a proactive approach to claims prevention

If individuals cannot meet their basic needs for daily living, it becomes increasingly difficult for them to focus on their health care needs.

We can help.

The Southern Ohio Care Transitions Project was one of 120+ nationwide teams contracted with CMS for the Community-Based Care Transitions Demonstration Project and was one of less than twenty high performing teams whose CMS contract was continually renewed to complete the five year demonstration.

Large Scale Project Management Experience:

The Southern Ohio Care Transitions Project included five hospital partners and three Area Agencies on Aging covering 26 Ohio counties and contiguous counties in West Virginia and Kentucky.

Demonstrated Cost Savings:

The Southern Ohio Care Transitions Project successfully transitioned over 14,500 high risk patients with a successful readmission reduction rate for participants by 30%, preventing over 900 readmissions and saving CMS over $10M.

High Return on Investment: 59.5%

High Customer Satsfaction and Impact Rates:

99%

CUSTOMER SATISFACTION

67% reported feeling more confident about managing issues related to their healthcare.

COMMUNITY- BASED
HEALTH INTERVENTION™
IMPROVING POPULATION HEALTH ONE PERSON AT A TIME.

About The Community-Based Health Intervention™

- Community-based visit by Licensed Nurse or Social Worker
- Medication Inventory
- Assessments for falls, depression, nutrition
- Risk Stratification
- Disease Specific Health Education
- Social Determinants Review and Referrals
- Advance Directives Education and State-approved forms
- Weekly Touchpoint throughout 30-day intervention
- Assurance of timely post-discharge follow-up with PCP when appropriate

National recognition for best practices of data-driven program management, highly effective data use and highly formalized accountability.

ADDRESSES SOCIAL DETERMINANTS OF HEALTH:
Social determinants of health are driving up health care costs from 60-80%. CBHI™ identifies disparities related to social determinants of health and provides referrals to community supports and services.

SUPPORTS QUALITY MEASURES:
CBHI™ supports STAR measures, HEDIS, Health Outcomes Survey, CAHPS and Quality Improvement Activities related to the Medical Loss Ratio.

ASSESSES RISK:
CBHI™ is more than a "care transitional" model. A CBHI™ Coach completes a risk stratification and risk assessments for falls, depression, and nutrition during the community visit. Referral to appropriate resources and programs are made to address identified needs and disparities.

STATEWIDE COVERAGE:
Through an established, long-standing network with over 40 years of experience, CBHI™ has a wide reach across the state of Ohio and a deep reach into the community.

INFORMATION TECHNOLOGY:
CBHI™ is built into an interoperable HIPAA compliant high-performing data platform featuring electronic billing and referral capability, data analytics and reporting

FEEDBACK TO PROVIDERS AND PAYERS:
Timely information is provided to the providers engaged in a Client's care to facilitate effective communication and provide information unavailable to the healthcare provider.

Change in health behavior
starts at home.

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