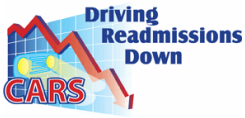

Partnering with Skilled Nursing Facilities & Home Health Agencies to Prevent Hospital Readmissions

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Turning on the High Beams

October 10, 2013

Cedars-Sinai Health System

Largest private, not-for-profit medical center in the Western United States, with 923 beds

- 10,000 employees
- 2,000 physicians on its medical staff
- Consistently named one of America's Best Hospitals by *U.S. News & World Report,* with 12 specialties nationally ranked in 2012
- Cedars-Sinai Medical Group repeatedly ranked one of California's top performing physician organizations for highest overall quality by the Integrated Healthcare Association

Los Angeles market for SNFs & Home Health Agencies

There are over 60 independently owned Skilled Nursing Facilities & over 65 Home Health Agencies that operate within Cedars-Sinai's Primary Service Area.

The Problem

The Cedars-Sinai 30-day all-cause readmissions rate for SNF & Home Health patients was higher than the average for all UHC hospitals.

All-Cause 30-day readmission rate
July 2010 – June 2011

	Discharged to SNF	Home with Home Health
Cedars-Sinai	20.2%	18.3%
All UHC Hospitals (Average)	17.8%	17.1%

Project Charge

Focus	SNF Patients and Home Health Patients
Metric	30-day all-cause readmissions to CSMC
Target	50% reduction

Objectives

- Explain the methodology utilized by a nurse practitioner to partner with private physicians to reduce readmissions for patients discharged to local skilled nursing facilities.
- Discuss the challenges for implementing a nurse practitioner-driven program across various facilities.
- Describe how rigorous home health services can prevent readmissions for patients discharged home.

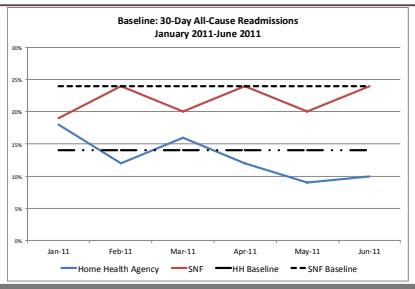
Our Results

By engaging in robust performance improvement, Cedars-Sinai Health System identified interventions that reduced 30-day readmissions for SNF & Home Health patients by more than 50%.

	Discharged to SNF	Home with Home Health
Baseline 30-day readmission rate	**25%**	**14%**
Pilot Period 30-day readmission rate	**11%**	**7%**

Understanding our Baseline

Six months of facility/agency specific data was analyzed to capture a baseline readmissions rate.



Root Causes for SNF Readmissions

A chart review of 150 SNF patients revealed recurring factors that likely contributed to preventable readmission within 30 days.

- Infrequent visits by a physician or advanced practice nurse
- Patient not seen by physician within first week of discharge
- SNF nursing staff unable to communicate with physician when needed
- Patient/Family not communicating Red Flags to SNF staff
- Lack of clinical oversight on weekends
- Medication Management/Reconciliation between hospital and SNF
- Patients at end of life without an Advance Directive/POLST completed

SNF Intervention: Enhanced Care Program

Pilot 1: October/November 2011

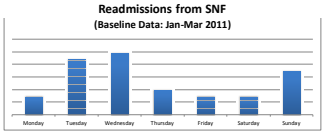
Pilot 2: January/February 2012

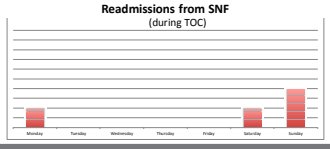
A Nurse Practitioner followed 115 CSMC patients in the SNF.

- They saw the patient in the hospital
- They saw the patient in the SNF 24 hours after discharge
- They saw the patient 1-2 times per week in the SNF
- When they saw something, they said something…
  (to the patient's MD, the SNF staff & to the family)

Cycle I: October/November 2011

The first pilot demonstrated a 60% reduction in 30-day readmissions.
During these two months, readmissions occurred mostly on weekends,
when Nurse Practitioners were not working.





Cycle II: January/February 2012

The second pilot, in which NP coverage was extended to include weekends,
yielded a 50% reduction in 30-day readmissions.
During this iteration, the NPs prevented 13 likely readmissions.

