

**>> November 28, 2018: Improve Quality : Improve Relationships
How one organization developed clinical systems to improve outcomes for
individuals and relationships with payers.**

Good afternoon thank you for joining today's webinar. Improved quality: improve relationships. I am Erica Lindquist, I'm Erica Lindquist, Senior Director at the National Association of States United for Aging and Disabilities (NASUAD)

This webinar is presented through the Business Acumen Center, a part of the Business Acumen for Disability Organizations grant managed by NASUAD and made possible by the Administration on Community Living. Shortly after today's session, you will be able to find the PowerPoint and recording of this webinar (along with the archives of all of the Disability Network Business Acumen webinars) at hcbsbusinessacumen.org/webinars.

There will be time for Q&A at the end of the presentation. Please enter your questions in the Q&A box in the lower right hand corner of your screen.

Today's speaker is Debra the executive director at United Disabilities Services. Debra will describe how UDS incorporates the use of clinical tools and language to improve outcomes for their clients and providers of health services. UDS is one of the first place winners from stories from the field contest as a reminder this is a contest that we held earlier this year. Where we ask people to submit stories that highlight the strategies used for a changing environment and demonstrate a positive impact on the people served and on the administration of services and improve the delivery and accessibility. We encourage to highlight business practices working with or for managed care, Private pay, Health systems to these counties other CBO's universities or really any other place to help improve the financial performance of their business. With that I'm excited and pleased to share Debra and her story. On how quality drives business. Debra?

Thank you for joining. We believe that quality drives business. And we make an effort in everything we do to prove that. We think that that is the area that is most important to maintain with the integrity that we have as an organization. But we are looking at this particular event. On how we have to engage in culture change to fully embrace personal center character quality measures. That is all a little bit new for us and as far as measuring everything that we do and come up with what will be our action items. And will be our eventual outcomes. That we hope to achieve. Let me tell you a little bit about UDS first what are we? We are the United Disabilities Services. We have been in business for 54 years. We started out as a small organization. And have continued to grow throughout the year. We do care management with accessible home modifications. We have service dogs and custom wheelchair feedings. We have non profit management solutions who work towards goals but they might have as well. We do some HR management for other entities. And some planning for those organizations. We have actually just enrolled in an additional county. 57 and all for

preparation for the phase 3 rollout. So in Pennsylvania. We have something called community health choices that is coming into the area. In January of this coming year. January 1. We will be rolling out in the Southeast area where we are engaged and then after that next year rolling out into the rest of the state of Pennsylvania. So in preparation for that. I guess we say we are better equipped with quality measures and enrolled in other areas. We have our main office in Pennsylvania but we have two remote offices on Williamsport. So who do we serve? Well we have 350 employees that work for us and we serve about 5000 people last year we helped improve their lives. And we work with them where they are and take them where they want to go. We are very persistent in our application.

United Disabilities care management. Okay. So we are placed in center care at the core and what we do in care management programs. Care management has been referred to as a service coordination entity in Pennsylvania. It was traditionally considered service linkage. The person that would be clinically eligible for nursing home care was put at the center of the services. The service coordinators provide resources to assist the individuals living independently in the community. As you can see many of the following slides needed to become more clinical to meet the needs of this population. In Pennsylvania the cost for services skyrocketed as hospital admissions became shorter and patients were discharged not just quicker but sicker than in the past.

This started back in the 1980s right? With introduction of DRGs. And this has continued. It is not new and has been a focus since the overact since the late 1980s. However it is a newer philosophy so as we merge the medical and social model. Action become more centered in our approach.

So we're going to talk about next is the financial benefits of quality measures that merge social medical model to better promote and create quality performance measures within your site of service. That can produce positive outcomes to participants and payers. So this is an approach that really is the best practice for the participant and the payer. For the participant allows them to live themselves as they see fit. It encourages them to take an action. It reduces the sense of helplessness and can replace it with control and purpose. Helplessness and entitlement come from the same place the government place of desperation. People that are engaged in their healthcare make healthier choices. Healthier choices lead to better help -- health. So we are going to discuss the message we employ to reduce healthcare costs through quality measure. In our services make sense to begin social medical models to promote personal center care. I will share our approach and hopefully give you some ideas on how you can create something similar that makes sense for you. And with that we will go on to our next slide.

