PROJECT TITLE: Homecoming: Eliminating Physical and Occupational Therapy Next Site of Care Recommendations

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The Problem:
Our hospital consistently discharges nearly 30% of patients to Skilled Nursing Facilities (SNFs). Currently, Physical and Occupational Therapy (PT/OT) documentation dictates next site of care. PT/OT recommends how much therapy is needed upon discharge and where the therapist believes these services should be provided, which is often a SNF. This practice eliminates meaningful conversations between provider and patient regarding patient wishes and next site of care choices. Patients would most often choose home instead of a SNF.

Project Goals:
In the baseline period from January 2016 through September 2016, 25% of Bundled Payments for Care Improvement (BPCI) patients at Highline were discharged to a SNF, while 54% were sent home. Our goal was to eliminate PT/OT next site of care recommendations and achieve the following goals within three months post implementation:

- Decrease BPCI discharges to a SNF from 25% to 18%
- Increase BPCI discharges to home from 54% to 60%

Actions Taken:

1. We assembled a multidisciplinary team consisting of PT/OT Leadership, Sound Hospitalist service, Care Management, Home Health and Hospital Administration.

2. The team provided input to assist PT/OT Leadership in making changes to their documentation. PT/OT altered their Electronic Medical Record template for all patients to eliminate next site of care recommendations. New therapy documentation focused on how much and often therapy would be needed at discharge.

3. We held meetings to educate our Sound Hospitalists and Care Managers by providing examples of new therapy documentation. PT/OT documentation no longer included a next site of care recommendation so emphasis was placed on provider and patient conversations to optimize home discharges using the new therapy documentation.

Results:
Physical and Occupational Therapy eliminated next site of care recommendations from their documentation from Nov 1, 2016 through Jan 31, 2017:

- In the comparison period there was a decrease in patients that were discharged to a SNF (25% to 20%, p=0.03). *(See Graph 1)*
- We also demonstrated an increase in patients that were discharged to home (54% to 61%, p=0.032). *(See Graph 2)*
- Data source: Ensemble, BPCI patients, regular, not matched

Lessons Learned:

- Hospital administration found the new process to be so successful that it is being adopted by all eight CHI Franciscan facilities as a best practice, two of which are Sound sites.
- This is only one solution to a very complex issue. Work will continue to be done around early patient mobilization to decrease PT/OT evaluation orders, increase home health utilization, and optimize home discharges.
- Many providers mistakenly believe if they do not follow PT/OT recommendations for next site of care they will be liable in case of an untoward event. Ongoing education is imperative.
- We were able to engage PT/OT Leadership in changing their documentation by sharing relevant statistics (SNF discharges, readmissions and outcomes).
- This pilot has become a sustained change in practice at our site.
- We would recommend piloting this change in therapy documentation at additional Sound sites.