>>Slide 1

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 II

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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

Quick Summary of Webinar 1

- Planning process — concept of the program and vision
  - Program design
  - Funding
  - Financial analysis
- Building a relationship/partnership with the hospital
  - Internal champion
  - Finding pain points and helping to alleviate them

The part 1 webinar is available on-demand on the ILRU website at https://www.ilru.org/training-on-demand

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.

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

Building a Relationship with the Hospital

- Building relationships with the hospital case managers and social workers
  - Contract employee have access to electronic medical records (EMR) system and physical desk
  - In-services
  - Attend weekly meeting
- This relationship with hospital staff directly effects the referrals received as they become the source.
  - Without referrals, the program does not expand.

Referral and Eligibility

- Referral is received from hospital staff – call or email.
- Review the electronic file about patient.
  - Review therapy and doctors' notes to see what services are needed after discharge.
  - Determine when discharge will be.
- Discuss with our internal team about the case – do we have the resources and skills to successfully transition this patient home safely?
  - If no, then recommend other community options (if there are any).
  - If yes, then continue with the process.

Partner with Hospital Staff, Patient, and Family

- Create a plan.
  - With hospital staff about recommendations for services to be put in place and timelines.
  - Meet with patient and family to discuss what they need.
    - Assessment tool for daily living tasks needed to help determine services.
    - What does the patient believe they need to be successful?
- Offer to do a home visit prior to discharge to assist with DME and other needs around the home – check for safety and any accessibility barriers
- Have the patient sign any forms that are needed (release of information, care plan, or any waivers).

H2H Assessment

- Activities of daily living (ADLs)
- Family and community support
- Home environment for safety and accessibility
- Benefits
- Barriers to discharge

Set up Services

- Based on the plan created with hospital staff, patient, and family:
  - Contact any agency that is needed to fulfill the services the patient needs.
  - Keep in mind funding and cost for the services – do you have enough to cover 60 days post discharge?
- Ensure that services begin at discharge.
- Go to the patient's home to deliver any DME needed and check for safety and access issues
- Does the plan cover all needs?
  - Adjust as needed.

Case Management for Transitions

- 60 days of case management post discharge
  - Continue to follow services and adjust them as needed.
  - Some services may need to increase or decrease to meet the needs of the patient.
- Do weekly check ins for the first 30 days.
  - Monitor for readmissions or ER visits.
  - Monitor that services are going well.
- Continue to check in until day 60.
  - Adjust frequency to match the needs of the transition.
- Continue to monitor cost.
  - Check invoices when they are received.
  - Ensure all partner agencies know when the last day of service is.

Streamlining the Process – Pilot to Program

- Assessment tools changed – started with over documenting to finding the right amount of information needed.
- Created a database to hold all information…

  …instead of tracking data in multiple places (i.e. Word document or Excel).
- PDF files created for all client documents.
  - Avoids extra paperwork to scan.
  - Patient gets a paper copy, and The IC has the electronic version.
- Access to the EMR system from the hospital from The IC laptop

Marketing the Program

- Collaborated with Marketing to create different tools
  - Process map for hospital staff
  - Brochure (2) – one for patients/families and one for the hospital staff
  - Created folders to give to all patients and families that explains about The IC.
    - Information about the agency and all programs that are offered beyond H2H
- Collection of stories to use for a newsletter
  - Local Business Journal and UCHealth story
  - https://www.uchealth.org/today/hospital-to-home-program-helps-patients-return-home/

Data Collection

- Knowing what data to collect – based on hospital pain points
  - Basic demographics (age, gender, reason for hospitalization)
  - LACE+ scores
  - ADLs (initial, 30 & 60 day)
  - Services used
  - Number of days from referral to discharge
  - Confidence & anxiety (patient & family) – *for pilot only*
  - Readmissions & ER visits
  - Per patient costs
  - Satisfaction surveys (patient, family & hospital)

Evaluation

- The data collected needs to match the pain points determined for the hospital to continue to show success.
  - We show success by lowering readmissions and ER visits, along with shortening length of stay as those are UCHealth's pain points.
- Using evaluations from hospital staff, patients, and families also can show success and ways to improve the program.

Cost Analysis

- Determining cost per patient
  - Collecting data on cost per patient
    - Services utilized, insurance or not, and complexity of patient
    - This is important to understand and learn with each patient as these items can help predict cost for future patients.
    - Average 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.)
- Track program cost – salaries, benefits, equipment, supplies, etc.

Administrative

- Annual lump sum contract
  - Receive invoices from partners.
  - Bill hospital monthly based on actual cost.
  - Report based on active patients and services they are receiving.

Success Stories – Consumer 1

- Seizure and fall at home
  - In the hospital for 17 days
- Services utilized:
  - Benefit support
  - Meals
  - Transportation
  - Skilled and unskilled care
  - Home modifications
  - DME
  - Community resources
- Without H2H, predicted that he would be in a facility at age 59.

