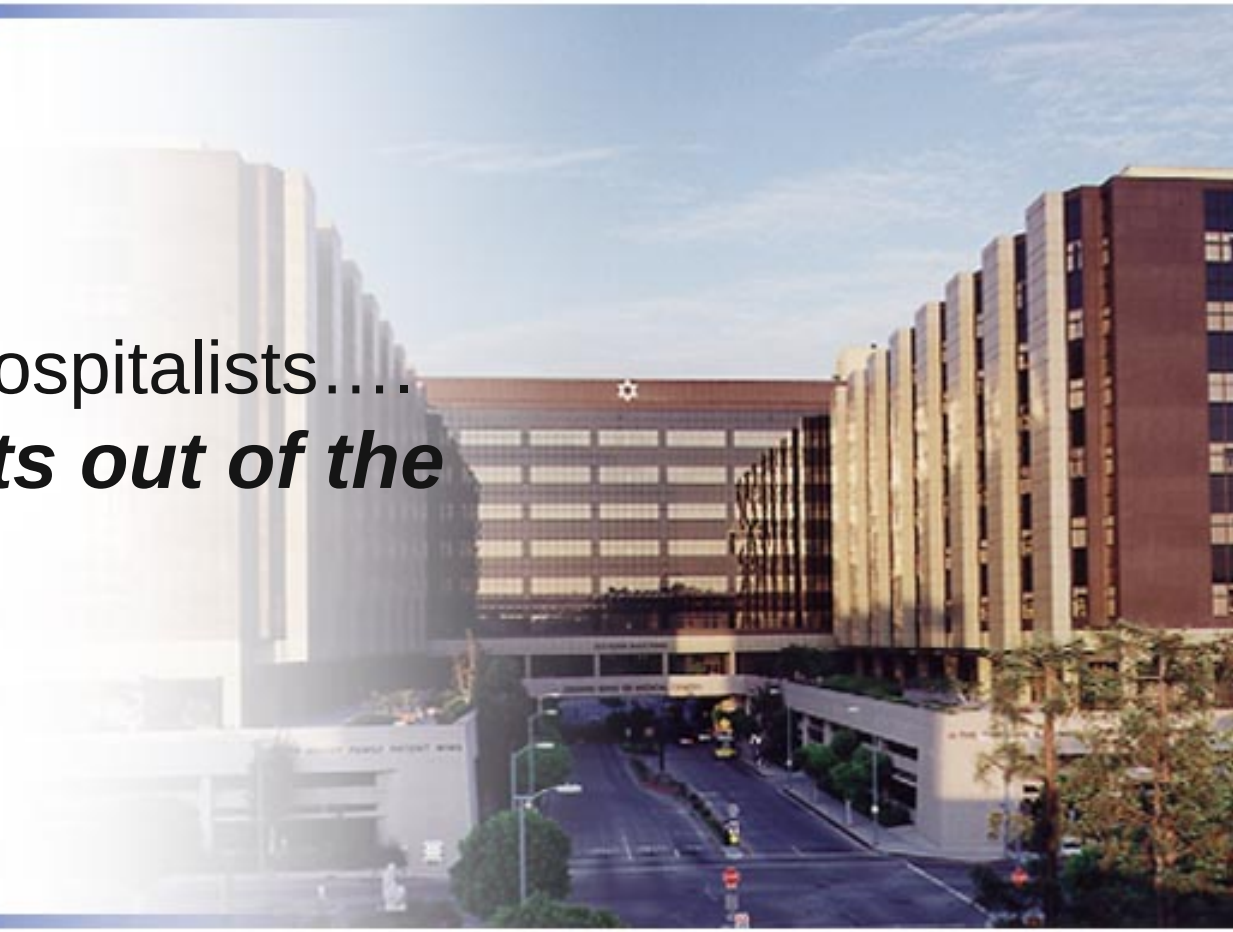
Cedars-Sinai

The new role of hospitalists….
Keeping patients out of the hospital



Cynthia Litt, MPH
Eugene Kim, MD

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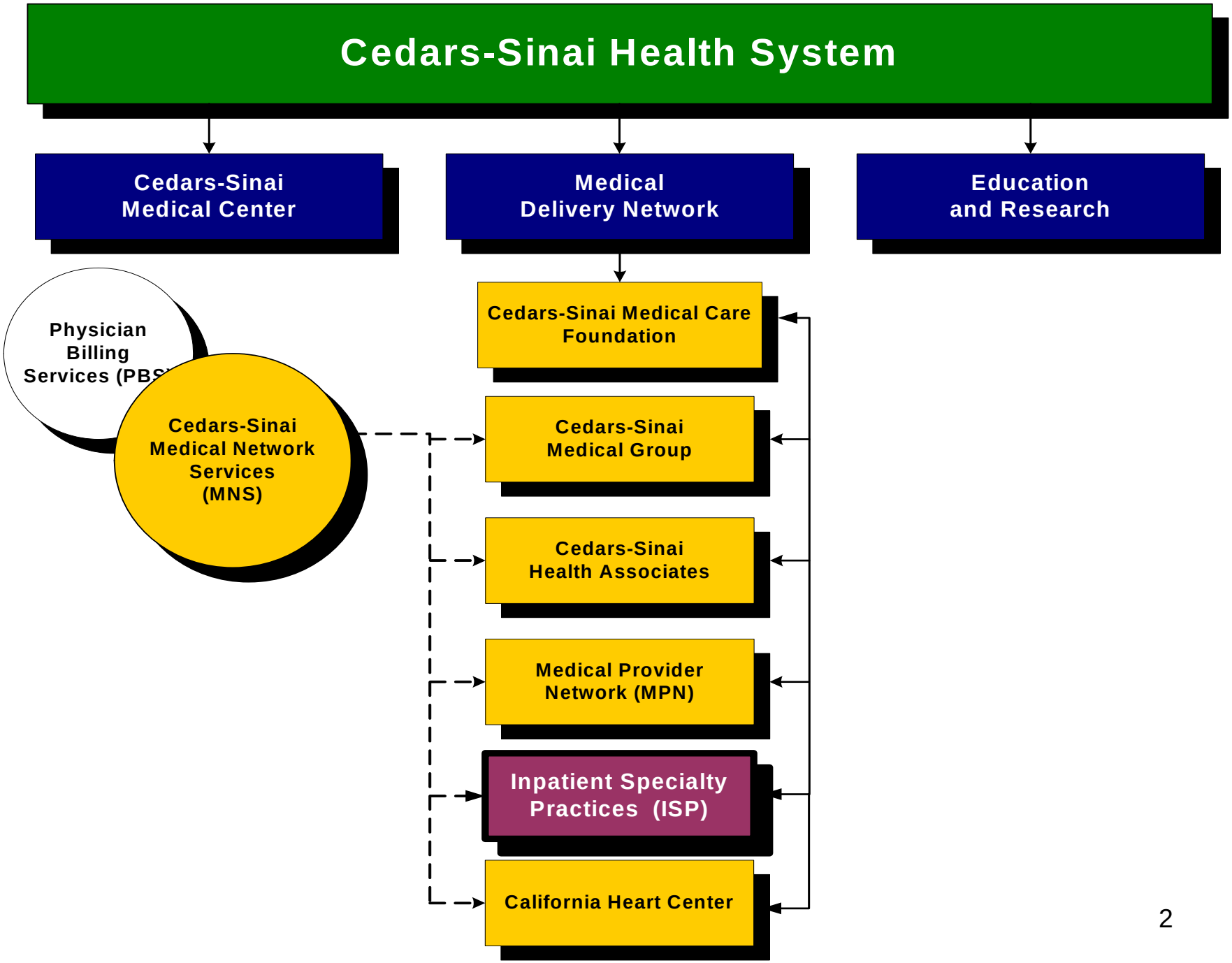
Cedars-Sinai Health System
Cedars-Sinai Medical Center
Medical Delivery Network
Education and Research
Physician Billing Services (PBS
Cedars-Sinai Medical Network Services (MNS)
Cedars-Sinai Medical Care Foundation
Cedars-Sinai Medical Group
Cedars-Sinai Health Associates
Medical Provider Network (MPN)
Inpatient Specialty Practices (ISP)
California Heart Center