13 Potential readmissions averted by Nurse Practitioner

- Duplicate Medication Administration averted (Warfarin)
- Patient's family's concerns alleviated (2 different patients)
- Patient's medication concerns addressed
- Weekend contact with MD with lab results & Rx dosage issues
- Patient code status changed to DNR/DNI, patient expired in SNF
- POLST form completed in SNF- patient expired in SNF

Results

This intervention, tested twice, has demonstrated a statistically significant reduction in 30-day all-cause readmissions.

	n	30-day All-Cause Readmission Rate
Baseline Data: (Jan- Mar 2011)	150	25%
Test of Change I (Oct-Nov 2011)	48	10%
Test of Change II (Jan-Feb 2012)	67	12%

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Cedars-Sinai Enhanced Care Program

Target Population: CSMC Patients discharged to a SNF

Key Players: CSMC Social Workers, Attending MD at SNF, Nurse Practitioner, ECP Medical Director, ECP Coordinator, SNF Administrator

Goal: To prevent re-hospitalization during the 30 days following hospital discharge and to improve transitions of patient care between CSMC and Skilled Nursing Facilities.

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

- **In-Hospital Notification by Social Worker**
- **In-Hospital** Introduction by Nurse Practitioner
- **In-Hospital** Pharmacy Review of Discharge Medication List
- **Day after Discharge** SNF assessment by Nurse Practitioner
- **Weekly & PRN Visits** SNF visits by Nurse Practitioner
- **Addressing Issues** If clinical issues arise, SNF contacts NP

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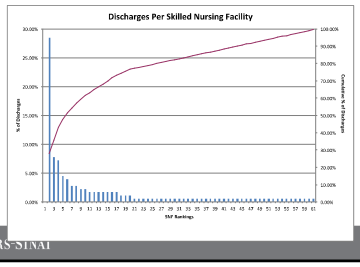
Spreading Intervention to other SNFs

In 2013, Cedars-Sinai spread this intervention to seven Skilled Nursing Facilities that see over 50% of SNF discharges.

# of SNFs	6	10	15	20	25	30	45
% Volume	52%	62%	70%	76%	80%	82%	90%



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Enhanced Care Program (ECP) Path

November 2012
- ECP launched to 3 SNFs

January 2013
- ECP expanded to 3 additional SNFs

April 2013
- ECP expanded to its 7th SNF

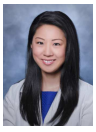
The team has expanded…

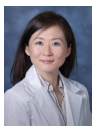
MSN, RN, ACNP-BC, NP

MSN, RN, ACNP-BC, NP

RN, MSN, AGPCNP-BC

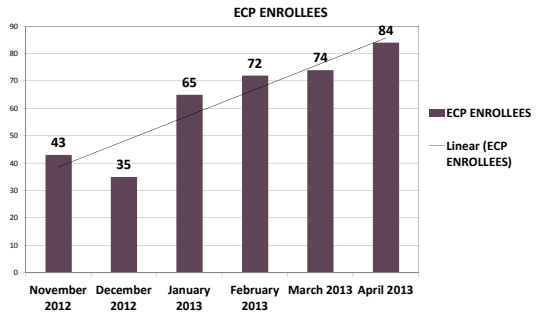
PGY-2 Pharmacy Administration Resident


MSN, RN, NP


MSN, RN, NP

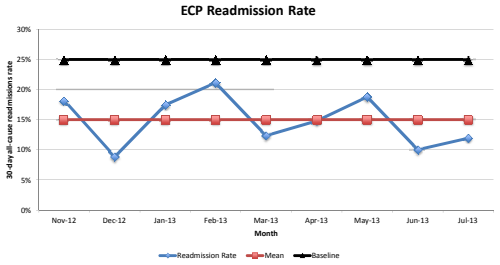
RN, Nurse Educator

ECP Enrollment, November 2012 to April 2013



ECP Readmission Trend

ECP has made a significant impact on 30-day all-cause readmissions reducing the rate from 25% at baseline (Jan-March 2011) to 15% from November 2012-July 2013.



Root Causes for Home Health Readmissions

A chart review of 45 Home Health patients revealed recurring factors that likely contributed to preventable readmission within 30 days.

