Bridging Traditional Long Term Services and Supports

With New Models of Value-Based Care

September 1, 2015

HCBS
National Home & Community Based Services
CONFERENCE

Using Community Care Coordination and Mobile Technology to Impact Health Outcomes and Reduce Avoidable Hospital Encounters

Care at Hand

THE COORDINATING CENTER
INSPIRED SOLUTIONS

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The Mission

To partner with people of all ages and abilities and those who support them in the community to achieve their aspirations for independence, health and meaningful community life

The Coordinating Center

Our Care Transitions Approach

- Hospital to Home
- Hospital to SNF/Acute Rehab.

- Goals:

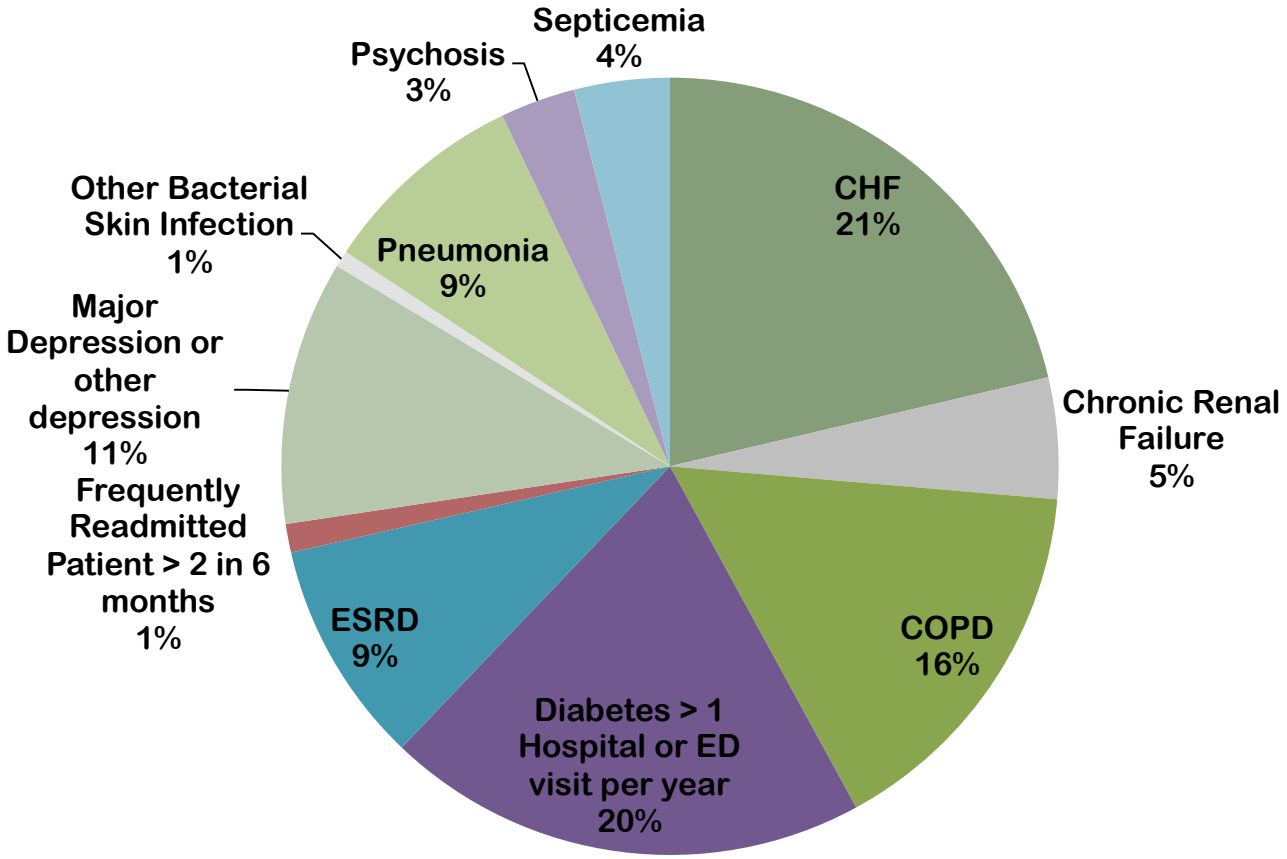
  - To reduce hospital readmissions and other avoidable hospital encounters

