

# **The Silver PACER**

## **Patient Activation & Community Engagement Resources**

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# Peer Support as a Strategy to Reduce Re-hospitalization

- **Several studies (Coleman et al. 2006, Naylor et al. 2004, Jack et al. 2009) have demonstrated the effectiveness of transitional care after hospital discharge in reducing re-hospitalization rates.**
- **The role of the peer supporter would be to reinforce clinical messages, help solve problems, provide social support, and link patients to outpatient care.**

# Prevention = Payoff

- **The Affordable Care Act is taking an aggressive course to rapidly reduce excess hospital readmissions.**
- **Preventing even one readmission has enormous payoff, considering hospital days costing upwards of \$1,000.**
- **This effort will require greater coordination of care and cooperation between hospital AND community resources.**

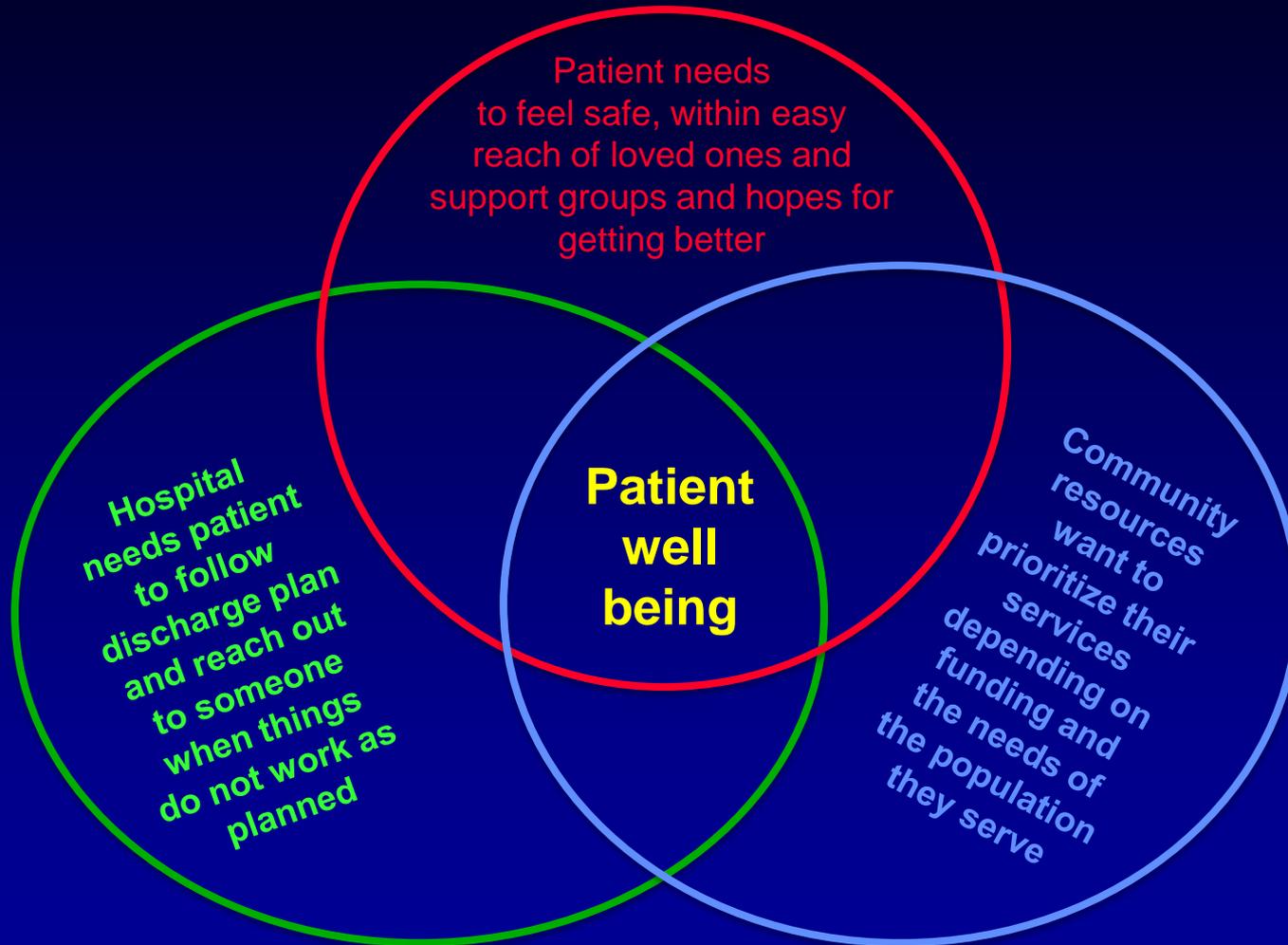
# Medicare spending per person

- 2009 spending per enrollee was \$10,365. Ohio matches closely the national average.



