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years  
Leading the way back ▶▶ to life.

***An Inter Professional  
Collaborative  
Approach:  
Reducing Acute Care  
Discharges***



**Adventist Rehabilitation  
Hospital of Maryland**

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Presented by:

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&

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## **Demographics:**

77 Bed Acute Free Standing Rehabilitation Hospital

## **Two sites**

53 beds at Rockville, Maryland

24 beds at Takoma Park, Maryland

## **Outpatient Services**

Rockville

Silver Spring

## **Accreditations**

TJC Accreditation in 2001, 2004, 2007, 2010

CARF Accreditation in 2002, 2005, 2008, 2009

## **Inpatient and Outpatient Services:**

- Brain Injury
- Spinal Cord Injury
- Strokes
- Amputations
- Neurological Conditions
- Multiple Trauma
- Medically Complex
- Orthopedic conditions, such as, hip fractures, bi-lateral joint replacements, etc.

## Performance Improvement Activities:

*Increase Discharge to Community*

**Decrease Discharge to Acute Care**

*Decrease Discharge to SNF*

Fall Prevention

Eliminate HAI – CAUTI

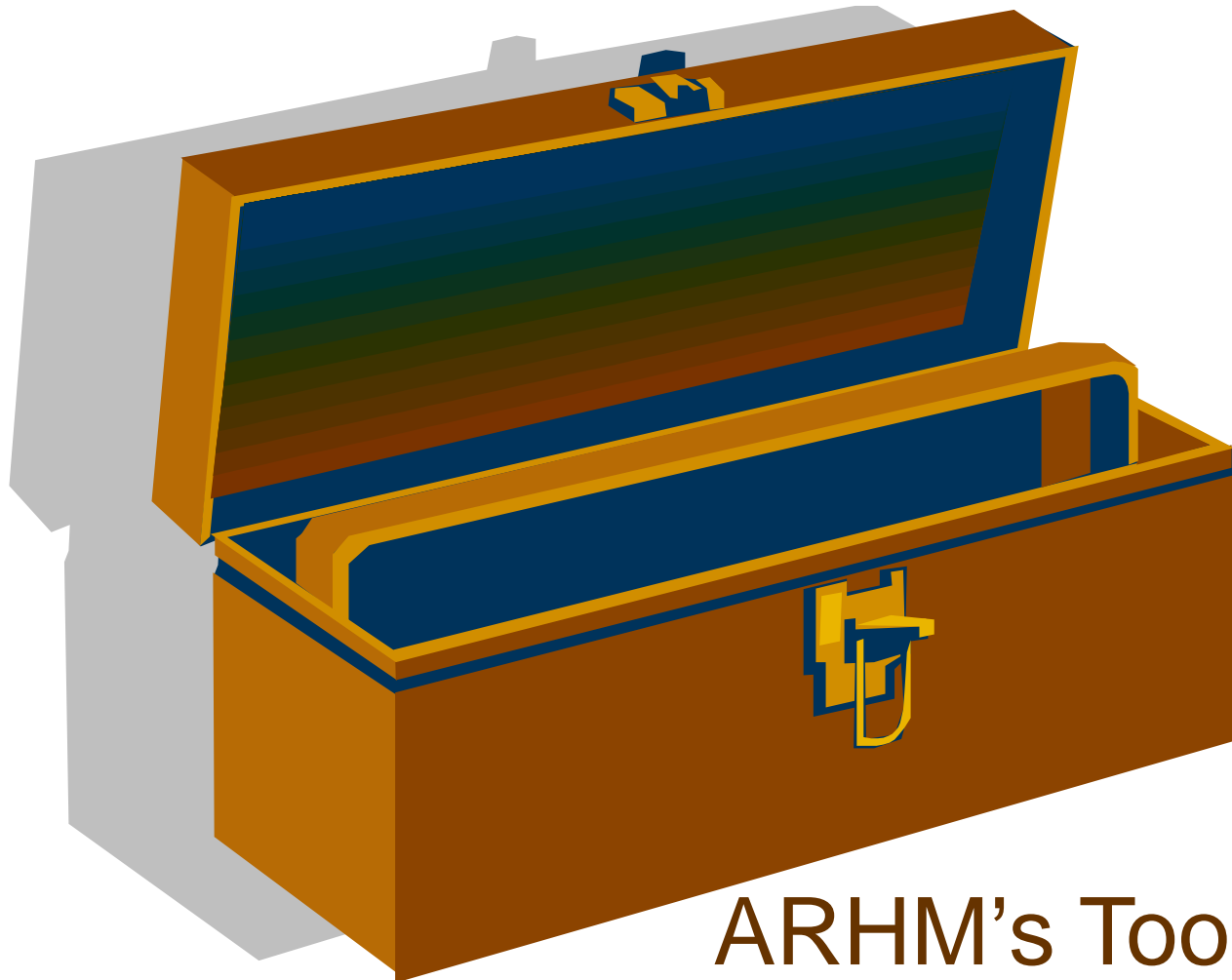
Eliminate Pressure Ulcers

Hand Hygiene Compliance

Increase Patient Satisfaction Scores to the 75th percentile

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**ARHM's Tool Box**

**Acute Care Transfer Review Form**

**Demographic Data: to be completed at time of transfer by RN, Therapist & MD caring for patient**

Admitted from: \_\_\_\_\_ Admitting DX to ARHM: \_\_\_\_\_ Transfer within:  24 hrs  48 hrs  72 hrs  
 ER  CVA  Cardiac  BI  Gen/Ortho  SCI  Other \_\_\_\_\_  >72 hrs of admission

Patient Unit:  RV  TP Patient Room number: \_\_\_\_\_

Date of ACT: \_\_\_\_\_ Time of ACT order: \_\_\_\_\_ Day of week: \_\_\_\_\_ Accepting Acute Care Hospital: \_\_\_\_\_

Internal Medicine Consultant of Record: \_\_\_\_\_ Physician ordering transfer: \_\_\_\_\_  Written  Telephone

