

Safe Transitions LAN Event

Rhode Island's Community Approach To Safe Transitions – One Year Later... What We Did, What We Achieved, and What We Learned Along The Way

Event Details

Date / Time: Thursday – September 20, 2012 - 7:30am-11:30am (registration opens at 7:00am)

Agenda

Registration Check-in	7:00am - 7:30am
Welcome Lynne Chase / Stefan Gravenstein, MD, MPH ~ Healthcentric Advisors	7:30am – 7:45am
Provider presentations	7:45am – 8:35am <i>(Round 1)</i>
	8:35am - 9:25am <i>(Round 2)</i>
	9:25am - 9:45am BREAK
	9:45am - 10:35am <i>(Round 3)</i>
<ul style="list-style-type: none"> • Reducing Readmissions through appropriate End of Life Care <ul style="list-style-type: none"> ○ Presentations facilitated by Therese Rochon, MSN, MA, RNP, ACHPN ~ Home and Hospice Care of Rhode Island <ul style="list-style-type: none"> ▪ Jennifer Cellar, RNP ~ Evergreen House <i>End of Life Planning: The importance of having the conversation</i> ▪ Nancy Forte BSN, RN ~ Home Care & Hospice of New England <i>Partnering in the Care of Advanced Illness: Educating patients and providers on specialized Palliative and Hospice care</i> • Communication Matters! Providing Effective Patient Education and Post-Discharge Follow Up <ul style="list-style-type: none"> ○ Presentations facilitated by Rebekah Gardner, MD ~ Healthcentric Advisors <ul style="list-style-type: none"> ▪ Amy Paul, RN, BSN, CCM ~ Memorial Hospital <i>Using post discharge outbound calls to influence readmission rates</i> ▪ Carol Bramley, RN, BSN, Linda Zabbo, RN, BSN, and Jennifer Gillis, NP, MSN~ VNA Care New England <i>Heart Failure Program Pilot</i> • Overcoming Medication-Related Barriers <ul style="list-style-type: none"> ○ Presentations facilitated by Stephen J. Kogut, PhD, MBA, RPh ~ University of Rhode Island College of Pharmacy <ul style="list-style-type: none"> ▪ Jackie Costantino, RPh, MBA ~ South County Hospital <i>Medication Reconciliation Transitions of Care</i> ▪ Lynne Driscoll, RN, CCM ~ South County Hospital <i>Improving medication management during transitions of care – A collaborative effort</i> 	
Debrief Session Therese Rochon, MSN, MA, RNP, ACHPN, Rebekah Gardner, MD, and Stephen J. Kogut, PhD, MBA, RPh	10:35am - 11:20am
Wrap Up & Next Steps Lynne Chase ~ Healthcentric Advisors	11:20am - 11:30am



*Rhode Island's Community Approach
to
Safe Transitions - One Year Later:
What We Did, What We Achieved, and
What We Learned Along the Way
(The PDSA Way)*

Provider Poster Presentations



Reducing Readmissions through appropriate End of Life Care

*Presentations facilitated by:
Therese Rochon, MSN, MA, RNP, ACHPN ~
Home and Hospice Care of Rhode Island*

Jennifer Cellar, RNP ~ Evergreen House

End of Life Planning: The importance of having the conversation

Nancy Forte BSN, RN ~ Home Care & Hospice of New England

*Partnering in the Care of Advanced Illness: Educating patients and
providers on specialized Palliative and Hospice care*

End of Life Planning

The Importance of Having the Conversation

Jennifer Cellar, RNP
Evergreen House

Providence Transitions Coalition (PTC)

Advanced Directive Planning

- Leading cause for hospital re-admissions is lack of discussion surrounding advanced directives.
 - 61% population have preferences about the medical care/interventions they would receive if they were unable to make decisions
 - Only 34% population had signed advanced directives depicting their wishes
 - (Verna & Leon, 2010)

Importance of Having the Conversation

- Goal to facilitate discussion of advanced directives
- Provide education about interventions
- Improve family members understanding of basic terms
- Increase comfort level with making advanced directive decisions.

