Bringing the Focus to Complex Care

Highlighting: South County Health
Hospital Care Transitions Initiative

February 9, 2023

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CENTERS FOR MEDICARE & MEDICAID SERVICES
iQUALITY IMPROVEMENT & INNOVATION GROUP

Please chat in…

- Who is on the webinar with us today,
- What organization you are with,
- Where are you located, and
- Your role within your organization?

Introducing Speakers

Ansje Gershkoff, BSN, MBA, CMC, CDOE,
DVDOE Director, South County Home Health

Nina M Laing, RN BSN CCM-Manager of Case Management Department, South County Health

SOUTH COUNTY HEALTH

PEPERFORMANCE & STRATEGY MANAGEMENT
RFOPERFORMANCE & STRATEGY MANAGEMENT
RMANCE & STRATEGY MANAGEMENT

South County Hospital, Wakefield RI

Hospital Care Transition Initiative

SOUTH COUNTY HEALTH

2022 Strategic Plan Readmission Reduction Initiative

Ansje Gershkoff RN, MBA,CMC
Nina Laing RN, BSN,CCM

Key Initiative Planning Matrix

Key Initiative

Achieve & Maintain Service Band of Excellence

Key Initiative measure of success:

Stabilize readmission rate at 10.5%

Dedicated Core Team:

Dr. Kornas, Elaine Desmarais, Nina Laing, Lynne Driscoll, Claudia Chighine, Brooke LaVallie

Key Initiative Planning Matrix

Strategies Implemented Successfully:

- ✓2021: Readmission Taskforce Team created to include: Dr. Kornas, Quality, Pharmacy, Case Mgmt., CHT, Respiratory, SCHH, Care Manager PCPs, Cardiology, Pharmacy (Now Dietary)

- ✓2021: Review past 3 years of discharges to identify factors correlating with readmissions

- ✓2021: Daily report auto generated on patients with LACE score >10 for case management follow up.

  - LACE is an acronym for LOS, Acuity of the admission, Co-morbidities, ED (was the pt was in the ED in the past 6 months).

  - LACE scores range from 1-20 and predict how likely the patient is to be readmitted within 30 days of discharge. A score of 10 or above indicates a high risk of readmission.

Key Initiative Planning Matrix

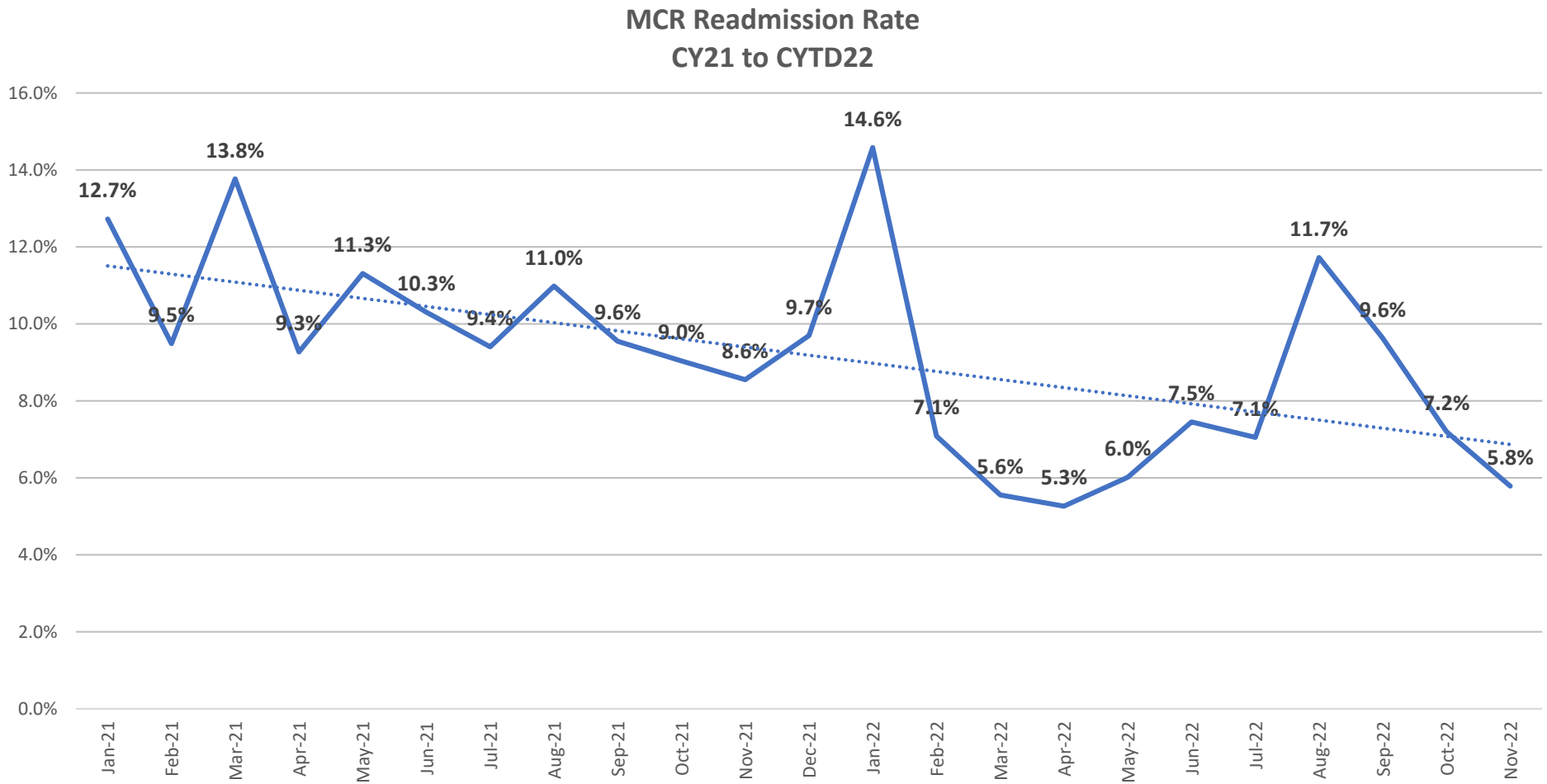
Strategies Implemented Successfully (con't):

