Ending Hospital Readmissions
A Blueprint for SNFs

Barbara Acello, MS, RN
ENDING HOSPITAL READMISSIONS

A Blueprint for SNFs

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Reimbursement drives the healthcare system, and you will see how the length of a hospital stay has decreased markedly from 1940 to the present time. The decrease in length of stay corresponds with changes in the Medicare payment system. Originally, Medicare had few limits on the medical costs of hospitalization. However, this eventually proved too expensive, and reimbursement was limited to “reasonable and medically necessary” care. Despite this change, reimbursements were still quite generous and hospital stays were lengthy. In the 1980s, Medicare changed the payment structure from a reimbursement-based model to a prospective payment system with diagnosis-related groups. Prior to this time, physicians were patriarchal and all important. They ran the hospitals, set the rules, and few questioned their decisions to keep patients in the hospital for prolonged periods of time. The balance of power changed markedly with the change in the Medicare payment structure, and hospitals started limiting physician power. One casualty was a marked reduction in the average length of stay. This change in Medicare reimbursement policy affected most of the healthcare providers and insurers in the United States.

As Medicare continued to look for ways to contain costs, they reviewed the expenditures associated with length of stay, admissions, and discharges. One of the most common causes of delayed hospital discharges is due to waiting for a bed in a long-term care facility. This is often due to delays in hospital discharge planning, not inaction by long-term care facilities. Nevertheless, the issue appeared on their radar screen. In the process of studying costs associated with hospital discharges, Medicare also discovered high numbers of preventable readmissions. Thus, they began focusing on ways of reducing costs associated with these two areas.
Introduction

It is estimated that Medicare spends $25 billion per year for unnecessary readmissions. At the present time, there are no disincentives for returning residents to the hospital soon after discharge. We can expect to see deterrents in the future because rehospitalization is such a costly issue, and saving Medicare dollars is a priority. Some readmissions are necessary, but many others are not. Caregivers and family members have long expressed concern about the negative effects of hospitalization on elderly persons, such as a deterioration of cognitive status in long-term care elderly. Repeated hospitalizations are stressful as well as physically and emotionally traumatic, and often lead to poor outcomes. There is often no continuity between acute and long-term care facilities, which compounds the difficulty for the residents transitioning between the two. In addition to having adverse effects on the residents, admissions, and discharges are very stressful and time consuming for facility staff. Emergency transfers can be particularly difficult. The numerous small tasks involved in admitting and discharging a resident increase the risk for errors. It stands to reason that preventing unnecessary admissions would be more beneficial and less stressful for residents, their families, and facility staff.

On the surface, the subject of rehospitalization does not seem relevant to long-term care nurses. Have you ever stopped to consider the residents your facility admits, discharges, and readmits? How many of your admissions return to the hospital within a brief period of time? Have you ever analyzed the reasons for the readmissions? Many Charge Nurses and Directors of Nursing accept rehospitalizations as a fact of life. But are they? Some believe that improved monitoring will solve the problem. Is this the only factor? Would an analysis of the readmissions in your facility lead to improvements in care delivery? Since this is an area of governmental focus, it would be wise for facilities to analyze their information and implement corrective action as needed. This book will help long-term care facility staff:

- Understand the financial and quality of care implications associated with rehospitalizations

Ending Hospital Readmissions: A Blueprint for SNFs
• Explain why maintaining the census is a priority in long-term care facilities

• Identify priorities and develop protocols and practices for reducing a resident’s risk of returning to the hospital after admission to the long-term care facility

• Teach staff the skills needed to help prevent rehospitalization

• Understand the importance of communication and documentation, the role of care plans and clinical care pathways, and the importance of advanced care planning

• Develop effective discharge protocols

• Understand the importance of medication reconciliation and management

• Understand the importance of careful, frequent monitoring of residents who were recently admitted

• Develop protocols for monitoring residents

• Recognize early changes in resident status

• Understand how to ensure residents derive maximum benefit from the Medicare program

• Identify communication problems and enhance communication with other healthcare providers about a resident’s change of status

• Identify strategies for preventing rehospitalizations

• Describe methods for ensuring smooth transitions

• Provide effective, individualized postdischarge care
Preventing unnecessary readmissions involves using the nursing process and the information in your book to analyze your facility admissions and discharges and develop a plan to reduce unnecessary readmissions:

- **Assessment phase** – Analyze your admissions, discharges, and reasons for them. Ask yourself these questions: If a resident returns to the hospital, how long did he or she stay in the facility? What is the reason for the rehospitalization? Could it have been avoided? What is the process for discharging the resident to home or a lower level of care? What predischarge planning and teaching are done? How does the facility follow the resident after discharge? Why is postdischarge monitoring important?

