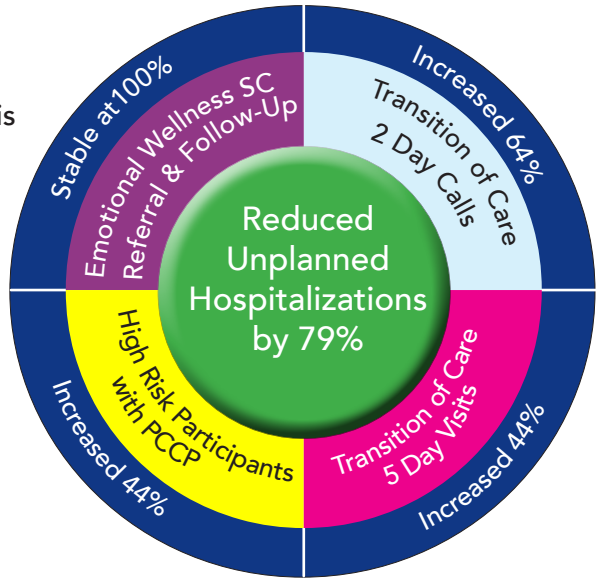
CARE COORDINATION OUTCOMES
REDUCING UNPLANNED HOSPITALIZATIONS
JUNE 2017 - DECEMBER 2018

As part of strategic planning, United Disabilities Services Care Coordination (UDS) developed an overarching goal to decrease unplanned hospitalizations by our participants. UDS considers this goal as a category of excellence under Business, Clinical, Staff and Customer Service.

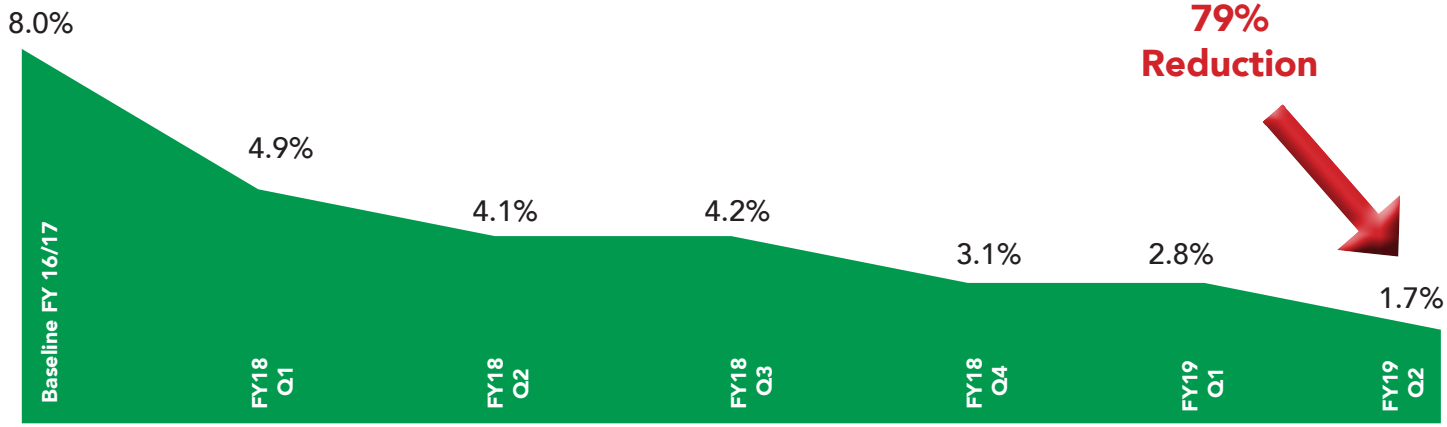
There were several sub-goals created to achieve this goal. Four of the sub-goals are highlighted below.

- Transition of Care calls at 2 days post discharge
- Transition of Care Visits at 5 days post discharge
- Amending the Person Centered Care Plan for High Risk Participants
- Emotional Wellness referral and follow-up by the Service Coordinator



UDS recognized that as an overall measure of quality improvement, reducing unplanned hospitalizations had the potential to impact the strategy for excellence. By addressing areas that most impact the overarching goal, UDS was able to validate accuracy and provide necessary support to participants.

