Snuffing out SNF Readmissions: A Quality Improvement Project

"Snuffing out SNF Readmissions" is a quality improvement project initiated in May 2015 to reduce 30 day hospital readmissions from skilled nursing facilities (SNFs). The aim is to reduce readmissions from the current rate of 17.7% (in Quarter 1 of 2014) to 15% or lower for at least 6 consecutive months by June 30, 2016. The team will plan and launch iterative rapid cycle improvement efforts to address root causes of readmission. This project will impact frail older adults with complex medical needs who are discharged to the five SNFs included in the project. Older adults are particularly vulnerable during healthcare transitions, when adverse drug events and other poor clinical outcomes can result from discontinuity of care. Improving processes that lead to hospital readmissions will reduce the anxiety and negative clinical outcomes that older adults may experience during multiple transfers to and from the hospital.

Our Division of Geriatric Medicine consists of employed providers who deliver nursing facility based post-acute and long term care. Dyads of physicians and nurse practitioners provide care in the SNFs serving Scott & White Memorial Hospital, the hospital at which this project is based. The clinical team noted variability in the accuracy of discharge medication lists and completeness of transfer documents for patients discharged from our hospital to our SNFs. Likewise, our hospital colleagues were frustrated by incomplete documentation when individuals were transferred from our SNFs back to our hospital. Therefore, we chose to focus the project on the problem of readmissions from our SNFs.

Cycle 1 will implement INTERACT (Intervention to Reduce Acute Care Transfers) tools in participating SNFs. Tools will accompany residents who are transferred to the hospital. An "Enhanced RN" position is proposed (and included in the budget) to support this implementation. The Enhanced RN will work within the five participating SNFs to support consistent use of the INTERACT tools for all hospital transfers. This initial rapid cycle improvement step is intended to reduce some of the variability in communication identified as a strong theme in our problem analysis.

Data collection on medication reconciliation and other related processes is ongoing and will be used to plan the next improvement cycle. The team will select the exact process changes to be implemented once Cycle 1 is complete. By early December 2015, we will have data on medication reconciliation processes that the team will use to identify potential solutions to the issue. Those potential solutions will be prioritized, and the top 1-2 priorities will be implemented with ongoing monitoring. One example that will be considered is the IMPACT (Improving Post-Acute Care Transitions) an intervention piloted at Vanderbilt Medical Center.

Reduction of hospital readmissions is a goal for Scott & White Temple Memorial Hospital in Fiscal Year 2016. This project addresses a subset of readmissions that contributes directly to that goal. In addition, Baylor Scott & White Health has demonstrated a strong commitment to improving the health of populations through partnerships. The Baylor Scott & White Quality Alliance (BSWQA) is a large ACO in Texas that actively partners with providers (within and outside of our parent organization), post-acute care sites, payers and other stakeholders to reduce cost and improve quality. This improvement project is a unique opportunity to demonstrate population health impact, across payer groups, driven by hospital-community partnerships.