NO WRONG DOOR

Care Transitions Special Session

ACL
Administration for Community Living

Today's Agenda

- Welcome & Introduction
- NWD Systems & Care Transitions
- Care Transitions During the COVID-19 Pandemic
- Partnership Building with Hospitals and Health Care Providers
- Program Implementation & Sustainability
- Conclusion

Characteristics of Successful Transition Programs

- Hospital liaison and field worker staffing model
- Home visit and follow-up phone calls
- Seamless data processes
- Include targeting individuals with non-diagnosis-based risk factors
- Arrange supportive services
- Medication reconciliation
- Implementation/adaptation of existing care transition models

No Wrong Door Systems & Care Transitions

NWD Framework

ACL, CMS and VHA worked with leading states over multiple years to develop and refine a framework that helps aligns this infrastructure into a coordinated No Wrong Door system.

KEY FUNCTIONS OF A NO WRONG DOOR SYSTEM

- State Governance and Administration
- Public Outreach and Coordination with Key Referral Sources
- Person-Centered Counseling (PCC)
- Streamlined Eligibility for Public Programs

Public Outreach and Coordination with Key Referral Sources

- Success is dependent on having formal relationships with entities where major transitions occur across settings and programs.
  - Hospitals, Health Plans, Medicaid, Medicare, etc.
- Transitions can dramatically affect the well-being and quality of life for people.
- Experienced staff play a defined role in individuals' transitions home.

Heightened need due to the COVID-19 Pandemic and the need to transitions people safely home from high risk environments.

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Care Transitions – Critical to NWD System

Core mission of maximizing independence for at risk populations

New revenue stream

Specialized role within changing LTSS landscape

Existing clients are high risk for readmission

Supporting Care Transitions from Hospital to Home

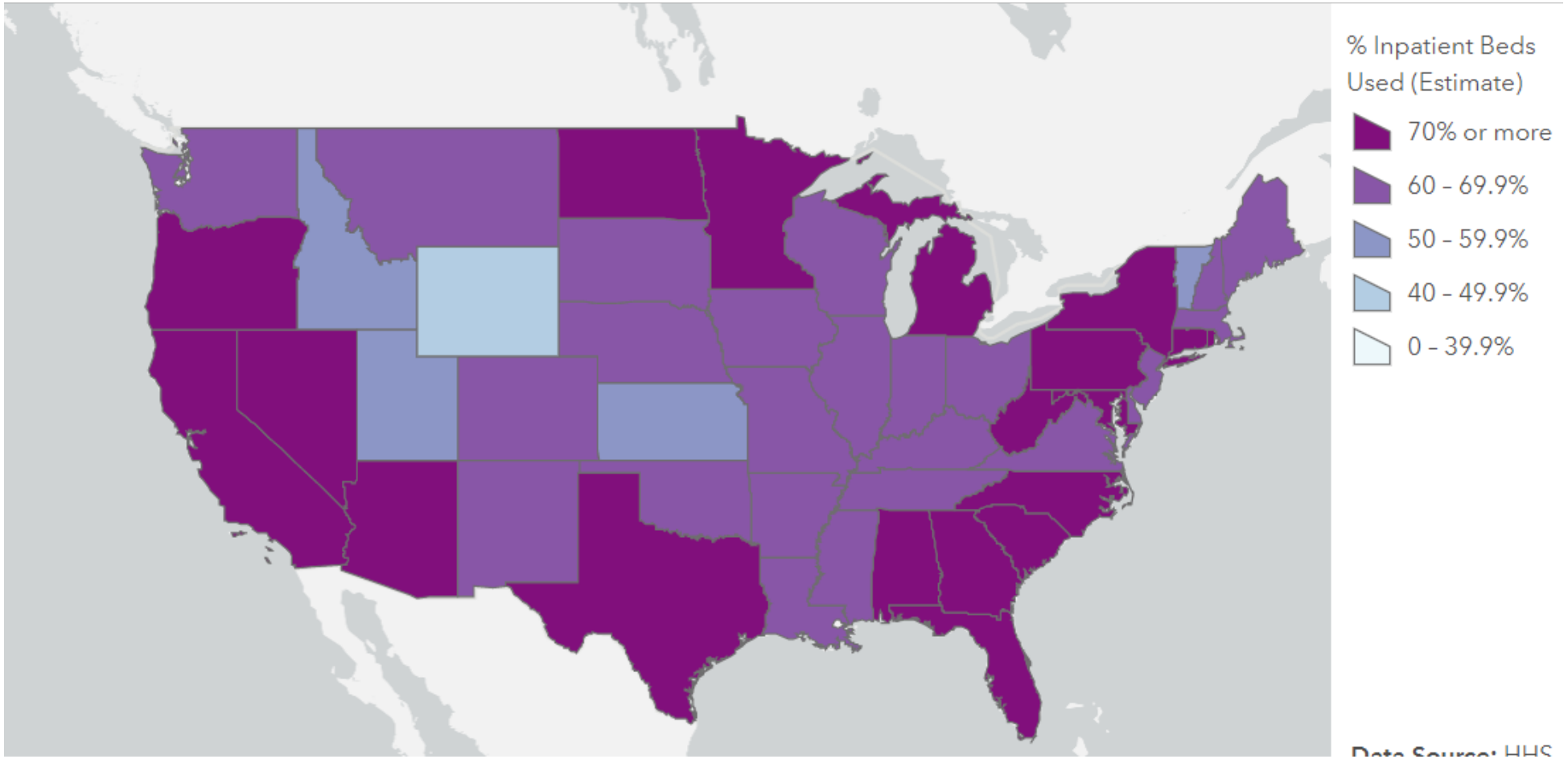
Leverage existing skills of the Aging and Disability Network, building on hospital readmission prevention program:

Connections to Services and Supports During Hospital Transitions

Home Delivered Meals
Nutrition Services and Counseling
Personal Care/Homemaker/Chore
Medication Management
Home Injury/Risk Screenings
Blood Pressure Monitor
Care Management
Benefits Assistance
Transportation
Pharmacy Delivery
Assistive Technology
Chronic Disease Self Management Programs
Diabetes Self Management Programs
Mental Health and Substance Misuse Programs
Falls Management and Prevention
Alzheimer's Programs
Support Groups
Socialization Activities
Additional Options Counseling
Home physician visits
Housing
Caregiver Support
Handyman Services
Respite
Money Management Program
Legal Services
Exercise Programs
Pet care

Care Transitions During the COVID-19 Pandemic

State Hospital Bed Occupancy (as of 11/11/20)



https://protect-public.hhs.gov/pages/hospital-capacity

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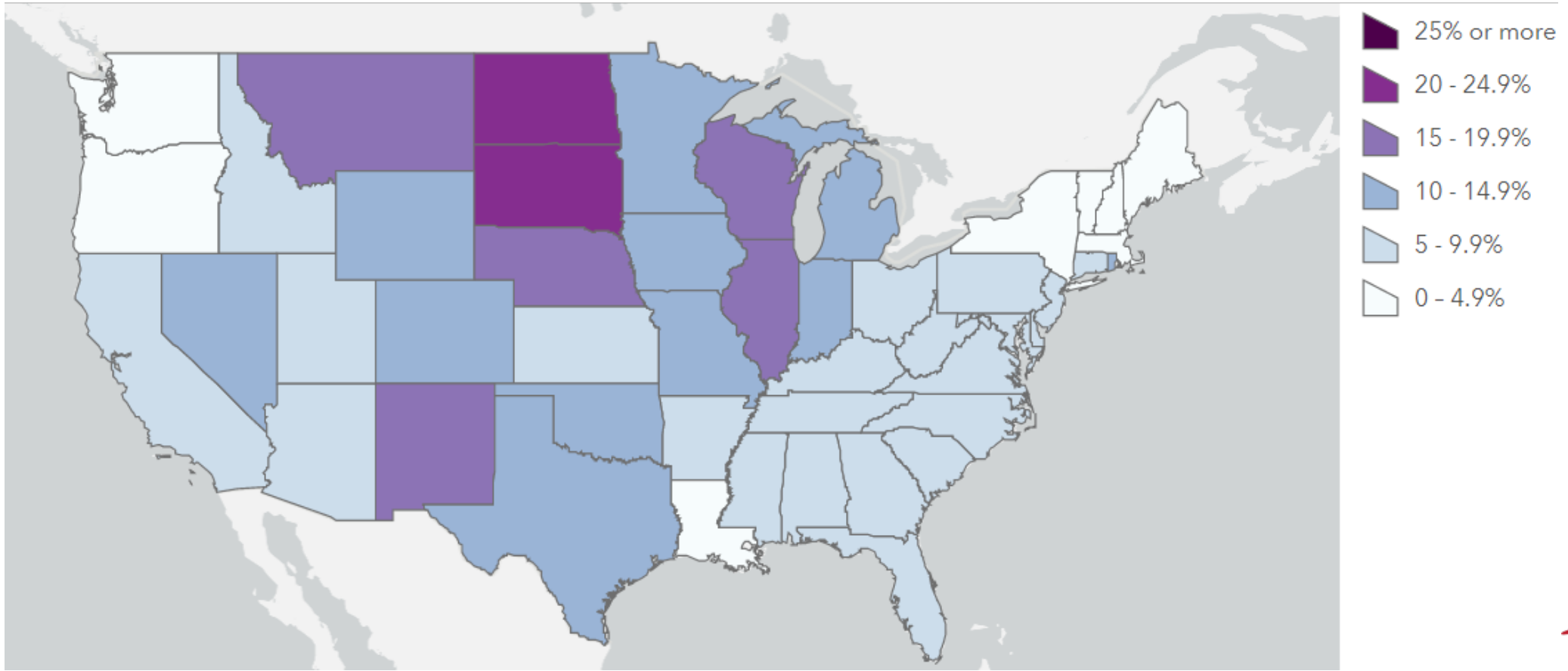