I love this slide actually. This is our approach and how we look at everything in our organization. So while we start with a strength-based approach will be good at? Where are we now. What will it take for us to get to where we want to go? So we look at what our outcome is we begin with the end in mind. We begin with the end in mind. So the end in mind for a stock of the wanted to achieve is to reduce unplanned hospitalizations. We wanted to be doing that to a variety of measures. But there had to be other things. If I were just to say let's reduce

unplanned hospitalizations I would need to be able to say how am I going to do that. And is of the actions and measures. The things I can actually design that can help to reduce hospitalizations. So whether we are working with and individual staff member or an entire organization. It really is best to identify existing strengths which is not really easy for any organization. Strategic planning begins with defining actionable items by dividing them into categories that make sense to your organization. For us we use categories that we call our areas of excellence. Clinical excellence, and our customer service excellence. Then it is best to know what is coming down in terms of change. If we review our strategic plan. So our actionable measures are planned to result in company growth. So let me give you a common example that many organizations irregardless of what you do but probably want to see as an outcome. Many organizations would like to have an outcome of engaged staff. They might administer staff engagement surveys to determine staff receptions of their ability as an agency to one provide growth opportunities hiring promotions and change on work to satisfaction with upper management communications three satisfaction with direct supervisors leaderships. And for quality incompetence. These are actionable measures and actionable items and was they are achieved ideally they result in the outcome that you would want. Which would be an engaged staff. It would result in an outcome such as job engagement. Organizational engagement. These actions and measures are the items that organization can influence. To get to that outcome. Quite often actually measures from one category may influence other categories. For example. A staff member that is job and organizationally engaged or better equipped to produce better clinical business and customer service outcomes. So the outcome that I'm going to discuss in this presentation as I said earlier is our desire to reduce unplanned hospitalizations for our participants. We selected it. Because it involves all four areas of excellence. Our assumption was an outcome that touches all areas of excellence will lead to significant values to our organization participants and players. So we decided to start with merging the social and clinical model. Would build apart our current strengths to strength. And we believe that this improve our excellence in all four areas. It would ultimately yield growth opportunities. If we built the quality organization participants will come. Out of the philosophy. We aspire to be the HCB F program choice in our area. A program that can demonstrate quality participants and cost savings to its players to be recognized as such right? In fact our belief is that quality drives business. We look at quality in terms of all four areas. So let's talk about how we started down this journey. So. Let's look at that question have you heard that question before? I can hospital readmissions repeat emergency room visits be reduced that is a common question among healthcare providers across the nation. I started my career working as a hospital administration. Primarily in behavioral health you will see how that ties in later with how we decide to do some of the things that we did. It is all based sometime on experiences that we bring forward. Rising healthcare costs and recognition that certain groups of patients or high consumers of healthcare resources. That has stress for everyone. And these patients often have multiple chronic conditions that we need repeated hospital visits to manage them. Sometimes referred to a super utilizer with complex medical needs to make up a small fraction of U.S. patients.

They count for half of the nation's overall health care spending. So approximately 25 % of U.S. healthcare expenses are incurred by one percent of the U.S. population. And 50 % of expenses are incurred by five % of the population. According to the research and quality in 2017 the average cost for one day in the hospital in the U.S. is about \$2000. The average length of stay is five days. So the average cost for a hospital visit of Laura \$10,000. I'm taking \$2000 a day. An average length of stay for five days to give us \$10,000. Member that number later on. The average cost for any emergency room visit is \$1200. Compared to the average rate in Pennsylvania for one-bedroom apartments which is 880 her month. So keeping someone at home is considerably less expensive right? Then there's the human side to consider. Every time we send someone to the hospital it is stressful for both the patient and the caregiver. We sent someone in. And we kind of shut or are they going to come out any better it appears that there is an opportunity to make a difference. And we at care managers really are situated to make that difference because we know the resources and we have the relationship with the participant and their family. So we are the ones who should be able to carry this forward. So. We do a lot of reading. However we plan we are going to forward an idea. We look to journal articles. We look to research. So we pile out everything first. And we start to look at some of the literature that talks about post hospital syndrome. We know that older people include people with disabilities well in the hospital in recent years researchers coined the term post hospital syndrome to describe a abundance of issues that describe risks of adversity. The New England Journal of Medicine describes post hospital syndrome as an acquired condition of generalized rest nearly 1/5 of Medicare patients discharged from the hospital approximately 2.6 million individuals have been accused with a medical problem and the subsequent 30 days that necessitate another hospitalization. Well guess what. We look at our population. 90 % of our participants are through Medicare and Medicaid. As a population that is impacting right? Another reason why we selected unplanned hospitalization especially within 30 days. Was that it really was something that we felt would be the best outcome measure for us. How do we get there? How do we control it? So you're going to look at the 30 day admissions a little bit more. These are folks that were recently discharged patients. They have a heightened risk of a myriad of conditions. Many of which appear to have little in common with the initial diagnosis as we look at this graph. For example patients admitted for treatment of heart failure and chronic obstructive pulmonary disease did --. Because is the same for only 37 % 29 % and 36 % respectively. The cause of readmission regardless of the original diagnosis commonly includes heart failure, pneumonia, COPD, infection, gastrointestinal conditions. Mental illness. Emotional wellness. They played a big factor. The diagnosis has been shown in studies using administrative claims. So you know what. This observation is not likely to be nearly the result of a coding variation. Further evidence of the distinctiveness of this syndrome is that information about the severity of the original illness predicts poorly with patients

to have an adverse medical events soon after discharge and require readmission. So how much of the hospital syndrome emerge? Hospitalized patients are not only enduring and acute illness. Which can agitate physiological symptoms. But their expensing substantial stress. During hospitalization patients are commonly deprived of sleep experience.

