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

Keith Bakken, MS, RN

Audrey Klopp, PhD, RN, NHA; Mary Shehan, DNP, RN

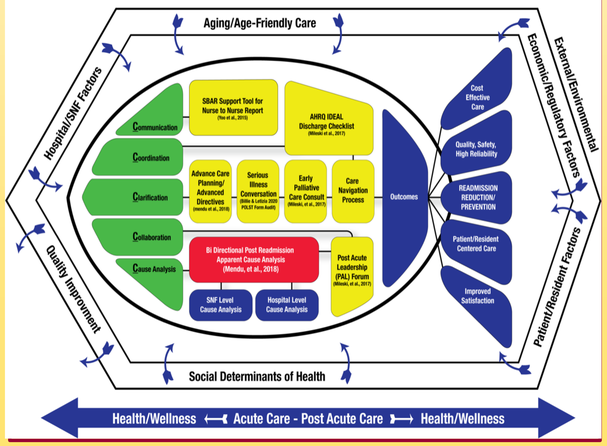
Marcella Niehoff School of Nursing, Loyola University Chicago

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 (Yahusheva 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

Conceptual Model

Navigating the High C's of SNF Readmission Prevention Conceptual Model



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 Review of Acute Care Transfer Form (Ouslander et al., 2009, 2014)
- Identify actions to address the problem/immediate condition that led to the readmission.
- Discern Preventability; if preventable, what steps would prevent this from reoccurring?
- Collect readmission data that aids in the identification of organizational trends (Mendu et al., 2018)
- Project began January 18, 2022. Currently in progress. Ending July 2022
- IRB Determination of Exemption Letters obtained from Weiss Hospital, Loyola and North Park Universities

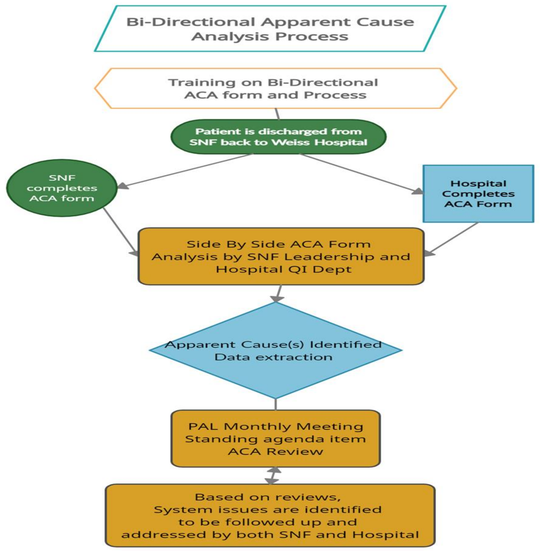
Problem Statement: Readmissions

- Care Transitions between levels of care cross established 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

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

Protocol Steps



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