

3) Integrated Patient-Centered Care In Chronic Critical Illness (IP4CI) – FINALIST

Brigham and Women's Physicians Organization/Brigham and Women's Hospital

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PROJECT DESCRIPTION

For patients, the transition between acute and post-acute care is rife with risk. Even with modern electronic medical records and responsible clinicians who seek to collaborate with each other, information can be lost or misunderstood, patients can decompensate, and setbacks are common. Particularly challenging is coordination of care amongst patients who are "chronically critically ill." Defined as patients who have required long stays in the intensive care unit, or who require continued advanced therapies (mechanical ventilation, etc.) up on discharge, these patients often bounce between acute hospitals and post-acute facilities, frequently being readmitted to acute care hospitals within days of discharge. Never recovering enough to resume outpatient-based care, traditional care coordination models (e.g. patient centered medical home) fail to help quarterback their complicated care. At our institution, we found that patients who had spent time in the medical intensive care unit and who were subsequently discharged to long term acute care rehab (LTAC), had a 30 day readmission rate of 40%. We viewed this as unacceptably high and launched a pilot to improve peri- and post-discharge care in this population. This became our IP4CI program.

The IP4CI program focuses on preparing patients for discharge from the acute care hospital by introducing a "critical care continuity team" consisting of intensivist physician and clinical social worker. The team meets the patient and his/her family prior to discharge, working to set expectations for transfer and rehab, exploring and understanding goals of care, and becoming familiar with the patient's ongoing medical and social issues. After discharge, the team holds weekly video conference "rounds" with a multi-disciplinary team located at the LTAC. During these meetings, the teams from the two institutions can collaboratively review patients enrolled in the program, and arrive at the most appropriate care plans. Between weekly "rounds," the critical care continuity team is available to LTAC clinicians 24/7 via pager and/or phone should urgent questions arise. In addition to the weekly reviews between clinicians, the hospital-based "continuity team" continue to participate in direct patient care at the LTAC through weekly visits with the patients/families either in person at the LTAC, or via "virtual" video based teleconferencing, and by participating in any family meetings at the LTAC via videoconference—providing perspective from the acute care institution as the patient's medical status and goals continue to evolve over the course of their rehabilitation.

The intervention has been successful in reducing readmission rates by 1/3, and is being expanded to additional ICUs across our institution.

OUTCOMES ACHIEVED

- In the pilot, the project reduced 30-day readmission rate by 1/3 (from 40% to 25%)
- Since the pilot, we have maintained lower readmission rate at 29% while expanding program, preferentially triaging most complicated patients into program, and focusing on earlier transfer/discharge from acute care hospital for appropriate patients
- The program has enrolled 172 patients since inception
- The reduced readmissions and improved care have generated Total Medical Expense (TME) savings of over \$450,000 per year

LESSONS LEARNED

- Traditional care coordination efforts often fail to serve patients who are "chronically critically ill."
- A multi-disciplinary approach between clinicians and administrators from two institutions can be successful in improving patient outcomes, quality of care, and patient and provider experience.
- Technology (virtual visits, video conferencing) can enable hospital-based teams to efficiently extend their reach and improve communication and coordination among collaborative institutions.