  - To build partnerships to positively impact health

  - To provide effective person-centered services

The Coordinating Center

Target Population and Conditions



Total Served 5,471

Geographical Area of Focus - West Baltimore

Community Demographics

	Southwest Baltimore	Baltimore City	Maryland
Unemployment	43%	34%	23%
Median HH Income	$23,070	$30,078	$56,250
Infant Mortality Rate (per 1,000 live births)	18.0	11.7	7.9
Life Expectancy	64.2	70.9	77.5

Sources: U.S Census Bureau, Maryland Department of Planning, Maryland Department of Health and Mental Hygiene, Baltimore City Health Department

Mortality Rate Comparison (per 10,000)

	Southwest Baltimore	Baltimore City	Maryland
Heart Disease	39.1	28.9	21.9
Cancer	27.7	23.4	19.2
HIV/AIDS	9.8	5.2	0.96
Stroke	6.5	5.8	4.9
Diabetes	5.8	3.6	2.6
Chronic Lower Respiratory Disease	4.9	3.9	4.0

CLRD includes COPD, emphysema, bronchitis, and asthma.

Sources: U.S Census Bureau, Maryland Department of Planning, Maryland Department of Health and Mental Hygiene, Baltimore City Health Department

Staffing Composition

- **Program Director**
- Hospital Liaisons
- **Scheduler**
- RN Care Coordinator
- **Health/Transition Coaches**

* **Ancillary Staff**

Finance

Quality

The Hub Model

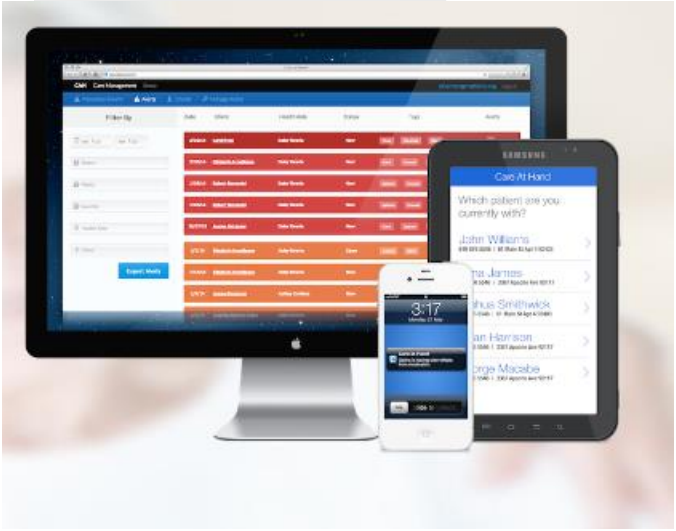
Intervention

- **30 day Intervention based on the Coleman Model with a modified BOOST Model incorporated**
- Liaison in each hospital to identify high risk population and enroll
- **Pre-discharge visit and personal goal**
- Post-discharge visit within 3 days
  - Emphasis on physician follow up within 7-14 days
  - Emphasis on Red Flags (early symptoms)
  - Medication review
  - Personal health record
  - CAH – Care at Hand Survey
- **3 follow up phone calls (and CAH Survey)**
- Tier 2 Option

