SASH

SUPPORT & SERVICES at HOME

a caring partnership

Blueprint for Health Empowering People

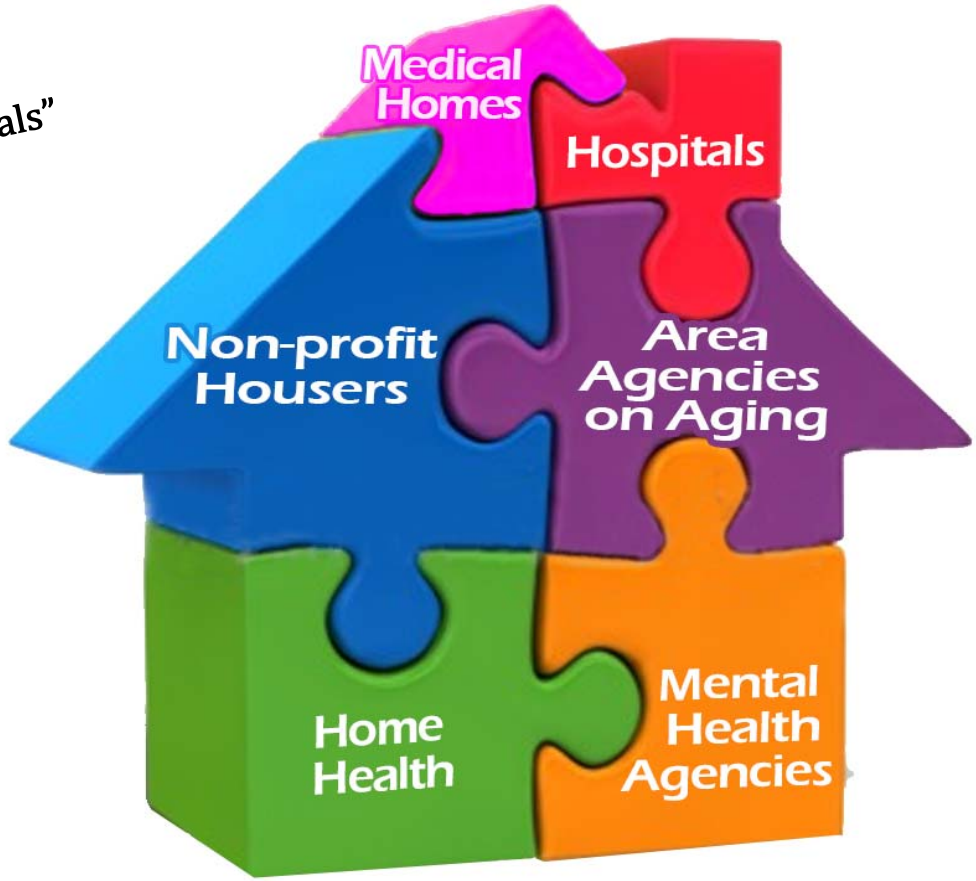
SASH “Deep Dive” Session

April 9, 2014

SASH is a Home-Based System

It is effective because it provides care and services where behaviors are shaped and participants spend their time.

"Housing is a point of natural aggregation of high risk individuals" at 93 locations across Vermont!



Description of SASH

- Panels of 100
- 3,100 Participants
- 80% Medicare
- 18% live in a community setting
- 73% 65 +
- 27% under 65
- Participants span all health care needs – no discharges

Participation in SASH- The Details

Medicare Funded MAPCP Funds Two Groups:

1. Any Medicare beneficiary who lives in a SASH Hub
2. Medicare beneficiary living in a community setting near the SASH Hub (apartment, single-family home, mobile home, etc.)

