

## Operation Single Digits

Submitted by: Prospect Medical Holdings—Coordinated Regional Care (CRC), RI

Gold Winner

Innovation Challenge

### Overview

The team at [Prospect Medical Holdings – Coordinated Regional Care \(CRC\), RI](#) launched its Care@Home program in July 2020 to address social isolation, system access issues, and an above-average readmission rate for their Medicare population. The Care@Home program primarily focuses on delegated Medicare Advantage patients and traditional Medicare patients who would benefit from in-person home visits by a team of providers, nurses, and social workers. The goal: to prevent disease exacerbations, improve symptom management, and reduce unnecessary utilization—all while working closely with the patient's primary care providers.

Serving as an extension of the primary care physician in the home setting, the Care@Home team provides patients with 24/7 access to the team, including after-hours visits. Prior to patients having access to the program, emergency department (ED), hospital, and skilled nursing admissions were the only options for patients outside of normal business hours. The results have been striking. Care@Home program utilization metrics for 2022 showed a readmission rate of only 3%, along with a 63% reduction in inpatient admissions, 81% reduction in ED visits, 89% reduction in urgent care visits, and a 17% reduction in skilled nursing admissions.

### Impact

'Operation Single Digits' was born out of the need for Prospect Medical Holdings – Coordinated Regional Care (CRC), RI, to recognize an issue with their average readmission rate (15%), and to develop clinical programs tailored to their patients' acuity and needs. They use the slogan 'Operation Single Digits' daily, as it helps define their initiative, to bring their overall readmission rate down (below 10%)—regardless of payor and patient.

To do this, their first major initiative was to develop their provider-led in-home program, CAH. It would primarily serve as an extension of a primary care physician (PCP), treating/diagnosing in the home setting to avoid unnecessary ED/hospital admissions. From there, they implemented a remote patient monitoring program; a COPD disease management program with zero-cost medications; a preferred urgent care network to solve access issues; and an at-home physical therapy (PT) program to solve for a high rate of falls related to delayed therapy services for post-op surgical patients.

As for time, there never seems to be enough. Time is a hot commodity in the world full of providers practicing at the top of their license, all while balancing obligatory payor contractual commitments and COVID burnout.

That said, the CAH team provides an extended time commitment to patients by developing trusting relationships, as well as 100% follow-up and follow-through. They bring a sense of emotional cohesiveness to an otherwise “hurried” health care system, giving their patients the gift of time.

Developing a true understanding of their patients' disease burden while creating patient-centered goals of care allows their patients to achieve the highest level of self-actualization. This occurs while reducing social isolation, bringing a sense of purpose, happiness, and control over their lives. Their patient satisfaction yields a Net Promoter Score (NPS) of 90, much higher than the industry average, which is a success that they directly tie back to their staff. Everyone can develop and implement clinical programs, but hiring the right person is a true art that took several attempts to perfect. They are in the process of expanding their CAH program to include other payors, based upon payor request and interest in replicating similar outcomes with their payor populations.

## Outcomes

Care@Home presents excellent outcomes for 2022. In addition to their 90 NPS for patient experience, they measure utilization patterns for inpatient admits, ED visits, Urgent Care visits, Skilled Nursing Facility (SNF) admits, and length of stay. All measures for 2022 came in drastically below the benchmark goal, except for SNF LOS, which was right at goal.

CAH program utilization metrics for 2022 reflected the following results, compared to payor benchmark goals: Inpatient admits per thousand of 56 compared to the goal of 153 (a 63% reduction); ED visits per thousand of 57 compared to the goal of 295 (an 81% reduction); Urgent Care Visits per thousand of 16 compared to the goal of 141 (an 89% reduction); SNF admits per thousand of 29 compared to the goal of 35 (a 17% reduction); SNF length of stay of 14, which met the benchmark goal of 14 days. Along with these reductions in utilization, the CAH team achieved their goal of 'single digit' readmit rates for their MA patients enrolled in CAH, with a 3% readmission rate for calendar year (CY) 2022.

A more global comparison of CRC's Blue Cross Blue Shield of Rhode Island (BCBSRI) MA total patient population readmits for CY 2019 (n=271; 15.44% readmit rate) to CY 2022 (n=195; 11.81% readmit rate) yields a reduction of 6 readmissions per month, for an average savings of \$13,630 per patient. They used 2019 as the control year due to COVID variables in CY 2020/2021. These cost savings enable their CRC provider system to truly provide the right care at the right time to the right patient.

