A Post-Acute Care Transition (PACT) Program: Targeting 30-Day Readmissions

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Beth Israel Deaconess Medical Center | HARVARD MEDICAL SCHOOL TEACHING HOSPITAL | THE SILVERMAN INSTITUTE For Health Care Quality and Safety | Post-Acute Care Transitions PACT Program

The Problem

Avoidable 30-day readmissions represent unfavorable health outcomes for patients and are now associated with significant financial penalties for hospitals.

- Our hospital's readmission rate was too high.
- Care transitions post-hospitalization were fragmented and confusing for patients.
- Changes were needed to smooth care transitions for patients across all diagnoses in order to improve outcomes and avoid costly readmissions.

Aim/Goal

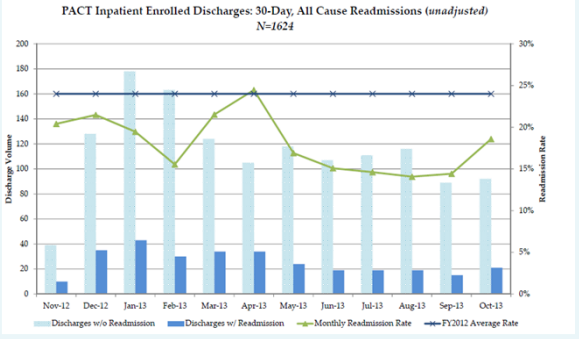
To improve patient outcomes and prevent avoidable cost in the high-risk 30-day period following acute care hospitalization.

The Interventions

- Program deploys a nurse and a pharmacist to visit newly admitted patients and to provide 30 days of telephone support following discharge.
- 2011-12 pilot achieved a 20% reduction in readmission rate for the targeted population and led to an expanded program with $4.9 million funding from the Center for Medicare and Medicaid Innovation.
- Innovative staffing model employs 10 nurses and 5 pharmacists who are each paired with one of six primary care practices, facilitating collaborative relationships with primary providers.
- PACT clinicians visit patients from their assigned practices who have been hospitalized and facilitate all aspects of post-discharge care according to patient needs: ensuring medication compliance, facilitating in-home and outpatient support, communicating with primary care team, helping to ensure patient gets to follow-up appointments, and more.

The Results/Progress to Date

We have achieved a significant reduction in 30-day all-cause readmissions over the first 12-months of the three-year demonstration project.



Lessons Learned

- Intensive care management takes time but yields results.
- Inpatient nurses have been well suited to the PACT role, being familiar with acute care needs of newly discharged patients.
- Aligning care transition staff with particular practices enhances communication but creates variation in caseload for PACT staff.
- Having PACT team members sit in an open space facilitates cross-fertilization of ideas and sharing of information on community resources.
- Patients at home will almost always respond they are "doing fine." PACT nurses have learned to unpack "fine" and assess how the patient is really doing.

Next Steps

- Continue to refine systems throughout the demonstration period.
- Enhance relationships with post-acute care facilities and home care organizations.
- Refine metrics to measure effects of particular interventions.
- Identify populations that benefit most from PACT services.

Team

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