Care Transitions Peer Hour
Hospital to Home

Agenda

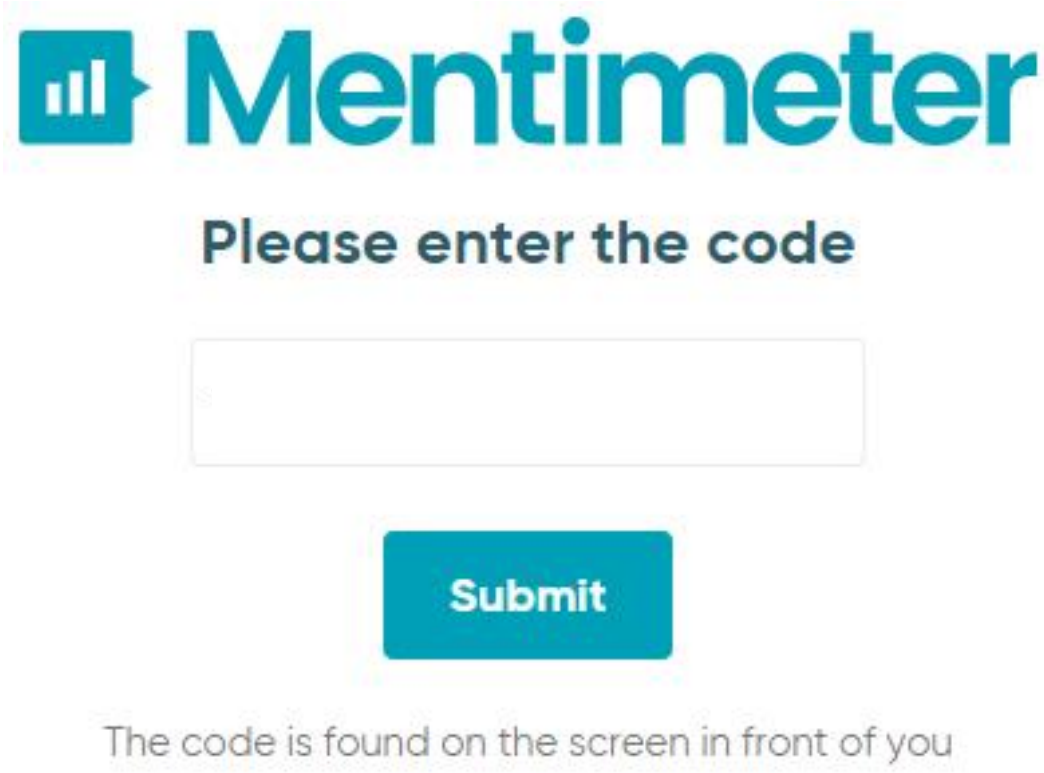
Agenda Item
Welcome & Introduction from ACL
Overview of the Importance of Care Transitions During COVID-19
Review of the Known Care Transitions Challenges During COVID-19
Feature Best Practice: -Multnomah County, Oregon AAA: Care Transitions Staff Interview -Oregon Wellness Network
Question & Answer

