IL‑NET National Training & Technical Assistance Center for Independent Living

**Hospital to Home: A Collaborative Between Community Partners ‑ Part One**

June 10, 2020

>> TIM FUCHS: Welcome. Good afternoon, everybody. I'm Tim Fuchs with the National Council On Independent Living and I want to welcome you all to today's webinar, Hospital to Home: A Collaborative Between Community Partners.

So, before we get started today I wanted to go through some housekeeping items and accessibility information. Of course, as you expect, captions are available today. There's a couple ways to access them. You can turn them on in Zoom if you haven't already.

So ‑‑ in your More options or right there on the your menu bar under closed caption, you can select show subtitle. Zoom recently allowed ‑‑ or offered some new options.

You can actually enlarge your font and change some other aspects of the captioning that you weren't able to do. So that's nice.

There are still some limitations to how big you can make it and you can't control the contrast. So we are still offering simulcast captions at Streamtext.net. That URL is a little too long to read out. Most of you are familiar with it and we sent it to you in the confirmation email. I'll put it in the chat when I am done with the introductions.

If you do want a larger font captions, you want the full‑screen captions, you're welcome to use that. That also includes a chat feature. So that Streamtext link there is a chat feature there. I'm logged in. You are welcome to use that during the Q&A breaks a if that's easier for you. You can submit questions there. I will be happy to voice them during the Q&A break.

This is set up as a webinar right now. All of you are muted but we have a lot of time for questions today. We want to encourage you all to ask questions. We've got two Q&A breaks, one on, I think it's slide 24, and one at the end on slide 32. So we've got plenty of time to take your questions, and here are the ways you can submit them.

We have a Q&A tab right there in Zoom. If you are able to access that feature, we would like to ask you to use that. It makes it easier to moderate the questions and get through them efficiently, but if that feature is not accessible for any reason, we have a number of other options you are welcome to use.

First is that Streamtext chat I just mentioned. If you want to type your question there I will be happy to invoice it for you. You can email me at tim@ncil.org.

Maybe you're on the phone and looking at a printed copy of the PowerPoint. If you can access email, you can submit your questions that way and I will voice them for you.

If you are on the phone and unable to access those other options you can press \*9 to raise your hand. I would like to save that as an accommodation for folks that need.

Reason being we have a big audience today. We already have 150 people connected and I know that number will grow. I have to go through the list of participants to see who on the phone has raised their hand and unmute their line. I'm more than happy to do that, but if everyone does that, it can be a little too much to keep up with.

So thanks for your cooperation there.

Finally, there is an evaluation for today's webinar, and it's ‑‑ there is an evaluation for each of the webinars in this two‑part series. We want you to fill out an eval for each one.

We put a lot of work into reviewing those evaluations and we do take them seriously and use that information when we talk about the webinars that we offer and how to improve them. So it's a short evaluation. When you close the webinar today it will actually pop up on your screen. So it couldn't be easier. If you really don't have time to fill it out, the eval link was also included in the confirmation email.

But if you're like me, if you don't do it at the end of the webinar, you're probably not going to go back and hunt down that confirmation email so please say a moment to tell us what you thought of the presentation after today's webinar.

I have had the [Inaudible] you are working with all the presenters today on some other programs we've had and I am thrilled and have 100 for some time to invite them to do one of the IL‑NET webinars.

So we have Indy Frazee, the home health administrator for The Independence Center in Colorado Springs. Mandi Strantz, the care transition coordinator. Patricia Yeager who, of course, is Executive Director of the Independence Center, and Joe Foecking, director of rehab for UCHealth southern region.

I first learned about the Hospital to Home Program through the business acumen learning collaborative we have been doing through the IL‑NET over the past year and I was out in Colorado Springs when these same folks did that presentation for that group and I was excited to hear about it as were a number of people in the room.

In fact a number of people in that group have tried to replicate this program in their area and we thought this is really something that centers should know about and there's been a lot of buzz about it. So I am so happy we are doing this. And I'm going to actual ‑‑ I need to catch up on my slides here.

Here on slide 3, everyone has been generous enough to share their contact information.

I wanted to go over these learning objectives quickly on slide 4 before I turn it over to Patricia to start the presentation.

Strategies for partnering with healthcare 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 to their homes and communities.

And strategies for setting up community networks to provide support services after discharge from hospital stay.

Today's call as you saw in the announcement is really an overview.

So we're going to give you a broad sense of what this program looks like so you can understand what it does, how the relationship works, and then Part II next week we're going to drill down for those of you that are interested in how do I do this, how do I replicate this?

So that's the division between Part One and Part Two.

For now though I'm going to go to slide 5 and turn it over to Patricia for our overview of the Independence Center. Patricia?

>> PATRICIA YEAGER: Thanks, Tim.

Good afternoon, everyone.

We are thrilled to be here and talking about this program.

We're biased.

It's a great program.

Let me tell you about The Independence Center.

You can see our mission is working with individuals, their families and the community.

We create independence so that all may thrive.

We were founded in 1987 by a woman who was ‑‑ became a quadriplegic and wanted to stay out of the nursing home and started our home health program in are Medicaid.

In 1994 we became one of the nine Centers for Independent Living in Colorado.

We serve people in the PIKES peak region.

We serve people in six counties through our CIL services and Holt services are provided in an additional 11 counties, all in southern Colorado.

We call ourselves the local home of civil rights for people with disabilities.

Take it away, Joe.

>> JOE FOECKING: So ‑‑ hold on.

There we go.

Sorry about that.

Thanks for joining us today, everyone.

I'm Joe, director of rehab for UCHealth in the southern Colorado region.

You can see the mission of UCHealth.

Just in terms of simplicity, we improve lives.

That's what we strive to do and you can see the ways we do that.

When you put together the mission of UCHealth and the mission of the Independence Center there's a lot of synergy right off the bat.

In terms of our staffed beds in the City of Colorado Springs we have three hospitals and there's 555 staffed beds across there.

We also have a critical access hospital in woodland park.

Memorial central is a level 1 trauma Center.

We're also a comprehensive stroke Center, and really our catchment area includes all of southern Colorado, northern New Mexico as well as western Kansas.

So in terms of the population or the patients we're seeing, they come from a very large, diverse geographic area with a multitude of different problems.

As you can see, we have 187,000 ER visits in fiscal year 2019.

That makes us the second busiest ED in the state of Colorado.

In regards to inpatient admissions we're just over 44,000.

I give you that information or those demographics so you can understand, really, the scope and size and scale of what we're looking at in terms of patient population.

>> INDY FRAZEE: Good afternoon.

I'm Indy Frazee with The Independence Center.

I'm going to give you a brief overview of the Hospital to Home Program.

What occurred is The Independence Center and the UCHealth collaborated and ‑‑ to become successful ‑‑ help individuals become successful in transitioning back to their homes.

Instead of a skilled nursing facility.

We work specifically with complex or difficult discharges.

Through the hospital to home, we provide support services and address also the social determinants.

So you'll learn later that Mandi works with the hospital and the patient and the patient's family, if involved, to determine what the barrier is to get home from the hospital.

We'll talk a little bit more about how we assess the services, how we determine what services to build our network, how we coordinate with the hospital, the patient and the family, and also just the community‑based organizations that we work with.

