



Executive Office of Elder Affairs

RESPECT INDEPENDENCE INCLUSION

Hospital to Home Partnership
January 14, 2025, 3:00pm-4:00pm




Agenda

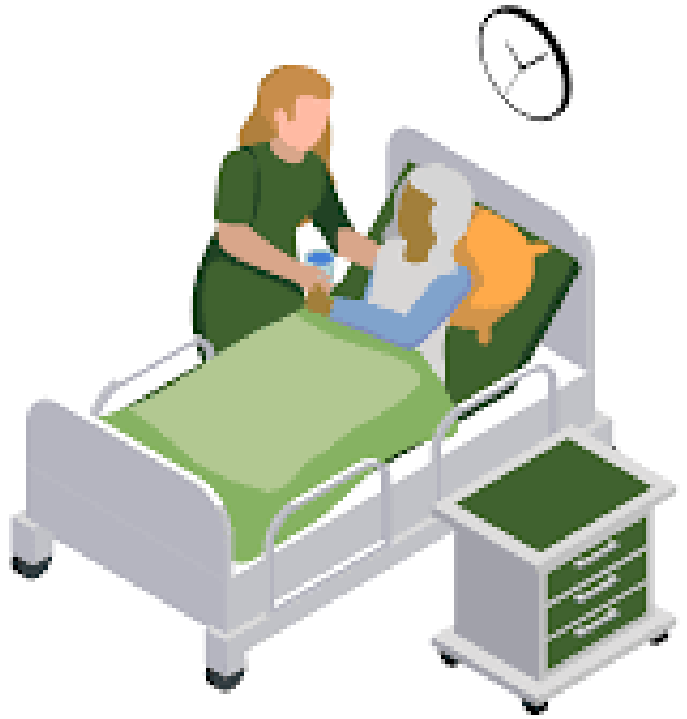
- HCBS Supports Data
- HHPP Presentation: Highland Valley Elder Services and Cooley Dickinson Hospital
- HHPP Presentation: Elder Services of Cape Cod and the Islands and Cape Cod Hospital
- Discussion: How has your program changed?
- Questions?

HCBS Supports

- Requested additional breakdown of Home and Community Based Services Supports for Interim Metrics
  - Data submitted in the interim report included outliers from program reporting of HCBS Supports
    - Programs reported a range of 0% to 95% across all programs
  - Gain a better understanding of how hospital systems quantify an HCBS discharge disposition type
  - HHPP is an ARPA HCBS funded program
    - Unclear if SNF or transfers to other medical facilities were being counted as an HCBS Supports discharge

Examples of Discharge Dispositions Submitted for HCBS Supports

Left AMA
Home – Health Care Services
Home or Self-Care
Hospice – Home or Facility
Court/Law Enforcement
Expired



The discharge disposition metrics varied across HHPPs

Highland Valley Elder Services & Cooley Dickinson Hospital

HHPP Learning Collaborative Presentation 1/14/25

Program Structure

Hospital Liaison

- Work Schedule 8:30am-4:30pm to accommodate daily Rounds
- Has their own workstation within the CDH Case Management Department
- Trained as an Options Counselor
- Has their own cellphone connected to CDH's healthcare messaging app (Voalte)

Rounds

- Hospital Liaison attends daily Rounds from 9am-10am which cover two different units

Referral Sources

From Hospital Staff:

- RNCMs and SWs send messages to Hospital Liaison through Voalte
- Patients identified during Rounds

From Highland Valley:

- ASAP staff (CM, RN, PSW, CTLP) will outreach to Hospital Liaison if a consumer has gone to the hospital for further assistance with ASAP/Hospital communication and Discharge Planning

Hospital Liaison Follow-Up

Once referral is received, Hospital Liaison:

- Reviews CDH CM notes in CDH electronic medical system, Epic, to see service recommendations and current IADL/ADL needs
- Meets with patient to discuss need for services and other resources. Depending on the needs of the patient, Hospital Liaison will either conduct a SHC Initial Assessment or an OC Visit.

