

Addison Gilbert Hospital

GLOUCESTER, MA

\$291,581

AWARD EXPENDED

Patients with behavioral health and social needs in addition to physical health issues often both have worse outcomes and are more costly to the health care system compared to patients without these comorbidities. Addison Gilbert Hospital created a multidisciplinary team (high risk intervention team) to address gaps in the care of patients with complex social, behavioral and medical needs in its community. The pilot focused on improving quality of care and access to services for these patients, with the intent to reduce cost to the Commonwealth.

RAPID-CYCLE PILOT

149

PATIENTS SERVED.

7,040

ENCOUNTERS.

The high-risk intervention team's goal was to reduce 30-day readmissions by connecting patients to services after discharge from the hospital, coordinating care across settings — including more effective follow up — and by improving medication management both during an admission and post-discharge.

The Addison Gilbert Hospital team developed new procedures and workflows, established new relationships within the hospital and with community partners, and collected and analyzed data. A dedicated pharmacist reviewed medications for these patients, two-thirds of who used eleven or more, and solved several medication errors and omissions. Addison Gilbert Hospital measured the hospital-wide readmission rate in CHART Phase 1 to assess the impact of the pilot. The six-month readmission trend is promising; however, given the limited population served and the focus on an all-cause readmission rate, no definitive conclusions can be drawn.

CHART PHASE 2 AWARD

Addison Gilbert Hospital will scale the high risk intervention team in CHART Phase 2 in a direct continuation and expansion of CHART Phase 1 activities, aiming to reduce 30-day readmissions for patients with a history of recurrent hospital or emergency department use, social complexity, and/or need for palliative care services. Addison Gilbert Hospital is also a participating site in a joint award in partnership with other Lahey Health community hospitals and Lowell General Hospital to enhance care for patients with behavioral health needs across the care continuum.

Hospital-wide 30 day readmission rate

