IMPROVE QUALITY : IMPROVE RELATIONSHIPS

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

November 2018
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
HCBS Culture Change
Merging Social & Medical Models in HCBS to fully embrace Person Centered Care through Quality Measures
Who We Are…
United Disabilities Services

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)

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...

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

### Actionable Measures

<table>
<thead>
<tr>
<th>Clinical Excellence</th>
<th>Financial Excellence</th>
<th>Staff Excellence</th>
<th>Customer Excellence</th>
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**Outcomes**
Can hospital re-admissions and repeat emergency room visits be reduced?

- 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

- 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?”


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
## Performance Improvement Analysis (PIA)

<table>
<thead>
<tr>
<th>PERFORMANCE IMPROVEMENT ANALYSIS</th>
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<td>Goals:</td>
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<td>Baseline: =</td>
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<td>4th Quarter:</td>
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<tr>
<td>ACTIVITY/INDICATOR</td>
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<td>(Discovery)</td>
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<td>Why are we looking into this indicator:</td>
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<tr>
<td>- New Directive</td>
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<td>- Suspect need</td>
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<td>- Best Practice</td>
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<td>What we find once we look at the indicator.</td>
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<td>What is needed to improve the process, generate a better outcome, etc.</td>
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<td>Process steps</td>
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<tr>
<td>- What will we do and why</td>
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<tr>
<td>- Who will do what</td>
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<td>- How will we communicate the process</td>
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<td>- How we track and trend</td>
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<tr>
<td>Will be reviewed monthly and written updates to this plan quarterly. Results shared with all team members (stakeholders).</td>
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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

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.
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
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

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

- Due to structural changes in the brain and loss of function, stroke commonly causes:
  - Depression
  - Anxiety
  - Frustration
  - Anger
  - Sadness
  - Sense of loss

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

- Fear

- Pseudobulbar Affect (PBA) – Outbursts of uncontrollable crying or laughing at inappropriate times
Post Stroke Depression

- 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

- 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

Fatigue in MS: Reciprocal relationships with physical disabilities and depression

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.


“Emotions” are your feelings

&

“Wellness” is a way of being

So:

Feelings + Healthy = Emotional Wellness
All Achievable Outcomes start with a good plan

- 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

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?

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 any 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 (PHQ-9)

Over the *last 2 weeks*, how often have you been bothered by any of the following problems? (Use ‘✓’ to indicate your answer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
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<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
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<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>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</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
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#### Scoring

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?

<table>
<thead>
<tr>
<th></th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
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<tr>
<td></td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
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</table>

For office coding: 0 + □ + □ + □ + □  

= Total Score: □
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/prac.../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 Hewitt, 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?

<table>
<thead>
<tr>
<th>1. Achievable goals</th>
<th>13. Mastery – control over environment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. To have purpose</td>
<td>14. Meaningful activities</td>
</tr>
<tr>
<td>4. Social connectivity</td>
<td>16. Leave a legacy</td>
</tr>
<tr>
<td>5. Hobbies</td>
<td>17. Avenue for self expression</td>
</tr>
<tr>
<td>6. Human touch- therapeutic touch</td>
<td>18. Mindfulness activities</td>
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<tr>
<td>8. Reading inspirational writings</td>
<td>20. Spiritual life</td>
</tr>
<tr>
<td>9. Attitude of gratitude- coping skills</td>
<td>21. Clinical Therapy – 1:1 or group</td>
</tr>
<tr>
<td>10. Support groups- MHA</td>
<td>22. Peer Support – No Longer Alone Ministries /Compeer</td>
</tr>
<tr>
<td>11. Arts – painting, drawing, etc.</td>
<td>23. Mandalas</td>
</tr>
</tbody>
</table>
Great Person Centered Goal Writing

**SMART GOALS**

- **S** - Specific - write out clear, concise goals.
- **M** - Measureable - the ability to track your progress.
- **A** - Achievable - set challenging, yet achievable goals.
- **R** - Relevant - set goals that are relevant to your overall life plan.
- **T** - Timely - goal has a target finish time attached.

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”

<table>
<thead>
<tr>
<th>#1</th>
<th>Mood Disorders</th>
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<tr>
<td>#2</td>
<td>Psychotic Disorders</td>
</tr>
<tr>
<td>#3</td>
<td>Diabetes</td>
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<tr>
<td>#4</td>
<td>Chemo/Radiotherapy</td>
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<tr>
<td>#5</td>
<td>Sickle cell anemia</td>
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</tbody>
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#### Top 5 Diagnoses of MA Hospital Readmissions

- 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?

