# Grant Outcome Report

## Collaborative to Improve Care and Reduce Readmissions in the Bronx

**KEY INFORMATION:**

GRANTEE: Care Management Company of Montefiore Medical Center

GRANT TITLE: The Bronx Collaborative Care Transitions Program

DATES: Phase 1: August 2009 – June 2010
Phase 2: June 2010 – January 2013

GRANT AMOUNT: Phase 1: $69,689
Phase 2: $574,090

FUNDING: Coverage

## The Problem

In 2010, per capita health care expenses for the 1.4 million residents of the Bronx averaged around $8,500 per person—22% higher than the national average. Most of the borough's residents are low income and Latino or black, as well as disproportionately suffer from chronic illnesses—such as diabetes, obesity, and asthma—at rates exceeding State and City averages. Residents with these chronic conditions are susceptible to frequent and costly hospitalizations, and costs are further increased when rehospitalization occurs within 60 days. On average, each admission costs $12,600. Research indicates that some of these costs—especially readmissions—could be avoided with timely and appropriate post-hospital care. In 2009, the New York State Health Foundation (NYSHealth) awarded the Care Management Company of Montefiore Medical Center (CMO) a planning grant to establish a Bronx Collaborative and design a care transition model to reduce the rate of hospital readmissions and associated costs in the Bronx. In June 2010, NYSHealth awarded a second grant to CMO to implement and test this model: the Bronx Collaborative Care Transitions Program (Care Transitions Program).

## Grant Activities and Outcomes

The Collaborative involved partnerships among three major hospital systems (Montefiore Medical Center, Bronx-Lebanon Hospital Center, and St. Barnabas Hospital) and two insurers (Healthfirst and EmblemHealth). The Collaborative aimed to achieve the following goals:

- Reduce the 60-day readmissions rate by 25% (from a baseline of 29% of patients rehospitalized within 60 days to below 22%);
- Increase the percentage of patients having a physician office visit within 14 days of discharge;
- Improve patient satisfaction; and
- Create a sustainable and replicable model of a cooperative provider-payer enterprise.

During the phase 1 planning period, an executive steering committee of Collaborative leaders designated senior medical personnel from each member organization to form model design task force. To develop the Care Transitions



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Program model, the task force built on highly effective existing models: namely, Project RED (Re-Engineered Discharge), Project BOOST (Better Outcomes by Optimizing Safe Transitions), and Dr. Eric Coleman's Care Transitions Program. The task force developed a standardized care transition model that included interventions such as pre-discharge educational sessions for patients, informative booklets provided to patients and caregivers at discharge, and patient follow-ups through post-discharge calls and other interventions. Part of the task force's work included developing an electronic care transition record with the Bronx Regional Health Information Organization (Bronx RHIO) and its information technology (IT) vendor to support the care transition model.

Shortly after the Care Transitions Program was developed, NYSHealth awarded CMO a second grant to support the implementation and evaluation of the model at the Collaborative's three hospitals. Each participating hospital hired a registered nurse as a full-time care transitions manager (CTM) and a part-time care transitions analyst to assist the CTM. A centralized pharmacist was hired to support the CTMs and patients, and a home health care agency was retained to conduct home visits to patients who were readmitted within 60 days of their initial hospital admission. CMO staff members coordinated the program; provided a standardized 75-hour training program with reference manuals for hospital-based staff; worked with the Bronx RHIO and its IT vendor to develop a care transition record; performed data analysis; and developed a final report.

The Care Transitions Program was available to Medicare and Medicaid beneficiaries, as well as to commercial members of EmblemHealth and Healthfirst who met certain criteria. The Collaborative targeted approximately 1,650 patients for the program, of whom 1,394 consented to participate. However, after applying eligibility criteria and accommodating for a comparison group, 515 participants were selected for the program.

The Collaborative succeeded in involving the Bronx RHIO to support data sharing; having the hospitals and payers collaborate on the model's design and financing; hiring and training appropriate staff; and enrolling a large number of patients in the intervention. In addition, outcome data from the evaluation suggest the intervention reduced hospital readmissions. For example, the intervention group's 60-day readmission rate was 3.5% lower than the comparison group's rate of 26.3%, and nearly met the original objective of reducing the 60-day readmission rate from a baseline of 29% to below 22%.

Furthermore, participants who experienced two or more program interventions had a readmission rate of 17.6%, which is 39% lower than their baseline readmission rate and 33% lower than the 60-day readmission rate of the comparison group. Evaluation of the Care Transitions Program also helped identify 5 key factors that reduced the likelihood of a hospital readmission within 60 days, which included participants receiving at least one intervention through the program and having a physician office visit within 14 days of discharge.



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However, these results were tempered by the following limitations:

- Incomplete claims data from phase 1 patients (index claims data are missing for 7% of the intervention group); and
- Seasonal variation in admissions. The phase 1 comparison group was selected four to six weeks prior to program start-up, during November and December, when admissions and readmissions are generally lower than in January.

Although the program resulted in positive outcomes, it produced no change in post-discharge visits to the emergency room or in patient satisfaction. Additionally, 10% of participant readmissions were to hospitals outside of the Collaborative, so program staff was unable to offer either in-hospital or post-discharge interventions. Finally, intervention services were bundled, making it difficult to determine the extent to which each service contributed to the overall program effect.

## The Future

The Bronx Collaborative partners demonstrated an interest in further developing programs to reduce hospital readmissions. They expressed support for the Care Transitions Program and value provider-payer partnerships, a central element of the program. As a result of the experience gained during the course of the program, the partners became convinced of the importance of personal contact and building relationships with patients. The Collaborative discussed strategies on how to improve post-discharge activity and have looked to formalize certain approaches at each participating hospital. It recommended greater integration of Care Transitions Program staff into the regular routine of the hospital units to improve pre-discharge educational sessions with patients and the coordination of the discharge process as a way to more effectively prevent readmissions. The Collaborative aimed to make several more modifications to improve the Care Transitions Program.

Reducing readmissions continued to be a focus of all three Collaborative hospitals. Montefiore used elements of the Care Transitions Program, specifically post-discharge follow-up calls, with some success, and worked to integrate elements of the program into usual care. To identify eligible patients, Montefiore used a predictive model that was developed from lessons learned during phase 2 of the grant. St. Barnabas Hospital also adapted elements of the Care Transitions Program into its overall program to reduce readmissions, and the program continued approximately as designed at Bronx-Lebanon Hospital Center. Montefiore continued to work with both St. Barnabas Hospital and Bronx-Lebanon Hospital Center when beneficiaries of the Montefiore accountable care organization were admitted to either facility, and Montefiore worked with the Bronx RHIO on other areas of care coordination.



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## BACKGROUND INFORMATION:

### ABOUT THE GRANTEE

Founded in 1996, Care Management Company of Montefiore Medical Center is a wholly owned subsidiary of Montefiore Medical Center. It is one of the first provider-driven health care management companies with the infrastructure and expertise to assume financial accountability for a patient population and successfully manage the delivery of high-quality clinical services. Its services are designed to manage and improve process, quality, and continuity of care while managing medical expenses and improving patient outcomes.

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