
*Email Korespondensi : yurikesepti1209@unusa.ac.id

ABSTRAK

Pendahuluan: Salah satu strategi untuk mengurangi penerimaan perawatan ulang pasien stroke di rumah sakit adalah dengan mengimplentasikan perawatan transisi (*transitional care*). Tujuan studi ini untuk mengidentifikasi penerapan perawatan transisi terhadap tingkat penerimaan kembali pasien stroke di rumah sakit.
Metode: Database Pubmed, CINAHL, SAGE dan Science Direct digunakan untuk mencari artikel yang dipublikasikan sejak Januari 2016 sampai 28 September 2021. Partisipan penelitian merupakan dewasa berusia 17 tahun atau lebih yang telah menjalani perawatan transisi dari rumah sakit ke rumah. Data yang berkaitan dengan karakteristik studi dan temuan penelitian diekstraksi dari artikel yang disertakan.
Hasil: Delapan artikel direview terkait hasil penerapan perawatan transisi terhadap angka penerimaan kembali dan kepuasan pada pasien stroke. Artikel yang direview seluruhnya menunjukkan penurunan angka penerimaan kembali dan peningkatan kepuasan pasien. Terdapat beberapa perbedaan pada proses perawatan transisi, koordinator tim, durasi tindak lanjut perawatan transisi, dan kepuasan layanan.
Simpulan: Temuan kami menunjukkan penerapan perawatan transisi berdampak positif pada penurunan angka penerimaan kembali sebelum 30 hari dan peningkatan kepuasan pasien terhadap layanan keperawatan. Kebijakan perawatan transisi perlu dipertimbangkan untuk mengurangi angka penerimaan kembali sebagai upaya meningkatkan mutu pelayanan rumah sakit.

Kata Kunci : discharge planning, kepuasan, perawatan lanjutan, perawatan transisi, penerimaan kembali, stroke.

ABSTRACT

Introduction: *One strategy to reduce the hospital readmission rate of stroke patients is to implement transitional care. The aim of this study is to identify the application of transitional care to the hospital readmission rate of stroke patients.*
Method: *PubMed, CINAHL, SAGE, and Science Direct databases were used to search for articles published from January 2016 to September 28, 2021. Participants in the study were adults (17 years old or older) who had transitioned from hospital to home care. The included publications were mined for information on study features and research findings.*
Results: *Eight articles were reviewed regarding the outcomes of implementing transitional care on readmission rates and satisfaction in stroke patients. All reviewed articles showed decreased readmission rates and increased patient satisfaction. There were some differences in the transitional care process, team coordinator, duration of transition care follow-up, and service satisfaction.*
Conclusions*: Our findings show that the application of transitional care has a positive impact on decreasing readmission rates before 30 days and increasing patient satisfaction with nursing care. Transitional care policies need to be considered to reduce readmission rates in an effort to improve the quality of hospital services.*

Keywords*: continuity of care, post-discharge, readmission, satisfaction, stroke, transitional care.*

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INTRODUCTION

Stroke is the greatest cause of chronic illness and mortality in the United States, affecting about 60% of the world's population, primarily in developing nations. (1–3). A stroke is expected to cause 795 000 illnesses and 137

000 fatalities each year in the United States (4). Stroke is a condition that strikes elderly individuals frequently and can significantly affect everyday functioning and quality of life (5). Every year, there are more people in Indonesia suffer from strokes. In 2018, there were 2.6 million stroke victims in Indonesia, making it the country with the most fatalities (6). Nearly 20% of people with stroke experience recurrence, with ischemic stroke being the most frequent type (7). Three times as many acute stroke patients end up in the hospital than non-stroke patients (8). Up to 20% of adults experience readmissions to the hospital within 30 days of receiving a medical ward release; this is a significant indicator of the quality of treatment received (9).

The cost of treating stroke patients may rise as a result of readmission incidents (10). According to estimates, readmissions account for 17% of Medicare hospital expenditures in the United States and 11% of all inpatient care costs in Canada, excluding physician fees. Greater-than-anticipated hospital readmission rates in the US may now result in financial penalties from Medicare (9). During this transitional period, a primary care provider's (PCP) engagement may be crucial. A lack of prompt PCP follow-up (within 4 weeks after discharge) has been shown to be linked to an increased risk of hospital readmission for the same condition and is likely to lead to a longer hospital stay. Patients are more likely to experience unfavorable outcomes following discharge if prescription mistakes, inadequate follow-up on unfinished tests, or lost opportunities for advised testing or outpatient procedures are present (11,12).

