Descriptive Evaluation of Healthy Howard's Community Care Team
A Care Transitions Program

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The Community Care Team (CCT) is a *care transition and patient empowerment program* in Howard County, Maryland. The program, which began receiving referrals on January 13, 2014, is designed to reduce preventable hospitalizations among *super-utilizers of health care* in Howard County, defined as residents with two or more hospitalizations in the past six months and at least two chronic conditions. The CCT uses *Community Health Workers (CHWs)* to work with program clients over a three month period to set health goals and develop the skills needed to manage their illnesses. CHWs conduct home visits, chronic disease management education, and medication reconciliation, coordinate patient visits with primary care and specialty providers, and connect patients with community resources.

Research Questions

- Have preventable hospitalizations among clients declined?
- Have clients experienced improvements in access to care/social support services and self-management of disease/care?
- What are the lessons learned that could improve program design and implementation?

Methods

Quantitative Data and Methods

- Client-level data collected by the CCT which tracked enrollment, demographics, and pre- and post-program graduation health care outcomes.
- Descriptive analyses: frequencies, percentages, graphical analysis of trends, and measurement against benchmarks.

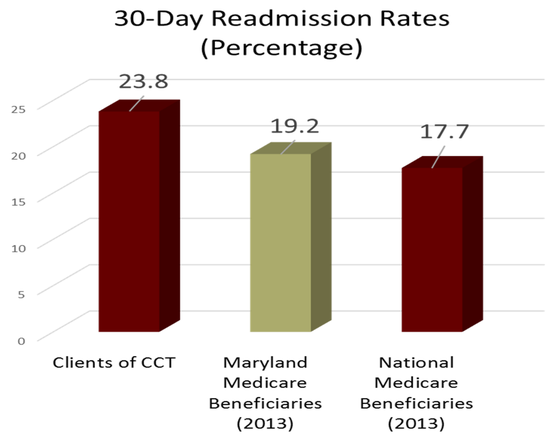
Qualitative Data and Methods

- Interviews of program personnel, clients, providers, and referral practices.
- Coding and summarization of open-ended questions and tabulation of structured rating questions.

Limitations

- Exploring associations; not causality.
- Small sample sizes.
- Lack of a comparison group.

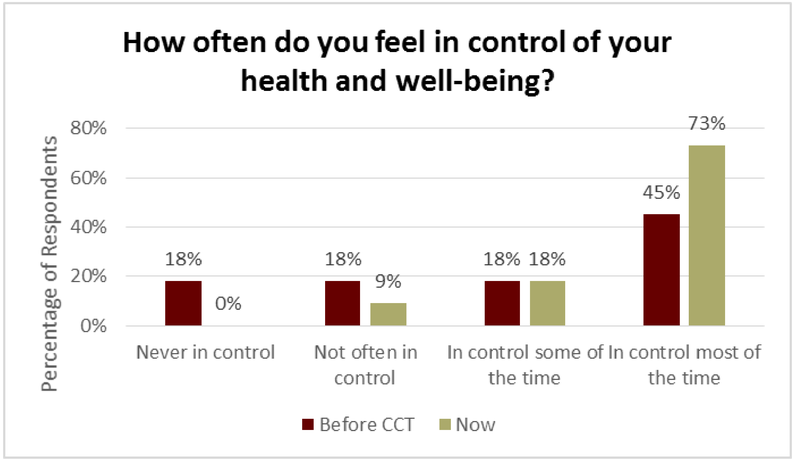
Findings



60-day Readmission Rate for CCT Clients	60-day Readmission Rate for County's High Utilizers
32.7%	**48.0%**

"When I was suffering from depression and all, they pulled me out of it so that I wanted to improve my health. They inspired me to do things differently."
-CCT Client

- All clients had at least 2 readmissions in the six months before enrollment in the program. In the three months they were enrolled, **59 percent** of clients did not have a readmission.
- Providers of care for CCT clients praised the program for its flexibility and for not being "stuck" with one model of care.
- All but one client reported being "very satisfied" with the CCT Program.



Conclusion

- Program on track to achieve process metrics.
- The CCT has so far been successful in improving patient education and empowerment.
- Clients more comfortable navigating healthcare.
- Readmissions have fallen.
- Without a comparison group, difficult to ascribe decrease in readmissions to the program. However, both clients and CCT staff gave numerous examples of the program preventing hospitalizations.

Next Steps

- Creation of a comparison group from other super-utilizers of healthcare for impact estimation
- Return on Investment Analysis to determine cost-savings to the county as a result of the program

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