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

Independent Living Research Utilization

www.ilru.org
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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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/](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/

The IRLU Business Acumen Learning Collaborative (BALC)

Hospital to Home (H2H) Resource Page

Below are resources for reference, that were developed for The Independence Center’s Hospital to Home (H2H) program.

Marketing Materials for Hospital to Home

The brochures found within the section below are used as a tool to promote the H2H program to consumers and hospitals, and provide answers to the questions that individuals learning about the program may have.

As part of the program, the H2H Coordinator received several branded dress shirts to wear when having interactions with consumers and hospital staff. Additionally, promotional items were available to program participants.

- H2H Frequently Asked Questions
- H2H Patient Brochure (Original)
- H2H Patient Brochure (Final)
- H2H Hospital Brochure
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_bebMplh aMsgldr7
ILRU’s IL-NET Attribution

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