Disruption of normal rhythms. Are nourished poorly have pain and discomfort. Have a baffling array of mentally challenging situations and receive medications that can alter cognition and become decommissioned by bedrest or inactivity. Each of these stresses can adversely affect health during the early period. An inability to fend off diseases leads to mental error that is what it looks like when he first command the hospital. The recognition of post hospital syndrome can provide ways for developing novel implementation to promote recovery succumbing out of the hospital environment myself I know firsthand. That we hospitals. We track readmissions.

And we are challenged to reduce those unplanned readmissions. There's a financial incentive for hospitals to do that. That is why some of the novel ideas you may see if you have not been in a hospital in quite a while is to go back into the hospital. You might see now. That he most likely will be given earplugs. Or a sleep mask. Or some machine to help mask the sound. Or maybe some lotion with some sense to help calm. And you might also notice things have changed a lot in hospitals and men hospitals now you can have food at will and choose exactly what it is you want. It is an effort to help patients get stronger before discharge. And to sleep better and to do all those types of things that we know are disrupted during the hospital stay. After all. You know we are in the same business. Of keeping people out of the hospital. So we will discuss some of what we decided to do to address this concern in the following slide. This is our lovingly calling performance improvement analysis we take everything through this. We use this just about in everything we do that we are going to change. It is kind of our change model right we begin this for any number of reasons such as when a new directive is issued. Or if we want to ensure our compliance. Or simply and this is probably the main reason. Something because we have learned about a best practice model that we think we may want to adopt. We always want to be cutting edge. We want to be able to show and prove that we are doing the best for our participants. Generally our discovery include sessions and compliance regulations you'll see a lot of references to the journal articles that we use. When we designed our program. We start with that pilot that I told you about and have a control group. We track data that we can make corrections for along the way. Employees like to have some background and expectations for success on embarking upon the tasks that help to answer that question what's kind of on everyone's mind. If you change roles will I be good at it? So change to management. We have got to manage change. When you're looking at that. When we first rolled out something. And we were first talking about how to be more effective doing things the questions I got back to where we already do personal center care. What we do but we can do it better. We are not medical. We are not a strictly medical model. But we do need to look at the medical part of the person. To be realistic. We have always used the social model yes we have. And now we are changing. We do not want to change. It is working this way. While we are going to change because change is coming down we know with Trinity health choices changes coming. And we are going to be ready for them. Because that's who we are. But then the last question. Will this mean more forms? Of course that is something they want to know. Is there going to be more tracking? Is there going to be more work. But behind all that they're really saying what I be good at it. I'm confident in what I'm doing now. So. The answer to some

of those questions is medical necessity. That is the new temperate right? For care managers. Our role is essential as it relates to social determinants of health. For talk about social determinants of health and how it leads to medical necessity. It's a good starting point for us. Let's start with something that is less intimidating towards us. And a place that is easier to build upon let's talk about Stark which is let's talk about talking to people. We are good at talking to people. Let's start there. Let's start with emotional wellness. Did you know that depressed and anxiety are often undiagnosed and maybe a strong factor in repeat unplanned hospitalizations? So why do depression and anxiety what is ago undiagnosed? Well. It is a don't ask don't tell culture right? Reasons why people don't ask they don't know what to do about it they do not want to be responsible for knowing. They don't want to see the person as depressed they don't want to take the time to hear the story. Not my job. Someone else would do it. And that's why people don't tell. It is a stigma they do not want to be seen as weak. They don't believe in themselves if they are depressed. Simply no one asked. So we started to ask. How do you overcome don't ask don't tell? Specifically how do you overcome that? How did we do it? By plotting it of course. We decided that we need to understand the basics. We needed to be able to understand the basics. And be able to ask the basics of our participants. We needed to be able to use an emotional wellness survey that was well validated. So that we had confidence in the tools that we were using. We need to understand how we personally could help. What can we do? And how can we tell that back to personal center care things that we are working on all the time. We know our resources. We need to know them better. Communicate with those able to help and provide follow-up services. So we're lucky here. We actually have a resource center. That compiles all kinds of information. And resources for us. And all the counties that we serve. So our case managers find it very easy to be able to get some of their resources together. As they share. Which is a wonderful thing. There is a lot of sharing that goes on in our department. Sophie focus on the practical needs to be addressed there is a general agreement that long-term services and support programs must address a range of social and needs like emotional well-being. And medical problems. There is other places that show that this is a direct focus that we will be going on. We are one of the first accredited case management for long-term support services. That is a great practice to go to. If you have not gone there. I encourage you to do that. Okay so let's talk about mood disorders. Depression and anxiety does play a role in unplanned hospitalizations and visits among people with long-term conditions. We looked at 16 independent studies. This is what was identified. They pulled the effects and identified that depression was associated with 49 % increase in the odds of urgent health care utilization. The study attempted to better understand the factors that drive the use of urgent health care and unplanned hospitalizations among people with chronic disabilities the studies conducted with a systematic review to examine the strength of association between depression , anxiety, subsequent use of urgent health care. Among chronic people with LTC. The study included patients with diabetes asthma. Chronic obstructive pulmonary disease. Coordinated heart disease. Some of the other typical diagnosis is that we would see. And these were very much the typical patients but dispensed that we take care of. In our practices. So let's talk about some of those

