CARE COORDINATION
Eddy Heritage House Nursing and Rehabilitation Center

In recognition of longstanding organization-wide commitment to quality improvement and for establishing a cross-setting community partnership approach to improve transitions of care.

Initiatives to Reduce Acute Care Length of Stay (LOS)

BACKGROUND

Eddy Heritage House Nursing and Rehabilitation Center, a 120-bed nursing home facility in Troy, New York, is a member of St. Peter's Health Partners, a non-profit health system affiliated with Trinity Health. Eddy Heritage House offers skilled nursing care, including rehabilitative therapies and medical treatments for subacute and long-term residents.

To qualify for skilled nursing facility (SNF) extended care services coverage, the Centers for Medicare & Medicaid Services (CMS) requires that Medicare patients meet the 3-day rule which requires them to have a medically necessary inpatient hospital stay of three consecutive days excluding the discharge day, pre-admission time in the emergency department (ED), or outpatient observation.

Patients in need of skilled nursing for short term rehabilitation require up to 3 additional overnight stays due to the process and timeframe required for pre-authorization from insurance payers.

The goal of this project was to decrease at least one avoidable day stay due to:

- Delays related to the insurance pre-authorization process for patients in need of short-term rehabilitation;
- Availability of skilled nursing facility staff to complete the initial or admission assessment; or
- Transportation issues resulting in transfer of patients from acute care to the skilled nursing facility in the late afternoon/early evening when limited facility staff are available for a new admission.

APPROACH

Avoidable delays were tracked related to three key areas:

- Authorization delays;
- Delays in transportation;
- Late transports, leading to an avoidable day stay in an acute care hospital.

The Eddy Heritage House Nursing and Rehabilitation Center team facilitated improvements by

- Streamlining completion of onsite admission assessments prior to hospital discharge to prevent duplication of effort.
- Accepting patients from the St. Peter's Health Partner health system's acute care hospitals prior to receiving the insurance authorization, which eliminated the three-day wait period for confirmation and resulted in a decrease in hospital LOS.
  - The team tracked pre-authorizations and reported to senior leadership when authorization was denied after transfer. As part of the SPHP Care Continuum, Eddy Heritage House follows a process to ensure the cost of care is covered and the patient is not held responsible for denials.
- Hiring a part-time wheelchair van driver to assist with late discharges from hospital to nursing home, eliminating the need to rely on outside transport companies for timely pickup.

St. Peter's Health Partners and Eddy Heritage House have been a long-standing collaborative partner with IPRO since the first IPRO Care Transition Coalition in 2009. Eddy Heritage House has worked with IPRO to implement evidence-based, cross-setting interventions targeting improved resident outcomes. They often serve as best practice presenters for IPRO educational Learning and Action Network (LAN) events and IPRO-sponsored LINKS Forums. Heritage House is also one of two nursing homes partnered with IPRO on a Neighborhood Enrichment Team (NET) initiative, supporting community involvement to augment resident quality of life with a focus on health equity, cultural diversity, and health literacy.

RESULTS

Based on data collected and analyzed and results to date, the initiative to reduce LOS was a success, and the programs have continued.

Data was collected on late transportation events and those that led to an additional overnight hospital stay. Having an RN in acute care to complete assessments helped decrease the burden of late transportation, which meant the facility could accept the patient later in the evening as the initial assessment was already complete. ROI was determined to be positive.

CONCLUSION

Challenges:

- Hiring a RN who has a comprehensive understanding of all regulations surrounding short term rehabilitation in a skilled nursing facility.
- Embedding the RN Assessor into the acute care culture and ensuring close collaboration.
- Hiring and training a new hire for safe patient wheelchair transportation.
- Ensuring that the receiving facility has the capacity for after-hours acceptance of patients whose assessments were completed by the RN Assessor in the acute care facility.

Successes:

- Improved patient and caregiver satisfaction with securing and maintaining date and time for transfer from acute to SNF.
- Improved acute care clinical staff satisfaction with process to directly impact reduction of avoidable hospital days that lead to extended LOS.
- Decompressed the emergency department by opening acute care beds for patients who require an acute level of care.
- Timely transfer of patients out of the acute care setting where there is risk of nosocomial infection.

ACKNOWLEDGEMENTS

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REFERENCES

CMS 3-Day Rule:
https://www.cms.gov/files/document/skilled-nursing-facility-3-day-rule-billing.pdf