We've also incorporated some of our CIL core services during the transition to help with the individual that's being sent home.

>> PATRICIA YEAGER: How did we get started with this?

Our community health foundation, the Colorado Health Foundation, invited us to participate in what they call the linkage lab program.

People in California will know this from the scan foundation.

We spent 18 months, both Indy and I and our former Director of Independent Living, who recently retired, and our ‑‑ who else did we have?

Our home health administrator.

Indy was the CFO at the time.

And we spent 18 months learning about business acumen and figuring out what kind of program could we provide?

Where was there a gap?

We'll talk more about this.

You're going to hear me say this several times.

Repetition is a good thing.

During that 18 months we had to create the plan for the ‑‑ for this service, and we had to start from what happens when we walk into the patient's room all the way to when we get them to home and when they're no longer needing our services.

You have to plan who, what, when, where, how long and with ‑‑ and who with.

What were the other services that might be needed that we couldn't provide?

You have to have all those details written down, put in a spreadsheet, figuring out the timelines in order to be able to make sure you have everything and be able to negotiate the price later on of how much money you need to charge or need to ‑‑ need from your customer.

So you create a detailed picture of the process.

The first question we ask is: what does the end result look like?

Then you work backwards to fill in the blanks.

We'll talk a little bit about the end result was we really wanted people to not go to nursing homes, particularly people with disabilities, to not go to nursing homes, but to go home and heal at home.

So you work that from goal, you work backwards to fill in the blank.

One important component is to consider the risk and plan for them.

What if somebody has a heart attack or gets sick at home?

What will you do?

What patients could you not take?

Think about ‑‑ address all of those up front so that you can make a plan and be ready for whatever happens.

One concept we started with was that we ‑‑ that service coordination and IL

Independent Living Services staff are different.

The IL staff are trained not to leap in and overserve or overhelp the consumer.

We wait for the consumer to come to us and we don't work any harder than the consumer, because it's consumer controlled and directed.

But when you are doing ‑‑ coming out of a hospital, generally the family member and the patient, our consumer, they're in a crisis situation and they're really needing more support than perhaps an IL skills specialist might provide.

So we decided not to mix those two.

I think ‑‑ we do use other IL staff, benefits, peer support.

We do not use our IL skills.

It's too confusing to go from loss of support to only support you need.

One of the thing we had to learn, we had to learn a whole new language to speak to the hospital.

One of the terms is pain points.

What is the hospital's pain point?

What gap do they face around serving people with disabilities?

And you'll hear more about that as we go through this.

Let's go back and look at the planning process.

How did we start this?

We didn't go to the linkage lab with this situation in mind, this gap.

So we identified a gap in the community, and how we did that, serendipity, our transition staff said to me, you know, we have a lot of people in nursing homes that shouldn't be there.

You know, they're diabetics and they need support on food or have mental health issues and need support on med monitors.

Why are they in there?

I'm thinking, yeah, how do we divert that?

Because the hospitals have discharge planners need to get those people out quickly and safely, and that means the nursing home, if family are not vigilant or even present.

So we identified that as a gap for people with disabilities, keeping them out of the nursing home to begin with instead of having to take them out later at a cost from the state.

So we wondered, can we disrupt that process of people going to the nursing home?

That was our central question.

So how did they get there?

How did they get to the nursing home?

Well, they get referred by the hospital case managers.

So that meant we needed to go and talk to the hospital.

We put out a call in our network looking for a potential board member who was staff at Memorial to come and work with us, and that's how Joe has ended up in our orbit, we ended up in his orbit, for the last six years putting this together, and it's been a delightful experience.

So we talked with Joe quite a bit about the services, what services we're good at and what were the pain points that they had.

We know that the IC is good with home health.

We've done home health services, both skilled and Medicaid, for 30 years or more.

And we're also good at dealing with social determinants of health, an AT person, assistive technology person on staff, employment person on staff, peer support.

So we have a lot of staff that can deal with social determinants of health.

The question is, did we have the skill to effect a change in the hospital?

That's one question.

And the big question that I walked around for 18 months with was who would pay for this service?

Yes, we're going to provide it to the hospital, but the hospital really ‑‑ they don't get dinged if they send too many people to the nursing home.

So what's in it for the hospital?

Who would pay?

The hospital ‑‑ I always think Worker's Comp might pay to have this happen.

So we're always looking for new customers to pay for the beneficiaries to use our services.

>> JOE FOECKING: If I could just interject there, to expound on some of those pain points, if you look at what the hospital is experiencing, and gave you those statistics in the first slide for a reason, what we end up seeing in the hospital is we have a number of people come in through the emergency department.

So as they go through the emergency department, we identify do they need intensive care unit, acute care?

What are their needs and what level of care are they best in?

What we quickly realized in Colorado Springs was we did not have any acute care beds.

We had a full hospital.

And so now one of the first terms that we introduced was through put.

That we were having issues with through put in terms of taking a person from ED into the acute care and discharging them.

In order to free up the hospital bed, Patricia makes a great comment, yes, we need to free up that hospital bed and maybe we're moving that person to a nursing facility because there may not be any other level of care for that individual.

So we're very conscious of through put, keeping acute care beds open.

We're also very conscious of readmission and what would readmission look like.

And soap when you consider partnering with that hospital, really understand, as Patricia points out, their pain point?

What is their through put?

Are 30 full or exceeding compassion tea?

Just things to keep in the back of your head.

>> INDY FRAZEE: Thanks, Joe.

I think it highlights, the comment you just made, it is extremely important.

That's one every our lessons learned, is finding an internal champion in the hospital.

As Patricia mentioned, we kind of scanned our network and Joe fell into our orbit, but it's finding ‑‑ and Joe is an administrator in the UCHealth system.

So it's even the level of engagement that you need to find that makes it very important in this Partnership that we have with UCHealth.

We also needed to determine who in the hospital was going to be making these decisions.

Joe was really helpful on that end as well because, again, we weren't familiar, necessarily, with how the hospital system was working, and so he helped us kind of identify and championed internally for us all the way up to the chain that we needed to go.

It's interesting, we have another large hospital system here in town, and we've been trying to get our foot in the door with them, and they're learning a different culture.

They have a completely different culture than UCHealth.

So, again, trying to find that internal champion.

We have not found one yet.

I think that's been on our challenge there.

So I want to highlight how important it is to know someone within the hospital system that can help you ‑‑ help find those people to make decisions and sell the program internally.

Joe, did you have anything to add on that?

>> JOE FOECKING: Yeah, when you look at that internal champion, a go‑to in my mind would be a director of care management or case management or a director of social work.

Those really are going to be an excellent contact.

As director of rehab I'm a physical therapist by background and so immediately when the Independence Center came on my radar screen I thought, wonderful, this is an outstanding organization because this aligns with exactly what I grew up with in terms of education and training, in terms of promoting independence, fostering independence, and getting people back home and back to the community.

So that to me was a great synergy and a great way in where we could partner.

But I do know as we progressed through that program we brought in care management, we brought in case management and social work, we ended up having many meetings with the chief financial officer, the Chief Executive Officer to really explain the synergies that we had, the things that we had in common, and how this community Partnership could really impact not only The Independence Center, not only UCHealth, but really the community of Colorado Springs.

>> INDY FRAZEE: So, Patricia mentioned a little about determining pain points.