Sending Problem to acute hospital: \_\_\_\_\_ Did the patient return to ARHM? \_\_\_\_\_ If yes, date and time? \_\_\_\_\_

Was the patient admitted to Acute hospital? If yes, date and time: \_\_\_\_\_ Admitting Dx to acute hospital: \_\_\_\_\_

**NURSING Review of Sending DX:** Provide brief summary of events leading to transfer, include labs and review the previous 72 hours:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**THERAPY Review of Sending DX:** Provide brief summary of events leading to transfer in the previous 72 hours:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PHYSICIAN Review of Sending DX:**

Was the pre-admission screening completed?  
 < 48 hours before admission  > 48 hours before admission

Were there any significant changes at time of admission compared to pre-admission assessment?  
 \_\_\_\_\_

\_\_\_\_\_

**Post-Admission Assessment**

Was there any delay in treatment?  Yes  No (e.g. no respiratory available, EKG not completed, xray not available)

Comments: \_\_\_\_\_

**Physician Consults: Were they timely?**

**Internal Medicine:** \_\_\_\_\_ Date ordered: \_\_\_\_\_ Date completed: \_\_\_\_\_  
 Completed within 48 hours  Yes  No

**Consultant:** \_\_\_\_\_ Date ordered: \_\_\_\_\_ Date completed: \_\_\_\_\_  
 Completed within 72 hours  Yes  No

**Consultant:** \_\_\_\_\_ Date ordered: \_\_\_\_\_ Date completed: \_\_\_\_\_  
 Completed within 72 hours  Yes  No

Patient Demographics

Nursing Review

Therapy Review

Physician Review of  
Sending Diagnosis

Post Admission

Physician  
Consultation Timely

**Best practice:** Acute Rehab Hospitals review all acute discharges weekly to identify quality improvement opportunities.

**Involvement:** Nursing, Therapy and Medical staff

**Procedure:** Last clinical care giver who worked with patient completes the Nursing, Therapy and Physician Review.

**Procedure:** Nursing initiates form, completes demographic information then hands off to therapy manager.



## RED FLAGS

Were there any **Red Flags** ?

Were **Red Flags** communicated to the physician or other team members ?