Welcome from ACL

CAROLINE RYAN

Mentimeter Polling

- Go to www.menti.com and enter code

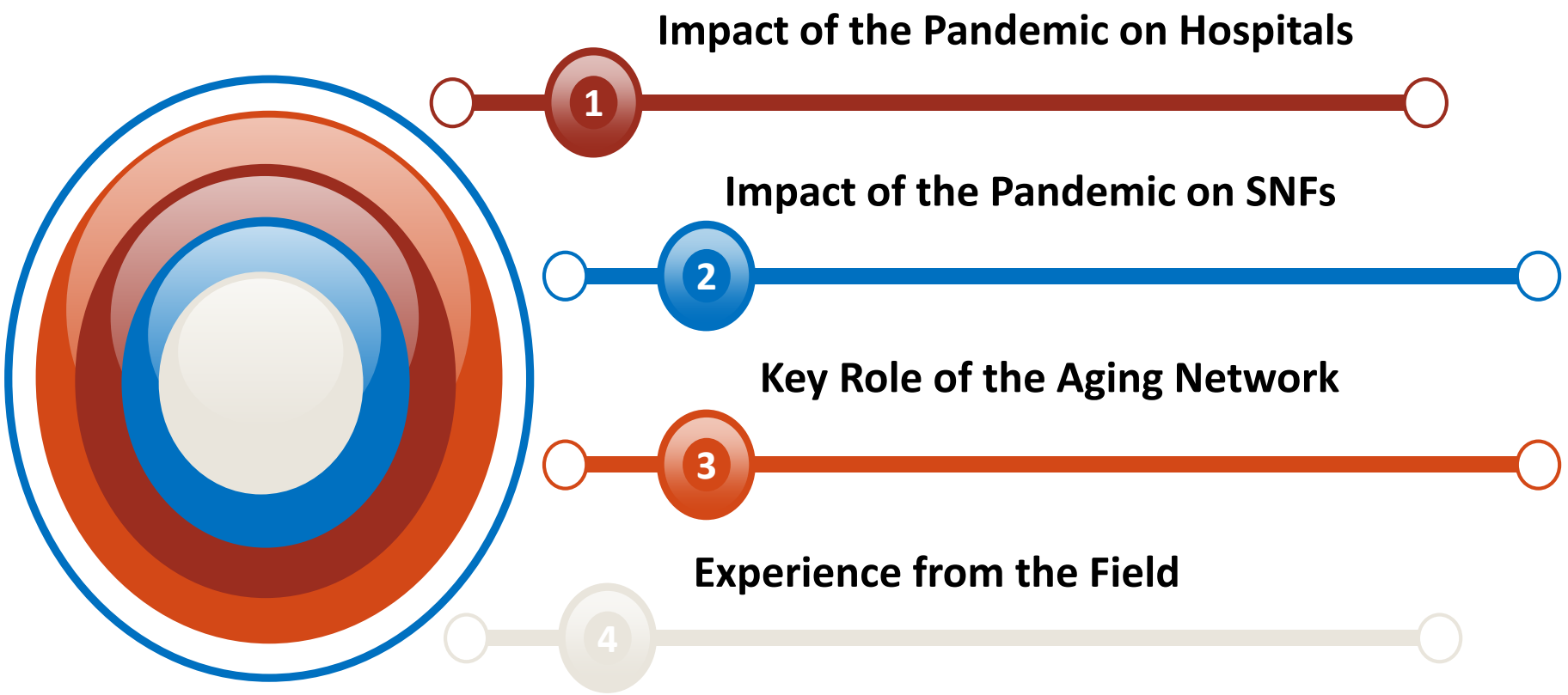


Care Transitions During the COVID-19 Pandemic

TIMOTHY MCNEILL, RN, MPH

FREEDMEN'S HEALTH

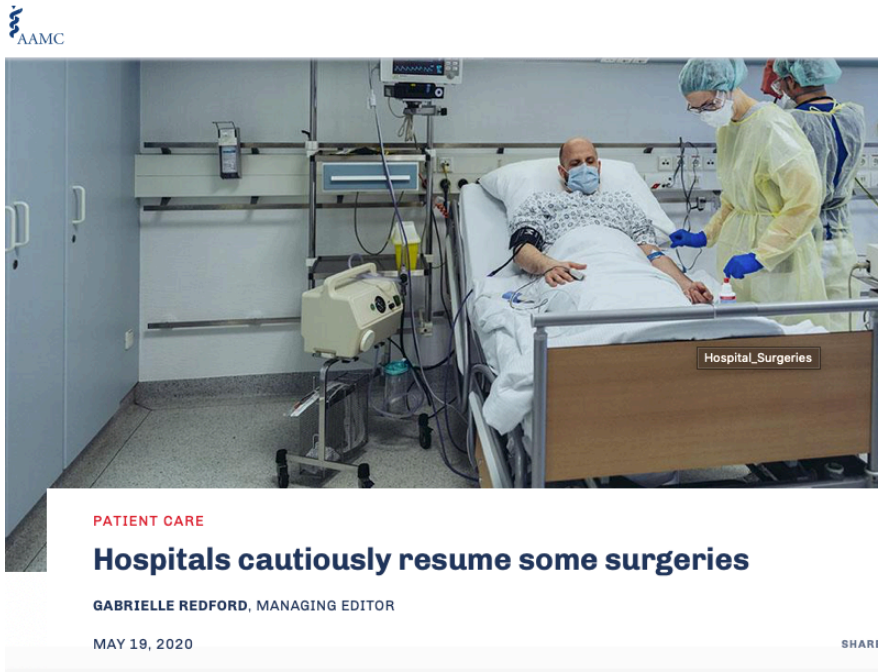
Overview


Impact of the Pandemic on Hospitals
1
Impact of the Pandemic on SNFs
2
Key Role of the Aging Network
3
Experience from the Field
4

The Pandemic has had a Profound Impact on Hospitals

Elective Surgeries

- March – May: Elective surgeries cancelled
- More than 250 hospitals report laying off or furloughing staff
- Analyst predict U.S. hospitals lost approximately $200 billion between March and June
- One of the major challenges impacting restarting elective surgeries: How do you convince patients it's safe to return to the operating room or emergency department, when for the last two months you've told them to stay away?



AAMC. May 19, 2020: Available Online [https://www.aamc.org/news-insights/hospitals-cautiously-resume-some-surgeries]

Readmission Reporting during the Pandemic

CMS issued guidance that they will not count data from January 1, 2020 through June 30, 2020 for Hospital performance or payment programs:

- Includes the Hospital Readmissions Reduction Program


CMS.gov | Centers for Medicare & Medicaid Services

Newsroom Press Kit Data Contact Blog

Press release

CMS Announces Relief for Clinicians, Providers, Hospitals and Facilities Participating in Quality Reporting Programs in Response to COVID-19

Mar 22, 2020 | Data, Hospitals, Quality

Share

Today, the Centers for Medicare & Medicaid Services (CMS) announced unprecedented relief for the clinicians, providers, and facilities participating in Medicare quality reporting programs including the 1.2 million clinicians in the Quality Payment Program and on the front lines of America's fight against the 2019 Novel Coronavirus (COVID-19).