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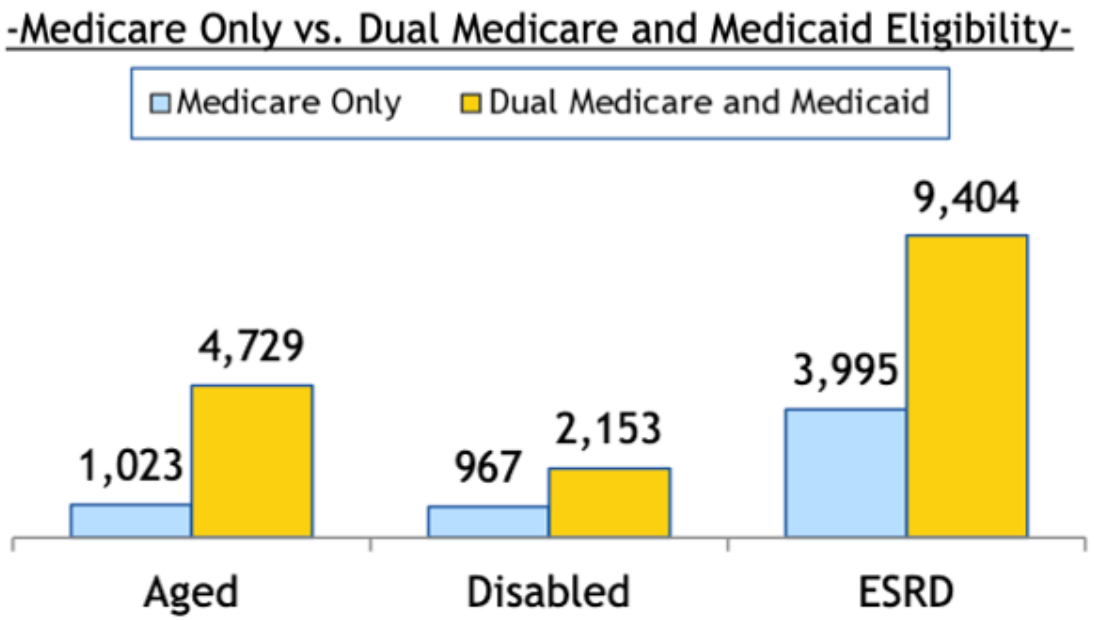
Changes in Demand for Care Transitions

Hospital and nursing facility surges in COVID-19 cases is causing increased demand for Care Transitions.

Adapting care transitions models during the COVID-19 Pandemic:

- Embedded hospital transition coaches reduced or working remotely
- Post-discharge in-home visits eliminated or drastically reduced
- Increased video visits
- Increased demand for a range of LTSS to support community stabilization
- Persons that require assistance beyond a 30-day time period to address items identified in the assessment

COVID-19 Cases per 100K by Beneficiary Characteristics



Disclaimer: All data presented in this update are preliminary and will continue to change as CMS processes additional claims and encounters for the reporting period. COVID-19 cases are identified using the following ICD-10 diagnosis codes: B97.29 (from 1/1-3/31/2020) and U07.1 (4/1/2020 and after). Medicare claims and encounter data are collected for payment and other program purposes, not public health surveillance, so caution must be used when interpreting the data. For additional details on data limitations, please see page 2 of this data update and view the methodology document available here.

