Reducing avoidable rehospitalizations among seniors

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The rehospitalization of senior patients within 30 days of discharge from a skilled nursing facility (SNF) has risen dramatically in recent years, at an estimated annual cost of more than $17 billion. A new study from Hebrew Rehabilitation Center (HRC), an affiliate of Harvard Medical School, demonstrates improvements in discharge disposition following a three-pronged intervention that combines standardized admission templates, palliative care consultations, and root-cause-analysis conferences.

The study, published in the June issue of the Journal of the American Geriatrics Society, compared patients' discharge disposition from HRC's Recuperative Services Unit (RSU) in Boston, a skilled nursing facility, before and after implementation of the intervention. The rate of patient rehospitalization fell from 16.5 percent to 13.3 percent, a drop of nearly 20 percent. Discharges to home increased from 68.6 percent to 73.0 percent, and discharges to long-term care dropped to 11.5 percent from 13.8 percent.

"The change in discharge disposition observed between the two periods, we believe, reflects an improvement in patient outcomes," says lead author Randi E. Berkowitz, M.D., a geriatrician at Hebrew Rehabilitation Center and medical director of the RSU. "Specifically, a lower acute transfer rate likely reflects improved processes of care in the SNF."

One out of five Medicare beneficiaries was rehospitalized within 30

days of hospital discharge, costing an estimated $17.4 billion, according to recent estimates. In addition, hospitalized patients admitted to a skilled nursing facility have a high rate of early, unplanned rehospitalization. There are many risk factors that correlate with future hospitalization, says Dr. Berkowitz, such as recent hospitalization, specific diagnoses (such as congestive heart failure), acute medical illnesses, depression, and other factors.

From the older patient's perspective, hospital readmission can lead to a steady decline in functional status, ending in disability. As a result, these seniors must often trade their independent living for a long-term care facility.

As part of national health-care reform legislation, Medicare will stop paying hospitals for preventable readmissions for conditions such as heart failure and pneumonia, beginning in October 2012. Two years later, the list will expand to include additional medical conditions.

"Reducing rehospitalization has become a national target of health-care reform," says Robert J. Schreiber, M.D., HSL's chief medical officer. "Readmissions have a significant impact on the nation's health system and are often preventable."

Developed by HSL's Department of Medicine and key nursing, administrative and social service leaders, the admission template includes care guidelines for common geriatric syndromes, medication reconciliation, and goals of care, as well as a question about how many times the patient had been hospitalized over the past six months. A section on advance directives asks whether the patient or health-care proxy would want subsequent hospitalizations if the patient's condition deteriorated while on the SNF.

HRC's palliative care team consulted with patients who had three or

more hospitalizations in the past six months to determine whether rehospitalization was consistent with the patient's goals of care, or if worsening symptoms would be managed best on a SNF, in long-term care, or at home.

Team Improvement for the Patient and Safety (TIPS) conferences were held bimonthly to examine the root causes of rehospitalizations. Selected cases of preventable rehospitalizations were reviewed to identify ways in which the team could have operated more effectively. Depending on the specific causes identified, further information would be sought and additional staff or outside experts would be invited to participate in subsequent TIPS sessions.

"We designed the intervention to promote the importance of patients' goals of care and to help staff see transitions of care as an important part of their work product," says Dr. Berkowitz, an instructor in medicine at Harvard Medical School.

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