- There are 55 million beneficiaries in 2015 according to the Department of Human Health Services. In Ohio there are approximately 1.9 million beneficiaries.

# Convergence of needs



Patient well being will ultimately lead to a reduction in unneeded hospital visits

# Tech Savvy Elderly?

- Health illiteracy
- Cognitive decline
- Tech aversion
- Harder to reach
- No connectivity
- Trust issues

## Smartphone ownership by demographic group— gender, age, race/ethnicity

*% within each group who own a smartphone*

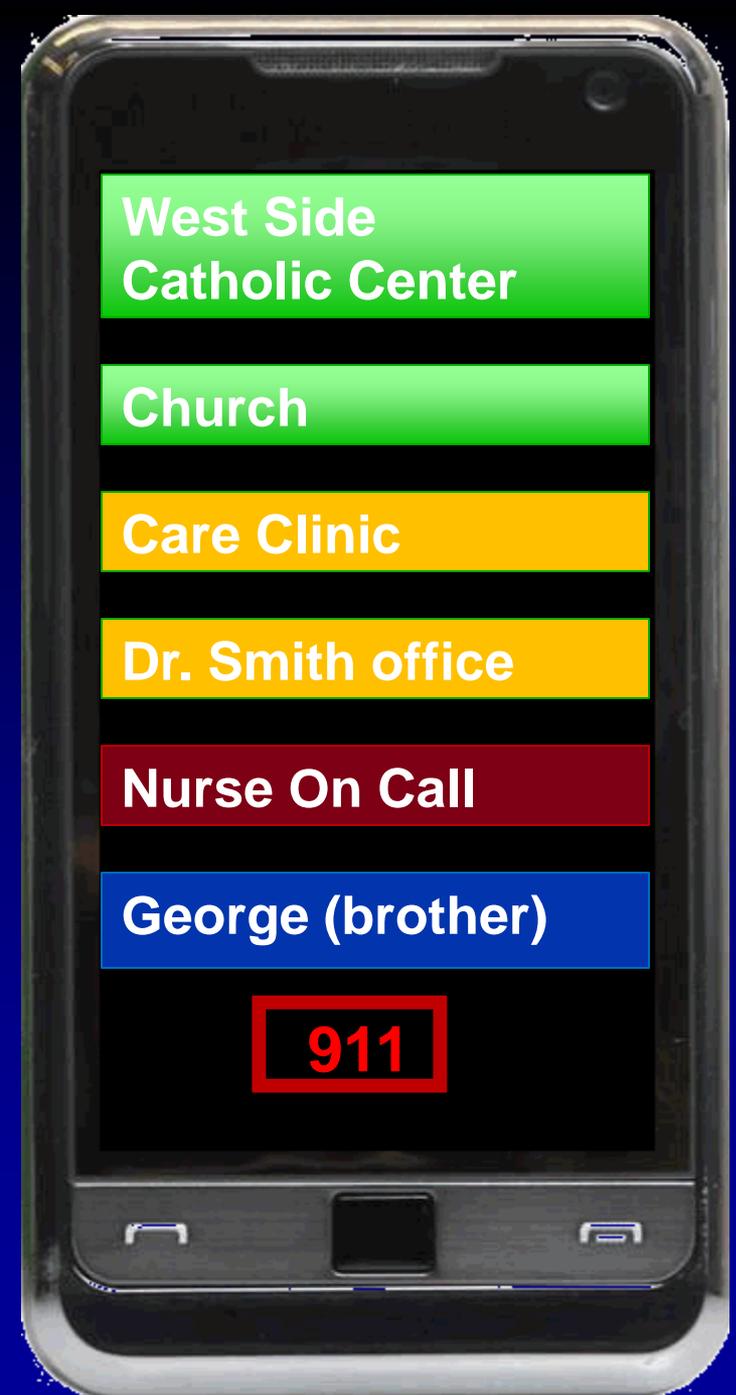
|                      |               | Own a smartphone   |
|----------------------|---------------|--------------------|
| All adults (n=2,252) |               | 56%                |
| Age                  |               |                    |
| a                    | 18-24 (n=243) | 79 <sup>cdef</sup> |
| b                    | 25-34 (n=284) | 81 <sup>cdef</sup> |
| c                    | 35-44 (n=292) | 69 <sup>def</sup>  |
| d                    | 45-54 (n=377) | 55 <sup>ef</sup>   |
| e                    | 55-64 (n=426) | 39 <sup>f</sup>    |
| f                    | 65+ (n=570)   | 18                 |

