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IL-NET National Training and Technical Assistance Center for Independent Living

Independent Living Research Utilization

www.ilru.org

>> Slide 2

Hospital to Home:
A Collaborative Between Community Partners
Part I

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Evaluation Survey & Presenter Contact Information

Your feedback on this webinar is important to us. At the end of the presentation you will have the opportunity to complete a brief evaluation survey.

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People with disabilities building community
THE INDEPENDENCE CENTER

uchealth

What You Will Learn

- Strategies for partnering with health care entities to improve the lives of people with disabilities by providing support services after discharge from a hospital stay.
- The basic elements of a hospital to home program that assists people with disabilities to safely transition from the hospital back into their homes and communities.
- Strategies for setting up community networks to provide support services after discharge from hospital stay.

The Independence Center (The IC)

- Mission: Working with individuals, their families, and the community, we create independence so that all may thrive.
- Founded in 1987 by people with disabilities who saw a need for home health services in the community.
- Designated in 1994 as one of nine Centers for Independent Living (CIL) in Colorado.
- Our CIL provides services in six counties and our Home Health provides services in an additional eleven counties; all in southern Colorado.
- The local home of civil rights for people with disabilities.

UCHealth Memorial Hospital (UCHealth)

- Mission: We improve lives. In big ways through learning, healing, and discovery. In small, personal ways through human connection. But in all ways, we improve lives.
- 555 staffed beds across the three hospitals in the city.
- Level 1 Trauma Center
- Comprehensive Stroke Center
- Catchment area includes all of southern Colorado, northern New Mexico and western Kansas.
- 187,341 ER visits in FY2019
- 44,414 inpatient admissions and observation visits in FY2019

What is the Hospital to Home (H2H) Program

- The IC and UCHealth collaborated to facilitate successful transitions to home for patients with a complex or difficult discharge.
- Through H2H, The IC provides support services that address social determinants of health for patients discharging from hospital, so they can successfully thrive at home, including—
  - service assessment
  - coordination, and
  - a network of local community-based organizations
- CIL core services of transition and diversion

Linkage Lab Project

- 18 months of business acumen training to create a sustainable program offered by The Colorado Health Foundation.
- Writing the plan: who, what, when, where, how, how long, who with…ALL the details.
- Create a detailed picture of the project.
- First question: What does the end result of this program look like?
- Work backwards to fill in the blanks.
- Consider risks and plan for them.
- Service Coordination and IL staff
- Learning a new language to speak to the hospital about pain points*.

**Pain points – specific problems that prospective customers are experiencing*

Planning Process

- Identify a gap in the community:
  - Can The IC disrupt the process of individuals going into nursing homes when it is not a necessity?
- How did The IC decide to create a program that partners with a hospital?
  - What services is The IC good at providing?
    - Home Health (skilled and unskilled) is in our DNA
    - Social Determinants of Health
- Does The IC have the skills to effect change in a hospital?
- Who would pay?

Finding a Partnership

- It is extremely important to find an internal champion at the hospital.
  - The IC found a hospital administrator to become a board member.
- Determine who in the hospital can make the important decisions about a partnership.
  - Is it the CFO/CEO?
  - What department would the program fall under?
  - Having the correct contacts in the hospital is vital.

Determining Pain Points

- It is crucial to understand the pain points of the hospital you plan to partner with.
- How do you determine those?
  - Meet with the hospital and ask questions.
  - The internal champion from the hospital may be able to give insight.
  - This is where learning a new language (hospital lingo) becomes important.
- Once pain points are determined, align your program to help alleviate those pain points.
  - At the end of the day, the hospital pays for services that save them more money than they spend.

Our Hospital Pain Points

- Long lengths of stay for complex discharges
  - H2H works to shorten the length of stay which allows the hospital to increase bed utilization.
- Readmission rates and unnecessary ER visits for complex discharges
  - H2H meets this need by working with the patient for 60 days after discharge.
- Desire better outcomes for patients
  - H2H allows the patient to heal at home surrounded by medical and social supports.

Program Design: The More Detail the Better

- Work your way backwards:
  - What is your outcome?
  - What services are needed to get to that outcome?
  - Who provides what services? How many hours daily, weekly monthly?
  - What is the process the patient will go through to get these services (assessments)?
  - What is the process the hospital will go through to refer that complex patient to you?
- The more detail you have, the better able you are to establish costs.

Program Design, cont'd.

- Identify and address risks:
  - Who will you not take on? (homeless with no home to go to?)
  - What medical conditions might be beyond your team's skills?
  - What if a team contractor fails to deliver?
  - What if there is a medical emergency in the home? How will you handle?

