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IMPROVE QUALITY : IMPROVE RELATIONSHIPS

HOW ONE ORGANIZATION DEVELOPED CLINICAL SYSTEMS TO IMPROVE OUTCOMES FOR INDIVIDUALS AND RELATIONSHIPS WITH PAYERS.

November 2018

NASUAD
National Association of States United for Aging and Disabilities

Today's Speaker

- Debra Scheidt, Executive Director – HCBS
  - United Disabilities Services (UDS)

Stories from the Field Contest

- Contest to obtain stories that:
  - highlight a strategy that was used to improve the financial position of disability CBO.
  - are relevant and replicable to disability CBOs navigating a changing environment.
  - demonstrates a positive impact on the persons served.
  - demonstrates a positive impact on the administration and/or delivery of the CBOs services.
  - improves the delivery and accessibility of the CBOs services to a diverse range of inquirers.

Highlight successful business practices working with or for…

- Managed care
- Private pay
- Health systems
- Cities, counties or municipalities
- Other Community Based Organizations
- Universities
- Any other organization that helped to improve the operations or financial performance of your business

Quality Drives Business

HCBS Culture Change

Merging Social & Medical Models in HCBS to fully embrace Person Centered Care through Quality Measures

Who We Are…
United Disabilities Services

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UDS Foundation is a non-profit organization based in Lancaster, PA with a presence in 40 PA counties and beyond.

Committed to helping people with disabilities, including veterans and the elderly, lead more independent and fulfilling lives.

In our over 50 years, we've developed a wide variety of services and programs that improve quality of life and expand boundaries – including:

- **Care Management**
- **Accessible Home Modifications**
- **Service Dogs**
- **Custom Wheelchair Seating**
- **Non-Profit Management Solutions!**

Who We Serve…

- Over 350 caring, dedicated employees proudly serve people with disabilities throughout Pennsylvania.
- Last year alone, we provided services to more than 5,000 clients, enabling them to live more happily, more independently, and in control of the decisions that affect their lives.

United Disabilities Services (Care Management)

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Care Management to help individuals with physical and age-related disabilities live independently in the community

- Coordination of Person Centered Care
  - Maximizing health and safety
  - Assistance to link to chosen treatment, natural supports & other services
  - Help addressing basic physical needs and supports for a stable community life
    - Home Modification, Vehicle Modification, Medical Equipment
  - Preventing and managing crisis with intervention and stabilization services
  - Coordinating an individuals physical and mental health treatments, determine the best methods of finding funding for treatment, help with transportation
  - Assisting in maintaining eligibility for Waiver via appropriate documentation
  - Connecting individuals and family to kindred, peer, and other social support networks

What we're going to talk about next…

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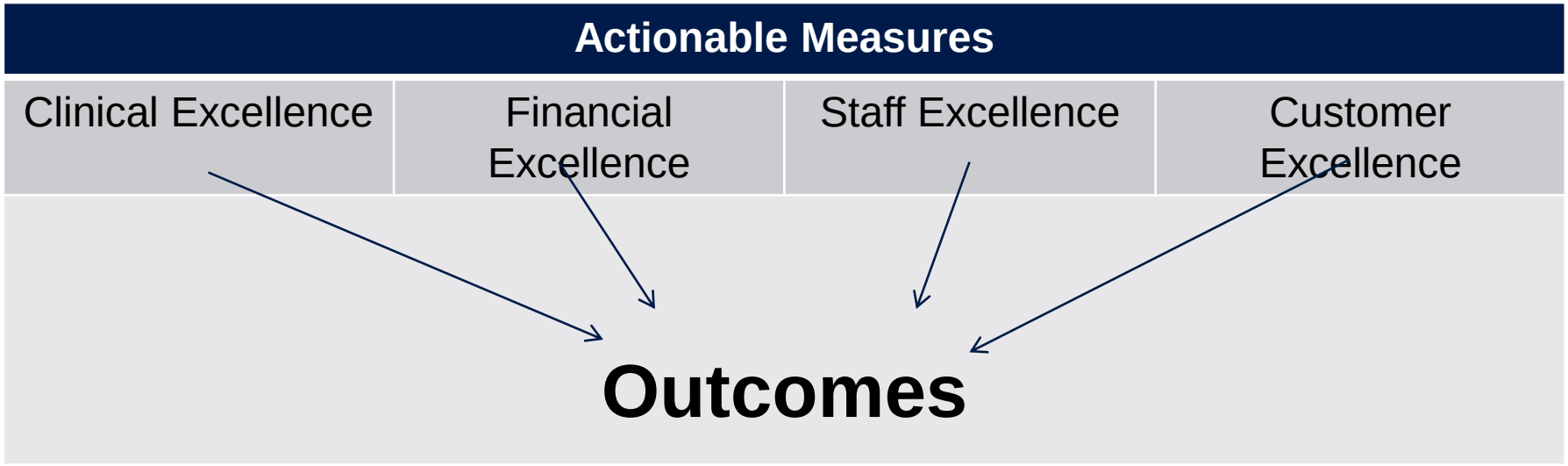
1. The financial benefits of Person Centered Initiatives

2. Quality measures that merge a social and medical model to better promote person centered care

3. How to create quality performance measures within your site of service that can produce positive outcomes for participants and payers both.

A Strength Based Approach



Can hospital re-admissions and repeat emergency room visits be reduced?

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- High Utilizers sometimes referred to as “Super-users” with complex medical needs make up a small fraction of U.S. patients, but they account for half of the nation’s overall health-care spending

Health Care Costs: Financial and Human Side

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- Approximately 25% of U.S. health care expenses are incurred by 1% of the U.S. population, and 50%of expenses are incurred by 5% of the population.
- According to the Agency for Healthcare Research and Quality 2017: The average cost for one day in the hospital in the US is $2,214. The average length of stay is 5 days. Thus, the average cost for a hospital visit is over $10,000.
- The average cost for an ED visit is $1,233.
- Compare this to the average rent in Pennsylvania for a one bedroom apartment which is $880 per month.
- **Then there is the human side to consider**. Every time we send someone to the hospital, it's stressful," for both the patients and caregivers." "We send someone in [and] we kind of shudder, *Are they going to come out better*?"