Hospital readmissions are caused by a variety of factors, such as comorbidities, exposure to inpatient allostatic load, and residual illness burden. These elements combine to create a "post-discharge syndrome" that momentarily raises a patient's susceptibility to unfavorable incidents. The capacity of the transitional caring (TC) team to lessen this susceptibility is correlated with the probability of developing post-discharge syndrome (8). The inability of families to care for patients, poor communication between patients, families, and service providers, non-adherence to medicine taking, missing control regimens, and difficulty accessing home care are all factors that lead to repeated readmissions (13,14).

Healthcare executives and providers have improved their understanding of how the care transition process can improve patient care and patient safety during the past ten years. A patient's sustained connectedness to the medical team is ensured via targeted interventions used throughout the hospital stay and continuing after discharge. It's interesting to note that research by specialists in health policy has revealed that bad transitions have a significant role in low quality and waste (15).

Transitional caring (TC) is one of the comprehensive and integrated nursing management that can reduce the readmission rate (1,16). Transitional care is expected to improve communication between health workers, patients, and their families during the transition from hospital to home (14,17). Some literature shows the effectiveness of TC in reducing the readmission (8,18–20), improving the patient outcome (21–23), and increasing the service satisfaction (24,25). The review was conducted to see outcomes that focused on the management of health services in general, not on patient outcomes because the indications that had to be measured were numerous and complex. The purpose of this literature review is to identify the application of transitional care to reduce readmission rates and increase satisfaction in stroke patients.

METHOD

Eligibility criteria

PICO criteria (Population, Intervention, Comparison, and Outcome) were used to develop eligibility criteria for study inclusion and exclusion in qualitative reviews (26). The population in this study is stroke survivors, intervention is transitional care which is compared with usual care, and outcomes are hospital readmission.