It's really crucial as pointed out to understand what those pain points are and how to communicate how your program is going to help to eliminate those pain points, or at least lessen those pain points.

That speaks to also the language for those of you who might not work with hospitals very frequently, they have their own set of language just like here at the Independence Center we have our own set of language and acronyms.

So understanding those pain points and speaking to them in their language is really helpful.

How did we determine those?

As Joe mentioned, wield a lot of meetings.

We had several meetings with several different teams within UCHealth just trying to gain some understanding as to what was that, and as Joe mentioned earlier, that throughput was totally new to us until they introduced us to that concept and what their pain point was.

Why don't that we go to the next slide.

Joe's already talked a little about this, but this is our hospital, or UCHealth memorial's pain points.

We are looking to reduce the length of stay for complex discharges.

So that speaks to the throughput.

We're trying to identify individuals who have barriers to discharge to go home.

They're medically ready but for whatever ‑‑ they have the need to get out is in their way and so that's where hospital to home comes in and works with individuals to get them home and decrease that length of stay.

Most of you, I'm assuming, are familiar with that hospitals are dinged when an individual is readmitted within the first 30 days, and so we also ‑‑ our Hospital to Home Program actually works with the patient for up to 60 days after discharge, but we're really focused on that first 30 days and helping the individuals stay out of the hospital, unnecessary ER visits, owe readmissions.

And then the third is really a desire for better outcomes for our patients and proving to UCHealth that this Hospital to Home Program allows the patient to heal at home and be surrounded by those medical and social supports, and how we describe it to the hospital is that we're expanding their mission outside of their walls.

Those were the pain points that we had identified.

Joe, was there anything else you wanted to add to that?

>> JOE FOECKING: Yes, we just ask folks, consider when an individual is admitted to the hospital all of the different pieces, parts that are going into that individual's stay.

By that I mean, if an individual comes in through the ED, in that ED we need to identify if they can return back to the community or not.

If they can't, then they're entering into what we would consider acute care services.

If they have the good fortune of being able to be discharged back home, that's outstanding.

If they don't, now we're talking about post acute care services which could be an inpatient rehab setting, skimmed faux nursing setting or simply a nursing home.

Yes, they could go home with home health.

There are considerations there.

I believe all hospitals, especially UCHealth, do an excellent job at the medical piece of what we're doing.

Really what I found with this hospital to home is this has been an excellent bridge that allows us to focus on that medical care and then have the patient or the consumer return back to the community and have their needs related to social determinants of health met, and when we’re doing that, we're noticing that's reducing our readmission rate.

Again I talked about throughput.

When we have people we're holding in the ED, meaning we don't have be a acute care bed for them, we're not providing the best care we can.

That's not where they belong, in the ED.

We need to get them up to the acute care floor.

But we can't if we can't free up a bed.

So while we might have cured them medically or helped them medically, if we can't get them back out to the community because of steps they can't get up or they don't have flooring in their home, that's where we need to fill in that gap and understand, yes, we can get you back to the community.

It's not a medical need that's preventing you from going back there.

It's really more of the social determinant of health need.

The other thing I would ask folks to consider is how is the hospital potentially being paid?

Typically the hospital is paid through a DRG or diagnostic related group.

So we're very focused on keeping our length of stay low.

If you are getting a flat rate for a certain amount of money, you get that same flat rate, that certain amount of money, regardless of whether you keep the patient two days or 20 days.

So there is a tipping point in terms of that hospital stay where we want to know, we've done everything for you medically, but now we can move you through that continuum of care.

We can go to slide 13.

>> PATRICIA YEAGER: Let me interject a store he.

When I first met Joe they had what's called a complex patient, had been in the hospital for eight months.

And they did not know where ‑‑ how ‑‑ what were they going to do with him for a safe discharge.

No nursing home would take him.

Now, at roughly $2,000 a day times eight months, they have pretty much funded the whole program right there.

That was a huge selling point for all of ‑‑ for us to be able to say, we know these people.

We deal with them all the time.

We know disabilities, we know how to make this work, and that person got out and was much happier outside than spending eight months in a hospital bed.

>> JOE FOECKING: Very true.

>> PATRICIA YEAGER: Yes.

This next one is mine.

You can see I'm the person that's promoting program design because if you don't have a clear program, I'm about to make the statement the third time, you will not ‑‑ you won't be successful.

You'll be floundering in this ‑‑ in your business.

Because this really becomes a business.

You're providing a service to the customer, who is the hospital, or the beneficiary, who is the patient or consumer as we would say.

Work your way backwards.

What is your outcome?

What services do you need to get to that outcome?

We sat down for several ‑‑ we met every week, Wednesdays after director's meeting, we met for an hour at least, and we mapped out, okay, if a patient comes home, how are we going to get them home?

What do we need to get when they go home, medication, DME, the first two weeks we figure there is going to be medical ‑‑ more medical services than social services.

And then as we plan this out over 60 to 90 days, what we thought might happen for an ‑‑ a patient who is ‑‑ may have lots of support and not so much need and a patient who has no support, no insurance, and a lot of needs.

We figured out what services might be needed, who is going to provide those services, how many hours day daily, monthly, and what will the cost of all those hours be so that we could make a range of someone who doesn't have a lot of needs, is a low‑cost patient, so to speak, and someone who has a lot of needs, and so we could see the range of costs.

It also identified for us our partners because we don't provide all the services that are ‑‑ that you will hear about as we go through this.

We also sat and did a flowchart of what happened from the day that the case manager who we did not have on staff at the time, the service coordinator, what happens when he or she walks in all the way home and the service coordinator walking out the door for the last time.

We had to plot all of that out, and it was very helpful to do it.

If you put time into it at the beginning, it will really help you as you move it through ‑‑ we did a pilot to see if we could make this work, and it was very helpful as Mandi will talk about.

And we also talked about what will the process be for the staff of the hospital to tell us that they have a patient.

You'll again hear from us how that happens.

Very critical.

We found to have our staff person embedded at the hospital really made a huge difference in he people remembering her, remembering what we do, and her roaming the halls looking for people to serve or hear about it from the social workers or the discharge planners.

The more detail you have, the more you're able to figure out your costs, because it's ‑‑ you know, you talk about people who don't have insurance and need home health.

They're not on Medicaid.

You have to figure out what that cost is going to be and we will talk about how we pay for that as we go forward.

Next slide.

Risks.

We all slept better at night knowing that we figured out at the beginning ‑‑ we didn't think we could take someone who was on a ventilator.

We did not believe that we could take on, and we still don't, someone who is homeless with no home to go to.

That population is very difficult, and it is a pain point for the hospital.

We talked about what happens if one of our service providers failed to deliver?

So we are not a Medicare provider, we're a Medicaid home health provider.

But our ‑‑ many of our clients need ‑‑ consumers need Medicare providers.

So we have contract with Medicare agencies in town, and when one of them didn't show up as happened, we had to scramble and find another ‑‑ a backup.

So if you can think those risks through and where things might fall apart, what if there's a medical emergency in the home, how would you handle that?

You are dealing with people's lives here.

And so all the preplanning and thinking through that you can do is extremely important.

>> MANDI STRANTZ: I'm the care transition coordinator.

I meet with the families and kind of coordinate everything after we get a referral from the hospital.