INPATIENT SPECIALTY PROGRAM (ISP)

- Founded in 2006
- Began with 2 hospitalists and now consists of 18 full time hospitalists, 2 nurse practitioners, and 8 case managers
- 24/7 presence/availability at Cedars, Olympia, and local SNFs
- 400-500 acute discharges/month
- Average daily inpatient census: 40-85 patients on 5 services

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C.A.R.E. Initiative

"Carefully and Appropriately Redirected Encounter"

A Value-Added Service from a
Well-Integrated Hospitalist Program

- Rationale for and description of the "CARE" process
- Case Example
- Challenges and Pitfalls
- Data/Outcomes

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Value Proposition

Hospitalists are **perfectly positioned** to serve as an **additional layer of screening** prior to a patient being hospitalized. In the right circumstances, they can help redirect the patient to an appropriate level of care.

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The Challenge

- **ER physicians tend to be risk averse**
  - For an ER doctor, “Erring on the side of caution” = Admission
- **As we know, hospitals are not safe places to be:**
  - Nosocomial infections
  - Medication errors/Adverse reactions
  - Procedural complications
- **In addition:**
  - Hospital beds and resources are limited
  - Payors are becoming increasingly concerned with the appropriateness of admissions
  - We know that some patients who don’t meet medical criteria for observation/inpatient hospitalization are still admitted

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DEFINITION OF THE C.A.R.E. INTERVENTION

Definition:

- When a hospitalist redirects a patient, who would have been admitted by the ED, to a lower level of care
- The C.A.R.E. process ensures that patients meet criteria for (and require) inpatient/observation admissions to the acute care setting
- Avoids unnecessary/low-risk admissions

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Initial Engagement in the ED

1. The ER physician evaluates a patient and makes the decision to admit. Then the on-call hospitalist is paged.

2. The triage hospitalist comes to the ER and performs an independent clinical assessment.

3. The hospitalist determines that the patient may not require acute care hospitalization.

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Disposition Planning and Buy-in

4. The hospitalist engages a team-based case manager to arrange for appropriate outpatient follow-up appointments and testing.

5. The hospitalist discusses alternative disposition plans with the ER doctor in a collaborative manner to achieve buy-in. The PCP is also notified by the hospitalist.

6. The patient is discharged from the ED.

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No Slipping Through the Cracks!

8. The case manager provides a follow-up phone call to the patient within 48 hours to ensure clinical stability, review appointment details, etc.

9. Outcomes are tracked, data is collected, and results are analyzed.

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Case Example

- ER calls the hospitalist about an 87-year-old female with history of DVT and remote history of paroxysmal atrial fibrillation and mild dementia who was brought to the emergency department after falling out of bed.
- There was no evidence of syncope, fracture, arrhythmia, infection, etc.
- The patient has less mobility and is unable to be taken care of at home.
- ER requests that the patient get admitted for further care.

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Case Continued

- The patient was seen and assessed by the hospitalist in a timely manner.
- The patient did not meet admission criteria as long as placement could be arranged.
- The case manager was called and found a skilled nursing facility.
- Placement was discussed with the patient, daughter, and the ER physician. All were in agreement to transfer the patient to the facility.

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Case Continued

“In the emergency department, the above tests were done. The patient feels fine. The daughter states, however, that she really is unable to care for her. She says she cannot leave her alone and really she needs her to go to a nursing facility... I spoke with ISP, Dr. Kim came down and saw the patient. He had his case manager see the patient and the patient's daughter as well. They were able to arrange for them to get to a skilled nursing facility today. The patient and the patient's daughter are comfortable with that as is Dr. Kim, and thus the patient is going to a skilled nursing facility today.”

