Home to Stay

A regional Collaborative to support skilled nursing facilities

in implementing a standardized discharge process, with the overall goals of:

- Ensuring short-stay residents remain safely at home after being released from a SNF
- Reducing 30-day rehospitalizations
- Improving short-stay residents' satisfaction

How many of your short-stay residents make a U-turn back to the hospital? How great would it feel to ensure that more of them stay on the road to recovery? And wouldn't it be wonderful to have a reliable, streamlined discharge process in place—so that your staff isn't scrambling to handle the myriad details each time a patient is ready to be discharged?

There are proven methods for doing just that.[1] A standardized discharge process and related best practices can reduce rehospitalizations, improve short-stay residents' satisfaction, and protect the bottom lines of both your facility and the referring hospital.

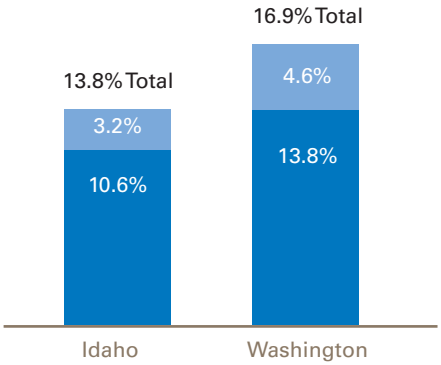
Join Qualis Health and your peers across Idaho and Washington in our IHI-style Breakthrough Series Collaborative *Home to Stay*. Our consulting assistance is provided free of charge, thanks to our recent Special Innovation Program award from the Centers for Medicare & Medicaid Services.

Nearly a fifth of patients discharged from a hospital to a skilled nursing facility are rehospitalized within 30 days.

Will your Medicare rates be cut in 2018 because your 2016 return-to-hospital rate is too high?

- Rehospitalizations occurring after discharge from skilled nursing facility ("indirect")
- Rehospitalizations occurring directly from skilled nursing facility ("direct")

Hospital discharges to SNFs readmitted within 30 days, 2014



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Home to Stay is a 13-month program, with an "all teach – all learn" structure:

Webinars

Teleconferences

In-person meetings

This Collaborative is also designed to incorporate feedback from short-stay residents and their families—resident-centeredness in action!

During this Collaborative, participants will use Plan-Do-Study-Act (PDSA) cycles and real-time data to systematically implement a standardized discharge process and related best practices.

Get started today!

The kick-off is scheduled for January 2016.

Learn more about the benefits of participating in Home to Stay by contacting:

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www.Medicare.QualisHealth.org/HometoStay

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1 Berkowitz, RE, et al. Project ReEngineered Discharge (RED) Lowers Hospital Readmissions of Patients Discharged From a Skilled Nursing Facility. *JAMDA.* 2013;14(10):736-740.