



# Perspectives



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## COORDINATED CARE TRANSITIONS

All cause vascular readmission are costly and most are preventable. Incision infection is one of the leading causes of most vascular readmissions. According to Engelbert et al<sup>1</sup> an estimated \$17.4 billion per year was spent on only Medicare readmissions over the past decade. Achieving optimal

healthcare outcomes in efforts to reduce 30-day all cause readmissions is the goal of healthcare institutions. Rising healthcare costs and healthcare reimbursement reductions have led to innovative process improvements. Focusing on the Hospital Readmission Reduction Program (HRRP), providers and healthcare administrators develop methods of monitoring patient status when discharged from the inpatient setting. For the medical patient, the use of Coordinated-Transitional Care (C-TraC) protocol has demonstrated reduction in 30-day all cause readmission.<sup>2</sup> The C-TraC protocol program, initiated in the Department of Veterans Affairs (VA), whereby the discharge process and direct patient contact originates in the inpatient setting involving hospital-based nurse case managers, inpatient healthcare team, and post discharge follow up phone call.<sup>3</sup> Medical C-TraC demonstrates a more comprehensive approach to caring for the patient in the outpatient setting and ensuring they are understanding their discharge instructions, medications, and follow up appointment. Considering there are a number of post vascular surgery patients who do not meet criteria for home healthcare; this leaves a care gap for patients to readmit.

Currently, there is not an evidence-based established coordinated care transitional care program protocol for surgical patients. Hence, a constant challenge for healthcare providers and institutions to adjust coordination of care in the postoperative population. Poor discharge planning coupled with poor quality healthcare transitions leads to increase all cause readmission.<sup>2</sup>

Healthcare changes drive how and where we provide care for our vascular patient population. We look for innovative methods in caring for patients and reducing hospital days. A pilot study by Archer et al.<sup>2</sup> utilized a surgical Coordinated - Transitional Care (sC-TraC) protocol, which included a patient led medication reconciliation, educating patients on "red flag" symptoms such as erythema, drainage, and fever with direct contact to the surgical coordinator nurse. This pilot study revealed increased patient engagement, increased medication reconciliation discrepancies, and closed the gap for patients who did not meet criteria for home healthcare. Coordinated transitional care is promising for our vascular surgery patient population. There is opportunity to close this gap in healthcare and provide patients with the appropriate transition in care and reduce overall readmissions.

## REFERENCES

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*J Vasc Nurs* 2019;37:77.

1062-0303/\$36.00

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<https://doi.org/10.1016/j.jvn.2019.05.002>