- **Planning phase** – After collecting and analyzing data, develop a preliminary plan to reduce unnecessary hospitalizations. Determine what resources are needed. Identify educational needs of staff. Determine whether practices, processes, policies, and procedures need to change. Involve staff at all levels in developing the plan. They are much more likely to make it work if they have an investment in the process.

- **Implementation phase** – Implement the plan. Keep objective records during the implementation phase. The records will be useful when you begin to evaluate the effectiveness of the plan. Do not be disappointed if the plan is not 100% effective. This is normal. Identifying and working through problems encourages growth. Set a target date for evaluating the plan.

- **Evaluation phase** – The frequency of admissions and discharges in your facility will help you determine the target date for evaluating the plan. Facilities with many admissions and discharges will be able to evaluate the plan more quickly than facilities with little resident turnover. When you have collected the necessary information, call a meeting of the original planning committee. Evaluate...
the effectiveness of the plan based on the information you have collected and comments from the residents, families, and staff. Make modifications as needed and begin again until you have fine tuned your facility processes and the plan is as effective as it can be.

This writer commends and respects those who dedicate their careers to improving quality of life and quality of care for our long-term care facility elderly. Your facility can make a difference in reducing unnecessary rehospitalizations while improving quality of care and the quality of residents’ lives. Best wishes on your journey!

Barbara Acello
January 2011
bacello@spamcop.net
An informed and proactive nursing home staff is a vital weapon in the struggle to keep residents from being readmitted to the hospital. To assist your facility in reducing rehospitalizations and improve transitions of care, download the tools, forms, and additional materials found in the appendix of this book. For a complete listing of available tools and forms, reference the Appendix section of the Table of Contents of this book.

Website available upon purchase of this book.

Thank you for purchasing this product!
Introduction: Why Are Hospital Readmissions a Problem?

Medicare and Senior Healthcare

The Medicare program pays for the healthcare for most senior citizens in the United States. Fifty-one percent of covered individuals experience at least one Medicare-covered event each year (Table 1.1). Approximately 2.2 million Medicare beneficiaries lived in long-term care facilities sometime during 2006. This is about 6% of the total Medicare population. Residents living in the various types of long-term care facilities account for a disproportionately large portion of the total Medicare spending (17%), with high rates of hospital care, skilled nursing facility (SNF) care, and other Medicare-covered services (Table 1.2). The cost that the Medicare program paid for these services was $25 billion, or 9% of total Medicare spending in 2006 (Table 1.3). This is about twice as much money as Medicare spent for the care of persons not living in facilities.

As much as 40% of the 2006 costs were paid to hospitals for emergency department visits, inpatient and observational admissions, and skilled nursing care. In addition to being costly, hospitalizations often cause untoward physical and mental effects, such as weakness, delirium, and declines in cognitive status. Approximately 600,000 Medicare beneficiaries are admitted to long-term care facilities annually. The average Medicare spending for residents who lived for at least six months after admission in 2003–2006 was more than twice the average monthly spending for those who had lived in the...
Table 1.1 Medicare Beneficiaries With at Least One Covered Event

<table>
<thead>
<tr>
<th>Event</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Visit</td>
<td>51%</td>
</tr>
<tr>
<td>Hospital Visit</td>
<td>38%</td>
</tr>
<tr>
<td>SNF Stay</td>
<td>30%</td>
</tr>
<tr>
<td>Hospice Event</td>
<td>14%</td>
</tr>
<tr>
<td>Home Health Visit</td>
<td>9%</td>
</tr>
</tbody>
</table>

Table 1.2 Medicare Beneficiaries With More Than One Covered Event, 2006

<table>
<thead>
<tr>
<th>Event</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room Visit</td>
<td>30%</td>
</tr>
<tr>
<td>Hospital Visit</td>
<td>20%</td>
</tr>
<tr>
<td>SNF Stay</td>
<td>17%</td>
</tr>
<tr>
<td>Hospice Event</td>
<td>15%</td>
</tr>
<tr>
<td>Home Health Visit</td>
<td>10%</td>
</tr>
</tbody>
</table>
Ending Hospital Readmissions: A Blueprint for SNFs

Introduction: Why Are Hospital Readmissions a Problem?

