The Road Home: A Multi-Disciplinary Care Team Decreases Skilled Nursing Facility Utilization While Maintaining Quality Metrics After Geriatric Hip Fracture Surgery

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Purpose: Geriatric hip fracture care continues to increase nationwide with a reciprocal increase in cost of care, a large portion of which is attributed to prolonged stay within skilled nursing facilities (SNFs). An abundance of literature exists demonstrating a "home is best" approach to recovery after joint arthroplasty with benefits of decreased infection, readmission, and cost of care. We sought to determine whether a multidisciplinary approach to hip fracture care would result in a decreased SNF utilization rate while maintaining safe, high-quality care.

Methods: A multidisciplinary team, consisting of an attending trauma surgeon, a physician assistant, a nurse manager, and a social work manager, was installed. The team studied all geriatric hip and femur fractures admitted to our facility daily for a 3-month trial period. The following metrics were documented: SNF utilization, readmission, length of stay, and Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores. We then compared these variables with a matched cohort of patients who were treated prior to the installation of this care team.

Results: There were 111 total patients treated during the trial period. The discharge to SNF rate was 51% in the intervention group, which was significantly improved from 62% prior to intervention. The overall readmission rate was 26 of 111 (23%). The readmission rate from an SNF facility was significantly higher than from those who were discharged to home (40% SNF; 12% home). Of the 26 readmissions, SNF readmissions accounted for 20 patients (77%). Length of stay did not significantly increase (4.8 days vs 5.0 days, $p>0.1$). HCAHPS scores significantly increased among "Physician communication" and "Nursing communication" domains (76.3 vs 82.5 and 69.5 vs 80.0, respectively; $p<0.05$). "Care coordination" and "Kindness" domains also improved, although they did not reach statistical significance.

Conclusion: A multidisciplinary effort can not only decrease SNF utilization, but result in increased quality of care and patient satisfaction with regard to their experience. Most importantly, discharge to home can be done safely. This has fiscal impacts for individual hospital systems partaking in Bundled Care Payment programs, but also for societal cost of care as a whole.