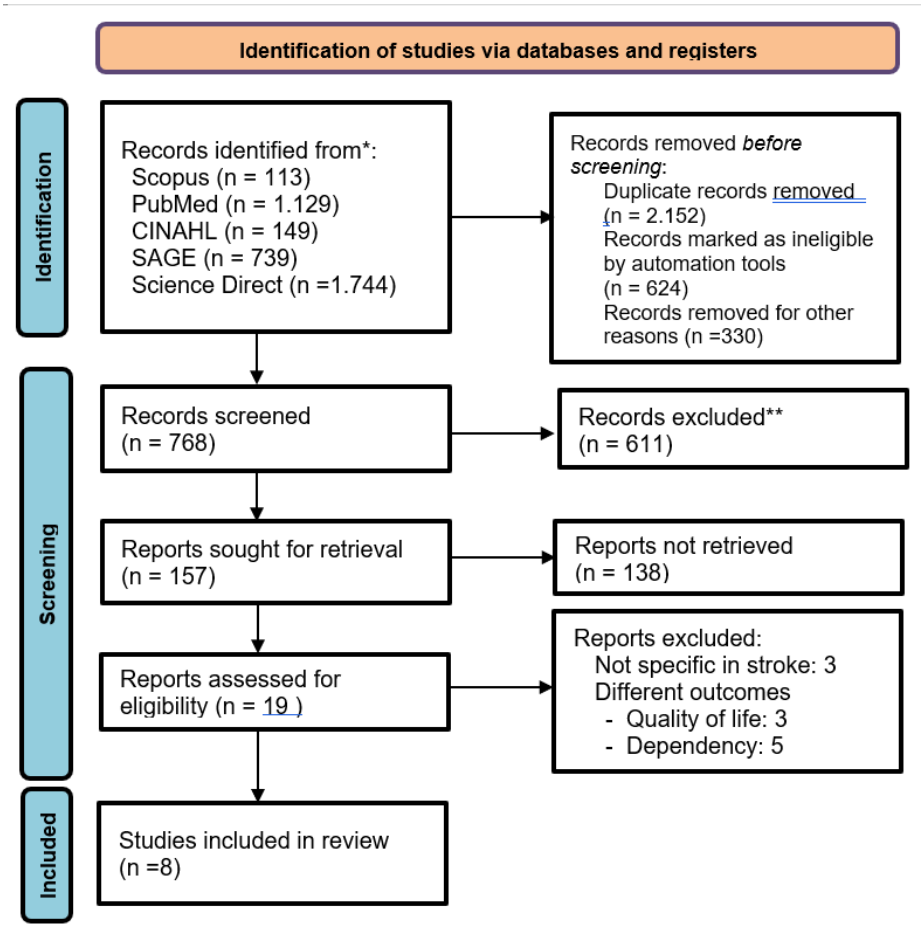

Figure 1. Flow diagram (PRISMA) of the study

Search strategy

The phrases "discharge planning," "hospital discharge," "discharge care pathways," "discharge care protocols," “follow-up after discharge”, "transitional care," “continuity of care”, and "transitional care pathways" were used in a search for peer-reviewed journal papers. To create concept groups, these terms were added to the phrase "from the inpatient environment to the home." Additionally, these concept groups were coupled with stroke”, “cerebrovascular accidents”, “acute stroke”, “readmission”, and “re-hospitalization”. Five databases were searched: CINAHL, Scopus, PubMed, Science Direct, and SAGE.

Inclusion criteria

1. Types of participants: Adults with stroke (over 17 years old) in all stages following stroke
2. Types of outcome measures: readmission and satisfaction
3. Types of interventions: transitional care intervention
4. Publication year: limited to the last five years from January 2016 to September 28, 2021
5. Language: articles published in English

Selection Process

Articles were added to a Mendeley database for screening, and duplicates were eliminated. To find studies that met the inclusion criteria, two reviewers independently skimmed each study's title and abstract. Records from the full-text

journal article were filtered out if their relevance could not be determined just by their title and abstract. The consensus was reached by reviewers when there was disagreement over whether a piece was relevant enough to be included.

Search outcome

The first 768 titles from the search results were filtered based on the title and abstract. The eligibility of the remaining 61 articles was determined after reading the entirety of each one. Seventeen articles were included in the review after duplicates were eliminated. The PRISMA diagram in the figure presents the article selection procedure and outcomes (Figure 1).

Quality Appraisal

The methodological quality of the obtained articles (n = 8) was evaluated independently by authors and observed using the Joanna Briggs Institute (JBI) Critical Assessment. The paper will be included for additional data synthesis if the final methodological quality assessment score reaches a minimum of 75%, it meets the crucial assessment criteria. all articles (n = 8) received scores of more than 75%, indicating that they were prepared for data synthesis.

Data Abstraction

On a data extraction form, the following details were recorded: the author's name, the year the study was conducted, the sample size, the facilitator, the intervention and control, method use, intervention duration, and the outcomes. The final dataset was examined in terms of 1) the transitional care process, 2) the team coordinator, 3) the duration of transition care follow-up, and 4) service satisfaction.

Table 1 Risk assessment of bias using the JBI critical assessment checklist

No	**Author, year**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**Total**
1	Lin *et al.* (2021)	√	√	√	√	√	√	√	√	√	√	√	√	X	92,31%
2	Condon *et al.* (2016)	√	√	√	√	X	X	√	√						75%
3	Ballard *et al.* (2018)	√	√	√	√	√	√	√	√	√	√	√			90,9%
4	Duncan *et al.* (2020)	√	√	√	√	√	√	√	√	√	√	√			81,82%
5	Leonhardt-Caprio *et al.* (2021)	√	√	√	√	√	√	√	X	√					77,78%
6	Kitzman *et al.* (2017)	√	√	√	√	√	√	√	√	√	√	√	√	X	92,31%
7	Eicner *et al.* (2021)	√	√	√	√	√	√	√	√	√	√	√	X	X	84,62%
8	Nkemdirim Okere *et al.* (2020)	√	√	√	√	√	√	√	√	√	X	√			90,9%

Table 2. Characteristics of studies

Author, year, design	Sample size	Facilitator	Intervention	Control/usual care	Method use	Duration	Outcome
(Lin et al., 2021), RCT	140 patients (dyad) and caregiver	nurse	Health coaching program	Traditional discharge planning: verbal health education before discharge and two follow-up telephone calls after discharge	establishing transitional care objectives, enhancing and strengthening self-care abilities, changing the home environment, enhancing physical function, managing medications, and managing and preventing stroke-related side effects.	12 weeks and 24 weeks follow-up	During the 24-week follow-up, the intervention group showed a statistically significant reduced risk of unplanned hospital readmissions than the standard care group (5.7% vs. 20%, p = 0.01).
(Condon et al., 2016), a prospective pre- and post-study	510 stroke patients	Nurse practitioner	nurse practitioner (NP)–led Transitional Stroke Clinic (TSC)	Prior to TCM, stroke/TIA patients who were sent home after being treated in a clinic only had a clinic visit with a nurse practitioner (NP) every four to twelve weeks,	Only high-risk patients who were sent home within a week and had an office visit between two to four weeks of discharge were called by nurse practitioners. All patients who	2-4 weeks and 90 days follow-up	Patients readmitted within 30 days were less likely to show for TSC visits (60.85% versus 76.3%; P=0.021). Multivariable modeling showed that TSC visit was associated with a 48%

