HomeAdvantage™

Program Description

HomeAdvantage™ is a 60-day case management program providing tailored services through in-home and telephonic support to Snohomish County members who are chronically ill. Members benefit from personalized support and a range of services offered directly by Homage. Results include increased confidence in navigating the healthcare system and greater awareness of and access to community resources. **HomeAdvantage™** closes the gap between social and medical issues impacting member health and quality of life through proactive care management.

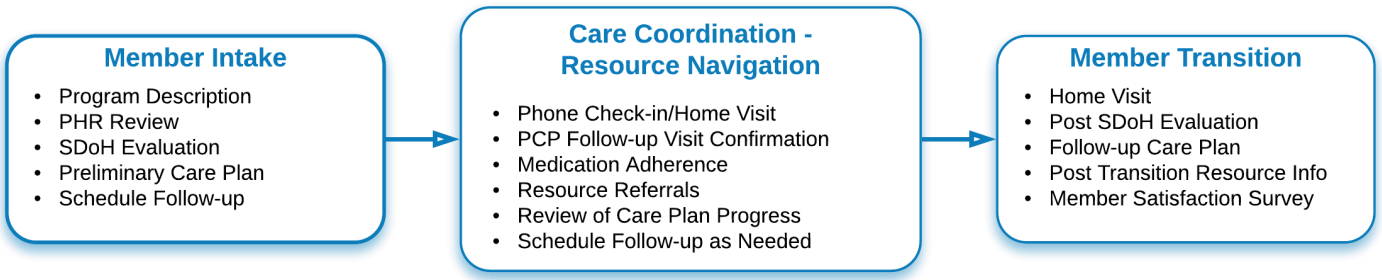
Homage has been providing vital non-medical services directly impacting Social Determinants of Health (SDoH) in the community for over 45 years. Having a suite of services under one roof uniquely positions Homage to provide comprehensive support. **HomeAdvantage™** Care Coordinators are the established link to helping people age well in place.

Member Experience

A **HomeAdvantage™** Intake Specialist receives a referral from the hospital, clinic or health plan, and connects the Care Coordinator with the member to schedule their first visit. This visit will include an initial SDoH evaluation and preliminary care plan developed for the member's specific needs.

Care Coordinators assist members to review and better understand their Patient Health Record (PHR) to identify 'red flags', ensure follow up appointments and transportation are scheduled, review medication adherence and coordinate resources to encourage their recovery. Services provided directly by Homage include in-home care coordination, transportation, meal delivery, and fall prevention strategies and resources.

Prior to program discharge, members will be provided with post-transition resource information as part of a Follow-up Care Plan. A member satisfaction survey and post-service SDoH evaluation will be conducted after program is completed.



Program Summary

Services Offered

- In-home Care Coordination
- Medical Related Transportation
- Home Delivered Meals
- Fall Prevention

Eligibility

- Enrollment in a Snohomish County Medicare Advantage Plan
- One or more chronic conditions including:
  - CHF
  - COPD
- One or more hospital events in the past 12 months
- Requires intensive case management

Outcomes

- Increased well days
- Decreased hospital length of stay
- Reduce hospital readmissions
- Improved member experience
- Reduced SDoH risk score
- Improved awareness of available resources

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Homage® Senior Services

Demonstration Pilot: Transitions of Care

Homage and Providence Regional Medical Center Everett

Pilot Overview

Homage and Providence Regional Medical Center Everett entered into a pilot agreement in December 2017 with a goal to positively impact patients care by addressing social determinants of health. The initial focus of the pilot was on COPD and CHF patients, expanding to additional vulnerable groups. Homage's role is to reduce social barriers in accessing follow up care, transportation, food, housing, in-home care coordination and other community resources. The pilot is ongoing with an expectation to convert into a transitions of care program in 2019.

Outcomes

- Prevent unnecessary readmissions and ER visits
- Reduce the overall length of stay for admissions

Pre and Post LOS Summary			
Status		**Before Referral**	**After Referral**
Active	# Pts Admitted	8	7
	Ave. LOS	4.8	2.9
Closed	# Pts Admitted	55	37
	Ave. LOS	8.3	3.9
Discontinued/Deceased	# Pts Admitted	7	3
	Ave. LOS	14.3	6
Refused	# Pts Admitted	34	27
	Ave. LOS	5.8	5.8

Eligibility

Pilot eligibility consisted of the below criteria, screened at Providence Regional Medical Center Everett::

- A chronic illness that is preventing them from performing activities of daily living (ADLs/IADLs)
- Services are not covered by their insurance
- Income less than 400% of the federal poverty level (FPL)
- Higher than normal admission, readmission rate, or ER visits.

Pre and Post Intervention Admission Summary		
	Before Referral	**After Referral**
# Pts Admitted	86	63
# Admissions	266	148
# of admits/pt based on total referral population	3.1	1.7
# of Admits/pt for only those that had an admission	3.1	2.3
% Change in total # of admissions		-44.40%

Statistics reflect a comparison of total number of admissions and length of stay, looking six months pre and post referral date. Referrals include anyone referred between Dec 2017 and June 2018. Total number of patients referred, pilot to date, is 147 patients. Total patients included in statistics above is 112 as they meet all comparison period criteria.

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