Intervention

- Collaborative effort between:
 - Evergreen House (Dr Dennison, Jennifer Cellar RNP)
 - Hospice & Palliative Care
 - Terry Rochon (Director of Palliative Care)
 - Denis Lynch (Hospice Chaplain)
 - Evercare (Michelle Debeste, CSM)
- Event to bring families together for discussion of advanced directives
 - Video viewing
 - Discussion
 - Presentation of advanced directives

Video Viewing

- "When Doctors and Daughters Disagree: twenty-two days and two blinks of an eye"
 - (Abadir, Finucane & McNabney, 2011)
- Examine one families struggle with end of life decisions
- Panel members to facilitate discussion and answer questions.
- Spurred discussion about participants own experience with making medical decisions
- Polar views about wishes expressed

Education

- Presentation of basic information about advanced directives.
- Reviewed current laws/terms
- Role of POA-HC
- Types of advanced directives
- Benefits and burdens of interventions
 - CPR
 - Artificial Nutrition
 - Intubation
 - Repeated hospitalizations

Evaluation

- Pre-test and Post-test used to assess participants baseline understanding of information and effectiveness of discussion/education.
- Simple 3 question format used to improve compliance
- Identical questions asked in written format before and after to determine effectiveness of lecture and discussion
- Participation of pre and post test requested but not required

Pre/Post Test

I feel comfortable making end of life decisions.

Circle your level of comfort. 1 being not comfortable and 7 being very comfortable.

2 3 4 5 6 7

What are the two most common forms of *advanced directives*?

A) *Health Care Proxy*

B) *Living Will*

C) *Financial Will*

What is the role of the person who has been elected to be the Power of Attorney for a patient?

A) *To make decisions based on their wishes for the patient*

B) *To make decisions based on what the patient wants*

C) *To make decisions based on what the family wants*

D) *To make decisions based on what the doctor says or feels*

Results

- Findings suggest improved understanding of role of POA-HC
- Intervention did not reflect increase comfort level in making EOL decisions
- Findings may be related to other factors including literacy level of participants and participation
- Increased understanding of decision making may contribute to decreased comfort level
- Findings may also reflect more educated decision making

Next Steps

- Continued advanced directive education to patients and families
- Encourage discussion and documentation of wishes
- Review risks and benefits of interventions to ensure educated decisions
- Continued collaboration with Evercare, Palliative Care and Hospice



Home Care & Hospice
OF NEW ENGLAND



Partnering in the Care of Advanced Illness:

Educating patients and providers on specialized Palliative and Hospice Care

Nancy Forte BSN, RN

Home Care & Hospice of New England

Director of Growth Strategies

nforte@visitingnursehc.org



Visiting Nurse
HOME CARE



Home & Hospice Care
OF RHODE ISLAND



Plan

- **Background**

It is widely recognized that despite patient preferences to die at home, a large percentage of patients at End of Life (EOL) die in the hospital.

- Impacts quality of life for both patient and family
- Increases the financial burden incurred due to unnecessarily aggressive care¹

February of 2012 , VNHC and HHCRI formally affiliate

- With the approval of the DOH, the two independent non-profit agencies formed a synergistic relationship to serve the community

- **Goal**

Patient receives the right care, at the right time in the right place as evidenced by reduced ED visits and hospital readmissions

1. Goodman, DC et al. Trends and Variation in End-of-Life Care for Medicare Beneficiaries with Severe Chronic Illness. The Dartmouth Atlas Project, 12 April 2011

Do

- **Intervention**

Collaborative education was provided by HHCRI educators to VNHC staff (including Nurses, Therapists, Home Care Aids and Medical Social Workers) to expand and improve upon the care of patients with advanced illness:

- FY '12, Q1: Assisting Patients & Families to Navigate Difficult Medical Decisions
- FY '12, Q2: The Concepts and Practice of Hospice & Palliative Care
- FY '12, Q2: Advance Directives

Study



- **Evaluation/Data**

(Goal: Patient receives the right care, at the right time in the right place, as evidenced by reduced ED visits and hospital readmissions.)

