A plan for avoiding readmissions after surgery

A Medicaid patient is admitted to the hospital for repair of an enterocutaneous fistula. He’s considered a high risk for readmission after surgery because he doesn’t have a working refrigerator or telephone. That means he won’t be able to keep fresh food on hand or call his physician if he has problems. More likely, he’ll go to the emergency room and become a readmission.

To avoid that result, a transition planning nurse makes arrangements before his surgery so he can have the refrigerator repaired and install a phone. The patient recovers well, and a potential readmission is headed off.

“That’s the direction I’d want to head,” says John F. Sweeney, MD, FACS, chief, division of general and gastrointestinal surgery at Emory University School of Medicine in Atlanta.

He is senior author of a study finding that postoperative complications are the single most significant independent risk factor of readmissions after general surgery. The report was published in the Journal of the American College of Surgeons (sidebar).

Dr Sweeney is fostering a pilot program at Emory to lower surgical complication and readmission rates, with an emphasis on early transition-of-care planning.

Focus on readmissions

Readmission rates are a focus for hospitals. On October 1, 2012, the Centers for Medicare and Medicaid Services (CMS) began penalizing hospitals for excess 30-day readmissions for 3 conditions: acute myocardial infarction, heart failure, and pneumonia. There are plans to follow suit for surgical patients.

The penalties are mandated by the Affordable Care Act and spelled out in regulations from CMS. The program will expand to more conditions starting in fiscal year 2015.

A surgical procedure itself places patients at risk for readmission, beyond any medical problems, Dr Sweeney notes. It’s also possible to intervene early because surgery generally is a scheduled event. Having a plan to assist patients with care transitions should prevent readmissions.

‘A triple word score’

“Hospitals can’t look at the problem of readmissions without thinking about length of stay and complications. They are all intertwined,” Dr Sweeney told OR Manager.

Programs that make even a modest difference in all of these areas will lead to significant movement in costs and the value of care patients receive, he says.

It’s like a “triple word score in Scrabble,” he says. “When you have a 10% reduction in readmissions, plus a 10% reduction in length of stay, plus a 10% reduction in complications, it adds up to significant savings.”

Getting ahead of discharges

In Emory’s pilot transition-of-care program, a nurse practitioner interviews high-risk patients, assesses their risk for readmission, and develops a plan that allows patients...
to be discharged and followed as outpatients.

The program includes complication prevention bundles and standardized care, which Dr Sweeney says can support the costs to hire a nurse practitioner and the additional personnel needed for the program.

Emory is developing plans to pilot this program. The goal will be to track these outcomes to see if patient management protocols and transition management actually do improve readmissions rates and whether the improved quality supports the program financially.

Identifying risks
Patients who develop a complication in the hospital have an increased risk of readmission, but the risk is 2 to 3 times higher if the complication develops after they go home, says Dr Sweeney, who is also director of the Department of Surgery’s clinical quality and patient safety program.

“The problem is that when a patient starts to have trouble, he makes a call, and is told to go to the emergency room. When he shows up in the emergency room, he’s admitted, and there’s your readmission,” Dr Sweeney notes.

Preadmission screening helps not only to identify medical-surgical readmission risks but also potential problems for patients who don’t have the resources and family support they will need when discharged.

Having a nurse practitioner screen patients, make sure the transition plan is implemented, and interact with the patient after discharge could make a difference, he says.

Zeroing in on UTIs
Like the decision to operate on a patient, Dr Sweeney points out, a physician’s decision to send a patient home “is a very expensive decision that carries a fair amount of risk.”

He and his research group are examining what information a physician needs to make the right decision about discharging a patient. They started by identifying factors associated with readmission.

In the study, they found that the leading surgical complications associated with the risk of readmission were wound infections, pulmonary complications, and urinary tract infections (UTIs).

UTIs, though infrequent, were associated with the highest readmission risk—8 times higher than for a patient without a UTI.

“When we compared ourselves nationally, we found we’re doing better than average with the occurrence of UTIs. Looking closer, we saw a chance of reducing the number even further with a simple protocol for taking catheters out as soon as possible on a regular basis,” he says.

“Decreasing UTIs by 25% may not be a huge number, but one UTI costs about $12,000 and increases length of stay by 2.5 days.”

The protocol, which includes removing catheters based on Centers for Disease Control and Prevention criteria, is being piloted on 1 surgical unit and eventually will be rolled out to all units.

Postop complications drive readmissions
Postoperative complications are the leading risk factor for readmission after general surgery, in a finding by researchers from Emory University School of Medicine, Atlanta.

Patients with complications were 4 times more likely to be readmitted than those without.

The most common reasons for readmission were:
• GI problems/complications (28%)
• surgical site infections (22%)
• failure to thrive/malnutrition (10%).

In all, 11% of patients were readmitted within 30 days of discharge in the analysis of more than 1,400 patients from Emory University Hospital.

The study provides a framework for developing a simple readmission-prevention plan that includes early transition-of-care planning.

UTI rates persist with SCIP

He notes that UTI rates persisted even though the hospital was fully compliant with the Surgical Care Improvement Project (SCIP) measure to remove the Foley catheter within 48 hours after surgery. That was because the SCIP measure says a catheter can be left in beyond 48 hours if the physician documents why the catheter should not be removed. An analysis of patient records found some of the documented reasons for leaving the catheter in weren’t valid (sidebar).

“We found we are just really good at documenting why we’re leaving the catheter in, and the biggest risk for our urinary tract infections is the amount of time the catheter is in place,” he says.

“Our protocol now is that catheters are removed within 48 hours [after surgery] unless patients have had a urologic procedure or low rectal surgery. We’re going to be aggressive and track our results. I’m convinced that something as simple as what we’re talking about will move the dial and will make a difference,” he says.

With a “little effort and ingenuity,” Dr Sweeney says he is optimistic that a lot of readmissions can be prevented.

—Judith M. Mathias, MA, RN

Adhering to SCIP doesn’t lower postop UTIs

Most urinary tract infections (UTIs) after surgery happened in patients considered exempt from the SCIP Inf-9 measure that promotes removing urinary catheters within 48 hours of surgery, finds a study from Emory University Atlanta. (SCIP refers to the Surgical Care Improvement Project.)

In the study, John F. Sweeney, MD, and colleagues examined the relationship between adhering to the SCIP measure and the postop UTI rate.

For 2,459 patients analyzed, they found that though SCIP compliance increased over time, this was not linked with improved monthly UTI rates.

Of 69 UTIs found, 61 were cases that were compliant with SCIP, but 49 were exempt from the measure, and catheters were not taken out within 48 hours after surgery. Patients can be exempted if a physician documents a need and justification for leaving the catheter in place.

For 100 random controls, compliance was similar, but the exemption rate was lower.

The odds of a postop UTI were 8 times higher in patients deemed exempt from SCIP.

In view of the result, the researchers advise modifying the SCIP guidelines so there are fewer exemptions, and more catheters are removed earlier.

Indwelling urinary catheters account for 80% of UTIs.


References


Surgical care improvement project: Percent of surgical patients with urinary catheter removed on postoperative day 1 or postoperative day 2 with the day of surgery being day zero. www.qualitymeasures.ahrq.gov/content.aspx?id=27416&search=surgical+care+improvement+project