St. Tammany Quality Network

Quarter 1 STQN Newsletter

Transforming Care and Empowering Lives:

Exploring the benefits of STHS Home Health and Transitional Care Programs and understanding the Enhanced Annual Wellness Visit for Medicare patients.

Dates to Remember:

1Q STQN Finance & Operations Committee Meeting
March 12 | 5:30 p.m. | Ponchatoula Conference Room

2Q STQN Performance Management Committee Meeting
April 9 | 7 a.m. | Ponchatoula Conference Room

Spring Medical Staff Meeting
April | TBD

Mental Health (1 CME)
Rachel Csaki, MD
April 25 | Zoom

2Q STQN Board Meeting
May 14 | 5:30 p.m.

Managing High Risk Pregnancy (1 CME)
Naiha Mussarat, MD
May 30 | TBD

Foot Ailments (1 CME)
Jay Groves, DPM
June 27 | TBD

2023 4th Quarter Medical Director's Award

Medical Director's Quality Award
Is awarded to:
Dr. Angela Buonagura
Dr. Jennifer Daly
Dr. Natalie Fitton
"for their contribution in creating a Center of Excellence at the St. Tammany Health System Women's Pavilion"

A Message from our Chairman:

STQN Physicians,

I would like to thank everyone for an exciting and successful 2023. We made great strides towards our goals last year, and I expect that momentum to continue into 2024.

I would also like to express my gratitude to everyone who attended the STQN Annual Meeting at the Southern Hotel. The opportunity to interact with our colleagues as we discuss our shared desire to improve the health of our communities is both energizing and informative.

While the information can be obtained by other means, I cannot overemphasize the value of being there in person.

Our objectives for 2024 are as follows:

- Establish a baseline for shared savings for the BCBS EPO contract.
- Improve the health of STHS employees and dependents.
- Maintain physician alignment.
- Increase physician satisfaction.
- Continue to educate providers on the development of value-based care.

I hope this finds everyone doing well in 2024, and I look forward to working together to bring our goals to fruition.

Sincerely,

L. Phillips Jenkins

St. Tammany Quality Network

Home Sweet Home:

Discover how St. Tammany Health System's dedicated team of healthcare professionals is redefining the way healthcare is delivered, ensuring a seamless transition from hospital to home.

STHS Home Health Care

- St. Tammany Home Health Care offers services for residents of St. Tammany, Washington and Tangipahoa parishes.
- To qualify for Home Health Care, a patient must have a skilled need, be homebound and under care of a physician or allowed practitioner (NP or PA).
- If you are unsure if a patient qualifies, a staff member from STHS home health will be happy to assist with an evaluation.
- STHS Home Health Care is committed to admitting patients the day after the referral is received with prompt follow-up on medication reconciliation and durable medical equipment needs with the hospitalist, even after hours and on weekends.
- Physical therapy, occupational therapy and speech therapy are available as well as specialty therapies such as Big and Loud for Parkinson's Disease and Lymphedema Therapy.
- Social workers are available to help connect patients with community resources and psychosocial or long-term planning/placement.
- Telehealth units are available to place in patients' homes for daily monitoring of vital signs, weight and pulse oxygen saturations. These units also enable STHS Home Health staff to utilize video visits with patients to follow up on compliance or to provide patient education.
- Collaborates with Palliative Care team and Transitional Care team.
- May "bridge" patients to Hospice Care as deemed appropriate.
- EPIC electronic medical record is utilized, assisting with maintaining continuity of care.
- Excellent patient satisfaction scores.

If your patient does not have a Home Health preference, you may place an order in EPIC or call (985) 898- 4414 to refer to St. Tammany Home Health Care.

St. Tammany HEALTH SYSTEM
Home Health

St. Tammany Quality Network

Transitioning Towards Wellness:

Explore how St. Tammany Health System's Transitional Care Program ensures world-class healthcare after hospital discharge.

If you have any questions, please contact the Transitional Care team at (985) 871-5955.

St. Tammany HEALTH SYSTEM
Transition Home Care

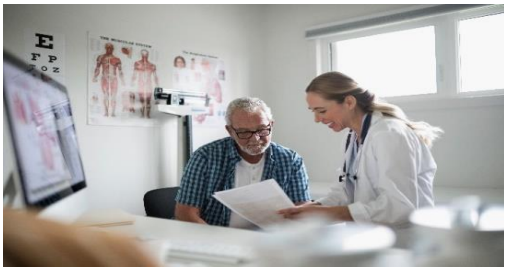
STHS Transitional Care

- Being discharged from the hospital to the comfort and familiarity of a patient's own home is usually welcomed by most patients, but with that, a few tasks are often required for proper healing and recovery to prevent rehospitalization, leading to stress for patients and loved ones.
- Transitional Care sets itself apart from Home Health Care by bringing the healthcare provider directly into the patient's home.
- STHS's highly trained Transitional Care team provides an extra layer of support for 30 days after hospital discharge.
- The goals of Transitional Care are for patients to receive ongoing support and resources to help them successfully transition from the hospital to a home setting and to prevent any potential complications or readmissions.
- The Transitional Care team can provide services to patients by scheduling home appointments or telehealth appointments via phone or internet video.
- A team of nurse practitioners and registered nurses collaborate with the patient and the patient's family to create an individualized plan of care.
- This plan may include support for follow-up appointments, medication management, Home Health services, durable medical equipment, and education to the patient and patient's family.
- While your patient is in the hospital, you can make a referral for STHS Transitional Care.
- If your patient agrees to Transitional Care, a registered nurse will contact your patient within two business days of their discharge.

St. Tammany Quality Network

Embracing a healthier future for Medicare patients through the Enhanced Annual Wellness Visit (eAWV):

Did you know the enhanced annual wellness visit goes beyond a standard annual wellness visit by adding components to help accurately risk adjust patients and close gaps in care?



The eAWV includes several essential elements, outlined below, that emphasize the importance of preventive care rather than focusing solely on acute complaints or chronic disease. The eAWV can be performed by primary care physicians or APP in various settings, including the clinic, patient's home or via virtual visit.

To code the eAWV appropriately, for the initial eAWV use code G0438 and for subsequent eAWVs use code G0439*

- Health Risk Assessment (HRA)
- Patient's medical history
- List of patient's current providers
- Vital sign measurements
- Assessment of cognitive function (or decline)
- Personal prevention plan
- Personalized advice and referrals to minimize risks
- Advanced Care Planning (ACP)
- Review of current opioid prescriptions
- Screening for potential substance use and referral for treatment as appropriate
- Mental health/depression screening
- Functional capacity and current safety level