People with disabilities building community

THE INDEPENDENCE CENTER

HOSPITAL TO HOME ANNUAL REPORT

July 20, 2020

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PROGRAM SUMMARY

The Independence Center (The IC) appreciates the opportunity to partner with UCHealth Memorial Hospital (UCHealth) in Colorado Springs to provide the Hospital to Home (H2H) program to their patients. The H2H program promotes the mission of UCHealth beyond the walls of the hospital, which is improving lives. By focusing on complex discharges, the H2H program has potentially saved the hospital money by reducing the average length of stay, readmissions, and ER visits.

The H2H program has successfully demonstrated when a person returns home after being discharged from the hospital, with surrounding supports, they are less likely to be readmitted to the hospital within 30 days and successfully return to the community within 60 days. Below are a few statistics for the contract year, August 1, 2019 – July 31, 2020 (data available through July 20, 2020); full detailed reports have been included at the end of this report:

- 52 patients transitioned
- 2 patients had a readmission
- 3 patients had an ER visit in the first 30 days after discharge; 2 of those 3 became the readmission patients
- 46% Self-pay / 31% Medicaid / 15% Medicare / 4% VA / 4% Commercial Insurance
- H2H services utilized by patients:
    - Home Health (skilled and unskilled) & Therapies (PT/OT/SLP) – 91%
    - Durable Medical Equipment (DME) – 73%
    - Benefit Counseling and Peer Support – 36%
    - Transportation – 32%
    - Medication (fill/delivery) – 10%
    - Meals – 5%
    - Other (home modifications, assistance with utilities, etc.) – 23%

The H2H program has a well-established network of community partners and the expertise to support the discharged patient. The Care Transition Coordinator for the H2H program provides patients and their families access to, and understanding of, community resources. The H2H program enhanced clinical outcomes because it provides intervention

in the home for 60 days after discharge resulting in fewer hospital readmissions and ER visits.

The H2H program has enabled UCHealth to extend their reach into the community and model this innovative partnership for the health care industry. As a result of the H2H program's success, The IC wishes to renew our contract and continue the partnership. Thank you for the opportunity to serve the UCHealth patients.

PATIENT SUCCESS STORY

The patient came into the hospital after having a stroke. She was in the ICU and had a PEG tube and trach. She was hoyer lift only and was unable to complete any daily living tasks on her own. She needed rehab; however, she did not have a payor source. RPCU was able to take on the patient if there was a discharge plan in place. H2H became the discharge plan to assist with all her needs for a safe discharge home.

H2H was able to assist by setting up skilled home health to include physical, occupational, and speech therapy to continue after her rehab stay. Unskilled caregivers were also put in place to assist the family. The patient needed 24/7 supervision and the caregivers were able to assist while her daughters were able to coordinate new schedules to take care of her. H2H also assisted with DME to include a tub transfer bench, gait belt, front wheeled walker, 3 in 1 commode, wheelchair, and incontinence supplies. Finally, since there was no elevator at the patient's apartment complex, Beo Mobility was utilized for the stair chair transportation to get the patient into her apartment at discharge.

The patient had a successful transition home after being in the hospital for 61 days including her stay with RPCU. She did not have a readmission to the hospital, and she did not need to utilize the ED.

Hospital To Home Participant Report (8/1/19 - 7/20/20)