Medicare funds panels of participants:

1 panel = 100 Medicare benefitted participants

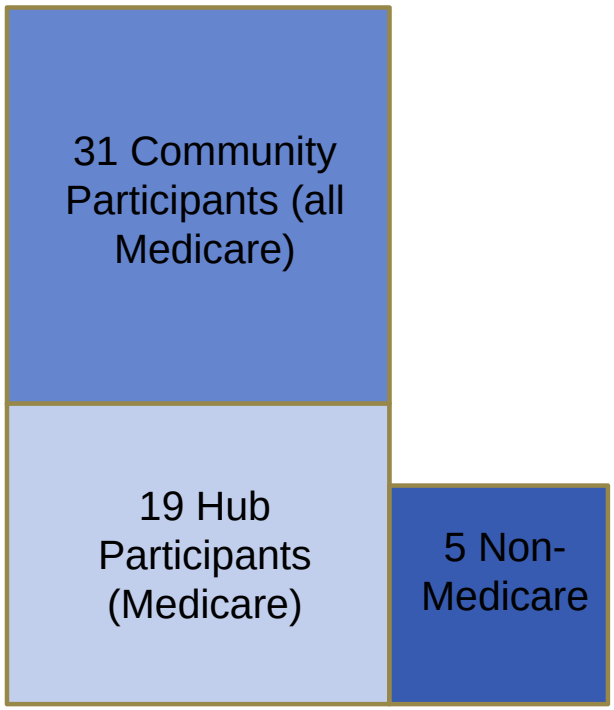
Participation in SASH – The Details

Existing Revenue Sources and Grants Fund Two Groups:

1. Any resident of a SASH Hub that is not enrolled in Medicare.

2. Non-residents who can be served by a specific funding source such as the Dept. of Health's Community Transformation Grant

Example of Participants in a SASH Panel



Assumption:

- Panel of 50 Medicare Funded
- 24 Residents at SASH Hub
  - 19 Enrolled in Medicare
  - 5 are Non-Medicare.
- 31 Community SASH participants

Total SASH Participants = 55

The SASH Team Focuses on the Three Components of Care Management

- Coordinates with discharge staff, family and neighbors
- Personal visit to review discharge instructions
- Helps ensure a safe home transition

Transitional Care

- Develops healthy living plan
- Coaches SASH Participants
- Provides reminders and in person check ins
- Organizes presentations and evidence based programs

Self Management

- Conducts wellness assessment
- Convenes SASH team
- Understands participants needs and preferences
- Coordinates individual/community healthy living plans

Care Coordination

SASH Coordinator- Duties at a Glance

SASH Coordinator	General	Transitions Support and Coordination	Self-Management	Coordinated Care
	Educates and informs about SASH	Communicates with discharge staff at hospitals and skilled-nursing facilities	Develops Community Healthy Living Plan (CHLP) with SASH team	Coordinates with Nurse to schedule SASH assessment for SASH participants
	Point of contact for SASH Hub	Attends discharge planning meetings	Provides individual and group encouragement to SASH participants in meeting self-management goals	Convenes SASH Team meetings
	Recruits and supports volunteers	Communicates with family members/support persons	Provides regular reminders and/or in-person checks with SASH participants as needed	Conducts individual person-centered interviews
	Develops calendar of events and regular newsletters	Visits SASH participant to review discharge instructions	Organizes educational presentations and evidence based programs	Develops individual Healthy Living Plans (HLPs)
	Follows privacy protocols (HIPAA)	Coordinates with SASH team to help facilitate a safe transition home		Supports SASH participants in meeting their HLP goals

Wellness Nurse- Duties at a Glance

Wellness Nurse	General	Transitions Support and Coordination	Self-Management	Coordinated Care
	Oversees wellness care and coaching for SASH participants	Communicates with SASH team and family members regarding transitions home	Provides individual home visits to high risk SASH participants	Conducts SASH assessments
	Builds relationships with SASH participants	Visits SASH participant at home as soon after discharge as possible	Assists SASH participants in setting up medication management systems	Participates in SASH team meetings
	Documents relevant information in Participant Records	Works with SASH team to coordinate regular check ins and/or medication reminders as needed	Provides individual and group preventative interventions such as blood pressure checks and weight monitoring	Supports participants to meet their HLP goals
	Follows privacy protocols (HIPAA)	Updates Participant record with new medications or treatments as appropriate	Provides information and education on self-management strategies	Identifies level of risk among SASH participants

