



CENTERS OF CARE
Nassau University Medical Center
A. Holly Patterson Extended Care Facility
Family Health Centers
Elmont • Westbury • Hempstead • Roosevelt

Psychiatry and Behavioral Sciences

Readmission Reduction:

A Department-Wide Performance Improvement Initiative

April, 2014

**NASSAU HEALTH CARE CORPORATION
BOARD OF DIRECTORS**

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Performance Improvement (PI) Coordinating
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**Child &
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**Chemical
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**Psychiatric
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Room (ED)**

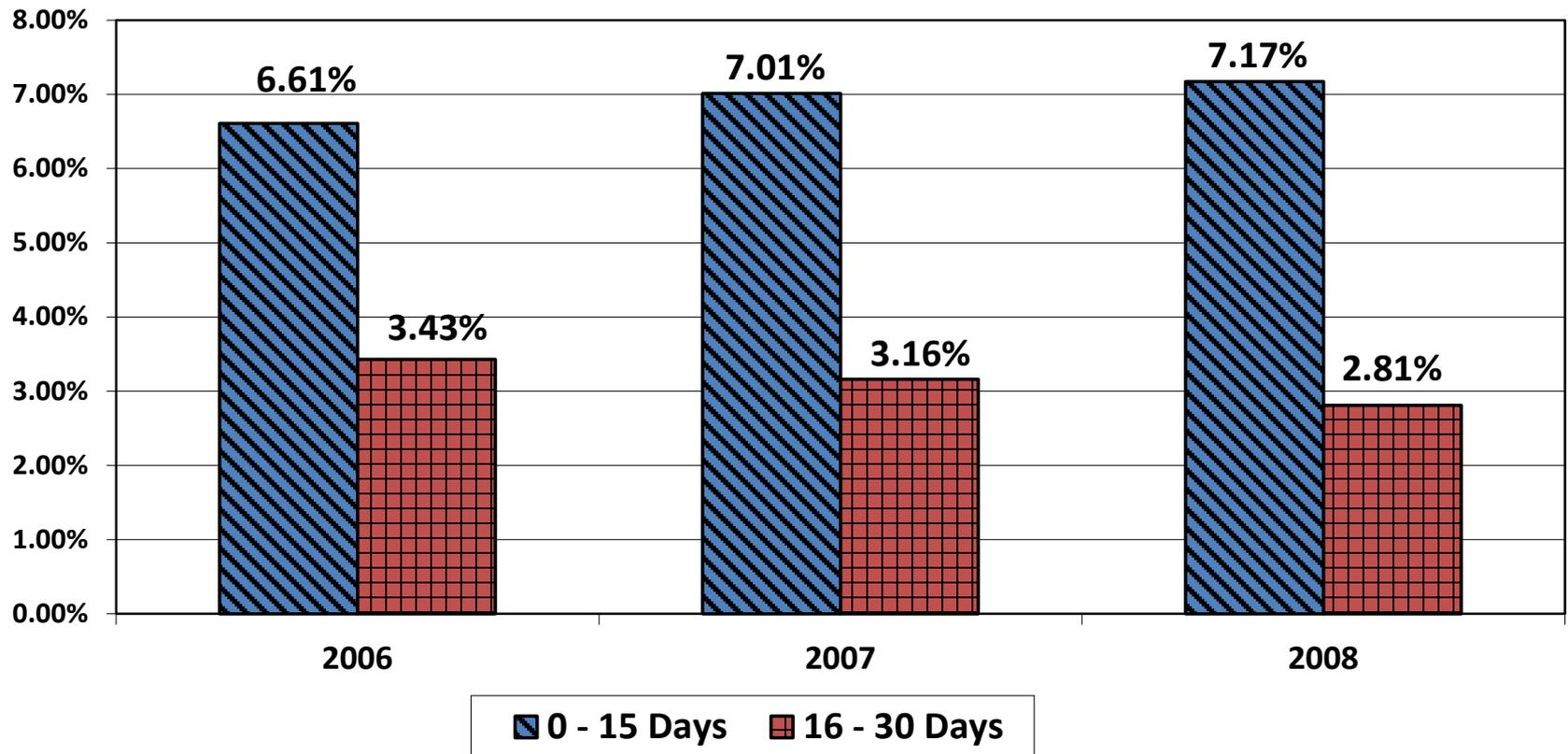
**Adult
Inpatient
Service**

Readmission Reduction: A Department-Wide PI Initiative

- After 15-day readmission increased from 6.6% in 2006 to 7.0% in 2007 and 7.1% in 2008, the dept adopted the goal of reducing the rate of readmission to equal or better than the Mental Health Inpatient benchmark of 5.5% and 2.5% for 16-30 days.**
- Pilgrim Psychiatric Center to be considered as a placement option very early in the discharging planning process, if patients need long-term hospitalization.**
- Case Management services were incorporated into the referral process for all patients regarded as high risk for readmission.**