MRN	Name	Discharge Date	Inpatient Days	Gender	Age	Diagnosis	LACE+	Referral Unit	Days From Referral	Days In Program	Payer
6******		8/4/2019	12	F	60.5	Gastrointestinal Hemorrhag	50	75	6	42	CICP
6******		8/18/2019	19	M	35.5	Guillain Barre	57	55	3	61	Self Pay
3******		8/19/2019	2	M	67.5	Cancer	76	75	0	1	Self Pay
7******		9/12/2019	3	M	81.9	Alzheimer; CVA	72	55	0	7	Medicare-Huma
4******		9/13/2019	48	M	74.6	Vascular Dementia w/ Beha	68	56	1	7	Medicare/Medi
5******		9/14/2019	3	M	59.1	Nonischemic Cardiomyopat	80	55	1	7	Medicaid P3631
4******		9/20/2019	0	M	36.3	TBI (multiple)		ED	0	25	Medicaid
7******		9/26/2019	31	F	55.6	Subarachnoid Hemorrhage	40	55	7	4	United Medicar
6******		10/11/2019	24	F	65.4	Oral Cancer	52	45	7	61	CICP- Level F
3******		10/18/2019	11	F	80.2	Diabetes/Wound	71	66	2	7	Kaiser Medicare
5******		10/24/2019	39	M	47.6	Renal & Respiratory Failure	60	45	20	67	Self-Pay
3******		10/29/2019	23	M	28.1	Pulmonary embolism		35	1	43	Self-Pay
3******		10/29/2019	32	M	56.6	Auto vs. Bicycle Accident	35	45	5	62	VA
6******		10/30/2019	81	M	31.1	Gun shot wound		45	1	31	Medicaid
7******		11/10/2019	13	M	34.3	Impulse control d/o	26	75	3	7	Medicare/Medi
5******		11/21/2019	3	M	29.4	Ankle Fracture		66	0	1	Self-Pay
7******		11/21/2019	65	M	65.2	Stroke; Respiratory Failure	75	55	41	29	VA-447564279
2******		11/22/2019	32	M	34.7	Wound infection and SI	52	56	1	1	Medicare A/B a
3******		11/26/2019	8	M	64.9	Congestive Heart Failure	61	35	0	61	Self-Pay
6******		12/2/2019	8	M	59.6	Heart Failure	58	75	6	18	Medicaid- P538
7******		12/9/2019	22	F	57.0	Acute Respiratory Failure	58	65	4	7	Self-Pay
4******		12/12/2019	32	M	42.0	Respiratory failure	60	35	1	62	Self-Pay
5******		12/20/2019	15	M	63.1	L. Below Knee Amputee	44	76	3	62	CICP
7******		12/27/2019	95	F	39.1	Thrombocytopenia	25	46	72	167	Self-Pay

MRN	Name	Discharge Date	Inpatient Days	Gender	Age	Diagnosis	LACE+	Referral Unit	Days From Referral	Days In Program	Payer
3******		12/30/2019	23	M	64.6	Abscess of Heel	44	North	18	63	Self-Pay
7******		1/6/2020	30	M	42.7	Pedestrian vs. auto accident	31	55	11	67	Self-Pay
4******		1/7/2020	13	M	31.5	MVA	29	66	7	60	Self-Pay
4******		1/10/2020	60	F	48.6	Stroke	39	46	31	65	Self-Pay
1******		1/15/2020	4	M	44.3	Subdural Hematoma	26	55	1	61	Out of State Me
1******		1/22/2020	13	F	61.8	Wernicke's encephalopathy	61	4E	2	8	Self-Pay
7******		2/7/2020	48	M	59.9	Thalamic Hemorrhage	31	RPCU	1	63	United Healthca
3******		2/10/2020	17	F	62.2	Congestive Heart Failure	57	35	6	60	Self-Pay
5******		2/13/2020	4	M	79.4	Cogestive Heart Failure	71	North	2	60	Humana Medica
5******		2/19/2020	19	M	27.0	Seizures	24	66	9	56	Anthem BC/BS P
2******		2/19/2020	17	F	57.7	Non-Traumatic Hemmorrha	46	55	1	7	Humana Medica
6******		3/13/2020	3	F	84.5	Hip Fracture	55	66	1	63	Self-Pay
7******		3/24/2020	120	M	38.7	Stroke	38	55	28	67	Medicaid-O7795
4******		4/7/2020	31	F	60.8	Pedestrian vs. Motor Vehicl	61	66	20	64	CICP
3******		4/18/2020	10	F	60.4	Rectal Prolapse; End Colost	70	65	1	2	Medicaid Pendi
7******		4/21/2020	7	M	81.7	Parkinson/Dementia	67	66	5	85	Self-Pay
5******		5/4/2020	6	F	52.0	C. Diff Colitis	51	2S	0	7	Medicaid-O9567
4******		5/10/2020	17	F	38.0	Stroke	57	55	3	61	Self-Pay
3******		5/19/2020	22	M	38.8	Motor Vehicle Accident (MV	34	66	8	13	Medicaid- Y428
7******		5/27/2020	16	F	59.7	Leg Wounds	59	56	8	54	Self-Pay
7******		5/29/2020	11	M	32.1	Sepsis in LLE	26	66	1	7	Medicaid
6******		6/3/2020	68	M	39.6	Subarachnoid Hemorrhage	38	55	16	47	Medicaid Pendi
4******		6/4/2020	9	F	42.2	Lupus	67	North	8	6	Self-Pay
7******		6/4/2020	0	M	66.6			ED	0	6	Self-Pay
1******		6/8/2020	23	F	53.4	Wernickes encephalopathy	71	2E	3	42	CICP