COVID-19 Long-Term Care Facility Guidance

COVID-19 Long-Term Care Facility Guidance
April 2, 2020

The Centers for Medicare & Medicaid Services (CMS) and the Centers for Disease Control and Prevention (CDC) are issuing new recommendations to State and local governments and long-term care facilities (also known as nursing homes) to help mitigate the spread of the 2019 Novel Coronavirus (COVID-19). Long-term care facilities are a critical component of America's healthcare system. They are unique, as they serve as both healthcare providers and as full-time homes for some of the most vulnerable Americans.

iv. State agencies including health departments, hospitals, and nursing home associations will have to ensure coordination among facilities to determine which facilities will have a designation and to provide adequate staff supplies and PPE; and, if possible, isolate all admitted residents (including readmissions) in their room in the COVID-19-positive facility for 14 days if their COVID-19 status is unknown; and

Nursing Home Death Rate and SNF bed reduction increasing demand for In-Home Care

Learn How To Save
When You're Driving Less.

U.S.News NEWS

Home / News / Health News

Coronavirus Deaths in Nursing Homes Climbing Again

Aug. 14, 2020

By Robin Foster and E.J. Mundell
HealthDay Reporters

FRIDAY, Aug. 14, 2020 (HealthDay News) The novel coronavirus is surging once more in U.S. nursing homes, where it killed tens of thousands at the start of the pandemic.

(HEALTHDAY)

Federal data cited by two long-term care associations this week illustrated the troubling trend: The number of new cases in nursing homes bottomed out at 5,468 during the week of June 21, but it climbed to 8,628 for the week of July 19, the *Washington Post* reported. That's a 58 percent increase, which roughly parallels the rise in overall U.S. cases during that period.

Major Investors are Flocking to New Home-Care Opportunities

OPERATIONS

June 25, 2020 11:11 AM

Mayo Clinic to launch national hospital-at-home model

ALEX KACIK

TWEET SHARE SHARE EMAIL

dispatch HEALTH

DispatchHealth Raises $135.8 Million in Series C Financing

June 23, 2020

PR Newswire

Investment recognizes immediate and long-term need for in-home medical care for high-acuity patients

DispatchHealth, a provider of tech-enabled in-home health care, today announced the closing of $135.8 million growth capital financing. The Series C round was led by Optum Ventures and included participation from existing investors Alta Partners, Questa Capital, Echo Health Ventures, new investors Oak HC/FT, Humana Inc. (NYSE: HUM) and additional strategic investors.

Remedy Partners (Now SignifyHealth) & Dispatch Health both Launch SDoH Interventions supporting hospital transitions

signifyhealth

Health is more than healthcare

Impacting the social determinants of health happens outside the healthcare system. See how we're helping to break down the barriers between health and community care.

Unforgettable experiences

Signify Health has the privilege of providing high-touch clinical and social support to more than a million people ever year, improving their outcomes and experiences.

Hear From Our Members

VIEW ALL NEWS

Tivity Health and DispatchHealth Partner to Provide Patient Nutrition Support

4/29/20

Wisely Well™ meal plans will be customized by clinicians to support patient recovery

NASHVILLE, Tenn., April 29, 2020 /PRNewswire/ -- Tivity Health® (Nasdaq: TVTY), a leading provider of nutrition, fitness and social engagement solutions, today announced a new partnership with DispatchHealth, a provider of technology-enabled in-home health care, to deliver healthy, convenient meals for DispatchHealth patients. The new service will initially be offered in the Denver metro area for patients returning home after a hospitalization, those that are hospitalized in their home or for the most vulnerable patients with food insecurity.

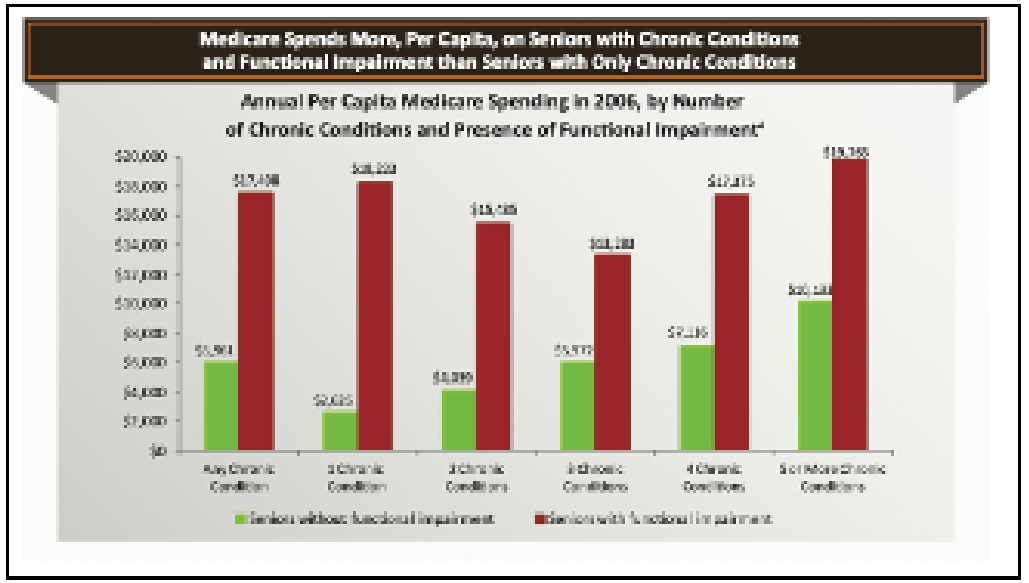
Role of the Aging Network in Care Transitions