people that we take care of in our practice. People with physical disabilities and depression. I have Stephen Hawking's picture up there. Because there's a little bit I want to tell you about him. You all know him for sure. He is a world renowned scientist. And he is known for providing us with complex and invaluable insights into space time and physics. However talks that he gave applied his brilliant mind to a more emotional matter. Hawkins gave a moving message to people suffering from depression making a poetic comparison between depression and a black hole. The matter how dark they seem neither are impossible to escape. The message of this lecture is that black holes are not as black as they are painted. They're not the eternal prisons that we once thought. Things can get out of a black hole on the outside and possibly to another universe because of you feel you're in a black hole do not give up there is a way out. Yet it was not just to keep going for the purpose of survival. But to transcend this by producing extraordinary work. And you know that he did through writing books and lectures. Much of what he has done he did from a wheelchair. Or from being quite handicapped physically handicapped. But it would appear that Stephen Hawking's had purpose and control over his environment and what I say to you is when we provide our folks with purpose. And control over their environment. They do well. All persons required to control over their environment. And I believe all persons desire sense of purpose. This is another justification for the person's of center care model that we emphasize. How do we create independence? And there is 1 million ways to do that. Major depression and struck patients another population that we take care of. So in this study referenced the prevalence of major depression with 25 % of this stage approximately at the same at three months 31 percent and decreased to 16 % with 19 % and two years it increased to 29 % at three years. The most important predictors of immediate major depression were left with anterior brain lesions dysphasia and living alone. So they were not able to speak well. Comedic it well. Alone. They were dependent. Dependent and activities with the most important predictor at three months. From 12 months on the patients have a few social contacts outside of the immediate family contributing to most depression. And in three years cerebral atrophy also contributed. At one year 60 % of the patients with early depression 0 to 3 months have recovered. Those not recovered have a high risk for development of chronic depression. , And emotional changes post stroke. Some degree of these are normal. An expected except for BTA however I look at that and say that does probably continue to feed back into depression and anxiety. I'll just put that up there on the screen for you to look at. And then also. Post stroke depression. It is important because it impacts recovery significantly. Impacts between 30 % of stroke patients regardless of type. So if we have folks that are recovering from stroke. When it makes sense that we would be checking in on their emotional recovery? Post stroke anxiety. I think of anxiety is even more difficult to deal with than depression. So depression with anxiety is probably at the top of the list of the most difficult things to deal with. It impacts approximately one in five of the struck patients most commonly within a few months of the stroke. And you can look at some of those symptoms there. Difficulty with concentration. That would be really difficult what in it? To be able to make decisions going forward. And when you think about that somebody with anxiety if they're not sure what is going on. They would attend to maybe use the

emergency department more frequently. Because anxiety does impact our ability to make good decisions. So reclaiming your life after a stroke with the recommendations are confront rational catastrophic thinking and went to evaluate negative thoughts. Recognize limitations as well as abilities. Take control where you're able. Rely on someone you trust. Who knows what you Valley to help the process decisions. And resume prior roles and activities as soon as you can. Without a singer take control where you're able. It implies a clinical indicator that personal center care is beneficial.

