

# ***Reducing Short-Term Readmissions***

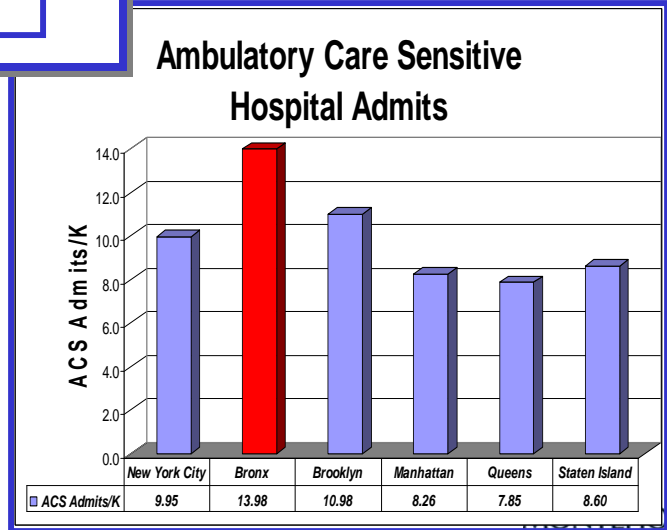
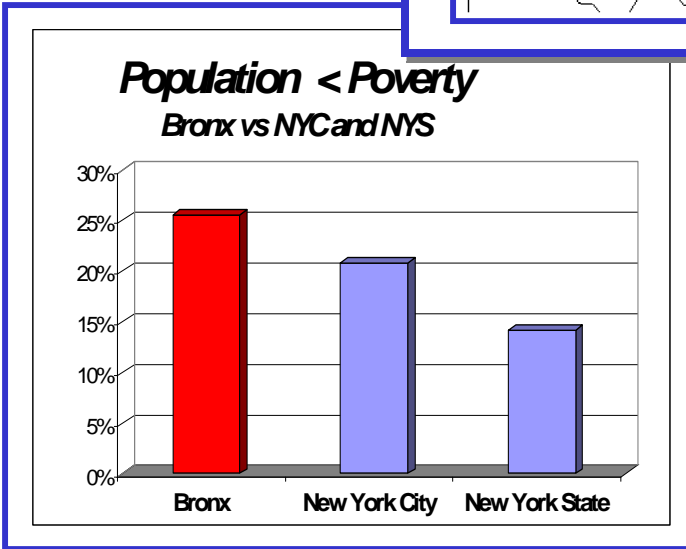
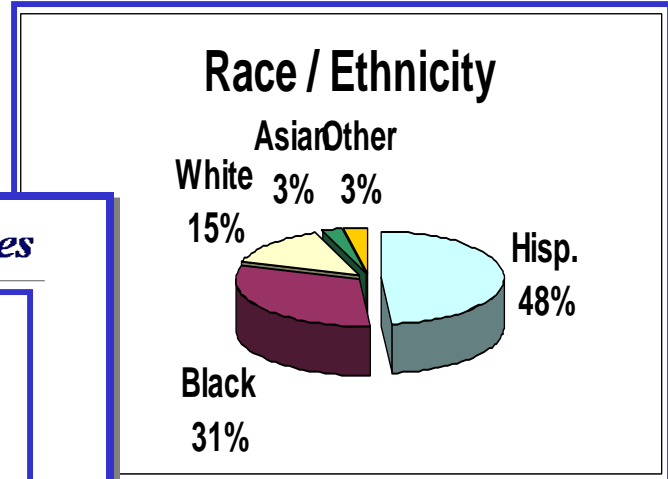
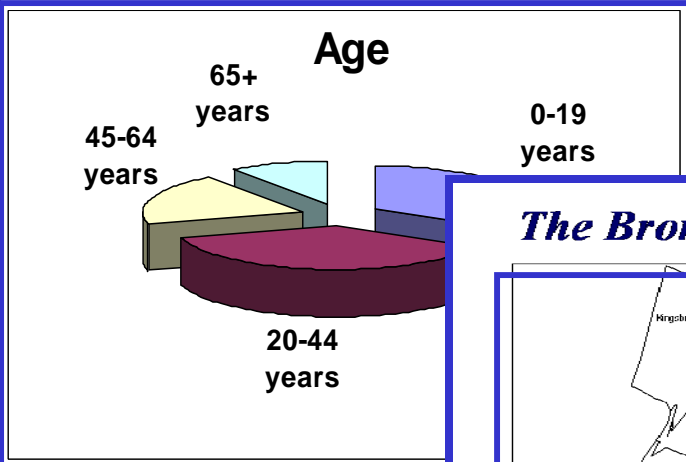
## ***What Works?***