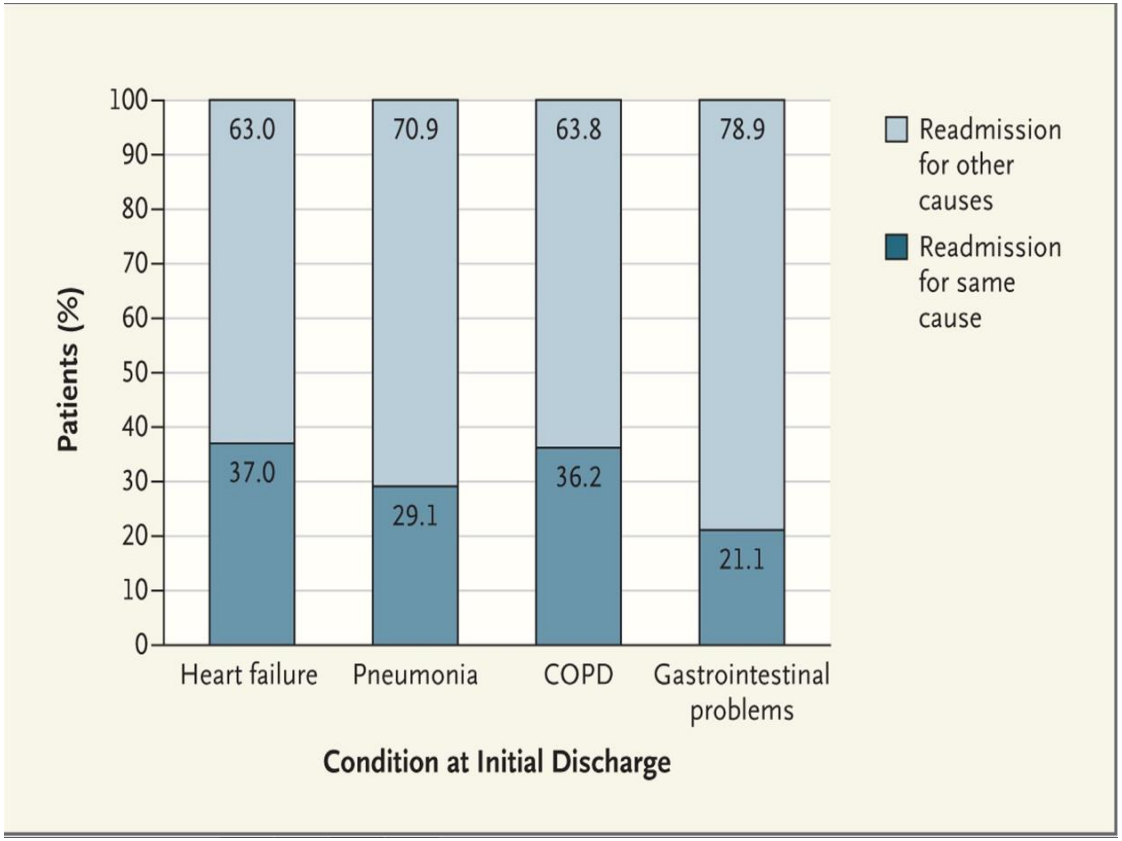
1. https://www.ahrq.gov/ . *Kaiser State Health Facts, accessed in 2017 and based on 2015 data.*
- *https://www.kff.org/other/state-indicator/total-population/*
- 2. *The Atlantic https://www.theatlantic.com/business/archive/2012/01/5-of-americans-made-up-50-of-us-health-care-spending/251402/*

Post Hospital Syndrome

The New England Journal of Medicine describes it as “An acquired, transient condition of generalized risks.”

Nearly one fifth of Medicare patients discharged from a hospital –approximately 2.6 million individuals– have an acute medical problem within the subsequent 30 days that necessitates another hospitalization.

30 Day Re-admissions



Reference: Post-Hospital Syndrome — An Acquired, Transient Condition of Generalized Risk
Harlan M. Krumholz, M.DN Engl J Med 2013; 368:100-102 DOI: 10.1056/NEJMp1212324

Performance Improvement Analysis (PIA)

PERFORMANCE IMPROVEMENT ANALYSIS				
Goals:		**Baseline: =**		
1st Quarter: _ _____ 2nd Quarter:_____		3rd Quarter:_____	4th Quarter: _____	
ACTIVITY/INDICATOR (Discovery)	FINDINGS (Analysis)	CONCLUSIONS (Design) Update material	ACTIONS/RECOMMENDATIONS (Implementation)	Evaluation (Outcome)
Why are we looking into this indicator: • New Directive • Suspect need • Best Practice	What we find once we look at the indicator.	What is needed to improve the process, generate a better outcome, etc.	Process steps • What will we do and why • Who will do what • How will we communicate the process • How we track and trend	Will be reviewed monthly and written updates to this plan quarterly. Results shared with all team members (stakeholders)

Change Management

- We already do person centered care
- We are not medical
- We have always used a social model
- We do not want to change – it's working this way
- Will this mean more forms?

Translation…

- Will I be good at it? I am confident in what I do now.

Again, We are Social Workers after all…So let's start with emotional wellness our strength.

How to overcome Don't Ask/ Don't Tell

- Understand the basics
- Ask the basics
- Use an emotional wellness survey
- Understand how you can help
- Know resources
- Communicate with those able to help and provide follow up services

Focus on the practical needs to be addressed

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There is general agreement that Long-Term Services and Supports programs must address a range of social and pragmatic needs, like transportation, housing, nutrition, isolation, **emotional well-being**, and medical problems.

Mood Disorders

Depression & Anxiety does play a role in unplanned hospitalizations and ED visits among people with long term conditions (LTCs)

16 independent studies were identified. Pooled effects indicated that depression was associated with a 49% increase in the odds of urgent healthcare utilization.

Does depression predict the use of urgent and unscheduled care by people with long term conditions? Journal of Psychosomatic Research Volume 73, Issue 5, November 2015, Pages 334-342

