THE WHOLE PATIENT AND THE IMPACT OF SOCIAL DETERMINANTS OF HEALTH

A Pediatric Perspective

16 September 2019
• Why addressing social determinants is critical to child health
• What CHOP is doing to address these social determinants
• How you can support our efforts
Why social determinants are critical for child health

Healthcare Factors

Socioeconomic Factors
- Education
- Job Status
- Family/Social Support
- Income
- Community Safety

Physical Environment

Health Behaviors
- Tobacco Use
- Diet & Exercise
- Alcohol Use
- Sexual Activity

Health Care

50% of health is related to zip code...

...while only 20% is related to clinical care
What CHOP is doing to address social determinants

- Improving housing
- Disrupting hunger
- Tackling poverty
- Diminishing trauma
### Consider policy solutions to help kids and families via:

<table>
<thead>
<tr>
<th>Spending flexibility</th>
<th>Support the ability of Medicaid and other programs to reimburse for community partnerships which help address social determinants, such as home visits for asthma patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Simplified enrollment</td>
<td>Consolidate social services applications into a single application with consistent eligibility requirements</td>
</tr>
<tr>
<td>Continuous eligibility</td>
<td>Allow children to maintain coverage in Medicaid or CHIP for a full year, regardless of fluctuations in family income</td>
</tr>
<tr>
<td>Benefit portability</td>
<td>Permit benefit portability between states and counties so kids can access needed care, including assistance with activities of daily living</td>
</tr>
</tbody>
</table>
Thank you for listening!

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267-426-2124

Ahaviah D. Glaser
Director of Government Affairs, External Affairs
Health Policy Director, PolicyLab
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Healthcare Leadership Council: 
The Whole Patient and the Social Determinants of Health

Jennifer Tinajero, RN, MSN
Executive Director,
MemorialCare Clinically Integrated Network

September 16, 2019
**What/Where is MemorialCare?**

*Southern California*

**Total Assets**
- Annual Revenues: $2.3 billion
- Bond Rating: AA- stable

**Hospitals**
- Patient Discharges: 67,000
- Patient Days: 317,000
- ER Visits: 214,000
- Babies delivered: 10,500
- Surgeries – IP/OP: 30,000

**Ambulatory Access**
- “At Risk” Lives/ACOs: 276,000
- Seaside Health Plan (Medicaid +): 44,000
- Medical Group Visits: 600,000
- Ambulatory Surgeries: 63,000

**Workforce**
- Employees: 11,000
- Affiliated Physicians: 2,600
- Employed Physicians: 230

**Lives Touched – Safety Goals**
- CY 2018: 22,665
- Last 12 years: 157,231
Community Benefit Initiatives: Community Assessment

- Hospitals conduct community health needs assessments every three years

Health Priorities identified include:
- Food Insecurity
- Transportation
- Housing
- Mental Health

- Focus: MemorialCare invests in projects and platforms to improve SDOH for our community and patients
Community Benefit Initiatives: 
*Food Insecurity*

**Food Pantry: MemorialCare Family Medicine Clinic in Long Beach**

**Project:** After appointments, patients that responded “yes” to questionnaire on food insecurity are asked if they want to visit the onsite food bank (non-perishable items). In addition, social workers work with patients to help apply for local programs like CalFresh.

**Patients screened – data drilldown:**
- 32.3% of patients screened positive for food insecurity
- 16.8% on food stamps
- 7.7% report transportation a problem
- 55.5% reported that may be helpful to have an on-site food pantry

**Expansion plans:** Vouchers and gift cards to farmers markets
Community Benefit Initiatives: Grant Programs & Partnerships

Our Orange county hospitals established a grant program to partner and fund local organizations that have a comprehensive infrastructure on transportation, housing, and food.

- City of Fountain Valley Senior Transportation Program. The grant funds allowed City staff to increase the service hours of the Hop On! Senior Transportation Program from 8:30am – 4:30pm to 8:00am – 7:00pm.
- SeniorServ’s Senior Nutrition Program. Through this program, SeniorServ provided nutritious meals to low-income, ethnically diverse and underserved seniors in Orange County.
- Family Assistance Ministries’ (FAM) Care Coordination Program. FAM provided needed health and social services to individuals and families in South Orange County who are low-income or poverty level, and are homeless or at risk of homelessness.
Behavioral Health:
Addressing the needs for our patients...

