# FOURTH NATIONAL READMISSIONS SUMMIT

Washington, D.C.

SASH a caring partnership
SUPPORT AND SERVICES at HOME

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# Readmissions Can't be Fixed Within Hospital Walls or Doctor's Offices Alone

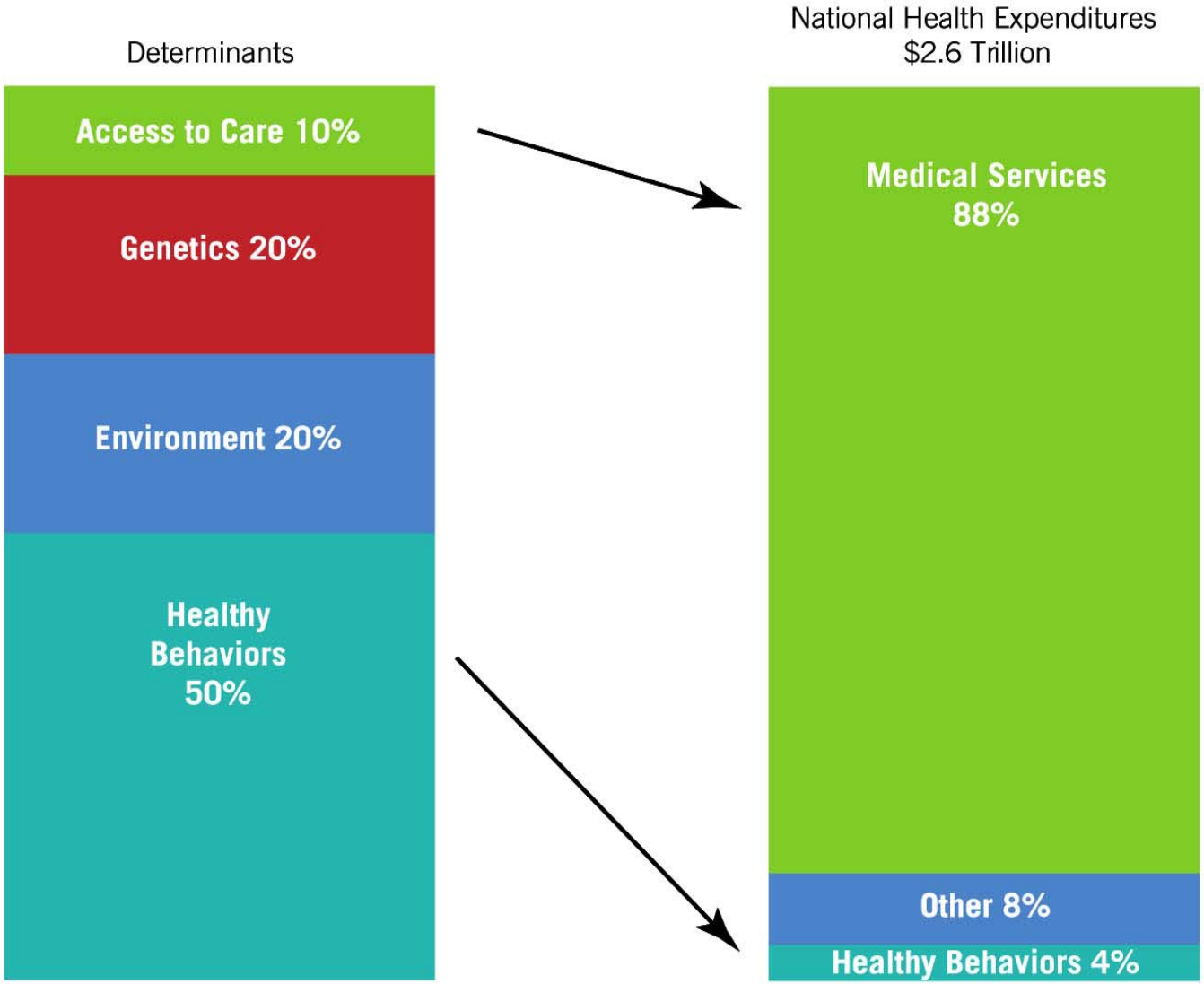
## Reasons for Readmissions:

