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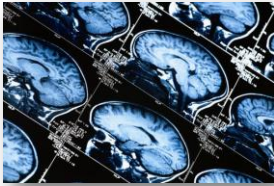
Hebrew
SeniorLife
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Hebrew SeniorLife | Affiliated with Harvard Medical School

Hebrew SeniorLife Introduction

- Eight site system of senior housing and health care
- Largest non-profit provider of senior housing, long-term and post-acute care in New England
- International geriatric research center
- Harvard-affiliated academic teaching center



PPACA Hospital Re-admissions Reduction Program

- Reduce Medicare payments to hospitals with high rates of risk-adjusted re-admissions for 3 conditions determined by Secretary (eff. 10/12 and may be expanded)



Case Study: Reducing hospital re-admissions in an HSL 50-bed post-acute unit

The Problem:

- Nationally, more than 1 in 5 Medicare patients discharged from hospital to SNF are re-admitted within 30 days
- Estimated 80% are avoidable



Case Study: Reducing re-admissions

The Cost:

- Unnecessary patient and family suffering
- Increased use of LTC
- Approximately \$5B annually



Case Study: Reducing re-admissions

Our Assessment:

- Poor communication between hospital and SNF
- PCP out of loop
- Inadequate care plans for recurrent symptoms
- Disciplines in silos
- Failure to learn from mistakes



Case Study: Reducing re-admissions

Our Interventions:

#1 Admission template, with -

- Guidelines for common geriatric syndromes
- Medication reconciliation
- Advance care planning/barriers to discharge
- Advance care directives



Case Study: Reducing re-admissions

Our Interventions (cont.)

- #2 Recommend palliative care consult if patient has been hospitalized 3 or more times in past 6 months.
- #3 EMR where available




Case Study: Reducing re-admissions

Our Interventions (cont.)

#4 CQI: Team Improvement for the Patient and Safety (TIPS)

- Review avoidable re-admissions and near misses
- Talk to hospital
- Blame-free root cause analysis at TIPS conferences



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The common initial reaction when an error occurs is to find and blame someone [but] blaming an individual does not change these factors and the same error is likely to recur.

The focus must shift from blaming individuals for past errors to a focus on preventing future errors by designing safety into the system. People must still be vigilant and held responsible for their actions. But when an error occurs, blaming an individual does little to make the system safer and prevent someone else from committing the same error.

[A] **major force for improving patient safety is the intrinsic motivation of health care providers**, shaped by professional ethics, norms and expectations.

