Hospital AT Home USERS GROUP™

Can We Deliver Skilled Nursing Facility Care at Home? Should We?

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AAHCM AMERICAN ACADEMY OF HOME CARE MEDICINE

The John A. Hartford Foundation

Webinar
December 5, 2023

We appreciate the generous support of

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Hospital AT Home USERS GROUP

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- Please submit your questions via the Q&A option.
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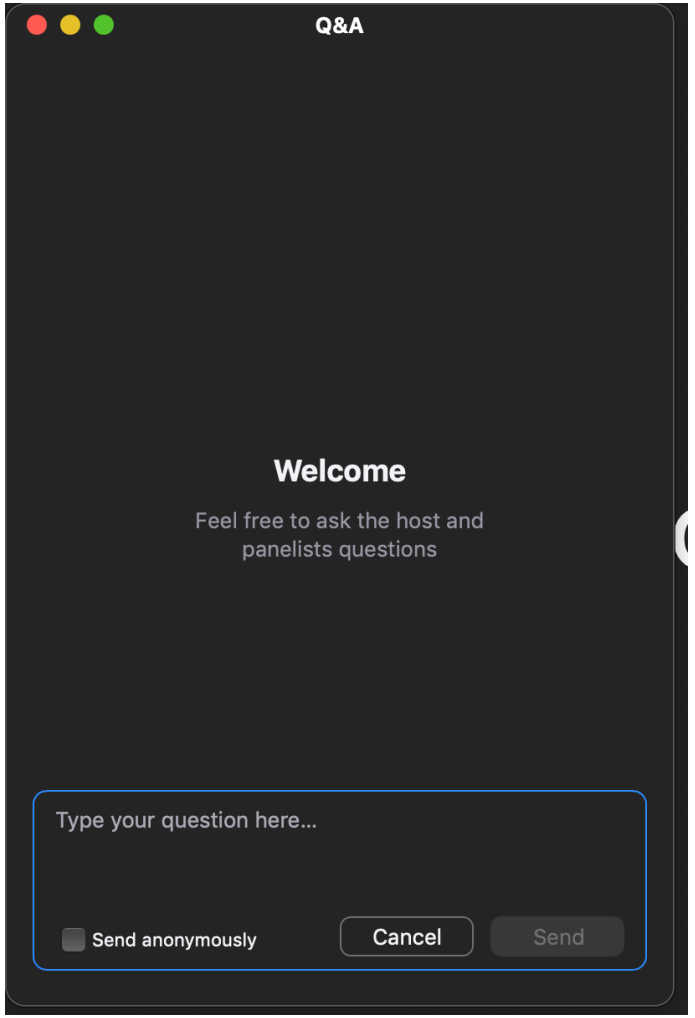
- If you have any technical issues, please contact Jane Donahue (jdonahue@aboutscp.com) or send her a message via the Zoom chat feature.



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Users Group Caregiver Experience Study

- A team of researchers at the Icahn School of Medicine at Mount Sinai is looking to interview HaH Users Group program leaders for their input on the caregiver experience and their expertise on caregiving issues.

- To participate, scan the QR code or contact *info@hahusersgroup.org*

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David M. Levine, MD MPH MA

Clinical Director,
Research and Development,
Mass General Brigham
Associate Professor of Medicine,
Harvard Medical School

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Today's Webinar

Can We Deliver Skilled Nursing Facility Care at Home? Should We?

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Lots of Rehab

	LTAC	Acute Rehab (IRF)	Subacute	SNF	Home Health Care (HHC)
Which Patients	Technology dependent: trach, vent, TPN, dialysis	Mostly CNS or neuro-muscular	Complex med or surg	Med or Surg	Homebound. PT or skilled nursing to open
Hospital Stay	Required	Not required	3 midnight unless waived by Medicare advantage plan. Excludes ED observation		Not required (can order from the office)
Therapy	Not specified	3 hr 5d/wk	1.5 hr 5-6 d/wk	1 hr 5-6 d/wk	PT/OT 2-3/wk. SN 1/wk
Length of Stay	Aggregate > 25d	1-4 wks	Aggregate < 2wk	Avg 30d	Usually 1-8 wks
Medicare Part A	100%	100% (if show progress)	100% d1-20, then 80% d21 – 100 plus copay		No co-pay
Physician Visits	Daily (hospitalists, pulmonologists)	Daily (mainly PM&R physicians)	Every 30d or as required by facility (usually 2-3 days) (primary care clinicians)		As outpatient, Face-to-face encounter w/in 90d prior to or 30d after start HHC
Usually Excludes		Complex wounds	In-house dialysis, TPN, Vent, PCAs, continuous infusions		Unsafe environment
Approx cost range	$1500-3000/d	$1000-2000/d	$600-700/d	$150-400/d	$100-300/d
Comment	Can have complex wounds		Unusual: Medicaid	Medicaid can provide copay	HHA 6 hr/wk. Can add SW, ST. Can have SN daily early.

