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

Hospital to Home: Part Two

June 17, 2020

>> TIM FUCHS: All right.

Good afternoon.

I'm.

>> TIM FUCHS:

>> TIM FUCHS: With the National Council on Independent Living.

I want to welcome you back to Part II of our IL‑NET webinar, hospital to home, a collaborative between community partners.

I want to go through some housekeeping and accessibility items before we start today.

As you know, captions are available in Zoom.

You can turn those on now if you haven't already by going to your closed caption options in your Zoom menu bar.

You can click closed caption or click show subtitle is the new language if you are using the updated version.

We're also running those captions in Streamtext.

Again, you heard me say this last week, but in case you joined late, or weren't on Part I, you can access Streamtext and that allows you to adjust the contrast, font size and font color of those captions.

There's also a chat feature there.

So, if you do want to use the caption, the larger captions at Streamtext, you're welcome to submit questions or comments during the Q&A breaks and I'll be happy to voice them for you.

If you prefer to use Zoom and can follow the captions here and submit the questions via that method, that's absolutely fine, too.

So, speaking of captions, just a couple things that I want to mention here ‑‑ excuse me ‑‑ speaking of questions.

There are a few things I want to mention if that for our Q&A break, we have a break at the end.

We will save plenty of time for your questions.

And I want to point you all to that Q&A tab in Zoom.

If you're able to use that, we prefer that you do that.

It makes it easy to follow the questions, prioritize them and respond to you.

If that Q&A tab is not accessible to you, that's fine, we have a few other options.

You might remember you're welcome to email me, tim@ncil.org.

I have my inbox open.

I will be happy to voice questions that come in through my email.

Similarly, the Streamtext chat you're welcome to submit questions there.

And, again, just a reminder, if you're on the telephone today or otherwise cannot access those other options, you can press \*9 on the phone to raise your hand.

So, again if ‑‑ I would like to save that as an accommodation for folks that can't use the other options, reasons being we have a large audience today and I have to scroll through and find the user and unmute your line.

If you need it as an accommodation, I am more than happy to do that, but it could be a lot if everybody tried to use that.

Finally, the last thing I wanted to mention regarding housekeeping is that just that eval.

Thanks to those of you that filled it out.

We do have a new version today that's specific to Part II.

So, you guys saw it.

It's quick, easy to complete.

We would like your thoughts on today's webinar.

That again, when I close the webinar, that will appear on your screen, and if you need to run or if you're on the phone, that eval link was also sent to you in the confirmation for Part II that you received by email.

Back with us today we have our same speakers to delve into much more detail.

So, we've got Indy Frazee, Mandi Strantz, Patricia Yeager and Joe Foecking.

So, thanks so much for being back with us today, folks, for this Part II.

You know, when we started planning this event, we realized that we were going to get into a lot of detail, potentially, and that we wanted to break this out into two.

So, the idea was to spend our first presentation together that we did last Wednesday, kind of giving you an overview what does this look like?

Where did this come from?

And that we would offer today's presentation for those of you that really wanted to do this.

Right?

The nuts and bolts.

How does this work?

Literally, how did you get this up off the ground, what does it look like day to day, how do you pay for it, those sorts of things.

I'm glad to see we have 124 people connected already and I know that's going to continue to grow.

So, I'm just happy that it's been so popular.

And so here on slide 4 are our objectives for today.

We're going to learn 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 a 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.

Before I turn it over to Patricia for the next slide I just want to mention quickly, if you signed up for Part II today and you weren't on last week's webinar, that's fine.

Don't forget that archive is now up on ILRU's website so you can go back and watch that.

I think today is going to make sense on its own but if you want to review Part I, you can access that at ILRU.org under on demand training.

So that's it for me.

I'm going to earn at this time over to Patricia and go to slide 5.

Patricia?

>> PATRICIA YEAGER: Welcome back, everyone.

It's so nice to see you, so to speak.

We're delighted to provide some more detail on our services.

Just like any good television program, they have to do a little bit of what happened last week.

So, we're going to do the same and just review a few slides to give you some background, particularly for those people who were not here last week.

The Independence Center is in Colorado spring, Colorado, and our mission, as you can see, is working with individuals, their families and the community.

We create independence so that all may thrive.

In 1987 several people got together with disabilities who saw a need for home health services in the community and we became an early Medicaid skilled service provider for people with ‑‑ wanting to live in the community.

Then flash forward to 1994 and we became one of the nine Centers for Independent Living in Colorado.

So, we have a home health side, both skilled and unskilled, Medicaid, and we have traditional Independent Living Services.

Our CIL provides services in six counties and our home health provides services in an additional 11.

And all of these ‑‑ we're across Southern California.

We consider ourselves the local home of civil rights for people with disabilities, and we have a lot of advocacy going on around the southern part of the state.

Next slide.

>> JOE FOECKING: As Patricia mentioned, thank you for opportunity to speak with you again and welcome to those who didn't join us last time and welcome back to those who did.

My name is Joe Foecking, director of rehabilitation for UCHealth, southern region of Colorado.

Our mission at UCHealth is to improve lives through learning, healing and discovery, in small ways that are personal through human connection, but in all ways, we improve lives.

That's really our mission.

That's what we strive to do.

When you look at the southern Colorado region, there's 555 staff beds across three hospitals in the city.

We're a level 1 trauma Center at UCHealth memorial central.

We're also a comprehensive stroke Center at UCHealth memorial central.

Our catchment area includes all of southern Colorado, northern New Mexico, as well as western Kansas.

We have 187,000 ‑‑ just over 187,000 ER visits which makes us the second big busiest ED in the state and then there's 44,414 inpatients add missions and observation visits in the fiscal year 2019.

The reason I provide those statistics to you is so that you have some idea of the size and scope of the facility.

We have a number of people that are coming in and out of that facility and so throughout or getting people through the hospital into a discharge destination is really critical for us.

We can advance to slide 7.

>> INDY FRAZEE: For those of you who are just joining us, a little more about the Hospital to Home Program, and really what this program is from The Independence Center is we're provide Inc. that support services that addresses the social determinants of health for our patients that's discharging from the hospital and successfully thriving at their home.

Some of the services include the assessment at the beginning, or while the patient is in the hospital, the coordination of all the services an individual will need when they get home, and then the network of local community‑based organizations that provide the different services that the patient might require.

This is an effort and a collaboration between Independence Center and UCHealth, and ultimately, we're facilitating successful transitions to home for patients with complex or difficult discharges.

We also, obviously, as a Center for Independent Living provide those core services during that transition as well.

Next slide.

>> PATRICIA YEAGER: My turn.

This is a quick summary of our webinar ‑‑ our first webinar and as some of you will remember, I am the queen of planning in that to me you have to ‑‑ you really have to plan this thing step by step.

I never planned a program like we planned this one, and now we do it all the time.

You have to have a concept of the program and the vision.

You start from what your end result will be and work your way back.

You must plan your program design step by step.

What happens when you meet the patient to what happens when you say good‑bye at the end of 30, 60, 90 days.