Market Segmentation and Risk Stratification are key to defining the target population that the Aging Network can have the greatest impact over and above commercial entrants

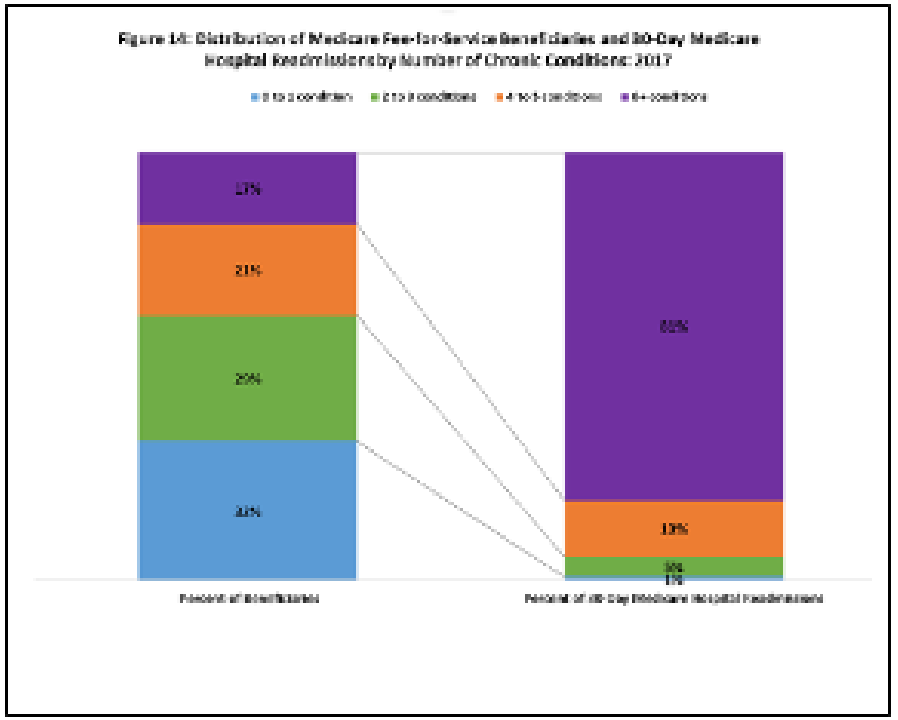
There is a clear role for the Aging Network for a key demographic that is most at-risk

- Persons with multiple chronic conditions and a functional impairment
  - Over 90% of hospital readmissions are caused by persons with 4+ chronic conditions
- Persons with a functional impairment that are dual-eligible or meet the CMS low-income subsidy definition have the most risk
- Persons with a functional impairment and 1+ social determinants of health

Populations with Functional Impairments are driving the bulk of the Costs & Readmissions

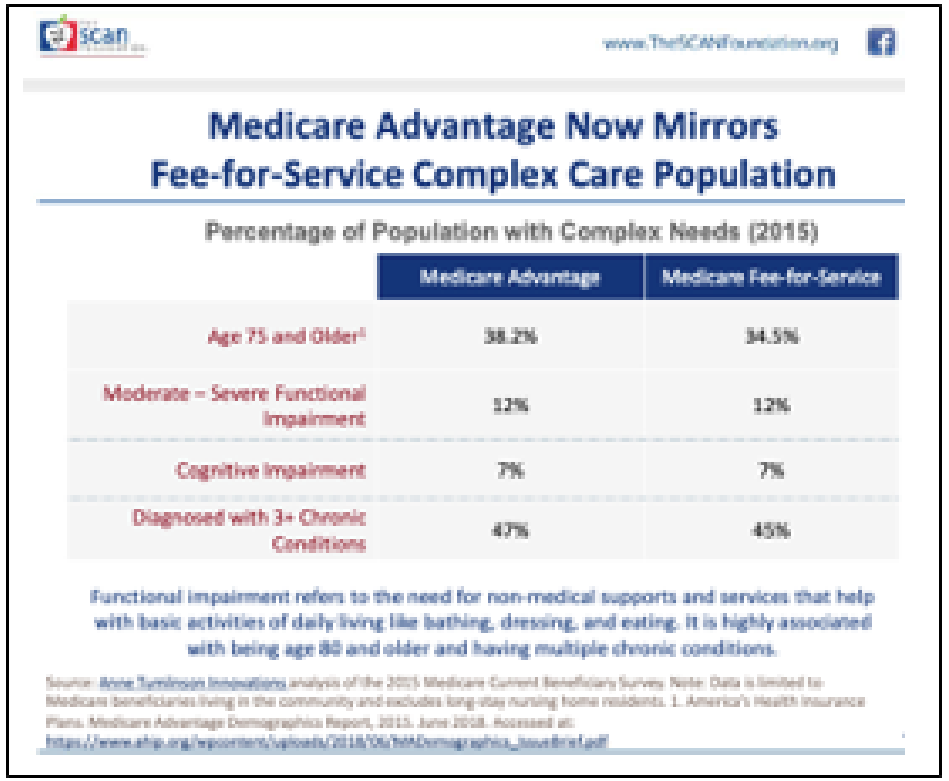


Source: The Scan Foundation. Data Brief Series. October 2011. No. 22.



