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Re-engineering the Geriatric Inpatient Stay and Transition Home (REGISTRY) Project

This project hopes to change the way in which we care for hospitalized older patients to focus not only on the acute medical illness but also prevent complications that inevitably develop during an inpatient stay such as deconditioning, delirium, falls, polypharmacy, and adverse drug events. Functional decline during a hospitalization may also be a contributor to unplanned readmissions after discharge.

The overall aim of this project is to improve the care for hospitalized older patients with a goal of 1) improving patients' health and functional status throughout a hospitalization and after discharge and 2) increasing the likelihood of successful discharge to home without unplanned readmissions or ED visits.

This project will use a specialized Elder Care Team (which was implemented successfully in the past and was able to show improved outcomes of decreased length-of-stay and increased home discharges) which is a multi-disciplinary group comprised of nurses, physical therapists, care managers, and physicians. The team developed interventions designed to improve an older patient's functional and health status during a hospitalization. Specific interventions include regular assessment of a patient's cognitive and functional status through a modified HARP screen, daily physical and occupational therapy, daily walks and regular transfers out of bed, and assessment of patient and family's desired discharge disposition, home safety, and health care needs prior to discharge. This project also hopes to connect discharged patients to existing community resources to improve the transition home and continue the recovery process to potentially decrease unplanned readmissions and ED utilization.