So that planning underpins the whole process from funding, financial analysis, staffing, all of that.

You must have a plan and realize that you'll be adding to it as you go on.

The funding, we have funding from the California ‑‑ the Colorado health foundation and also the Colorado Springs healthcare foundation and UCHealth also put some money into this program, and our board was willing to put money in as well.

We really recommend that you do a pilot program where everybody puts money in to see how this works and see what your outcomes and pricing will look like.

The financial analysis Indy is going to get into, that's going to be really important to have someone who can ‑‑ an accountant who can understand how to forecast, look at prices for every step of the way, and then figure out how much does it cost you to do this program and how much should you charge for the program?

So that financial analysis is very sophisticated.

That's the first part.

The second part we talked part was building relationship or Partnership in our case with the hospital.

Some of you may be looking at this with managed care agencies.

But you've got to have a Partnership with the hospital.

Joe came to us as a potential board member knowing that we were looking for someone to help us get into the hospital, and as the director of rehabilitation, he understood immediately what we do and has been a ‑‑ we call him our Knight in shining Armor because I don't think we would have gotten where we are without having someone in the hospital as an internal champion looking ‑‑ teaching us how to talk hospital talk and teaching the hospital what it is these people do out there in the community.

So really critically important.

I think that would ring true in a managed care organization as well.

And then we talked quite a bit about finding the pain point.

The pain point ‑‑ what's the problem that the hospital has that maybe you can alleviate.

We found that the largest pain points were several.

One was complex cases, which to us weren't so complicated, but to the hospital were, like, what do we do now?

Could be somebody speaking Spanish.

It could be not having a good discharge place.

So that pain point is really important.

Now, they have a pain point for homeless folks that have no place to go, but we don't have a fix for that.

So there's going to be several pain points that the hospital is going to tell you about, and then it's up to you to tailor your program, your services, to meet their needs addressing those pain points.

Next slide.

>> INDY FRAZEE: So as Patricia just mentioned, the pain points, these ‑‑ there's two.

The top two are the pain points that after several meetings with UCHealth and our internal team really identified, hey, these are two that we think that the Hospital to Home Program can help the UCHealth get through.

The first one being the long length of stay.

As Joe mentioned a little earlier, that throughput, moving an individual through the hospital system in a as short of a time as they can from a medical perspective, but helping them not to take up a bed if they were medically ready or had some barriers to the discharge.

So, the Hospital to Home Program works to shorten that length of stay and it allows the hospital to increase their bed utilization.

The second one that we talked about a little bit in Part I was the readmission rate, and that a hospital has ‑‑ has to make sure they don't have any readmissions because they're not getting paid if an individual is coming into the hospital within the first 30 days of them being discharged.

Also, unnecessary ER visits.

We know ER visits are expensive, and insurance doesn't like to pay for ER visits, and so we're hoping we can help those individuals that are discharging not to use the emergency room as much.

So, we feel that our Hospital to Home Program also meets the need because we work with that patient for up to 60 days after discharge.

The third bullet point is that we at the Independence Center, as well as UCHealth, both desire better outcomes for the patient, and we really spoke with UCHealth about extending their mission outside of their walls.

Joe talks a lot about how the hospital works within their walls, and we want to just expand that out outside of it.

So, helping an individual heal at home with the surrounding medical and social supports is truly the heart of what the Hospital to Home Program does.

Anything you would like to add, Joe, to this?

>> JOE FOECKING: Indeed.

You did a beautiful job, in my opinion, really explaining kind of the concept of throughput in terms of that length of stay and then preventing any sort of readmission rate.

A couple other things I would ask you to consider.

Consider what the hospital is good at.

The hospital should be very good at providing medical care and improving the health of the individual during that hospitalization.

That's why we're there.

That's why we exist.

That being said, impacting the medical care or the health is much different than impacting the social determinants of health.

That's really where I think this Hospital to Home Program really takes the ball and runs with it.

Another thing to consider would be the hospital or hospital system you're considering working with.

What do they have in place?

By that I mean, do they have home healthcare in place, or do they farm home healthcare out to a different agency or a different organization?

We here at UCHealth, we have our intensive care units, our acute care units, we have an inpatient rehab unit.

We do not have home health.

And so, we do have outpatient services but there is a gap between being in the hospital setting and being in the outpatient setting, and that's really where the Hospital to Home Program is excellent in filling that gap.

We can move to slide 10.

In terms of building the relationship with the hospital, Patricia pointed out I came in as director of rehab, as a physical therapist and so I had an appreciation what the Centers for Independent Living would do.

Another thing to consider with that initial relationship from my relationship with the Independence Center and The Independence Center's relationship with UCHealth was in theory talking about concept, figuring out what we're going to do, how is it going to look, but then the rubber needed to meet the road, and that's really where Mandi stepped in to say how are we building a relationship with the hospital case managers and social workers.

Mandi came to us as an employee of the Independence Center.

And so, she was a contract employee to UCHealth.

That being said, she still attended our new employee orientation.

We got her access to the electronic medical record.

And gave her a shared office where she could sit down with one of the care managers to get her feet wet and get accustomed to the hospital.

She attended in‑services.

We've a weekly meeting related to complex discharges.

And so, Mandi came with me to that meeting to hear some of the cases that we, the hospital, were struggling with in terms of coming up with a successful discharge disposition.

In those initial meetings like any initial relationship it may have started off a little bit awkward in terms of who is this new individual and what are they going to do.

Now in those weekly meetings, those weekly meetings will not start unless Mandi is there.

So, Mandi has created a critical piece of the relationship for her to be there, but the hospital loves her.

In terms of the relationship with the hospital staff, yes, it directly affects the referrals that they receive because, really, the face of Mandi is identified as a face of help.

It's a face of assistance.

Mandi's also, interestingly enough, been pulled into other things in terms of while this may not be hospital to home, how else can you help us?

What other programs are you aware of in the community?

And so, without that relationship, you don't have the referrals, and without the referrals, you don't have the expansion of the program.

We can move to the next slide.

>> MANDI STRANTZ: All right.

Over the next few slides, I'll kind of dig into how exactly from referral through the 60 days with the patient, what happens.

And so first, of course, we're going to go through the referral and eligibility.

So, as we've talked about, the referrals coming from the hospital staff, typically the social worker or case manager for that patient.

And then usually I receive a call first, and I discuss the patient kind of an overview with the hospital staff, and we talk about what their needs are and can hospital to home maybe meet those needs.

If we think it's definitely a good possibility, that's when I have them send me over the medical record number so I can go into their file to take a look, and I will review doctor's notes, therapy notes, anything like that that would help us determine what kind of support will be needed from the medical view.

So, does the doctor or therapist think ‑‑ what kind of equipment, do they need skilled care, et cetera?

I take a look to see what is recommended there.

Once I have a good idea of what we think the patient needs, I actually will sit down with a couple of my co‑workers, depending on the needs, and then Indy as well.

Then we discussed, do we think we can safely provide the services the person needs along with will they be successful?

So, every now and again we do say no.

Doesn't happen very often.

