Reducing Short-Term Readmissions

What Works?

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In response to the MQC, this information is provided under Section 2805-m of the NYS Public Health Law

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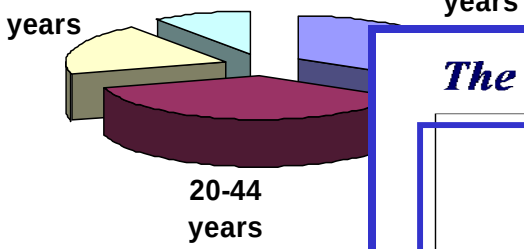
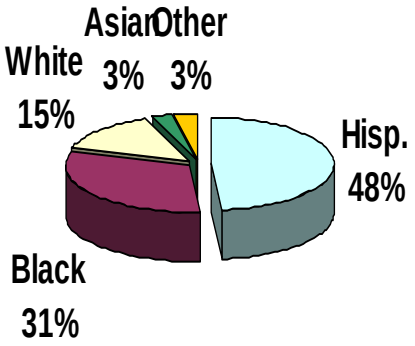
The Bronx:
Young, Minority, Poor, Heavy Disease Burden

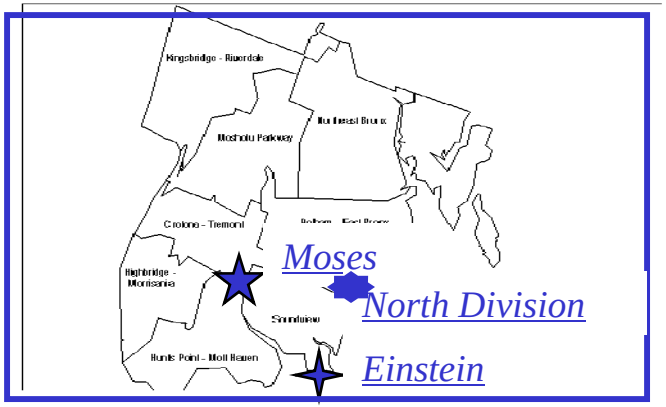
Age



Race / Ethnicity

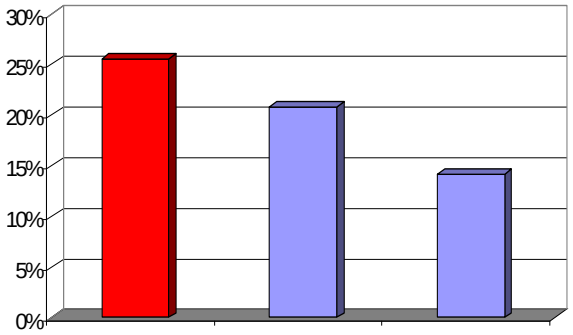


The Bronx and its Communities

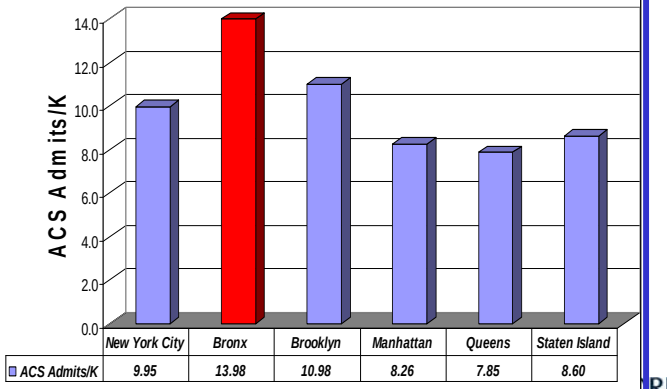


Population < Poverty

Bronx vs NYC and NYS



Ambulatory Care Sensitive Hospital Admits



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Montefiore, An Integrated Delivery System

Montefiore Medical Center is a nonprofit, academic medical center and integrated delivery system affiliated with the Albert Einstein College of Medicine.

Montefiore offers preventive, primary, specialty, acute and long-term care. The Montefiore system has four hospitals with over 1,400 combined beds and over 2,500 physicians on the medical staff.

- 1,579 Employed
- 942 Voluntary

Montefiore operates a hospital-based Rehabilitation Center and a Home Health Agency.

Montefiore Medical Group has 23 ambulatory care sites throughout the Bronx and lower Westchester County.