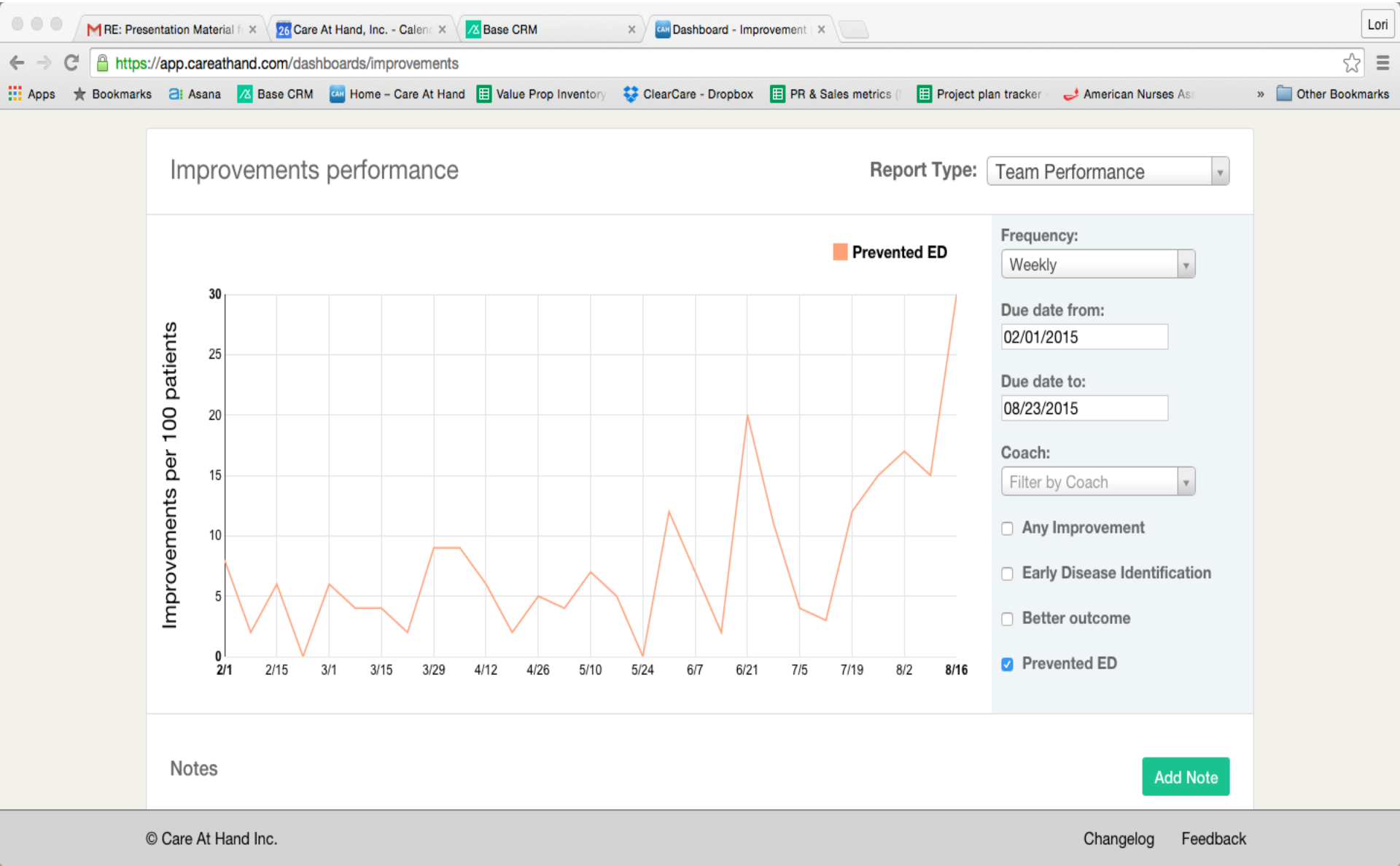
Care at Hand

Mobile Technology

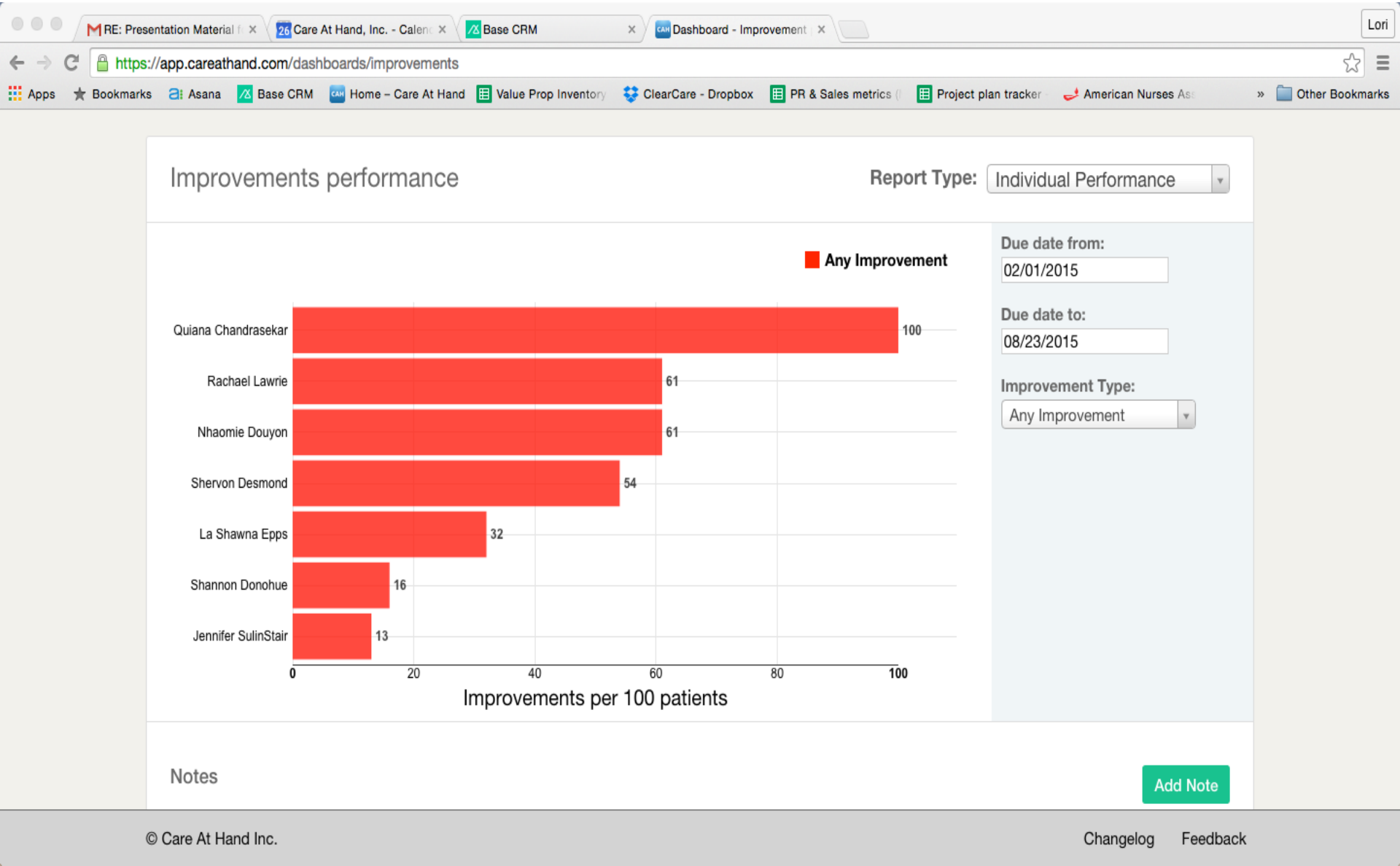
- **Community Coaches survey person at each encounter**
- Survey questions are based on the person's active issue(s)
- **Risk alerts of early health decline are sent to RN Care Coordinator**
- Deployment of clinical staff as needed, driven by data
- **Creation of dashboards for trending and performance**