So to continue from what Patricia was staying with the program design, after we determined what our hospital pain points were, the services that we needed to have ready started to come to light.

So some of those include we needed home health like we've talked about the skilled and the unskilled, along with durable medical equipment, medications, meals, transportation, benefit counseling which is a huge one because I would say most of the patients, probably 70% of the patients that we actually help and serve, have no insurance, which is what is causing so many barriers for them.

Along with that case management that happens for 60 days after discharge.

Again, we decided on 60 days because we wanted to really focus on that medical piece for the first 30 days to avoid those readmissions and keep them out of the hospital, and then from day 31 to day 60 we took the time to focus even more so on any social determinants of health.

How can we get them connected in the community to continue after this program ends?

So to keep in mind, every person is very different and every transition is different.

Their needs olivary.

So some ‑‑ you know, I gave you that list on the previous slide of some of the services that we have.

It's almost like some needed two or three, some needed all of them.

I even have a category for other because it's those off the wall not sure what we need to do ‑‑ for example, we had one patient that wouldn't be able to discharge home with home health because he had holes in his flooring.

So all of the home health agencies were refusing to go in for safety reasons.

That's something we were able to step in and assist the family to get that fixed so he could get the services he needed.

We need to focus our funding, another thing to keep in mind when you're looking at the services as well, focusing the funding on exactly what that person needs.

>> PATRICIA YEAGER: Before you go forward, I just want to say, all that planning that you heard me talk about, when we hired Mandi we gave her the blueprint and said, here you go, and she made it come to life.

And, really, it was a pilot program where she modified it and made it real.

So ‑‑ but our hats off to her for really making this program come alive.

It was a dream in our head and on paper, and she took it and made it real.

So it's ‑‑ it's a salute to her.

>> JOE FOECKING: If I can add to that, truthfully, in a breakfast of ham and eggs, the chicken is involved, the pig is committed.

UCHealth wanted to know we had a community partner committed to this program.

And so I can remember the very first meeting.

We had meetings every Thursday at noon where we would talk about complex discharge cases, and I can remember accompanying Mandi to that first meeting and introducing her, just the uncertainty and unfamiliarity of who is this individual, where are they from, where are they here, and what services can they offer?

Mandi immediately showed that commitment.

It's very fun now to go to that meeting because that meeting will not start until Mandi is present.

And so we've made the smooth transition to where is our community partner, where is Mandi, where is The Independence Center, and how are we doing on the cases that we sent to them?

So that's critical and we were thrilled to have Mandi on board.

>> INDY FRAZEE: So we've talked a little bit about identifying the services and what is it you can provide as a CIL and then what is it you're going to have to find other community partners to provide the ‑‑ those services.

So it's really important to understand the specific services before you get started and then figuring out what other agencies that you need.

So the services that Mandi was talking about, we had mentioned at the Independence Center we have home health, and so we can sometimes fulfill it.

Due to our capacity limitation or staffing limitations, sometimes we do have to work with other community providers for home health.

And so we've identified a few and have MOUs with those community providers, and then DME, food service, we have identified those providers as well.

And so it's really just finding those agencies that are well‑known in the community and that you feel that you that you can have a trusting relationship with.

As Patricia mentioned earlier right in the beginning, we thought we had a good community partner in home health and determined that wasn't a great fit, and so moved on and found a few other agencies to help us.

But it's good to have ‑‑ we found that it's good to have a few agencies because like all community providers are some are better at some services than others.

For example, one of our home health agencies is usually our go to because they can do the therapies as well as the nursing, and there's another home health agency where we just use them ‑‑ not home health.

Sorry it's a therapy agency where we just use them for therapy.

So it's good to have multiple agencies for each of the services that you're looking for.

We have two agencies that have ‑‑ that we do for food service, and so all of the agencies sometimes have capacity issues, and so that's why we always have looked for multiple ‑‑ two to three so you're a little further deep in case you run into your first one that can't service.

So one thing that we ‑‑ I know Patricia asked a lot was when we were working through the project was how are we ‑‑ how is it that the hospital won't just go hire Mandi, because she does just an excellent job, and really it's that network that we've built and we have established with the agencies that we work with, and so if you think about it from a hospital perspective, yeah, they might have access to each of those community partners, but they would have to ‑‑ they have to coordinate all of it.

Instead, we can do all that coordinating, we have MOUs with everyone, and so we're taking that burden away from having them to create this program internally.

>> JOE FOECKING: If I could interject there, too.

Another key component, in my mind, for that is, and I used the example when we were setting this up, Mandi is really the conductor of the orchestra.

And so if the hospital is going to hire it, not only are they going to have to hire the conductor, they're going to have to hire the entire orchestra in order to make this work, is one of the keys I think comes in.

Another key I think comes in is Mandi is boots on the ground, feet on the streets, in the clients' home.

In terms of the hospital we stop at our walls.

We don't go into that client's home.

One clinical example that stands out in my mind that exemplifies the importance of that, we had an 18‑year‑old individual, gunshot to the abdomen, spent months in the hospital, on tube feeding.

We were able to discharge that individual home because of the Hospital to Home Program.

Mandi went into the home.

It was an apartment, upper level apartment, it was August and August in Colorado, while it is lovely, it's also very hot.

Mandi walked in and realized he's on a tube feed.

And so nutrition and hydration is already a concern.

He's sweating.

And this apartment has really no other source of cooling than opening the windows.

There was no air conditioning.

There was no fan.

Mandi could see him sweating and really put together the idea of, if we don't do something, he is going to end up with dehydration.

If that individual had come back to our ED with dehydration, the hospital would have done a wonderful job of putting in an IV, working through that dehydration, hydrating them again but then we would have discharged that individual back to the community.

We would not have made the link of there is no air conditioning, there is no fan in the window, there's no source of cooling.

So we would have had that readmission rate because we would have identified the medical source, you are dehydrated, but we wouldn't have dug deeper and said, why are you dehydrated?

Is it because it's so hot?

Is it because you don't have a fan.

Is it because you don't have an air conditioner?

For Mandi to go in there and recognize that, Mandi's solution was just that.

Let's get him an air conditioner, let's get him a fan and put it in his window.

Once she went back the next day, he is in much better shape, not in distress.

So by doing something so seemingly simple she prevented a hospital readmission.

And so that, to me, really kind of encapsulates the importance of being in that individual's home, picking up on all of the clues that are going on and understanding where to intervene and how.

>> INDY FRAZEE: Thank you.

Next slide.

So part of the planning process is also to determine your funding.

As Patricia mentioned earlier, you're trying to identify who your customer is.

We have identified the hospital as our customer.

Because it's a new program, the hospital, although seeming on board, was probably a little like, well, let's try it, and so we ‑‑ that's when we pitched the pilot program.

So we searched out for grant funding to get us started, and we ran it for about a year.

We really were just trying to prove to UCHealth that this was going to be a successful he ‑‑ and an efficacy of the program.

So that's where we started with our funding.

Now, all hospitals across the nation are obviously different.

So we just found here to be successful that a pilot was something that UCHealth and ourselves could really appreciate at the time.

That took some time as far as getting grants.

I'm sure a lot of you are familiar with the grant process.

So we had to get all of our grant funding in place before we could get the pilot started.

So being mindful much that timing can help you identify when to start the program.