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Hospital Readmissions are Complex

- They are system wide problems that include:
  - Hospitals
  - Physicians
  - Post Acute Care Providers
  - Patients and their
  - Families
- Many may be unavoidable
  - Natural Progression of Disease
  - Lack of patient compliance and
  - Community resources

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	Patients Not Readmitted (N=51)	Patients Readmitted (N=50)	Relative percent difference
Median Age	62.0	68.5	
Medical/Social History			
Number secondary diagnoses	7.0	8.5	+21%
Percent with dementia	5.9%	26.0%	+342%
Percent with psychiatric diagnosis	2.0%	22.0%	+1022%
Percent with alcoholism history	5.9%	6.0%	+2%
Percent with substance abuse history	3.9%	8.0%	+104%
Homeless	2.0%	0.0%	-100%
Unstable housing	3.9%	2.0%	-49%
Discharge Disposition			
Home care	25.5%	20.0%	-22%
SNF, Rehab., or Other Facility	13.7%	38.0%	+177%

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	Patients Not Readmitted (N=51)	Patients Readmitted (N=50)	Relative percent difference
Clinical Factors upon Discharge			
On intravenous medication	0.0%	6.0%	n/a
WBC normal	74.0%	78.7%	+6%
Pain score > 3	4.1%	2.1%	-49%
Discharge Needs			
Number Of DC medications	6.0	8.1	+36%
Seen by Social Work on DC day	17.7%	28.0%	+59%
Wound care required	13.7%	22.0%	+60%
Assistance with ambulation	30.0%	43.8%	+46%
Assistance with feeding	21.6%	34.0%	+58%
Assistance with toileting	27.5%	54.0%	+97%
Assistance with dressing	27.5%	54.0%	+97%
Eloped or left AMA	0.0%	2.0%	n/a
Patient desire to leave early	3.9%	6.0%	+53%

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MMC Personnel Views
Discharge Process and Readmission Drivers

	What Works	What Does Not
Nurses	•Intensive RN discharge education •Home care RN visits •Telehealth "when used well"	•During stay, insufficient time devoted to symptom and medication instructions •Inadequate family support •Discharge process is different everywhere •Late or no follow up with a PCP •Last minute discharge notification
Social Workers	•Strong primary care follow-up •CMO disease management and telehealth •House calls program •Addressing psychosocial factors	•Stays too short to manage acute illness, pain, multiple medications •Late MD follow-up •Poor care at sub-acute facilities
Inpatient Physicians	•Pre-discharge education, with family •Medication reconciliation •Telehealth for CHF •Transmitting information pre-discharge	•Patient non-compliance with follow up and medications •Insufficient coverage for medications and home care •Inadequate inpatient education •Inability to change patient lifestyle
Primary Care Physicians	•Prompt follow up appointments •Good communication with PCP by inpatient team prior to first follow-up appointment	•"Premature" discharge •Insufficient inpatient education •Medication non-compliance •Poor nursing home care

Literature Review
Care Coordination Interventions

Intervention	Description	Intervention Initiated In-Hospital	Impact on Readmission
Home Telecare	Use of remote monitoring devices that transmit real time video and biometric data	**No**	**Inconclusive**
Home Visit	Follow-up home visit by RN within 30 days of discharge	**Yes**	**Inconclusive**
Telephonic Follow-up	Post-discharge telephonic follow-up by hospital-based health professionals	**Yes**	**Inconclusive**
Disease Management	Programs providing disease-specific education and patient support at a minimum	**No**	**Yes**
Discharge Medication Program	Focus by discharge RN on ensuring cardiac patients are prescribed medications per evidence-based guidelines	**Yes**	**Yes**
Heart Failure Discharge Education	In person, one-hour heart failure education session with RN prior to discharge	**Yes**	**Yes**
Palliative Care	Institution of in-home Palliative Care delivered by an inter-disciplinary team	**Yes**	**Yes**
Comprehensive Discharge Planning	Various models of enhanced DC planning involving contact with patient pre/post discharge either in person or by phone focusing on medication reconciliation, education and coordination of aftercare services	**Yes**	**Yes**

Literature Review
Common Themes and Observations

- Many studies involve patients older than 65 and/or with heart failure
- Most studies exclude non-English speaking and cognitively impaired patients
- Multiple studies support effectiveness of comprehensive discharge planning
  - Programs using in-person communication achieved greater reductions in readmissions
  - Interventions with both in-hospital and in-home components very effective
- Interventions require some degree of organizational culture change

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Clinical Programs: Impact on Admissions

Provide Services at the Point of Care

- Involvement in hospital discharge planning
- Medical House Calls program
- Individual patient and group education at the outpatient centers/physician's office

Integrated Care Coordination

- Integrated care management model including medical/behavioral and case/chronic care coordination
- Medication assessments by a PharmD

Utilize Real Time Data and Patient Information

- Real time access to ED data and hospital clinical information system
- Tele-monitoring

Offer Greater Connectivity to the Physicians

- Physician rounding program

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