

# A Little Love in Your Heart: Strategies for Reducing Heart Failure Readmissions

## Welcome!

- All lines are muted, so please ask your questions in Q&A
- For technical issues, chat to the 'Technical Support' Panelist
- Please actively participate in polling questions that will pop up on the lower righthand side of your screen

**We will get  
started shortly!**



**Quality Improvement  
Organizations**

Sharing Knowledge. Improving Health Care.  
CENTERS FOR MEDICARE & MEDICAID SERVICES



The Quality Improvement Services Group of  
ALLIANT HEALTH SOLUTIONS

# Ken Peach

EXECUTIVE DIRECTOR, HEALTH COUNCIL OF E. CENTRAL FLORIDA

Ken Peach directs the Health Council of East Central Florida serving metropolitan Orlando and the Space Coast.

Ken has managed or led hospitals, hospital associations, medical groups, and nursing homes. Additionally, he has owned commercial radio stations and a health insurance agency.

Ken holds degrees from Seton Hall University and the Florida Institute of Technology.

*Resources destroy creativity.*

**Contact:**

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# Objectives

- Learn Today:
  - Learn how partnering with multiple community agencies can reduce heart failure readmissions.
- Use Tomorrow:
  - Identify three tools to use to identify and minimize barriers discovered during home visits to reduce readmission risk.
  - Understand two approaches that resonate with patients and families as you partner to reduce readmission risk.

# Our Organization



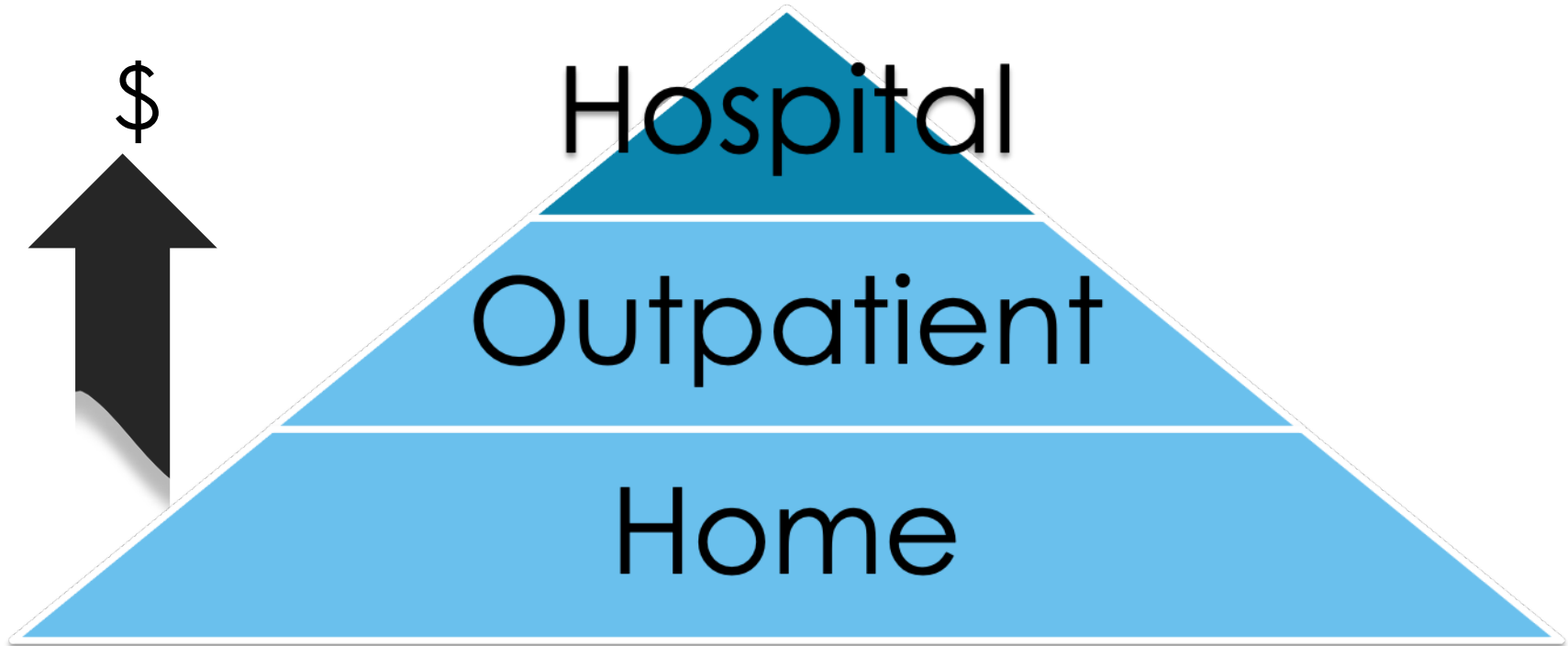
11 local health councils cover 67 Florida counties