Research shows a link that if behavioral health diagnosis is not managed, then the downstream affect is that the patient is at risk for developing other chronic medical conditions.

- ACO patients with anxiety, depression, social isolation and dementia noted to be 2-3 x medical spend
- In 2018, MemorialCare piloted a Behavioral Health Integration (BHI) model within three larger primary care clinics
  - Team includes Behavioral Health Care manager, Psychiatrist (MD) consultant, and Primary Care Physician.
  - Care management supports patients receiving behavioral health treatment; and regular psychiatric inter-specialty consultation to the primary care team, particularly regarding patients whose condition are not improving.
  - 6-month pilot: ACO (Boeing, Vivity) and Medicare Advantage populations
- Due to success of program and patient satisfaction – PHQ9 improvements and time to remission – now expanded to 4 more sites in 2019 as well as adding virtual health access tools
MemorialCare Community Resource Platform: Wellist partnership – Innovation focus

- **Co-branded Website & Call Center for non-medical community needs** (Call Center supports >200 languages)
- **MemorialCare prioritized resources & education**
- **Connects** patients, caregivers & employees to vetted resources – local & national
- **>5,000 free, discounted to full priced resources**

**Utilization:**
- 3100+ enrolled since March 2018 - Cardiac Pilot
  - 63% patients
  - 17% Family & friends
  - 19% Employees
- Most popular categories:
  - Transportation
  - Meal delivery
  - Financial Assistance
Questions?
The Whole Patient and the Impact of Social Determinants of Health

Romilla Batra, MD
Chief Medical Officer

September 16, 2019
Background on Senior Care Action Network (SCAN)

1977
Founded by seniors for seniors

1979
State MSSP Contract

1985
National Social HMO Contract
SCAN Health Plan Products

Medicare Advantage Prescription Drug (MAPD) Plans

Special Needs Plans (SNPs)
- Dual-eligible SNPs
- Chronic Condition SNPs
- Institutional SNPs
- Fully Integrated Dual Eligible SNPs (FIDE-SNP)
# SCAN Personas

**Chronic Conditions**

<table>
<thead>
<tr>
<th>Condition</th>
<th>Up to 48% of Membership</th>
<th>Up to 30% of Membership</th>
<th>Up to 22% of Membership</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age</td>
<td>73</td>
<td>75</td>
<td>78</td>
</tr>
<tr>
<td>Average STAR Score</td>
<td>3.9</td>
<td>4.1</td>
<td>3.9</td>
</tr>
<tr>
<td>Part C Average Risk Adjustment Factor Score (RAF)</td>
<td>0.67</td>
<td>1.24</td>
<td>2.28</td>
</tr>
<tr>
<td>Rx Prescriptions PMPM</td>
<td>1.4</td>
<td>2.5</td>
<td>3.8</td>
</tr>
<tr>
<td>PCP Visits Per Member Per Year</td>
<td>2.1</td>
<td>3.1</td>
<td>3.9</td>
</tr>
<tr>
<td>Hospital Admits Per K Per Year</td>
<td>43</td>
<td>139</td>
<td>518</td>
</tr>
<tr>
<td>Average medication adherence rate</td>
<td>84.1%</td>
<td>84.2%</td>
<td>82.9%</td>
</tr>
<tr>
<td>Depression or Bipolar</td>
<td>8%</td>
<td>31%</td>
<td>51%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>14%</td>
<td>42%</td>
<td>54%</td>
</tr>
<tr>
<td>Heart Conditions</td>
<td>4%</td>
<td>27%</td>
<td>68%</td>
</tr>
<tr>
<td>COPD</td>
<td>3%</td>
<td>20%</td>
<td>46%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>53%</td>
<td>75%</td>
<td>87%</td>
</tr>
<tr>
<td>Hospitalizations for Potentially Preventable Complications per K (Observed out of Expected)</td>
<td>4 out of 10</td>
<td>17 out of 24</td>
<td>107 out of 92</td>
</tr>
</tbody>
</table>

*Analysis performed using Jan 2018 H5425 membership, of which 96% can be attributed to a persona. There is a representation of Hispanic and other ethnicities within each profile.*
SCAN’s Approach to Addressing SDOH

