RIPIN
PERSONAL SUPPORT BUILT ON PERSONAL EXPERIENCE

May 1, 2024

The Honorable Marvin L. Abney
Chair, House Committee on Finance
RI House of Representatives
By Email To: HouseFinance@rilegislature.gov

Re: **H-7597 - SUPPORT**
Hospital Care Transition Initiative (HCTI)

Dear Chairman Abney:

We write today in **support** of H-7597, which resolves to fund the **Hospital Care Transitions Initiative (HCTI)**, an item not included in the Governor's proposed budget. This program – operated jointly by RIPIN and South County, Kent, and Rhode Island Hospitals – embeds RIPIN Community Health Workers (CHWs) into hospital discharge teams to help vulnerable older patients discharge safely to home. This innovative approach saves the State money by avoiding long term skilled nursing facility (SNF) stays before they start, while also meeting the desires of most patients and their loved ones to receive care at home. **Without new funding for this successful program, it will shut down at the end of this fiscal year.**

Launched in early 2021 and federally funded so far, the HCTI program is an innovative model to rebalance Medicaid long term services and support (LTSS) spending towards community-based (rather than institutional) options. Caring for patients at home aligns with most patients' preferences and is far more cost-effective. **A long terms SNF costs the State more than $65,000 on average.** The HCTI is **successful with 75% of patients:** of the more than 500 high risk patients supported annually, more than 350 discharge successfully to home. If even one in ten of these patients would have otherwise needed a long SNF stay, that **would reduce Medicaid expenditures by $1,750,000, an ROI of nearly 4-to-1.**

One of the program's **key innovations** is that it **serves patients even before they become eligible for Medicaid.** For decades, Medicaid programs nationally have noticed a difficult pattern: Patients spend several months in a SNF before spending down their resources and becoming eligible for Medicaid, at which point it is extremely difficult to transition them back to the community. Supports for home-based care are far more effective when provided just before or during the first week or two of a SNF stay, but programs that are only made available to current Medicaid recipients miss this crucial population of "near Medicaid" SNF patients who gain Medicaid coverage when it is too late for effective interventions. The HCTI program is specifically designed to serve patients with any kind of insurance so as to catch this important population missed by other Medicaid nursing home diversion programs.

With federal funding expiring at the end of FY2024, the Governor's budget proposal does not include funding for this important program. HCTI is a successful and cost-effective program with genuine ROI that also improves the patient experience. It should be saved.

Please also find enclosed a letter from the participating hospitals and from the Hospital Association of Rhode Island (HARI) outlining their views on the effectiveness and importance of this program to

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their patients as well as a one-pager with program data. Thank you for your careful consideration of the FY2025 budget and of this public testimony.

Sincerely,

/s/

Samuel Salganik, JD
Executive Director
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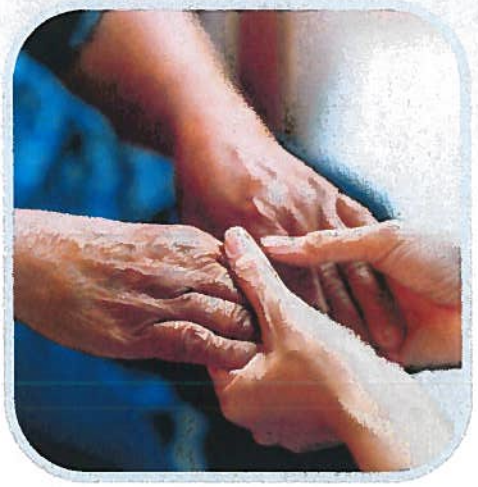
HOSPITAL CARE TRANSITIONS INITIATIVE (HCTI)

Helping Vulnerable Older Patients Discharge to Home

WHAT IS HCTI?

The **Hospital Care Transitions Initiative (HCTI)** is an EOHHS-RIPIN partnership to **help patients discharge to the community** and **avoid long skilled-nursing facility (SNF) stays.**

- **HCTI is cost-effective**: A long SNF stay costs the State more than $65,000 on average.
- **It's what patients want**: The vast majority of patients want to be home.



THE RIPIN MODEL

HCTI embeds **Community Health Workers (CHWs)** into hospital discharge teams.

→

CHWs connect with patients and families while inpatient, and follow the patient into the community with multiple home visits over several weeks.