Services Provided

- After determining our hospital's pain points, these services appeared to be what was needed.
- H2H services include but are not limited to (% utilized):
  - Home Health (skilled and unskilled) & Therapies (PT/OT/SLP) – 91%
  - Durable Medical Equipment (DME) – 73%
  - Medication (fill/delivery) – 10%
  - Meals – 5%
  - Transportation – 32%
  - Benefit Counseling and Peer Support – 36%
  - Other (home modifications, assistance with utilities, etc.) – 23%
  - Case Management for 60 days after discharge

Services Provided, cont'd.

- Every person is different, and every transition will be different.
- Not every transition will utilize every service.
- Focus the funding and support specifically to meet the person where they are and to help them recover.

Building a Network in the Community

- It is important to understand the specific services you want to offer with your program.
- Determine what services your CIL can offer of those services.
- Figure out what other agencies around the area can complete the services your CIL does not offer.
- It is important to have multiple agencies per service because as the program grows, so does the demand.
- Without enough community partners, it will become extremely difficult to expand the program further.

Building a Network in the Community, cont'd.

- H2H is a sustainable program because of the network in the community.
- H2H has a memorandum of understanding (MOU) agreement with eight (8) agencies in the community.
  - We work with many other agencies without MOU agreements as well.
- The IC provides the services we already offer, and the other agencies provide what The IC cannot.

Determining Funding

- First question – pilot program to prove the program to the hospital or straight to a contract?
- Pilot program – how much grant funding do you need to get started? To run for one year?
- Focus on getting approved funding early on in the planning process to be aware of how much funding will be available.
- It is important for both the CIL and hospital to put money towards the program, so everyone has skin in the game!

Financials

- Identify costs
- Per patient – strawman example
- Program costs
  - New staff, program supplies, IT, etc.
- Administrative costs
- Start-up
  - Where is the funding coming from?
  - Applying for grant funding?
  - How much do you need to start the program for one year?
- Cash flow considerations (start-up and on-going)

Financials, cont'd.

- Determine pricing strategy
  - Do you start with a pilot program to show the benefits to the hospital?
  - Do you attempt to get a contract right away?
- Return on investment (financial & impact)
  - What is the impact of the program on the hospital and on The IC?
- Identify risks
- Average cost breakdown for patient utilization:
  - 56% Home Health (Skilled/Unskilled) & Therapies (PT/OT/SLP)
  - 17% Durable Medical Equipment (DME)
  - 15% Medications
  - 8% Transportation
  - 3% Meals
  - 1% Other (home modifications, assistance with utilities, etc.)

Meeting with the Hospital

- Several meetings are in your future.
- Ask questions about the pain points which will guide your program design.
- Present how this partnership will benefit the hospital.
  - Discuss what the pain points are for the hospital and how the program will help alleviate them.
- Present the pilot program or program proposal.
  - Discuss funding sources and length of the program.
- Determine if/how the hospital wants to move forward.
  - MOU for pilot or full contract.

Contract with UCHealth Memorial Hospital

- H2H was first under an MOU agreement with UCHealth Memorial Hospital to complete a one-year pilot program.
- After demonstrating the success (data collection and evaluation), UCHealth and The IC negotiated a contract to continue the services.

Questions & Discussion

Implementing H2H – Building the Process

- Creating assessment tools
- Collaborated with marketing
- Determine data collection
- Creating client forms

Implementing H2H – the Hospital is our Customer

- Building relationships with the hospital case managers and social workers
  - Contract employee has access to electronic medical records (EMR) system and physical desk.
  - In-services
  - Attend weekly meeting
- This is the referral source, and the relationship is a major component for the program to take off.

Process for H2H Transition

- How do we do this?
  - Referral from the hospital
  - Determine eligibility
  - Partner with case managers, patients, and family to create discharge plan
  - Coordinate services in the home and set up DME
  - Services included
  - Continue service coordination for a minimum of 60 days after discharge

Statistics from Pilot

- 27 Transitions in 16 months; our goal was 16.
- Readmission rate: 2 of 27 had a readmission.
- ER Visits: 9 of 27 patients had an ER visit in the first 30 days after discharge. 2 of those 9 became the readmission patients.
- The average number of days from referral to discharge was three (3).
- Average patient participation was 72 days.
- LACE+ Score (scores explained at https://www.besler.com/lace-risk-score/):
  - Low Risk (green zone): 22%
  - Moderate Risk (yellow zone): 39%
  - High Risk (red zone): 39%