The last bullet point here, it is important for both the CIL and the hospital to put some money towards the program so that we all have skin in the game.

That was important also to our funders.

So ultimately we had two grants from the Colorado Springs health foundation and the Colorado Health Foundation, and then we also asked UCHealth to put some money in and we did as well as the CIL.

Next slide.

From a financial perspective, as Patricia mentioned, I was the CFO for The Independence Center when we started the project and so we did a lot of work of identifying costs and we got all the way down to on a daily basis per service what we thought the patient discharging ‑‑ we did a few different scenarios like if a patient only used some of the services, if they had a home.

Originally we were going to try to do a homeless individual.

So we knew that that was going to add cost.

So we have ‑‑ we really dug deep into all the services and how much they were going to cost ‑‑ for each day to get and idea how much this program was going to cost us per transition and then kind of backed into if we did so many transitions how much that program would cost us as a whole.

So really looking into also the ‑‑ how many staff we were going to have, all the saw supplies that go with it and all ‑‑ you know, I.T. and a cell phone for Mandi and just all of those program costs.

We also looked at administrative costs as far as occupancy and facility cost and Mandi was going to have a desk here, and so looking at some of those costs as well.

As I mentioned, we looked at the funding and how we were going to get funding for it, applying for the grants, and really trying to identify how long we were going to do the program which dictated how much grant funding we were going to need.

We also looked to cash flow and considering ‑‑ sometimes grants pay you all up front.

So trying to understand what that cash flow consideration might have to be.

Next slide.

After the pilot program, we really had to also determine what our pricing strategy was going to be.

Our hospital has determined ‑‑ once we got through our pilot program, UCHealth was willing to do a lump sum contract.

So good in the sense that we know exactly how much money we have to spend on an annual basis, but it doesn't give us as much flexibility when it comes to if we were to do maybe a per transition pricing.

So I think it also will determine once you work with your hospital what kind of ‑‑ how they like to or tend to contract.

However, I would say that try to be creative when it comes to coming up with your pricing strategy and maybe throwing out two or three different ways of doing it to see where the hospital might be interested when it comes to contracting.

Identifying risks.

We've talked a lot about.

But certainly from a financial perspective we wanted to identify risks as far as what if the hospital didn't ‑‑ started not paying or not wanting to pay.

So looking at the financial risks there.

And then on the bottom of the slide we ‑‑ this is specific to our Hospital to Home Program, but really looking ‑‑ this is from a pilot as well as a program, this is kind of our average cost of what the patient is utilizing from a service perspective.

So you'll see a majority of our transition costs go to home health or therapies, that medical piece.

So 56% of that.

17% go to DME.

15% to medications.

Then you'll see 8% for transportation, 3% for meals and so forth.

So, really, it's helpful from a pilot perspective that we are then able to identify the financial aspects of all the services that we provide to that patient during their transition.

>> JOE FOECKING: If I could just interject here as well.

Also for those participants, when Indy is saying hospital, please remember Memorial Central has both an acute care portion of the hospital but we also have a rehabilitation hospital or an.

>> EUFPLT: RF, inpatient rehab facility.

So there is a hospital inside the hospital.

So if you are considering a hospital for your community, quote‑unquote, hospital, please don't leave out the rehabs.

Look at the acute care hospital but also look at the rehappen hospitals because a number of clients Mandi has worked with have gone from than a acute care setting into that post‑acute care setting, that inpatient rehab facility and then needed this program in order to have a successful discharge home.

So in terms of marketing or reaching out for this program, it's not just the acute care hospital, it's also a rehab hospital.

We can move to slide 22.

I can start on this one.

Truer words were never spoken than the first sentence on slide.

Several meetings are in your future.

I can remember having meetings with The Independence Center in regards to just really working with them do explain what is the reality inside the hospital and what could this program look like?

I learned their terminology.

They learned my terminology.

And we understood each other's reality.

So we were kind of chuckling before this started he the number of meetings that occurred to take this program from concept or idea into reality is amazing, but now that it's reality, I don't know how ‑‑ I don't know what we would do without it, truthfully.

Consider the meetings you're going to have internally to problem solve this program.

Consider the meetings you're going to have with your hospital representative in order to really tease out the details of this program.

Also consider the meetings you're going to have with the hospital in regards to explaining the program.

This program, in my opinion, is very novel.

It's very unique.

So when we first sat down to really explain it, it took a couple times before it sunk in.

Then it took, really, in my opinion making it real, explaining how this could impact a client and then once we saw the impact that it did have on our patients and the clients, that's really where I think it took off like wildfire and just spread.

And so focus on internal meetings, focus on meetings to establish what does this look like for both parties, consider meetings related to marketing, and then to Indy's point as well, UCHealth has decided in regards to funding we have provided a lump sum.

That's not a case rate amount of money per case.

Here's the lump sum.

How many patients can you help transition?

That's where we also have meetings to come back and say, let's do some auditing, how did that work, where did the money go, looks great, you guys are doing a fantastic job.

Let's keep going.

Indy would have more about that, or Patricia?

>> PATRICIA YEAGER: One of the things that was really interesting to me is we had questions for Joe about how do we market this to you?

How do we ‑‑ I mean, should we do a PowerPoint?

Or should we have a brochure?

Or should we ‑‑ how is it that we can present this to be best understood?

And Joe advised us to do a PowerPoint but to bring it and hand it out instead of putting it up on the wall so then we could walk through it.

It was much more community‑based, not so formal, and they did have the PowerPoint, and we asked a lot of questions.

What kind of hospital patients do you have trouble with, trouble getting out of the hospital?

I mean, we had to struggle through quite a bit of that language, and to get the questions right so that people could respond to us.

So that marketing piece is not a flyer that you ‑‑ like sometimes we do in nonprofits.

A brochure might not be enough.

But the PowerPoint seemed to work in this instance.

So ‑‑ anything else we need to do on this slide.

>> JOE FOECKING: There is a question in regards to what are pain points.

To go back to the hospital piece, one of the pain points in the hospital is if we're holding in the ED.

If we're holding in the emergency department, that means that all of my acute care beds are full.

And so one pain point would be that throughput piece.

How can I free up an acute care bed in order to improve throughput so that I'm not holding in the ED.

Another pain point for us would be any sort of readmission.

If an individual comes into the hospital, we treat them in the hospital, and then discharge them, if they come back into the ED or back into the hospital in a 30‑day window, that hospitalization is free.

They don't have to pay for that because insurance companies would say, you should have solved the problem in the first place.

So we're not taking care of this readmission.

So to me when I look at that term or phrase pain points, that's describing readmission.

That's describing throughput.

That's describing a complex patient with a challenging or no discharge.

So hopefully that answers or clears up any confusion out there in regards to pain points.

>> PATRICIA YEAGER: Next slide.

>> JOE FOECKING: Hospital to home.

We did the pilot.

After the pilot was done, that's where we sat down to do an MOU agreement with UCHealth memorial and then to transition from pilot into fee‑for‑service or paying for that service.

After demonstrating success, data collection was huge.

We wanted to see data regards to what services were used, and that's where the two parties sat down and negotiated a contract.

>> PATRICIA YEAGER: Sorry, I kind of checked out for a minute.

One of the things I wanted to mention here, we asked the hospital, how do you evaluate?

How do we tell them how much money we saved them?

