12) Reducing Readmissions, or How Post-Acute Care Organizations Reduced Transfers Back to Acute Care Hospitals

Spaulding Rehabilitation Network and Partners Healthcare at Home

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PROJECT DESCRIPTION

Our health care system's unique post-acute care (PAC) continuum of Inpatient Rehabilitation Facilities, Long Term Acute Care Hospitals, Skilled Nursing Facilities and a Home Health Agency created and implemented a strategy deploying a portfolio of tactics which resulted in significant, sustained, 30 day readmission rate reductions to acute care hospitals.

The actions and interventions that were most effective, constructive or innovative include:

The creation of an Acute Transfer (AT) Steering Committee with representative medical staff from not only all of the PAC settings but also the most frequently referring hospitals, to whom patients were at risk to return.

Weekly /bi-weekly interdisciplinary AT work groups at each facility, reviewing each and every acute transfer to identify characteristics and factors contributing to readmission, and making a determination of "preventability." Engagement of rotating medical staff provided just-in-time education and raised awareness.

An AT database of all the reviews permitted trending, determination of preventability, detailed analyses, and actionable findings to reduce readmissions especially those deemed potentially preventable. Data mining from the AT database and other sources led to innumerable, iterative pilots and interventions at both network and entity levels.

Novel cross-continuum collaborative approaches using telemedicine for populations from specialty units such as burns or MICU. Teleconferences and family team meetings with the acute-based intensivist continue while the patient is in the PAC setting, also engaging the patient and family more closely in their care.

A "mobile observation unit" provides same day home visits by an advanced practice clinician for patients with urgent care needs referred from ED, ED OBS units and selected PCP Practices.

Development of an algorithm identifying home health patients at high risk for 5-day readmission, communication of the findings and plan, followed by a standard visit protocol with consistent care givers, as well as tele-monitoring and tele-health for more timely and direct interventions.

Creation of standardized communications with EDs using a templated SBAR hand-off note embedded in the EHR, giving the receiving ED providers key information often lacking in these transfers, including post-acute provider contact numbers. This evidence-based care transitions improvement initiative is informed by Project BOOST as well as review of our own AT database which suggested that suboptimal care transition communication was a potentially modifiable readmission opportunity.

Using INTERACT principles developed in nursing homes, we implemented a SIRS/sepsis early identification and intervention program, at all levels, including unlicensed staff such as CNAs who may be the first to notice a drift in vital signs or patient condition.

Implementation of medical provider-to-provider and RN-to-RN warm handoffs between the sending acute care team and the receiving post-acute care team.

Education of acute care providers as to the clinical capabilities of PAC hospitals and SNFs, so that "really sick patients" will be returned from the ED once an acute clinical dilemma is solved.

OUTCOMES ACHIEVED

- All facilities met the goal of >10% reduction in acute transfers The overall rate for facilities decreased 10% from CY2012 to CY2013 and decreased 3% from CY2013 to CY2014.
- The home health agency met goal of 8% reduction in hospital admissions.
- The process measures to improve the rate of completion of "interdisciplinary review of all readmissions within 30 days" showed compliance at:
    - 80% in 2012,
    - 88% in 2013
    - 93% in 2014.
- In 2014 a new process measure was developed to focus on increasing the completion of ED SBAR Handoff Note for patients sent to an ED, with compliance of:
    - 44% in 2014
    - 67% for CY2015 to date.
- Improvements were achieved with cycles of feedback to the entities and CMO communications to their staff.
- Telemedicine for burn patients in rehabilitation and for post-ICU patients in long term acute care resulted in fewer ambulance trips between facilities and the related costs, less patient dissatisfaction and provider inconvenience as well as fewer ED visits and readmissions.

LESSONS LEARNED

- Development of local learning clinical communities that were supported, guided and held accountable by a central organizing committee of medical and quality leadership from each entity.
- Development of a knowledge database as a foundation for clinical analytics.
- Executive Leadership engagement and commitment to align and facilitate goals being accomplished.