Sign your name and identify any follow-up you feel is necessary

Recommendations for clinical quality improvements



### Acute Care Transfer Review Form

Were RED FLAGS applicable?  Yes  No

- Family comments about changes in behavior
- Increased fatigue or irritability
- Refusal of therapy
- Mild cognitive changes (may also lead to falls)
- Worsened or increased sleep pattern
- Low grade temperature elevation
- Lower food/fluid intake (increasing BUN/Creatinine/ammonia)
- Regressing in therapy
- Hypo/hypertension
- Silent aspiration

Were Red Flags communicated to Physician or Staff?  Yes  No

Comments: \_\_\_\_\_

Was the Acute Care Transfer appropriate?  Yes  No

Could this problem/condition have been identified prior to admission to ARHM?  Yes  No

Could this problem/condition have been identified earlier in the patient's stay?  Yes  No

Comments: \_\_\_\_\_

**Follow up:**

No Follow up indicated

Follow up indicated - Refer to \_\_\_\_\_

Nurse Reviewer \_\_\_\_\_

Date \_\_\_\_\_

Follow up findings/Recommendations: \_\_\_\_\_

Physician Reviewer \_\_\_\_\_



Date \_\_\_\_\_

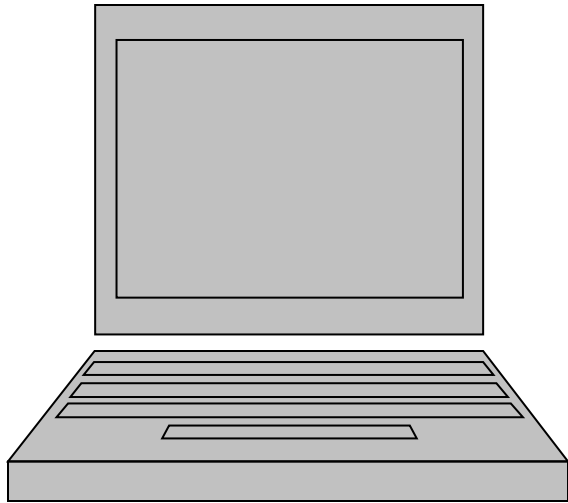
Follow up findings/Recommendations: \_\_\_\_\_

Therapy Reviewer \_\_\_\_\_

Date \_\_\_\_\_

Follow up findings/Recommendations: \_\_\_\_\_

-  Family comments about changes in behavior
-  Increased fatigue or irritability
-  Refusal of therapy
-  Mild cognitive changes
-  Worsened or increased sleep pattern
-  Low grade temperature elevation
-  Lower food/fluid intake (BUN, Creatine)
-  Regressing in therapy
-  Hypo/hypertension
-  Silent aspiration



## Patient's Medical Record

Pre Admission

Rehabilitation Stay

Post Discharge



## EXCEL

From	Date of Admission	Date of Discharge	Day of D/C	Admit Time	Discharge Time	LOS by Hours	Patient	Phys	Reason For D/C To	Admit	D/C	RETURN
	1/31/2011	1/31/2011	Monday	14:45	2:20	5 hrs		B	Acute increased L sided weakness	CV A	Neuro	Y
	4/14/2011	4/16/2011	Saturday	14:12	7:10	41 hrs		K	unresponsive/ Bi DVT	CV A	Neuro	N
	4/21/2011	4/22/2011	Friday	16:00	7:45	15 hrs		B	increased HR. admitted	Ortho	Cardiac	Y
	1/18/2011	1/20/2011	Thursday	18:30	7:50	37 hrs		B	Resp. Difficulty/ and increase abd. distension	Cardiac	Resp	Y

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# Inter Professional Collaboration?

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## **Inter Professional Collaborative**

