The PACT Program: Improving Care for the Chronically Critically Ill

**AIM:** Lower costs, decrease length of stay and reduce readmissions for a subset of Spaulding Hospital Cambridge patients by addressing the unique set of obstacles facing chronically critically ill patients and their families

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**CONCLUSIONS:**
- 7-8% of ICU discharges are defined as chronically, critically ill. This population is marked by lengthy hospitalization, high risk of mortality and high overall costs
- Transitions are the time of highest risk for readmission due to gaps in communication and care
- Face to Face coordination of care improves the quality of transitions for these patients
- In home assessment identifies multiple risks for readmission

**NEXT STEPS:**
- Partners has multiple programs designed to follow patients into the community with which we plan to connect SHC patients

**RESULTS:**

- **Length of Stay (D/C patients only) as of 9/4/18**
  - Baseline (Control): 15.2 days
  - Baseline (Intervention): 15.2 days
  - Control: 15.2 days
  - Intervention: 15.2 days

- **Readmissions within 30 Days Rate as of 9/4/18**
  - Baseline (Control): 13%
  - Baseline (Intervention): 13%
  - Control: 18%
  - Intervention: 15%

- **Bouncebacks as of 9/4/18**
  - Baseline (Control): 44%
  - Baseline (Intervention): 34%
  - Control: 30%
  - Intervention: 30%