



Care Transitions Program to Reduce Readmissions in the Bronx

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New York State Health Foundation
Paying for Health Reform: The Imperative of Cost Containment
November 2010



Agenda

- The Bronx Collaborative
- Health Care Spending in the Bronx
- Potential of Readmission Strategy
- Care Transitions Program



What is the Bronx Collaborative?

A not-for-profit corporation established by Montefiore, Bronx Lebanon, St. Barnabas, Healthfirst and EmblemHealth to develop new approaches to improve patient outcomes and reduce costs across the continuum of care



Health Care Spending in Bronx

- Per capita expenditures 22% higher than national average
- Medicare and Medicaid account for 80% of expenditures
- Inpatient expenditures excluding births: \$2.74 billion
- 30-day readmission rates in the Bronx are higher than the NYS average
- Impending changes in reimbursement will penalize hospitals with high readmission rates
- Can align providers and payers on quality and cost



Why a Care Transitions Program?

- Care transitions programs shown to be effective in reducing readmissions (Coleman, Naylor and Jack have shown readmission rates reduced by 15-30%)
- Care transitions programs shown to improve patient satisfaction with discharge process and to reduce medication problems and over-use of the ED



Bronx Care Transitions Program

- Scope: 1,600 care transitions over 12 months
- Staffing: One care transitions nurse and a half-time care transitions analyst for each 400 patients and one program pharmacist
- Services:
 - Enhanced education on discharge instructions (medications, signs and symptoms)
 - Assistance with follow-up physician appointments
 - A post-discharge telephone call within 72 hours
 - Pharmacist available for consultation
 - In some cases, a care transitions home visit (VNS or Montefiore Home Care)

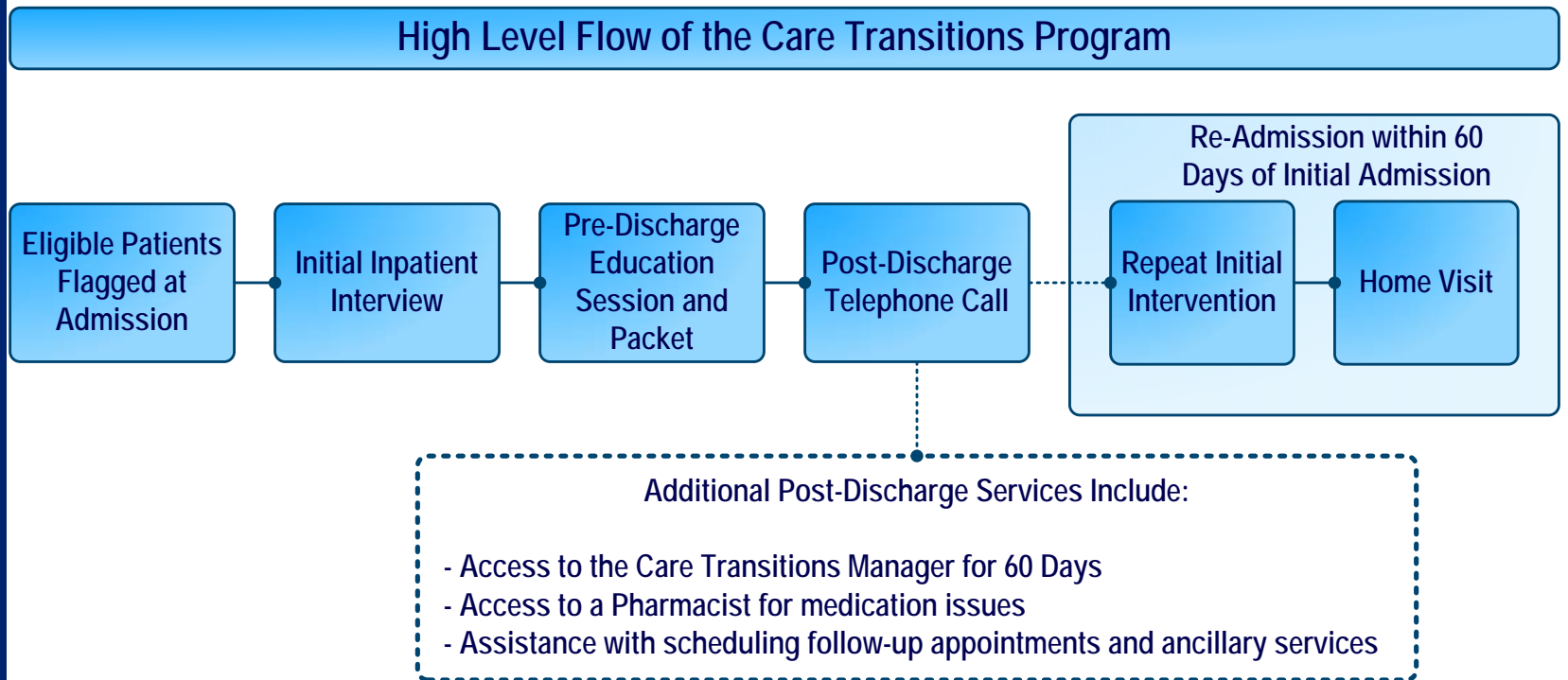


Eligible Patients

- Emblem and Healthfirst Medicare, Medicaid, commercial members
- Medicine Service admissions at Moses, Einstein, Bronx Lebanon and St. Barnabas
- Bronx residents aged 50 and older being discharged home
- English or Spanish speaking people with a telephone



Care Transitions Program Design





Program Uniqueness

- Cross-organization intervention
- Information sharing through the Bronx RHIO
- Automated work flows and patient record being developed by Collaborative members, Bronx RHIO and Axolotyl
- Involvement of care givers
- Covers a wide range of medical diagnoses



Evaluation Plan

- Control group of 200 patients selected the month before the program begins
- IRB-approved design with patient consent to participate
- Metrics:
 - 60-day readmission rate
 - Number of ED visits within 60-days of discharge
 - Timeliness of post-discharge MD visits
 - Patient satisfaction with discharge process (CTM-3 score)



Program Funding Mechanism

- Provider in-kind support
 - Program planning and implementation
 - Personnel management
 - Office space and equipment
- Health plan payments
 - Per-discharge fee for transition services
 - Care transitions home visits
- NYS Health grant will cover one-time costs associated with creation of the care transition record and fund the pharmacist for 1 year



Potential Savings

If program were provided to all 9,300 potentially eligible discharges:

- Estimated readmissions (26%) = 2,418
- 25% reduction = 605 admissions
- Cost per admission (including Physician fees) = \$12,600
- Gross savings = \$7,623,000
- Estimated operational costs = \$3,000,000
- Net savings = \$4,623,000



Sustainable and Replicable Model

- Straight forward funding model that's easily expandable to additional patient populations and organizations
- Care transitions record at Bronx RHIO can be made available to other providers
- Eventual integration into standard discharge planning process
- Exploring use of predictive tool that may increase program effectiveness in reducing readmissions
- Collaboration is key in care coordination in order to eliminate the breakdowns in care transitions.