Statistics from Program

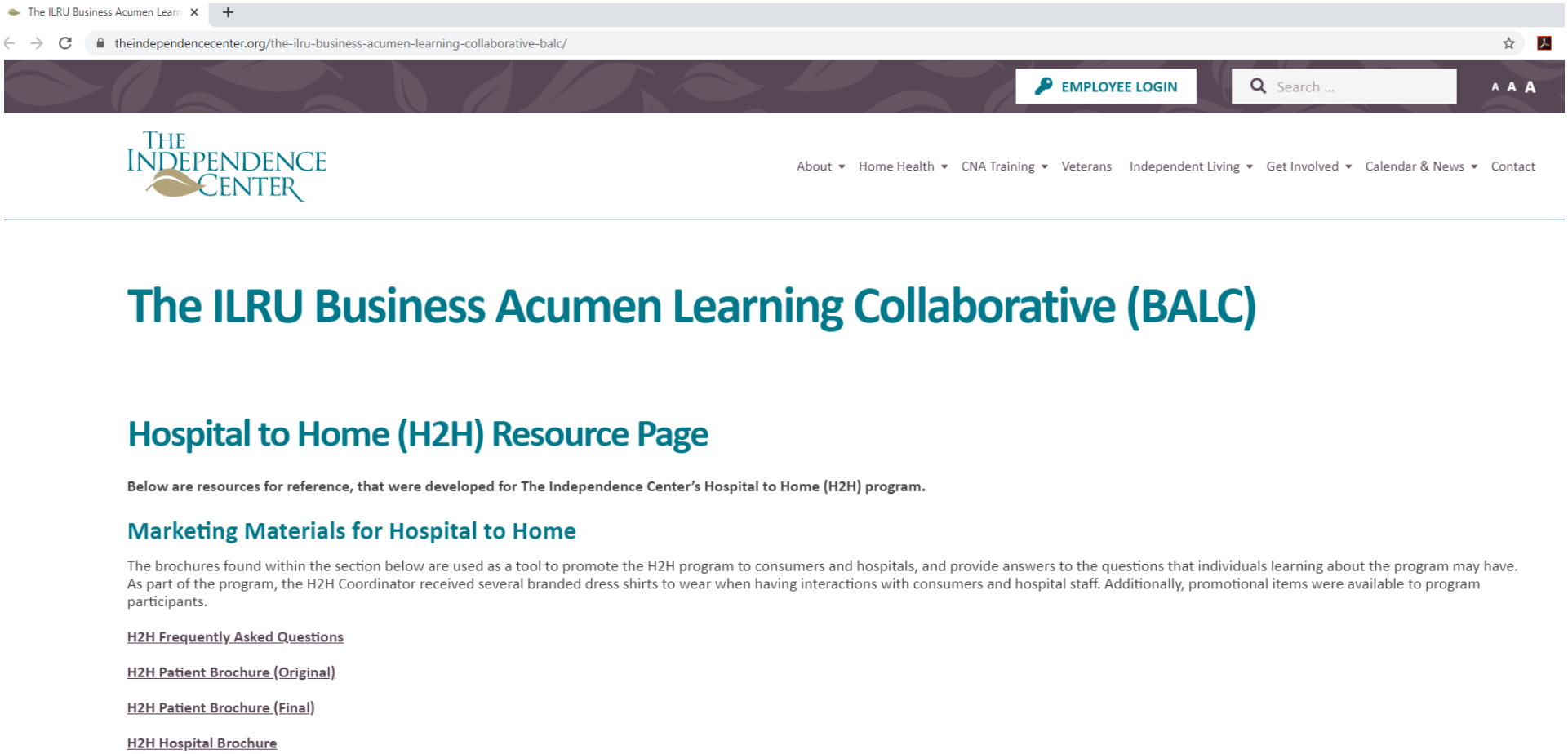
- 33 Transitions in 9 months.
- Readmission rate: 2 of 33 had a readmission.
- ER Visits: 3 of 33 patients had an ER visit in the first 30 days after discharge. 2 of those 3 became the readmission patients.
- Average patient participation was 70 days.
- LACE+ Score:
  - Low Risk (green zone): 12%
  - Moderate Risk (yellow zone): 63%
  - High Risk (red zone): 25%

Lessons Learned

- Substance abuse
- Unable to serve homeless population.
- Costs were not as high as originally expected.
- More family and community support, the less services and case management needed.
- Language barrier

Resource Website

https://www.theindependencecenter.org/the-ilru-business-acumen-learning-collaborative-balc/



Questions & Discussion

Final Questions and Evaluation Survey

Any final questions?

Directly following the webinar, you will see a short evaluation survey to complete on your screen. We appreciate your feedback!

https://usu.co1.qualtrics.com/jfe/form/SV_bebMplhaMsgIdr7

ILRU's IL-NET Attribution

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