

Rehospitalization Reduction on a Geriatric Skilled Nursing Unit  
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**Introduction** - Hospital readmissions from skilled nursing units (SNF's) are associated with decline in patient function, increased risk of medication errors from poor communication between sites, and excess cost. By implementing procedures to prevent unnecessary readmissions, our SNF will improve the quality of patient care while seeking to decrease annual hospital readmission rates by at least 10% as of August 2010. This will position Hebrew Senior Life SNF as a top performing subacute care provider as hospitals seek to decrease readmissions and contain costs. As Medical Director, I will lead the effort to meet this goal by standardizing the physician admission process for assessing the appropriateness of "Do Not Hospitalize" orders, improving team communication and learning from cases of avoidable readmissions, standardizing the home discharge process, and sharing knowledge with referring hospitals.

**Admissions** - As part of the history and physical, physicians will use a standardized process to identify and treat geriatric syndromes early, to evaluate goals of care for patients at increased risk of rehospitalization, and to determine whether a "Do Not Hospitalize" order is appropriate. **Team**

**Improvement for the Patient and Safety Conferences (TIPS)** - Each unplanned discharge to the hospital will be reviewed to assess root causes of avoidable discharges. Multidisciplinary care teams will meet monthly to review avoidable discharges and redesign care delivery. Staff will complete biannual AHRQ surveys to track improvements in patient safety, team cohesiveness, and changes in staff attitudes.

**Discharges** - As one of six pilot sites for Boston Medical Center's "Project Re-Engineered Discharge" (RED), a project that has already demonstrated 30% reduction in readmission rates in hospitals, a computer-based program will be used to educate patients about their diagnoses, medications, and follow-up appointments to ensure understanding of their home care plan. As the only SNF participating in this program, this program will be customized to serve geriatric patients with a goal of decreasing rehospitalizations by 10% after discharge from the SNF.

**Sharing knowledge across continuum** - I will work with the Institute of Health Care Improvement's State Action on Avoidable Rehospitalizations Initiative to improve communication with our partner acute care hospitals. This will include sharing lessons learned from TIPS case reviews and other avoidable discharges. Knowledge learned in this project will be disseminated to other hospital systems across the country.

Please [email Randi](#) with any questions or comments regarding this project.