We plan to measure the following indicators:

- Comfort level of nurses with difficult EOL conversations
- Hospice and Palliative Care referrals
- Number of patients who obtain Advance Directives

Study



- Results

- Regular review of patient needs and goals of care
- Identified a need to expand and improve clinical skills
- Identified and filled new positions
 - Care Transition Coordinator
 - Director of Clinical Informatics
 - Dedicated Clinical Staff Educator



Act

- Next Steps: Opportunities for future internal and external collaboration include:
 - Expanded services in the home
 - Continued State-wide EOL care education focusing on palliative vs. curative thinking
- Barriers
 - Resistance of clinicians to discuss EOL options with patients
 - Fear and lack of understanding of terms like “hospice” and “palliative” by both clinicians and patients/families
 - Regional tendency to utilize unnecessarily aggressive care in the last 6 months of life²

2. Goodman, DC et al. Trends and Variation in End-of-Life Care for Medicare Beneficiaries with Severe Chronic Illness. The Dartmouth Atlas Project, 12 April 2011

Collaboration



- Advice for others
 - Patience, persistence, passion, vision
 - Be a “Fire Starter”³
- Partnership opportunities
 - Pharmacists, Urgent Care Centers, ER Staff, Ambulance Services
 - Technology partners

1. Studer, Quint. *Hardwiring Excellence*. Gulf Breeze, FL: Firestarter Publishing, 2003

Thank you!



Questions?



*Communication Matters!
Providing Effective Patient
Education and Post-
Discharge Follow Up*

*Presentations facilitated by:
Rebekah Gardner, MD
~ Healthcentric Advisors*

Amy Paul, RN, BSN, CCM ~ Memorial Hospital

Using Post Discharge Outbound Calls to Influence Readmission Rates

Carol Bramley, RN, BSN, Linda Zabbo, RN, BSN, and Jennifer Gillis, RN, MSN ~ VNA Care New England

Heart Failure Program Pilot



Development of a Post Hospitalization Outbound Call Program

Amy Paul, RN, BSN, CCM



Director, Continuing Care
amy_paul@mhri.org

Northern Rhode Island Coalition



Plan

- **Background**

- Opportunity: MHRI's Medicare 30 day overall readmission rate to the same or another hospital was 25.3% in Q2 of FY 2011*
- Systems analysis:
 - *Medical record audit of readmission events
 - *Patient interviews using IHI STAAR tool
 - *Interviews with Case Managers / anecdotal reports from Nurses, Homecare Practitioners, and Post Acute Care Providers

- **Goal**

- The Medicare 30 day readmission rates for pneumonia, heart failure, and acute MI will be reduced by 20% over the next three years.

Do



- **Intervention/Project**

- Implementation of post discharge outbound calls to patients was chosen for testing
 - *streamlined four question assessment
 - *question content built around known drivers and risk factors for readmission
 - *scripting based upon tenets of motivational interviewing
- Project participants and partners: Continuing Care clinicians (Case Managers), Case Manager from MHRI Family Care
- Formal evaluation of intervention to occur Q2 FY 2013

Study



- Evaluation/Data

- Outcomes measure: Medicare 30 day overall readmission rate to the same or another hospital
- Operational measure: Number of discharged patients who engaged in an outbound call within 3 business days of hospital discharge*
- Proximal outcome measure: Patient satisfaction
- Balance measure: Average length of stay

- Results

- Patient identification need not be static, but any changes to the population targeted must be tracked to support validation of outcomes data
- Baseline: 25.3% in Q2 FY 2011 Now: 22.2% in Q2 FY 2012



Act

- **Next Steps**

- Improved transitions of care will result in decreased avoidable readmissions and increased patient satisfaction
- Streamline patient discharge teaching materials for maximum value and engage Nurses in evidence based discharge teaching interventions
- Leverage oversight, guidance, and operational support from MHRI Transitions of Care Team to support successes over time

- **Barriers**

- Finite resources
- Operational reporting and patient identification for programs are currently manual processes



Collaboration

- Advice for others

- Organizational support is critical; enlist a project champion
- Establish oversight via a multidisciplinary workgroup with representation from many practice and care settings

- Partnership opportunities

- Collaborating with external entities: Safe Transitions Learning and Action Network, the Hospital Engagement Network, and the Partnership For Patients
- Collaborating with other MHRI crossfunctional teams: Performance Improvement Committee, Patient Flow Committee, Utilization Review Committee
- Working with providers of post acute levels of care is critical



Heart Failure Program Pilot

VNA of Care New England

Carol Bramley, RN, BSN

Linda Zabbo, RN, BSN

Jennifer Gillis, NP, MSN



VNA of Care New England

Safe Transitions Learning & Action Network Event

September 20, 2012



Plan

Targets for Improvement:

- Reduce 30-day hospital readmission rate for heart failure patients.
- Improve MD and VNA communication and collaboration in care management of CHF patients



Plan

Targets for Improvement:

- Standardize home care education plan for heart failure patients
- Improve early intervention of symptom management by VNA staff and self management by patients.
- Enhance staff education regarding the care of HF patients



Plan

AIM Statement:

Improve overall patient experience, increase symptom management skills and reduce re-hospitalization by 20% by September 30, 2012

Do 

Project:

Develop a Home Health and Hospital Collaborative Care Model and improve the safe transition of heart failure patients from hospital to home, increase patient self management skills and reduce the hospital re-admission rate of HF patients

Do 

Interventions:

- Upgraded remote monitoring technology to provide more effective symptom management
- Developed a dedicated team of nurses to follow remote monitor transmissions 7 days a week / Begin remote monitoring within 24 hours of SOC
- Enhanced use of SBAR communication between VNA staff and physicians
- Employed a nurse practitioner to provide staff education / HF patient consultation visits

Do 

Interventions:

- Developed new HF patient education handbook / new HF care pathway
- Began bi-monthly meetings with the Kent Hospital HF pilot team for program collaboration and case management
- Collaborated with Kent Hospital HF team to standardized HF Zone education to be used across the continuum of care

Do 

Who is Involved?

- VNA of Care New England
- Kent Hospital Department of Cardiology
- Patients and their families

Do 

Timeline:

- **January, 2012-** NP began performing cardiac consult visits for HF patients, installation of new remote monitoring system, staff education regarding SBAR communication and chronic care management
- **May, 2012-** developed staff education program for management of HF patients, developed new HF patient handbook, and new HF care pathway
- **July, 2012-** began discussions with Kent Hospital to begin collaboration for a HF patient pilot program
- **September, 2012-** Launch of Kent Hospital collaboration HF patient pilot program

Study



Evaluation:

- VNA HF patient readmission rate to Kent Hospital within 30 days
- Self Care Index to measure pre and post self care maintenance ability and adherence to prescribed medication regimen
- Compliance with MD HF clinic follow up
- VNA SN feedback

Study



Results:

- Increased remote monitoring units to 60
- Developed and tested HF care path and added NP consult visit to path
- Provided additional cardiac care education to staff
- Educated all staff about SBAR
- Implemented revised patient symptom management tool
- Reduced re-hospitalization rate by 35%



Act

Next Steps:

- Begin patient enrollment into the HF patient pilot program in collaboration with Kent Hospital Department of Cardiology
- Evaluate care path / staff and patient adherence to visit schedule
- Assess patient participation in structured education program and improvement in patient self management (Self Care Index)



Next Steps:

- Expand number of patients followed by remote monitoring
- Transition patients from daily remote monitoring to daily self – initiated reporting
- To establish additional MD partnerships to expand and enhance our HF homecare program and ensure optimal care for our HF patients



Ensuring Success:

- Develop standards of care
- Electronic record auditing
- Adherence to care pathway
- Ongoing staff education and feedback
- 6 month evaluation of pilot program successes and areas needing revision

Collaboration

Project Barriers:

- Change in staff practice
- Patient compliance
- MD collaboration

Recommendations for Others:

- Form a team and collaborate among multi-disciplines
- Frequent review and flexibility to modify plan as necessary

Collaboration

Partnership Opportunities:

- Develop programs to include additional chronic conditions (stroke, COPD)
- Begin collaborative partnerships with additional home medical groups and private practices

Partnership Needs:

- MD collaboration
- Integrate with cardiac team at Kent Hospital
- Integration of electronic patient medical record



Overcoming Medication-Related Barriers

*Presentations facilitated by:
Stephen J. Kogut, PhD, MBA, RPh
~ University of Rhode Island College of
Pharmacy*

Jackie Costantino, RPh, MBA & Jonathan Mundy, RPh, MBA ~ South County Hospital
Medication Reconciliation Transitions of Care

Lynne Driscoll, RN, CCM ~ South County Hospital
Improving Medication Management during Transitions of Care – A Collaborative Effort



Medication Reconciliation Transitions of Care

Jonathan M. Mundy, R.Ph., MBA
South County Hospital Healthcare System
Director of Pharmacy & Disease Management Services
jmundy@schospital.com