Source: The Centers for Medicare & Medicaid Services (CMS) Chronic Conditions Chartbook and Charts. Chronic Conditions Charts: 2017. Available online: https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Chartbook_Charts

Aging Network is the Leading Expert in Managing Persons with Functional Impairments in Community Settings – Medicaid and Non-Medicaid Populations



www.TheSCANFoundation.org

Medicare Advantage Now Mirrors Fee-for-Service Complex Care Population

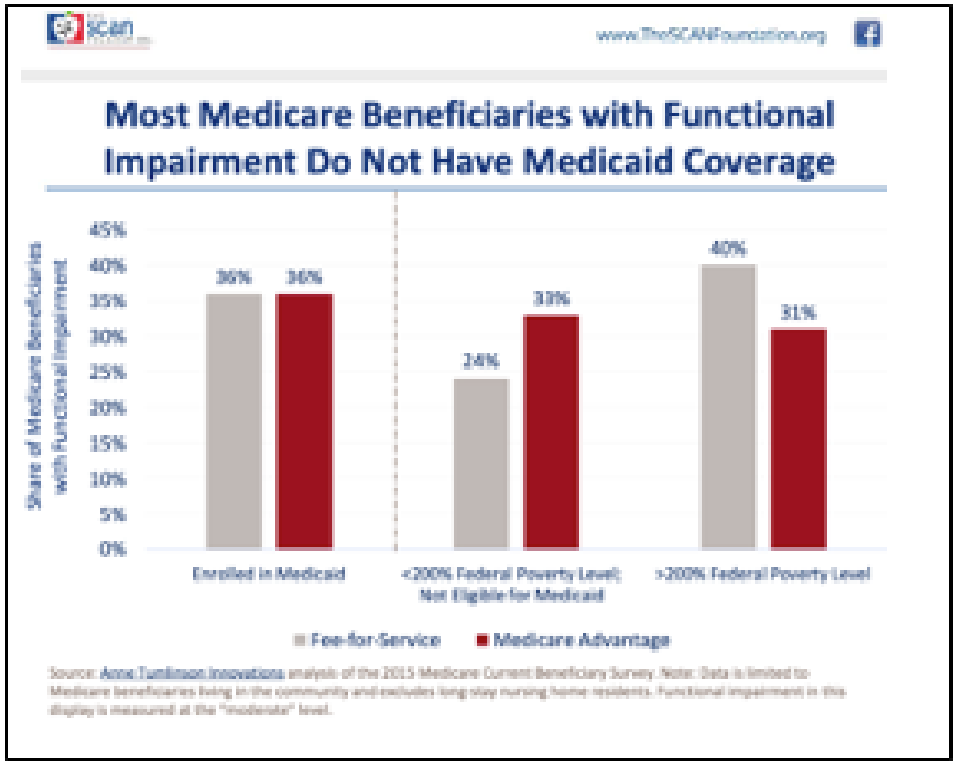
Percentage of Population with Complex Needs (2015)

	Medicare Advantage	Medicare Fee-for-Service
Age 75 and Older[1]	38.2%	34.5%
Moderate – Severe Functional Impairment	12%	12%
Cognitive Impairment	7%	7%
Diagnosed with 3+ Chronic Conditions	47%	45%

Functional impairment refers to the need for non-medical supports and services that help with basic activities of daily living like bathing, dressing, and eating. It is highly associated with being age 80 and older and having multiple chronic conditions.

Source: Avalere Health analysis of the 2015 Medicare Current Beneficiary Survey. Note: Data is limited to Medicare beneficiaries living in the community and excludes long-stay nursing home residents. 1. America's Health Insurance Plans. Medicare Advantage Demographics Report, 2015. June 2018. Accessed at: https://www.ahip.org/wp-content/uploads/2018/06/MADemographics_1pagerBrief.pdf

Source: SCAN Foundation. New Opportunities for Serving Complex Care Populations in Medicare Advantage. Presentation, December 2018.



www.TheSCANFoundation.org

Most Medicare Beneficiaries with Functional Impairment Do Not Have Medicaid Coverage

