CARE COORDINATION
Yale New Haven Hospital - New Haven, CT

In recognition of the hospital's commitment to safe care transitions and cross-continuum collaboration.

YaleNewHavenHealth
Yale New Haven Hospital

Interventions to Reduce Readmissions: Interdisciplinary Care Transitions

BACKGROUND

Yale New Haven Hospital is

- A 1,541-bed hospital located in New Haven, Connecticut
- The second-largest hospital in the United States
- The primary teaching hospital for the Yale School of Medicine and the Yale School of Nursing
- A Magnet hospital, accredited by the Joint Commission, and a Level I Trauma Center for adult and pediatric patients

Despite previous efforts to reduce readmissions from skilled nursing facilities (SNFs), Yale New Haven Health System's (YNHHS) two largest hospitals – Yale New Haven Hospital and Bridgeport Hospital – continued to experience high readmission rates. Based on Medicare Fee for Service (FFS) 30-day readmissions, rates for patients discharged to SNFs from Yale New Haven and Bridgeport Hospitals were above benchmark when compared with similar hospitals. A review of the Q2 2022 IPRO QIN-QIO Care Transitions Data Reports showed that Yale New Haven patients discharged to nursing homes had a higher rate of readmissions (25.5%) than the state rate (21.6%).

An analysis of the data revealed that 80% of the SNF 30-day readmissions came from medium- to large-volume SNFs with readmission rates of 20% or higher. The hospital team and the IPRO QIN-QIO collaborated to strengthen a data driven, evidence-based approach to care coordination with a goal to reduce 30-day readmissions for Yale New Haven and Bridgeport Hospitals' Medicare FFS patients discharged to 14 SNFs between January 2024 – June 2024 by 20 cases (5%) in six months and by 40 cases in 12 months.

APPROACH

Representatives of key departments of YNHHS and the IPRO QIN-QIO convened a focus group of SNF administrative and clinical leaders to evaluate readmission causal factors from the perspectives of both the SNFs and the hospital. The group ranked the top causes of readmissions.

Identified Opportunities for Improvement	
SNF	**Hospital**
Time-critical medications are not always provided to patients on the first day of admission to the SNF.	Late-in-the-day discharges to SNF often result in care delays for patients.
Delayed intervention for early patient decompensation at the SNF	Patients and family members are not made aware of what to expect when the patient is discharged to a SNF.
Facility competencies are not clear to patients and families	Hospital clinical staff members lack understanding about care in an SNF

YNHHS partnered with IPRO QIN-QIO to facilitate a cross-continuum Mind the Gaps exercise (see table below). Participants identified and prioritized gaps and goals and developed interventions for both the hospitals and the SNFs to remediate causal factors.

	Cross Setting Conversation	
What is needed to ensure a safe transition?	**Nursing Home** (What do you need from other provider?)	**Hospital** (What do you need from other provider?)
Communication	We need an early report from the hospital as well as notification of what medication(s) will be needed. Understand that we do not have an in-house pharmacy and medication cannot be ordered until the resident arrives. We need to improve an understanding of each other across all settings; hospital, SNF, Home Health, LTC, Areas of Aging, so we may effectively exchange information and look at goals for each resident. Respect. Assume positive intent. Trust.	Transparent communication (for example, explain why the facility cannot accept the patient so we may learn from you) Understand we cannot dispense medication for discharged patients. Utilize a liaison to come into the hospital in order to assist the patient and family for transition.
Education	Educate differences in policy (i.e. Infection control and isolation procedures) Keep patient informed and educated.	Educate about reason for not taking patient. Educate about what your facility can and cannot provide for a resident.
System Process	Unified Medical record whereby all electronic medical records interface with each other. Utilize a Bedside Assessment Team Real time updates	Need a more robust transportation system. Use Medical Ubers

Interventions Implemented	
SNF	**Hospital**
Bedside Assessment Team (BAT) Implementation/Optimization – Timely identification of patient deterioration and intervention	**Pre-noon discharges to SNF to facilitate safe transitions** Expansion of YNHHS's existing work to set an 11:00 am deadline for patient discharges Launch of the YNHHS Transportation Logistics Hub
Readmission Case Reviews and individual SNF interventions - Monthly Team Conferences to review readmission cases Reinforcement of INTERACT® Tool and Decision Guide Monthly meetings with the QIN-QIO to develop individualized SNF SMART goals	**Provide education on what patients can expect when discharged to a SNF** Provide information to YNNH hospitalists Patient and family education

RESULTS

The performance period for this initiative is January 2024 – June 2024. Final data will be evaluated in July and August 2024 through analysis of Medicare FFS 30-day readmission data for patients discharged to the focus group of SNFs and the overall YNHHS Medicare 30-day readmission performance for discharges to SNFs.

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Core Project Team Members:

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- Healthcentric Advisors – Neila Odom and Kristin-Rae DelSesto.

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