Nassau University Medical Center (NUMC) Readmission Rates: 2006-2008

Comparison of Data for Readmission rate:
2006 - 2008



Readmission Project

- **In 2007, all six inpatient teams met to discuss long-acting injectable medications before discharging patients home.**
- **Readmission Prevention Committee established – Quality Improvement (QI), MD, Social Worker (SW).**
- **Review of data by unit undertaken for comparative analysis of readmission data between the adult inpatient units.**

Issues in Readmission

- **One unit (a 35-bed co-ed unit) had higher rate of readmissions than the other two units.**
- **Readmission chosen as unit-specific PI project.**
- **Focused review of each readmitted case was done – factors examined: diagnoses, demographics – age, gender; diagnostic groupings; meds on discharge; where discharged to – home or Department of Social Services; co-morbidities, substance abuse, medical history, etc.**

Findings

- **Results showed unanticipated outcomes; housing status and psychiatric diagnoses were found to be non-predictors of readmissions within 15 or 30 days of discharge (D/C).**
- **Majority of readmitted patients were discharged home, with homelessness not a major factor.**
- **Inability to fill prescription for oral or depot shots, either due to general non-compliance with aftercare plan and/or drug refills due to drug affordability – lack of funds, drugs not on list of approved formulary of health insurance companies, etc., were better predictors of readmission.**

Actions Taken

- **Patient and family education regarding med compliance – risks and benefits of taking meds as prescribed after D/C from hospital. Medication education became part and parcel of D/C.**
- **Family members were actively enlisted to participate in this process either during family visits or whenever they showed up to pick-up their loved ones from the hospital upon D/C. No D/C is effected until this education requirement is satisfied.**
- **Readmission adopted as department-wide PI projected led by SW division utilizing the monthly support group meeting as the avenue to disseminate helpful information regarding disease management to family members to prevent re-admission.**
- **The multi-disciplinary teams on the unit ensured that D/C planning was initiated on all patients upon admission.**

Actions Taken

- **Since inability to refill meds after discharge was a major contributor to readmission, psychiatrists were educated regarding the need to replace certain expensive atypical antipsychotic meds pts might have been admitted on with readily available and affordable meds while on the inpatient units, to ease med refills and increase the likelihood of continued med therapy after discharge.**
- **The hospital's Information Technology (IT) department helped set up electronic notification system whereby the department's director of QI and SW receive email alerts each time a discharged patient is readmitted into the service.**