They developed their CAH program based on Dr. Bruce Leff's idea that "hospital level of care at home" significantly improves patient outcomes. Elderly patients recover quicker in their home setting while also reducing the risk of hospital-acquired infection and deconditioning that they so often see as a result of extended time lying in a hospital bed. While they do not provide hospital level of care, they do provide point-of-care testing and treatment for COPD, CHF, DM, cellulitis, and urinary tract infections—all considered minor exacerbations if they are treated timely and at home. All CAH provider treatments prevent ER, hospital, and/or SNF admissions. Better outcomes enable the PCP to manage the patient base with more minor sicknesses, and provide prevention treatments and education, enabling a healthier elderly patient, downstream.

## Feasibility

The clinical team was tasked in the summer of 2020 with building a home-based, provider-led program to reduce unnecessary utilization for their highest-risk members while improving patient outcomes and overall patient experience. Readmission rates for their fully delegated utilization management/case management (UM/CM) population had remained elevated in years 2018 (14.48%) and 2019 (15.44%), with a reduction in readmit rates due to the pandemic in 2020 (13.31%). With the addition of the CAH program managing their most vulnerable members, they saw a 24% decrease in readmissions for 2022. With the expansion of their CAH team to augment primary care practices' reach into the home setting, they were confident they would further reduce readmission rates to single digits—their focus and goal for 2023—and 'Operation Single Digits' was born.

In addition to rolling out the CAH clinical program, CRC became the first and only system of care in RI to be fully capitated for their BCBSRI MA population. This value-based contract enables them to provide the very best care for their patients while improving the quality of care that is being set forth. They are well on their quest to become the premier system of care in RI.

Key partners for the initiative were: Steve O'Dell, CEO, Dr. Lidia Vognar, CAH Medical Director, and Monica Walston Kucks, VP of Care Integration & Transformation. The initiative was funded by CRC, combined with provider billing for home visits, which offset some expenses.

The skillset needed included providers to diagnose, treat, and code; nursing for maintenance and sick visits; social workers for social determinants of health (SDOH) needs; level of care transitions; advance care planning discussions; and pharmacists for medication reviews and education. The main barrier to implementation was the pandemic itself. Since COVID impacted the elderly the most, they naturally were weary and afraid, while also extremely lonely and isolated. The acceptance and engagement rate out of the gate was around 60%, which is above average for an in-home program. They initially focused on transitions of care (TOC) visits for any post-discharge patient. Within 4 months, they expanded to enrolling the TOC patient into a longitudinal CAH program. They enrolled 200 patients within 6 months, all during the pandemic, when their nation and the world faced staffing shortages, and clinicians recovered from COVID.

## Scalability

The CAH program can be replicated to include additional patient populations with a few minor adjustments. For the commercial population, they would focus on incorporating more virtual telehealth visits and alternate site-of-care visits. The meeting place should be tailored according to patient needs (i.e., work, home, PCP office). For the Medicaid population, their focus would be more on SDOH and access needs; adding a community health worker to help with peer recovery and engagement.

CAH has been successful due to its staff, including their skill set and level of commitment to follow-through, as well as care coordination with PCPs and specialists. They have aided in solving PCP access issues caused by the

pandemic and capacity issues in primary care, and served as an alternate site of care to traditional brick-and-mortar ED, urgent care centers, or SNF.

## Equity

Health equity was a big focus in the design of CAH during the COVID pandemic. This population was at the highest risk of death, and fear was rampant. Their patients were told to stay home, mask up, and socially isolate, though social isolation increases the risk of death by 32% (source: NIH Pub Med). Plus, many of their senior Medicare population are from the Depression era and are proud people. They were taught to “grow up,” but there is little teaching on how to grow old gracefully and what services come at little to no cost to them, especially their CAH program. The biggest hurdle to overcome was, “This is too good to be true; where is the catch?” and the fear of being scammed and exposed to external pathogens.