Blame Free

Equal Say Members

Fostering Patient Centered

Input to from All Professionals to Ensure Best Care

Agree on Opportunities

Assess Possibilities and Take Back to Front Line

What Did We Miss As A Team

Was This An Appropriate Admission for Acute Rehab

Decision Makers

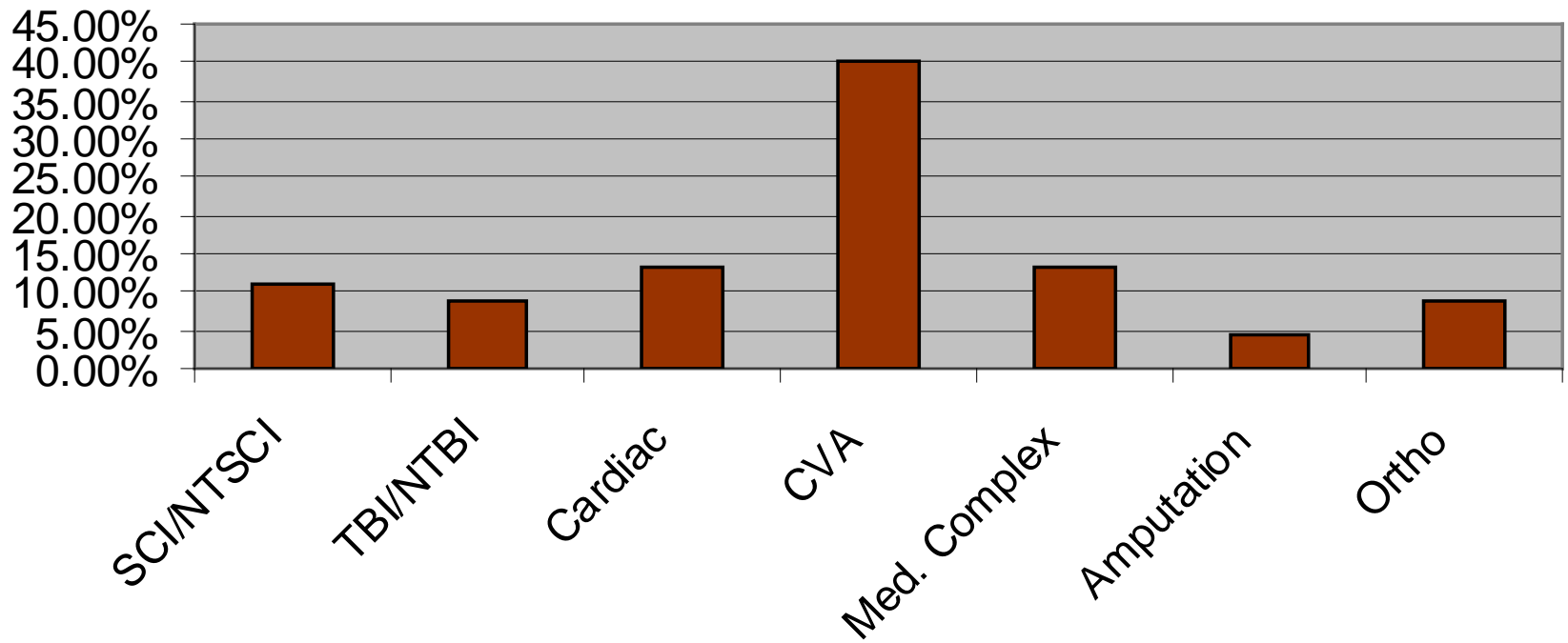
## *Membership*

- Physiatrists
- Chief Nurse Officer
- Director of Case Management
- Quality and Risk Management
- Therapy Manager
- Liaison
- Nurse Manager