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

73% were determined not to be at risk for a mood disorder

27% were screened further with the PHQ9

48% Low Risk

52% High Risk
So how has this changed our culture?

https://youtu.be/anPWbN3cNR4
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**

**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:

- **Limited**: 4-12
  - 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.

- **Marginal**: 13-16
  - May need assistance; may struggle with patient education materials.

- **Adequate**: 17-20
  - Will be able to read and comprehend most patient education materials.

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*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;  
Alcohol Usage Assessment

- Drinking within Recommended Limits
- Risky Drinking
- Alcohol Abuse
- Alcohol Dependence
- Alcohol Use Disorders
- CAGE
- Alcohol Misuse
- AUDIT-C
# Daily Structured Routine

<table>
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<tr>
<th>Time of Day</th>
<th>Energy Level</th>
<th>Typical Activity Pursued</th>
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<tbody>
<tr>
<td>Early Morning 6a - 8 a</td>
<td>High Medium Low</td>
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<tr>
<td>Mid-Morning 8a - 10a</td>
<td>High Medium Low</td>
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<td>Late-Morning 10a - 12 n</td>
<td>High Medium Low</td>
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<td>Early afternoon 12n - 2 p</td>
<td>High Medium Low</td>
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<td>Mid-Afternoon 2p - 4 p</td>
<td>High Medium Low</td>
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<td>Late-Afternoon 4p - 6p</td>
<td>High Medium Low</td>
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<tr>
<td>Early evening 6p - 9 p</td>
<td>High Medium Low</td>
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<tr>
<td>Late-evening 9p - later</td>
<td>High Medium Low</td>
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</table>
Ability + Preference = Time

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

Completed by & Time Needed
- Participant
- Attendant
- Natural Support
Navigate to the top menu and select "Needs Assessment". This section is designed to assess the direct services needed for the participant, focusing on their preferences and ability to perform daily activities independently or with assistance. The goal is to promote health and safety while respecting individual preferences.

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 makeup. So, the SC would complete the area’s who assistance was 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.

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Total Hours This Section: 0
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
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

## Post Hospital Discharge Plan

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

<table>
<thead>
<tr>
<th>Date/Time Initiated</th>
<th>Short Term Goals – (What the participant will do to reduce symptoms, in measurable terms)</th>
<th>Target Date</th>
<th>Changed Date</th>
<th>Resolved Date</th>
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<tbody>
<tr>
<td>A</td>
<td>Will review discharge instruction and complete the ticket to home within one week of discharge</td>
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<td>B</td>
<td>Will make a follow up appointment with physician within 7 days of discharge</td>
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<td>C</td>
<td>Will not have a repeat unplanned hospitalization within 30 days</td>
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### Interventions

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<th>(Focused actions caregivers and informal supports will do to help participant meet short term goals)</th>
<th>Person Responsible</th>
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<tbody>
<tr>
<td>1. Complete a 2-day post hospital discharge call and review status</td>
<td>SC</td>
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<td>2. Schedule a 3-day post hospital visit</td>
<td>SC</td>
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<tr>
<td>3. Assist in completing the &quot;Ticket to Home&quot; and display in a prominent place, update direct caregivers of info and location</td>
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<td>4. Assist in making a list of questions to ask physician during follow up appointment.</td>
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<tr>
<td>5. Provide transportation to follow up appointments</td>
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### Signatures of those in attendance at Care Plan Meeting:

<table>
<thead>
<tr>
<th>Participant</th>
<th>Date</th>
<th>Personal Representative/Relationship</th>
<th>Date</th>
<th>Service Coordinator</th>
<th>Date</th>
<th>Title/Relationship</th>
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Key: (TC)=To be decided; (HC)=Home Care Worker; (SC)=Service Coordinator; (SW)=Social Worker; (PAS)=Personal Assistance Service Agency; (HME)=Home Medical Equipment; (HMD)=Home Modifications; (MS)=Medical Service; (HI)=Home Health; (SIA)=Informal Support/Family/Relative; (PONA)=Power of Attorney.
Falls Assessments – Fall Reduction

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

High Risk

High Risk with PCCP

# Removed from High Risk
So did our unplanned hospital admissions decrease?

Unplanned Readmissions

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

% of those hospitalized this month that have been hospitalized 2x’s YTD

% of total Population Unplanned Hospitalizations Reduced 5%

% of total Population Hospitalized

3%
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!

hcbsbusinessacumen.org
For more information, please visit: www.hcbsbusinessacumen.org
E-mail: businessacumen@nasuad.org
Or Call: 202.898.2583