



Implementing a High-Risk Screening Checklist to Reduce 30-day Readmissions in Skilled Nursing Facility Residents

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Problem & PURPOSE

Problem

- 30-day hospital readmissions from skilled nursing facilities (SNFs) remain a significant challenge.
- Readmissions negatively impact patient outcomes, delay recovery, and increase healthcare costs.
- SNF placement delays, staffing shortages, and nursing home closures reduce care capacity and contribute to avoidable readmissions.
- Hospitals face increased strain and potential Medicare penalties due to excessive readmissions.

PURPOSE: The purpose of this project was to implement a nursing protocol utilizing a standardized readmission risk screening checklist for adult residents aged 65 and older at a local skilled nursing facility, with the goal of improving identification of high-risk patients and decreasing preventable hospital readmissions within the first 30 days of admission.

Available Knowledge & Rationale

- Evidence identifies key contributors to readmissions, **including poor communication, weak interdisciplinary collaboration, inadequate discharge planning, organizational resource limitations, and patient risk factors (e.g., advanced age, multiple chronic conditions, frailty, and polypharmacy).**
- Research supports comprehensive risk assessment, effective care coordination, and strong hospital-SNF communication to improve transitions of care and reduce preventable readmissions.
- A standardized high-risk screening checklist provides a **structured, evidence-based method to identify vulnerable patients early and guide targeted interventions.**
- Rationale: The project was guided by the Chronic Care Model (CCM), which promotes proactive, coordinated, patient-centered care. Implementing a standardized screening checklist supports early risk identification, improves care coordination, and aligns with best practices to reduce 30-day hospital readmissions.

Methods

- Context: Implemented in a **94-bed, locally owned skilled nursing facility** in a Midwestern U.S. city. Facility provides **short- and long-term care, rehabilitation, respite, hospice, and specialized nursing services.** Target population included **residents aged 65 years and older** admitted during the implementation period. Project involved the **interdisciplinary team**, including nursing staff, therapy providers, social workers, and facility leadership. Leadership support and team collaboration helped integrate the screening checklist into **routine clinical workflow.**
- Intervention: A standardized, evidence-based **high-risk readmission screening checklist** was implemented for **8 weeks** for all skilled nursing facility residents admitted aged **65 years and older.** The checklist, completed within **24 hours of admission** by the Director or Assistant Director of Nursing, assessed key readmission risk factors and categorized residents as **low, moderate, or high risk** to guide targeted care. Staff received education before implementation, and weekly monitoring ensured consistent use. The primary outcome was **30-day hospital readmission rates**, comparing data collected **8 weeks before** and **8 weeks during** implementation using existing staff and facility resources.
- Study of Intervention: The effectiveness of the intervention was evaluated by comparing **30-day hospital readmission rates** before and after implementation of the high-risk screening checklist. Readmission data were collected for **60 days before** and **60 days during** implementation using retrospective and prospective reviews of the facility's **electronic health record (EHR)** and transfer logs. Demographic information, checklist completion, and readmission outcomes were analyzed using de-identified data to protect resident confidentiality.
- Measure: An investigator-developed, evidence-based **high-risk screening checklist** was used to identify skilled nursing facility residents at increased risk for 30-day hospital readmission. The checklist assessed five key domains: **patient demographics, medical conditions, functional and cognitive status, medications, and social and behavioral concerns.** Residents were systematically evaluated for established readmission risk factors, allowing the checklist to serve as both a **process measure** for risk screening and an **outcome measure** to support targeted interventions and reduce preventable readmissions.

Data Analysis

The project was originally designed as a **quasi-experimental pre-post study** to evaluate the impact of a standardized high-risk screening checklist on 30-day hospital readmissions. Due to insufficient implementation data, outcome comparisons could not be completed. Instead, the project used **descriptive statistics** to summarize resident demographics, clinical characteristics, screening results, and readmission outcomes during the **8-week pre-implementation** and **8-week post-implementation** periods.

Results

- **Pre-implementation (n = 22)** Mean age: **78.6 years**
- Mean length of stay: **26.4 days**
- **1 hospital readmission (4.5%)**
- **Post-implementation (n = 16)** Mean age: **78.1 years**
- Mean length of stay: **29.6 days**
- **75% classified as high risk**
- **25% classified as moderate risk**
- **1 hospital readmission (6.3%)**
- **Overall Findings** Small sample size and limited outcome data prevented inferential statistical analysis.
- Results were summarized using **descriptive statistics** (means, standard deviations, frequencies, and percentages).

Table 1

Demographic Characteristics of Residents During Pre- and Post Implementation Phases

Variable	Pre-implementation (n = 22)	Post-implementation (n = 16)
Age, mean (SD), years	78.64 (7.72)	78.06 (7.90)
Length of stay, mean (SD), days	26.36 (14.87)	29.63 (21.24)
Number of comorbidities, mean (SD)	Not collected	2.81 (1.76)
Male, n (%)	10 (45.5)	7 (43.8)
Female, n (%)	12 (54.5)	9 (56.3)
Moderate risk for readmission, n (%)	Not assessed	4 (25.0)
High risk for readmission, n (%)	Not assessed	12 (75.0)

Discussion

Summary

- Implementation of the screening checklist improved **identification and stratification of high-risk residents**, with 75% classified as high-risk post-implementation.
- **Readmission rates remained relatively unchanged** (4.5% pre-implementation vs. 6.3% post-implementation).
- The intervention strengthened **staff awareness, risk recognition, and care planning processes.**
- The checklist was **low-cost, feasible, and easily integrated** into routine workflow, supporting early identification of vulnerable residents.
- Findings suggest potential for **long-term reduction in readmissions with sustained use**, despite limited short-term outcome change.

Interpretation

- Findings align with literature emphasizing **structured risk assessment, communication, and care coordination** in reducing SNF readmissions.
- The checklist improved identification of high-risk residents, supporting **early intervention and proactive care planning.**
- Results reinforce evidence that **transitional care quality and interdisciplinary collaboration** are key to reducing preventable rehospitalizations.
- Lack of significant reduction in readmissions may reflect **short timeline, small sample size, and high patient acuity.**
- Overall impact was primarily on **clinical processes rather than immediate outcome reduction.**

Limitations

- **Small sample size** and single-site setting limit generalizability.
- **Short implementation period** may not capture long-term effects on readmissions.
- Lack of pre-implementation comorbidity data limited ability to control for **baseline differences in patient complexity.**
- **No control group and no randomization**, reducing ability to infer causation.
- Potential **confounding factors** (acuity, staffing, provider decisions, family support) may have influenced results.
- Documentation variability and unequal group sizes may have affected data consistency and comparisons.

Conclusions

Using the SQUIRE 2.0 framework, this project demonstrated that implementing a standardized high-risk screening checklist improved the identification of residents at moderate and high risk for hospital readmission, strengthening clinical awareness and supporting more consistent risk recognition. Although 30-day readmission rates did not show substantial improvement within the project timeframe, the intervention enhanced proactive care planning and interdisciplinary communication. The checklist was a low-cost, feasible tool that integrated easily into routine workflow and has potential for long-term sustainability and spread to other facilities. Future efforts should focus on larger samples, longer evaluation periods, and expanded clinical data collection to further assess effectiveness in reducing preventable hospital readmissions.