But there have been some situations where maybe they were a little too medical and home wasn't the safest option or maybe they didn't have a home to go to.

That's where we try to bring some other options.

If that's the case, again, I try to recommend any community support that I can, not just leave the social worker or case manager hanging.

I have lots of brainstorming sessions.

Again, that comes back to building the relationship like Joe was mentioning.

The other option s yes, we think we can do this and then we kind of continue moving forward.

Next slide.

Once we say yes, let's do this, I work with ‑‑ again, it's the hospital staff, the patient and the family, and we create a plan.

So will get recommendations from the medical side, and then, of course, before COVID I was meeting with the patient in the hospital before they discharged and I was talking with them, you know, what do they think they need?

What do they feel would best ‑‑ provide the best assistance for them in their home to thrive?

I use an assessment tool.

We'll talk about daily living tasks.

All kinds of different things to find out these shall the services we can put in place, and during those meetings with the patient and with the family I typically can find out if there's any cause for concern?

Is the patient hesitant about going home and why?

And if there is something there, that's, again, where we try to brainstorm what service can we put in place to help alleviate that, that fear?

I also offer to do a home visit prior to discharge.

What I do in those, if the patient wants that, I will take a look, make sure the house is safe.

Do we need any kind of equipment in the home?

Is there any kind of accessibility barriers?

And then we try to put a plan in place to overcome those.

If the patient is not interested in the one they discharge, I do a home visit the day of discharge and I go over there and we kind of discuss what's going on and what kind of services we can put in place, then, as well.

Then, finally, before the patient discharges, of course, we have to have some forms signed.

That's just part of any good programs.

A release of information, talking about the care plan, making sure that everyone is on the same page.

Next slide.

I mentioned a little bit that I do my assessment.

Like I said, typically before COVID it was I would actually meet face to face with that patient in the hospital.

Right now, I've been doing this over the phone.

So, it's a little bit different now.

But we'll talk about daily living tasks.

Do they need any hands‑on assistance with bathing, dressing, anything like that?

I also ‑‑ another big thing for us is is there any family or community support for the patient?

Do they have someone that can come over and help cook them meals if they're not able to get to the kitchen on their own?

Or are they able to get to and from their appointments.

So, the family and community support really effect what types of services we can put in place.

So, if the patient doesn't have that support, then I know I need to schedule transportation to and from every appointment and so on.

Again, like I mentioned in the previous slide, I do an environmental, kind of safety check at home for accessibility and just making sure that the patient has what they need.

Do they have food in the fridge?

Do they have running water?

Things along those lines.

We also talk about benefits.

So, if they don't have insurance, I will work with the patient, if we can get Medicaid or long‑term Medicaid in place, Social Security benefits, things along those lines.

I will work with the patient and the family to make sure that we meet those needs.

So that's definitely talked about during my initial assessment.

Then there are also other benefits such as in the community that do, we need to connect them to a food bank or to food stamps or any other kind of assistance like that.

Then I also will assist with any applications that they need assistance with.

Finally, during that initial assessment, I really want to know what does the patient believe their barrier to discharge is?

What do they think is holding this up and how can we make sure we overcome that?

Next slide.

So, after I meet with the patient and the family and work with the hospital staff, now I have a good idea what services to set up.

So, we do that within the first 24/48 hours and hopefully we have everything set up before the person discharges.

Or, again, within a few ‑‑ a day or two of them getting home.

So what that means for me is I contact ‑‑ if we aren't able to do it internally, I will contact one of our partner agencies and we create a plan together when can they go out and make sure that all of the services are being provided?

Of course, another thing to keep in mind while setting up the services is, we do need to keep funding in mind.

I don't have an unlimited amount of funding for every patient, so we really try to focus in on the most important first and then kind of branch out from there.

Next thing, like I mentioned before, I do home visits.

Typically, I will do anywhere from two to four over the course of the 60 days.

Some patients need more than that and I'm happy to do as many as the patient needs, but typically what I'm seeing is about two to four home visits as well.

And then we adjust those services as needed.

So sometimes we have a little bit more at the very beginning, but as the person is at home and experiencing their new normal, we find either we need more or less of those services and we adjust as needed.

Next slide.

So, then the case management part, like we've mentioned before, I typically am involved for about 60 days post‑discharge.

So, we follow the services.

We adjust as needed.

And I do weekly check‑ins by phone for the first 30 days, and then monitor if they've had a readmission, if they needed to go to the E.R.

And we try to give them alternatives, specifically for the E.R.

So we have an agency in the community that will bring urgent care to your home so that we try to recommend if that is something that is feasible, try that first to avoid an unnecessary E.R. visit of course, if only an urgent care visit is the correct route to go would we recommend that.

But we try to make sure they have everything in place for them so they can avoid those.

And then I continue to check in, offer those home visits, and I always monitor the costs.

So, I check invoices, make sure all of our partner agencies are sending those correctly and providing the care that we have agreed to.

Next slide.

So, like we have mentioned before, we did start as a pilot and moved to an actual program.

So, we learned a lot during our pilot phase.

So, at the very beginning we were overdocumenting.

I have, oh, my goodness, I think 15 Excel spreadsheets.

It was all over the place.

Information was everywhere.

It was also in different internal systems that the IC was already using.

So, I kind of tested out using those as well.

And what we found is that not one of those things really hit all of the points, so for the program we actually created a database.

And so, the database is specifically for hospital to home, and it captures everything that I need it to, it makes it very easy.

I have a monthly report I always send to the hospital and that database is able to ‑‑ I type in a few numbers and it spits out the report for me.

So, it's a wonderful tool we have created.

We also moved some of our client documents.

Before I was getting signatures on paper and scanning them in.

And so now that we have figured out exactly what documents we want this program to have, we have PDF files and I'm able to get everything electronically.

So, we're able to kind of save on paper and all of that.

And finally, one of the biggest helps as well, I was able to get the hospital's medical record system on to my laptop.

So before in the pilot I actually was going into the hospital every time I received a referral if I wasn't already there, which was great during that build ‑‑ during building that relationship process, seeing my face, but now that we have that relationship, I'm able to respond quicker having access at my fingertips for those medical records.

Next slide.

Another bug piece between the pilot and the program, of course, was marketing that program.

So, we needed the hospital staff and the patients to understand what is this program?

What are we doing?

And so, what we did to begin with was we created a process map for the hospital staff.

So, during those in services, I explained here is how the program works, but that way the hospital staff could take away something physical.

They could walk away and have a piece of paper that says okay, does the pay shunted have this, this, and this, okay, refer to hospital to home.

Or we also had a couple brochures, again, explaining how does the program work?

So, we actually have two different types.

I have one that talks about the services and how it works for patients and families, and then I also have one specific for more like hospital staff that explains on the hospital side of things what does this program do and when is a good time to refer somebody?

Another part of marketing the program, we created folders for all the patients and families that explains a lot more about The IC as a whole.

It's not just talking about hospital to home, but what other services The IC can offer from all of our Independent Living programs to our home health, everything in between.

And then finally we had a couple really great stories come out in local news.