I think I'm putting my fact that person centered care is very beneficial. Another population that was served is TBI. Traumatic brain injuries. 42 % of patients with brain injuries met with a visit number of symptoms for diagnosis of major depressive disorders. Traumatic brain injury causes physical impairment that reduce participation in employment leisure and social relationships. Psychological resilience is associated with participation outcomes following mild to severe traumatic brain injuries so in the study many outpatients with brain injuries were referred for conference of assessment and study. Depressive symptoms were characterized using the standard criteria. And the newer behavioral functioning inventory. There is also 42 % of patients with brain injuries met with a prerequisite number for symptoms of major depression depressive disorders. And poor concentration was 38 % which was the most common manifestations of depression. Okay. So MS that is another population that we serve. The degree of physical fatigue that a person with an existing physical mobility such as MS experiences can be predicted. More physical fatigue leads to higher risk of increased physical disability a year later right? So physical fatigue had to have more to do with increased physical disability than physical disability had to do with creating physical fatigue. Depression was a factor that most significantly predicted physical fatigue. Depression leads to physical fatigue. Physical fatigue leads to physical disability. Fatigue does not lead to depression. So having to deal with depression. It is pretty important in this population. Another population that we serve and the depression in older adults. About 50 % of older adults medically diagnosed with depression were treated phonologically. Depression is widely underrecognized grid and undertreated among older adults. It should not be considered a normal part of aging. I just feel like I always have to say that. It should not be considered a normal part of aging. I think more and more people are realizing that. If you look at the circles there. I drew that delirium and dimension because it is really important for us to be able to distinguish sometimes is it delirium is it dimension. Because in some instances. It can overlap. A person can have a little bit. Of dementia. Become depressed. And look very demented. So it is good for us to be able to determine those factors. Another reason for us is to some kind of a server to figure this out. So emotions and wellness. We decided that we will make it simple so teams can easily explain it to participants. I'm hoping that my previous slides were able to convince her that there is a large relationship between sad and anxious moods and unplanned hospitalizations. All come start with a good plan. We had to select the tools that we were going to use. We use a PHQ nine. We trained a pilot group. We used two PR questions to persuade certification on all of our folks who are certified in that. In fact actually hired him but he and page to have them trained as a trainer so all of our staff is trained

initially and then annually to keep their skills up. We reviewed progress trends for the last six months. We make corrections along the way. We allow the pilot group to roll out the program. The administrative staff does not have to rule out the program. The pilot group does. They're the ones I have the experiences to share. We allow for a lot of testimonials. We highlight successes and we celebrate. We like to know that we make a difference. We have to be very flexible in the beginning and encourage questions and challenges from staff. Because again they have got to become comfortable with the change. We provide staff with tracking and trending data. We track and trend a lot. In our operations. We like to graph best. We make sure that managers understand the hypothesis and can speak to us. If we are speaking the same language. About the same goals. And the reason are doing it. Okay so here is certifications. The simple three steps that anyone can learn to save a life from suicide. People are trained in CPR the -- and Heimlich maneuver is. And how to question and persuade and pursue someone for help. I do have the Institute where you can click on to get more information about it. So now okay we are looking at this. So how do we do this? What do we do with this?

This means that this is two questions right and these are the two questions that we see on the slide in front of you. The PHQ program with the presence of depressed mood over the past two weeks. It is actually the first two questions of the PHQ nine. The first PHQ is a first step screen for depression. It is not used to establish a diagnosis or monitor depressive symptoms or severity. Those that screen positive from the PHQ TR should be further evaluated to determine whether they meet criteria for depressive disorder. As for clinical utility. Reducing depression evaluation to two screening questions about the most prevalent disorders in primary care. So I belong to an organization in Lancaster that has really been encouraging our physician offices to use the PHQ's in assessment of anybody coming into their office. And what we have heard from a lot of the physicians pushed back the reasons as to why they did not do that is that they did not know what to do with the patients after that. If they were to determine that the patient was at risk for depression. That is really were not that skilled in managing medications themselves. So what do we do? So together a list of referral sources in the area. Clinical therapist. And we found that you can link to clinical therapy visit very quickly. You may not be able to visit a psychiatrist as quickly but a clinical therapist situation can communicate back to the physician. And we really are look at some of the medicine that we would like to see used in the future. At any rate we started the plan. About how do we get that more involved. So this is a PHQ nine. I digress.

It is translated into 30 languages. Yeah you heard me 30 languages. Used for years in the assessment and long-term care facilities. So folks that are social workers and long-term care facilities have been asking these questions. Objectively determining initial systems severities and monitor symptoms and challenges over time. And ideally asking questions by the same person used to provisionally diagnosed depression and general medical and mental health settings. Score each of the nine DSM criteria is of major depressive disorders. As zero, not at all, to three every day. Providing a 0 to 27 severity scale. And the last item is 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

included in this score but it is a good indicator of the patient's global impairment and can be used to check treatment responses. Higher scores are associated with decreased functional status and decreased system sick days at healthcare utilization. Okay. So that is a lot of something new that our staff is learning to do. So we had to make sure that there is a way that they could follow. An algorithm that would tell them clearly what to do when you got a certain score. So he made it clear.

