



SOCIAL WORK LEADERSHIP INSTITUTE OF THE NEW YORK ACADEMY OF MEDICINE

KEY POLICY POINTS REGARDING COMPREHENSIVE CARE COORDINATION INTERVENTIONS WHICH POSITIVELY IMPACT HOSPITAL LENGTH OF STAY JUNE 30, 2010

In May 2010, the Social Work Leadership Institute at the New York Academy of Medicine completed a systematic search of nine databases for studies of comprehensive care coordination interventions. The search covered the years between 1995 to October 2009 and yielded 33 studies. Twelve (including two meta-analyses) of the 33 studies showed a reduction in hospital length of stay among the older adults receiving the intervention.

Two key policy points can be gleaned from the results of the search, which show common features among the 10 comprehensive care coordination interventions which reduced hospital length of stay. These points are noteworthy as policy makers conduct ongoing efforts to improve quality of care while addressing burgeoning costs of health care for individuals with multiple chronic conditions.

1) The use of interdisciplinary teams is an important component of care coordination interventions which successfully reduce hospital length of stay.

Each of the 10 original studies and two meta-analyses revealed that comprehensive care coordination interventions, which reduced hospital length of stay, used interdisciplinary teams that were composed of at least two of the following participants: physician, physician assistant, nurse, nurse practitioner, geriatrician, social worker, psychologist, pharmacist, physical therapist, occupational therapist, speech therapist, community service member, or dietitian.

2) Care coordination interventions which use a discharge plan *along with* follow-up contact/services in the home yield a significant reduction of hospital readmission days.

The interventions in all but one of the 10 original positive outcome studies and seven of the 9 studies included in one of the meta-analyses incorporated a discharge plan and phone/human contact follow-up, while only five of the 21 negative/no difference outcome studies employed both protocols. One of the meta-analyses reviewed found that nurse-assisted case management post-hospital transition interventions “could reduce hospital days over periods ranging up to 12 months.”ⁱ

Based on a cost analysis of all the interventions in the second meta-analysis, “post-discharge support with a home visit could prevent 84,000 readmissions with an estimated reduction in Medicare payments of \$424 million per year.”ⁱⁱ

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ⁱ Chiu, W. K.; Newcomer, R.; , (2007) A systematic review of nurse-assisted case management to improve hospital discharge transition outcomes for the elderly, *Professional Case Management*, 12(6), 330.

ⁱⁱ Phillips, Christopher O.; Wright, Scott M.; Kern, David E.; et al. (2004) Comprehensive discharge planning with postdischarge support for older patients with congestive heart failure: a meta-analysis, *Journal of the American Medical Association*, 291(11), 9.