Success Stories – Consumer 2

- Toxic shock and became a triple amputee
  - In the hospital for 95 days
  - In rehabilitation for 31 days
- Services utilized:
  - Benefit support
  - Transportation
  - Skilled therapy
  - Home modifications and applications for grant funding
  - DME
- Without H2H, it's unknown where she would be because many facilities would not accept someone age 38, and she originally had no funding source.

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

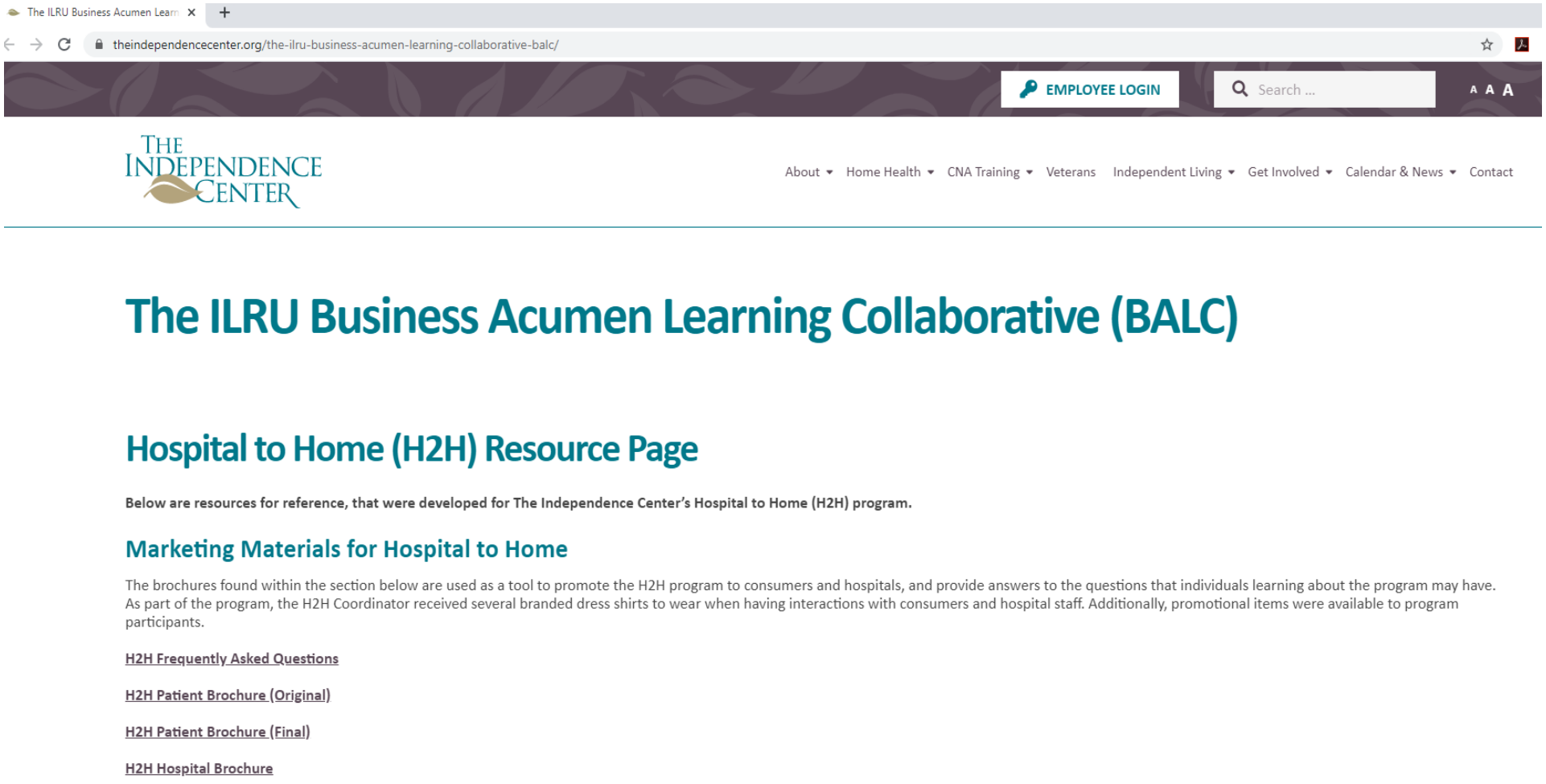
- 33 Transitions in 9 months.
- Readmission rate: 2 of 33 had a readmission.
- ER Visits: 3 of 33 patients had an ER visit in the first 30 days after discharge. 2 of those 3 became the readmission patients.
- Average patient participation was 70 days.
- LACE+ Score:
  - Low Risk (green zone): 12%
  - 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_bCvrUMn0xDPZ58V

ILRU's IL-NET Attribution

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