By following our algorithm on what we do when we get a certain result and we included discussed with a supervisor. Leadership must be willing to support any change anyone in leadership was aware of that. At a minimum. If anybody went for me to the PHQ nine. We provided education resources. For them if they scored low. Maybe if they scored at the very lower end. If they scored a little bit higher. We would notify the physician. And I will show you what a typical letter is that we sent to the physician it is a typical letter that was in the physician letting them know a little bit about the PHQ two. And the pH to nine and what our concerns were. If they scored much higher. We would often involve crisis management. So something that was really unique. We started in our Williamsport office because they have very limited resources for behavioral health. And they quite often had calls coming in from crisis that required them to investigate to the 302 which is an involuntary commitment in the state of Pennsylvania. We started there. And a surprising thing happened. Our crisis interventions went down. We were proactive. We were seeing patients that had been seeing their doctors for six or seven years and was still having signs of depression and anxiety. On the same medication with no change. As we give a voice to be able to say because they would tell us that they did not have enough time when they went in. They did not feel like they knew what to say to the physician. So we would help them with that. We broke the ground by sending them the letters first to the physicians. We found a lot. The one thing that we found that surprised us the most. No one not one person refused to participate in answering PHQ to the pH to nine. That was remarkable to us. So medication alone is not the answer. So that is why I am saying sending them back to the PCP alone is not enough. What else can we provide to them? What else can we do? And Hadley help them with some of the things at home that they can do for themselves to bring them joy and control and mastery over their environment again? That is for the personal center care comes in. What reduces depression and anxiety? Achievable goals to have a purpose all of these things on the slide. All these things and many many more. Help to reduce depression and anxiety. So great personal center goal writing. We do a lot with goal writing as well. We write high-risk plans that are very person centered and they may not be the typical plan that you think that you would look at for somebody with disabilities. I will give you an example of one for this person her name is Jane she is at risk for sad and anxious mood symptoms that impact the quality of life in her care motivation as evidenced by scoring in the moderate range for depression on the PHQ nine. She has been on the same antidepressant for the past nine years. She has frequent hospital admissions. For somatic symptoms. She goes to the emergency department and comes back home. She comes back in with palpitations chest pain. She is admitted for a day or two and comes back home. She feels that her medication is not working real well. She is the one I told you about a little bit

ago. And she has not talked with her primary care physician. She just does not know what to say. We had this conversation and we have known Jane for a long time all the started to come out. So Jane has bilateral lower knee amputations due to a traumatic vehicle accident. Nine years ago. She has become more socially isolated over the last year.

Her strengths

are always identifying strengths first with the participant. Jane is fully articulate she has an adult daughter that lives nearby and provides assistance. When she is not working. Generally she can adjust her workday to accommodate Jane. Jane can make her needs known and follow multistep directions. She has a history of hobbies and pastimes that she really used to enjoy. So a long-term goal for Jane would be to establish a routine that promotes health and safety while proving her effects. So her short-term goal. The first one is Jane will participate for at least 30 minutes into pastimes

per day that is what she said she wanted to do. She said she would like to get back to doing her past times again. Her second short-term goal was that Jane will identify and employ two new coping skills within two weeks and report on their success within 90 days. It was a great report to? She said she was going to report to her care manager right? Or SC. These were goals that were important to her. And one that she selected. So we look at long-term goals, short-term goals and interventions are those of the things that we are going to do to help her meet her goals. If you notice that each of the short-term goals we started with Jane's name. We did not say participant. We said Jane. Because Jane gets a copy of this. It has to be written with her. For it to be effective. And we have to involve the physicians. And her other care providers as well. So the interventions. They will forward pH 29 results to PCP and follow-up with a telephone call. Jane said that is good. I wanted to do that. PCP will review medications with Jane and make adjustment recommendations as needed. PCP said that they would do that. The daughter will take Jane's -- -- Jane will take her for craft paint that is something she wanted to do she wanted to make candles. And put them in a glass container. The daughter will take Jane to purchase a simple crop pot recipe and food items. And the PAS worker will help oversee cooking activities for Jane and the daughter will stop by on Wednesdays to help have dinner with Jane. All these things were agreed-upon by the worker who was helping the daughter Jane of course. And her SCM physician. So that is kind of the way we look at it. Having our smart goal specifically. Smart goals or specific right clear concise goals. The ability to take and track your progress. Achievable. Set challenges. Yet achievable goals. And relevant. Set goals that are relevant to your overall life plan. And timely. A goal that has a target is really important because how do you know if you are working towards that goal unless you have that target to help you achieve that? So. Mood disorder and unplanned admissions. More proof on why this is important. Top five diagnoses of Medicaid super uses. Mood disorders. Psychiatric disorders and that will be more serious ones like schizophrenia chemotherapy sickle cell anemia prescription medications and that was from the 20 12 healthcare projects top five diagnoses of mental health hospital admissions mental and behavioral was number one. 19 to 24 % of the Medicaid. Readmissions.