Association: physical disability and depression

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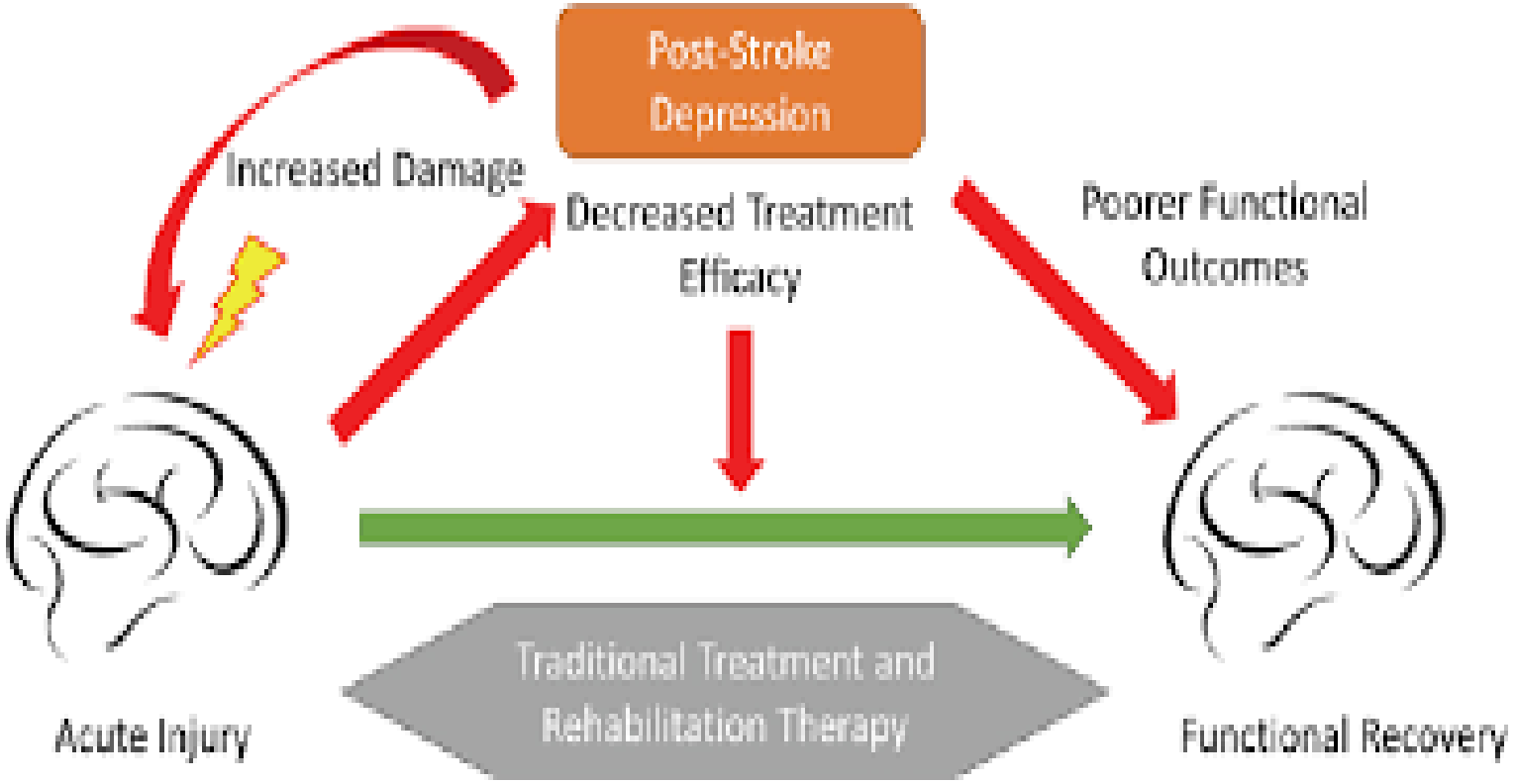
The disabled are at dramatically elevated risk for depressive symptoms for both men and women of all ages. Longitudinal analyses show eventful stress and chronic strain to be significant determinants of depression. The positive effects of mastery and social support are clearly observable within all age groups.

"Incredible mental fitness – both intellectually and emotionally;" words that described scientist Stephen Hawking

- *R. Jay Turner and Samuel Noh, Journal of Health and Social Behavior Vol. 29, No. 1 (Mar., 1998), pp. 23-37*

Major depression in stroke patients



- Monica Åström, MD; Rolf Adolfsson, MD; Kjell Asplund, MD
- https://doi.org/10.1161/01.STR.24.7.976 Stroke. 1993;24:976-982

Common Emotional Changes Post Stroke

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- Due to structural changes in the brain and loss of function, stroke commonly causes:
  - Depression
  - Anxiety
  - Frustration
  - Anger
  - Sadness
  - Sense of loss
  - Fear
  - Pseudobulbar Affect (PBA) – Outbursts of uncontrollable crying or laughing at inappropriate times

- Some degree of these are normal/expected (except PBA)

Post Stroke Depression

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- Important because it impacts recovery significantly
- Impacts between 30-80% of stroke patients, regardless of type
- Common signs of depression after stroke:
  - Sad mood
  - Loss of pleasure in previously enjoyable activities
  - Feeling hopeless, "arguing against recovery"
  - *Excessive* grief response over deficits
  - Often looks like anger, irritability, or "overreacting"
  - Fatigue
  - Sleeplessness or hypersomnia
  - Loss of appetite
  - Desire for death

Post Stroke Anxiety

- Impacts approximately 1 in 5 of stroke patients
- Most common within a few months of stroke
- Common signs after stroke:
  - Excessive worry, rumination
  - Fear or panic, commonly over: Falling, abandonment, behaving inappropriately
  - Restlessness
  - Difficulty with concentration
  - Irritability
  - Muscle tension
  - Sleep disturbance

Reclaiming Your Life After Stroke

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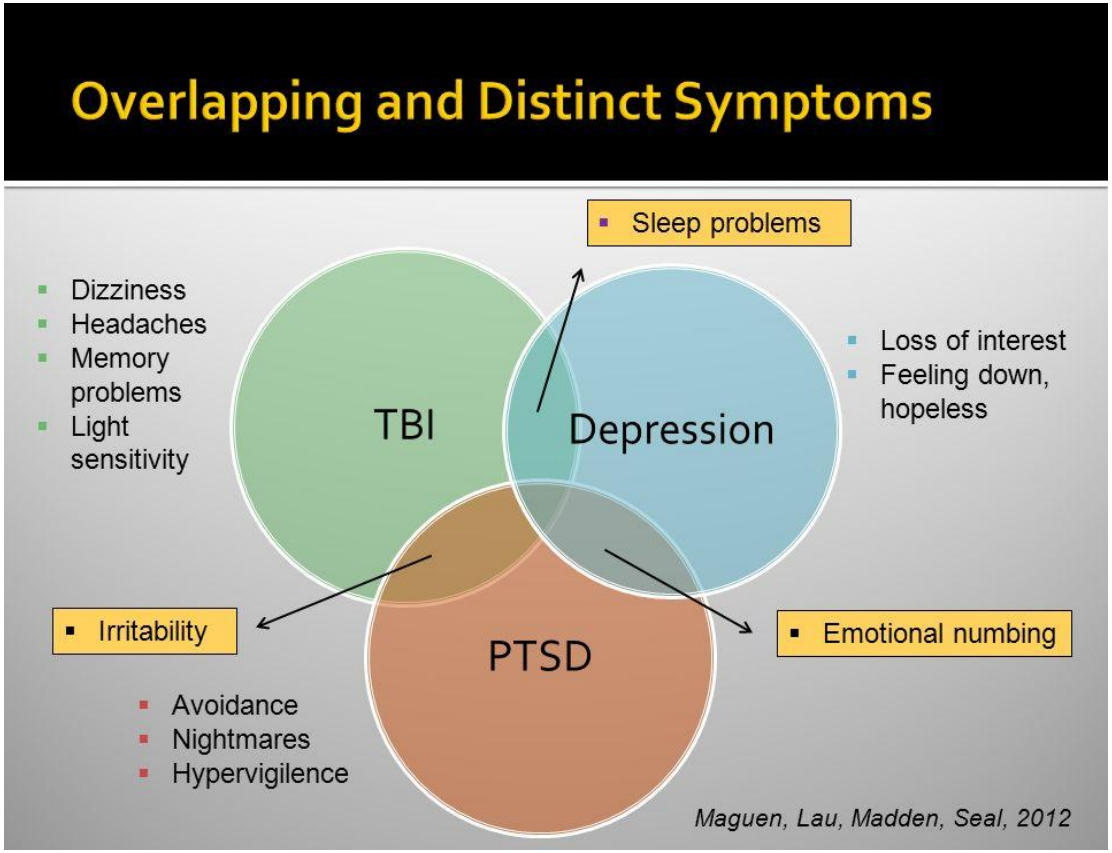
- Confront irrational, catastrophic thinking
  - *Learn to evaluate negative thoughts*
- Recognize limitations as well as abilities
- **Take control where able**
  - *Rely on someone you trust, who knows what you value, to help you process decisions*
- Resume prior roles and activities

The prevalence of Depression after TBI



Carla & Hicks, Amelia & Sherer, Mark & L. Ponsford, Jennie. (2018). Psychological Resilience Is Associated With Participation Outcomes Following Mild to Severe Traumatic Brain Injury. Frontiers in Neurology. 9. 10.3389/fneur.2018.00563.