- Health Council of East Central Florida serves metro Orlando
- 501(c)(3) organization
- Must seek new business opportunities

# Our Belief: Care Cost and Convenience...



## ...Will Move Care to the Home



# Health Council Research Revealed



Public safety paramedics doing home visits to keep patients from having to frequently call 9-1-1

# We Created a Different Care Model

- EMS Paramedic



- Care-A-Medix Paramedic





# Our Paramedics are Prepared

## Background

- Paramedic educator
- Hospital ER
- Minimum 3 years experience

## Qualification

- National certification
- Florida license
- In-services, training

## Requirements

- Level 2 background
- Medical liability policy

# Turning the Calendar Back to 2016

- Grant to Care-A-Medix funded a community paramedic and a vehicle for 3 years
- We needed a place to pilot our different care model



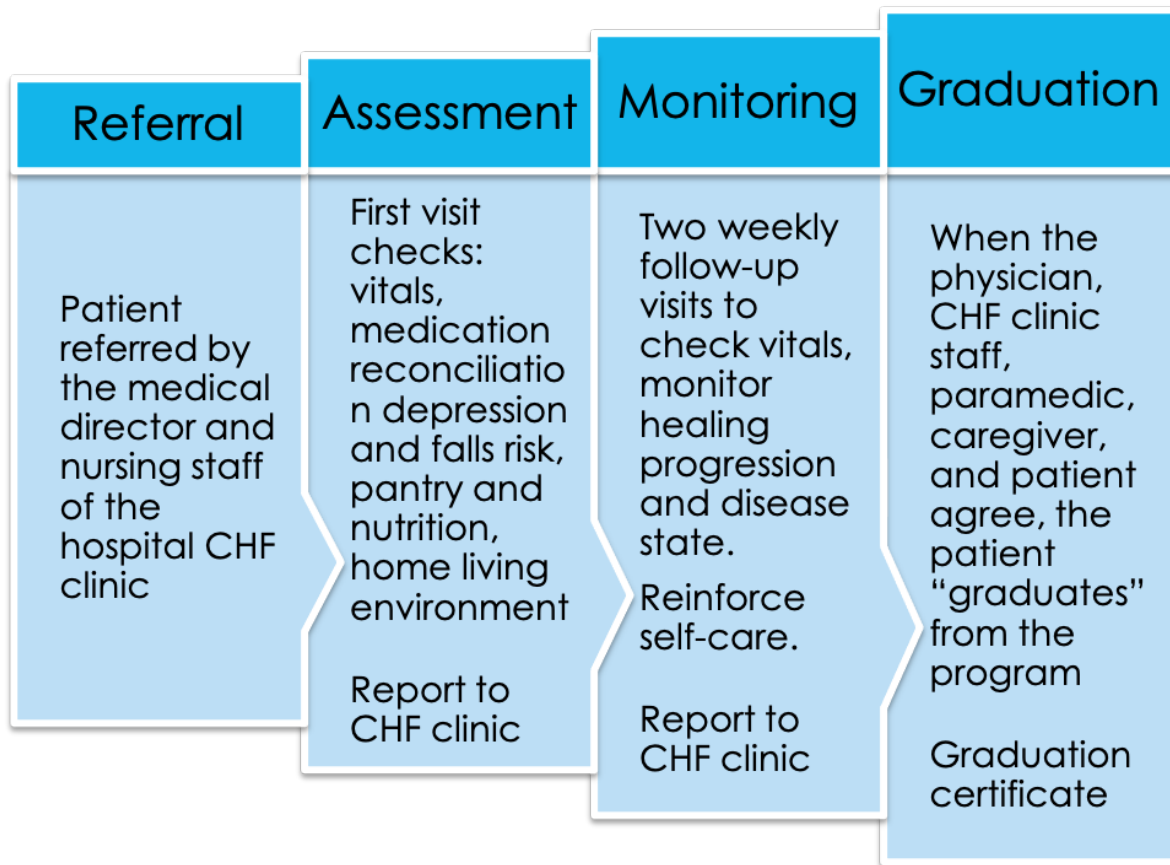
# We Found a Hospital Eager to Participate



“Readmissions for heart failure management continue to be above IBM Watson Top 100 Hospital Performers for the past 12 months.”