MRN	Name	Discharge Date	Inpatient Days	Gender	Age	Diagnosis	LACE+	Referral Unit	Days From Referral	Days In Program	Payer
7******		6/8/2020	12	F	77.9	Wound RLE/COVID-19	66	2 E	7	42	CICP
6******		6/30/2020	13	F	53.0	Bowel Perforation	57	66	1	20	Self-Pay
7******		7/11/2020	13	M	61.3	CVA	57	RPCU	8	9	Self-Pay

Hospital To Home Services Report (8/1/19 - 7/20/20)

MRN	Name	Service	Notes
6******			
		DME	Rented hospital bed for 2 month- discharge was delayed due to family being unable to secure a hospital bed. H2H secured and delivered hospital bed same day.
5******			
		DME	Hoyer Lift and Sling; wheelchair; bedside commode
		Transportation	Round trip 3x per week for dialysis. Doctors appointments.
		Skilled HH	No payor.
7******			
		Community Resources	Connecting family to other resources as they have multiple children and one child on the way.
		Unskilled HH	Patient needs 24/7 supervision because he is unaware of safety. Caregivers will assist while family figures out new schedules to take care of patient.
1******			
		Skilled HH	H2H covered skilled PT and OT as there is no insurance to cover.
		DME	H2H covered DME as there is no insurance to cover.
7******			
		DME	H2H provided a wheelchair. Patient was non-weight bearing on LLE. Medicaid would not cover another wheelchair as one had been covered recently. Delivered same day.
7******			
		DME	H2H covered DME as there is no insurance to cover.
		Skilled HH	H2H covered skilled RN for the wound care as there is no insurance to cover.
		Wound Care Supplies	H2H covered wound care supplies as there is no insurance to cover.
		Oxygen	H2H covered oxygen as there is no insurance to cover.

MRN	Name	Service	Notes
1******			
		Benefits	Medicaid application- had out of state Medicaid.
		Transportation	Transportation provided to daily IV Infusion appointments and doctors appointments.
3******			
		Skilled HH	RN for wound care and IV antibiotics.
		DME	No insurance to cover DME. H2H provided a FWW, 3 in 1 commode, and a knee scooter.
		Medications	IV antibiotics for 4 weeks.
4******			
		DME	No insurance to cover. H2H assisted with shower chair, raised toilet seat, FWW, and blood pressure monitor.
		Medications	No insurance to cover pain medication.
		Unskilled HH	Patient lives alone and is non-weight bearing on 2 extremities. Little to no family or friend assistance is available.
		Transportation	Wheelchair transportation is needed.
2******			
		Community Resources	Utilized case management time only.
7******			
		Benefits	Utilized case management time.
		Community Resources	Utilized case management time.
7******			
		Community Resources	Case management for VIC program, LTC waivers, H2H. H2H partnered with Pikes Peak Hospice to bring FC home. FC passed away after being home for 8 days.
5******			

MRN	Name	Service	Notes
		Benefits	Assisting with Medicaid Benefits.
		Skilled HH	PT and OT covered as there is no insurance to assist.
		DME	Wheelchair, FWW, and Tub Transfer Bench needed as there is no insurance to assist.
3******			
		DME	H2H provided a wheelchair. Patient was non-weight bearing on LE. Medicaid would not cover another wheelchair as one had been covered recently. Delivered same day.
5******			
		Community Resources	Utilized case management time.
7******			
		DME	Barrier to discharge was DME. H2H provided DME same day as requested. No other services provided.
5******			
		Unskilled HH	Patient needs 24/7 supervision due to lack of safety awareness. Patient appears to have dementia. Caregivers will assist while family figures out new schedules to take care of patient.
		Community Resources	Connecting family to other resources in the community to assist.
3******			
		Skilled HH	PT/OT/SLP covered due to not having insurance.
		Benefits	Assistance with Medicaid application.
7******			
		Unskilled HH	Patient needs 24/7 supervision due to lack of safety awareness. Patient appears to have dementia. Caregivers will assist while family figures out new schedules to take care of patient.
		Community Resources	Connecting family to other resources in the community to assist.
6******			
		Skilled HH	