Credit: Cleveland Clinic

Problems with Rehab

22% experience adverse event

11% experience temporary harm

26% HAI

Unintended Clinical Consequences[1]

Often >100% capacity

Variable care experience

Insufficient Rehab

Fastest-growing part of Medicare

Expensive[2]

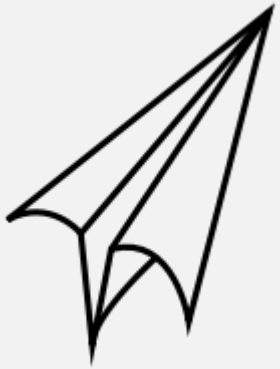
1: Levinson, DR. HHS. 2014. OEI-06-11-00370
2: Chandra, A. Health Affairs. 2013.

Need for Rehab at Home

Design Methodology 101

Phase 1

It might work



Interest

Phase 2

It does work

Measurable Outcome

Phase 3

How we work

Impact

Credit: David Asch, MD MBA

Previous Rehab at Home Work

Characteristic	Sinai RaH (n=264)
Age, mean	85
Female, %	66
Diagnosis, %	
Infection	17
HF	2
Mechanical fall	16
MSK Pain	5
Other medical	42
Other surgical	16
Visits, mean #	
MD/NP	2.2
Nurse	2.7
PT	10.4
OT	2.4
SLP	0.3
SW	1.2

Outcomes	Sinai RaH (n=264)
LOS	14
30-day ED visit	4.7
30-day hospital readmission	19
30-day mortality, %	2.3

DeCherrie LV. JAGS. 2019;
Augustine MR. JAGS. 2020.

Today's Speakers

Jessica A. Hohman, MD MSc MSc

President, Cleveland Clinic Accountable Care Organization
Investigator, Center for Value-Based Care Research

Joshua Johnson, DPT PhD

Assistant Professor, Lerner College of Medicine
Director, PM&R Outcomes Research, Cleveland Clinic

Emily Downing, MD

System Clinical Officer, Continuing Care
Allina Health

Swetha Gudibanda, MD

Medical Director, Hospital at Home/Home Recovery Care
Medical Director, Telehealth Program (Virtual Care Services)
Marshfield Clinic Health System

Moving Post-Acute Care into the Home: HomeCare +

Jessica Hohman, MD MSc MSc
President, Cleveland Clinic Accountable Care Organization (ACO)

Josh Johnson, PhD
Director of Outcomes Research,
Cleveland Clinic Department of PM&R