Fatigue in MS: Reciprocal relationships with physical disabilities and depression

- *Journal of Psychosomatic Research: September 2012 Volume 53, Issue 3, Pages 775–781*

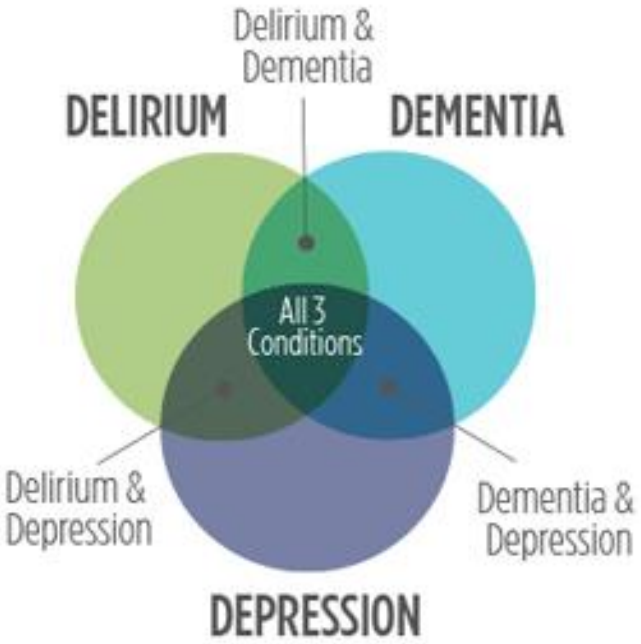
Depression in Older Adults

Causes of Depression in Older Adults and the Elderly

As you grow older, you face significant life changes that can put you at risk for depression. Causes and risk factors that contribute to depression in older adults and the elderly include:

- **Health problems** – Illness and disability; chronic or severe pain; cognitive decline; damage to body image due to surgery or disease.
- **Chronic diseases** – Parkinson's disease, Alzheimer's disease, stroke, heart disease, cancer, diabetes, lupus, multiple sclerosis, thyroid disorders, vitamin B12 deficiency and dementia and side effects from their treatment medications.
- **Loneliness and isolation** – Living alone; a dwindling social circle due to deaths or relocation; decreased mobility due to illness or loss of driving privileges; isolation due to hearing and vision deficits.
- **Reduced sense of purpose** – Feelings of purposelessness or loss of identity due to retirement or physical limitations on activities.
- **Fears** – Fear of death or dying; anxiety over financial problems or health issues.
- **Recent bereavements** – The death of friends, family members, and pets; the loss of a spouse or partner.

Source: http://www.helpguide.org/articles/depression/depression-in-older-adults-and-the-elderly.htm



- *Frank, Christopher. "Pharmacologic Treatment of Depression in the Elderly." Canadian Family Physician 60.2 (2014): 121–126. Print.*

Emotions and Wellness

All Achievable Outcomes start with a good plan

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- Select the tools – We used PHQ2 and PHQ9
- Train a pilot group – **We used QPR (Question, Persuade, Refer) Certification**
- Review progress/trends for at least 6 months
- Make corrections along the way
- Allow the Pilot Group to roll out the program
- Allow for a lot of testimonials
- Highlight successes – We like to know we make a difference
- Be flexible in the beginning. Encourage questions and challenges from staff
- Provide staff with tracking and trending data –We like Graphs
- Make sure managers understand the hypothesis and can speak to it.

QPR Certification

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Q - Question

P - Persuade

R- Refer

QPR stands for Question, Persuade, and Refer — the 3 simple steps anyone can learn to help save a life from suicide.
Just as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help

https://qprinstitute.com

How do you do it?

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Inform Participant:

Part of routine screening for your health includes reviewing mood and emotional concerns.

Ask the participant:

"During the past two weeks, have you often been bothered by of the following problems?"

"Feeling down, depressed, irritable or hopeless?" Yes No

"Little interest or pleasure in doing things?" Yes No

Scoring Instructions:

If the response is "yes" to either question, administer the PHQ-9 Questionnaire.

If the response to both questions is "no", the screen is negative. Do not administer the PHQ-9

Kroenke K, Spitzer RL, Williams JB. The Patient Health Questionnaire-2: Validity of a Two-Item Depression Screener. Medical Care 2003, (41) 1284-1294.

Patient Health Questionnaire - 9

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PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

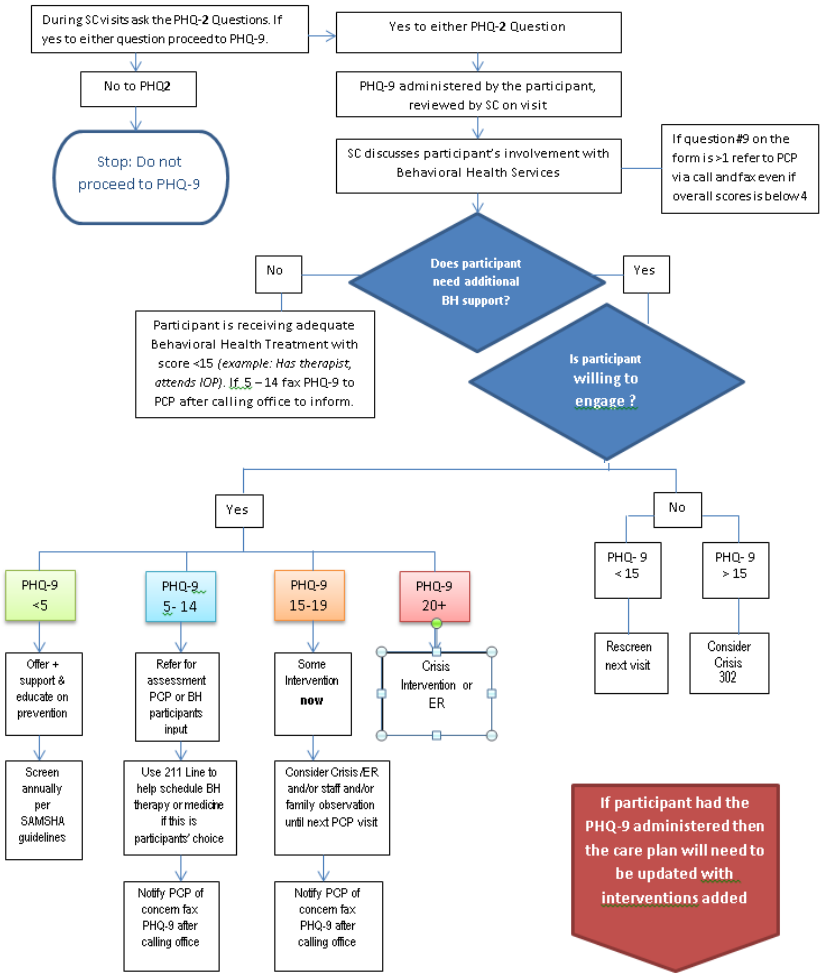
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Scoring