- Poor transfer of info to patient and caregivers:
  - Nature of condition
  - Test results
- Confused about meds
- Lack of scheduling follow up visit or lack of transportation to visit
- Lack of knowledge by family

## Solutions to the Revolving Door:

- Improved nutrition
- Tobacco cessation
- Listen to patient/family support
- Information systems

# Spending Mismatch: Health Care and Other Key Determinants of Health




Source: NEHI. 2012.

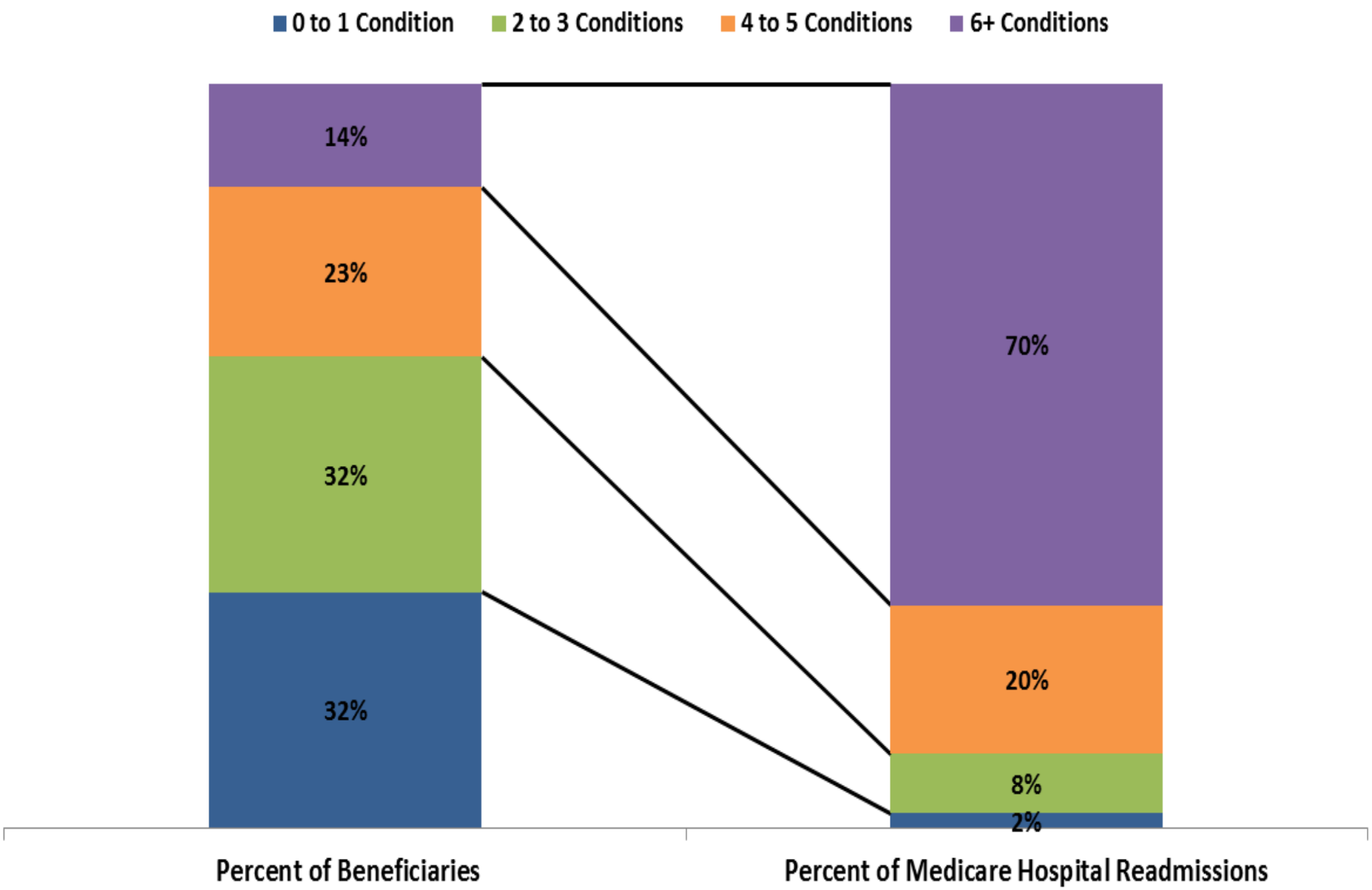
# Poverty and Age Increase Admissions and Readmissions