MRN	Name	Service	Notes
		Benefits	Provided support to determine if benefits would be an option.
		DME	Wheelchair, Walker, Tub Transfer, Gait Belt
		Community Resources	Provided assistance finding resources for the patient and family.
7******			
		Benefits	Long Term Care Medicaid Application- He needs HCBS services to continue his success at home.
		DME	H2H covered DME recommended by therapy that insurance did not cover.
		Unskilled HH	Patient needs 24/7 supervision because he is unaware of safety and he is unable to complete his ADLs.
3******			
		Unskilled HH	Assistance with ADL's.
		DME	Wheelchair, walker, tub transfer bench, bedside commode- on loan until VA will cover equipment.
		Medications	Covered 3 days until PCP appointment with VA. No coverage until the appointment.
		Transportation	Transportation home with stair chair and to/from Aurora for PCP appointment to set up HH and medications.
6******			
		DME	H2H covered DME as there is no insurance to cover.
		Skilled HH	H2H covered skilled PT and OT as there is no insurance to cover.
2******			
		DME	Barrier was his broken wheelchair. H2H provided a chair same day as requested.
7******			
		Wound Care Supplies	H2H covered supplies as there is no insurance to cover.
		Skilled HH	H2H covered skilled RN for the wound care, PT and OT, as there is no insurance to cover.
6******			

MRN	Name	Service	Notes
		Community Resources	Finding housing, moving assistance, etc.
		Appt Assistance	Provided CG to assist during appointments to ensure husband could go to work to ensure they could pay bills.
		Community Resources	
		Transportation	
		Unskilled HH	
		Benefits	I provided assistance to determine if medicaid is an option. It appears that it will be if she is approved for a waiver.
6******			
		DME	H2H covered DME as there is no insurance to cover.
		Skilled HH	H2H covered skilled RN for the wound care, PT and OT, as there is no insurance to cover.
		Wound Care Supplies	H2H covered supplies as there is no insurance to cover.
5******			
		DME	H2H provided a wheelchair. Patient was non-weight bearing on LE. Medicaid would not cover another wheelchair as one had been covered recently. Delivered same day.
3******			
		Skilled HH	H2H agreed to assist with skilled RN for new ostomy and any DME needs. Patient refused all services. No funding was spent on patient.
3******			
		DME	No insurance to cover. Glucometer with test strips needed to monitor diabetes.
		Oxygen	No insurance to cover.
		Skilled HH	No insurance to cover. Needing RN, PT, and OT.
1******			

MRN	Name	Service	Notes
		DME	Patient lives in Trinidad. Unable to set up more support. H2H was able to step in to assist with the DME needed as there is no payor.
4******			
		Community Resources	Utilized case management time.
		Benefits	Utilized case management time.
3******			
		Skilled HH	No payor- recommended rehab. Put HH skilled therapy in place. RN/PT/OT
		Community Resources	Utilized case management time.
		Benefits	Application for Medicaid.
7******			
		Community Resources	Utilized case management time.
		Benefits	Utilized case management time.
4******			
		Community Resources	Contacted family to offer resources on 2 occasions. Family stated they would reach out when they were ready for support.
4******			
		Skilled HH	No insurance to cover. PT and OT needed.
		DME	No insurance to cover DME. H2H provided a wheelchair, bedside commode, slide board, and tub transfer bench.
7******			
		Transportation	Wheelchair transportation is needed as she is not able to transfer into a vehicle.
		Community Resources	Case management-home modifications & grant funding for them, LTC waiver/market place insurance, transportation options.