Source: Pew Research Center's Internet & American Life Project, April 17-May 19, 2013 Tracking Survey. Interviews were conducted in English and Spanish and on landline and cell phones. Margin of error is +/-2.3 percentage points based on all adults (n=2,252).

Note: Percentages marked with a superscript letter (e.g., <sup>a</sup>) indicate a statistically significant difference between that row and the row designated by that superscript letter, among categories of each demographic characteristic (e.g. age).

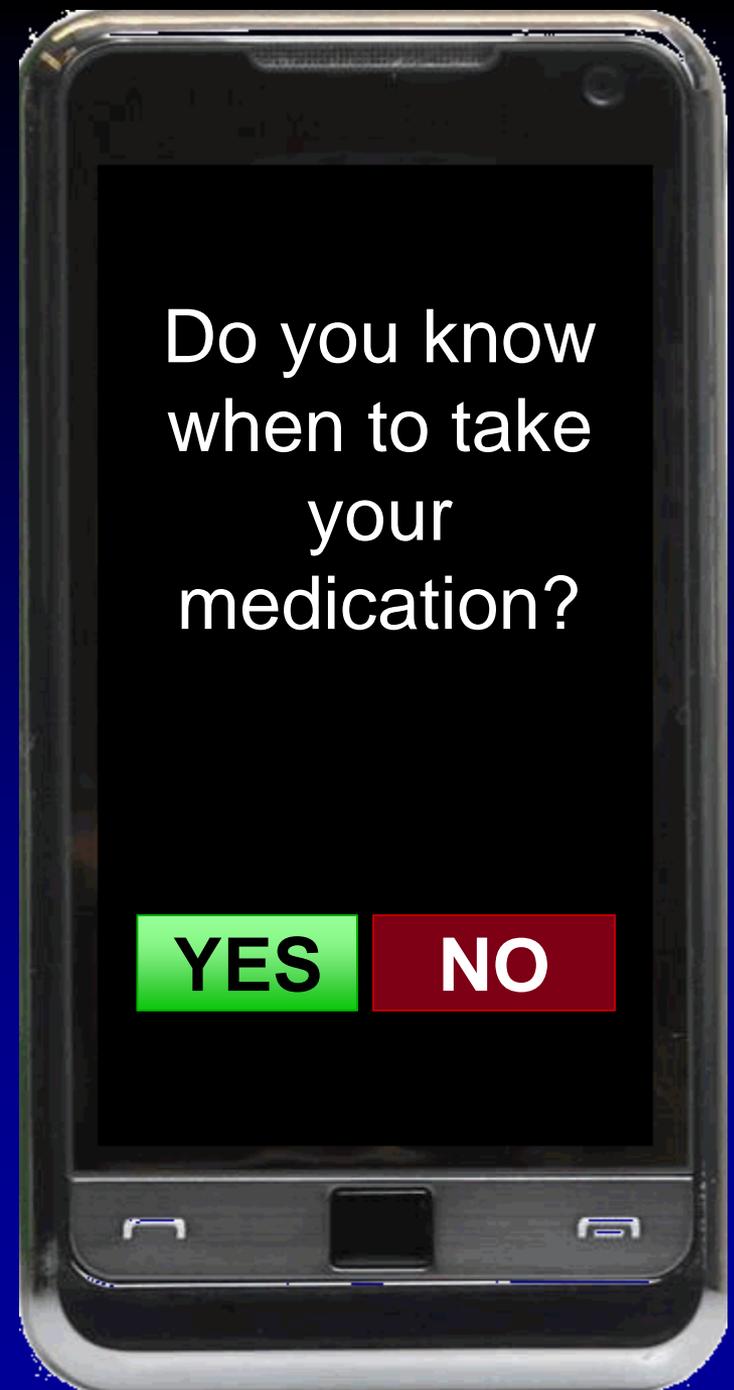
# Minimalist smart phone

- Care coordinators identify need at discharge
- Pre-programmed contacts
- Opens only into the health app
- Daily Yes/No questions to reinforce clinical messages
- Peer supporters from the community within easy reach



# Reinforce clinical messages

- **Status checking with Yes/No questions:**
  - **Ex: Have you walked today?**
- **Reminders:**
  - **Ex: You have an appointment on Friday with Dr. Jones at 2:30pm**
- **Patient interaction is saved and actions may be triggered depending on answers.**



# Calling the patient

- If patient requires a call-back then care coordination nurses can call on same phone
- Depending on the potential problem social workers can be engaged or appointments set
- Community resources can be a point of contact



# The right thing to do

- The costs to implement and deploy are minimal while there are positive cost saving results for hospitals burdened by the payment reductions.
- Our patients feel better when they are within easy reach of loved ones, community and medical professionals.



# Heather Blonsky



- **BA, Medical Anthropology, Wayne State University, Detroit, MI**
- **Systems Analyst on Cleveland Clinic's Quality Improvement Data Team**
