HealthBridge™

Case Study: Evergreen Skilled Nursing Facility

From Award-Winning Experts

HealthBridge
CASE STUDY

Evergreen Skilled Nursing Facility
2025 Engagement

Reducing Preventable Readmissions Through Data-Driven Care Coordination

Evergreen Skilled Nursing Facility, a 95-bed skilled nursing facility in Greenville, SC, partnered with HealthBridge in Q1 2025 to address a troubling pattern of preventable hospital readmissions. With a 30-day readmission rate well above the national benchmark, the facility faced mounting financial penalties and declining resident satisfaction scores. HealthBridge deployed its signature **CareConnect Framework** — a structured, data-led engagement designed to identify systemic gaps and embed sustainable solutions across clinical and administrative teams.

AT A GLANCE

Issue:	24.7% thirty-day readmission rate — nearly double the state average of 13.2%
Engagement:	HealthBridge CareConnect Framework with embedded consultants over 12 months
Goal:	40% reduction in preventable readmissions within 12 months of engagement
Result:	Readmission rate fell from 24.7% to 11.3% — a 54% reduction, with zero CMS penalties in 2025

The Challenge

Evergreen's clinical team was highly skilled, yet readmission data told a troubling story: **24.7%** of discharged residents were returning to the hospital within 30 days — nearly double the state average of 13.2%. Root causes were diffuse. Discharge planning was inconsistent across shifts, medication reconciliation was largely paper-based, and follow-up communication with families and outpatient providers was fragmented. Staff turnover in 2024 had also disrupted institutional continuity, leaving knowledge gaps in high-acuity care protocols.

HealthBridge Engagement

HealthBridge assigned a dedicated senior consultant and a clinical data analyst to Evergreen for a 12-month engagement. The team embedded on-site three days per week during the first

Interventions Implemented

Based on findings, HealthBridge co-designed a **7-point action plan** with Evergreen's leadership. Interventions were phased across three quarters to prevent operational disruption and allow for iterative learning and course-correction.

- Introduced the **IDEAL Discharge Protocol**, with checklists tailored to risk level.
- Implemented a cloud-based medication reconciliation platform integrated with the facility EHR.
- Established a **Friday Discharge Moratorium** for high-risk residents unless clinically urgent.
- Launched a 48-hour post-discharge phone outreach program staffed by two new care transition nurses.
- Trained all charge nurses in motivational interviewing and teach-back communication techniques.
- Created a real-time readmission dashboard reviewed in every morning clinical huddle.
- Partnered with 11 local primary care practices to establish a warm-handoff referral protocol.

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six months, conducting structured interviews with nursing staff, social workers, and the Director of Nursing. A full **workflow audit** was completed across all three nursing units using HealthBridge's proprietary Transition Risk Scoring tool, which stratifies residents by readmission likelihood based on diagnosis, medication complexity, and social determinants of health.

Key Findings

- **Discharge timing misalignment:** 61% of discharges occurred on Fridays, when outpatient follow-up capacity is lowest.
- **Medication reconciliation gaps:** 38% of charts had at least one unresolved discrepancy at the point of discharge.
- **Absent warm handoffs:** Fewer than 20% of residents had a documented physician-to-physician transfer call upon hospital return.
- **No risk stratification:** All residents received the same discharge checklist regardless of clinical complexity or readmission risk level.

Outcomes & Results

By Q4 2025, Evergreen had achieved measurable, sustained improvements across all tracked metrics:

Metric	Before	After	Change
30-Day Readmission Rate	24.7%	11.3%	↓ 54%
Medication Discrepancies at DC	38%	6%	↓ 84%
48-hr Post-Discharge Follow-Up	22%	91%	↑ 314%
Resident Satisfaction Score	71/100	88/100	↑ 24%
Staff Turnover Rate	41%	27%	↓ 34%

KEY OUTCOMES

54%	$1.2M	91%	5-Star	4.8×
Readmission Reduction	Penalty Avoidance	Follow-Up Rate	CMS Quality Rating	Estimated ROI

Return on Investment

By reducing readmissions by more than half, Evergreen avoided an estimated **$1.2 million** in CMS value-based purchasing

Staff & Culture Impact

Morning huddles became data-rich conversations anchored around resident risk scores. Staff turnover

Looking Ahead

Following the success at Evergreen, HealthBridge has been engaged to replicate the **CareConnect**

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penalties. Improved star ratings drove a **17% increase** in referral inquiries from hospital discharge planners, directly contributing to higher census. The HealthBridge engagement yielded an estimated **4.8× ROI** within the first year of sustained improvements.

dropped from **41% to 27%** year-over-year, attributed in part to clearer protocols. The Director of Nursing noted: "For the first time, our team felt they had the right tools to actually prevent readmissions — not just react to them."

Framework across two additional partner facilities in the area.

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