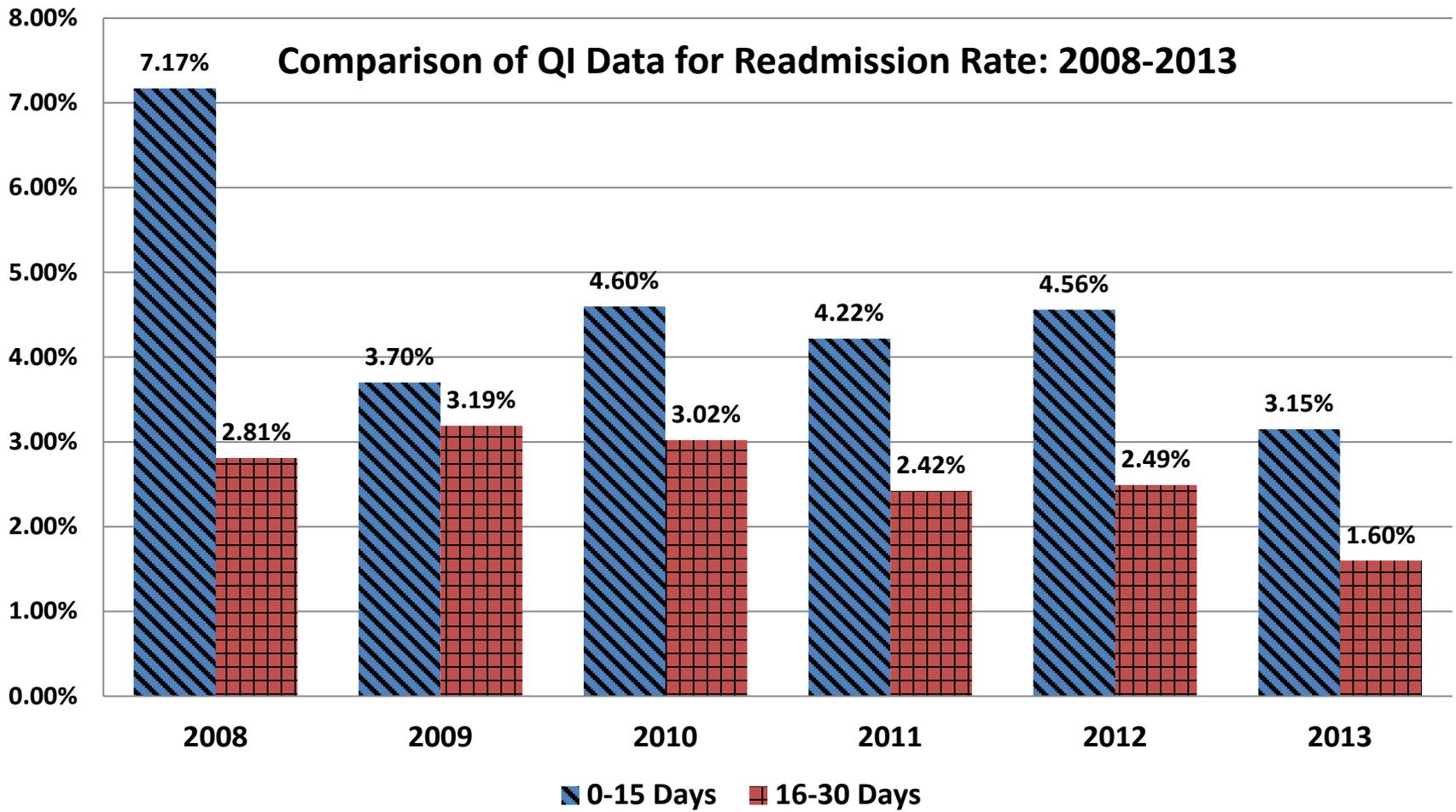
More Actions Taken

- **To further enhance communication among caregivers and better coordinate care , in addition to daily Morning Report forum where discipline heads and department leaders review clinical and programmatic issues by ward, the Thursday meetings were expanded for inpatient-outpatient collaborative conferences.**
- **Outpatient (OPD) residents co-facilitate D/C planning groups with the inpatient residents and SW with patients being prepared for D/C to the hospital's OPD.**
- **Working together on these cases enable staff from both services to achieve common goals of keeping patients out of the hospital for as long as possible.**

Plans to further Reduce Readmission Rates:

- As the hospital with the only locked psychiatric ED on Long Island, but without a designated Comprehensive Psychiatric Emergency Program (CPEP) status, the department has applied for a CPEP with an Extended Observation Bed component, among others, to better manage admission and readmission.**
- The department has also developed and submitted to the hospital administration, a business plan to seek to consider developing a partial hospitalization program at NUMC for very intensive outpatient care to prevent readmission.**
- Plan to add Electroconvulsive Therapy (ECT) program to the array of clinical interventions available for treating difficult to treat psychiatric conditions.**

NUMC Readmission Rates: 2008-2013



Why Reduce Readmissions?