South Seminole Hospital, Longwood, FL

# Our Process Used Multiple Steps



# Criteria Determined Participants

3 or more  
readmissions  
within 12 months

Patient  
approval

Acceptance of  
1-2 weekly visits  
for 60 days

# First Year Assessment Brought New Funding

- 21 total program referrals
- 10 patients actively enrolled at any time
- 15 known avoided readmissions
- \$10,000 approximate cost of readmission
- \$150,000 cost avoidance
- 2020-2021
- \$20,000 funded by the hospital foundation

# We Used Tools to Identify Needs



PEAT to assess  
safe home  
living  
environment



PHQ-9  
depression  
assessment



Pantry  
inspection for  
enough of the  
right foods

# The Pilot Involved Multiple Partners

PRN

Meals on  
Wheels

Uber

Hospital  
REDs

HealthLink



# Patients Will Embrace Paramedic Care

- Rack referral cards
- Tiny steps to improvement
- “Taken away one more excuse”
- Engage caregiver



# We Designed Our Own EHR

The screenshot shows a web browser window with the following content:

- Browser Tabs:** "florida" "map" "image" - Bing in X, florida-road-map-1.gif (2140x20 X, Project - CP - Sample Care-A-Me X +
- Address Bar:** File | C:/Users/kpeac/Documents/Project%20-%20CP%20-%20Sample%20Care-A-Medix%20patient%20assess...
- Logo:** Health COUNCIL OF EAST CENTRAL FLORIDA (with a map of Florida)
- Section Header:** IN-HOME ASSESSMENT
- Program:** COMMUNITY PARAMEDIC PROGRAM
- Identification:** No. 00015, Current Date: 08/06/2020
- Section Header:** Patient Information
- Fields:**
  - Last Name: Test
  - PCP: Dr. Unknown
  - Enrollment Date: 08/06/2020
  - First Name: Patient
  - DOB: 01/01/1910
- Section Header:** Patient Summary
- Summary of Visit:**

This is a test patient. Pt was discharged from hospital 7/27/20.

During visit, pt vital signs assessed. Further assessment, Pt denies chest pain, S.O.B., and abd pain during visit. Pt does report to have dizziness during visit. Pt's O2 SATs are 97% during visit. Lung sounds are clear and equal, bilaterally. No edema present to lower extremities, bilaterally. Pt has been blood pressures and weights.
- Taskbar:** Windows Start button, search bar (Type here to search), taskbar icons (Edge, File Explorer, Mail, 38 notifications, L, P, W), system tray (100% battery, 9:09 AM 12/30/2020).

## We Offer Clinical Consults to CHF Patients



- Paramedics carry iPad Pro with HIPAA compliant telehealth
- Clinical consults with the paramedic at the home