Share of Medicare Beneficiaries with Functional Impairment

45%
40%
35%
30%
25%
20%
15%
10%
5%
0%

36% 36%
24% 33%
40% 31%

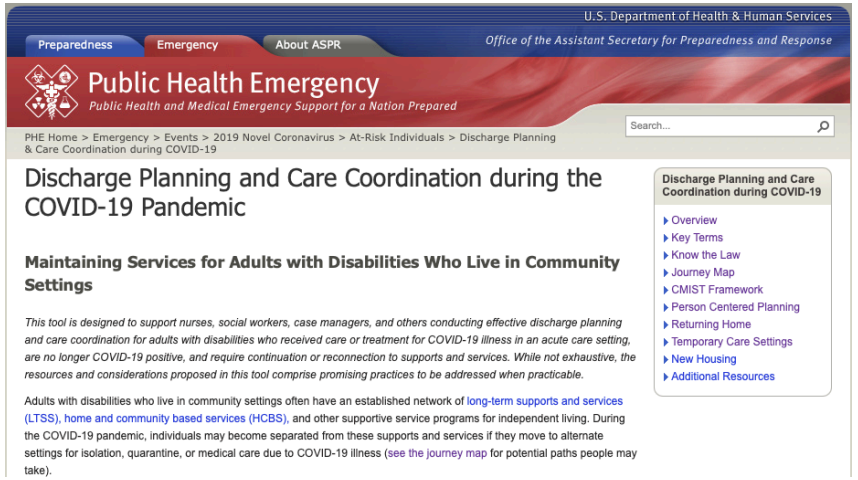
Enrolled in Medicaid
<200% Federal Poverty Level; Not Eligible for Medicaid
>200% Federal Poverty Level

Fee-for-Service
Medicare Advantage

Source: Avalere Health analysis of the 2015 Medicare Current Beneficiary Survey. Note: Data is limited to Medicare beneficiaries living in the community and excludes long-stay nursing home residents. Functional impairment in this display is measured at the "moderate" level.

Source: SCAN Foundation. New Opportunities for Serving Complex Care Populations in Medicare Advantage. Presentation, December 2018.

HHS Guidance on Discharge Planning during the COVID-19 Pandemic Validates the Key Role of the Aging Network



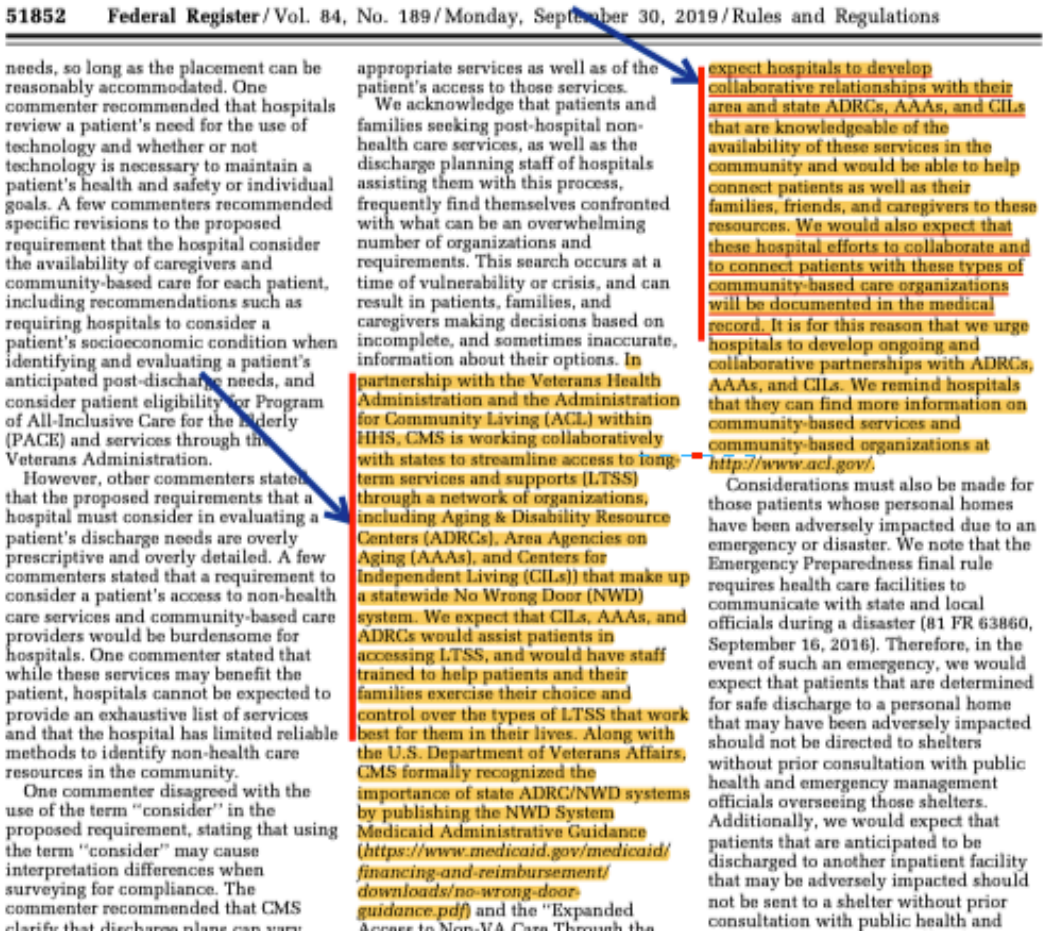
Available Online, September 2020:

https://www.phe.gov/emergency/events/COVID19/atrisk/discharge-planning/Pages/default.aspx

Maintaining Health

The Individual…	Your discharge planning process should…
…requires LTSS and/or HCBS	▸ If the individual was already receiving HCBS or LTSS prior to admission to the hospital, ensure that they are still able to receive these services in-person when they return home ▹ If not, can they transition to virtual services, or do they need another form of assistance? ▸ If the individual needs HCBS or LTSS, work to establish those services, either in-person or virtually ▹ For assistance in establishing these services, see the Aging and Disability Resource Centers (ADRCs) / No Wrong Door System, or your established local referral source.