Medicare Spending per LTC Resident, 2006

Table 1.3

Medicare Spending per LTC Resident, 2006

facility for a year or more (Table 1.4). Refer to the facility definitions in the Appendix of your book, then review Table 1.4 for a breakdown of admissions by type of facility. As you can see, Medicare spending is much higher immediately after facility admission. One reason for this is readmissions to the hospital.

Recent studies suggest that the incidence of complications can be reduced and many rehospitalizations can be prevented with careful monitoring and attentive care management, medical support in the facility, and better transitions to and from the hospital. Many preventable hospital admissions and readmissions are the result of poor communication.
Rehospitalization

The need for containing and reducing healthcare costs has been in the news for quite some time. You have undoubtedly heard that Social Security is running out of money. A significant cause of this problem is hospital readmissions. This refers to patients who are discharged from an acute care hospital and are hospitalized again within 30 days of discharge.

**Definitions, facts, and figures**

Rehospitalizations are unanticipated, unscheduled readmissions to the hospital that are clinically related to the initial admission. Although the person is typically returned to the original admitting hospital, a rehospitalization occurs when the person is admitted...
Introduction: Why are Hospital Readmissions a Problem?

Ending Hospital Readmissions: A Blueprint for SNFs

to any hospital for treatment of the original condition. This phenomenon is sometimes called bounce back. A newer term is complicated (or complex) transition. Patients who are repeatedly admitted are often called frequent flyers. Very few people want to return to the hospital. Likewise, hospitals do not want their discharged patients to return. It is usually a lose–lose situation for both parties. The facts are abysmal:

- According to the Institute for Healthcare Improvement (IHI), there are about 5 million hospital readmissions annually.
  - Approximately a third of these occur within 90 days of discharge
  - About 46% of these could be prevented

- Estimates vary by year, but 15% to 25% of all Medicare hospitalizations are rehospitalizations.

<table>
<thead>
<tr>
<th>Table 1.5</th>
<th>Average Medicare Spending After LTCF Admission</th>
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<tbody>
<tr>
<td>1 month</td>
<td>$2500</td>
</tr>
<tr>
<td>2 months</td>
<td>$2000</td>
</tr>
<tr>
<td>3 months</td>
<td>$1500</td>
</tr>
<tr>
<td>4 months</td>
<td>$1000</td>
</tr>
<tr>
<td>5 months</td>
<td>$500</td>
</tr>
<tr>
<td>6 months or more</td>
<td>$0</td>
</tr>
</tbody>
</table>

Average Medicare spending immediately after facility admission is substantially higher than it is after residence for one year or more.
• Rehospitalizations account for $15 billion in annual Medicare spending.

• Thirty-four percent of the Medicare beneficiaries were rehospitalized within 90 days.

• 68.9% of patients readmitted or had died within a year.

• Of those admitted to long-term care facilities, 22% to 29% were readmitted to the hospital.

• In 2006, the cost to Medicare associated with SNF rehospitalizations was $4.3 billion, with an average rehospitalization Medicare payment totaling $10,352.

• The death rate for stroke survivors was 26.7% in the first year after hospital discharge. The readmission rate was 56.2%. The overall risk of death or readmission was 61.9%.

• Medicare is collecting readmission data and will calculate a three-year average of readmission rates.

• Hospitals with high rates of rehospitalizations will be financially penalized in the near future.

• The state of Idaho has the lowest incidence of rehospitalizations.

• Rural hospitals have almost twice as many preventable readmissions than urban hospitals.

• About 60% of persons over age 65 had potentially preventable hospital stays.

• Approximately 5.4% of all individuals with private insurance or Medicare coverage were admitted for potentially preventable conditions.

• Men are more likely to be hospitalized for a chronic preventable condition than women.

Ending Hospital Readmissions: A Blueprint for SNFs
• Men are less likely than women to be hospitalized for a potentially preventable acute condition.