SHC Initial Assessment

- Completes Initial Assessment
- Connects with ASAP I&R Dept to ensure SHC referral data is inputted accurately and for primary CM assignment
- Submits service referrals prior to discharge
- Case discussion with primary CA for warm hand-off when appropriate

Options Counseling Visits

- Completes OC Visit
- Identifies patient needs and provides community resources and referrals

Other Follow-Up

- Connects with other ASAPs as appropriate if patient will be discharged outside of HVES catchment area
- Connects with CTLP if patient is going to rehab to ensure warm hand-off

Hospital Liaison Weekly Data Tracking Template

		24-Jul	24-Aug	24-Sep	24-Oct	24-Nov	24-Dec	25-Jan	25-Feb	25-Mar
Referrals to HL by CDH Staff (related to HCBS Hospital Liaison metric)	WEEK 1									
	WEEK 2									
	WEEK 3									
	WEEK 4									
	WEEK 5									
	MONTH TOTAL	0	0	0	0	0	0	0	0	0
Individuals Met with at CDH by HL (related to HCBS Hospital Liaison metric)	WEEK 1									
	WEEK 2									
	WEEK 3									
	WEEK 4									
	WEEK 5									
	MONTH TOTAL	0	0	0	0	0	0	0	0	0
Individuals Screened Out/Not Completed (Refused assessment, D/C'd before assessment)	WEEK 1									
	WEEK 2									
	WEEK 3									
	WEEK 4									
	WEEK 5									
	MONTH TOTAL	0	0	0	0	0	0	0	0	0
Option Counseling Visits Completed by HL in hospital	WEEK 1									
	WEEK 2									
	WEEK 3									
	WEEK 4									
	WEEK 5									
	MONTH TOTAL	0	0	0	0	0	0	0	0	0
SHC Initial Assessments Completed by HL in hospital	WEEK 1									
	WEEK 2									
	WEEK 3									
	WEEK 4									
	WEEK 5									
	MONTH TOTAL	0	0	0	0	0	0	0	0	0

SHC Initial Assessments Completed by HL in community	WEEK 1									
	WEEK 2									
	WEEK 3									
	WEEK 4									
	WEEK 5									
	MONTH TOTAL	0	0	0	0	0	0	0	0	0
SHC Referrals Made to I&R by HL	WEEK 1									
	WEEK 2									
	WEEK 3									
	WEEK 4									
	WEEK 5									
	MONTH TOTAL	0	0	0	0	0	0	0	0	0
Cases HL Discussed w/ CDH Staff (Individual not seen)	WEEK 1									
	WEEK 2									
	WEEK 3									
	WEEK 4									
	WEEK 5									
	MONTH TOTAL	0	0	0	0	0	0	0	0	0
Total # of Individuals D/c to community after formal hospitalization or after presenting in the ED										
Total # of individuals D/c to community with HCBS supports										
Total # of patients eligible for services who cannot be served due to lack of available staff										
Total # of otherwise eligible patients who cannot be served due to homelessness/housing										

Hospital Liaison Detailed Tracking Template

Date	Consumer ID	Consumer Name	SHC (Y/N)	Type of Visit	SHC Referral Made (Y/N)	Other Referrals Made	Topics/Services Discussed
1/8/2025	1234567899	Grandfather Doe	No	Inpatient	Yes		

Success Story!

SHC Consumer was enrolled in ECOP/NW program receiving 6 hours per week of HM/PC services. He was admitted to the hospital due to abdominal pain and multiple falls. While there, he was also diagnoses with hypotension. Family met with hospital liaison and expressed concerns they hadn't yet reported to his medical team including audio/visual hallucinations and difficulty giving himself insulin injections.

Follow-Up:

- Discussed concerns with CDH medical team and PCP office for further follow-up with concerns
- Submitted referrals for FEW and BSP to assist with MassHealth application
- Submitted referrals for a medication dispenser and CCT&O for RN assistance with medication management

Outcome:

- Consumer approved for MassHealth Standard w/ FEW and enrolled in Choices/Waiver
- Increased HM/PC services to 42 hours per week of HM/PC for daily oversight and assistance
- Addition of medication dispenser and CCT&O services

Supporting Data

From Interim Report:

- % of individuals who discharged from the hospital to a SNF or rehab facility went **down** from 4.1% to 3.3%

- % of 90-day Readmission Rates went **down** from 33.1% to 23.8%

Thank you!