Care Transitions Implementation Strategies during the Pandemic

- Alternative approaches during COVID-19 Pandemic: implementation before formal contract
- Increased demand for telehealth and remote patient monitoring
- Increased demand for LTSS is best implemented by ADRC/NWD teams supporting Hospital-to-Home transitions
- Targeting services to high-need populations based on available data

Expanded Use of Telehealth and Remote Monitoring

- Both are being used to increase support for individuals recently discharged
- CMS allows telehealth and remote monitoring nationwide, including in the home
- Broad acceptance of the clinical relevance of medical and case management services delivered via telehealth modalities
- Telehealth capability can support virtual case management and in-home assessments required during the care transitions process

Quote from American Hospital Association

Likewise, the pandemic has illuminated the advantages of having provider offices, community health clinics, home care services, prehospitalization services (ambulances), **community services**, public health offerings and other parts of the care continuum coordinated with hospitals and health systems.

- June 2020 American Hospital Association

https://www.gnyha.org/wp-content/uploads/2020/06/AHA-TOOLKIT-COVID-19-Pathways.FINAL-20200611.pdf

Partnership Building with Hospitals and Health Care Providers

Value Proposition of Transition to Home

- Hospital Beds are filling rapidly
- Discharges are difficult as patients still need extensive services
- Patients and families want to avoid nursing facilities
- Aging and Disability agencies can assess and counsel, develop a plan, and arrange support services to be delivered at home
- Agencies can continue to support individuals to sustain health and avoid hospital readmission
- All payers save money by delivering services at home, not at the hospital

Value-Proposition of Care Transitions

1. COVID-19 surges and increasing demand through coming months – impacting hospitals and nursing facilities
2. Populations that suffer disproportionately require more assistance and may be eligible for hospital-to-home transitions
3. HHS / CMS policy guidance requires hospitals to coordinate LTSS with ADRCs, AAAs, and CILs

The Aging and Disability Network (ADRCs, AAAs, & CILs) are best equipped to be the experts in facilitating Hospital-to-Home transitions that can include enrollment into the Medicaid LTSS system and coordination of public resources to activate Person-Centered plans of care.

Sample Pitch

- Older adults and individuals with disabilities are a population that is most impacted by COVID-19.
- ADRC programs are the experts in person-centered planning and ensuring that these high-risk populations receive LTSS to support Skilled Nursing Facility diversion and Nursing Facility avoidance.
- ADRCs can deploy a Hospital-To-Home transition program to target high-risk populations that are being impacted at your facility.

Program Implementation and Sustainability

Implementation and Sustainability Factors

Factors for Implementation:

- Staffing for hospital-to-home services (ex. hospital liaison)
- Time limited intervention model
- Contractual agreement between involved entities
- Bi-directional data sharing
- Ability to conduct a needs assessment, SDoH screening, and person-centered planning
- Sustainability planning, including continued financial support

Organizational Capacity – Key Elements

Funding to support staff deployment for Hospital-to-Home transitions

- Staff training on virtual communication, person-centered planning, and transitions
- Staff capacity to support transitions
- Organizational ability to enter into a contract and meet data-use requirements
- Secure communications capability
- Secure data storage and data sharing capability
- Ability to coordinate services in the LTSS system
- Ability to identify paid and non-paid resources to meet the needs of the person
- Documentation and tracking of assessments, person-centered plan, and outcomes data
- Return on Investment (ROI) calculation knowledge and access to data to track program impact

Sustainability

- Potential funding streams
  - Medicaid Contracting, Medicaid Administrative Claiming, Hospital Contracting, Health Plan Contracting, and additional Provider Contracting
- Collaboration with other aging and disability entities
- Data proving value and Return on Investment (ROI)
- Consumer satisfaction
- Provider referrals to other providers
- Expanding service offerings to satisfied provider customer
  - Medicaid; MCO; Hospitals; Other providers

Sustainability – Partnerships with Existing Programs

- Home Health
- Home Care
- Assistive Technology
- Durable Medical Equipment
- Home Modifications
- Housing
- Transportation
- Nutrition

Question & Answer

Questions can be submitted to through the chat feature on the platform.

Thank you!!

For any technical assistance needs, please feel free to reach out to ACL at

caretransitions@acl.hhs.gov