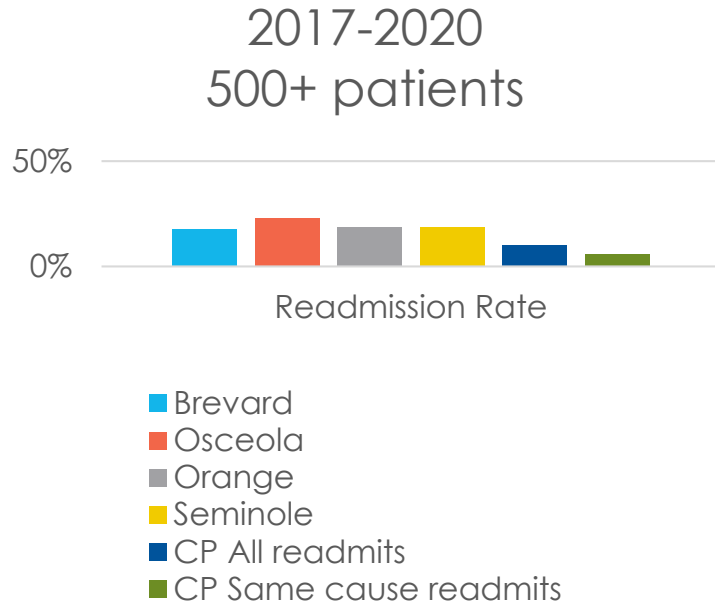
# Sure, We Encountered Barricades



- Physician understanding
- Referred patient rejection
- Patient confusion

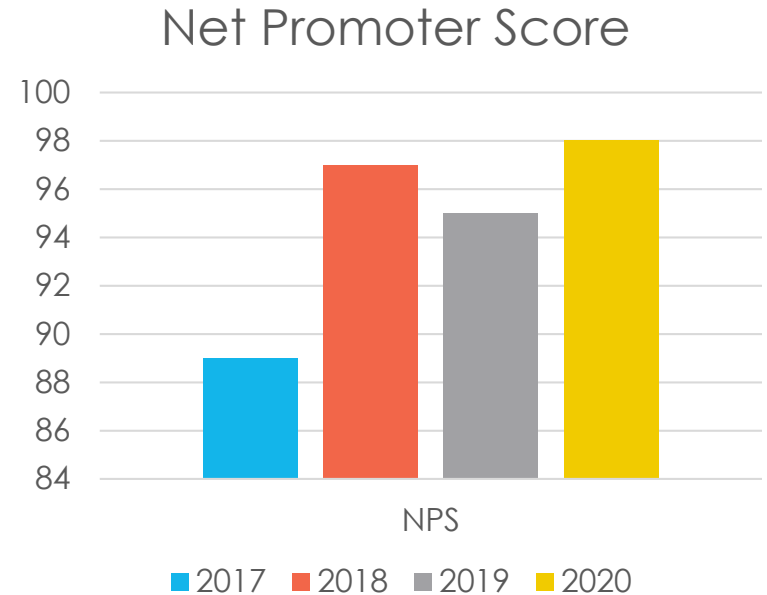
# Program Performance is Heartening

## Hospital Readmission Rates



Source: CMS FFS Medicare, Care-A-Medix

## Patient Satisfaction



Source: NPS at patient program graduation

# Where We Are Taking Our Program

- Growth since 2016
  - CHF care expanded to 4 additional Care-A-Medix clients
  - Programs now staffed by 6 paramedics
- Future
  - Subcontracting with medical offices to provide CPT reimbursed services for Medicare patients
  - Value-based contracts with ACOs, MA MSOs, self-insured employers

## Contact Information:

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# Objectives Check In!



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**Complete this sentence in Chat:** *I will...*





## Closing Survey

***Help Us Help You!***



- Please turn your attention to the poll that has popped up in your lower right-hand side of your screen
- Completion of this survey will help us steer our topics to better cater to your needs

# CMS 12<sup>th</sup> SOW

## Goals



### Behavioral Health Outcomes & Opioid Misuse

- ✓ Promote opioid best practices
- ✓ Decrease high dose opioid prescribing and opioid adverse events in all settings
- ✓ Increase access to behavioral health services



### Patient Safety

- ✓ Reduce risky medication combinations
- ✓ Reduce adverse drug events
- ✓ Reduce C. diff in all settings



### Chronic Disease Self-Management

- ✓ Increase performance on ABCS clinical quality measures (i.e., aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- ✓ Identify patients at high-risk for developing kidney disease & improve outcomes
- ✓ Identify patients at high risk for diabetes-related complications & improve outcomes



### Quality of Care Transitions

- ✓ Convene community coalitions
- ✓ Identify and promote optimal care for super utilizers
- ✓ Reduce community-based adverse drug events



### Nursing Home Quality

- ✓ Improve the mean total quality score
- ✓ Develop national baselines for healthcare related infections in nursing homes
- ✓ Reduce emergency department visits and readmissions of short stay residents

## Making Health Care Better *Together*



Georgia, Kentucky, North  
Carolina and Tennessee  
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# Program Directors

# Upcoming Events



## Learning and Action Webinars

Nursing Homes

Tuesdays, 2pm ET/1pm CT

Community Coalitions

Thursdays, 12:30 pm ET/11:30am CT

February 16<sup>th</sup>, 2021: Immunizations Fears,  
Myths & Truths

February 25<sup>th</sup>, 2021: Increasing Vaccine  
Acceptance Rates from a Community  
Perspective

March 16<sup>th</sup>, 2021: TBD

March 25<sup>th</sup>, 2021: Pain Management

## Shop Talk: NHSN and Data Reporting

Thursday, February 18<sup>th</sup>, 2021 2:00 pm

# Making Health Care Better Together

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