- **Prevalent across the U.S.**
- **Costly**
- **Indicators of a fragmented system or poor quality of care**
- **Federal Policies**
 - **Pay for Performance Indicator**
 - **Medicare Hospital Readmissions Reduction Program**

National Association of Public Hospitals (NAPH) 2010 Readmissions Study

- Survey to quality directors/contacts at 101 NAPH members (acute care only)
 - Received 51 completed responses (50% response rate)



- Phone interviews with 9 NAPH members
- Analysis of publicly-reported heart failure, acute myocardial infarction, and pneumonia readmissions on Center for Medicare and Medicaid Services Hospital Compare website

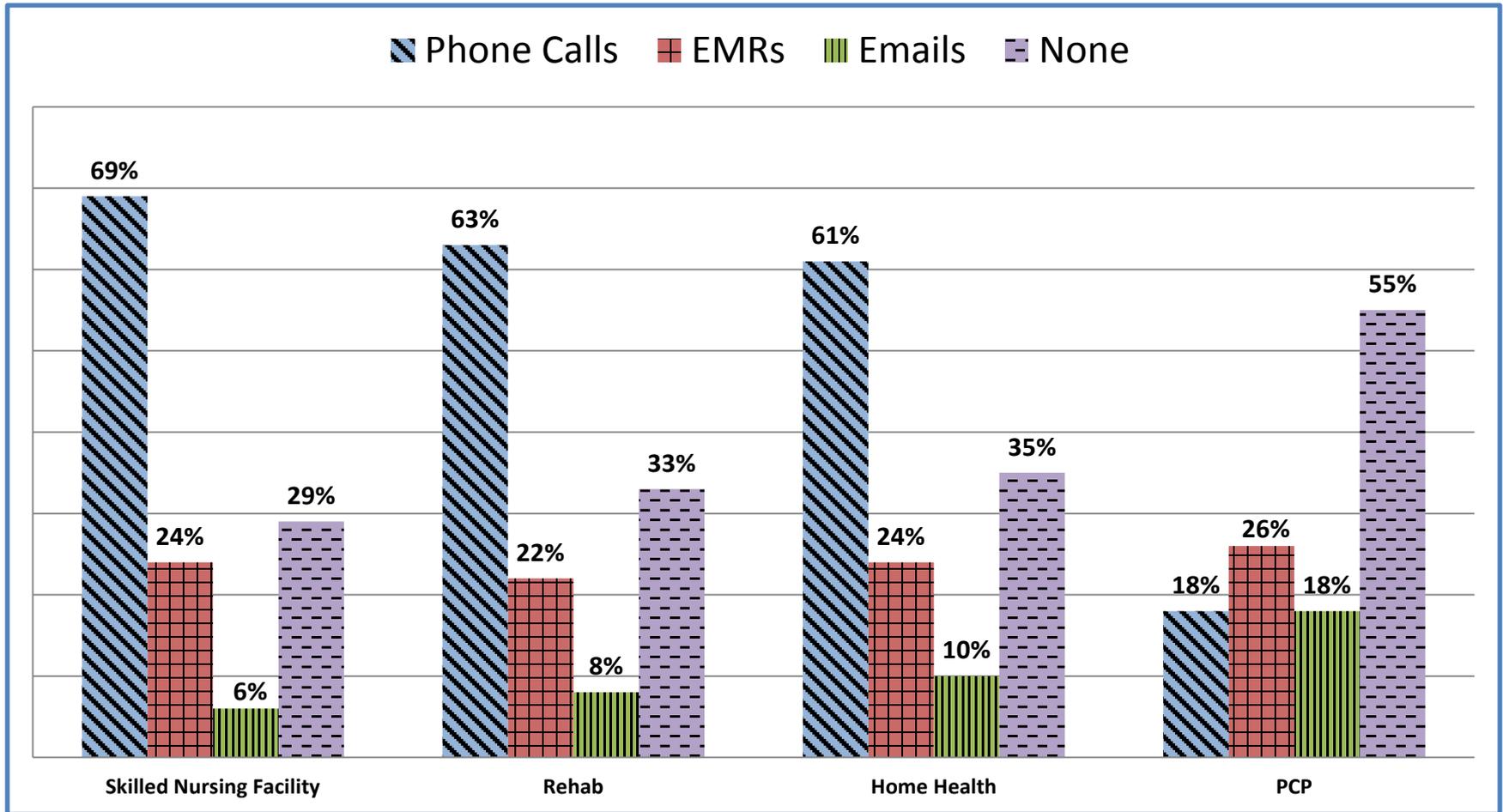
NAPH Readmissions Project

▶ Key findings:

- 1. The majority of NAPH members have focused on reducing readmissions within the last 2 years**
- 2. A majority of members followed up with discharged patients' skilled nursing, rehabilitation, or home health providers--but few contacted their Primary Care Physicians (PCPs)**
- 3. NAPH members provided more evidence-based care pre-discharge, than during or after discharge**
- 4. Some members have created new discharge coordinator or transitional care nurse positions without obtaining additional funding**

