Hospital to Home: A Collaborative Between Community Partners Part II

Presenters:
Indy Frazee
Mandi Strantz
Patricia Yeager
Joe Foecking

June 17, 2020
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.

- Joe Foecking – joseph.foecking@uchealth.org
- Indy Frazee – ifrazee@theindependencecenter.org
- Mandi Strantz – astrantz@theindependencecenter.org
- Patricia Yeager – pyeager@theindependencecenter.org
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/

The ILRU 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_bCvrUMn0xDPZ58V
ILRU’s IL-NET Attribution

The IL-NET is supported by grant numbers 90ILTA0001 and 90ISTA0001 from the U.S. Administration for Community Living, Department of Health and Human Services, Washington, D.C. 20201. Grantees undertaking projects under government sponsorship are encouraged to express freely their findings and conclusions. Points of view or opinions do not, therefore, necessarily represent official Administration for Community Living policy.