Renee Deauseault

HVES Hospital Liaison

Jennifer Da Costa

HVES Hospital Liaison

Supervisor

Briana Baird

HVES Home Care

Program Director

Valerie D’Aquisto

HVES Associate Director

Programs & Services

Susan Pierce

CDH Senior Manager

Care Continuum

Elder Services
of Cape Cod and the Islands

Hospital to Home Program with Cape Cod Hospital

FIRST STEPS

Elder Services
of Cape Cod and the Islands

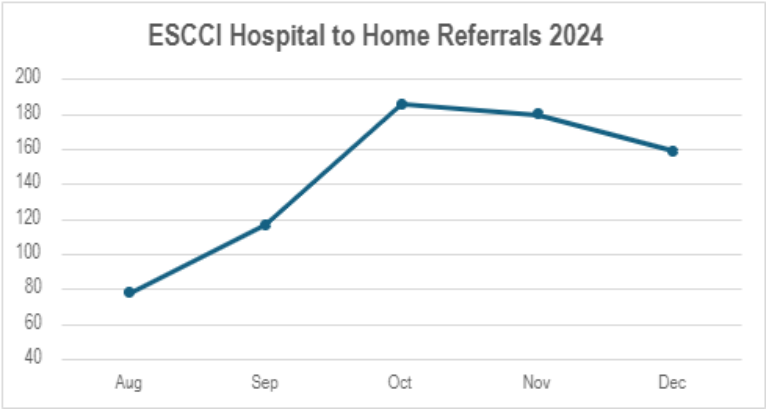
Hiring and onboarding

Referral Process

Getting familiar with external resources

REFERRALS TO ESCCI HOSPITAL TO HOME PROGRAM

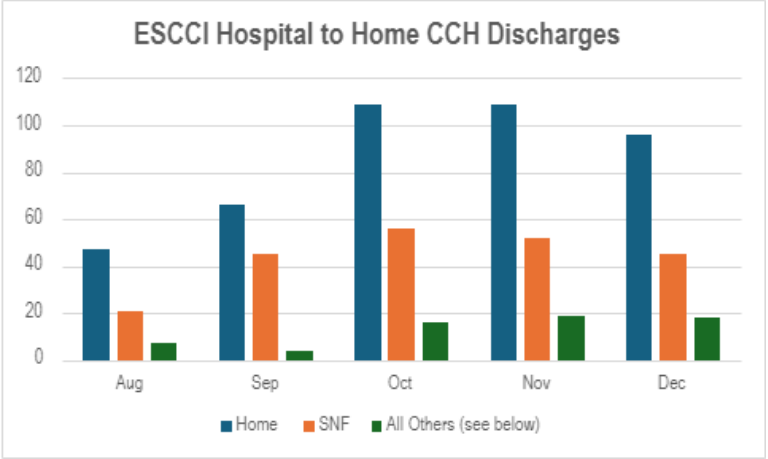
Referral Source	Aug	Sep	Oct	Nov	Dec
CCH	70	107	164	162	137
CCH ER	5	8	17	16	19
Other	3	2	5	2	3
Total	78	117	186	180	159



Elder Services of Cape Cod and the Islands

CCH DISCHARGES

Discharges	Aug	Sep	Oct	Nov	Dec
Home	47	66	109	109	96
SNF	21	45	56	52	45
All Others (see below)	7	4	16	19	18
Total	75	115	181	180	159



Elder Services of Cape Cod and the Islands

CCH REFERRALS TO ESCCI PROGRAMS

Elder Services
of Cape Cod and the Islands

ESCCI Hospital to Home Program

	Aug	Sep	Oct	Nov	Dec	Total 2024
Total Referrals	78	117	186	180	159	720
# referrals seen by H2H Liaison	48	91	125	103	100	467
# referrals current ESCCI csmrs	24	45	65	65	30	229
# new referrals to ESCCI	54	72	67	37	27	257
SNF discharges referred to CTLP	0	15	32	28	25	100
OC Referrals	1	4	3	3	3	14
Money Management Referrals	0	2	2	0	0	4
Family Care Giver Referrals	0	0	2	0	0	2
FEW	3	1	0	1	0	5

BENEFITS AND SUCCESSES

- Follow up post discharge
- Provider Specialists connection
- Direct Communication

Elder Services
of Cape Cod and the Islands

Discussion

- What has changed since your program began?
  - Have you developed any new tools?
  - Have changes in staffing at the ASAP or hospital affected your program?
  - Is there anything you would do differently?

Questions or Comments

Final HHPP Learning Collaborative

March 26th 1:30-2:30pm