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

Sad and Anxious Mood: Start the Conversation
PHQ 2 and PHQ9 Screening Tool



Dear Provider:

Your patient _____ Medicaid #_____
is currently a participant working with United Disabilities Services through the Independence Waiver program. As part of her annual visit with her service coordinator, she has completed the Patient Health Questionnaire Screening, used to identify her emotional well being. The screening has noted some symptoms indicating that the patient may require additional support.

Please see the attached PHQ-2 &PHQ-9 screenings.
We recommend that you review the screening, and consider scheduling a visit with the participant to discuss any needed support or intervention. Crisis information has been provided to the participant in the event that it would be needed.

Additional information on the PHQ-9 can be found at:
http://www.apa.org/pi/about/publications/caregivers/practice-settings/assessment/tools/patient-health.aspx

The PHQ-2, comprising the first 2 items of the PHQ-9, inquires about the degree to which an individual has experienced depressed mood and anhedonia over the past two weeks. Its purpose is not to establish final diagnosis or to monitor depression severity, but rather to screen for depression. Patients who screen positive should be further evaluated with the PHQ-9 to determine whether they meet criteria for a depressive disorder. The PHQ-2 has been validated in 3 studies in which it showed wide variability in sensitivity (Gilbody, Richards, Brealey, and Hweitt, 2007).

Medication alone is not the answer

Medication is an adjunct to

- therapy with a Mental Health Professional
- increasing control/mastery over the environment
- enjoyable activities.
- esteem building relationships
- a sense of belonging through social interaction

What Reduces Depression/Anxiety?

1. Achievable goals	13.Mastery – control over environment
2. To have purpose	14.Meaningful activities
3. Physical activity	15.Being outdoors – natural light
4. Social connectivity	16.Leave a legacy
5. Hobbies	17.Avenue for self expression
6. Human touch- therapeutic touch	18.Mindfulness activities
7. Medication	19.Sensory stimulation – natural oils, light therapy and more
8. Reading inspirational writings	20.Spiritual life
9. Attitude of gratitude- coping skills	21.Clinical Therapy – 1:1 or group
10. Support groups- MHA	22.Peer Support – No Longer Alone Ministries /Compeer
11. Arts – painting, drawing, etc.	23.Mandalas
12 . Music – relaxation/energizing	24.Journaling

Great Person Centered Goal Writing

Long Term Goals *(What needs to occur)*

- (LTG's)= Health and Safety

Short Term Goals **(What the person will do)**

- (STG)= SMART goals

Interventions = **(formal & informal supports)**

- Individualized approaches

Mood Disorders & Unplanned Admissions?

Top 5 Diagnoses of Medicaid (MA) "Super-Users"	Top 5 Diagnoses of MA Hospital Readmissions
#1 Mood Disorders #2 Psychotic Disorders #3 Diabetes #4 Chemo/Radiotherapy #5 Sickle cell anemia	19.4% Mental & behavioral 11.8% Pregnancy/birth 9.4% Respiratory diseases 8.5% Digestive diseases 7.9%. Circulatory diseases

- *2012 Healthcare Cost and Utilization Project (HCUP) Statistical Briefs*

What are those symptoms again?

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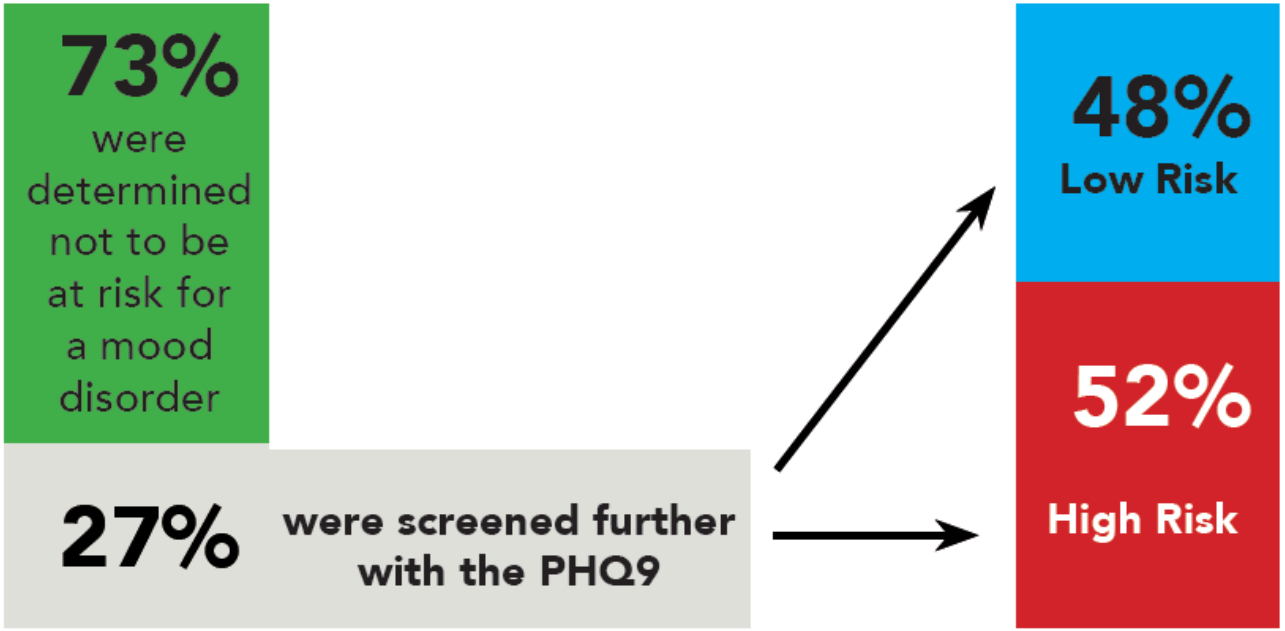
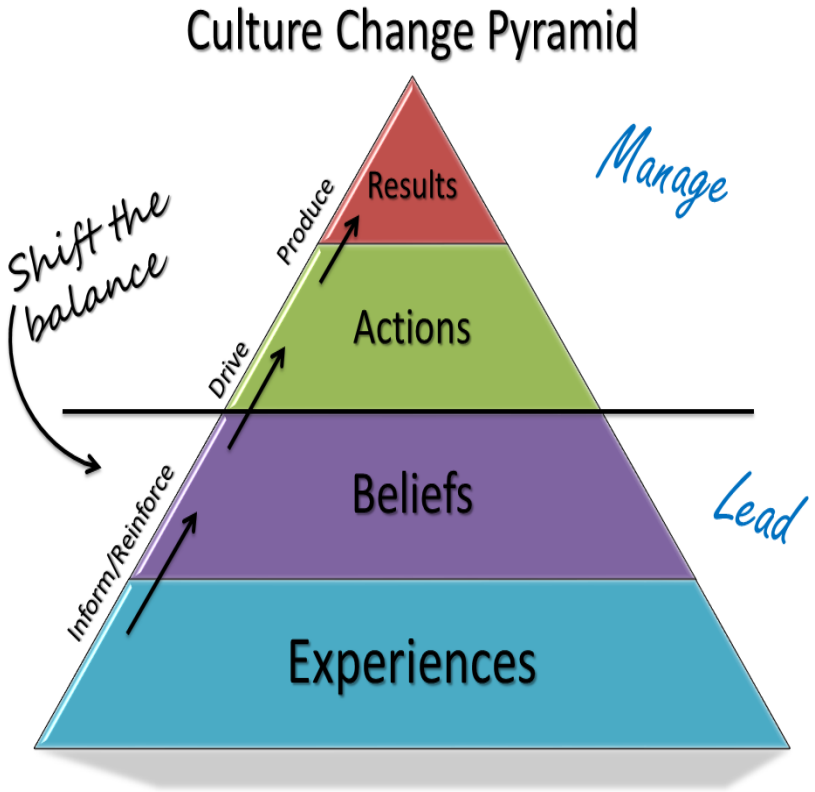
The following can be associated with sad & anxious mood