SASH Interprofessional Team Approach: The Antidote to Duplication

The SASH Team

Participant's Care Team

- Primary Care Provider
- Community Health Teams
- Hospital
- Nursing homes and rehab facilities

Creates, Implements and Monitors an Individualized Care Plan

Roles of Wellness Nurse and Home Care Nurse

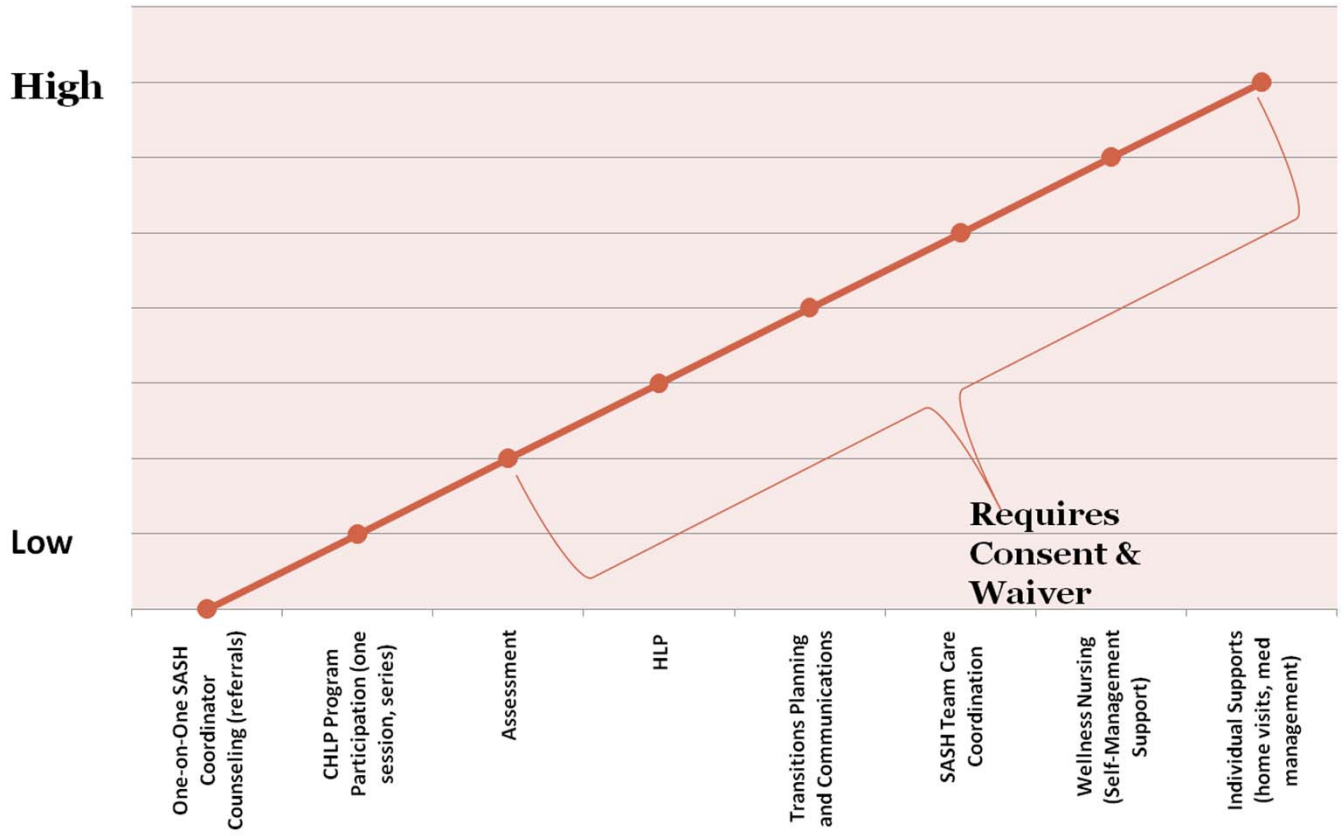
SASH Wellness Nurse	Home Health Skilled Care Nurse
Group wellness education	Provides updates on home care clients
Health coaching around self-mgmt of common chronic conditions	Communicates needs/gaps in support to SASH team
Conducts SASH Assessment	Shares expertise with SASH team
Preventative Services- blood pressure clinics, weight monitoring.	Informs SASH team when a Home care client will be discharged
Referrals for Skilled Care Nursing	Suggests referrals for other Home Health specialties- OT, PT, etc.
Coaching on medication management	Works with WN on medication challenges of shared clients
Care transitions support	Works with team to facilitate successful transitions