So, our local business journal put out a story about this program and UCHealth did a story as well.

They interviewed a couple of the patients that went through it, and it was a really great feel good story and healthcare stories just to get the word out about this Partnership and how wonderful it truly is.

Joe, I don't know if you have anything you wanted to add to this.

>> JOE FOECKING: I think in terms of one of the things that was instrumental with the marketing brochure was really an algorithm.

It helped the care managers and social workers know what decision they needed to make under what circumstances or conditions.

I think that was really critical to say if A, B and C, then please refer to this Hospital to Home Program because, really, they're the ideal candidate.

I think that was really very significant in terms of education and training, especially when this program was so new.

Obviously, the new news media much picked it up was wonderful.

The other thing that The Independence Center does that was very helpful was to close the loop.

When an ambulance pulls up to our emergency room and drops the patient and then pulls away, those ambulance drivers don't know what happened to that patient.

Similar to what happens to us sometimes with a patient being discharged.

Again, we did great at the medical care and then we discharge a person out to the community, but we have no idea what happens to that person in the community.

We know if they show back up in the E.D. and we know that's negative, but we have no idea where these complex discharge patients went.

And so, Mandi had the ability to come back and close the loop to say, in this particular instance, this person's been out in the community, it's been 45 days.

Everything is going very smoothly.

And so, it was very respective of personal or protective health information and HIPAA.

But that loop closure, the more we did that loop closure, the more people caught on and realized this is what it's all about, getting people back home and keeping them there safely.

We can advance the slide.

>> MANDI STRANTZ: Then like I mentioned earlier, specifically between the pilot to program, we wanted to collect all of the things we could think about, all kinds of data points so we can show why ‑‑ how is this successful and how did we do it?

This kind of lists off some of the things I do keep track of.

So, of course, in my database I keep track of age, the typical patient demographics, the LACE+ score which we hit a little bit on last time, which the hospital can use to look at the possibility of readmission.

So, I like to keep track of that to see the types of patients, are we taking the low readmission rates, the middle or the high, and what percentage of each.

Of course, like we talked about daily living tasks.

I keep track, are they improving?

Is there something we can do different to help those daily living tasks improve?

We also, of course, I have to monitor the services, what's used, what do we approve at the beginning, we can cover nine physical therapy visits, seven occupational, et cetera.

And then the one that we did for pilot only, we looked at confidence and anxiety between the patient and the family and whether or not it changed between the initial meeting before discharge at the 30‑day mark and at the 60‑day mark.

While this was a very interesting data point, didn't seem to be something that the hospital really focused in on, so I didn't move it on to my program and what I collect now, but, again, it was a very interesting data point when we were looking at the pilot.

Finally, I do satisfaction surveys, and I always send those to the referring hospital staff, the patient and the family, so we can get feedback and adjust the program as needed.

So, if something needs to change, if we need to do something better, this is a great way for us to in the moment learn what we can do better.

Next slide.

>> INDY FRAZEE: So, I'm going to give Mandi a few minutes to take a breath.

The next couple of slides, as Mandi mentioned, we do a lot of data collection, and your data is only as effective as if you analyze it and actually do something with it.

So, evaluation became huge for us as far as are we collecting the right data, what are we doing with this data, and really trying to help us understand, are we meeting the needs of the hospital?

It took a while for us, especially when we were creating the program, to understand what data points we wanted to collect, and if they were going to be helpful in determining the efficacy of the program and turning it from pilot to an actual program.

So one of the other things he ‑‑ some feedback we received from the first part of this webinar was what is it ‑‑ I think they wanted a little more explanation as to the money, and so I wanted to provide a little bit of a math example for you all.

I saw one of the questions in there was: How does the hospital make money on this?

The hospital is not making money.

It's an opportunity cost ‑‑ cost savings for the hospital.

So we're saving the hospital money, and my math example, although not on the slide, hopefully I can walk you through it a little bit, so if you assume an average hospital stay per day was $4,000, and you can get this information from your hospital, that would be ideal that you get that per‑day cost from them, there's some national averages out there you can use if your hospital either might not know it or doesn't feel like sharing it, but we use the average hospital stay of $4,000 per day.

We also asked our hospital kind of a question around length of stay.

One of the data points we were collecting was the number of days between when we get the referral and when we discharge, but really ideally shortening the length of stay was one of the data points we were trying to figure out.

So for our math example, we used five days, and that was making an assumption that the hospital had made along with us that if we did not discharge the individual, they were going to stay an additional five days from that referral.

So, with that you take the $4,000 per day and times it by those five days and you get $20,000 per patient.

So, that was the potential cost ‑‑ additional cost to the hospital.

So, if we times that by the number of patients that we served, that would be $540,000.

When we look at it, our cost to us was $5,000 per patient.

So, a difference of about $15,000.

And ‑‑ I'm sorry, our patient number was 27 for the pilot.

So, if you take the 5,000 times the 27 people that we served, that's $135,000.

So, if you think about it, the hospital could have paid $540,000, but they only paid us $135,000.

So, they have a cost savings of $405,000.

I will put that math problem I just did so that you can all see it written out.

We'll put that up on our website which you'll have access to at the end.

But it's about opportunity cost savings for the hospital.

It's not about the hospital making money with this program.

The last piece is using evaluations from the hospital staff and patients.

We've also been able to demonstrate our success when we were in the pilot phase, but we've also used it to make enhancements to our program.

We've tried to be very flexible and fluid.

And so, when we get that feedback, whether from the hospital or the patient, we are always trying to make improvements to our program.

And lastly, which is not a bullet point here, but Joe mentioned earlier the feedback loop, and so providing that feedback to the hospital staff, I think, has really grown our relationship with UCHealth as a whole.

Next slide.

>> PATRICIA YEAGER: Before we do that, I'm curious, Joe, do you have anything you want to add to the fact you're not making money but that you're saving money?

Is that important to the hospital?

>> JOE FOECKING: That's hugely important to the hospital.

The hospital understands that we're purchasing a service, and in that relationship it may be transactional in terms of purchasing that service, but if we're going to purchase a service, we want to understand that the entity we're purchasing it from shares our mission, vision and values, which The Independence Center does.

That's where I would say, take for an example, an individual who comes in, they're diabetic, they have poor blood pressure control and they end up having a legislature amputated below the knee.

They lived alone.

They were kind of making it on their own but not really.

Now that they've had this operation, the concept of returning home seems insurmountable, and that's where, again, picture the hospital providing the medical care.

Picture the hospital attempting to set up the discharge planning to get this individual back to their home.

But then consider the social determinants of health and where this individual may need some support.

Were they making their own meals before they even came?

Maybe, maybe not.

Did they have any nutritional value?

Make, maybe not.

Are they able to access everything in their home?

Do they need a ramp?

Can they get out and go to different appointments?

And so, when you look at that, I think that's a good example of here is what the hospital does and does very well.

But here's really where the hospital stops and where we need a community partner to address what's going to keep this individual in the community in a safe and healthy manner.

Hopefully that brings it to light.

I think case examples will bring it to life.