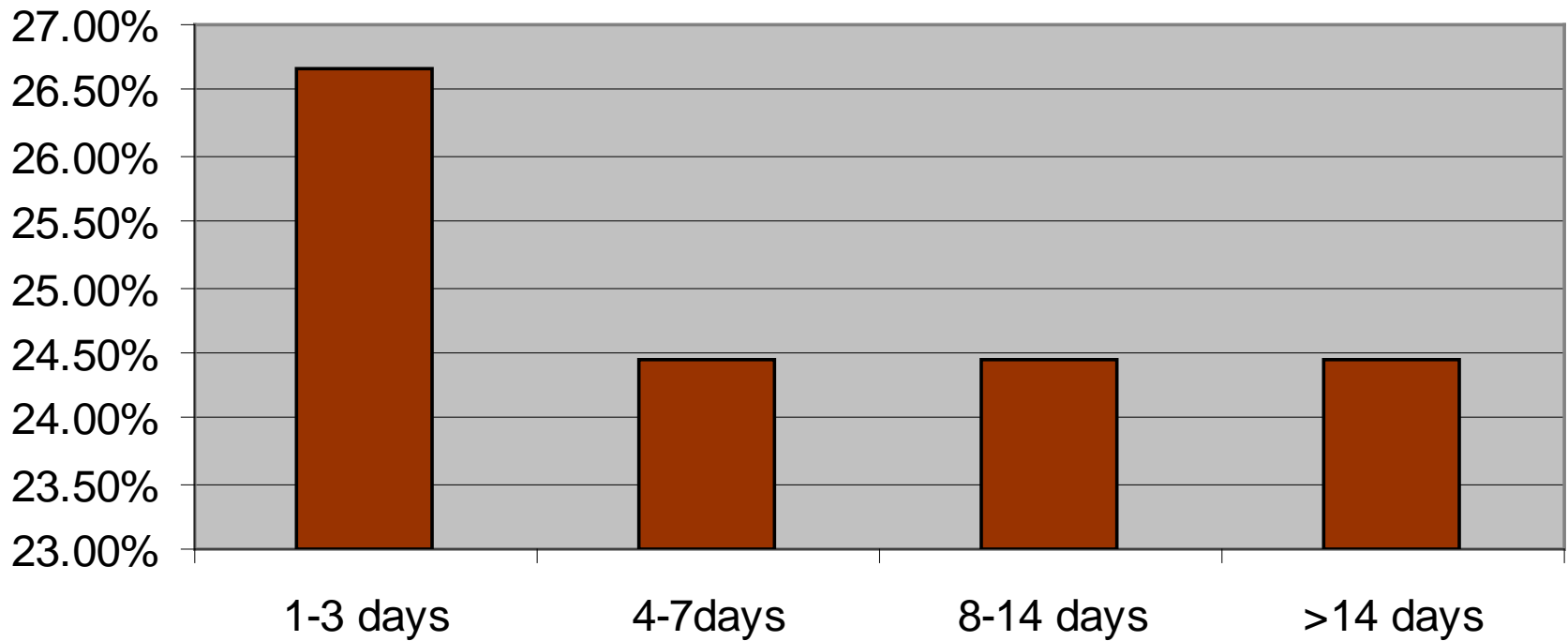
# Data And Process Improvements



### Admission Diagnosis



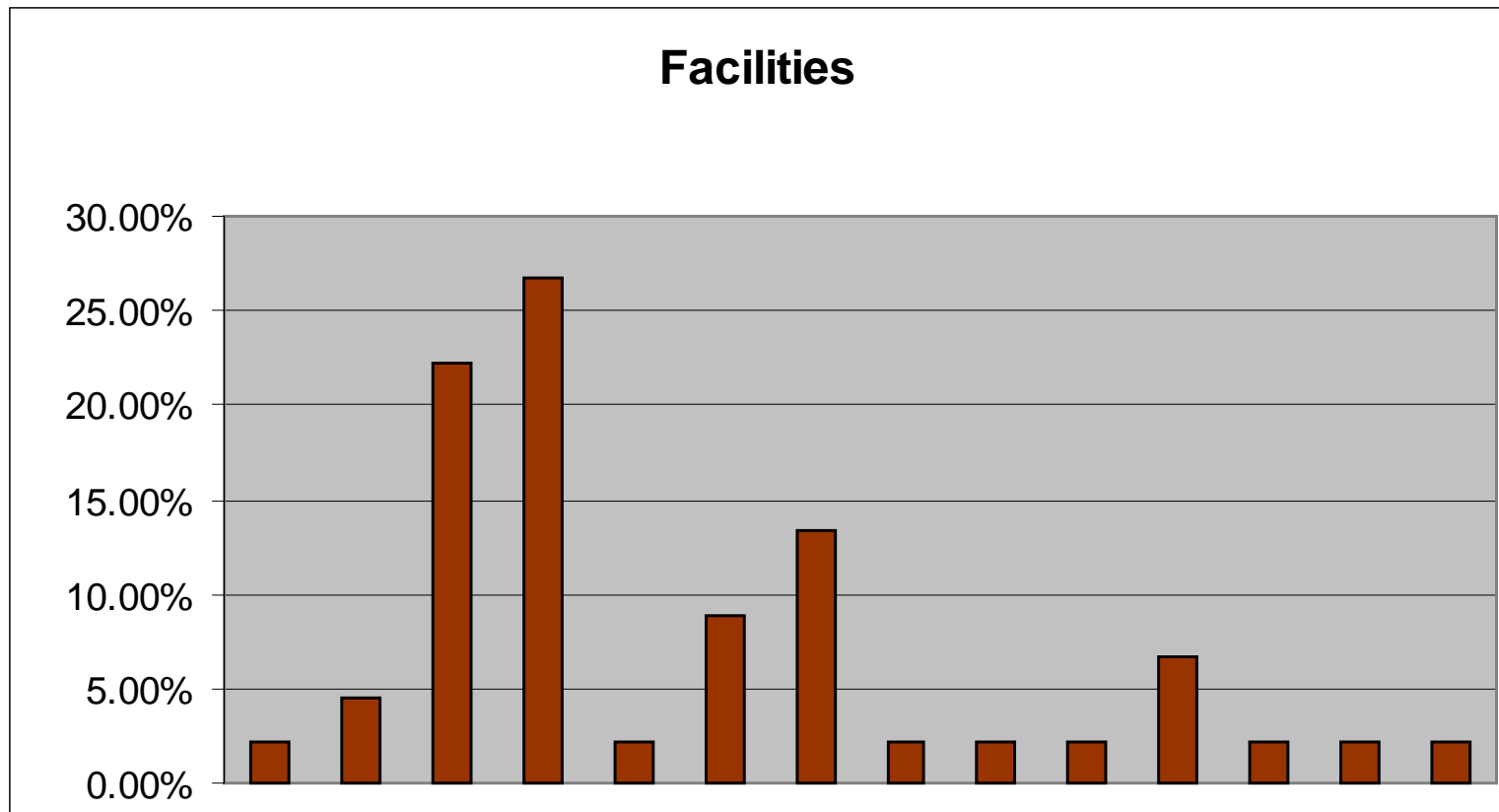