- Admissions in low income zip codes:
  - 4.6 times more HF
  - 5.8 times more COPD

  - Over 50% of patients with COPD and HF are readmitted within 12 months compared to 70% of geriatric patients

  - The largest volume of readmissions occurs among patients with chronic conditions

# Distribution of Medicare FFS Beneficiaries by Number of Chronic Conditions and Total Medicare Hospital Readmissions: 2010



# Confusion About Meds

- 72 % of elderly patients were taking incorrectly at least one med started in the inpatient setting
- 32% of meds were not being taken at all
- 49% of SASH pilot site participants failed cognitive screen

**The Solution:**

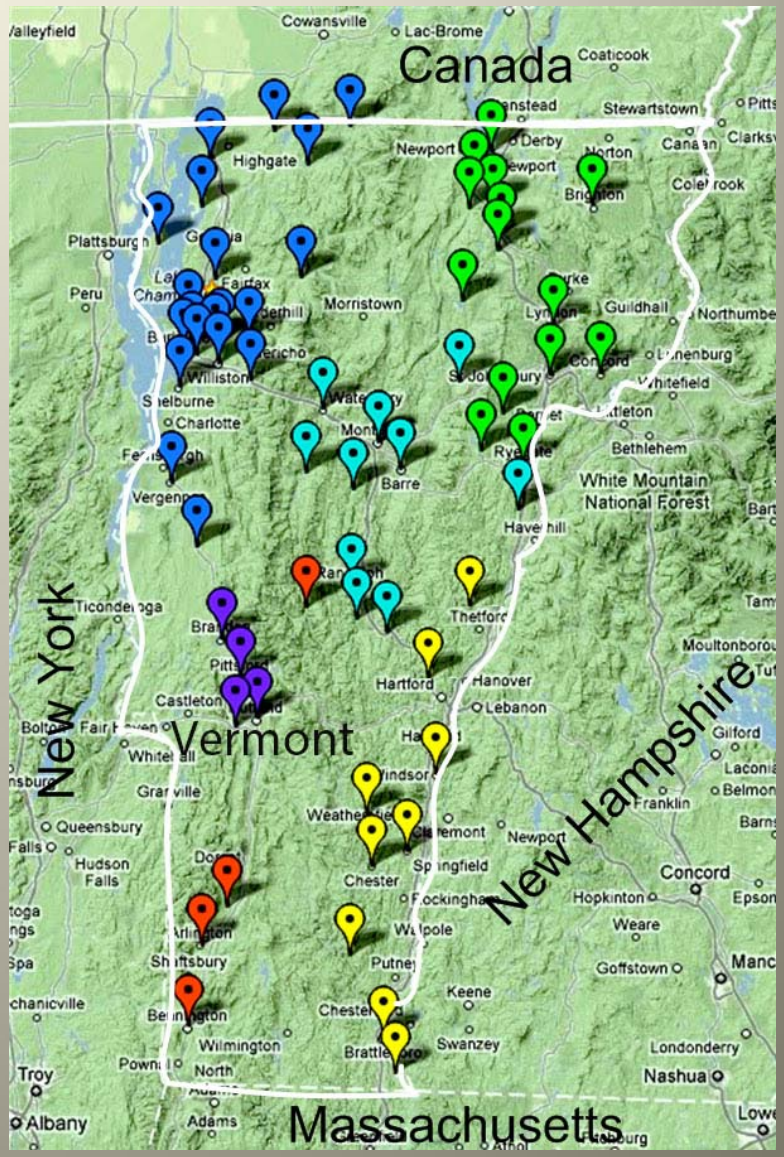
- Consistent presence
- Trusting relationship
- Knowledge of person