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



# *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.

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

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



# *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

	Patients Not Readmitted (N=51)	Patients Readmitted (N=50)	Relative percent difference
<b>Median Age</b>	62.0	68.5	
<b>Medical/Social History</b>			
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%
<b>Discharge Disposition</b>			
Home care	25.5%	20.0%	-22%
SNF, Rehab., or Other Facility	13.7%	38.0%	+177%



	Patients Not Readmitted (N=51)	Patients Readmitted (N=50)	Relative percent difference
<b>Clinical Factors upon Discharge</b>			
On intravenous medication	0.0%	6.0%	n/a
WBC normal	74.0%	78.7%	+6%
Pain score > 3	4.1%	2.1%	-49%
<b>Discharge Needs</b>			
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%



# MMC Personnel Views

## Discharge Process and Readmission Drivers

	What Works	What Does Not
<b>Nurses</b>	<ul style="list-style-type: none"> <li>• Intensive RN discharge education</li> <li>• Home care RN visits</li> <li>• Telehealth “when used well”</li> </ul>	<ul style="list-style-type: none"> <li>• During stay, insufficient time devoted to symptom and medication instructions</li> <li>• Inadequate family support</li> <li>• Discharge process is different everywhere</li> <li>• Late or no follow up with a PCP</li> <li>• Last minute discharge notification</li> </ul>
<b>Social Workers</b>	<ul style="list-style-type: none"> <li>• Strong primary care follow-up</li> <li>• CMO disease management and telehealth</li> <li>• House calls program</li> <li>• Addressing psychosocial factors</li> </ul>	<ul style="list-style-type: none"> <li>• Stays too short to manage acute illness, pain, multiple medications</li> <li>• Late MD follow-up</li> <li>• Poor care at sub-acute facilities</li> </ul>
<b>Inpatient Physicians</b>	<ul style="list-style-type: none"> <li>• Pre-discharge education, with family</li> <li>• Medication reconciliation</li> <li>• Telehealth for CHF</li> <li>• Transmitting information pre-discharge</li> </ul>	<ul style="list-style-type: none"> <li>• Patient non-compliance with follow up and medications</li> <li>• Insufficient coverage for medications and home care</li> <li>• Inadequate inpatient education</li> <li>• Inability to change patient lifestyle</li> </ul>
<b>Primary Care Physicians</b>	<ul style="list-style-type: none"> <li>• Prompt follow up appointments</li> <li>• Good communication with PCP by inpatient team prior to first follow-up appointment</li> </ul>	<ul style="list-style-type: none"> <li>• “Premature” discharge</li> <li>• Insufficient inpatient education</li> <li>• Medication non-compliance</li> <li>• Poor nursing home care</li> </ul>

# 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



## 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
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### Integrated Care Coordination

- ◆ Integrated care management model including medical/behavioral and case/chronic care coordination
  - ◆ Medication assessments by a PharmD
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### Utilize Real Time Data and Patient Information

- ◆ Real time access to ED data and hospital clinical information system
  - ◆ Tele-monitoring
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### Offer Greater Connectivity to the Physicians

- ◆ Physician rounding program