I say to you though that it is underdiagnosed. Somebody going into the hospital with chest pain may not admit to the fact that they're

having anxiety or depression. They maybe were willing to accept depression from some of the no case managers in their home setting where they're much more comfortable. We are the ones best able to do this. Okay. So what were those symptoms again? Sleep changes too much to little aches somatic complaints weights changes forgetfulness and impaired decision-making ability? Changes in energy level excessive worry and paranoia. My back hurts. And I have anxiety. And depression. I might start thinking that maybe I have a tumor in my back and I better go to the doctors to see. I'm not in a place where I can really process it right? Because now my concentration is off and I am having paranoia. I'm wearing. You can start to see why emotional wellness is so important. But we are finding that emotional wellness findings in our population. So 73 % was determined not to be at risk for a mood disorder. Yay. But 27 were screened further with a PHQ nine. On that 27 % 40 % were no risk. But 52 % were high risk. This associating us to contact their physician and set up follow-up appointments. Was either a therapist or with a physician or someone else of their choice. And then we had to initiate high-risk care plans. Because they were not high-risk for moods.

All right. Remember we are doing all this because our goal is to help to reduce unplanned hospitalizations. So has this changed our culture? You bet. We have used technology to track and train and analyze data. We should refine our processes and our people become much more comfortable with the medical model. It was our first actionable measure to move towards our outcome goal of reducing unplanned hospitalizations. We celebrated numerous success stories while using the simple assessment. We made a difference in our participants lives. We know that they told us so. There is a contact at the bottom of the screen. I encourage you to tap onto that at some point. And just take a few minutes. It is a three minutes presentation. One of our SEs talks about her journey. From not being able to do this to being able to do this and how she felt about it is really rather moving so I encourage you to get the chance to look at that. Okay. So one actionable item leads to another. Remember this is performance approve and analysis tools for person center profile. That was our profile that we did. A lot like an MDS assessments. But it has other things in it. Has a pH 29 audit scene. Daily structures. We started to look at things differently. We looked at our transition of care. We call the ticket to home. We have a two day, post discharge call and a five day post discharge visit. High-risk treatment plans versus interdisciplinary approaches like a to show you. We do fall assessment in the home. And report to the PCP on our findings. And do something called drug services and determinations. With paid and national support. We do not talk about each of these little bit more. Because those were additional items that lead us to and I was sorry at the end. Our final outcome measure.

Did we do some plan hospitalization and if so by how much? We build the tension for that. So we ask and assess the score we look at debris such as health and literacy assessment and you can see on the screen. What they are. We use this in our care plan to determine how to communicate with our participants who do they want us to utilize based on their understanding? And this is brief you can pull it up online if you want to look at it. It is something that we do with all of our initial and if there has been a change in that as we do that again.

Okay. Alcohol usage is a problem especially in some of our older populations. So

what do we do? How do we assess that? That was something that was really important for us. So we do something called the audit scene. It is simple we ask on our initial assessment as needed. And three questions are how often do you have a drink containing alcohol and they rank it. From never to four more times a week how many standard drinks containing alcohol do you have on a typical day? One, to 10 or more. How often do you have six or more drinks on one occasion? Never, daily, or almost daily. This gives us an indication of whether or not we should be discussing substance options with them. Coming forward. And then we look at the daily structured routines. So if you're going to be taking care of somebody. What is their regular schedule like? What time do they get up? What time do they go to bed. What time is their energy highest. If there's a pencil 10 in the morning. It doesn't make sense for us to have someone come in and help them get up at 6 AM to get ready for the day. That is a part of what the daily routine is. Support for us -- it is important for us to know those things. So we do what we call a needs assessment. It is lovingly called the DST. Direct service determination. So we know how many hours something is needed and it looks kind of like this could ability and preference equals time. With a person's ability of maximum assessment. And what is their preference because the choice matters. And who's going to do it? Is there national support I can do it? Can we work around a natural support Westmark do we need a paid attendance? What can be attended to do for him or his mouth -- for him or herself. And there's a page on the actual DST and you can see we are actually looking at personal preference for customer routines. What is their ability? What kind of computer they like? Here is what I want to say to you if I'm interested in that really just wants to run a comb through their hair and put on a sweatshirt and a pair of sweatpants and are good to go. Out of the doctor's appointment. It would not take so much time at five another person who wants to put on makeup and have their hair curled and they want to have their clothing iron. And they want to have you know stockings on. It will take a little bit longer. I need to know that. I need to know who is going to do a timely times a week to address and go out on average. I need us to know all of these things to determine how I can best provide for their ongoing care. If it is not within their preference. They probably are not going to be as successful. We want to be able to encourage that. And that ability to take care of yourself you to own your own health. -- To own your own health. The next actually designed to get a stack from -- so we developed this in partnership with aging and disability resources. It talks about education of those that we serve so we educate folks only go out we say look if you go to the hospital we needed to call us. We give you little cards that tell us to give out little cards to their case manager in the hospital. What I can give their card to their nurse. Anna has our name on the back our phone number. And it tells the name of the service provider. Because you want to be able to have the medication as soon as we get there. Sometimes I forget to tell that they're being hospitalized and it might be a day or two before we find out. So we want to ensure that as it is we know there hospitalized was in the tradition of care to the hospital which tells them the most daily information about our participant. What services they have at home. Who is taking care of them. Who is taking