→

CHWs help patients set up home care and other supports, **preventing long-term SNF stays** before it's too late.

PROGRAM FUNDING

- Launched in 2021 with COVID relief funding.
- Funded in FY2023 and FY2024 through Federal Money Follows the Person (MFP), $500,000 annually.
- NEED TO **IDENTIFY FUNDING** FOR FY 2025 AND BEYOND.

75% of our patients discharge successfully to home

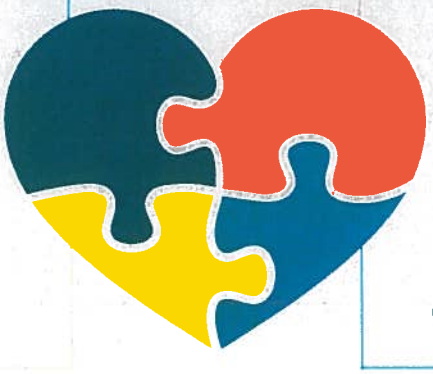
HCTI FOUR KEY PRINCIPLES

SUPPORT PATIENTS & CAREGIVERS

CHWs provide extra support to patients and caregivers beyond that which the hospital can easily provide.

CHWs coordinate with and use other care management resources when available, adequate, and appropriate.

SERVE AS CARE MANAGEMENT OPTION OF LAST RESORT



BUILD RELATIONSHIPS

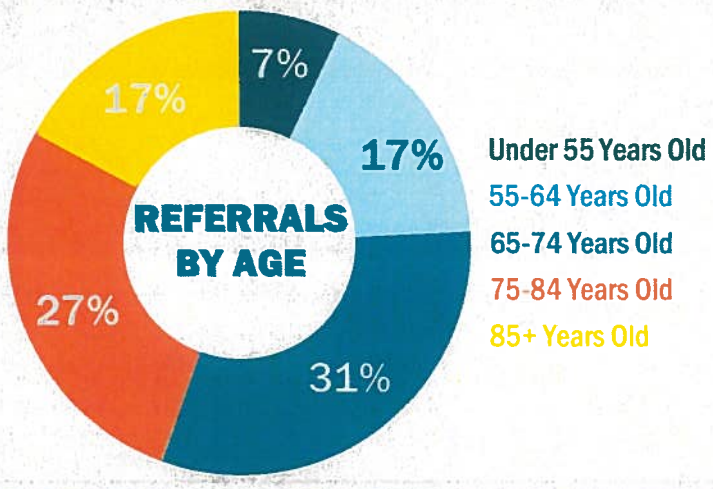
CHWs build relationships in the hospital, then follow-up with patients right after discharge to ensure smooth transitions.

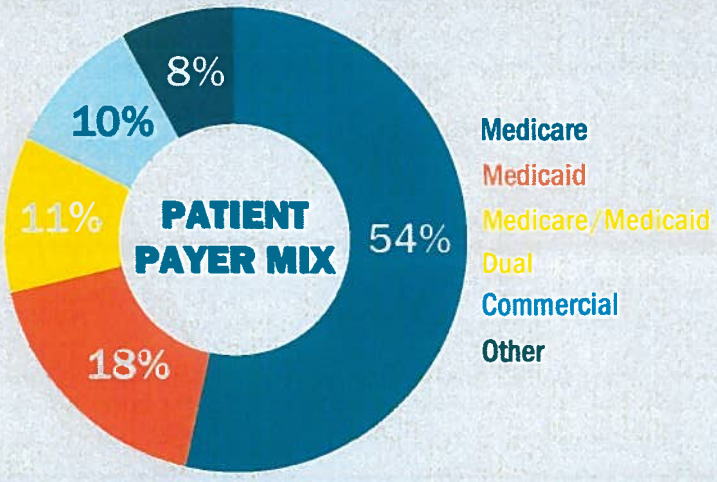
CHWs support patients who are ready to leave the hospital but not ready to go home through a discharge to another setting and then later to home.

NOT LENGTHENING A PATIENT'S HOSPITAL STAY

KEY PROGRAM DATA

- ✓ Actively engaged over 1,000 discharging patients.
- ✓ Now supporting about 50 discharges per month.
- ✓ Embedded in three hospitals: South County, Kent County, and Rhode Island.
- ✓ Built on evidence-based model of RIPIN sister program successfully evaluated by Brown.





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