- ✓ Palliative care referral added to order sets
- ✓ Standardize care – update 4 order sets
- ✓ Community Health Referral in placed based on criteria before discharge or during home health intake as well as RIPIN referral and SCHH
- ✓ Daily tracking of readmission
- ✓ Awareness; discuss readmission at Leadership Safety Huddle

Strategy/Projects with performance gaps:

- ➢ Follow up phone calls at 48 hours and 7 days. Pharmacy (& soon to be dietary)
- ➢ Follow up appointments with Cardiology/PCPs before discharge

Readmission Tracking



Pharmacy

Pharmacy Calls: Four Services Provided

Adverse drug events are the most common post-discharge complication

No focused medication review as part of the discharge process

1. Discharge med review and discrepancy/clinical problem resolution

2. One-on-one patient and caregiver medication education
   a) Discussion of patient concerns
   b) Overview of reason for each medication
   c) Common side effects and how to alleviate them

3. Updated discharge medication list with pharmacist notes

4. 72-hour follow-up call to address any patient concerns

- Strong literature evidence that pharmacist-led discharge TOC programs reduce readmissions and improve patient experience
- Best-practice recommendation by several national organizations
- Favorable financial program profile, despite conservative impact projection; significant financial upside
- Pilot program demonstrated immediate results in overall readmissions, patient experience scores, and medication errors avoided

Rhode Island Parent Information Network (RIPIN)

RIPIN

About

- Non-profit organization in Warwick, RI
- Peer to peer model of support
- Lived experience
- CHW embedded in hospital setting
- Consults received by Case Management

  2 year anniversary March 1st!
- 406 Referrals since the start
- Assisted with Medicaid, LTSS, SNAP

Key Initiative Planning Matrix

Key Initiative

Achieve & Maintain Service Band of Excellence

Key Initiative measure of success:

Stabilize readmission rate at 10.5% ***ACHIEVED*** ✓

Dedicated Core Team:

Dr. Kornas, Elaine Desmarais, Nina Laing, Lynne Driscoll, Claudia Chighine, Brooke LaVallie

