Evaluation Of Healthy Howard's Community Care Team, A Care Transitions Program

Empowering Patients To Navigate The Healthcare System

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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.

Over a three month period, Community Health Workers (CHW) help program clients 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

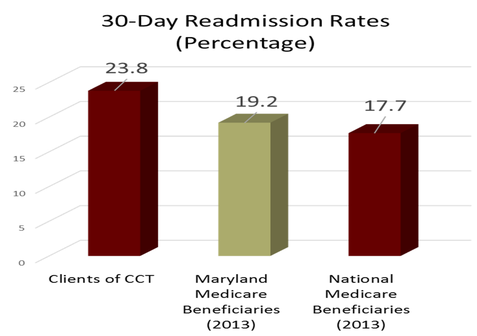
- Client-level data collected by the CCT which tracked enrollment, demographics, and pre- and post-program graduation health care outcomes.
- Descriptive analyses: frequencies, percentages, graphical analysis of trends, and measurement against benchmarks.

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

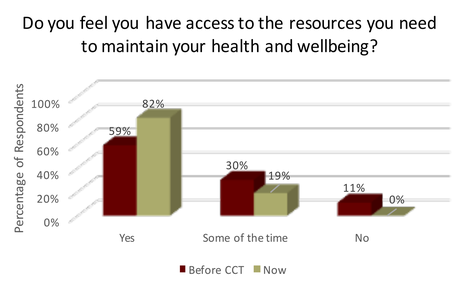
- Exploring associations; not causality.
- Small sample sizes.
- Lack of a comparison group.

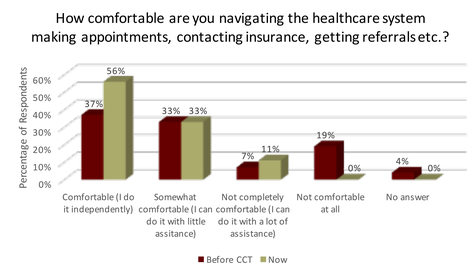


32.7% 60-day Readmission Rate for CCT Clients

40.0% 60-day Readmission Rate for County's High Utilizers

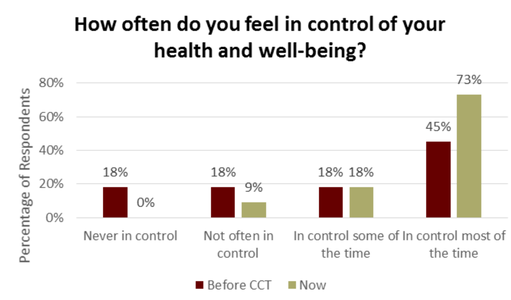
- All clients had at least 2 readmissions in the six months before enrollment in the program. In the three months they were enrolled, 59% of clients did not have a readmission.





"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."

- 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.



CONCLUSIONS

Intensive community-based care transition and patient education services can empower patients to better navigate the healthcare system and be more in control of their health and healthcare.

- 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.

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