### Lenght of Stay



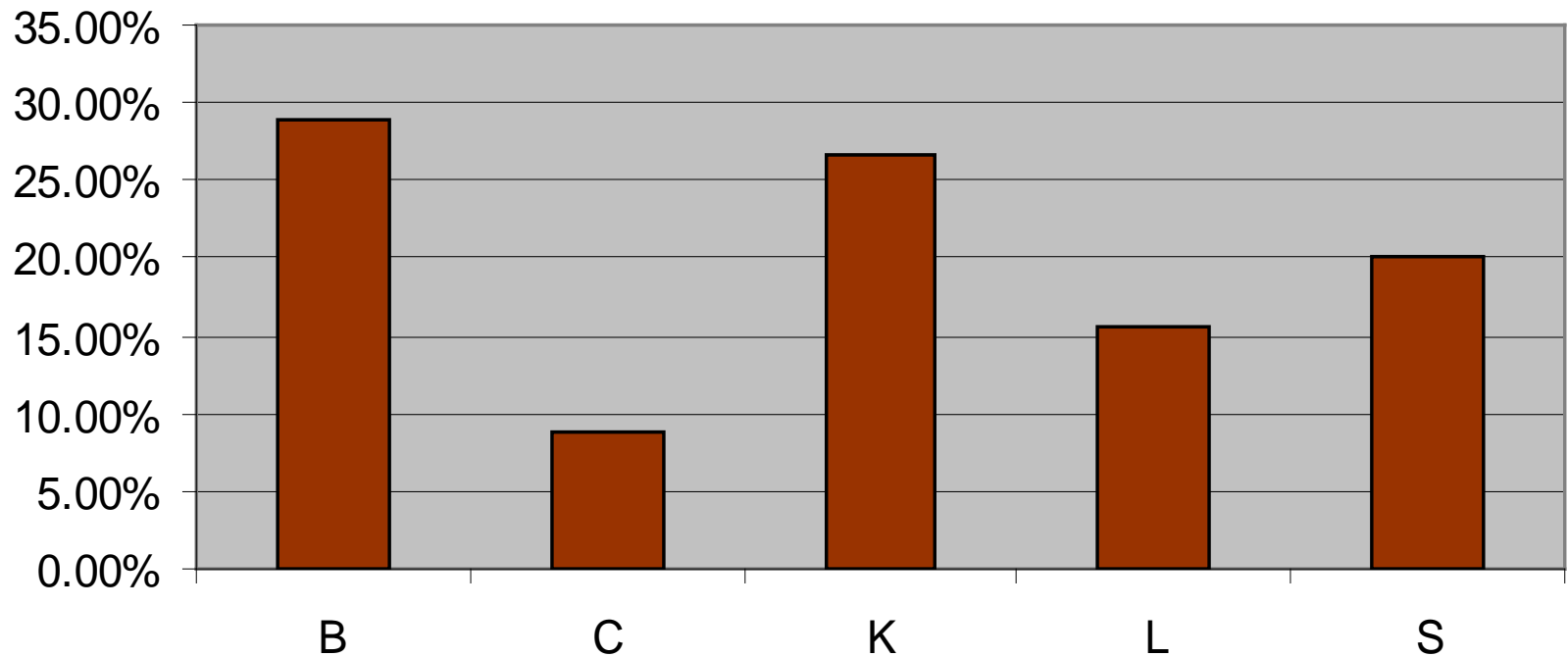
# VAIRABLE



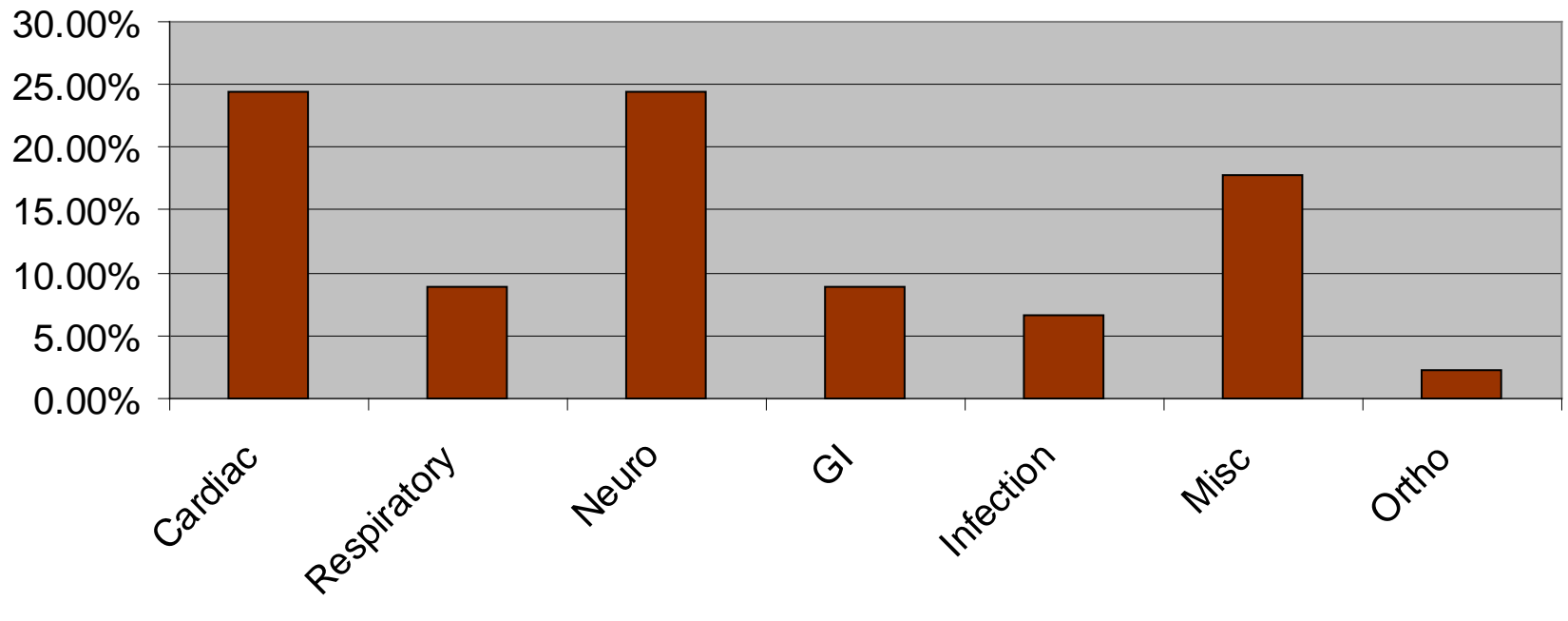
**Maryland Acute Care Hospitals are Reimbursed Under the Health Service Cost Review Commission (HSCRC) versus Diagnosis Related Groups (DRG)**