• Of all patients, 20% to 40% are rehospitalized at a different hospital.

• Twenty conditions account for 58% of all episodes of care.
  – Fracture and dislocation of lower extremities and bacterial lung infections are the only two that are acute.
  – The remaining 18 are chronic conditions (i.e., diabetes, chronic obstructive pulmonary disease, congestive heart failure, renal failure). Refer to the list in the Appendix of your book.
  – Ten of these conditions represent the fastest growing costs of care and represented 29% of Medicare spending in 2005.

**Implications of Rehospitalizations**

In addition to the financial implications facing hospitals, a high incidence of readmissions has the potential for sending a negative message about hospital quality and safety. The Centers for Medicare & Medicaid Services (CMS) Hospital Compare website lists readmission information as one of the indicators of hospital performance. Enlightened consumers may view a high incidence of readmissions as an indicator of unfavorable conditions or care, even if this is not the case. A high rate of rehospitalizations may also suggest:

• Inadequate care for persons with chronic illness

• Failure to plan and deliver the medical services necessary to prevent readmission

• Failure to plan and deliver discharge planning services needed for successful community reentry upon hospital discharge
Rehospitalization and Revenue

Medicare pays for rehospitalizations, except those in which the person is rehospitalized within 24 hours after discharge for the same condition for which they were originally hospitalized. Even a small reduction in readmissions would save a lot of money for Medicare. Recent policy proposals create payment incentives to reduce the rates of rehospitalization.

Another issue is that readmission rates vary by hospital and geographic region. This suggests that some hospitals and geographic areas do a better job than others at containing readmission rates. Some policymakers believe that reducing readmissions would result in improved quality of care in addition to reducing costs.

The Patient Protection and Affordable Care Act

Medicare has always promoted hospital discharge planning, but has never been particularly successful at containing costs due to improved transitions. No additional funding is provided for comprehensive discharge planning. Medicare has never provided financial incentives or any type of formal structure in the payment system to advance these goals. There has been a great deal of lip service about effective discharge planning, but there were no systematic measures to ensure the discharge plan was effective or that it improved quality. Because of this, discharge planning often does not begin until a utilization review plan has identified a patient for discharge. This is usually late in the admission. If this is the case, the time frame prior to discharge is simply too tight to ensure effective discharge planning and teaching.

Long-term care facilities are required to begin discharge planning at the time of admission. Although the hospital regulation is comparable, discharge planning is often a low priority. Beginning discharge planning on admission is a key step in ensuring all bases are covered. Hospital discharge planning requirements can be found in the Appendix of your book.
In March 2010, President Obama signed into law the Patient Protection and Affordable Care Act (PPACA), as amended by the Healthcare and Education Reconciliation Act. This comprehensive healthcare reform legislation contains provisions that change the Medicare program, including some that are designed to decrease the number of unnecessary hospital readmissions by reducing payment to hospitals with high rates of preventable readmissions. Other portions of this bill are demonstrations and experimental pilots that test reforms to the Medicare payment system for hospitals and other healthcare providers.

The change in the law is planned for implementation in October 2012. Aside from not paying for readmissions within 24 hours of discharge, Medicare will not penalize hospitals further. The October 2012 changes direct Medicare to recover payments for “unnecessary readmissions” within 30 days of discharge if the patient has one of three conditions:

- Heart attack
- Pneumonia
- Heart failure

During the first year of implementation, a hospital’s total Medicare payments can be reduced by up to 1%. The total payment reduction is up to 2% the next year and 3% the third year. CMS also plans to add more diseases to the list.

In the future, physicians will also be expected to provide better care, thus keeping patients out of the hospital. Cynics note that developing an incentive program to keep people out of the hospital could cause physicians and hospitals to discharge patients too early because they know they will be paid less. There are also concerns that hospitals will refuse to readmit patients with legitimate medical needs.
After the law changes, CMS plans to penalize “all readmissions” for any reason except planned readmissions, such as those needing additional procedures. Medicare will pay for these scheduled procedures. Although this change will be phased in gradually, the implications of this change in payment are frightening. For example, if a person who was hospitalized for treatment of pneumonia falls and breaks a hip three weeks after discharge, the hospital will be penalized. Although this may seem unfair, Medicare defends this action by noting that counting only rehospitalizations for the same condition would tempt the hospital to modify or alter the condition codes used for billing to avoid a penalty. Medicare hopes to reduce readmissions by at least 25%, which they consider a conservative figure because they believe 30% to 67% of all rehospitalizations can be avoided. A 25% reduction in readmissions would save Medicare over $2 billion in 2011. This figure does not include savings from avoidable emergency room visits and long-term care facility stays.

