

**LEAD Attendings:**



**Nazreen Jamal, MD**

Medical Director, Pediatric Emergency Medicine  
Associate Director of Quality, Pediatric Emergency Medicine  
Assistant Professor of Pediatrics in Emergency Medicine  
NewYork-Presbyterian Morgan Stanley Children's Hospital



**Brett Youngerman, MD, MS**

Associate Quality Chair, Department of Neurological Surgery  
Assistant Professor of Neurological Surgery  
NewYork-Presbyterian/Columbia University Irving Medical Center

**Sponsors:**

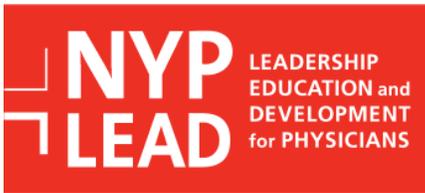
**Deepa Kumaraiah, MD, MBA**

SVP, System Chief Medical Officer at NewYork-Presbyterian Hospital

**Mentors:**

**Paul N. Casale, MD, MPH, FACC**

Professor of Clinical Medicine and Population Health Sciences  
Weill Cornell Medical College



Adjunct Professor, Columbia University  
Executive Director, NewYork Quality Care

Donna Tinling-Solages, MPA, RN, CCM  
Director of Care Coordination/SW  
NewYork-Presbyterian Hospital/Columbia University Irving Medical Center

### **Project Title**

All-Cause Hospital Readmission

### **Project Summary:**

Reduction in 30-day all cause hospital readmissions is a 2022 NewYork-Presbyterian Quality and Patient Safety goal. Unplanned rehospitalizations are costly, potentially harmful, and often avoidable. In addition, 30-day hospital readmission factors into the Hospital Readmission Reduction Program, Centers for Medicare and Medicaid Services star rating, and US News and World Report ratings.

Our project goals are to identify priority patient populations at high risk of readmission, provide best practices resources for preventing avoidable readmissions, and develop priority-specific metrics to monitor progress.

### **Project Details:**

We began by using the Tableau Readmissions dashboard to help each hospital campus identify data-driven priority populations to enable focused efforts to reduce readmissions. For each site, we identified high readmission risk conditions, such as heart failure, COPD, pneumonia, sepsis and sickle cell anemia, and the highest risk units and teams for each campus, including some units with readmission rates over 20%. We found that patients discharged to nursing facilities and with home nursing services often had high rates of readmission. We are developing metrics specific to each priority population to support iterative Plan-Do-Study-Act (PDSA) cycles of quality improvement and help monitor incremental progress towards the overall readmission reduction goal. We continue to work with the analytics team to improve the dashboard and make the data more actionable.

Additionally, we compiled and shared available Epic tools to identify individual patients at risk of readmission in real time. An automatically calculated LACE+ score can predict the risk of readmission at the time of discharge. A small number of high utilizers make up a disproportionate share of readmissions and auto-populated Epic lists can identify high inpatient and emergency department utilizers. Finally, currently readmitted patients can be flagged for root cause analysis and quality improvement.

Identification of priority populations and high-risk patients will allow the leadership at each site to efficiently allocate time and resources. Evidence suggests that the rate of preventable readmissions can be reduced by improving the discharge and transition processes out of the hospital. Currently, efforts are focused on improving post-discharge care coordination and communication with nursing homes and home health services to avoid preventable readmissions and targeted to patients at the time of arrival in the emergency department to create an outpatient care plan and avoid unnecessary readmission.