Home Health Resources
To Prevent Rehospitalization
South County Home Health

Readmissions

SHP **Rehospitalization**

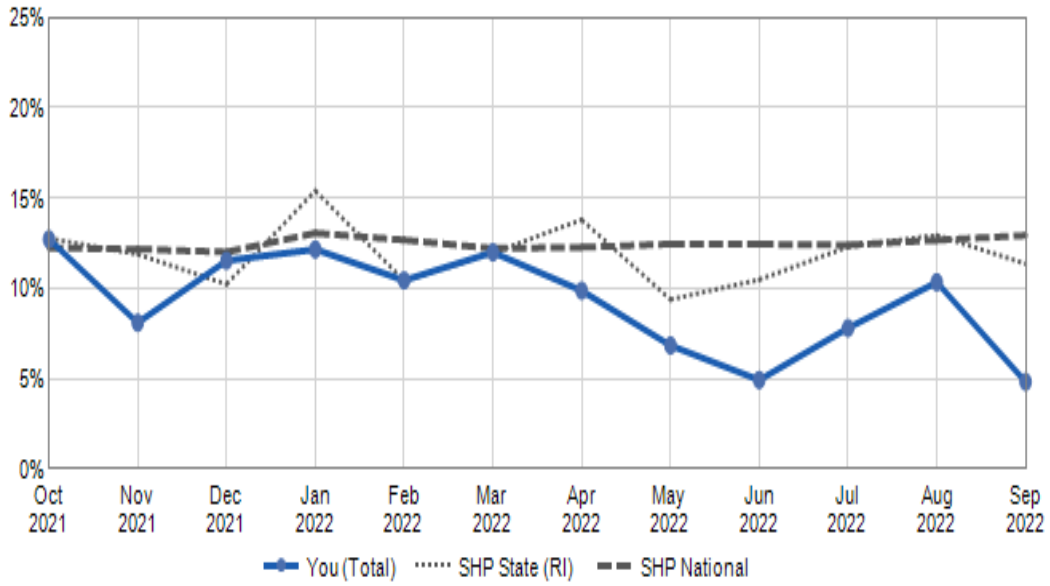
VNS Home Health Services

10/01/2021 - 09/30/2022

Report Date: 11/21/2022

Rehospitalizations within 30 Days

		You	SHP State (RI)	SHP National	Your % Rank
Within 30 Days of SOC (Hospital DC in the five days prior to M0030)	Count:	78	11.88%	12.46%	74%
	Cases:	842			
		9.26%			

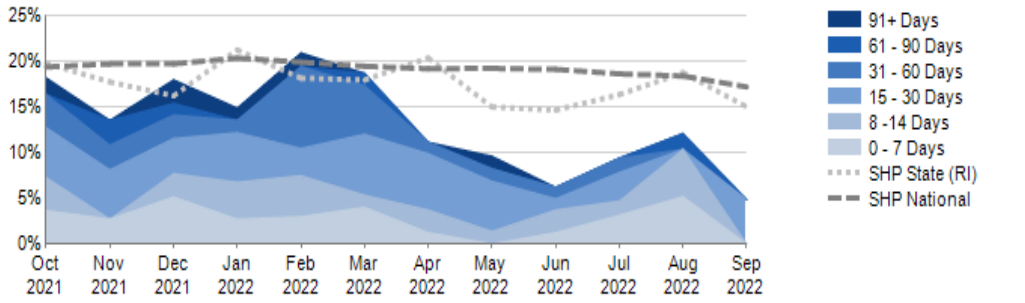


All Rehospitalizations as a % of Admits from Hospital - Rollup Totals (10/1/2021 - 9/30/2022)

	0 - 7 Days		0 - 14 Days		0 - 30 Days		0 - 60 Days		0 - 90 Days		All Days	
	#	%	#	%	#	%	#	%	#	%	#	%
You	22	2.6%	42	5.0%	78	9.3%	99	11.8%	104	12.4%	110	13.1%
Your % Rank		54.8%		70.4%		74.5%		80.7%		82.0%		82.8%
SHP State (RI)		3.3%		6.3%		11.9%		15.7%		16.6%		17.5%
SHP National		3.2%		6.9%		12.5%		16.7%		17.9%		19.2%

All Rehospitalizations as a % of Admits from Hospital (12 Months)

Within	Oct 2021	Nov 2021	Dec 2021	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Total	SHP State (RI)	SHP National
0 - 7 Days	3.6%	2.7%	5.1%	2.7%	3.0%	4.0%	1.2%	0.0%	1.2%	3.1%	5.2%	0.0%	2.6%	3.3%	3.2%
8 - 14 Days	3.6%	0.0%	2.6%	4.1%	4.5%	1.3%	2.5%	1.4%	2.5%	1.6%	5.2%	0.0%	2.4%	3.0%	3.7%
15 - 30 Days	5.5%	5.4%	3.8%	5.4%	3.0%	6.7%	6.2%	5.5%	1.2%	3.1%	0.0%	4.8%	4.3%	5.6%	5.5%
31 - 60 Days	3.6%	2.7%	2.6%	1.4%	9.0%	5.3%	1.2%	1.4%	1.2%	1.6%	0.0%	0.0%	2.5%	3.8%	4.3%
61 - 90 Days	0.0%	2.7%	1.3%	0.0%	0.0%	1.3%	0.0%	0.0%	0.0%	0.0%	1.7%	0.0%	0.6%	0.9%	1.2%
91+ Days	1.8%	0.0%	2.6%	1.4%	1.5%	0.0%	0.0%	1.4%	0.0%	0.0%	0.0%	0.0%	0.7%	0.9%	1.3%
All	**18.2%**	**13.5%**	**17.9%**	**14.9%**	**20.9%**	**18.7%**	**11.1%**	**9.6%**	**6.2%**	**9.4%**	**12.1%**	**4.8%**	**13.1%**	**17.5%**	**19.2%**