— *To Err is Human*, **Institute of Medicine**



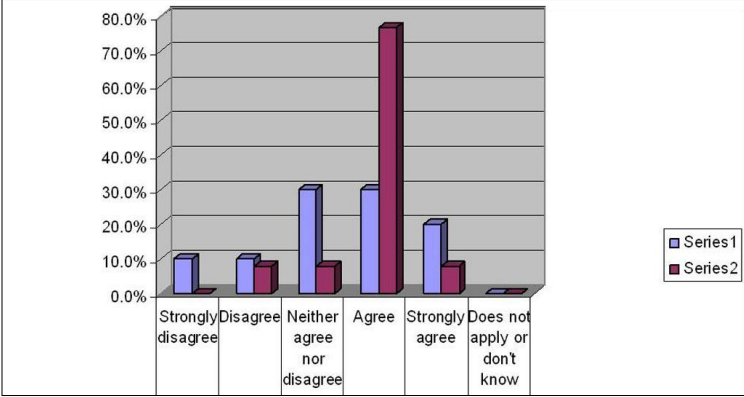
TIPS Conference



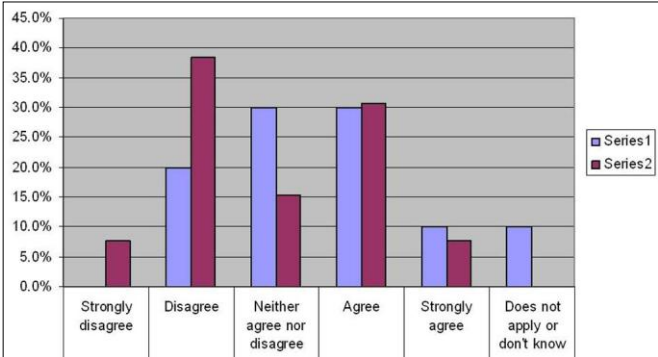
TIPS Conference



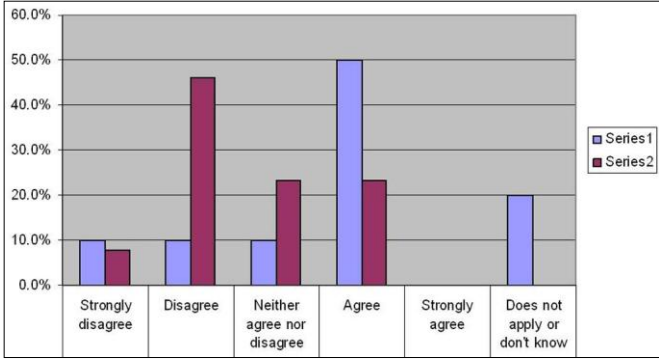
TIPS: Do you feel a part of a team?



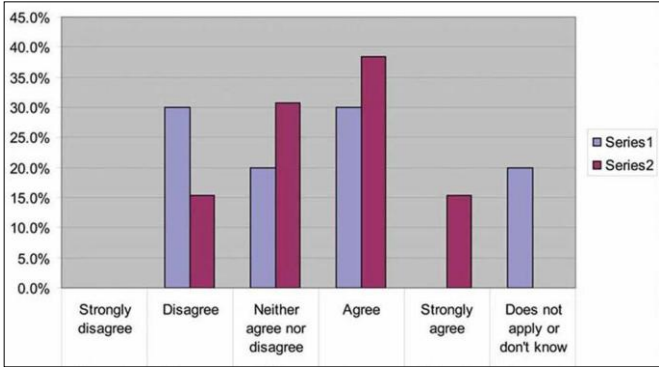
TIPS: Staff are blamed when a resident is harmed



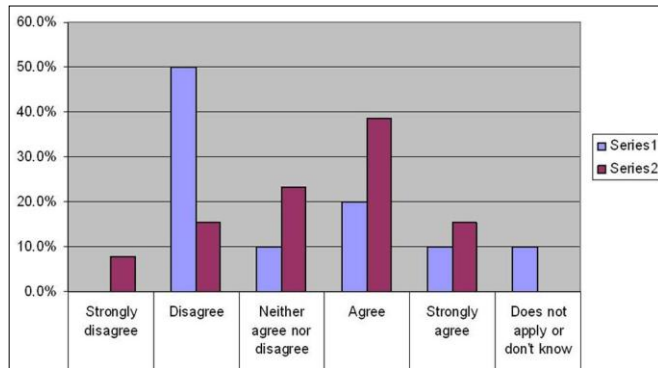
TIPS: Staff are afraid to report their mistakes



TIPS: Staff feels safe reporting their mistakes



TIPS: Staff are treated fairly
when they report their mistakes



Email from Randi Berkowitz

2010

I wanted to let everyone know we had a case this week of a patient that did not receive an antibiotic for a number of days. This was recorded as an official medication error and is being reviewed. There were no untoward effects to the patient.

I wanted to commend the staff for immediate transparency with the patient and family and giving a sincere apology.

This is a critical component of fostering a safe patient environment helping to create a positive culture on the RSU.

Thank you - Randi

Randi Berkowitz, MD
Hebrew Rehabilitation Center
Medical Director, RSU
Medical Director, Orchard Cove



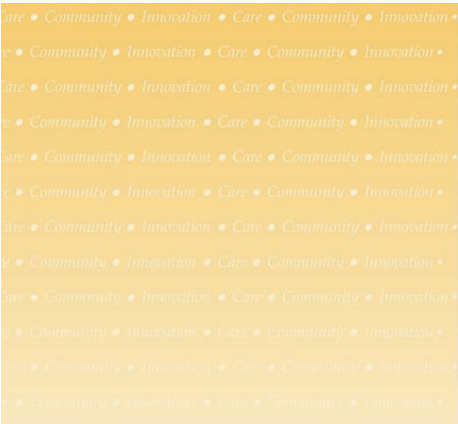
Case Study: Reducing re-admissions

Results:*

re-admission rates after 12 months

- Pre-intervention 16.5%
- Post-intervention 13.3%
- Rate reduction 19.4%

*Caveat: LOS < 30 days



- Center Communities of Brookline
- Hebrew Rehabilitation Center, Boston
- Institute for Aging Research, Boston
- Jack Satter House, Revere
- NewBridge on the Charles, Dedham
- Orchard Cove, Canton
- Simon C. Fireman Community, Randolph

