A VNSNY collaboration with a major NYC medical center reduced admissions and 30-day return visits among high-risk ED patients.

- Nearly 9 out of 10 high-risk ED patients discharged with VNSNY post-acute care did not return to the hospital within 30 days
- Program success led to expansion to 14 sites

The Need
Elderly patients account for up to 24% of all ED visits and have a hospitalization risk from 2.5 to 4.6 times higher than the general population. And studies have shown that these patients are also more likely to be discharged with unrecognized or untreated health issues, further exacerbating the problem.¹

One effective way for hospitals to reduce costs among this group is to reduce unnecessary inpatient admissions from the ED that could be avoided with appropriate post-acute care at home. That was the genesis of the VNSNY ED-to-Home Program, which began as a collaboration with one of New York’s largest integrated delivery systems.

Program Objective
The VNSNY ED-to-Home Program is designed to support the goals of the Triple Aim by:

- Improving quality of care in the ED and home care settings
- Reducing costs by avoiding unnecessary inpatient admissions
- Improving the patient experience by supporting patients and caregivers through the transition home

Patient Population
The targets for this VNSNY initiative are patients presenting to the ED who are found to be at high risk for unplanned hospitalizations or rehospitalizations, and meet home care criteria.

Risk factors may include:
- Over 65 years of age
- Recent ED visit or hospitalization (past 6 – 12 months)
- Multiple comorbidities
- ADL deficits
- Polypharmacy
- History of falls

Key Program Elements
VNSNY collaborates with the hospital’s interdisciplinary workgroup to identify patients who can safely be discharged from the ED with the appropriate post-acute service in place, in lieu of admission.

The protocol for this initiative leverages evidence-based ED guidelines, and includes:
- **Dedicated VNSNY RN Liaison.** On-site 7 days a week.
- **Interdisciplinary Team Workgroup** including:
  - Chairman of the ED
  - ED Case Manager, Social Worker, Physician
  - VNSNY RN on-site liaison
- **Ongoing Collaboration.** Regular workgroup meetings to discuss program outcomes and opportunities for improvement, including case reviews.
- **Risk Identification.** The ED team screens patients for presence of one or more risk factors and then collaborates with VNSNY RN, as appropriate, to develop a comprehensive home care plan.
- **Structured Outcomes Reporting.** Reports are issued monthly to provide the IDT with data on ED visits/hospital admissions, as well as patient-detail reports.

Results
- Between January 2014 and March 2016, the VNSNY ED-to-Home Program provided care for 908 ED patients who averaged over 78 years of age, with 5+ comorbidities and 7+ ADL deficits.
- Of these patients, only 11.4% returned to the hospital within 30 days.\(^2\)
- Estimated cost savings of over $4 million based on 50% of cases discharged directly to VNSNY Home Care from the ED.\(^3,4\)
- The success of the initial collaboration paved the way to launching this program in 14 ED sites by 2016, including many smaller, community-based hospitals.

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\(^4\)MedPac Report to the Congress: Medicare Payment Policy | March 2015.