Dictated by Dr. Lawrence Friedman (CSMC ER physician)

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Most Common C.A.R.E. Presentations

Chief Complaint/Diagnosis	Percentage
Chest Pain	24%
Abdominal Pain	12%
Cough/SOB/Asthma	10%
VTE/Phlebitis	8.5%
Syncope/Weakness	7.0%
Headache/Migraine	5.5%
Nausea/Vomiting/Diarrhea	5.5%
Fever	2.5%
Back Pain	2.0%
Dysuria/Hematuria/UTI	1.5%

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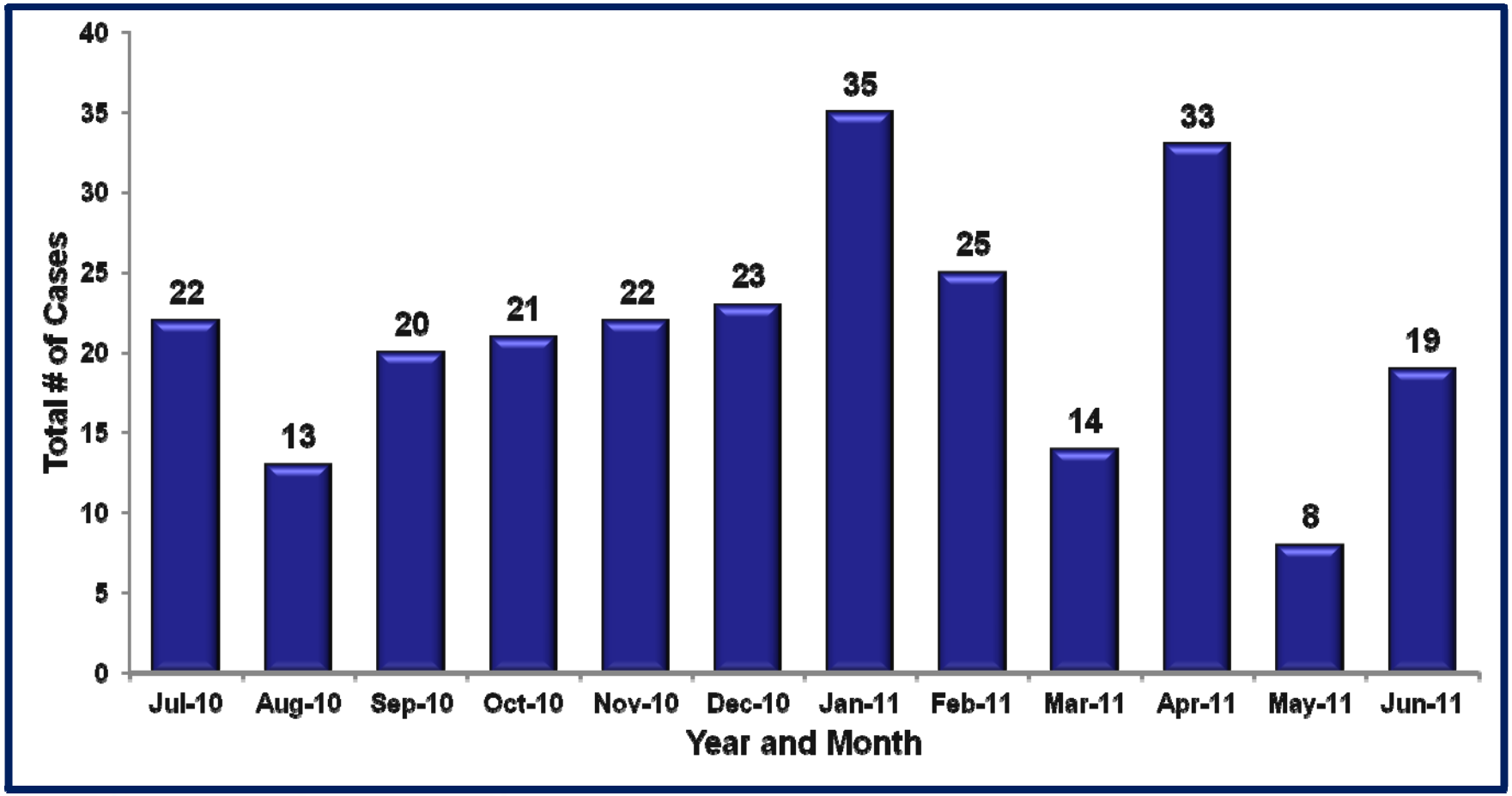
VOLUME OF C.A.R.E. INTERVENTIONS—FY11



255 Cases total

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What happened to these patients?