I think that sheds light on it.

We know we're purchasing a service, but we also know that what could be a five‑day length of stay in the hospital may turn into 10 days, may turn into 15 days, may into 20 days.

The patient is medically stable and ready to go but we can't get them out the door back into the community and that's where you do Indy's math with that $4,000 a day.

If they're there when they don't need to be there, everything continues to roll.

>> PATRICIA YEAGER: And when they don't come back ‑‑ when they're not readmitted, that's also provides a benefit to the hospital?

>> JOE FOECKING: Correct.

Remember what we talked about last week.

If I'm discharged today and I go home, there's a clock ticking now.

If I come back into the hospital, I come back into the emergency room and I'm admitted, that admission in the hospital is free.

We cannot bill for that readmission.

We cannot make any source of funding Opry admission because the argument would be you should have handled any issues in that first hospitalization.

The second admission is on you.

So, a huge motivator for the hospital to prevent readmissions.

>> INDY FRAZEE: Thank you, Joe.

So, on slide 20, we did a lot of cost analysis.

We talked in Part I in our spreadsheet of all the costs that we analyzed beforehand, before we even had our first patient, actually before we even hired Mandi when we were still trying to understand the concept and seeing if the money make sense, we did a lot of analysis then.

But then as we got into it and we had our funding from the grants and we started doing our pilot program, we also needed to monitor each patient cost and each transition and really collecting the data of what kind of services people were utilizing the most.

Did he they have insurance or not?

We had to take into consideration it's not as expensive a transition if insurance can pay for some of the services the individual is needing.

And we really also take a look at the complexity of the patient and what their needs are.

So, this is really important to understand and for us to learn what utilization that patients have and hopefully predict some of the costs for future.

I will tell you that predicting costs has been one of our challenges, but I think I mentioned at our webinar last week that we really kind of set a budget of $5,000 and very, very rarely do we go over for each individual transition.

Most time we're under the 5,000.

But each patient is very unique, and so the prediction has ‑‑ it gets easier, I will say that, but that's why your coordinator needs to really be focused on what that budget is and the services the individual is needing.

We provided a breakdown of the average of what patients are utilizing.

So, you'll see that home health and therapies are a bulk of what the services the individual is receiving, and then durable medical equipment, medications are second and third.

And then transportation, meals and kind of that other category.

So over half is going to go into that medical piece, and then from there it's making sure that people have transportation to get to their follow‑up doctors’ appointments and just making sure they're staying connected within their community.

We also not only do we track our cost per patient but of course we're also tracking our program costs, the time and the salaries and the benefits, any equipment and supplies that we have for the program.

But a bulk of it is definitely that per‑patient transition cost.

Next slide.

We are a lump sum contract, as we mentioned last week, and some of the pieces here just administratively that we need to do, Mandi does a lot of reviewing of invoices from all our different partnering agencies and keeping track of all of that.

We do bill our hospital monthly based on any actual costs that we incurred during the previous month.

And then Mandi mentioned this earlier, we also provide a report on a monthly basis of all our active patients and services they're receiving.

So that they are aware of where their money is going to.

Next slide.

>> MANDI STRANTZ: So, the next couple slides, I just want to tell a couple success stories to try to put it into perspective like how it actually works with a real‑life example.

So, this first one here was a gentleman.

He ‑‑ like it says, came into the hospital.

He had a seizure and a fall in his home and was in the hospital for about 17 days.

He needed a lot of assistance.

His was very focused on his social determinants of health.

So, getting him home was pretty complicated, especially from the hospital's point of view.

A lot of things that would have been out of their control.

So, after I met him, he had Medicare for his insurance to begin with.

We were going to be working on Medicaid.

But what happened first is I actually went to the home before his discharge.

He lived in a mobile home.

His home was a mess.

There was actually a squatter that had been living in his home while he was in the hospital.

And so, there was dog feces everywhere.

Someone had used his restroom and then for some reason it wasn't able to flush, so there were flies ‑‑ I mean, this home was not suitable for him to come home.

So that was one of the first things that the Hospital to Home Program was able to look at, was to help get this home cleaned up so he can come home safely, because he did not have, really, any family or community support.

The next thing that we found was that he did not have any running water.

So, we were able to connect him with a plumber to make sure that he would be able to come home and use the bathroom to take a shower and to do all those basic tasks.

He also needed some assistance with durable medical equipment.

So, he needed a ramp outside after his fall.

His Walker was what he used the most, but he had about four or five steps to get into his mobile home.

That was becoming even more difficult for him as he had lost about 60 pounds and was down to just over a hundred pounds as a 5'10" grown man.

So, we were able to assist with getting a ramp in place.

Then, of course, other things, like a tub transfer bench and things along those lines.

So, once we got him home, now we wanted to focus on what benefits can we put in place to make sure that after these next 60 days we can help him be successful in his home.

So, we needed to put a lot of different benefits in place.

So that included getting him on Medicaid, as he had a very strict income of ‑‑ I think it was about 950 per month on his Social Security.

We also applied for long‑term care Medicaid which would help bring caregivers into his home because he ‑‑ the reason he lost all that weight, like I mentioned before, was because when he was ‑‑ before he went into the hospital, he actually would be in so much pain after standing in the kitchen and cooking that he would end up not being hungry anymore, and so he wasn't eating ‑‑ he maybe was having one meal a day.

So with this long‑term Medicaid application and getting it approved, we were able to get caregivers to come into the home to help provide and cook meals for him and then, of course, daily living tasks he needed assistance with.

Again, with him being on his strict income, we helped him apply for food stamps and LEAP which is a program to help pay for heat during the winter months.

And then we connected him with other food banks and commodities in the community.

So that way he could get fresh food biweekly on top of what food stamps provided.

So again that made it so he could ‑‑ he didn't know where his next meal would come from, and we were able with the caregivers and having food in the home make sure that he was able to be successful that way.

We also assisted with helping him obtain a government phone as he didn't have a phone, and we also were able to get the lifeline in place since having seizures and falling was definitely a high concern for him.

So that was just within the first 60 days, and now ‑‑ I kept in contact with him, and he's thriving.

He's on The Independence Center's unskilled side care.

So, we provide caregivers to him to this day through his Medicaid waiver, and we were able to make sure that he hasn't gone back into the hospital.

Let's see, it's been just over ‑‑ well, a year and a half, I think, since this discharge, and he's only been back in for two planned surgeries.

No other reasons for him to go in, which is wonderful.

And then like that last bullet states, it was predicted he would be going to a facility had hospital to home not been able to step in and provide the assistance.

Next slide.

So, this second story, a little more recent, but 38‑year‑old woman, she ‑‑ I think it was a Sunday, she was ‑‑ she's not feeling very well.

She went to the emergency room and ended up with toxic shock, septic shock, and they ended up ‑‑ she ended up in the ICU, and I think I'm explaining this correctly, this is coming from the hospital staff, but it sounded like they actually needed to connect her to life‑saving equipment, and during that time she lost both legs and her hand due to the being on the machine basically to keep her alive.

She lost the use of those limbs.