				and these NP appointments were not scheduled.	were sent home under this phase received a follow-up phone call from a registered nurse within two days, as well as a follow-up appointment with a nurse practitioner within seven to fourteen days.		reduction in 30-day readmission (OR, 0.518; 95% confidence interval, 0.272–0.986), whereas multiple chronic conditions and previous stroke/transient ischemic attack increased the risk. TSC visit did not affect 90-day readmissions.
(Ballard et al., 2018), a retrospective cohort study	1884 stroke patients	a certified medical assistant	Transitional Care Management	-	Phase I: The NP began calling patients who were at high risk of readmission in a systematic manner. In Phase II, the structured follow-up phone calls were resumed, but TCM was performed by an RN within two business days after discharge as opposed to the RN who	7-14 days	Even in circumstances with low readmission rates from the admission index (less than 4% readmission), where it may be very difficult to discern differences related with TCM, TCM programs in primary care settings can lower

					handled it in Phase I.		readmission rates for patients.
(Duncan et al., 2020), a randomized pragmatic trial	A total of 6024 adult stroke patients	nurse	Comprehensive Post- Acute Stroke Services-Transitional Care (COMPASS-TC)	Usual care	After being released from the hospital, a call will be made within two business days, and a clinic visit is scheduled for seven to fourteen days afterwards.	7-14 days	At 90 days after discharge, the intervention's impact on functional status was negligible.
(Leonhardt-Caprio et al., 2021), a quasi-experimental	25 stroke patients	nurse	Transition of care model	Usual care	The time for making a post-discharge phone call was reduced from seven to three days after discharge.	7 days	a large decrease in 30-day all-cause readmission rates for IS patients who were released home after receiving an evidence-based bundled process improvement intervention. Ratings of patient satisfaction increased during the project's duration.
(Kitzman et al., 2017), clinical trial	30 stroke survivors	nurse	The Kentucky Care Coordination for Community	Usual care	In order to support transitions from acute care to the community, it is	3 months	There is no return to care for stroke patients, as demonstrated by the

			Transitions (KC3T)		important to first identify the types of resources used, such as healthcare plans, medication waiver programs, durable medical equipment (DME), and follow-up education. Next, you should identify the participants in the program's 30-day hospital readmission rates and ED visits, as well as their compliance with their medication regimens, doctor appointments, and outpatient rehabilitation visits. Finally, you should identify how well they are		implementation of transitional care, which focuses on enhancing communication between patients and medical personnel.

					using their ED visits.		
(Eichner et al., 2021), cluster randomized controlled trial	30 clusters with 2790 patients (93 per cluster).	General Practitioners	Strukturierte ambulante Nachsorge nach Schlaganfall' (SANO)	Usual care	hospital visits one, three, six, and nine months following a stroke to offer additional assistance in achieving the modification of cardio vascular risk factors	14 days	94 % overall expressed happiness or very pleased with the organization conducting the exam. Additionally, 95% of the patients thought the questionnaire was well-understood or extremely well-understood. The doctor who was contacted provided feedback that was mostly positive.
(Nkemdirim Okere et al., 2020), a retrospective cohort study	356,134 acute ischemic stroke patients	clinicians	Continuity of Care (CoC)	Usual care	Unclear	30 days	Patients in CoC experienced significantly less all-cause re-admission as compared to the control group. Those on CoC experienced a statistically significant decrease in all-

							cause in-hospital mortality as compared to patients in the control group.

DISCUSSION

Transitional Care Process

Transitional care is a structured set of nursing processes designed to prepare patients and their families after discharge from the hospital (14,19). Some of the transition care processes are described in the reviewed articles. Lin et al (2021) describe the transitional care process based on six components, namely (1) the setting of transitional care goals; (2) improvement and improve self-care skills; (3) modification of the home environment; (4) improving physical function; (5) drug management; and (6) the management and prevention of stroke side effects (18). Meanwhile, Condon et al. (2016) divided transitional care into two phases, namely: (1) implementing structured follow-up telephone calls by nurses for high-risk patients to be re-admitted within 7 days after discharge; phase (2) the nurse initiates a structured TC visit, which includes stroke education, secondary prevention, functional recovery, medication adherence, and evaluation for post-stroke complications (19). Ballard et al. (2018) describe the transitional care model (TCM) includes communication (phone calls) within 2 working days, follow-up scheduling, education, and assessment of medication adherence for patients after discharge from the hospital (20). Leonhardt-Caprio et al. (2021) implemented a TC process by completing post-discharge telephone calls within 7 days changed to 3 days after discharge. The call was completed by the inpatient ACC in the nursing unit. Phone call content is standardized through the use of narrative scripts (27). The entire TC process starts from preparing the patient to leave the hospital, and then continues with follow-up care through phone calls and home visits, this process is comprehensive and integrated.