### Attending Physician



### Discharge Diagnosis



## **Process Improvements**

Identify Needed Care During PAS Process

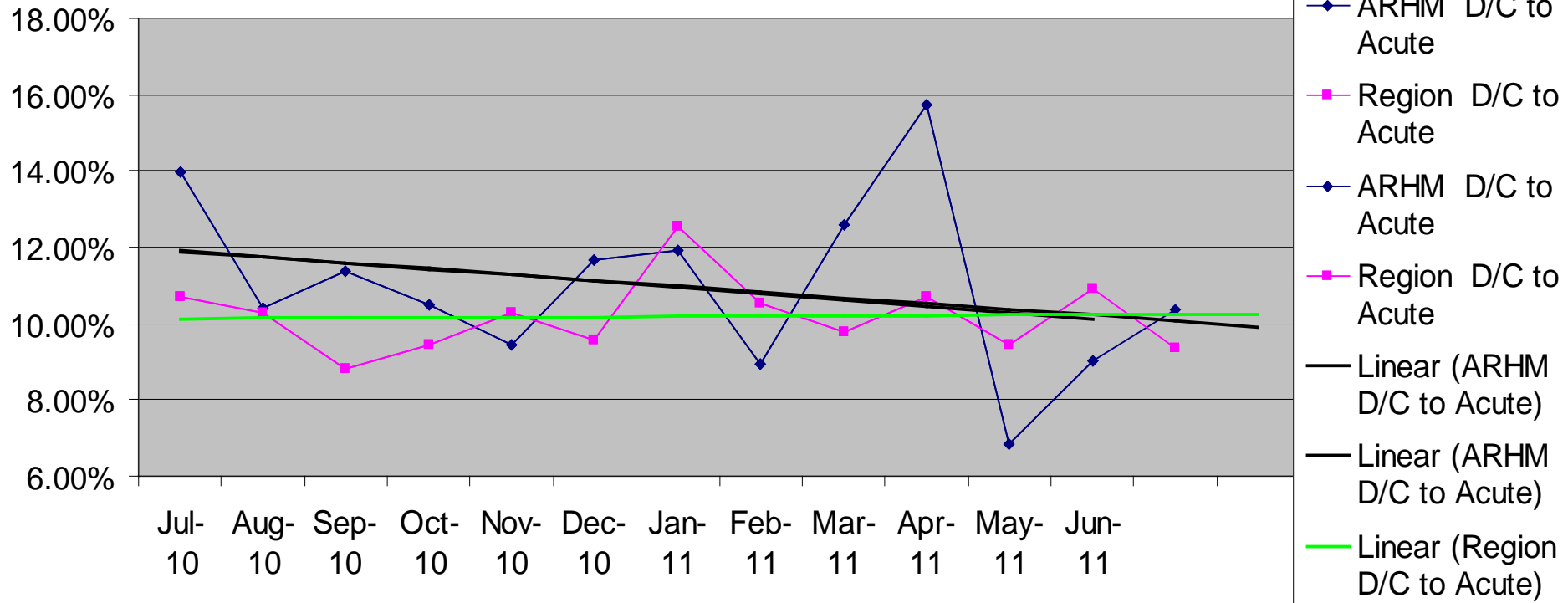
Use of Standing Orders/Pre-Printed Orders

Involve Everyone Who Touches the Patient

Engage the Patient and Family as Part of the Care

Change Patient Care Processes

### ARHM D/C to Acute



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# Lessons Learned

Collaboration

Education

Communication

Chronic Disease

Blame Free

Versus

No Easy Solution

High Risk Patients  
Through Predictive  
Modeling

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**Let the Conversation Continue...  
Thoughts or Questions?**