7 day revisits:

- ER visit only: 7 (2.7%)
- Admissions: 0

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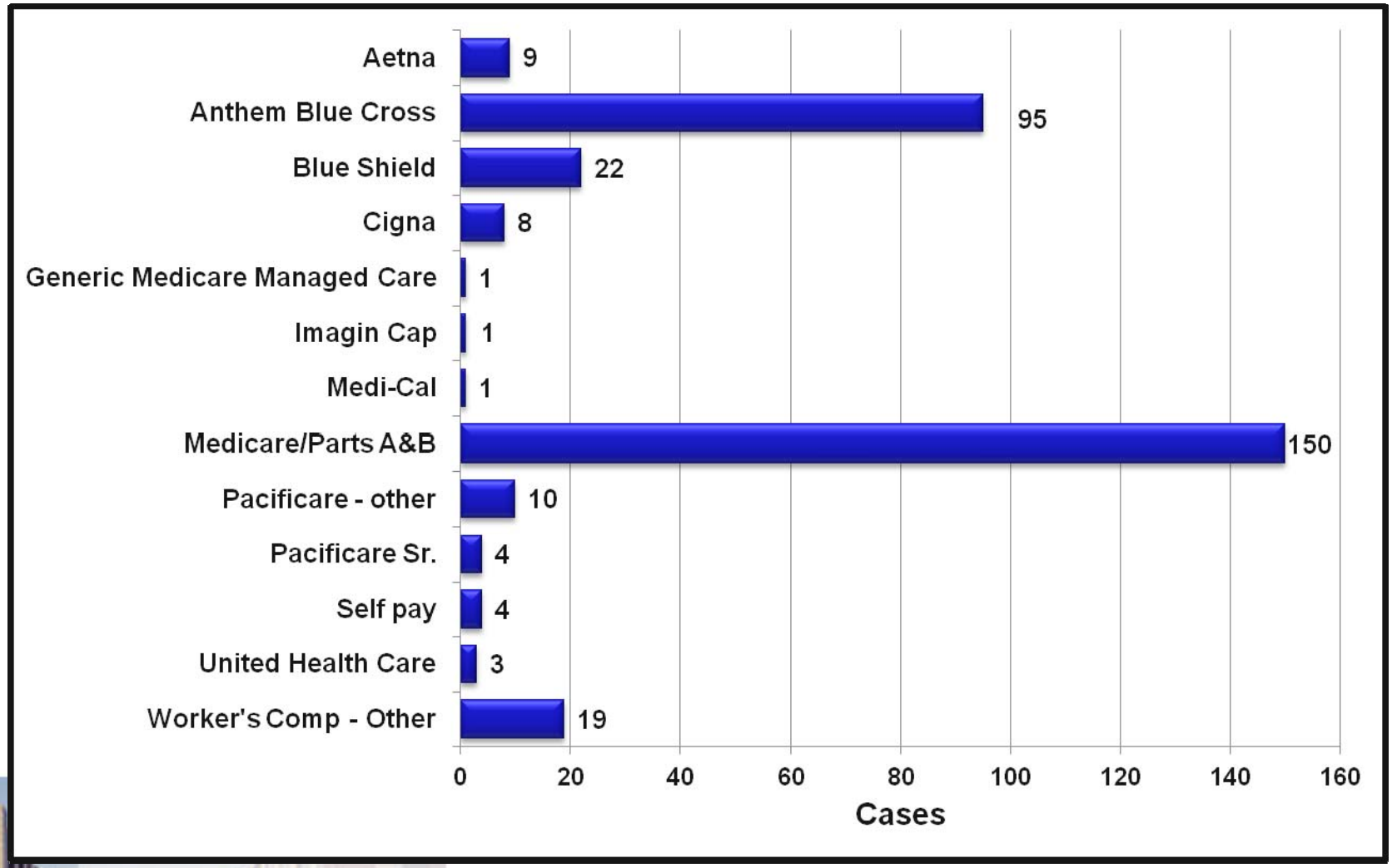
Our C.A.R.E. Initiative is Payor Neutral



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Challenges and Pitfalls

- A successful C.A.R.E. program requires confident and responsible decision-making by hospitalists.
- Hospitalists' workload/schedule must allow for 24/7 triaging capabilities in order to assess patients in the ER.
- Potential conflicts/disagreements over patient stability and disposition can compromise working relationships between hospitalists and ER physicians.
- Under-funded patients tend to have poor follow-up, making C.A.R.E. follow-ups more challenging.