Self Rating of Health
- Activation Self Advocacy
- Housing
- Nutrition
- Finances

Mental Health
- Cognitive Status
- Chronic Conditions
- Functional Status
- Gaps in Care

Cognitive Health
- Self Efficacy
- Social Determinants

Lifestyle Data*
- Bank, Finances, Gym, grocery

Experience Data
- Member Calls, Notes, And member interactions

HRA Data
- Age, Education, SDOH, ADL, Location

Claims Data
- Medical, Rx and Supplemental Claims

Enable Self-Service Guide
- Peers Technology
- Identify and Plan for Social Needs
- Activate and Facilitate
- Care Navigators Community Health Workers
- Identify, Plan, and Deliver Services Advocate and Integrate
- Community Health Workers Socials Workers

Identify
- Stratify

Serve
- Identify
- Stratify

Stratify Resources
- Serve

5

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Social Determinants & Social Needs

Social Determinants and Social Needs: Moving Beyond Midstream

- **Structural Determinant**
  - Community Activity (IAH and PGA)

- **Social Determinant**
  - Health Plan (Health Plan and Provider)

- **Social Need**

Source: Health Affairs (Jan 2019)
SDOH *Drives Up* Acute Utilization

**Help Transportation vs IP Admits PKPY**

- **LINDA**: Help Transportation No - 55.77, Help Transportation Yes - 209.87
- **TEDDY**: Help Transportation No - 84.95, Help Transportation Yes - 398.69
- **SANDY**: Help Transportation No - 131.57, Help Transportation Yes - 568.49

**Help Food vs IP Admits PKPY**

- **LINDA**: Help Food No - 57.04, Help Food Yes - 135.15
- **TEDDY**: Help Food No - 52.82, Help Food Yes - 183.31
- **SANDY**: Help Food No - 406.36, Help Food Yes - 507.82
Mr. E: Connecting *Provider to Home* Story

**Situation:**
Lived in mini RV with no running water, cooking facilities, or electricity
Multiple ER and hospital admissions due to COPD, HTN, cancer, depression, chronic pain, and more

**Intervention:**
Connected to resources to provide housing, behavioral health services, food pantry, personal care, meal prep, and transportation

**Results:**
No ER visits or hospital admits since enrollment in the program
Engaged in care and following through with treatment plan

To date, the pilot targeting chronically-ill at-risk seniors has included nearly 500 patients and six provider groups
Barriers and Recommendations for Addressing SDOH

**Barriers:**
- Hard to Track/Measure Impact
- Additional Workforce Needed with a Different Skillset than Existing
- Capacity of Community-Based Organizations
- Sustainable programs

**Recommendations:**
Support Policies and Legislation that Promote SDOH, such as:
- H.R. 3461 - Community-Based Independence for Seniors Act of 2019
- Reauthorization of the Older Americans Act (expires 9/30/19)
- SNAP
Examining Social Determinants of Health at the ‘Micro’ Level

Dr. Alan Abrams – Board of Directors
Senior Helpers
The Spectrum of Home-Based Care

Informal Services
Formal Personal Care Services
Medicare Skilled Home Health Care
Home-Based Primary Care
Hospital at Home

10-15M  2M  3.4M  500K  1-2K

Low acuity ------------------------------- High acuity
Chronic care ------------------------------- Acute care
Little or no MD involvement ------------ High level MD involvement

The Elderly Population in the US: Growing Rapidly and Living Longer

U.S. Population Age 65+ (Millions)

- 65-74
- 75-84
- 85+

Baby Boomers Turn 65


© 2015 Peter G. Peterson Foundation
## Potential High-Risk Medicare Beneficiaries