So, she became a triple amputee during that hospital stay.

So, she was in the hospital.

It was 95 days in the hospital, and then she was in a rehab facility for 31 days on top of that.

And so, at that point she had no health insurance.

So, she had no coverage for any of the support she would need afterwards, especially since she was going to have a new normal that she was going to have to get ‑‑ learn how to do.

So, when hospital to home stepped in, we actually became involved very early on in her hospital stay.

So I actually met her probably 45 days before she actually discharged and what we started working on was getting her connected to grant funding, because her home ‑‑ she lived in a tri‑level home, and now being a triple amputee, that was not going to be suitable for her to be able to meet her needs in her own home.

So we went through applications for some grant funding to help with those home modifications and we actually got approved for ‑‑ I think it was about $12,000 to assist with a ramp, we got her a stairlift so she could get to her bedroom and bathroom, we had bathroom modifications on there, and all of that.

We were able to get that going prior to her discharge.

Then, of course, we put support in place after her discharge as well.

So, we were able to set her up with some equipment that she needed because, again, she didn't have any type of insurance or support to cover any of.

She needed quite a bit of support.

She needed a hospital bed, a wheelchair, so on.

And then we started her benefit application while she was in the hospital as well.

I worked with her husband and worked with another agency in the community to get her approved for a long‑term care Medicaid waiver, and she ended up getting approved, I think, about 30 days after she discharged, which was huge for her.

Made it so she could continue her skilled therapy.

Made it so she can now ‑‑ she's going to be fitted soon to get an electric wheelchair and things like that for her home.

And she's able to use her Medicaid funding to continue her support.

Before hospital to home became involved they were looking at trying to see if she could be placed in a facility because we weren't really sure how it was going to work with her being at home, but I think with hospital to home we were able to put that support in place for her and she was able to get home and she's been successful since.

She has not had a readmission.

She did go to the E.R.

She had a catheter malfunction and her primary care wasn't able to fix it.

So, they did send her to the E.R. for that, but otherwise she has been home and thriving since.

She's been ‑‑ which has been probably three or four months now, and she has been a great success.

Next slide.

>> INDY FRAZEE: Thanks, Mandi.

I love hearing all the stories of the people that we impact with this program.

The next two slides are the statistics basically from ‑‑ the first slide on 24 is a pilot and the next one is our current program up through April.

Same numbers as last week but just to remind you, our pilot program, we started out going to do 12 months.

We extended it to 16 months because we had some additional funding ‑‑ not additional funding.

We just had funding we needed to use up from our grants.

When we started our pilot, we committed to one transition a month just to get our feet wet and see if everything that we've put in place or the concepts we had was working, and now ‑‑ and throughout that pilot process we started doing about three to four transitions a month.

Ultimately in the pilot we had 27 transitions, which our goal was 16.

We had two readmissions out of the 27, and we had nine ER visits, and two of those then became readmits.

Our average number of days from referral to discharge was three, and the patient participation is ‑‑ that says 72.

That's actually closer to 52.

The LACE+ Score, someone had asked what LACE was, and so that website there will explain a little more about what LACE is.

Our hospital uses the LACE+ score, which is a little bit different, but really what it is, it's a mechanism to ‑‑ hospitals can use to identify individuals' risk of being readmitted.

So you can see there that we took roughly over half, obviously, of moderate and high risk individuals for readmission, but it's not something that we turn someone away if they're not, if they're like in the green zone.

So, it's just another metric for the hospital to understand if that person is going to readmit.

Next slide.

And this is the statistics again from our program.

So, our contract runs August 1st through July 31st.

So, we're almost done.

This is nine months in data, and so we've done 33 transitions.

Only two readmissions there and three E.R. visits, two of them turning into readmission.

And then our average patient participation, I think we got happy with the seven because most people do not go over the 60 days, and then again, our LACE+ scores most being in that moderate or high risk.

Next slide.

>> MANDI STRANTZ: Finally, like we mentioned in the first webinar, we did have some lessons learned from pilot to program and continuing on.

So, one of the biggest lessons, I think, we've learned is we need assistance with other agencies, specifically around individuals with substance abuse history.

So once we figured out that that was not so much in our wheelhouse, we reached out to a mental health provider in the community, and we are working with them now to try to create an agreement so that we can work together to fill that gap when that is a need for a patient.

Then, of course, we did learn that we are unable to serve the homeless population.

We really just need someone to have a place to go, whether it's aunt's house, friends or a hotel.

We can make things work with that.

But an individual being discharged to the streets, that's just an area that we don't have the resources to provide the assistance for them.

Another thing we learned specifically between the planning process of the pilot is that costs were not as high for each person as we originally expected which is why Indy mentioned we were able to extend the pilot by a few months because we predicted a much higher cross‑.

And then another big thing here is a language barrier.

So, individuals, if they don't speak English or community members don't speak English, we just needed to make sure our network of agencies would be able to still provide for those patients.

I think we've done a great job creating our network.

That's become less of a barrier recently as we've added to our community of agencies.

Next slide.

>> INDY FRAZEE: So we were part of the ILRU business learn acumen learning collaborative that started I believe July of last year and during that collaborative we came up with a website and put all our materials on that website.

So the URL is up on the screen, and it can be access through the PowerPoint, and so we encourage all of you to, if you're interested in hospital to home, we've got a lot of information out there.

We're also very readily available if there's other questions, but I would encourage you to go take a look at this website and take a look at all the material we've put up there just to get more inform familiar with the Hospital to Home Program and how we got started.

>> TIM FUCHS: All right.

Here we are on slide 28.

So, we're going to work through these questions that have been coming in.

There were some good questions that came in early on that you all addressed in the slides.

So, I've marked those as responded to, about the LACE and other things.

But if ‑‑ to those of you in in the audience that asked those questions, if we didn't provide enough detail or you have lingering questions, let us know.

We have a bunch of questions to go through.

I will do my guest to bet through all these in the next 20 minutes.

I'm optimistic we can do that and if not, we'll try to get a response for you by email.

June was wondering if you were a home health agency before you were a Center.

She notes it's unusual for a Center to often home health, and I was wondering if you could share a little about that history and whether or not it was controversial when it happened.

>> PATRICIA YEAGER: In the mid‑80s a woman by the name of Vicki Skoog was in a car accident and became a quad and she had a young son, was facing going into a nursing home.

Barry Rosenberg whom I think June knows and several other people came down to Colorado Springs to teach Vicki how to set up a Medicaid‑funded home health agency, and so that's what started the organization.

She worked with young people, all sorts of people, to help them live at home with CNAs, because that's what Medicaid would fund in the home at the time.

So, it wasn't controversial.

It was sort of a natural progression from ‑‑ particularly given who the founder and the board was at the time, people with disabilities looking at how to keep people at home even in the late '80s and into the '90s.

So, she was a trail blazer for sure.

And then we became an Independent Living Center after that that added to the services that kept people at home.

So, we kind of did it backwards.

>> TIM FUCHS: Thank you, Patricia.

As I paste the link to someone and actually put it into the PowerPoint.