# SASH is a Home-Based System

It is effective because it provides care and services where participants are comfortable and spend their time.

# SASH: Targets Populations

- 93 SASH locations at subsidized housing statewide
- 1 in 3 Vermonters
  55+ in 2017
- Operating in all Health Service Areas



# Who SASH Serves

- 2,650 Participants
- 80% Medicare
- 20% Medicaid and Duals
- 82% Residents of Affordable Housing with average income of $11,000 - $17,000
- 18% live in a community setting
- 73%  65 +
- 27%  under 65

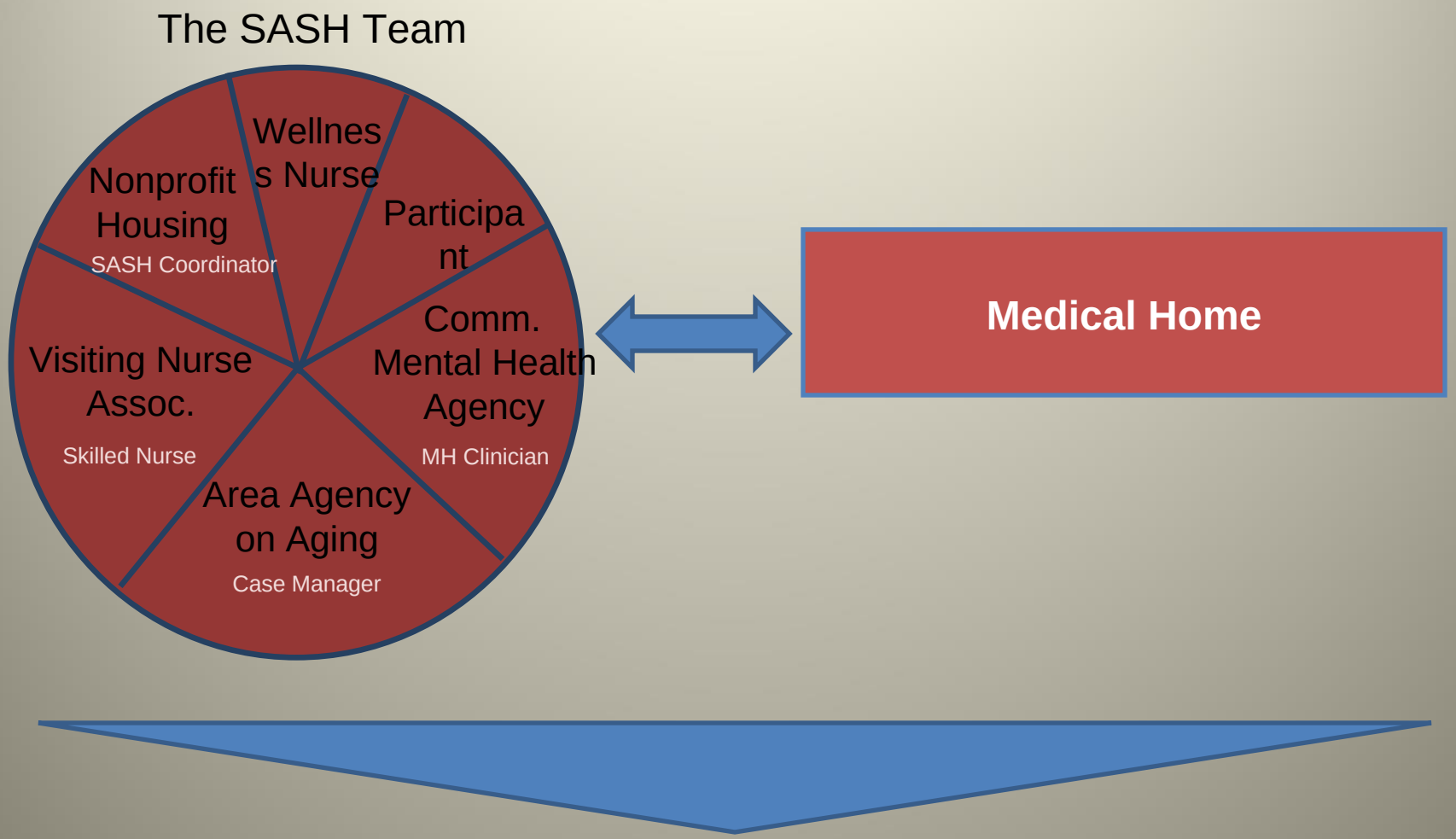
# Great Care Coordination Requires Great Information

