Slowing Down the Revolving Door of Rehospitalization from an Academic Skilled Nursing Facility

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Abstract

Background: Thirty-day hospital readmission rates are a key indicator of the quality of hospital care, and as a result of the Affordable Care Act, hospitals are now receiving financial penalties for excess readmissions. Skilled nursing facilities (SNFs) are also at risk for financial penalties if CMS proposes to reduce reimbursement rates by up to 2% for SNFs with high rates of readmissions beginning in 2017. Unfortunaltely, the relationship between hospital and SNF is often equated to a revolving door giving that nearly 25% of patients admitted to SNFs are rehospitalized within 30 days. As a result, we propose to quality improvement project to reduce 30-day rehospitalizations by implementing a standard protocol for patients admitted to Emory Healthcare’s Budd Terrace SNF.

Methods: Starting in February 2013, the initial intervention consisted of a four-step standard operating procedure (SOP) which included: (1) practitioner visit within 24 hours of admission, (2) a history and physical examination charted within 72 hours of admission, (3) a second practitioner visit within 7 days for patients identified as high risk with congestive heart failure, a history of organ transplant, a prior hospitalization within 6 months, a prior ICU stay within 30 days, a prior hospitalization totaling more than 21 days, or non-orthopedic surgery during the prior 6 months, and (4) a discharge meeting with the patient and responsible party. In addition, case conferences were held to review SOP compliance and to still down into patient readmission risks. During the intervention, an additional protocol was implemented to trigger palliative care consultations for certain high-risk patients who were transferred to Emory University Hospital within 30 days of discharge to Budd Terrace. In particular, patients receiving palliative care consultations if their readmission from Budd Terrace were their third acute care hospitalization within the last six months. Process and outcome measures recorded throughout the project included SOP compliance rates and the 30-day rehospitalization rates for high risk patients. Each month, feedback was provided to the multidisciplinary team on the appropriateness of the consultation and hospital eligibility of the patients.

Results: Compliance with the SOP improved from a monthly average of 48.5% of the start of the project to a monthly average of 92.0% by December 2013. The average rehospitalization rate for the project period in 2013 was 16.7%, compared to 17.1% for the same period in 2012. Patients that were deemed high risk had a prior hospitalization within a month (odds ratio = 2.13; P < .01) and hospital stay exceeding more than 21 days (odds ratio = 2.20; P < .05). An examination of the readmitted patient population uncovered that a readmitted patient had an average of 6 chronic diseases with 41% of readmitted patients having 6 or more chronic diseases. Palliative care providers at Emory University Hospital served a complex patient population and an average of 90 admissions and discharges per month. The average monthly compliance rate was near 90% by December 2013. The average readmission rate for the project period in 2013 was 17.1%, compared to 16.7%, compared to 17.1% for the same period in 2012. Patients that were deemed high risk had a prior hospitalization within a month (odds ratio = 2.13; P < .01) and hospital stay exceeding more than 21 days (odds ratio = 2.20; P < .05). An examination of the readmitted patient population uncovered that a readmitted patient had an average of 6 chronic diseases with 41% of readmitted patients having 6 or more chronic diseases. Palliative care providers at Emory University Hospital indicated that 100% of the patients consulted should have had a palliative care consultation prior to transfer to the SNF. A limitation of this study is that 75% of patients were by palliative care were deemed eligible for SNF admission and as a result of the Affordable Care Act, hospitals are now receiving financial penalties for excess readmissions. Skilled nursing facilities (SNFs) are also at risk for financial penalties if CMS proposes to reduce reimbursement rates by up to 2% for SNFs with high rates of readmissions beginning in 2017. Unfortunaltely, the relationship between hospital and SNF is often equated to a revolving door giving that nearly 25% of patients admitted to SNFs are rehospitalized within 30 days. As a result, we propose to quality improvement project to reduce 30-day rehospitalizations by implementing a standard protocol for patients admitted to Emory Healthcare’s Budd Terrace SNF.

Conclusion:

Establishing and maintaining nearly full compliance with an admission SOP allowed the program to achieve a 20 percent reduction (from 17.1% to 16.7%) in 30-day rehospitalization rates.

Objective

To achieve a 20 percent reduction (from 17.1% to 14.1%) in the all-cause 30-day readmission rate with the implementation of a standard operating procedure at Emory Healthcare’s Budd Terrace Skilled Nursing Facility.

Methods

Study Setting

Location: Budd Terrace is an Emory Healthcare-owned skilled nursing facility in Atlanta, GA with over 200 beds serving a complex patient population and an average of 90 admissions and discharges per month.

Data: Data was collected from March 2013 to December 2013 from patients that were admitted to Budd Terrace from an acute care hospital and subsequently discharged back to an acute care hospital within 30 days.

Standard Operating Procedure

1. 1st Practitioner Visit Within 24 Hours
2. Medication Reconciliation Within 24 Hours
3. History & Physical Charted Within 72 Hours
4. 2nd Practitioner Visit For High Risk Patients Within 7 Days

Results

Process Measure: SOP Compliance Rate

Average Monthly SOP Compliance Rate
- March: 30.0%
- April: 40.0%
- May: 20.0%
- June: 20.0%
- July: 30.0%
- August: 15.0%
- September: 5.0%
- October: 5.0%
- November: 5.0%
- December: 40.0%

Outcome Measure: 30-Day Readmission Rate

Average 30-Day Readmission Rate
- Base Year: 23.2%
- 2013: 17.1%
- 2014: 16.7%

Future Directions

Continue test of change incorporating palliative care consultations for patients with 3 or more hospitalizations in the past 6 months.

Explore initiation of palliative care consultations further upstream in a patient’s care episode.

Implementation of a similar admission protocol at the acute care hospital.

Conclusions

- SOP compliance improved when finding leaders responsible for the protocol and implementing checklists and reminders.
- There was no significant decrease in the 30-day readmission rate.
- Budd Terrace was already a highly medicalyzed skilled nursing facility with a low readmission rate.
- High risk factors predictive of a 30-day readmission includes a prior hospitalization within 6 months and a prior hospital stay of longer than 21 days.
- Readmitted patients have a high chronic disease burden with an average of 6 chronic diseases.
- Recent palliative care involvement has been a valuable test of change with early successes.
- Since December 2013, palliative care involvement has led to 9 prevented readmissions via complex decision making and advanced care/discharge planning support.

References

- Kneer T., Quiroga L, Cheng X., Cukierman E. The Revolving Door Of Rehospitalization From Skilled Nursing Facilities. Health Affairs 29 (1) [2010], 57-64.