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Identifying Risks of Readmission in Patients with Dementia in SNF for Targeted Community-Based Palliative Consultation (QI644)

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Objectives

- Describe the HOSPITAL score and apply it to patients with dementia discharged to skilled nursing facility (SNF).
- Compare risk factors including HOSPITAL score, Charlson Comorbidity Index, and high-risk discharge medications for risk of 60-day readmission from skilled nursing facility for patients with dementia.
- Identify patients with dementia at SNF who are at-risk for multiple transitions of care who may benefit from SNF-based palliative care consultation.

Background

Dementia patients are at high risk for preventable hospital readmission. This population could benefit from expert consultation in SNF to reduce readmission rates. Community-based palliative medicine focusing on symptom management and goals of care in post-acute care facilities can lower unnecessary transitions, hospitalization, and emergency department visits; reduce length of stay; and lower Medicare expenditures.

Aim Statement

Our study focused on determining risk factors associated with readmission from SNF in order to identify patients who would benefit from palliative medicine consultation. Tools used to assess risk included HOSPITAL score, Charlson Comorbidity Index, and determining if patients were on high risk medication defined by Beers Criteria.

Methods

A descriptive retrospective cohort study was conducted on patients with ICD-10 coding of dementia and discharged to SNF from 2017 to 2018 at the University Health System Hospital in San Antonio, TX. A chart review was conducted to calculate HOSPITAL Score and Charlson Comorbidity Index score. High-risk medication was determined using the 2019 AGS Beers Criteria list. Statistical analysis was conducted to determine if the variables were significant for hospital readmission.

Results

ICD-10 coding identified 132 patients with dementia discharged to SNF. Ten of these patients were readmitted within 60 days. HOSPITAL score was not predictive in assessing risk for hospital readmission (p=0.528). Hemoglobin at

discharge was the only HOSPITAL score variable statistically significant (p=0.012). Statistical analysis is still being conducted on the Charlson Comorbidity Index and high-risk medication.

Conclusions and Implications

Hospitalization and burdensome transitions of care negatively impact the dementia population and places them at risk for rehospitalization. Our study focused on identifying risk factors to better understand the high readmission rates. Understanding these could identify patients who would benefit from palliative care services to reduce hospital readmission and the negative impact of rehospitalization in dementia patients.