Did we save them money?

And the hospital said, well, if you keep somebody from coming back for a week, or you cut a week off their stay at the hospital, that saves us about $20,000 a week per patient.

And in that first pilot we served 24 people, Indy, am I right, 24 people, and so we estimated that we saved the hospital one week of care for each of those people.

One of them we saved them six months.

Another one might not have been back, but it was averaged out.

So at $2,000 a week over 25 patients we determined that we saved them almost $500,000 for that year.

That's a pretty significant savings for the hospital to look at, and it freed up their beds and it reduced their readmissions rate.

So it was ‑‑ it was a win‑win.

I can tell you that the CEO of the hospital, when we first proposed this, he didn't even want to meet with me.

We never ‑‑ I never ‑‑ I saw him at a cocktail party, but I never actually really got to talk to him.

Last February I saw him at a social event and he gave me a big hug and said, oh, my God, we're so glad you're with us.

That to me was a big win‑win to be able to show to the CEO of the hospital, hey, we are your partner in so many ways.

It was very gratifying.

>> JOE FOECKING: Patricia points out something really important as well to consider.

Yes, consider what the hospital's costs are, but also consider the indirect costs or the savings because if you can prevent a readmission, if you can reduce a length of stay, that also adds up in terms of the dollars saved.

That's a beautiful point, Patricia.

>> TIM FUCHS: Okay.

Great.

Here we are at our first Q&A break.

We have some great questions in the queue.

The first two questions from June and Mariah are similar.

Mariah already feels like she has some of these relationships.

How in the world do I do this during a pandemic?

I know this is something that came up a lot during our collaborative because I told you some folks are trying to replicate this and they've really been road blocked during the pandemic.

I'm not sure there is much we can do about that, but I will ask those of you in it, and, Joe, with you working in a hospital setting, Mandi, same for you, any tips for folks interested in pursuing these kinds of relationships or programs with so many healthcare settings shut down or operating differently.

>> JOE FOECKING: A couple things to consider.

One thing to consider is the, quote‑unquote, virtual meeting.

If you've already had these contacts in the hospital, then truthfully in my hospital you have a legislature up because you can set up a virtual meeting through Zoom or Skype or Teams, things that way.

The other thing is when the pandemic, one of the things that we focused on was getting people out of the hospital.

One of those would be if we had a surge of COVID patients, we need the resources in the hospital for those COVID patients.

So if we have an individual who is in the bed that could be discharged but the discharge is being prevented by something related to social determinants of health, this program is key to say, hey, we can get these people out the door, free up the bed and free up the resources in case there is some sort of a surge.

And so there was really a strong push to say who can we get out the door.

Another thing to consider truthfully is the idea of hospitals have sick people.

So what better than to get people back into the community.

My mother was ill during the course of this and one of the things they said, or her dock sir Ted was, I don't want you going to the hospital.

If there's any way you can go home and be cared for at home that's where I would prefer you go to because I don't want you exposed to all those different things inside the hospital.

Truthfully I think the pandemic really puts into focus get these people out the door so that the hospital resources are there for people that need them.

>> TIM FUCHS: Great points.

Thanks, Joe.

Pat is wondering about the role of the Medicaid managed care sir vision coordinator our case manager on the team.

I'm not sure if that came from your materials.

I know you all aren't an MCO state.

I might have missed that.

But do you all have a case manager on the feel or recognized pat's question about the role of the MCO service coordinator.

>> JOE FOECKING: I'm not sure if I understand the details of it but the way we're structured, we do have a strong department of case management or care management and social work.

That's where those individuals are really looking at setting up discharge planning in the hospital from DME, from home health services, things in that way, and that's where Mandi has a strong Partnership with the hospital‑based care management and social work team, but that's where I think Mandi takes that a step further and takes it into the community.

Mandi, would you want to speak to your relationship with our hospital‑based care management team?

>> MANDI STRANTZ: Sure.

That's where I get my referrals.

That's where I start the process of creating a plan for this individual.

So I, of course, talk to the patient and family.

But the case managers, hospital workers, hospital staff are huge when it comes to creating our plan.

And like Joe said, we kind of create the plan, get that person discharged, and I continue in the community with the case managers and hospital staff have been working on in the hospital.

>> PATRICIA YEAGER: So let me interject here.

Colorado is not a managed care state.

But I have talked to a couple of people who work in managed care states, and those care coordinators do not go to the home, and that's where you have an advantage, a marketing advantage and a service advantage, is you go to the home.

So the care ‑‑ the managed care folks often, and this might not be true for every day, but they don't really go to the home and see what the conditions are and what barriers might be there.

So you are still able ‑‑ that's still a service that you're able to provide.

>> TIM FUCHS: Great.

>> JOE FOECKING: In terms of that managed care I would also ask folks to consider, for some elective procedures, we're moving towards ‑‑ or the world is moving towards bundled payments.

So you get into a bundled payment model, that's really going to peak to the community partners.

One example would be a joint replacement, total knee, total hip replacement.

In that bundled payment model, you get a limited set of money for three days prior to the surgery for the surgery and the recovery of the surgery and then 90 days post surgery.

And so when we look at that total knee replacement, we're understanding here is X amount of money.

You need to make it last.

So it would not be smart of us to not partner with community individuals to say, we're going to do the surgery and now we're responsible for the client 90 days out.

And so who are we comfortable working with in regards to home health, skilled nursing facility, inpatient rehab facility, things that way because we have to capture that entire stay and that's when really when I look at that managed care piece, that's critical to know that again, if they are readmitted you're not going to get reimbursed for that in the hospital setting.

So that behooves the hospital to say, who are the community partners.

Who do we trust?

Because that's who we're going to share this amount of money with.

>> TIM FUCHS: We've reached the rapid fire round.

I want to see if we can roll through a couple questions quickly.

Stephanie is wondering with BAAs for data sharing.

Something you all have used?

Do you use a shared electronic healthcare record or shared outcome data with each other?

Frats yes, we have BAAs with our community partners and one thing that's built into our contract with UCHealth is Mandi has access to their EMR system.

So when she gets a referral, then she can ‑‑ she has access to all of that medical health information for that specific transition.

>> TIM FUCHS: EMR, electronic medical record, I assume?

>> Yes.

>> TIM FUCHS: BAA is?

>> INDY FRAZEE: Business ‑‑ I don't know what a BA ‑‑ I don't know ‑‑

>> JOE FOECKING: Business association agreement.

>> TIM FUCHS: So like a business agreement.

Great.

All right.

Gloria is asking, we may have to follow up on this one, if your SILC doesn't have home set services, what are some key areas CILs could provide in the gaps that a home health agency wouldn't already provide.

Patricia, can you tackle that one?

>> PATRICIA YEAGER: I will think you are the case manager.

You are the network manager.

So you will ‑‑ you would hire or contract with home health agencies that you're comfortable working with to provide that home health side.

So that just expands the amount of coordination that your case manager or service coordinator might be doing.

Benefits counseling.

And the peer support are both big parts of this, and those are pieces that your Center, your IL service side could provide, but you would be the coordinator of this whole thing and hire these other agencies to come in and provide the food, the transportation, home health services, that sort of thing.

>> TIM FUCHS: Great.