<table>
<thead>
<tr>
<th></th>
<th>Dual Eligible Beneficiaries With Both Medicare and Medicaid</th>
<th>Beneficiaries With Incomes &lt;200% FPL</th>
<th>Beneficiaries With Incomes &gt;200% FPL</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total, N (in millions)</strong></td>
<td>5.9</td>
<td>10.6</td>
<td>26.0</td>
<td>42.5</td>
</tr>
<tr>
<td>%</td>
<td>13.8</td>
<td>24.9</td>
<td>61.2</td>
<td>100.0</td>
</tr>
<tr>
<td><strong>By numbers of chronic conditions (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>4.7</td>
<td>4.1</td>
<td>6.7</td>
<td>5.7</td>
</tr>
<tr>
<td>1</td>
<td>12.4</td>
<td>15.2</td>
<td>18.7</td>
<td>17.0</td>
</tr>
<tr>
<td>2</td>
<td>23.1</td>
<td>24.5</td>
<td>28.1</td>
<td>26.6</td>
</tr>
<tr>
<td>3</td>
<td>21.9</td>
<td>27.4</td>
<td>24.0</td>
<td>24.7</td>
</tr>
<tr>
<td>4</td>
<td>18.5</td>
<td>16.6</td>
<td>13.5</td>
<td>15.0</td>
</tr>
<tr>
<td>5</td>
<td>11.2</td>
<td>8.1</td>
<td>6.5</td>
<td>7.5</td>
</tr>
<tr>
<td>6+</td>
<td>8.1</td>
<td>4.2</td>
<td>2.5</td>
<td>3.5</td>
</tr>
<tr>
<td><strong>By functional impairments (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 ADL</td>
<td>57.2</td>
<td>73.7</td>
<td>83.4</td>
<td>78.2</td>
</tr>
<tr>
<td>1 ADL</td>
<td>15.6</td>
<td>12.1</td>
<td>8.6</td>
<td>10.1</td>
</tr>
<tr>
<td>2+ ADL</td>
<td>27.2</td>
<td>14.1</td>
<td>7.9</td>
<td>11.6</td>
</tr>
<tr>
<td><strong>By living arrangement (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beneficiaries living alone</td>
<td>40.4</td>
<td>50.6</td>
<td>22.9</td>
<td>32.3</td>
</tr>
<tr>
<td>Living with family member or other</td>
<td>58.8</td>
<td>49.3</td>
<td>77.0</td>
<td>67.7</td>
</tr>
<tr>
<td><strong>By age and disability eligibility (%)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50-64 years</td>
<td>27.6</td>
<td>11.6</td>
<td>5.8</td>
<td>8.3</td>
</tr>
<tr>
<td>65-74 years</td>
<td>34.4</td>
<td>38.1</td>
<td>55.8</td>
<td>50.9</td>
</tr>
<tr>
<td>75-84 years</td>
<td>26.8</td>
<td>33.5</td>
<td>29.0</td>
<td>28.8</td>
</tr>
<tr>
<td>85+ years</td>
<td>11.1</td>
<td>16.8</td>
<td>9.4</td>
<td>12.0</td>
</tr>
</tbody>
</table>

Source: The Health Industry Forum

ADL indicates activities of daily living; FPL, federal poverty level.

Authors' estimates based on the 2010 Health and Retirement Survey, RAND file. Conditions and difficulties with ADL are self-reported and may not match claims data estimates.
Patient Profile

- 88 year old AAF who is at home awaiting daughter to come to the house.
- PMHx: COPD, CKD 3, CHF, DM2, depression, OA, mild cognitive impairment
- Social Hx: Lives alone, widowed, social security Medicare/Medicaid
  Homemaker weekly, MOW
- Meds: Singulair, furosemide, glyburide, citalopram, acetamenophen
• National Health and Aging Trends Study (NHATS)
• Population-based study
• Random sample > 65 Medicare enrollment rolls
• In-person interviews + physical and cognitive performance assessments
• Our N = 7603 non-NH subjects
• NHATS had no predefined measure of homebound – capacity and ability approach

JAMA Intern Med. 2015;175(8):1426
Demographics by Homebound Status

- Race - B
- Education < HS
- Married / w Partner
- Income < 15K
- MA Beneficiary

Chart showing percentages for different demographics:
- All NHATS
- Complete
- Mostly
- Not
Health and Function by Homebound Status

- Self Rep Health Fair or Poor
- Depression PHQ2
- Dementia possible or prob
- Can walk 6 blocks
- Hosp w/in 12 mos

Legend:
- All NHATS
- Complete
- Mostly
- Not
FRAILTY FACTOR IN CARING for ELDERLY

What is frailty?