SASH- A Continuum of Support and Services

- Intensity of SASH services/support will vary
- Access to full spectrum of SASH benefits require signed consent and waiver by participant
- Examples of SASH supports and services:
  - 1:1 Meeting with SASH Coordinator- general referrals
  - Wellness Seminar
  - Evidence –based program series
  - Wellness Nurse Visit
  - SASH Team Meeting Coordination
  - Discharge Planning visits and communication

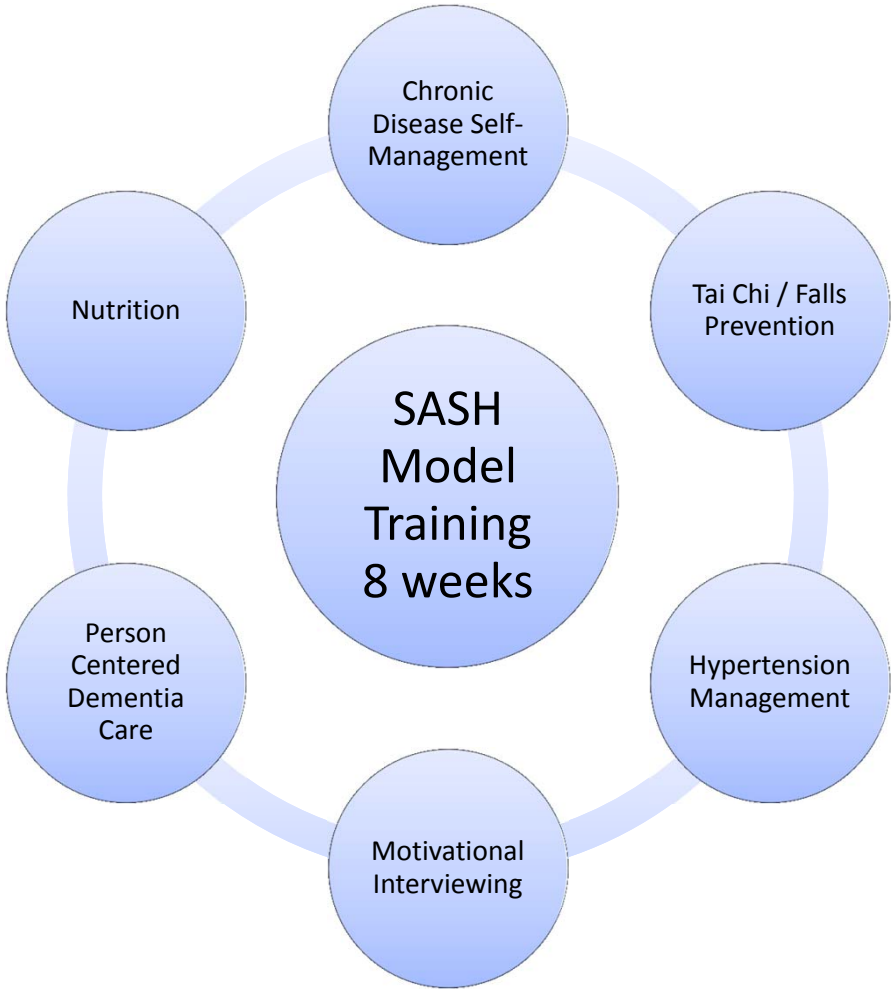
SASH – A Continuum of Support and Services

SASH Participants Include Those Receiving the Lowest Intensity of Services to the Highest Intensity of Services



SASH keeps “Katie” in the driver’s seat.