South County Home Health Data

All Rehospitalizations as a % of Admits from Hospital - Rollup Totals (1/1/2022 - 1/31/2023)

	0 - 7 Days		0 - 14 Days		0 - 30 Days		0 - 60 Days		0 - 90 Days		All Days	
	#	%	#	%	#	%	#	%	#	%	#	%
You	16	1.8%	35	4.0%	70	8.1%	89	10.3%	91	10.5%	97	11.2%
Your % Rank		69.1%		78.6%		79.8%		83.4%		85.2%		85.3%
SHP State (RI)		3.4%		6.6%		11.5%		15.2%		15.8%		16.6%
SHP National		3.2%		6.9%		12.1%		15.9%		16.9%		18.0%

Impact SCHH Planning Ahead VBP

60 Day Hospitalizations 35%

Community Provider Alignment

COPD CHF Diabetes Program

Pharmacy Program

Community Health Workers

HHVBP Proposed Quality Measures

OASIS	35.00%	
Self-care		
grooming (M1800)		
upper body dressing (M1810)		
lower body dressing (M1820)		
bathing (M1830)		
toileting (M1845)		
eating (M1870)		8.75%
Mobility		
toilet transferring (M1840)		
bed transferring (M1850)		
ambulation (M1860)		8.75%
Oral Medications		5.83%
Dyspnea		5.83%
Discharged to Community		5.83%
Claims Data	35.00%	
60-day Hospitalizations		26.25%
ED Use without Hospitalization		8.75%
HHCAHPS	30.00%	
Professional Care		6.00%
Communication		6.00%
Team Discussion – Specific Care Issues		6.00%
Overall Agency Rating 9, 10		6.00%
Willingness to Recommend %		6.00%
	100.00%	

Community Health Team

Community Health Grant

- Exciting news we now have CHW workers as part of our HH team
- This includes ability to outreach to our population w social determinants of health
- Will work with clinical team, social workers, chronic condition health coaching- Integration into IDT meetings on mutual patients
- Streamlined referrals
- BH referral
- Reduction in hospital readmissions from increased resources

Why Add Community Health Workers?

- 3-year grant funded through Rhode Island Department of Health (RIDOH)
- Home Health is leveraging Community Health Workers to work working directly with patients and families, as an extension of the HH team.
- BH Care Management resource through referral to LICSW for short term therapy in-home, community and office engagement.
- CHW work with patients to identify barriers to healthy living, provide linkages to community resources and develop plans to address long-term health needs.

Team Members of Community Health

Cathy Vars Wilkerson: Certified CHW, Home Health

Saul Richman: Certified CHW, Home Health

Nate Mazza: LCSW Behavioral Health Care Manager

Kylie Zoglio: BSW Certified CHW Lead/Supervisor

Liz Fortin: LICSW, Director Community Health

Pharmacy Pre-Pack Program

- Pharmacists Demetria Malone & Julia Manning
- Assists patients in **improvement of med management** at discharge are more independent this will improve **STAR rating**
- Target population patients with cognitive deficits
- Consultation via email for med pre packaging
- Medications separated by day of week and time of day that they need to be taken
- Increased compliance, medications consolidated

Example

Greenline Apothecary

245 Main Street
Wakefield, RI 02879

905 North Main Street
Providence, RI 02904

Walgreens

500 Broad Street
Providence, RI 02907

SimpleDose (CVS owned)

White Cross Pharmacy

1057 Mineral Spring Ave.
North Providence, RI 02904

McQuade's Pharmacy

106 Main Street
Westerly, RI 02891

10 Clara Drive
Mystic, CT 06355

Mgmt of Oral Meds
+
0.0-56.3
56.4-66.3
66.4-72.9
73.0-78.0
78.1-81.6
81.7-84.7
84.8-87.5
87.6-90.4
90.5-95.9
96.0-100.0

78.8
2.5

It Takes a Village !

Open Discussion

Upcoming Best Practice Learning Circles

Date	Time	Activity
02/16/2023	12-12:30pm	Medicaid Accelerated eXchange (MAX) Action Team- NYC Health & Hospital/ Queens Improving Care for High Utilizers and Sustaining Change
02/23/2023	12-12:30pm 12:30-1pm	SmartCare- Massachusetts Mobile Integrated Healthcare Wrap-up and Discussion