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Reducing Hospital Readmissions: Geriatricians Needed Now!

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The Bronx

- The poorest borough in NYC
  1.3 million; 10% aged 65+
- High rates of obesity, diabetes, asthma
- Per capita health care expenses 22% higher than national averages
- Medicare 30-day readmission rates higher than national averages
- 46 SNFs (12,033 beds) = 8.6 beds/1,000 pop.
  60% greater than NYC average

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Noteable Centers of Excellence
- Cancer Care
- Cardiac Care
- CHAM
- Transplant
- Neuroscience

Health System

Academic

M

Community

Home Care
- Home Health Agency
- House Call Program

Clinics
- Satellite
- Mobile
- School

Primary & Specialty Care
- Medical Group
- Outpatient

Hospitals
- 3 Campuses
- 4 Hospitals
- 1,491 Beds

Research
- Basic
- Clinical
- Translational
- Health Services

Teaching
- 1,200 Residents and Fellows
- 750 Medical Students
- 500 Multidisciplinary
- 1,200 Nursing Students
- Health Professional Ed.
- CME

Emerging Health

Information Technology

CMO

Care Management

17,500 Employees
2,562 Medical Staff
1,644 F/T Faculty
3,163 RN/LPN (F/T, P/T, PD)

Population Health
- Obesity prevention
- Lead poisoning prevention
- Teen pregnancy
- Nutrition
- Disease management
- Wellness

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Montefiore – an Integrated Health System and Urban Safety Net

- 66,125 adult med/surg admissions in 2010; 7,576 (11%) from SNFs
- 80% network patients insured by Medicare and/or Medicaid
- 15 year full risk managed care experience (CMO)
  - 94,000 risk lives (2010) → 140,000 (2012)
  - 2012 Bronx Accountable Healthcare Network Pioneer ACO - 23,000 Medicare FFS
  - 2012 NYS Health Home

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Geriatricians Needed

You are the experts in the care of these patients

- Managing complex decision-making
- Focus on iatrogenic issues: infections, functional loss, delirium, nutrition
- Understanding systems, services and team-based coordination in transitions

We Need You!

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Readmissions are a Problem; SNF Readmissions are the Perfect Storm

- 17.4% readmission rate (adult med/surg 2010)
  - 19.6% Medicare rate
  - 37.3% SNF rate (27% CMO SNF rate)
- Why are SNF residents readmitted?
  - Many SNFs – large and small
  - Different skills & services; different expectations
  - Increasing medical & psychosocial complexity
  - Pressures to reduce length of stay on both sides
  - Managing patient/caregiver expectations

Montefiore Programs to Reduce Readmissions

- Geriatrics Hospitalist Program
- Care Transitions Programs
  - ED navigator
  - SNF Programs
  - Bronx Collaborative
  - Post discharge Call Programs
- Care Guidance Programs
  - Home Visit Programs
  - Disease Management & Clinical Pathways
  - Case Management
  - Behavioral Health

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Geriatrics Hospitalist Program

- 3 - 4 Non-Unit based Geriatrician-Led Teams
- Rounds 7 days/week; nights onsite PAs/geriatrics on call
- Primary care and “consultations” (hip fx, surgery, SNF)
- Geriatrician hospitalists and rotating geriatrics faculty
- Teaching and nonteaching teams
- Funded by hospital, DOM, practice income, CMO
- Ongoing relationship with SNFs, House Call Programs

SNF Care Transitions Initiatives

- Emergency Department Patient Navigator
- Joint Oversight Committees (3 high volume SNFs)
  - Analysis of readmissions for performance improvement
  - Improve process to complete/share ADs, palliative care programs, do not hospitalize initiatives
- Shared clinical pathways (eg anticoagulation, pain)
- CMO: designated staff SNF contact; case conference post SNF admit; proactive screening for palliative/hospice needs
- INTERACT II (Interventions to Reduce Acute Care Transfers) tools integration
- AllScripts system facilitates SNF & home care discharges
- Centralized support unit assist with transportation and other discharge needs

Bronx Collaborative Care Transitions Program

- Reduce readmission & improve patient satisfaction
- Home discharges - enhance plans & post-hosp. followup
- Collaboration: 3 delivery systems and 2 insurance co. (220,000 [16%] Bronx residents; MA, MC & commercial)
- Participation of payers with per discharge fee
- Program conducted across multiple hospitals
- RHIO sets electronic care transition record, facilitates data exchange, reporting and uniformity
- Uses predictive model to target high-risk cases
- Focus on 60-day readmissions vs. 30-day
- Patients more clinically diverse & socially disadvantaged

Hospital Discharge Call Program

- Patient targeting: community discharges age > 69; adults discharged with home care services; readmission within 60 days; one insurer (Emblem Health)
- Standardized telephonic assessment by RN with patient/caregiver within 1 week of discharge
- Assessment logic generates patient-specific problem list and interventions

Medical House Call Programs

Geriatrics Home Visit Program

- Frail homebound (150 pts)
- Risk and FFS
- Teaching program
- Limited geography
- Limited emergency visits
- Geriatrician, ANP, fellows, SW, Geropsychiatrist