- Patients & families often turn away Home Health agencies after hospital discharge
- Inconsistency in frequency of home visits post-discharge
- 45% of readmissions occurred on a Saturday or Sunday
- Patient/Family not communicating Red Flags to Home Health agency
- Medication Management/Reconciliation
- Physicians not responsive when Home Health Agencies have questions/concerns

Cycle I: Enhanced Home Health

WHO	All CSMC Discharges to a high volume Home Health agency
WHAT	In-hospital visit by nurse + 6 touch-points after discharge • Home visit within 48 hours of discharge • Friday "Tuck-in" Phone call • Weekend Visits • Medication Reconciliation • 24-hour call number staffed by a nurse
WHEN	November 1 – 30, 2011
WHY	To determine if more rigorous home health services can prevent readmissions. (Baseline = 19% readmit rate)

Enhanced Home Health

Only 6.8% of the 59 TOC patients were readmitted within 30 days of discharge.
This rate is less than 50% of the baseline rate observed during FY 2011.

Patient Population	Time Frame	% Readmitted (All-Cause)
CSMC discharges home with Home Health **(any agency)**	Jul 2010 -Jun 2011	19%
CSMC discharges home with **TOC Home Health Agency***	Jul 2010 -Jun 2011	14%
Test of Change (n=59 patients)	November 2011	**6.8%**

* The agency selected for the Test of Change had the highest proportion of Home Health referrals from Cedars-Sinai Medical Center .

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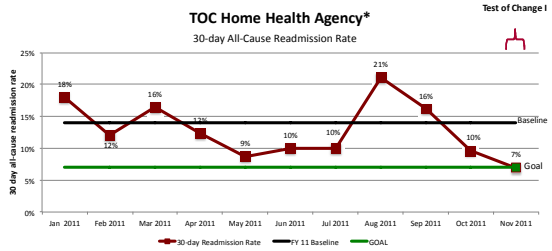
Trends: 30-day Readmissions

The 30-day readmission rate during the TOC (6.8%) was 50% less than the FY 2011 baseline rate (14%).



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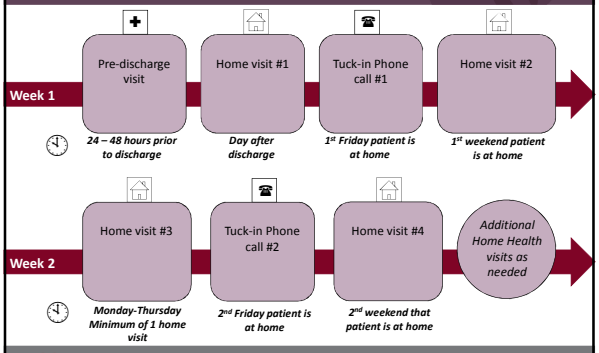
Enhanced Home Health Protocol

A minimum of 7 touch points to occur within the first two weeks of discharge



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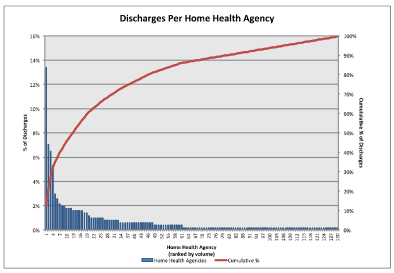
Spreading Intervention to other Home Health Agencies

Cedars-Sinai spread this intervention to three additional high-volume Home Health Agencies to determine if it would be successful when spread.



Enhanced Home Health Pilot

Four high volume Home Health agencies tested the 'Enhanced Home Health' bundle during a 6-week period in February & March 2012.
A total of 396 patients were enrolled.

Home Health Agency	BASELINE % 30-day Readmissions Feb 2011- Jan 2012	TEST OF CHANGE % 30-day Readmissions Feb 15-Mar 31 2012	# enrolled in TOC Feb 15-Mar 31 2012
Accredited	12.7%	10.3%	121
Universal	12.1%	7.8%	103
Paradise	14.7%	11.8%	110
Epic	17.3%	6.4%	62

35% Reduction

Conclusions

- Readmissions can be prevented when hospitals take the lead to collaborate with partner agencies in the community.
- Intervening during the 14 days following hospital discharge is crucial for preventing avoidable readmissions.
- Clinical resources in the community (SNF, Home Health) need to be bolstered on weekends.
- Involvement & leadership from Primary MD are key in executing improvements related to readmissions.

Questions