

Winchester Hospital

WINCHESTER, MA

\$286,500

AWARD EXPENDED

Winchester Hospital's CHART Phase 1 initiatives focused on decreasing readmissions for high-risk patients with conditions for which 30-day readmissions are penalized by Medicare. Some of these conditions have relatively few readmissions, for example Winchester Hospital had only one patient with acute myocardial infarction who was readmitted in 30-days, making this a very small target population. Winchester Hospital created a care management team to coordinate care through medication reconciliation, involving family caregivers in patient education and in introducing the concept of using palliative care services to eligible patients. The hospital also implemented care management services in their emergency department. Additionally, the hospital enhanced warm handoff transitions to skilled nursing facilities, with the goal of reducing readmissions.

RAPID-CYCLE PILOT

1,406

PATIENTS SERVED
ACROSS THE THREE
PROGRAMS.

The goal of the care delivery pilots was to reduce inpatient hospital readmissions for adult patients through enhancing communications and extending clinical support resources at vulnerable points in the care transition process.

Winchester Hospital created a *warm-handoff* process with skilled nursing facilities in its region. A warm-hand off is a verbal report on patient care needs from the inpatient hospital direct care nurse to the nurse in the post-acute facility. The implementation included training and nursing competency assessment, and the warm handoffs have continued beyond CHART Phase 1. Although the hospital reported increased satisfaction among providers as a result of this pilot, Winchester Hospital was unable to quantify its impact on quality or costs at the end of CHART Phase 1.

CHART PHASE 2 AWARD

Winchester Hospital received a CHART Phase 2 award to reduce 30-day readmissions for high utilizers and all discharges to post-acute care services. These initiatives draw extensively from Winchester's CHART Phase 1 readmission reduction activities, including warm handoffs with post-acute providers and enhanced coordination between emergency department clinicians and hospitalists to reduce admissions from the ED. Winchester is also a participating site in a joint award in partnership with other Lahey Health community hospitals and Lowell General Hospital to enhance care for patients with behavioral health needs across the care continuum.

Process flow for patients discharged to a skilled nursing facility

Patient requires SNF care after discharge

Inpatient Case Manager offers the patient choice of SNF which will best meet the patient's needs

Patient selects preferred SNF

SNF liaison screens the patient for admission eligibility

SNF accepts patient for transfer

Staff Nurse calls SNF for warm hand off on the day of discharge and documents handoff in patient chart