care of what. What medical clinic they have and so forth. -- What medical equipment they have and so forth. And when they discharged our plan is to do a two day call. And we have a script that we go through. Many many questions that meet CMS guidelines for hospital discharge. The RSC goes through. And then we go out and see them within five days. We actually asked the discharge plan is at the hospital to send us a one-page form with the most prevalent pieces of information in it. Like that you have an apartment set up with her doctor for the next seven days? You have a test pending where would we find them? And we talk about when the red flags are indicative on education and those red flags. What medications could they stop and when should they start? And we do not off to get that back. We do often get is a copy of this regular discharge summary. So we go off to the home and we complete one. Discharge papers called the to get the home on our own but as bigots one for them the SC gets one front of her or him they fill it out together the go to the packet. And they're getting the information. We will be fine with medication is not so hard for them to remember to start a new medication. Quite often we find that they forget to stop one. Oh rights and that we have assessed folks this is what our basic high risk personal center care plan looks like. For a person discharge from the hospital. We want to make sure that we have those calls completed and we are assisting their tickets to home. We assist them in making a list of questions to ask their position on their next visit. We usually start that with a two day call. We find out as much as we can. Then again transportations . How do you get there, do you have a ride? Do we need to get a ride for you? We see that a lot of the times participants don't follow-up because I do not want a ride and shared ride. That is a whole another story. That is something we look at very carefully to make sure that we have that covered for them. All right. So let's see we went backwards. All right. So here is our information. Fall assessments. We did fall reduction. The fall assessments are done baton -- between fall assessments. And if there is a risk for a fall due to medication changes or changes to the environment we do a fall assessment. Without that was really important. When we started doing it in July. We had more falls and we did now. We are finding that this is a proactive event. This is an actionable measure that can help us redo hospitalizations. All right. Here's the big one reducing unplanned hospitalizations. All right. So our high risk people if you look at where they were in July, August, September, October. They started to come down. They started to get really good at writing high-risk care plans and engaging them are high-risk drop is considerably dropped down to June during the year. And we have a high risk folk here high-risk with personal center care. At high risk numbers that were removed from high risk. So the purple line are the folks that were removed that had really good high-risk care plans. They were reviewed by program specialists. To make that determination. So know the high risk personal center care plans are employed and they are working. So did we meet our unplanned hospitalization decrease? Well, look at the bottom one. On the topic is in the percent of those hospitalized this month that have been hospitalized two times. And those I have been hospitalized within the last 30 days. Our focus really was in the last 30 days. That is what we thought we had the biggest impact on. So our total hospitalization the prior year was eight %. We ended this year at the percent. We ended at the percent that is a three % decrease in hospitalizations that are

unplanned. So how have quality helped us proceed we saved our unplanned hospitalizations. By five % not three %. It should be five %. But how that works is the number of our participants that would have been hospitalized otherwise.

Remember I told you at the beginning on average hospital per diem is 2000 average length of stay is 2000 or five days. So this is working on 200 prison Spence -- 200 participants that work this year on five % reduction and we grew our business participants and organizations asked for us by name. We grew 122 % overall with our regional growth this year. Our goal is to become the provider of choice. So that is me the executive director United disabilities services here's my number. I'm happy to talk to anyone who has any questions. As you probably can tell. I love doing quality measures. And I will be happy to take any questions.

Very good Debra. We have just a couple of minutes for questions. We have one in the system that is if you can just re-clarify what is a pH to Q and the PHQ nine

Those of the two surveys position health questionnaire you can find them online. There in 30 different languages. It is one of the most validated assessment tools. It is part of the full assessment.

So they provide that once a year. We are doing that now in the community. So that is what it is.

The assessment tools actually the measure to questions of the first two questions of the nine. Because it is to questions pH 29 for nine questions. The first two questions of the nine are the same from the two. So the idea is if they answer positively. There is an incident with either the first two questions then you would move on to the nine. And that measure is the risk for major depression disorder in accordance with the DSM.

Very good.

All right I do not see any other questions. We just had one pop in really quickly what outcomes do you measure in addition to ER and we hospitalizations to determine valued effectiveness of support coordination?

So we do participant satisfaction. We do falls. We do high risk. We do networking and development. We actually monitor I want to say 20 different quality measures and a lot of them I wanted to say 75 % of them feed into our outcome measure of reducing hospitalization. All right. I want to thank you Debra for this wonderful and extensive webinar. There is so much information here. And Debra shared current information. As a reminder. The webinar the slides and so forth are all available it will take us a couple of days to get this presentation up on the site. But then it will be available for all. If you have any additional questions. On today's webinar or anything else related to business for disability organizations feel free to email us. At any time. Thank you all. And have a wonderful day.