New CMS Discharge Planning Policy Reinforces the Expert Role of the Aging Network – September 30, 2019



51852 **Federal Register** / Vol. 84, No. 189 / Monday, September 30, 2019 / Rules and Regulations

needs, so long as the placement can be reasonably accommodated. One commenter recommended that hospitals review a patient's need for the use of technology and whether or not technology is necessary to maintain a patient's health and safety or individual goals. A few commenters recommended specific revisions to the proposed requirement that the hospital consider the availability of caregivers and community-based care for each patient, including recommendations such as requiring hospitals to consider a patient's socioeconomic condition when identifying and evaluating a patient's anticipated post-discharge needs, and consider patient eligibility for Program of All-Inclusive Care for the Elderly (PACE) and services through the Veterans Administration.

However, other commenters stated that the proposed requirements that a hospital must consider in evaluating a patient's discharge needs are overly prescriptive and overly detailed. A few commenters stated that a requirement to consider a patient's access to non-health care services and community-based care providers would be burdensome for hospitals. One commenter stated that while these services may benefit the patient, hospitals cannot be expected to provide an exhaustive list of services and that the hospital has limited reliable methods to identify non-health care resources in the community.

One commenter disagreed with the use of the term "consider" in the proposed requirement, stating that using the term "consider" may cause interpretation differences when surveying for compliance. The commenter recommended that CMS clarify that discharge plans can vary

appropriate services as well as of the patient's access to those services.

We acknowledge that patients and families seeking post-hospital non-health care services, as well as the discharge planning staff of hospitals assisting them with this process, frequently find themselves confronted with what can be an overwhelming number of organizations and requirements. This search occurs at a time of vulnerability or crisis, and can result in patients, families, and caregivers making decisions based on incomplete, and sometimes inaccurate, information about their options. In partnership with the Veterans Health Administration and the Administration for Community Living (ACL) within HHS, CMS is working collaboratively with states to streamline access to long-term services and supports (LTSS) through a network of organizations, including Aging & Disability Resource Centers (ADRCs), Area Agencies on Aging (AAAs), and Centers for Independent Living (CILs)) that make up a statewide No Wrong Door (NWD) system. We expect that CILs, AAAs, and ADRCs would assist patients in accessing LTSS, and would have staff trained to help patients and their families exercise their choice and control over the types of LTSS that work best for them in their lives. Along with the U.S. Department of Veterans Affairs, CMS formally recognized the importance of state ADRC/NWD systems by publishing the NWD System Medicaid Administrative Guidance (*https://www.medicaid.gov/medicaid/financing-and-reimbursement/downloads/no-wrong-door-guidance.pdf*) and the "Expanded

expect hospitals to develop collaborative relationships with their area and state ADRCs, AAAs, and CILs that are knowledgeable of the availability of these services in the community and would be able to help connect patients as well as their families, friends, and caregivers to these resources. We would also expect that these hospital efforts to collaborate and to connect patients with these types of community-based care organizations will be documented in the medical record. It is for this reason that we urge hospitals to develop ongoing and collaborative partnerships with ADRCs, AAAs, and CILs. We remind hospitals that they can find more information on community-based services and community-based organizations at *http://www.acl.gov/*.

Considerations must also be made for those patients whose personal homes have been adversely impacted due to an emergency or disaster. We note that the Emergency Preparedness final rule requires health care facilities to communicate with state and local officials during a disaster (81 FR 63860, September 16, 2016). Therefore, in the event of such an emergency, we would expect that patients that are determined for safe discharge to a personal home that may have been adversely impacted should not be directed to shelters without prior consultation with public health and emergency management officials overseeing those shelters. Additionally, we would expect that patients that are anticipated to be discharged to another inpatient facility that may be adversely impacted should not be sent to a shelter without prior consultation with public health and