The term "transitional care" (TC) refers to a healthcare intervention that aims to ensure continuity of care for patients when they move from one place to another (29). Reducing unexpected readmissions and emergency visits is TC's main goal. The intervention of transitional care comprises resolving the issues brought on by system fragmentation and socioeconomic disadvantages by boosting cross-site and interdisciplinary communication, standardizing care protocol, and improving the transitional care training (30).

All participants in the care transition process, including the patient, are process owners. Team collaboration, communication, and coordination are recurring themes throughout the interdisciplinary process. A network of support is created for the time after release when patients and caregivers are included in the interdisciplinary team process during the stay. Engagement between the patient and caregiver may start at the emergency department (ED), depending on the patient's condition, but it should surely happen once the patient is admitted. Although a variety of practices based on the concepts of transitional care can lower the risk of both short- and long-term readmission, no single transitional care activity has been demonstrated to effectively minimize hospital admissions (15,31).

Transitional Care Coordinator

Transitional care is an activity that involves many health workers related to patient care. Some articles mention that the team coordinator is led by a nurse (1,18–20,27). Nurses as team coordinators have an important role in maintaining communication with patients and families, as well as follow-up by telephone and home visits to see patient progress as a form of readmission prevention. Several articles mention that TC is led by another health worker who is called a community care worker (28), general practitioner (GP) (24), and doctor (8,16).

Across the care continuum, registered nurses are successful in coordinating care for various populations in a number of settings. Adults with stroke, disabled people with functional limitations, adults residing in skilled nursing institutions, and adults with chronic or severe conditions are some of the populations. The important role played by Registered Nurses in

delivering care coordination as an intervention for people, families, and communities is one of the essential elements of these effective models (32). The TC team was led by a registered nurse (RN) project manager, who was also entrusted with keeping track of results. The project manager played a key role in (a) setting up workflows, (b) producing reports, (c) organizing the team's tasks, and (d) forging connections with post-acute facilities and community providers (33).

A registered nurse outpatient case manager was hired for patients who were sent home, and she acquired training in and comprehension of the Coleman Model in order to support care continuity, communicate with community clinicians, and coach patients in identifying and managing symptoms (33). The nurse's role as coordinator of transitional care is very important because it is nurses who understand the needs of stroke patients during the transition period. Nurses, patients and families who are directly involved in transitional care to improve patients' quality of life

Readmission rate

After the application of TC there was a decrease in the readmission rate compared to the control group (18), or compared with usual care applied before TC (19,27). According to a study by Ballard (2018), even in situations with low readmission rates from index hospitalization (less than 4% readmitted), implementing a TCM program in a primary care context can lower readmission rates for patients (20).

Even the research of Kitzman et al. (2017) showed that the application of transitional care by focusing on improving communication between patients and health workers showed that there was no return to care for stroke patients. Follow-up readmission was carried out before 30 days, 90 days, and 6 months. All articles show a decrease in the readmission rate before 30 days (8,16,18–20,27), but not effective follow-up within 90 days (19).

Care satisfaction

Overall TC is proven to increase service satisfaction compared to the control group who did not receive TC (1). Almost all patients and families (94%) stated that they were satisfied or very satisfied with TC and gave positive feedback.

LIMITATION

This study has several limitations, including some articles that do not explain the transitional care process clearly, and the role of the care coordinator in the transitional care process. Some articles also do not explain the cost of transitional care, whether integrated with previous care or different from previous care.

IMPLICATION OF FINDINGS ON NURSING PRACTICE

Input from neurology nurses is very much needed in establishing transitional care guidelines for stroke patients because currently most of the transition care has never been implemented in Indonesia. So far, nurses carry out discharge planning when patients enter the hospital, during treatment, and before going home, but there has never been a continuation of care after the patient has gone home. Home care that is carried out is also not integrated with previous care, so not all stroke patients get home care because the cost of home care is quite large. With this data, hospitals, especially the Stroke Unit, can formulate policies regarding the implementation of transitional care..

CONFLICT OF INTEREST

There are no conflicts of interest, according to the author(s).

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