December 5, 2023

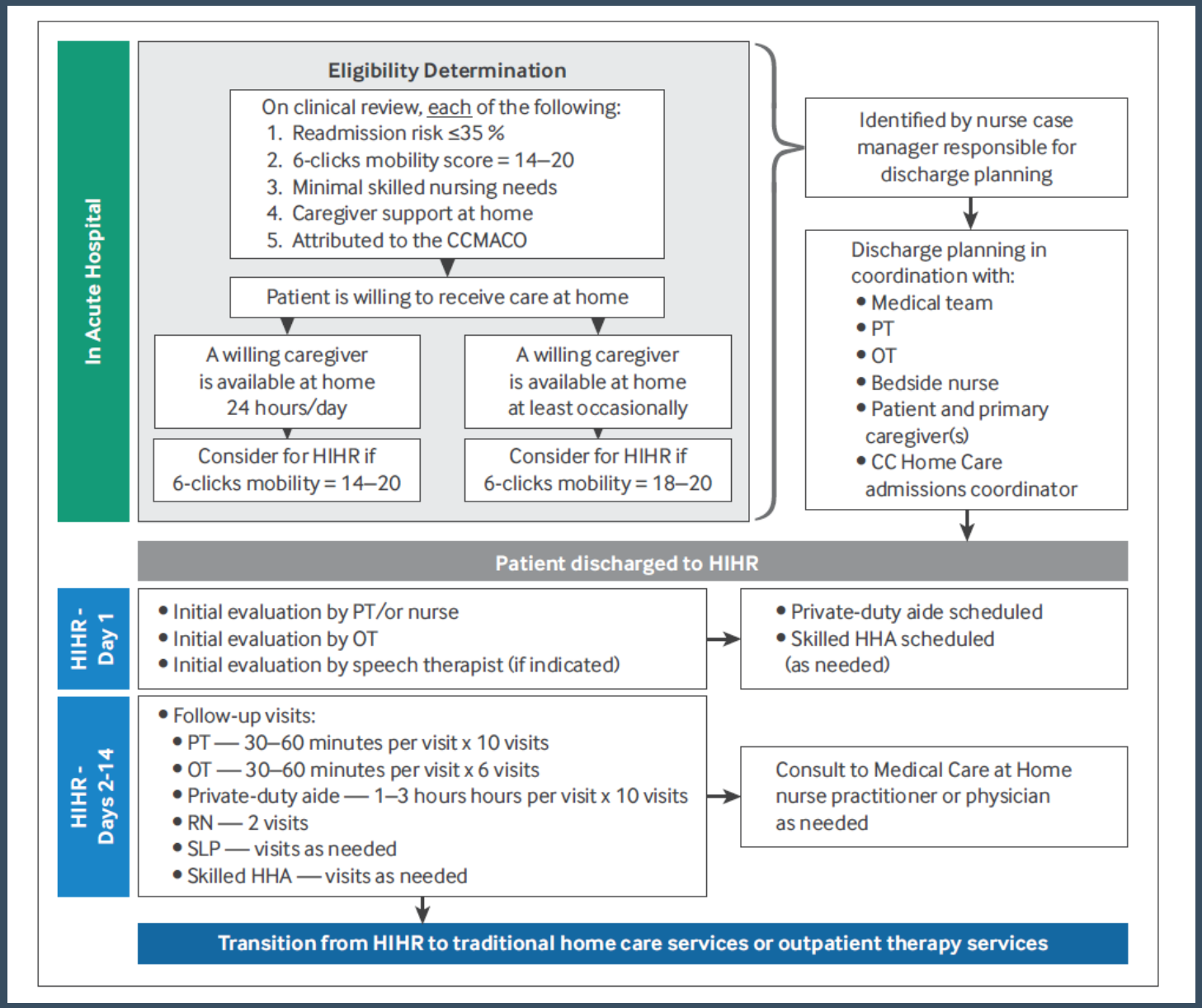
HomeCare+: A Multidisciplinary Collaboration

Goal: To offer a safe, home-based alternative to SNF for post-acute rehabilitative care

HomeCare+ Program Overview

- Partnered with internal home health agency to provide all skilled services for patients
- Contracted with vendor to provide additional custodial / private duty aide support for 3h/day (up to 14 days)
- Leveraged home-based primary care APP capacity to provide additional home visits as needed (up to two visits in 14 days)
- Designed program to include front-loaded, higher intensity contact in first 14 days
  - 5h/day total

HomeCare+ Eligibility Criteria



Initial patient eligibility criteria were established by a multidisciplinary team—including physical and occupational therapy, physicians, care management, and home care stakeholders. Extensive chart reviews and a review of the literature were also performed.

Additional exclusion criteria were implemented to ensure patient safety, including: delirium, severe mental illness, advanced dementia, metastatic cancer, 24/7 care needs, and lack of rehabilitation-appropriate needs.