HAPPY BIRTHDAY

HAPPY BIRTHDAY

Raymond
### CLINICAL FRAILTY SCALE

<table>
<thead>
<tr>
<th>Number</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Very Fit</td>
</tr>
<tr>
<td>2</td>
<td>Well</td>
</tr>
<tr>
<td>3</td>
<td>Managing Well</td>
</tr>
<tr>
<td>4</td>
<td>Vulnerable</td>
</tr>
<tr>
<td>5</td>
<td>Mildly Frail</td>
</tr>
<tr>
<td>6</td>
<td>Moderately Frail</td>
</tr>
<tr>
<td>7</td>
<td>Severely Frail</td>
</tr>
<tr>
<td>8</td>
<td>Very Severely Frail</td>
</tr>
<tr>
<td>9</td>
<td>Terminally Ill</td>
</tr>
</tbody>
</table>

### QUALITY OF LIFE

- **FUNCTION**
- **FRAILTY**
The more frail you are....
Impact of Frailty on Outcomes

- 1.2 to 1.8-fold risk for hospitalization
- 1.6 to 2.0-fold risk for loss of activities of daily living
- 1.8 to 2.3-fold risk for premature mortality
- 1.5 to 2.6-fold risk for physical limitation
- 1.2 to 2.8-fold risk for falls and fractures
Frailty is a risk factor for adverse health outcomes, independently of comorbidities

<table>
<thead>
<tr>
<th>Year</th>
<th>Country</th>
<th>Participants (n)</th>
<th>Length of follow-up (years)</th>
<th>Falls (HR/IRR [95% CI])</th>
<th>Worsening disability (HR/IRR [95% CI])</th>
<th>Hospitalisation (HR/IRR [95% CI])</th>
<th>Care home admission (HR/IRR [95% CI])</th>
<th>Mortality (HR/IRR [95% CI])</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Intermediate frailty</td>
<td>Severe frailty</td>
<td>Intermediate frailty</td>
<td>Severe frailty</td>
<td>Intermediate frailty</td>
</tr>
</tbody>
</table>
| Cardiovascular Health Study (CHS)
  2001 USA 5317 7 | 1.12* 1.23* | 1.55* 1.79* | 1.11* 1.27* | NA | NA | NA | NA | 1.32* 1.63* |
| Canadian Study of Health and Aging (CSHA)
  2004 Canada 908 5 | NA NA | NA | NA | 2.54* 2.60* | 2.54* 3.69* | 1.36* 1.55* | 1.55* 2.08* |
| Women's Health and Aging Study (WHAS)
  2006 USA 1438 3 | 0.92* 1.18* | NA | NA | 0.67* 0.81* | 5.16* 2.38* | 2.54* 3.39* | 4.45* 5.90* |
| Study of Osteoporotic Fractures (SOF)
  2008 USA 6701 4.5 | 1.23* 2.44* | 1.89* 2.79* | NA | NA | 1.54* 2.75* | NA | 1.40* 2.46* |

HR=hazard ratio. NA=not available. OR=odds ratio. *Hazard ratio. †Odds ratio. The comparator for hazard ratios and odds ratios is people who are not frail.

Table: Covariate-adjusted associations between frailty and adverse outcomes (falls, disability, hospitalisation, care home admission, and mortality) from four large prospective cohort studies.
Social Determinants of Health (SDOH)

- SDOH influence at least 70% of your health outcomes.
- 60% of your risk of premature death is determined by your SDOH
  - Genetics? About 30%
  - Clinical Care? About 10%

“Assessing SDOH requires looking through a telescope AND a microscope”

SDOH are both “Macro” and “Micro”
## Macro versus Micro SDOH

<table>
<thead>
<tr>
<th>Macro = Community Level</th>
<th>Micro = Patient Level</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EXAMPLES:</strong></td>
<td><strong>EXAMPLES:</strong></td>
</tr>
<tr>
<td>Homelessness</td>
<td>Home Safety</td>
</tr>
<tr>
<td>Food Insecurity</td>
<td>Functional Ability – day to day living</td>
</tr>
<tr>
<td>Access to (and Quality of) Clinical Care</td>
<td>Caregiver presence and burden</td>
</tr>
<tr>
<td>Access to (and Quality of) Social Services</td>
<td>Engagement with primary care</td>
</tr>
<tr>
<td>Air and Water Quality</td>
<td>Medication adherence</td>
</tr>
<tr>
<td>Neighborhood Safety</td>
<td>Social isolation and connection</td>
</tr>
</tbody>
</table>
How Much Does Function Matter?