I remember when ‑‑ Jody submitted this next question when you all were going through some of the list of items that you all have identified or provided, and she and someone else are wondering, the air conditioner example and other things, are they paid for from the Hospital to Home Program or from other sources?

>> PATRICIA YEAGER: They're paid for from the Hospital to Home Program.

In our grant we use that to figure out, you know, roughly, and Indy can correct me, but roughly we spent about $7 thousand thundershower or less on a patient.

So the hospital will reimburse us for the expenses that we pay for, and it's always cheaper than that person laying in the bed at the hospital.

So they paid for the air conditioner.

The grant paid for the floors being repaired, paid for some home modifications, and Mandy, can you jump that.

There is a pot of money for patient add administration, which includes Mandi's costs.

>> MANDI STRANTZ: My goal is to always try to find other funding and use the lump sum from the hospital as last resort.

If insurance covers it, if I can find other options in the community, I do try to do that first.

For example, a home modification, are ‑‑ around the community can that do that, a Medicaid waiver can do that in the state of Colorado.

We try to exhaust that first.

Then if we don't have any options, that's when we go to the other funding.

>> TIM FUCHS: Great.

June is wondering if we think this model could work with managed care organizations.

Again, Colorado is not an MCO state but, yeah, I think it could.

We should talk about that.

One of the reasons we want to share this is because we do think it's so replicable.

There's no reason why ‑‑ only apply to standalone hospitals, right?

Stephanie is wondering, the no‑cost aspect of readmission within 30 days of discharge, is that just in Colorado?

Or is that nationwide?

Do you all know?

I don't.

>> JOE FOECKING: Nationwide.

One of the shocking examples would be if I'm admitted today for pneumonia and the hospital treats me for that pneumonia then I'm discharged, if I go home and fall off a curb and break my hip and come back in within that 30‑day window, even though it's a drastically different diagnosis, it's considered a readmission.

>> TIM FUCHS: Okay.

Got it.

Wow.

Related question.

June is asking about penalties for readmission.

Are there financial penalties ‑‑

>> JOE FOECKING: There is no financial penalty.

We wouldn't get paid for that stay.

So if you consider a zero amount of payment as a financial penalty, you do have that.

The other thing is those readmission rates are reportable to the federal government.

So those federal government programs will grade you or judge you based on your readmission rate.

If your readmission rate is too high, they will start to reduce some of that government reimbursement.

And so, really, the government wants to see a person came in for medical condition A, you successfully treed medical condition A and then got them back into the community with no other problems.

And so you get dinged because you are you're not getting paid, but if your readmission numbers don't look good, something is wrong with the care you are providing.

>> TIM FUCHS: We do have a few more questions but I have already borrowed a couple extra minutes.

I want to make sure we finish the final slides.

We'll move through these last six slides quickly and then I'll begin with those questions we didn't answer when we take our final Q&A break in a few minutes.

For, I'm going to turn to slide 25, and, Mandy, I believe this is yours.

>> MANDI STRANTZ: Thank you.

Just to kind of give you a little bit of a teaser for actually Part Two, I'll jump into this really quick, but as we have talked about when I first started, I was given the concept and a lot of planning went into it before I actually came on board.

But I was given all of that.

Then I was able to take it and add detail.

That's when we broke it down.

The first thing I had to do was create an assessment tool.

What die I need to node about this person before they leave the hospital to make sure I have the right supports in place.

The next thick I worked on is I collaborated with my marketing team, which was a huge help.

How am I going to get the hospital staff, the case managers, social workers, to remember the program and to think about sending referrals to me?

How do I get in that door?

So our marketing team helped me out with creating brochures, handouts, things to leave behind with the staff to make sure that remember and that they would actually call me with referrals.

And then the next thing before we got started we needed to figure out what kind of data did we need to collect to show the hospital that this is going to work, that this saves you money, this is better for the patient, all of these outcomes that we want.

What type of data did we need to collect to show that.

So we did that.

At the very beginning.

And in the pilot program we actually adjusted as needed.

This is always a moving model and as the patient needs changes, the hospital needs change, we change with it.

And then finally I needed to create client forms.

I needed to have my information, I needed to have those documents that kind of protects us and the clients throughout this whole venture.

Next slide.

As we're implementing the Hospital to Home Program, the hospital is our customer, and the patients are our beneficiary.

They get to receive those services, which is great.

But the first thing again after creating, setting up a process, I got to go into the hospital, and I used to build those relationships.

That's my referral source.

So having a good relationship with the hospital and their staff is how we make this program work.

A couple other things to keep in 900, too, that we're extremely helpful, I am considered a contract employee with the hospital.

So I do have access, as I mentioned before, to the electronic medical records system and they actually have a space there for me to work.

I'm able to meet staff face to face when needed and, then, of course, the patients as well.

And then I do do in-services with the different departments at the hope to explain what is the program, why do you want to refer your patients to me, things like that to kind of get the ball rolling.

As we mentioned before, I do attend a weekly meeting and as patients come up that we might be able to help with, I am able to chime in and say, hey, let us talk after this meeting to kind of, again, build those referrals.

Build the referrals.

Next slide.

Again, here's what we came up with.

I start with the referral from one of the hospital staff, case manager, social worker.

That can be by phone, email or even an in‑person conversation when they pass me in the hallway.

Then we talk about is this something that our services ‑‑ can we meet the needs of that patient.

Do we think we can be successful?

If that's the case, that's when I go get ‑‑ I look at the medical record and pull out therapy notes, doctor's notes, what are the medical staff saying this person needs to be successful after leaving the hospital.

Then I meet with my team internally and we talk about, all right, yes, we can put in home healthcare.

We can put in caregivers, whatever that person needs.

And so if we all agree, that we can meet those needs, then we accept that patient.

That's when I start partnering with the case manager or whoever the referral source is with the patient and with the family.

I meet with everybody.

I get everybody's thoughts.

I want knee what's going on at home.

I always offer a home visit before they leave the hospital if the family and the patient thinks that will be beneficial, but if not, I go the day of discharge and see the home, lay eyes owe everything and we set up services from there.

And then, of course, with my case management for 60 days we put in the services that we discuss at the beginning, but, of course, those might change.

Needs always change.

And so if that person needs something else, we add services, we may decide, oh, we only needed that service for a month.

Well ‑‑ [inaudible] discontinue that service for them whatever that looks like and I try to connect them into community resources to make sure that they are as successful as possible even once the 60 days are over.

Next slide.

>> INDY FRAZEE: Just real quickly, I know we are running short on time, the next two slides just give you the statistics ‑‑ this first slide is the pilot and the second slide is our ongoing program at the time.

We did do 27 transitions in pilot.

Our pilot actually ran a little bit longer just because we had some ‑‑ we didn't utilize as much money to begin with when we started the pilot and it was a little slower to get started.

So we extended our pilot to finish out all our grant funding.

You'll see our readmission rate was two out of the 27 and we had nine ER visits.

Two of those becoming the readmissions.

And I wanted to point out the LACE score.

That just describes what LACE is.

Our hospital uses the LACE+ score.

It's basically how the hospital identifies the individual's potential to readmit.

So that gives you a breakdown between in our 27 transitions what their LACE score was.

Again, this slide just identifies our program up through ‑‑ so our program from a contractual standpoint started August 1st of 2019 and will glee July 31st of 2020.

These numbers are up through April ‑‑ is that correct, Mandi?