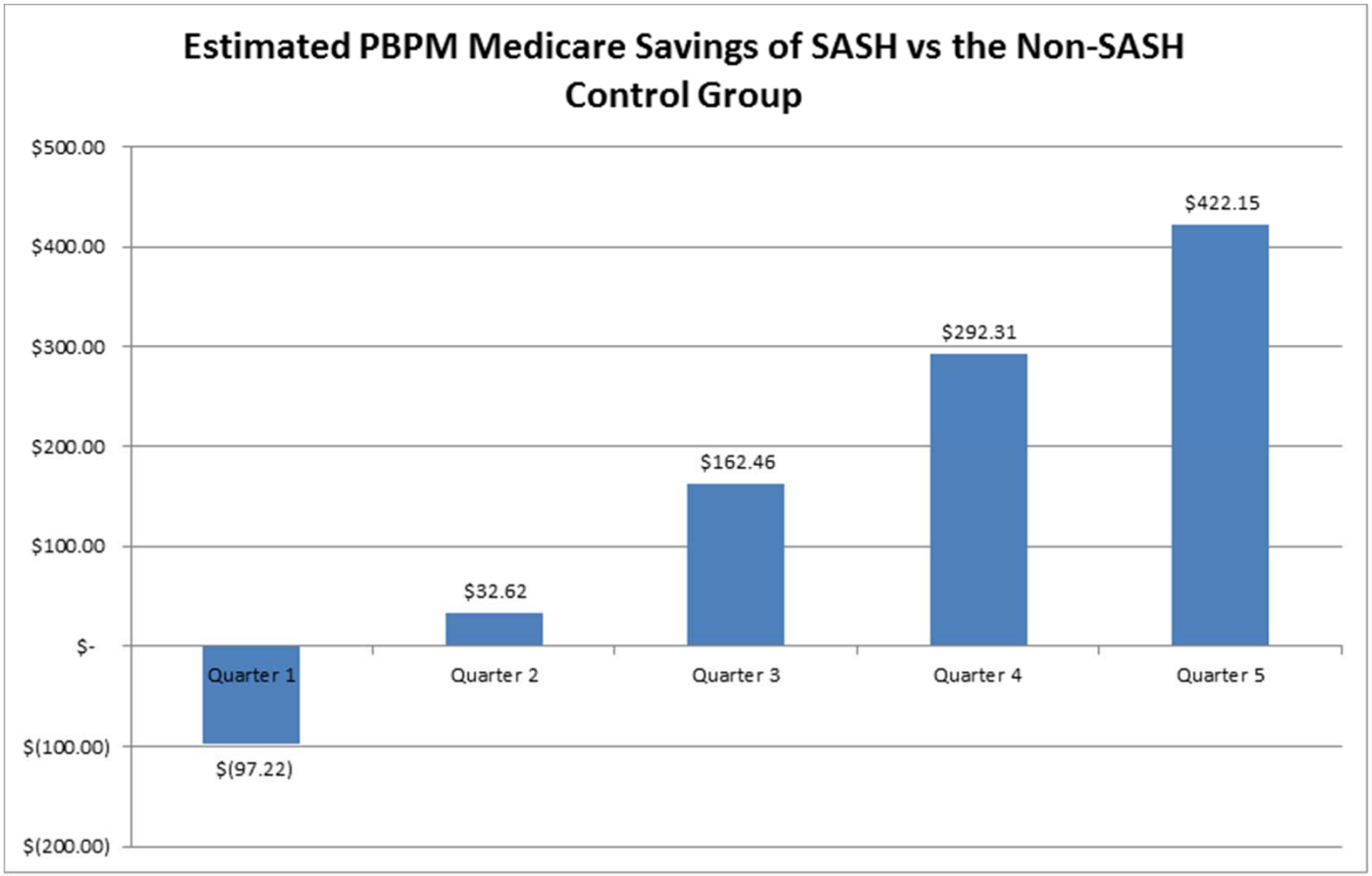
SASH Training Components



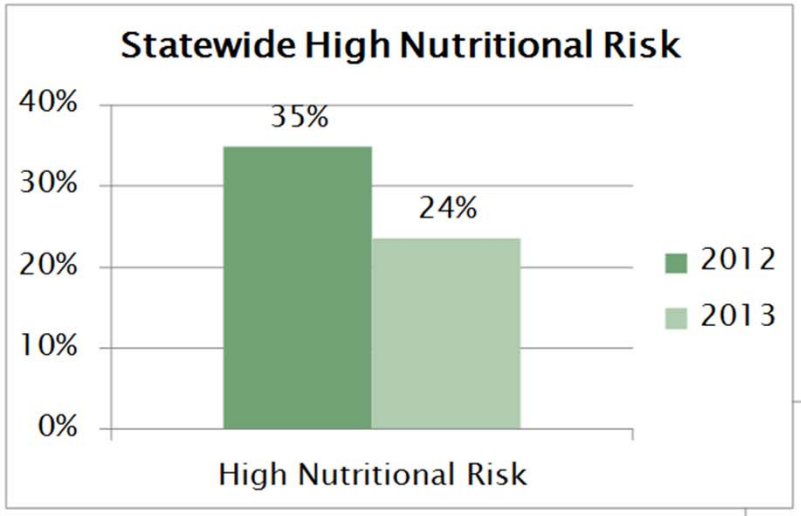
Chronic Disease Self Management:
Healthy Living Workshops

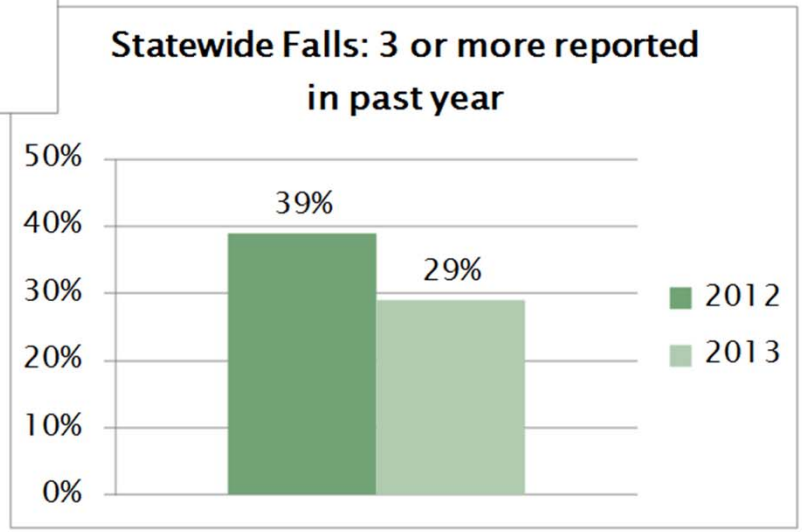
- SASH has 27 CDSMP trained leaders throughout Vermont!
- 150 SASH Participants enrolled in Healthy Living Workshops throughout Vermont in 2012 and 2013.
- A study by the National Council on Aging found that The Chronic Disease Self-Management Program (CDSMP) is having a significant impact on the health of seniors nationwide:
    - 21% improvement in depression
    - 15% improvement in unhealthy physical days
    - 12% improvement in medication compliance
    - $364 per participant net savings

Preliminary Evaluation Results from First Year Look at SASH



Nutrition and Falls Reduction in One Year of SASH Participation





THANK YOU

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HEALTHY HOMES CARING COMMUNITIES POSITIVE AGING