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Challenges and Pitfalls Continued

- Hospitalist programs should not be structured to allow hospitalists to financially benefit from C.A.R.E. interventions.
- Team-based case managers are essential in order to assist 24/7 with disposition planning and follow-up.
- Medicare requires an inpatient stay prior to transferring to a SNF.
- There is an increased risk of liability.

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Summary

- The C.A.R.E. process is *PAYOR NEUTRAL*
- Many patients express relief and appreciation that they don't need to be hospitalized
- Some patients returned, but NONE were admitted
- Collect and review the data
- A well-executed CARE program is yet another way to demonstrate the value of hospitalist programs to stakeholders

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Cedars-Sinai **Patient Centered ~~Medical~~ Neighborhood Home**

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ISP HOSPITALIST PROGRAM IS…

HOSPITAL BASED

PLUS

PART OF MEDICAL HOME CARE TEAM

VISITING AND MONITORING PATIENTS AT HOME

MANAGING CARE AT SNFs

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What are we trying to accomplish?

- Improve transitions of care through seamless handoffs
- Support patients to maintain best possible quality of life
- A model that is scalable for all Cedars-Sinai physicians and accountable care populations

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What are we trying to accomplish?

- Provide a consultative care service to the medical home care team for its most fragile patients, with the goals of:
  - Appropriate resource utilization
    - Reduce ER visits
    - Reduce readmission rates
    - Reduce ICU days
  - Improved patient and family satisfaction
  - Improve physician satisfaction

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LEARNING FROM ISP EXPERIENCE

CSMC calculated 30-day readmissions rates at local Skilled Nursing Facilities between Jun-Aug 2011.

Definition: Patient readmitted to any acute care hospital within 30 days of SNF Admission.

SNF	# discharges (Jun-Aug)	% Readmissions within 30 days
A	143	22%
B	246	19%
C	158	19%
D	207	23%
E	473	24%
F	148	27%
ISP NP	**189 (12 mo)**	**16%**

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On September 29, 2011, the SNF Team launched the Enhanced Care Program:
An intervention in which an ISP Nurse Practitioner
rounds on patients discharged to the Rehab Center E.

Target Population: CSMC Patients discharged to “E” between Sep 29 and Nov 9

Key Players: Supervising MD, Nurse Practitioner, “E” Administrator, Social Workers

Goal: To prevent re-hospitalization during the 30 days following hospital discharge.

Communication & Coordination
Seamless information flow between patient, family, LCSW, NP, PMD, & Supervising MD

In-Hospital Introduction by Nurse Practitioner	Day after Discharge SNF assessment by Nurse Practitioner	Weekly & PRN Visits SNF visits by Nurse Practitioner	Addressing Issues If clinical issues arise, “E” contacts NP to address issues.
• **Primary MD agrees to enroll patient into Enhanced Care Program** • **NP introduces herself to patient, family at bedside before hospital discharge**	• **NP assess patient in SNF within 24 hours of discharge.**	• **NP contacts PMD & Supervising MD for any issues she identifies.** • **NP writes orders, under the supervision of Supervising MD.** • **NP communicates with physicians to provide pertinent updates**	

The Nurse Practitioner works Mon-Fri 8:00am – 5:00pm. During nights and weekends, the PMD is the point of contact for all issues.

Next Steps

- Cedars-Sinai Medical Group: Patient Centered Medical Home
  - SNF coverage
  - Home visits
  - Post-discharge medication reconciliation
  - Biometric monitoring
  - Outpatient palliative care

- Other CSMCF affiliated groups
  - Case management
    - Pre-admission, Inpatient, Ambulatory, Social Work
  - Inpatient hospitalists
  - SNF and Home Visits

- Medical staff at-large
  - SNF test of change

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