Let's go back to the Q&A.

Stephanie was wondering, Mandi, you offered you will go to the consumer's home on the day of discharge if you haven't already been there and Stephanie was wondering, is going to their home on the day of discharge a bit much for everyone all at once or has that worked well for the person that's coming home, their family, et cetera?

>> MANDI STRANTZ: Typically, it works out well because most of our patients do need some kind of equipment, and so that's usually when I deliver that equipment.

That way they can have it as soon as they get home.

So, it's actually worked out really well and patients and families are very open to it, because I don't force them, I'm not saying, can't be in this program if I don't come.

Everyone has allowed me to come in a ‑‑ I try to make it short and quick.

I don't want to overstay my welcome by any means.

>> TIM FUCHS: This next question has come up.

It's kind of been asked a couple different ways here and we saw it in Part I, and how are you all paying for some of the things that people have received in your success stories and your examples, and this person is wondering, as a part of that, what services, if any, are your partner agencies providing that you are paying for?

So, my understand from Part I is that most those things like the air conditioner example in Part I, those are coming out of the grant funds.

Is that true of other provider services as well?

Are they expected to be reimbursed or compensated for the services they provide?

>> INDY FRAZEE: I'll take that one.

We do pay all of our service providers, that is being provided to the individual, is either being reimbursed by insurance.

For example, a home health agency, if the person has insurance to pay for the home health, then they'll bill ‑‑ the service provider will bill the insurance.

A lot of times we don't have a payor or insurance, and so we, The Independence Center, are paying those individuals ‑‑ not the individuals ‑‑ the service providers to do the work.

And so, we have all those negotiated and set up in MOUs as far as rates are concerned, and the hospital pays us for the service, and then we turn around and pay our providers.

>> TIM FUCHS: Okay.

Great.

>> PATRICIA YEAGER: Let me just expand a little bit.

When we put this together we thought ‑‑ it's in two buckets, one bucket is administrative, which is where Mandi's salary comes in, Indy is her supervisor, so it's about 3,000 for the administrative bucket and about 5,000 for services we may need, like the air conditioner or ramp or home health aides until benefits kick in.

When you do your own pilot, you go' come up with your own mix of funding based upon the patients you work with.

>> TIM FUCHS: Okay.

Great.

Mandi, Stephanie was wondering what the difference between an in‑home urgent care visit and a call to 911 that may include an ambulance visit or stabilizing procedures?

>> MANDI STRANTZ: There are some things you need to go to the E.R. for.

So, we would never want to tell somebody, well, no, since you are within the first 30 days, we don't want you to go.

So, if their health need is requiring the actual hospital, then, of course, we want that.

But if you need and x‑ray, if you need just a nurse to come out that you might be able just to go to urgent care and receive the correct care that you need for whatever medical thing that you're experiencing, then we do recommend to do that, call ‑‑ it's called dispatch health.

They take insurance.

They take a lot of insurances, actually.

So, it's just like going to an urgent care without having to physically leave your home.

So, if transportation is a barrier, things like that.

Does that help?

>> JOE FOECKING: To add on to that, consider your community.

Our community in Colorado Springs does not have the number of primary care physicians that we need to support our community, and so our E.D., our urgent cares, are seen, really, as primary care providers, and so one thing I would suggest is know and understand the landscape of your healthcare environment.

Here it is very common because folks don't have a primary care doc or couldn't get one, they go to the E.D or emergency room for primary care.

Another example would be is if somebody is having a raging infection, by all means, take them to the E.D.

They need to be treated at that level of care.

If, however, it's kind of a low‑level fever and just don't feel good, do we need an E.D. visit to address that need or could they have gone to an urgent or primary care to get an intervention, get an antibiotic.

That that was the case, that's connecting them with the right level every care to meet their needs.

We're not saying to people you can't come into the E.D in the first 30 days.

If they need the E.D, they need the E.D. and we'll provide them the care.

But it's identifying what exactly do you need.

>> TIM FUCHS: Great.

Thanks.

I'm going to toss this at Patricia and if somebody else wants to chime in, let me know, Franklin is asking, he says: In our location our MHP, which I think Franklin is in Colorado, too ‑‑ is that Rocky Mountain health, provides that kind of case management.

Is there a conflict between those two programs?

Or is it supplemental?

Or does that not apply in your area?

>> PATRICIA YEAGER: Our regional accountability entity, which is what he is talking about, it's not a managed care organization, and I believe yours is.

The thing that I understand that's different again the two is we're going to the person's home.

We're out after their discharge to their home providing services and all of those kinds of things.

It's my understanding that managed care may not do that, and so that's something that you can offer as a benefit to the managed care company to say, hey, we're keeping our eye out on this person every day.

Somebody either from Mandi or the home healthcare nurse or the OTPT or the homemaker is in the home every day.

Somebody is.

And so, we've got eyes on the consumer more so than the managed care company usually does.

But that's a benefit and a distinction that you can use to ‑‑ let me use this language ‑‑ you can use it to sell your service.

>> TIM FUCHS: Great.

Thanks.

Indy, June is wondering, regarding the eval and the satisfaction feedback, what are the most important questions in that survey from your perspective?

What feedback have you gotten that's helped you all to improve the program?

What do you look for there?

>> INDY FRAZEE: The questions, I don't have them off the top of my head, but we certainly ask, did you receive quality service?

We want to make sure that the services that maybe we're not providing and we're asking our service providers to provide are ‑‑ did you get good service from them?

Just so that we can keep an eye on making sure that we're still having our providers provide quality service.

Also, just satisfaction with the program as a whole.

You know, could we do anything different or better when it comes to the interaction they have with Mandy.

And so, I would say those are probably the couple of things off the top of my head.

Mandi is there anything else?

I guess the other thing I would say is we provide a satisfaction survey to the individual that received the services, so the patient that discharged and we also send one to the hospital and just ask them some questions on how we could do better as far as the referral and how everything went.

Mandi?

>> MANDI STRANTZ: No, I think you pretty much hit that on the head.

Then I also have one for family.

If a family is very involved, I want to make sure I get their feedback as well.

>> PATRICIA YEAGER: And the instrument is on the website if you want to see the questions, that sort of thing.

It's everything that we've done, worksheets, all of that, it's a do it yourself kit for how to set up a Hospital to Home Program.

You'll find it there.

>> TIM FUCHS: I've seen a lot of CILs that have shared success with folks and with the network given my work in the IL‑NET program.

I have never seen this much information about program design and program execution put online for everyone to borrow from.

It really is excellent.

And I got some questions in the chat about materials.

Just two things quickly.

First of all, you all should receive ‑‑ had received this PowerPoint in the confirmation email.

If you didn't notice that attachment, please go back and look.

It didn't just include the Zoom link.

Attached to that was this PowerPoint.

So, folks worrying about the web Lynn, was it's a little too long to read, you have that in the PowerPoint.

Then secondly just a plug to go to the website and use it because everything is there.

Also, there are several folks asking about the economics here again, the business case and how this is all paid for and how it saves the hospital money.