**Transitional Care**

Transitional care is coordinated care that ensures continuity. In the hospital it begins immediately after an illness or surgery in anticipation of the person’s return home or to a lesser care setting. It is based on a well-developed, interdisciplinary plan of care and the availability of qualified healthcare professionals who are familiar with the patient’s clinical status, treatment goals, and preferences. Transitional care also includes patient and family education and coordination of the health professionals involved in the transition. It should include comprehensive discharge planning and posthospital home visits.

**Transition of care**

Transition of care is the movement of patients between various settings in which care is delivered, different healthcare providers, or different levels of care within the same facility as a person’s condition and needs change. Each transition increases the risk of poor care coordination and inadequate communication across settings. The safest transitions are resident-centered. Some provisions of the PPACA will test various changes in care given...
to persons with chronic illnesses during the original hospitalization, in preparation for and at the time of discharge, and follow-up after discharge as these individuals transition out of the hospital, returning to their homes and long-term care settings.

Transition extends the responsibility of the discharging unit or facility into the new location or level of care. Responsibility of the original care team continues until all questions about the patient are answered and the new caregivers acknowledge the assumption of care. Some progressive hospitals have transitional nurses and transitional coaches who prepare the patient and receiving facility for the transfer, then follow up to address any issues that arise. In any care transition, all professionals who send and receive information must:

- Validate the transfer
- Accept the information
- Clarify discrepancies
- Accurately act on the information in a timely manner

**Relocation stress syndrome**

Transitioning from one setting to another has the potential for causing or increasing confusion and traumatizing an elderly resident. Signs and symptoms include:

- Increased dependence
- Delirium
- Depression
- Anger
- Withdrawal
- Changes in behavior
• Changes in sleeping habits
• Feelings of insecurity, loss of trust
• Weight loss (or, less commonly, gain)
• Falls

This is the phenomena known as relocation stress syndrome. Older terms that may still be used are transfer trauma and relocation shock. Relocation stress syndrome is a consequence of the stress and emotional shock caused by an abrupt relocation of a resident from one location or facility to another. Unless a proposed transfer is emergent, involve the resident in planning for transfer. He or she is ultimately the decision-maker in the relocation.

Evidence suggests that ensuring continuity of care for elderly persons during care transitions improves patient outcomes, reducing the rate of avoidable rehospitalizations. Comprehensive discharge planning and transitional care also improve quality of life and satisfaction with care, and reduce individual patient costs by as much as 37% in one year.

**The Bottom Line**

Improving care as a means of reducing hospitalizations is sensible—depriving residents of needed care is not. All involved professionals must use good judgment and not lose sight of the resident’s need for services. Some readmissions are not preventable and experts suggest that having some readmissions indicates the hospital provides quality care. What is certain is that readmissions are also the greatest avoidable cost that hospitals face. The readmission rate is listed as a quality indicator on the CMS Hospital Compare website. Refer to the Appendix of your book for a table listing facilities with the highest and lowest hospital readmission rates. Stephen Jencks, a healthcare consultant and former director of quality improvement at CMS, has stated

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that having a zero readmission rate “would be a very bad sign.” Others note that providing financial incentives to keep people out of the hospital could cause hospitals:

- Not to readmit patients
- To discharge patients prematurely
- To discharge patients solely because they know they will receive less reimbursement (i.e., not for medical reasons)

Introspective long-term care personnel may wish to ponder the results of a study in the *Journal of the American Geriatric Society* that noted a “greater risk of multiple complicated transitions (bounce backs) in patients initially discharged to skilled nursing facilities” and “a lower risk of multiple complicated transitions for patients initially discharged to rehabilitation facilities” (Kind et al., 2007). This is a potentially thorny issue because private insurers and Medicare encourage residents who require rehabilitation services after a stroke, hip fracture, or joint replacement to transfer to an SNF instead of an inpatient rehabilitation facility (IRF). Taken at face value, the SNF is a cheaper alternative. The problem is that the bounce back factor is much greater in the SNF setting. For example, the rate of bounce back for a person with a joint replacement in an SNF is 14.3%. It is 2% to 3% in an IRF. If a person is admitted to an IRF after a cerebrovascular accident, he or she is three times more likely to go home compared with a person with similar problems admitted to an SNF.