MRN	Name	Service	Notes
		DME	No insurance to cover. H2H assisted with hospital bed, hoyer, sliding tub transfer bench, bedside commode, and wheelchair.
		Skilled HH	No payor. PT, OT, and SLP are needed for recovery.
6******			
		DME	Walker, Tub Transfer Bench, Bedside Commode
		Benefits	Apply for LTC Medicaid Waiver- if approved, will have state plan medicaid benefits as well.
		Skilled HH	RN visits to train for tube feeding at home.
		Medications	Covered 30 days.
		Meals	Tube Feedings and Supplies covered for 30 days.
		Wound Care Supplies	
4******			
		DME	Barrier to discharge was a wheelchair for the patient. H2H was able to provide the wheelchair. No other services provided.
3******			
		Community Resources	Utilized case management time.
4******			
		DME	No insurance to cover. H2H assisted with tub transfer bench, gait belt, FWW, wheelchair, 3 in 1 commode and incontinence supplies.
		Skilled HH	No insurance to cover. PT, OT, and SLP is needed for recovery.
		Transportation	No elevator to apartment. Must use a stair chair with Beo Mobility.
		Unskilled HH	Patient needs 24/7 supervision. Caregivers will assist while daughters figure out new schedules to take care of patient.
6******			

MRN	Name	Service	Notes
		DME	No insurance to cover DME. H2H provided junior FWW, bedside commode, and tub transfer bench.
		Skilled HH	No insurance to cover. PT and OT provided.
7******			
		DME	Barrier to discharge from ED was a walker. H2H delivered a walker same day as requested. No other services in place.
7******			
		Skilled HH	H2H assisted with skilled PT, OT, and SLP as there is no insurance to cover.
		DME	H2H provided a tub transfer bench as there is no insurance to cover.
		Medications	H2H assisted with medications as there is no insurance to cover.
6******			
		Benefits	Completed LTC Medicaid paperwork while in the hospital. Utilized case management services only.
7******			
		Skilled HH	No insurance to cover. PT, OT, and SLP is needed for recovery.
		Unskilled HH	24/7 Supervision is needed due to patient not being oriented with time and place. Caregivers will provide some relief while family determines how to coordinate schedules.
		DME	No insurance to cover. H2H assisted with FWW, tub transfer bench, and a wheelchair.
7******			
		Community Resources	Utilized case management time only.
4******			
		Skilled HH	PT/OT covered as there is no payor.
		DME	Shower chair, front wheeled walker with platform arm, and bedside commode. No payor to cover DME.
4******			

MRN	Name	Service	Notes
		Skilled HH	H2H covered skilled HH as there was no insurance to cover. PT and OT provided.
		DME	H2H covered DME recommended by therapy as there was no insurance to cover.
5******			
		Transportation	Patient non-weight bearing on 3 extremities. Transfers in and out of vehicles extremely difficult. Transportation to/from doctor appointments.
		Unskilled HH	Patient lives alone and is non-weight bearing on 3 extremities. Caregivers assist with ADL's and meal prep.
		DME	H2H covered DME recommended by therapy that insurance did not cover.
5******			
		DME	Barrier to discharge was a walker. H2H provided a walker same day as requested.

Hospital To Home Readmission Report (8/1/19 - 7/20/20)

MRN	Name	Admit Date	D/C Date	Comments
6******		8/9/2019	8/11/2019	Brief Summary from Corhio- "Patient is a 59 y.o. female with PMH pertinent for h/o PVT and PE with also bilateral embolic CVAs at that time-on chronic AC, ACNA vasculitis pauci immune GN on Cytoxan and pred, resulting CKD 3, who was admitted for rectal bleeding x 2 days. She had colonoscopy w polypectomy 7/27 w Dr Hor, had melena after that and repeat cscope 7/29 where clip was placed to mucosal defect as visible vessel, but still bled so 3rd cscope 8/2. She was doing ok but now w melena for 2 days (had resumed OAC). GI consulted and she had yet another cscope today 8/10 that showed mucosal ulceration at prior polypectomy site which was clipped. Hb watch for bleeding. During this admission patient had no further bleeding. Her hemoglobin stabilized at 8.6. Her thrombocytopenia corrected to 175,000. Patient was able to tolerate diet without issue. She was discharged to home with outpatient follow-up for GI, oncology and renal."