Their CAH team has thankfully been backed by leadership, which affirms their team's belief that if you do right by the patient, good outcomes will follow, and everyone will benefit in the long run. Patient engagement was never an issue; rather, the patients craved human connection and interaction. Patients started calling on the CAH team with basic questions, then moved to calls for help with treatment for disease exacerbations. Now they call on them as they transition to hospice. Nothing can match the compassion of this team and their ability to connect with their patients on a personal level. They trust the CAH team empathically—to help them during their darkest days. They then turn these dark days into quality time with friends and family, transitioning from one level to another.

## Sustainability

Their overall readmission rate has been reduced by 24% since they rolled out CAH to their BCBS MA population, with an average 3% readmit rate for the patients enrolled in the CAH program. They saw immediate changes as their patients have another option in the provider world. They are no longer disgruntled with their PCP, as their CAH team has filled the void between regularly-scheduled primary care visits, and are always available after hours for treatment and support. Leadership and PCPs have seen the impact of savings in terms of improved patient care and the positive impact on patient outcomes over the past 3 years. Team members truly view their roles as the highlight of their careers—to be able to spend the appropriate amount of time educating, diagnosing, and treating patients in the comfort of their own homes and truly see the reality of a patient's daily life outside of the brick-and-mortar setting.

'Operation Single Digits' provides their organization with one focused goal: to improve the lives of their patients and to ensure they have the very best of care at the right time and in the right place—at home. Delivering improved patient outcomes, as they have demonstrated, only confirms that when you do right by the patient, good outcomes will follow and that everyone will benefit in the long run.

because of their location. In 2022, the Robert Wood Johnson Foundation explored the delivery of health care based on place (urban versus rural) and within rural communities. They found that more than one in every seven Americans lives in a rural place. Rural residents, in general, are disadvantaged by place—facing geographic barriers to services, resources, and opportunities. Within the rural population, there also are wide disparities in health and mortality among socioeconomic groups. Worse health is consistently associated with lower education or income as compared to urban counterparts. Rural residents are disproportionately impacted by preventable cancers, severe maternal morbidity, and opioid misuse, and they are less likely to receive critical health care services such as cancer screenings and childbirth care.

Rural risk factors for health disparities include geographic isolation, lower socioeconomic status, higher rates of health risk behaviors, limited access to health care specialists and subspecialists, and limited job opportunities. Rural residents are also less likely to have employer-provided health insurance coverage, and if they are poor, they often are not covered by Medicaid.

Low-income people of color living in rural settings are multiply disadvantaged by place, race, and class. Adult American Indian and Alaska Native (AI/AN), non-Hispanic Black, and Hispanic adults living in rural areas self-reported higher rates of fair or poor health compared to non-Hispanic White adults. Additionally, rural non-Hispanic Black and AI/AN adults were more likely to report having multiple chronic health conditions than non-Hispanic white adults; rural non-Hispanic Black adults were most at risk for obesity and severe obesity; and rural AI/AN adults reported the most activity limitations due to physical, mental, and emotional problems.

## Sustainability

As we look into the future for rural palliative care in Washington State, what will success look like? Patients and their families will be completing more advanced care plans in their own communities, where they feel comfortable with trusted local clinicians. Those clinicians will possess more skills to have goals of care conversations, deliver difficult news, and manage symptoms. As clinicians work together, overburdened physicians will be able to utilize trusted interdisciplinary team members in the delivery of primary palliative care and, when needed, be able to access telehealth case consults with trained specialists. Community members will increasingly have exposure to palliative care, and with that exposure, there will be a heightened awareness of its role and value.

What we have observed is that despite staffing changes, a national pandemic, and regional hospital program cutbacks, culture change within critical access hospitals is taking hold. Local advocates continue to carry the message forward. WRPCI staff are impressed with local problem-solving and care delivery with limited resources.

To help communities continue this effort, the portal contains multiple resources, including a webinar library providing information on: team development, assessing community telehealth capacity, legal issues at the heart of serious illness, and improving revenue streams for palliative services. The WRPCI Handbook includes a section on multiple sustainability strategies supporting communities in finding pathways to a fully sustainable palliative care service.

## Project Team

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## About the Challenge

The John A. Hartford Foundation Tipping Point Challenge is a national competition to catalyze the spread of skills, ideas, and solutions that will improve health care delivery for all people living with a serious illness. It is sponsored by the [Center to Advance Palliative Care](#) and [The John A. Hartford Foundation](#).

For more information, visit [tippingpointchallenge.capc.org](http://tippingpointchallenge.capc.org).