**Why Should I Care?**

Saving Medicare dollars is everyone’s problem. From a personal standpoint, you will need Medicare someday and it is important to ensure that our dwindling public resources last. From the facility standpoint, the census pays the bills. This includes the mortgage, utilities, food, and supplies. Salaries are the facility’s greatest single expenditure. If the census decreases, staffing is likely to decrease, which will not make you happy. Raises will not be as generous or may be frozen entirely.

*Ending Hospital Readmissions: A Blueprint for SNFs*
Facility survival

As nurses, we would like to believe that our services benefit humanity and that reimbursement is not an issue. However, we do not volunteer our time and most people work because they need a paycheck! We expect to be fairly compensated for the hours we work. The facility must generate an income to pay bills and meet the payroll. We prefer not to hear about census building, maintaining occupancy at or above the budgeted census, and other budget-related issues. Although these are not considered nursing functions, nurses have indirect control over them. These things are essential to meeting the payroll, keeping the lights on, ensuring quality care, and thus facility survival.

Keeping the lights on

Many workers believe that their salaries are the primary benefit received from the employer. You may not be aware of the intangible benefits that your employer provides. Although many frontline long-term care workers believe they are underpaid, researching the cost of your benefits can be enlightening. When you add up the employer’s contribution to withholding taxes, sick pay, insurance, holiday pay, and numerous miscellaneous benefits, you may be surprised to find that the facility is actually paying twice your hourly wage for your services. The money to do this is generated by keeping the beds full. Recognizing this often helps workers develop a greater appreciation of the work environment and keeps the employer’s contribution in perspective. One of the ways we ensure facility survival is by protecting the census and avoiding unnecessary hospital admissions and readmissions.

Where to Begin

Managing elderly residents with chronic illnesses is challenging. Residents of an SNF require close observation and attention to detail. Good communication, scrupulous care planning, identifying risk factors, anticipating and preventing complications, and
Introduction: Why are Hospital Readmissions a Problem?

coordinating care are essential services. With all these responsibilities, facilities must consider the causes of unnecessary readmissions and the many repercussions associated with rehospitalizations. Before transferring a resident, the nurse and physician should weigh the benefits versus risks and consider the potential for harm associated with transfer to another setting compared with the potential for benefit. Make the transfer only if the new setting will better meet the resident’s needs. Facilities should have systems in place to prevent rehospitalizations. Goals and objectives should include:

- Accurate transfer of resident information from one facility to the next
- Healthcare professionals involved in the transition communicate appropriately before, during, and after the transfer
- Careful monitoring of residents who were recently admitted or readmitted after hospitalization
- Ensuring the transition is atraumatic for the resident and responsible party and is as smooth and seamless as possible for all parties
- Good coordination of facility services
- Being prepared to receive the resident by ensuring necessary drugs, equipment, and supplies are available

The information in this book will help you develop a plan to:

- Ensure transitions of care are fluid and coordinated
- Reduce avoidable rehospitalizations
- Reduce avoidable transitions
- Provide essential information to the resident’s next care provider or setting

Ending Hospital Readmissions: A Blueprint for SNFs
• Communicate clearly and appropriately both verbally and in writing about the resident and his or her needs

• Ensure that the transition is safe and satisfying to the resident

• Reduce costs associated with rehospitalizations

• Eliminate duplication of diagnostic services

• Decrease or eliminate the number of hospital observation stays (Chapter 5)

• Reduce the incidence of hospital readmissions resulting from avoidable complications, medication problems, and adverse events

• Encourage the resident and family to participate in the transition

• Ensure the resident and family express satisfaction with the care given in your facility

• Maintain or improve the resident’s quality of life

Keep in mind that rehospitalization involves much more than paperwork errors. The hazards of readmission to the hospital include:

• Danger to residents

• Increased risk of errors, especially medication errors

• Disruption in the continuity of care

• Disruption in facility operations

• Economic viability of the healthcare system is affected