- Sleep changes – too much/too little
- Body aches/somatic complaints
- Weight changes
- Hair loss
- Forgetfulness
- Impaired decision making ability
- Changes in energy level
- Excessive worry - Paranoia

Emotional Wellness Findings in our Population



So how has this changed our culture?



https://youtu.be/anPWbN3cNR4

One actionable item leads to another….

Next came PIAs (Performance Improvement Analysis) for….

- Person Centered Profile – PHQ-9, Audit C, BRIEF, Daily Structure
- Transition of Care – Our Ticket To Home (2 day call/ 5 day visit)
- High Risk Treatment Plans – Person Centered & Interdisciplinary
- Falls Assessment in the Home - With report to PCP
- Direct Services Determination – Paid and natural support

Assess and Score

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Administer the BRIEF Health Literacy Assessment	
	1. How often do you have someone help you read hospital materials? q (1) Always q(2) Often q (3) Sometimes q (4) Occasionally q (5) Never 2. How often do you have a problem understanding the written materials about your medical condition? q (1) Always q(2) Often q (3) Sometimes q (4) Occasionally q (5) Never 3. How often do you have a problem understanding what is told to you about your medical condition? q (1) Always q(2) Often q (3) Sometimes q (4) Occasionally q (5) Never 4. How confident are you filling out medical form by yourself? q (1) Always q(2) Often q (3) Sometimes q (4) Occasionally q (5) Never

BRIEF Health Literacy Score Score Skill and Abilities by totaling the value of each of the above questions	
_____ **4-12 Limited**	Not able to read most low literacy health materials: will need repeated oral instructions; materials should be composed of illustrations or video tapes. Will need low literacy materials, may not be able to read a prescription bottle. Involve a participant representative in communication and education process whenever possible.
_____ **13- 16 Marginal**	May need assistance; may struggle with patient education materials.
_____ **17 – 20 Adequate**	Will be able to read and comprehend most patient education materials.

- *Brief Questions to Identify Patients With Inadequate Health Literacy Lisa D. Chew, MD, MPH; Katharine A. Bradley, MD, MPH; Edward J. Boyko, MD, MPH September 2004, Published in an article in Family Medicine; https://www.stfm.org/fmhub/fm2004/september/lisa588.pdf*

Alcohol Usage Assessment

Daily Structured Routine

Typical Activity & Energy Level over last year reflected

Time of Day	Energy Level	Typical Activity Pursued
Early Morning 6a - 8 a	High Medium Low	
Mid-Morning 8a – 10a	High Medium Low	
Late-Morning 10a –12 n	High Medium Low	
Early afternoon 12n – 2 p	High Medium Low	
Mid-Afternoon 2p – 4 p	High Medium Low	
Late-Afternoon 4p – 6p	High Medium Low	
Early evening 6p – 9 p	High Medium Low	
Late-evening 9p- later	High Medium Low	

Ability + Preference = Time

- ❑ Independent
- ❑ Assistive Device
- ❑ Supervision
- ❑ Hands on Assistance
- ❑ Maximum Assistance

+

=

Completed by & Time Needed

- ❑ Participant
- ❑ Attendant
- ❑ Natural Support

Needs Assessment

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Direct Services Determination (Needs Assessment)
Ability + Preference = Time

Check and fill in as appropriate for each category below to assist in estimating hours needed to promote health and safety for this person. If applicable ask family members and/or caregivers to supply comments regarding individualized approaches that help to make each of the following most successful. The approaches may help to establish a structured routine that honors this person's individual preferences.

You may check independent if no assistance is needed in a particular category thereby designating that it was reviewed. Under Preferences record the information supplied to you. For example under Personal Hygiene the participant may need help to shampoo hair but can put on own make up. So the SC would complete the area's where assistance is needed. In this example it would be Shampooing. Please write comments the area provided. List if the activity is completed by the Participant, paid Attendant or a Natural support.

P = Participant **A= Attendant** **N = Natural Support**

ADL Category	Preferences Customary Routine	Comments (Estimated hours per week)
PERSONAL HYGIENE & APPERANCE ☐ Independent ☐ Assistive Device ☐ Supervision ☐ Hands on Help ☐ Max. Help	**Shampoo hair**..... Where (beauty shop/shower) _____ Special Product? _____ ☐ **Denies Preferences** **Hair** Care Utensil Preferred: comb pick brush Are **Hair care accessories** important? Y or N Type: (scarf, clips) _____ _____ **Shaving**..... Applicable: ☐Yes or ☐ No Type shaver used? _____ Special Product? _____ ☐ **Denies Preferences** **Make-up** ..... Worn? ☐Yes or ☐ No Type of Make-up preferred:?_____ _____ How applied? _____ ☐ **Denies Preferences**	P A N Sun Mon Tue Wed Thu Fri Sat P A N Sun Mon Tue Wed Thu Fri Sat P A N Sun Mon Tue Wed Thu Fri Sat **Total Hours This Section::**_____

Ticket to Home

Developed in UDS partnership with ADRC

(Aging and Disability Resource Center)

PA LINK to Resources - aging.pa.gov

Transition of Care:

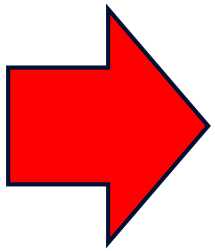
- Education of those we serve
- Communication with next level of care
- Two day call to CM on admission and call to participant on d/c
- Five day follow up to complete the Ticket to home

Ticket To Home

Don't

Re-admit

Me



D is for Doctor – I need to see my primary doctor within 7 days of getting home!