CAH Measures - Prevented ED visits



Improvement Performance – by Coach



ROI – Return on Investment

- **Financial Impact**

  - Money saved by reducing hospital encounters

  - Cost-savings on staffing configurations

- **Partnership Impact**

  - Hospitals, providers of care

  - Community-based organizations

  - Technology providers

- **Educational Impact**

  - Health disparities

  - In the hospital, in the community

- **Personal Impact**

  - personal empowerment

  - self-management skills

  - strategies for long term

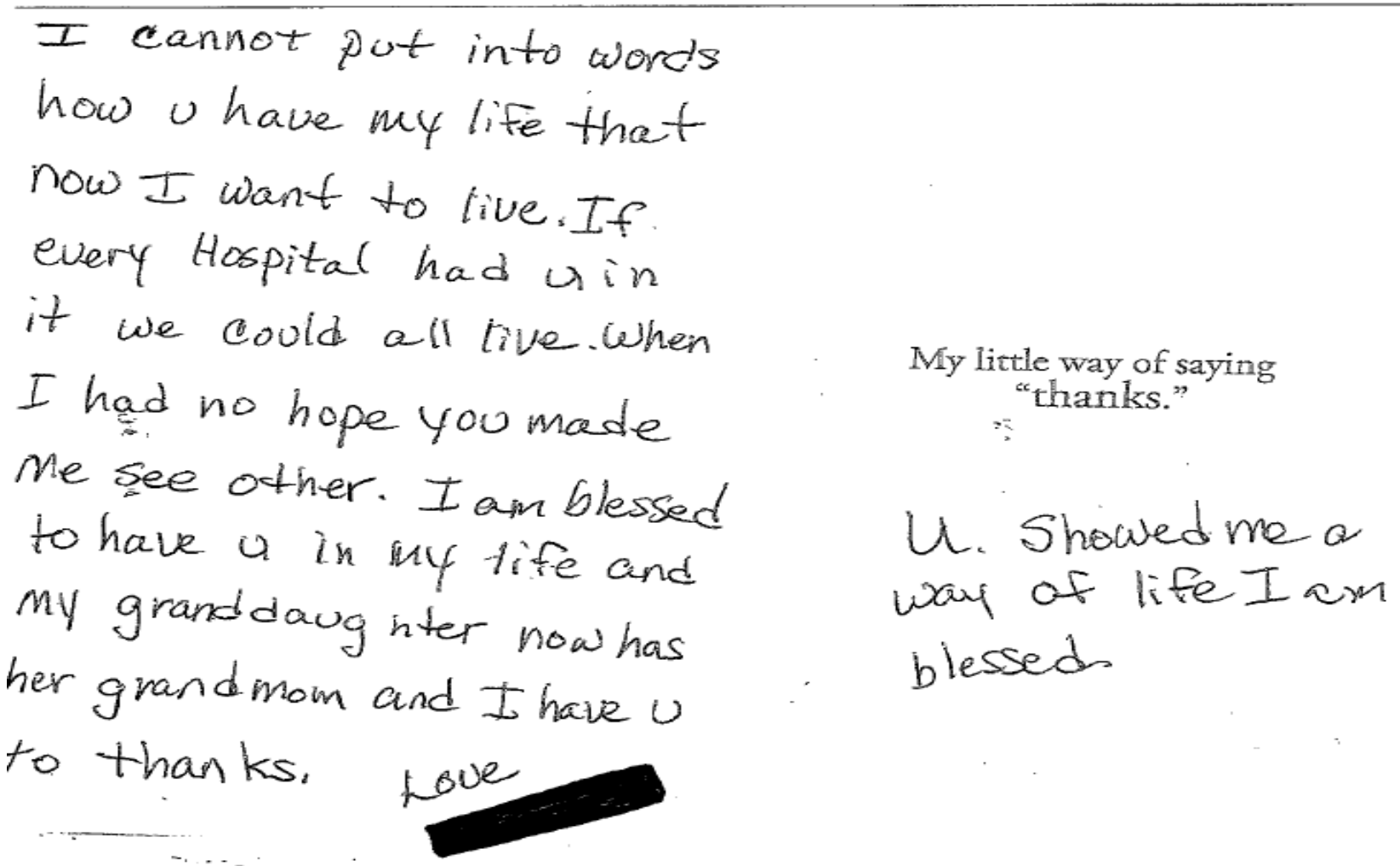
Mrs. Smith's Story
. . . and the Four Pillars

Personal Goal: Keeping her medication readily available and be well enough to go back to work as a cook.

Follow up Apt: Did not have PCP. Missed first apt. at community clinic, next available was one month later. Coach found an alternate clinic to take her sooner.

Medications: Trouble with transportation to pharmacy. In problem solving, coach found local pharmacy that delivered.

In her own words . . .



I cannot put into words how u have my life that now I want to live. If every Hospital had u in it we could all live. When I had no hope you made me see other. I am blessed to have u in my life and my granddaughter now has her grandmom and I have u to thanks.

Love [redacted]

My little way of saying "thanks."

U. Showed me a way of life I am blessed.

For questions or more info:

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