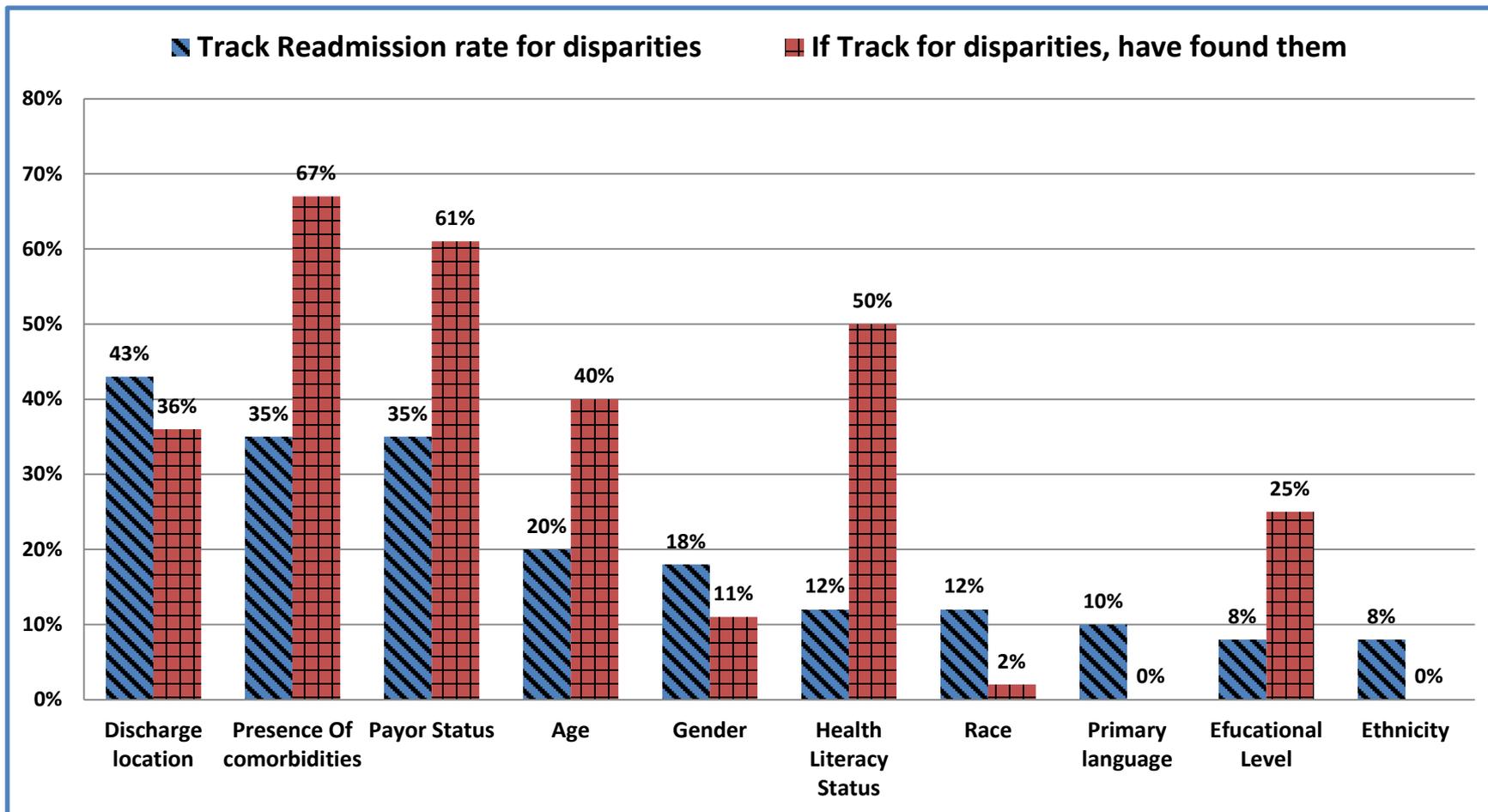
Strategies to Reduce Readmissions

Which modes of communication do you employ to communicate with patients' community providers?



Strategies to Reduce Readmissions

Factors contributing to disparities in readmission rates



Contributors/Causes of Readmission

Which issues contribute towards readmissions?