- **18 years of data management, analysis, and database development experience, including 13 years of consulting on database needs primarily with small non-profits in the human services fields around the Raleigh/Durham area of NC. Primarily interested in community organizations' contributions to health and well-being, and how hospitals and health care providers can collaborate with existing community resources to best serve their patients and the community as a whole.**

# Rob Watson

- **Robert B Watson CT PMP**
- **Electomechanical Engineering (Augusta Technical Institute), Science (Cuyahoga Community College), Management (Indiana Wesleyan University), Nursing (Lakeland Community College-pending). 25 years engineering consulting management of environmental, alternative fuels, and petro-chemical projects in multiple locations. Currently enrolled in nursing school and has worked as a PCNA / CT for 4 years at Cleveland Clinic in the Digestive Disease Institute and Emergency Services Institute. Recently accepted position as Research Coordinator in the Office of Nursing Research and Innovation. Has multiple submissions to Innovations for potential patenting.**

# John Iosub



- **John joined Cleveland Clinic's Care Management division in 2011 and has received his EMBA from Baldwin Wallace University. John is just as passionate about what happens to patients in the continuum of care as he is to about the business case and practical use of advanced technology. He has presented his expertise on various topics regarding business metrics, severity of illness and readmission rates, observation metrics, utilization review productivity and post-acute referral management. John has built several database solutions used in Non-Profit that have been awarded by CARF, and more recently has submitted ideas to the Cleveland Clinic Innovations Office regarding discharges to post-acute facilities and readmissions. With an Economics degree John has amassed 20 intense years of experience in IT Operations, Systems Management, Consulting, and SQL Database Solutions for Healthcare, Non-Profit and Manufacturing.**
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