R is for red flags- What are my symptom red flags and what should I do about them?

M is medications – Which medications I should stop and which I should start?

High Risk Person Centered Plans

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Post Hospital Discharge Plan

HIGH RISK: PERSON CENTERED CARE PLAN **Participant Name:** _____

Date Initiated:	**Focus # :**	**Focus Statement:** At risk for significant change in condition- impacting health as safety.
Evidenced by: Recent hospital discharge with a ___ day length of stay requiring transition back to home care		
Related to: Primary admission diagnosis of		
Strength Statement:		
Long Term Goal *(Must reach to discontinue this focus)* _____Establish health and safety measures sufficient to remove from High Risk		

.

Date/Time Initiated		Short Term Goals – *(What the participant will do to reduce symptoms, in measurable terms)*	Target Date	Changed Date	Resolved Date
	A	_____will review discharge instructions and complete the ticket to home within one week of discharge			
	B	_____will make a follow up appointment with physician within 7 days of discharge			
	C	____will not have a repeat unplanned hospitalization within 30 days			
	D				

Date Initiated	STG letter		Interventions *(Focused actions caregivers and informal supports will do to help participant meet short term goals)*	Person Responsible
		1.	Compete a 2 day post hospital discharge call and review status	SC
		2.	Schedule a 5 day post hospital visit	SC
		3.	Assist in completing the "Ticket to Home" and display in a prominent place, update direct care givers of info and location	SC
		4.	Assist in making a list of questions to ask physician during follow up appointment.	SC
		5.	Provide transportation to follow up appointments	
		6.		
		7.		
		8.		
		9.		
		10.		

Signatures of those in attendance at Care Plan Meeting:

Participant	Date	Personal Representative/Relationship	Date	Service Coordinator	Date
Title/Relationship	Date	Title/Relationship	Date	Title/Relationship	Date

Key: (TBD)= To be decided, (DCW) Direct Care Worker, (SC)= Service Coordinator, (SW) Social Worker, (PAS)= Personal Assistance Service Agency, (HME)= Home Medical Equipment, (HM)= Home Modification; (MD) Medical Doctor, (HH) Home Health; (IS) Informal support/Family/Friend, (POA) Power of Attorney

Falls Assessments – Fall Reduction

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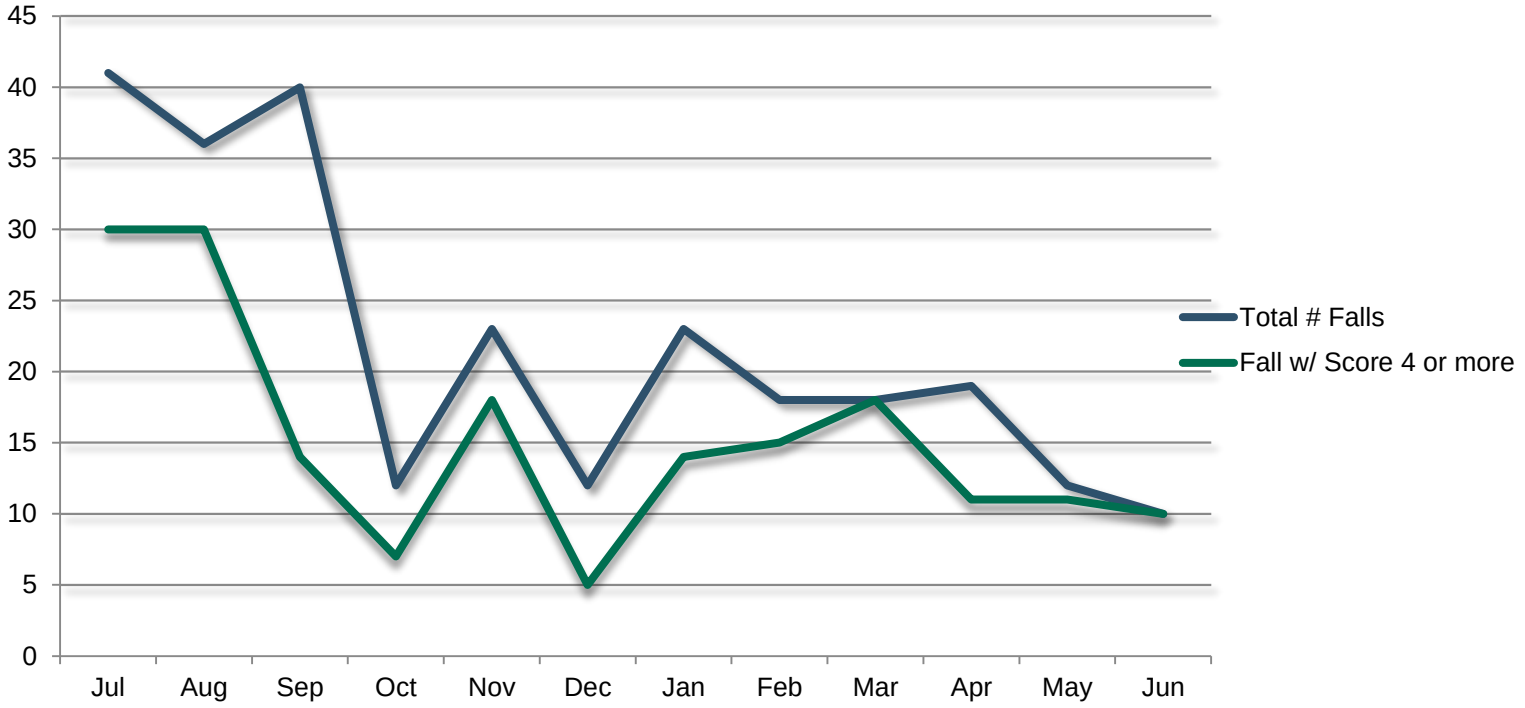
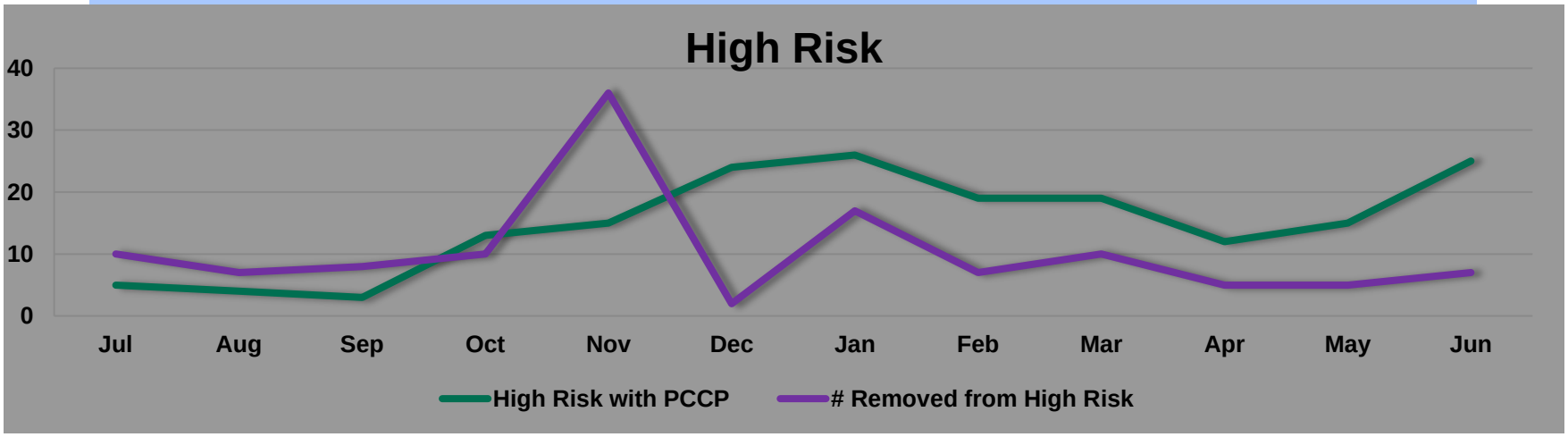