*Safe Transitions Learning & Action Network Event
September 20, 2012*



Plan

- **Background**

- Problem: *No formalized system for.....*

- Completing an accurate Medication History in the Emergency Department
 - Completing a comprehensive Medication Reconciliation upon admission
 - Completing a final and accurate Medication Reconciliation prior to discharge

Result –Physicians had no confidence in accuracy of our system

- **Goal**

1. Establish an interconnected system for accurately documenting and reconciling a patient's medications and ensuring that once complete, this information is shared with the patient and the patient's physicians
2. Define specific metrics for documenting Pharmacy Interventions
3. Attain a 90% Pharmacy completion rate on all phases of this system; ED, Admission, Discharge

Do



● Intervention/Project

- October 2011 - established a dedicated Pharmacist position solely responsible for performing Medication Reconciliation on all inpatients
- January 2012 - began training Pharmacy Technician's on performing Medication Histories in the Emergency Department
- January 2012 – began using external medication list – “Dr. First” to view and verify a patient’s community pharmacy medication history
- January 2012 – established stand-alone Medication Management Clinic
- April 2012 – deployed trained Technicians to the Emergency Department to begin performing Medication Histories
- May 2012 – began utilizing 5th & 6th year Student Pharmacists from URI, MCPHS, and Albany Colleges of Pharmacy to perform Medication Histories in the ED, and Medication Reconciliation on Inpatients

Major Partners: Administration, ED Physicians, Hospitalists, Case Management, Primary Care Physicians, Nursing, Nurse Care Managers

Study



- Evaluation/Data

- Data collection – joint effort through Case Management and Pharmacy
- Pharmacy established 16 individual metrics to track specific interventions
- Pharmacy Technicians/Student Pharmacists account for 33% of the admission histories done in the ED
- Jointly, 98% of discharged patients are seen by Pharmacy & Case Management
- Individually, 90% of discharged patients are seen by a Pharmacist

- Results

- Physician confidence now very high
- **Learned:** Need to refine metrics - “Do a deeper dive” into what interventions are being made during a reconciliation – and ask “why”
- **Concerns:** Knowing that medication list at discharge is truly accurate



- **Next Steps**

- Expand program - Educating Patients on their Medications - HCAHPS
- Expand program – longer hours during the week and weekends
- Implement Patient Portal for Pre-Admission Testing patients
- Increase utilization of Medication Management Clinic
- Include community Pharmacy in information loop at discharge
- Incorporate into Pharmacy Residency Program beginning July 2013

- **Barriers**

- Pharmacy Resources (Pharmacists and Technicians) – Off shift and weekends
- Obtaining drug information – patients, care givers, external sources
- Perceived value - Patient

Collaboration

- Advice for others

- Don't over analyze your startup
- Don't make the process complex
- Meet often with staff involved
- Ask them what works/doesn't work
- Expect to make lots of changes
- Most of all -----



- Partnership opportunities

- Primary Care and Specialist Physicians, Community Pharmacy, Long-Term Care Pharmacies, Rehab & Skilled Nursing Facilities



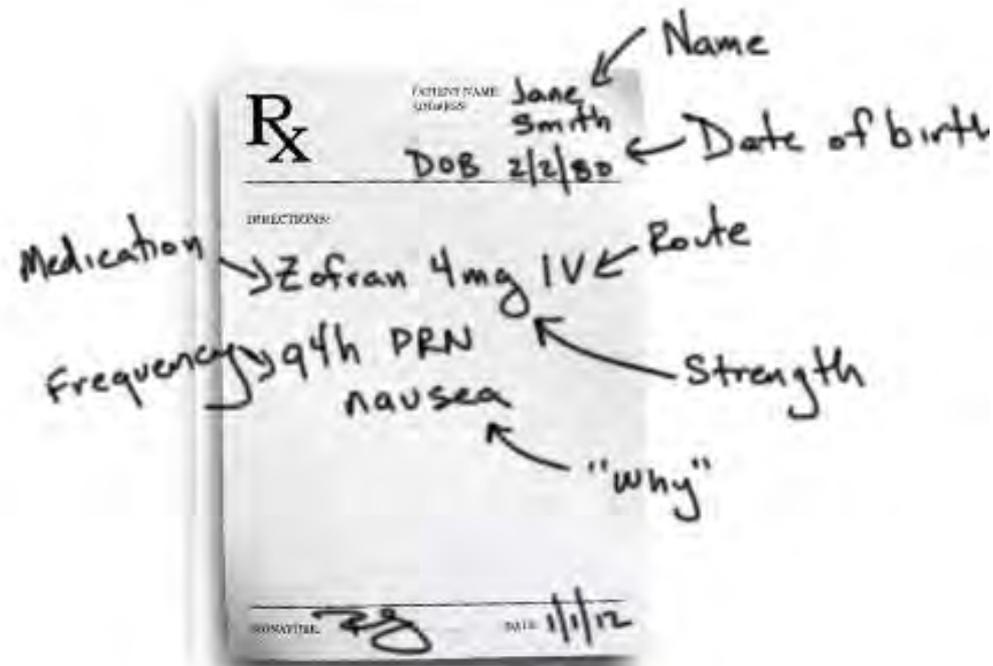
*Improving medication management
during transitions of care –
a collaborative effort*