Mentimeter Polling

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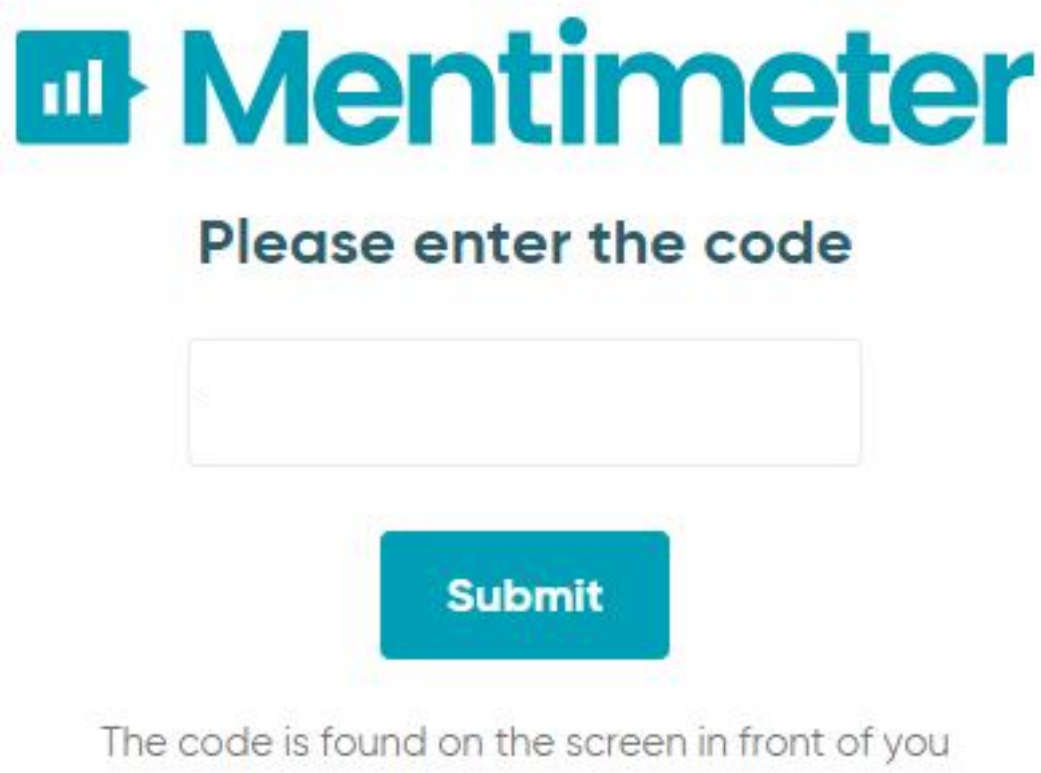

Experience From the Field

Multnomah County

Lynn Schemmer-Valleau
Multnomah County Aging, Disability & Veterans Services
Community Services Team
Program Manager

O4AD

Oregon Wellness Network

A Division of Oregon Association of Area Agencies on Aging & Disability

Lavinia Goto, RN, CDE, MPH, MBA, DHA
Project Manager, LTC Innovation & SDOH
Operations Manager, Oregon Wellness Network

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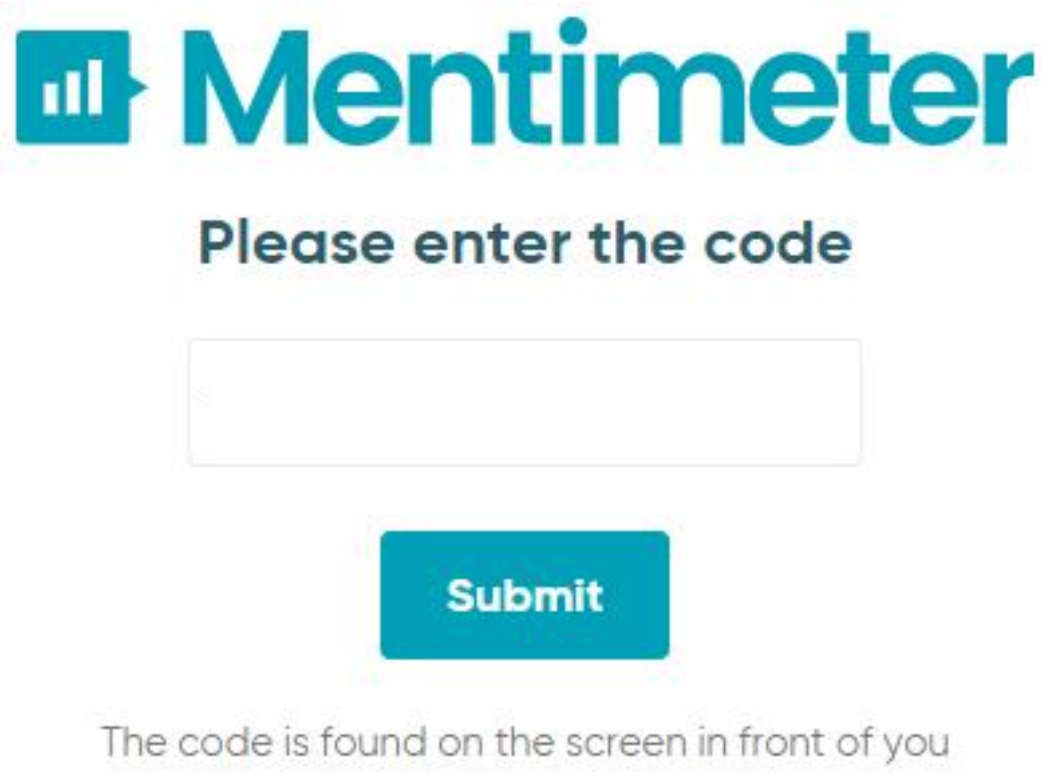

Questions?

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

Thank you!!

Please mark your calendars for the next

Care Transitions Peer Hour on September 15th!

An announcement with registration will be sent soon!