With the seven minutes we have left I want to get to some of these other questions.

But we covered that extensively in Part I, and Indy gave a good overview right at the beginning of this call.

I would encourage you to revisit those presentations to get the answer there.

And if you have specific questions about details of that, let us know.

Just quickly, Mandi, what was the ‑‑ what was the end of the pilot study?

How many people participated in the pilot study?

>> MANDI STRANTZ: We had 27 participants in the pilot.

>> TIM FUCHS: Okay.

Thanks.

>> PATRICIA YEAGER: And how many have we served since the beginning of the contract?

>> MANDI STRANTZ: So up to today I have 43.

>> TIM FUCHS: Great.

There are a number of people asking, too, does ‑‑ when you all talk about the cost, and we think about budgeting for this and your total cost, is this really everything?

So, when you all laid out the cost for the program, does that include Mandi's salary, does that include other staff salary?

Is that an all‑in number?

And I'm see young head nods.

So, it sounds like it is, Patricia.

Or Indy.

Either one of you.

>> INDY FRAZEE: The example I gave, and I thought a I saw a question in here, of the 135,000, that's with the hospital stays.

So, I will tell you our contract with the hospital this year that runs for 12 months is $180,000, and that's all in.

So whatever we can do Wes dollars, and we pay for Mandi's salary, pay for all the program costs, and so we kind of take that right off the top and whatever we have left over, that's what we're going to utilize to do transitions.

>> TIM FUCHS: Great.

Thank you.

Megan is wondering, how are the benefit and service applications completed?

Do you do those?

To what extent is the patient or their family involved in that procession?

>> MANDI STRANTZ: That's usually one of my home visits, I go to their house, and we go through the paperwork together.

If the family and the patient want to do it on their own, of course, I always offer that, but most of the time they prefer that I am involved, and then I ‑‑ once I have them fill it out, we sign it, and then I'll even send it into DHS, do follow‑up, make sure that they have everything.

>> TIM FUCHS: Great.

Apologies.

I'm just trying to type out a couple quick questions in the chat.

BDCIL is wondering, are you a social worker by training, Mandi?

>> MANDI STRANTZ: Yes, that's what my experience is.

>> TIM FUCHS: Thanks.

Karen is asking, you all talked about this a bit in your lessons learned on the last slide, but I thought I'd give you an opportunity, Mandi, just to add anything that you wanted to for Karen.

She says, how do you serve individuals with no natural supports or to fill gaps between services.

We saw in your lessons learned and in Part I you all realized there were some folks weren't going to be able to be helped effectively through hospital to home.

Any other insights into that or ways you found to help folks that don't have a lot of support in the community?

>> For those individuals, it's a lot more hands on for me, for those 60 days, for sure, and then my hope is that I'm able to find something in the community to connect them to to make sure that they continue to thrive after those 60 days when I'm no longer providing that case management.

>> TIM FUCHS: Great.

Indy, you touched on this a bit when you answered the financial question a minute ago, but just as a follow‑up from Lisa, she is wondering: How many of the CIL employees work on this program?

We know Mandi is all in.

You touched on the fact some others were involved.

Do you happen to know like an FTE equivalent or anything like that?

>> Probably not an FTE equivalent.

I know we utilize our benefits individuals as well as our ‑‑ like Mandi mentioned earlier, assistive tech person occasionally.

And I'm trying to think ‑‑ peer support.

So, I don't have an FTE necessarily because it depends on the transition, if someone utilizes those services or not.

>> TIM FUCHS: Okay.

>> PATRICIA YEAGER: It's important to know that Mandi really is not a member of the Independent Living Center team.

We have several teams here.

She's a member of the home health team, but there's a lot of cross pollination going on and we made the decision not to have an IL skills specialist do Mandy's job because we're training the IL skills specialist ‑‑ you're not doing hands‑on work.

You're waiting for the consumer to tell you what they want to do and it's much more consumer driven.

When it's coming out of the hospital, it's much more of an emergency or crisis situation for them and family and you need much more hands on until you can transition them over to the Independent Living, which happens in the second month.

>> TIM FUCHS: From your examples, was the program able to pay for the cost of the mobile home, water, bathroom, those other expenses that you all would have had?

>> MANDI STRANTZ: Yes, that was part ‑‑ that would kind of fall under how I have other.

I am sure you have seen that pop up under services.

That falls under our other category.

>> TIM FUCHS: Okay.

Good.

Franklin is wondering, quickly, if your readmission rate was linked to anything you did differently from the pilot, or has it just been good luck from them that the numbers improved?

>> MANDI STRANTZ: That's a good question.

I don't know if we just learned and were able to help, or if the patients just were healthier.

I don't really have a good explanation as to why.

>> TIM FUCHS: That might be an answer in and of itself.

Sounds like you didn't make calculated changes because of things in the blue but you did share some good lessons learned you all had along the way.

Quickly, Patricia, how many total employees does the organization have?

>> PATRICIA YEAGER: We have 338 employees, 250 of them are caregivers, family caregivers, CNAs that work in the home health side.

>> TIM FUCHS: Good.

So for everyone picking up their jaws right now, one of the nice things about this program, though, is it is scalable, and I've enjoyed ‑‑ I had the pleasure of working on the IL‑NET business acumen learning collaborative, not to be confused with the ACL business acumen learning collaborative.

But watching other CILs get excited and try to replicate this program, we had a couple people ask what other CILs are doing this around the country, I'm not aware of any CILs doing it yet but check back in a year because we have some folks very excited about this and pretty far along in the process.

That, coincidentally, is the end of our list of questions that we had.

So, thanks for working through those quickly with me.

Go ahead, Joe.

>> JOE FOECKING: If I could interject quickly.

Maybe a question for the CILs to answer their hospitalist how much charity care the hospital is providing, because the amount of charity care the hospital is providing, that's where you're hitting into that hospital savings.

Our hospitals made the decision it's a much greater investment to spend the money with the Independence Center and the Hospital to Home Program than to spend more money on a charity care.

>> TIM FUCHS: Great point.

Good point to end on, too.

So, for everyone, just again, acknowledging this was a two‑parter.

So if you didn't have a chance to watch Part I or if any questions remain about kind of the foundational cost and program design, how does this work, how does the hospital pay for it, how do they save money on this, go back and watch Part I.

If any questions remain, send them to me in email at tim@ncil.org.

Be more than happy to answer your question.

If I can't answer it from what I know about the program, I know the folks at the IC would be happy to get back to you.

Before we close, I want to plug this evaluation.

This actually isn't a live link but when I close the webinar today the evaluation form will open on your screen and if you need to run or you're only on the phone, you can get this same link in the confirmation email sent to you with the connection and PowerPoint instructions.

I can't thank you all enough, Indy, Patricia, Mandy and Joe for sharing everything you have learned along the way.

It's been a blast.

So lucky to have gotten to do this with you all a few times.

To our audience, thanks to you, too.

We had a great turnout on these two calls.

I hope you found it informational and let us know what you thought in the eval and send me your follow‑up questions.

We'll talk to you soon.

Bye‑bye.