Reducing Readmissions: Implementing a Bi-directional Apparent Cause Analysis to Reduce SNF Rehospitalizations

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Background

Hospital Readmissions from SNF’s are common & costly (Yoo et al., 2015).

Medicare patients discharged to a SNF have a 25% likelihood of readmission within 30 days (Mendu et al., 2018). Costing $14.3 Billion (Chandra et al., 2017).

CMS developed a financial penalty as a part of the PPACA: Hospital Readmission Reduction Program (Medicare.gov).

Readmissions are preventable (Mileski et al., 2017).

Readmissions are nurse-sensitive (Yahushkova et al., 2015). Thus, a worthy project for a DNP student.

This DNP Project is a Quality Improvement initiative that will seek to address hospital readmissions to Weiss Hospital from local SNF’s in Chicago’s Uptown and Edgewater neighborhoods.

Problem Statement: Readmissions

Care Transitions between levels of care cross organizational boundaries, can be ineffective, lead to adverse outcomes & unnecessary readmissions (Mendu et al., 2018).

Hospital-to-nursing home transfers are some of the most logistically complicated safety challenges in the American medical system (Sandvik et al., 2013).

Disruptive & unsettling to patients & families.

Increases workload, dissatisfaction in healthcare workers.

The problem is ripe for improvement.

Project Purpose and Plan

Quality Improvement Project that examines SNF readmissions Bi-directionally.

Facilitates a side-by-side analysis of readmissions from both the SNF and Hospital perspectives.

Results of ACA’s reported/discussed in Weiss Hospital PAL (post acute leadership) meetings.

Goal is to prevent potentially avoidable 30-day SNF readmissions.

Protocol started with Training Seminars for hospital and SNF leaders on use of the INTERACT Protocol.

Facilitates a side-by-side analysis of readmissions from both the SNF and Hospital perspectives.

Evaluation

Data being collected from the variables on the INTERACT form.

Based on results, apparent cause(s) are discussed and follow up by leaders in hospital & SNF using PDSA QI model.

Outcome Indicator NQF 2510 Skilled Nursing Facility 30-day All Cause Readmission Measure (Endorsed by CMS)

Readmission Penalties Averted for Weiss Hospital Readmissions from SNF’s are common & costly (Yoo et al., 2015).

Hospitalized SNF residents have a 25% likelihood of potentially avoidable 30-day SNF readmissions and the INTERACT tool.

PI: Outcome Indicator: Survey SNF & Hospital Staff on Knowledge, Skills, Attitudes toward the structured, bi-directional ACA of readmissions and the INTERACT tool.

Process Indicator: Survey SNF & Hospital Staff on Knowledge, Skills, Attitudes toward the structured, bi-directional ACA of readmissions and the INTERACT tool.

References