>> MANDI STRANTZ: Yes, I believe so.

>> INDY FRAZEE: Sorry.

Then we're currently at 43 transitions.

Next slide.

>> MANDI STRANTZ: So the last thing here that we have is lessons learned.

So from the pilot to the program, we are constantly learning and changing the program to make sure it's still meeting the needs forb the hospital and for the patients.

One of the first things we did learn is that substance abuse is very difficult for us to make sure we get the rye support in place.

So once we learned that that was something that we needed more assistance with, we reached out to a mental health provider in the community because we found that gap and we wanted to meet it as best that we can.

So that's one of the things ‑‑ like I said, it's constantly a learning what we need to add and if we need to add to our network, whatever that looks like.

Another one we noticed, too, is that we don't serve the homeless population.

We do have another agency in the community that is able to help out the hospital in that realm.

But, again, it's a little bit more difficult to put services on when the individual does not have a physical address.

Another thing, between the pilot and the program, we learned the costs were not as high as we originally planned for, which is great.

We were able to serve a lot more individuals than we anticipated through the pilot process, and now with that lump sum we're able to serve a lot more individuals.

Finally, another thing we've learned is that there's a lot of individuals that are Spanish‑speaking only.

So I had to sure we found community partners that could also meet that need.

So that's another thing that we did a little bit more research and went talking to our partners and before creating a Partnership, that's something we asked of them.

Next slide.

>> INDY FRAZEE: This is a resource that we created.

It actually was back when ILRU was doing their business acumen learning collaborative that Tim mentioned at the beginning, and what we've done is put together this website that has pretty much all the information that we can provide electronically as far as brochures that we have, we have our financial analysis in there, and so we just wanted to kind of share the information for agencies that are interested in potentially getting a Hospital to Home Program up in their community.

So that website is available for anyone to use with lots of resources on it.

Next slide.

>> TIM FUCHS: Thank you so much.

You guys have been so good about sharing what you have learned along the way.

We really appreciate that.

I'm going to work through these questions quickly.

We have just six minutes.

I think we can make a good dent in these.

The good news is a lot of this stuff will be covered in Part Two, where again we're going to go into much more depth about the actual program design and how to.

Jody is wondering, Patricia, how much does this cost?

What does it cost to stand up a program like?

I know it's going to depend and be different for each organization, but what's ballpark people can expect to create this?

Is it $40,000?

Is it half a million dollars?

What does it take?

>> PATRICIA YEAGER: Mandi may be a better person for that.

We have almost $300,000 in grants and $15,000 from the hospital to actually start the program, but ‑‑ and ‑‑ as you saw, it took us longer than a year.

Mandi, what do you want to contribute?

>> INDY FRAZEE: I would add that's for the pilot.

Actually it's a little less.

I think we had about 240,000 to spend.

The lump sum contract we have currently is actually half that.

So we're sitting at about $180,000.

What's interesting, though, is when we started we asked for a lot from the grant perspective, and as Mandi just mentioned, we ended up finding that the services we thought were going to be more expensive either turned out to not be as expense SUV or that the service combination was different than what we were kind of planning for.

So ideally what we're ‑‑ we kind of look at on a recollect basis is that a transition ‑‑ we try to keep a transition to about 5,000 a person.

Not everyone hits that.

In fact a lot are a lot less than that.

But that's kind of our gauge, as Mandy kind of sticks to that 5,000 per person budget so that we can stretch those dollars as much as we can, especially because we have that lump sum contract and have to cover our administrative costs as well.

>> PATRICIA YEAGER: One way to start this is we said we're going to do one patient a month.

We didn't know whether we were going to do this.

One patient a month times 5,000, that gives you a ballpark figure for starting up the program.

>> TIM FUCHS: Great.

Very helpful.

Thanks.

Cara is wondering, Mandi if you all transition any COVID survivors through the program.

I know you have been doing transitions through the pandemic.

>> MANDI STRANTZ: Yes, actually I think two of my patients had actually ‑‑ were COVID positive and are recovering at home.

>> TIM FUCHS: Great.

Good.

June is wondering if you all have thought about how this model could work as we move towards the hospital without walls model.

That's something I'm not familiar with that concept.

Joe, is that something that's ‑‑ that's on your radar?

>> JOE FOECKING: It's on the radar.

I don't know particular or specific details.

Truthfully, again, to me it would work, it would fit nicely because you have medical providers that are excellent at what they do but not necessarily the experts at the social determinant of health.

So it really goes back to that Partnership again.

>> TIM FUCHS: Thanks.

Quick question from Terry about readmission.

We talked about readmission, readmission limits.

She said, is that limited to ‑‑ when you talk about one readmission, is that per year ‑‑ what is the time limitation where a readmission would be ‑‑ where someone's admission would be evaluated as a readmission.

>> JOE FOECKING: If I am readmitted to the hospital today on Wednesday, discharged on Friday, that discharge day of Friday starts the clock of 30 days.

Get me past that 30 days.

If on 30 days I'm admitted again, great, that's a new hospitalization.

If I am admitted day 29, that hospitalization is free.

>> TIM FUCHS: Got it.

Jane is wondering if you only have Medicare, which is short‑term, how can you hip the consumer get longer term home healthcare?

Patricia, any ideas on that one?

>> PATRICIA YEAGER: Mandi, I think you have worked on getting people in the Medicaid benefits if they finally qualify.

If they don't, then we pay for it for the 60 days.

But long term we are working on getting them on to Medicaid to be able to get that.

>> TIM FUCHS: Okay.

Good.

Mandi, do you get any opposition from folks about home visits or the support you provide?

>> MANDI STRANTZ: No, everyone is really open to letting me typically come over.

Some individuals need it more.

So some individuals I have gone out, in‑person meetings, once a week for the first month to 45 days.

Then there are some it's only once a month.

But I kind of let the patient and family drive how many times I come into the home and see them.

But if I haven't heard from them, I reach out at least once a week to make sure services are going well, services are being provided, et cetera.

>> TIM FUCHS: All right. There are a few questions remaining. We're at time. The nice thing about this is that we have a Part Two coming up next Wednesday.vSome of them, like the cost breakdowns, we are going to get into a lot more specifics and details and it's ‑‑ if it's not in the materials, we can make sure to address it during the Q&A. So I look forward to having you all back with us next week. We had a great audience today.

We had over 170 people join. I know a lot of you are ‑‑ well, you're all registered, so you'll all get the connection information for next week I know a lot of you are planning to come back, Indy, Mandi, Joe, Patricia, thank you so much for sharing the overview of the project and I'm so glad we thought to break this out into two because next week we will be able to get a lot more specific and talk about the nuts and bolts. It's been a great call. I really appreciate your time. I hope you all have a wonderful afternoon. Don't forget, there is going to be an valuation that comes up when we close the webinar. Please take a moment to fill that out. Also keep in mind we record these webinars. This presentation will be up on ILRU's website within 48 hours. So if you want to review it before Part Two or maybe share it with a colleague, please do that, and for anyone, maybe a co‑worker on a colleague, maybe your director that didn't join Part One but wants to join Part Two, we have reopened registration on our website so you can sign up for Part Two even if you weren't able to participate live today. Let us know if you have any questions. I hope you all have a wonderful afternoon. Bye‑bye.