Geriatrics Hospitalist Service admits both

CMO House Call Program

- Risk pop with high utilization, homebound, social problems (>500 pts)
- Focused teams (2012) geriatrics, behavioral health, palliative care
- Geriatrician/NP team; SW; CMO & tele. support, no UM
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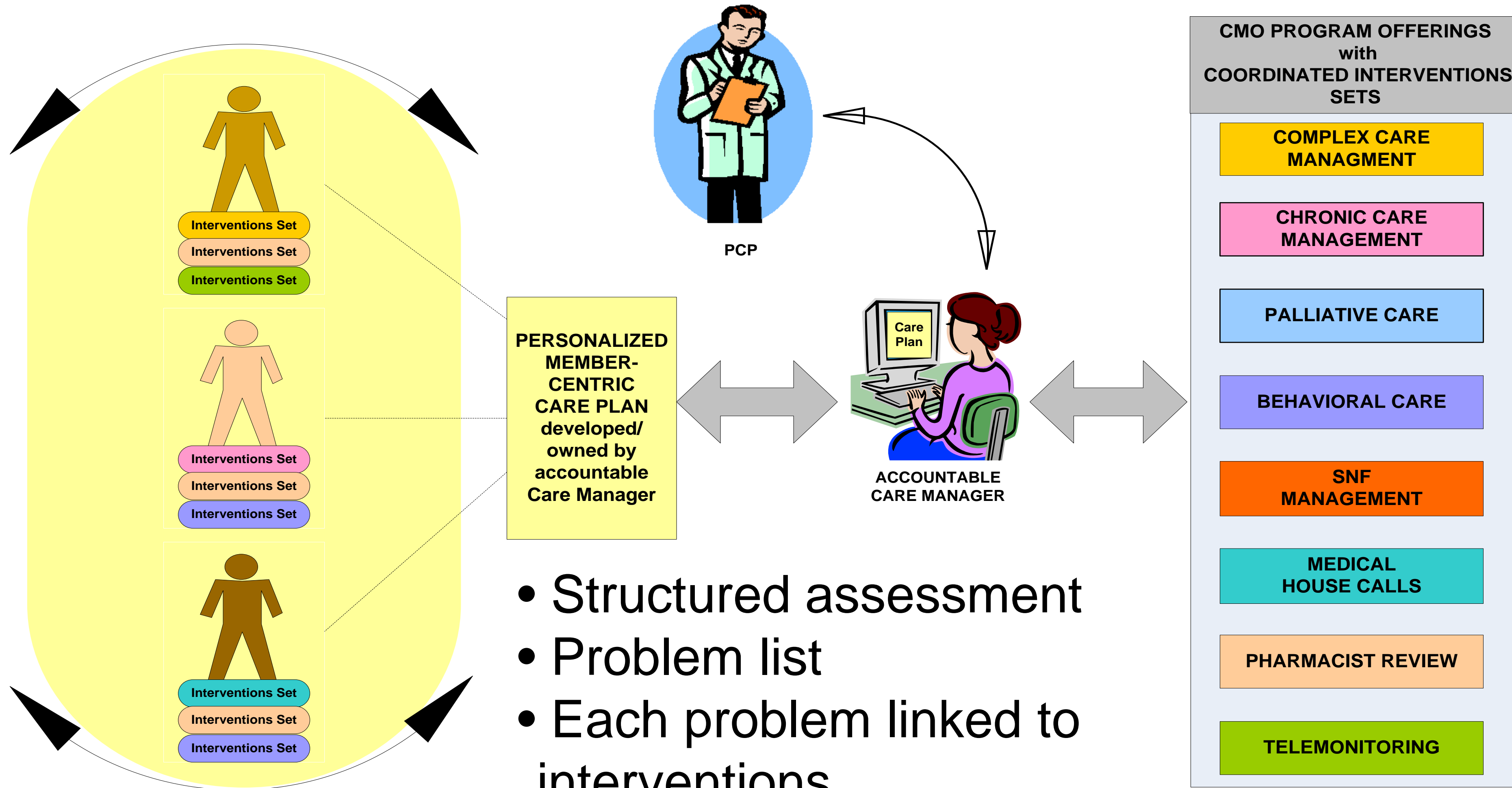
Care Guidance Programs

- Identify patients (complex, chronic dis., high cost)
- Assessment & care plan, including psychosocial
- Interventions
  - Chronic care mgmt programs – diabetes, HF, respiratory
  - Telemonitoring (HF, DM, frail elderly)
  - Medication reconciliation
  - Linkage to community supports, entitlements
  - Depression and alcohol screening
  - Palliative Care Program linkage
  - Inpatient care monitoring/ care managers
  - Caregiver support
  - Intensive case management
  - Behavioral health care management

Care Guidance Patient Management Process (Risk Population)



- Structured assessment
- Problem list
- Each problem linked to interventions
- Personalized care plans
- Periodic reassessment

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Clinical Pathways

- ED Chest pain assessment unit: Imaging, EST tests
- Heart failure programs: hospital svce; team training, medication clinic; SNF program; Telehealth; Home visits
- "Frequent Flyer" EMR ident. and intervention
- Thrombosis program & anticoagulation guidelines
- Back Pain guideline
- Pain clinics
- Palliative Care programs

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Moving from Vision and Philosophy to Successful Implementation:
Bronx Accountable Healthcare Network

- Accountable Care Organization: MIPA providers who are accountable for the quality, cost and overall care of patients.
- BAHN Pioneer ACO: 23,000 individuals
- No gatekeeping; choice of providers
- FFS provider billing to Medicare
- MIPA Board of Directors will determine method of (any) shared savings
- CMO will provide care coordination

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