Hypothesis Statement	The assumption is that mitigation strategies when implemented can reduce the risk of falls. First there is a need to identify those at high risk for falls and to implement fall reduction strategies. Falls contribute to increased Emergency Dept. (ED) visits and hospitalizations. Falls may contribute to a more rapid participant decline and negatively impact a participants ability to remain in the community as well as jeopardize a sense of well-being and safety

Reducing Unplanned Hospitalizations



So did our unplanned hospital admissions decrease?

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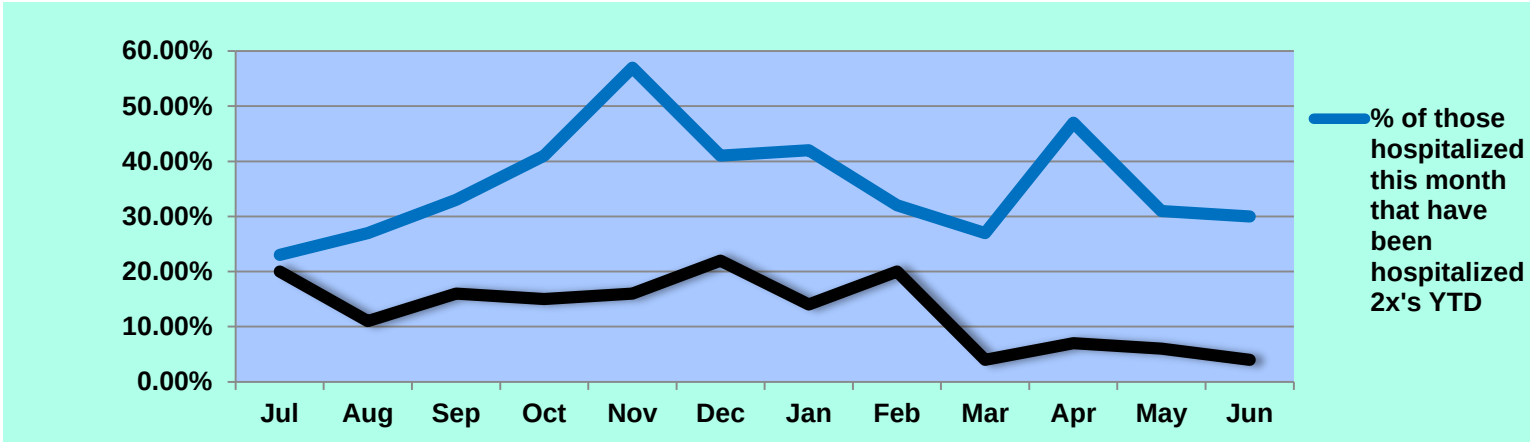
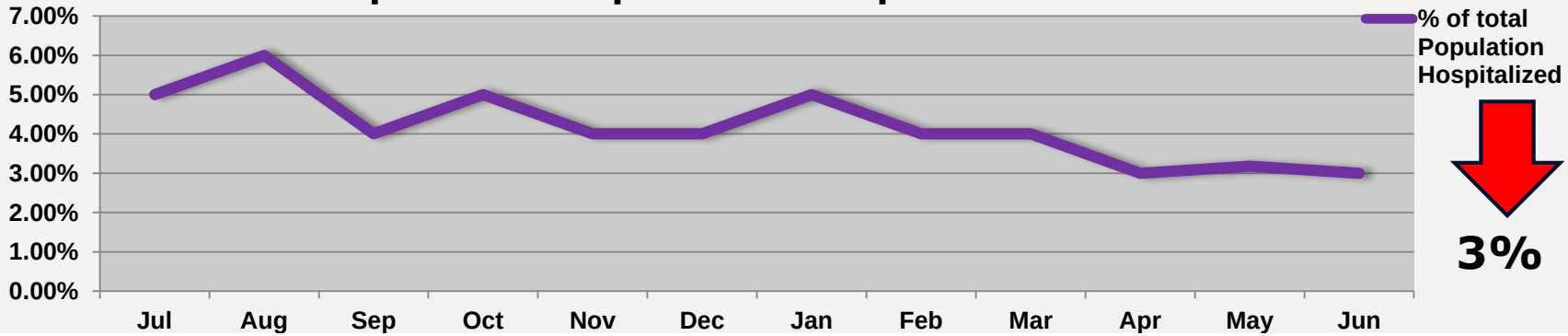
Prior Year Baseline
Annual Average July 2016 – June 2017
8%

Unplanned Readmissions



% of total Population Unplanned Hospitalizations Reduced 5%



Business Acumen through Quality Measures

So how has quality helped us succeed?

- We saved our payer over $1,000,000 by reducing unplanned hospitalization by 3%
- We have grown our business.
  - Participants and organizations ask for us by name.
  - We grew 123% over our original growth goal last FY.

Contact Information:

Debra Scheidt, Executive Director HCBS
United Disabilities Services
Lancaster, PA
717-397-1841
debrams@udservices.org

Thank You!

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For more information, please visit: www.hcbsbusinessacumen.org

E-mail: businessacumen@nasuad.org

Or Call: 202.898.2583

NASUAD
National Association of States United for Aging and Disabilities