Overall reduction in Unplanned Hospitalizations
June 2017 - December 2018



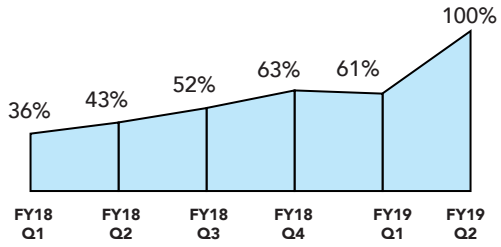
In Fiscal Year 2016/2017, the baseline average for unplanned hospitalizations among UDS participants was 8.0% with a total participant population of 1,838. By December 2018, unplanned hospitalizations decreased to a low of **1.4%** with a participant population of 2,211. Quarterly averages show a steady decline in unplanned hospitalizations during this period ending with an overall 1.7% for the second quarter of Fiscal Year 2019. This is a **79% decrease** in the number of unplanned hospitalizations during the 18-month period or a savings of approx. $1,380,000.

Affecting the Goal through Transition of Care Calls

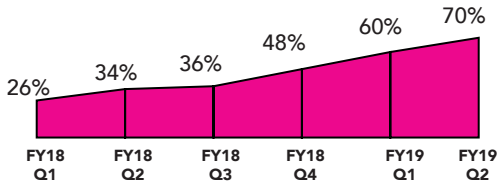
UDS implemented the Ticket to Home program to focus on the positive impact that can be achieved through helping to monitor participants' health following discharge from the hospital. Through this program, Service Coordinators (SC) have two participant touch points. The first is a phone call at 2-days post discharge and the second is a face-to-face visit with the participant at 5-days post discharge.

There has been a steady increase in both the 2-day and 5-day interactions. By the end of the Fiscal year 2019 second quarter (Q2), SCs were successful in achieving 100% of the 2-day calls. During this same period, the 5-day visits increased to a high of 70% completion. A 5-day visit is not always possible due to individuals declining to participate or other environmental factors that prohibit the face-to-face visit. As more attention is focused on helping participants following discharge, we see a correlation with a decrease in overall hospitalizations.

2-Day Calls - % Achieved

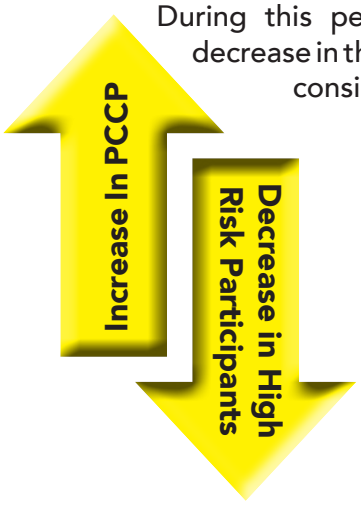


5-Day Visits - % Achieved



Affecting the Goal through Person Centered Care Plans

Over the past 18-month period, Service Coordinators began to access participants on their caseload to identify risks.



During this period there has been a decrease in the number of participants considered to be High Risk.

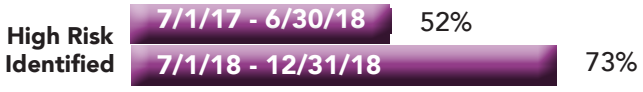
This decrease can be attributed in part to more focus on these risk factors.

Beginning in the second quarter in UDS' Fiscal Year 2019, a new key measure was added to the strategic plan to track the percentage of preventable incidents that were referred for High Risk mitigation. Participants who were referred for mitigation had their Person Centered Care Plan (PCCP) updated with goals to address these risk factors.

Affecting the Goal through Emotional Wellness

Using the PHQ2/PHQ9 tools to survey participants helps identify individuals at risk for anxious or mood disorders. Individuals considered not to be at risk based on the PHQ2 screening have increased by 3% in the past 18-month period.

Of the individuals identified to be at risk, the percentage of participants identified as High Risk based on additional PHQ9 screening increased from 52% to 73%.



100% of participants identified as High Risk for anxious or mood disorders were provided amended Person Centered Care Plans and were referred to a medical professional for follow-up.