Lynne Driscoll, RN, CCM
South County Hospital

Washington County Transitions Coalition

Problems Identified

- Lack of available medications with transfers
- No DEA number or lack of refills
- Lack of communication and respect



NO DEA and NO refill information

- Lack of required information
- The patient will not have the prescription filled
- Risk for pain and anxiety
- Decreased patient and family satisfaction

Increased communication

- Nurse to Nurse report using SBAR to assist with pain assessment and medication prior to transfer
- Nursing facilities are all using Interact Tool
- Ongoing Shadowing program to assist with transitional improvements and relationship building

SBAR for Nurses

S

Situation

Patient's Name: _____ Room Number: _____ Age: _____ Sex: _____

Diagnosis: _____

B

Background

History: _____

Allergies: _____

Attending MD: _____

Consults: _____

A

Assessment

Current Vital Signs: _____

Heart Rhythm: _____ Lung Sounds: _____ Oxygen Rate: _____

Skin: _____ IV site: _____ IV site Change Date: _____

Dressings: _____ Last BM: _____ Foley: _____

Activity: _____ Diet: _____ Drains: _____ Fall Risk: _____

R

Recommendation

Current Labs: _____

Pending Labs: _____

Awaiting Procedures: _____

Nursing Concerns: _____

Case Management

- Reviewing and clarifying orders prior to transfer
- Faxing medication orders directly to the facility pharmacy to expedite access to patient
- Fax to facility prior to transfer for review and questions
- Assisting nursing with report and paperwork

Sample Faxes

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Mary Lou	788-1460	763-0348	Marie	788-3819	763-0357
Kelly	788-1340	763-0087	Jayne	788-1462	763-0369
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Hospital commitment to Safe Transitions

- Medication reconciliations in the emergency room by pharmacy M-F
- Medication reconciliation by full time pharmacist on discharge M-F
- Out patient MTM program

Outcomes

- Improved access to medications for patients prior to transfer and upon arrival to facilities
- Improved adherence and review of prescriptions prior to transfer
- Ongoing relationships with the community of care.
- Respect and ongoing evaluation for improvements and interventions.

Participants

- South County Hospital
- Westerly Hospital
- Primary Care Providers
- Hospital Doctors
- Nursing Home Medical Directors
- Apple Watch Hill
- Apple Clipper
- Westerly Health Center
- South Kingstown Rehab Center
- South County Rehab Center
- Roberts Health Center
- Scallop Shell
- South Bay Manor
- Bright View Commons
- Nurse Care Managers
- Visiting Nurse Health Care Services
- South County Quality Care
- Home and Hospice of RI
- Odyssey
- Health Centric Advisors

Washington County Coalition Shadowing Program



Spend a day
in my Shoes...



Sue Dubuc – Nurse Case Manager ~ SCH
& Kelly Cookson - Admission Coordinator @ Scallop Shell (now @ SCH)



Nina Liang - Nurse Case Manager @ SCH
& Roy Harley – Social Worker @ South County
Nursing and Rehab



Lisa Johnson- RN @SCH
& Danielle Petit – RN @ South Bay Manor



Holly Fuscaldo - BSW Case Manager @ SCH
& Maria England-Berdy - South Kingstown Nursing and Rehab