“High-Need” Patients = 3+ Chronics and Functional Limitation
= 5% of U.S. population, 22% of all healthcare spending

<table>
<thead>
<tr>
<th>Stat</th>
<th>3+ Chronic Conditions Versus average</th>
<th>High-Need Versus average</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual Healthcare Spend</td>
<td>+55%</td>
<td>+333%</td>
</tr>
<tr>
<td>Emergency Room Visits</td>
<td>+35%</td>
<td>+235%</td>
</tr>
<tr>
<td>Hospital Visits</td>
<td>+37%</td>
<td>+535%</td>
</tr>
<tr>
<td>Home Health Visits</td>
<td>-78%</td>
<td>+1525%</td>
</tr>
<tr>
<td>Primary Care Visits</td>
<td>+72%</td>
<td>+167%</td>
</tr>
</tbody>
</table>

Source: The Commonwealth Fund, Feb 2019: “Targeting High-Need Beneficiaries in Medicare Advantage: Opportunities to Address Medical and Social Needs.”
What Does Function Mean?

Functional Limitation Means Trouble in Performing “Activities of Daily Living”

Source: The Commonwealth Fund, Feb 2019: “Targeting High-Need Beneficiaries in Medicare Advantage: Opportunities to Address Medical and Social Needs.”
What Can Help?

Inadequate support for functional limitation cost Medicare more than $4 Billion in 2015 alone…

Source: “Medicare Spending and the Adequacy of Support with Daily Activities in Community-Living Older Adults with Disability,” Annals of Internal Medicine, published online May 28, 2019.
# Home Care Can Help

## TYPICAL SERVICES

**“Personal Care”**
- Mobility/ Transfers/ Fall Prevention
- Bathing, Eating, Toileting Assistance

**“Companion Care”**
- Companionship
- Homemaker Services
- Respite Care

**Clinical Support Programs**
- Transitional Care/ Bridge Programs
- Chronic Care Management
- Specialized Dementia Care

## MARKET CHARACTERISTICS

- Those of scale typically franchised
- Take care of people for months and years
- Customer base is largely high-need patients
- “Eyes and Ears” for potential problems.
- Deep knowledge of local community & aging resources
- Challenged by labor shortages

* ‘Home Care’ is not ‘Home Health’
Case Example – Ms. M

- Age: 82
- Lives alone
- Has Parkinson’s disease
- Progression of disease causing anxiety and depression.
- Stopped doing her exercises
- Loves culture and museum visits
- Likes to relax at end of day with a glass of wine.
Ms. M - Home Care Assessment

- Functional deficiency in range of motion and lower body strength.
- No reliable way of monitoring vital signs.
- Evidence of improper medication use (wrong time of day).
- Lack of assistive rail on basement stairway.
- Unsecured rugs in key pathways.
- Little evidence of regular bathing.
- Difficulty managing laundry, garbage and meal preparation.
Every day Ms. M likes to go to her finished basement to relax with a glass of wine.

Ms. M's Parkinson's is advancing.

There is no assistive rail to help her if she is unsteady on the basement steps.

Unsecured rugs present trip hazards.

The nearest basement phone is in the room next to the TV....
Ms. M - Home Care Assessment

Typical Consequences of (Non-Fatal) Fall - Geriatric Patient
- Bone breakage esp. fingers
- Internal & head trauma
- Moderate to severe bruising

Typical Costs – ER Admission
- Intake & Stay (30 days): $X000
- Surgery: $X000
- Pharmacy: $X00
- PAC: $X000

Nursing Homes
- Average monthly cost: $8,200 (+2.5%/yr)
- Average length of stay: 2 years
- Most common reason for discharge...
Supporting Ms M.

Home Care Plan:
- Assistive railings on both sides of stairs
- Remove trip hazards
- Assistive devices to make showering easier
- In-home support for day to day tasks. M/W/F – 6 hours/day
- Phone installed by basement couch.
- Plans to visit gallery show for motivation.
- Assistance with exercises.
- Exercise and medication journal

Cost of Home Remediation: $845.00
Monthly Cost of Home Care: $2016.00
Questions?

- Thank you for your attention.