- Collect data in the home
- Enter assessment data and progress notes directly into the state's Central Clinical Registry
- Update data on Healthy Living Plan progress
- Share individual data and aggregated population data with:
  - physicians
  - Blueprint Community Health Teams, and other vital team members

VERMONT Blueprint for Health

Smart choices. Powerful tools.

# SASH interprofessional team approach ensures Vermonters have access to needed services



# What are the Essential Elements?

- Person-centered
- SASH Staff
- Partnerships
- Information Sharing
- Prevention and Wellness through Healthy Living Planning
- Volunteers

# SASH Keeps “Katie” in the Driver’s Seat

# Prevention and Wellness

Tai Chi over Skype

Chair Yoga over Video Conferencing

# Potential SASH Assistance with ACO Outcomes Measures

| Metric Domain | Relevant Standard | SASH Assistance |
|---|---|---|
| Patient/caregiver experience | 1-7 Patient survey of providers | • SASH participants likely to have better view of providers since care is more closely coordinated through SASH team |
| Care coordination /patient safety | 8. Readmissions<br>9. COPD/Asthma readmissions<br>10. HF readmissions<br>12. Medication reconciliation<br>13. Screening for future fall risk | • SASH coordinators ensure ambulatory follow up and minimize readmissions<br>• Wellness Nurses document meds<br>• SASH participants agree to home visit and fall risk evaluation |
| Preventive Health | 14.- Influenza immunization<br>15. Pneumococcal vaccination<br>16. Body mass screening<br>17. Tobacco use screening<br>18. Depression screening<br>21. HBP screening and follow-up | • SASH facilitates easy access and high attendance for immunization clinics<br>• Screenings part of SASH protocol. Can expand to include PCP requests and recommendations<br>• Home based care more likely to result in follow-up |
| At-Risk Populations | 24. Diabetes blood pressure control<br>25. Diabetes tobacco control<br>28. HTN blood pressure control | • Screenings part of SASH protocol. Can expand to include PCP requests and recommendations<br>• Home based care more likely to result in follow-up |

# SASH Program is Delivering Results

- Heineberg Pilot results
  - 19% reduction in hospitalizations
  - No bounce backs from Nursing Homes
  - Reduced falls by 22%
  - Increased physical activity
  - Reduced nutritional risk

*Better health, better care & lower costs*

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SUPPORT AND SERVICES at HOME

*"Sometimes patients are sent home before they are ready."*

*…. or is it that the patient is ready and the home is not?*

# Reducing Readmissions Starts at Home

- Continuity of Care – no discharges
- High level of presence
- Person focused
- Strong communication and listening skills
- Public health focus
- Interprofessional team