Johnson JK, Hohman JA, et al. High-Intensity Postacute Care at Home. NEJM Catal. 2021;2(6):CAT.21.0125. doi:10.1056/CAT.21.0125

Leveraging IT Tools to Identify Eligible Patients

ACO Home Care Plus

Hourly

This report uses the 2020 CMS prospective assignment list

Reset | Akron | Avon | Euclid | **Fairview** | Hillcrest | Lutheran | Main Campus | **Marymount** | Medina | South Pointe | Weston | All | My Units

View Report Guide

Primary Plan Patient Type	Bed PCP	Admit Date Date Of Birth	Name (from Epic) Name (if different in ACO list)	EMPI MRN	6 Clicks PT Rec	Has SNF Referral? Attending Physician	High Risk Score HICN
MEDICARE A AND B	FV 5PAV / FV-5PAV-0555-02				14	Yes	31
Inpatient 3.04 days	Lisa A Marsh, MD				Subacute/SNF	ALAHMAD, JALAA	269285151D
MEDICARE A AND B	FV PKTA / FV-PKTA-05				17	No	33
Inpatient 3.13 days	Kelly A Raj, DO				Subacute/SNF	RAJ, KELLY	302446125A
MEDICARE A AND B	MM 3EST / MM-3EST-0307-01				16	No	29
Inpatient 6.21 days	Charles Wu, MD				Subacute/SNF	BRAR, PRABHJOT	275202107D
MEDICARE A AND B	MM 3WST / MM-3WST-0324-01				17	Yes	12
Inpatient 5.29 days	Irina Chteingardt, MD				Subacute/SNF	CHTEINGARDT, IRINA	270265772A
MEDICARE A AND B	MM 4EST / MM-4EST-0401-01				18	Yes	28
Inpatient 5.21 days	Avi S Marocco, MD				Subacute/SNF	MAROCCO, AVI	285287142A

Adapted from John Crisafi

We partnered with ITD and Analytics to identify appropriate patients each day and flag them for our clinical teams to make it easy to identify patients who are both definitely and potentially eligible for the program

Early Hospital Implementation

- **Engagement with key clinical stakeholders**
  - Care Management, Therapy, Clinicians, Home Care, ITD
  - Education and Bidirectional communication (PDSA)
- **Engagement with patients**
  - Patient-facing communication about intervention
- **Gradual scaling to regional hospitals**
  - Contracting with additional custodial care vendor locations

Evaluation Objectives

- Primary: Examine functional status at PAC discharge for patients in HCP versus a SNF.
- Secondary: Compare…
  - hospital length of stay
  - 30-day readmission

Adjusted Outcomes

	SNF (N=774)	HCP (N=139)	Δ (HCP vs SNF)
Adjusted last AM-PAC mobility score, mean (95% CI)	48.9 (48.3-49.4)	55.0 (53.9-56.2)	6.3 (5.1-7.6)
Adjusted hospital LOS (days), mean (95% CI)	7.3 (7.0-7.6)	6.7 (6.0-7.4)	-0.6 (-1.4-0.1)
30-day readmission, odds (95% CI)	1.16 (1.13-1.19)	1.17 (1.11-1.24)	1.02 (0.95-1.08)

Lessons Learned

- The model is feasible with collaboration
- Outcomes are promising
- Fidelity influenced by internal & external drivers
- Continue to iterate

Cleveland Clinic

Every life deserves world class care.

Elevated Care at Home

At home care providing a SNF alternative, and an early discharge track from the hospital

Dr. Emily Downing, System Clinical Officer Population Health and Continuing Care

Allina Health

Who are we serving in Elevated Care at Home?

- Patient with medical complexity beyond the scope of traditional skilled home health
- **Minimum** threshold of meeting Skilled Nursing Facility criteria for skilled nursing care:

  - High medical complexity and risk (often fills gaps in medical complexity needs of either skilled nursing facility care or home health)

  - High functional status

  - Strive to support earlier discharge from the hospital due to enhanced clinical capabilities

Elevated Care at Home vs. SNF vs. Home Health- Patient qualification

Home Health

- Skilled qualification required for PT, skilled nursing, or speech therapy, not typically on a daily + frequency
- Stable clinical condition, may have high chronic medical complexity, anticipated straightforward care plan in place
- Homebound status

Elevated Care at Home (SNF alternative)

- Medical complexity meeting skilled nursing needs- minimum daily
- Unstable clinical condition
  - Medical Plan of care anticipated to change
  - Functional mobility at Min- mod assist of 1 or less with caregiver
- May or may not meet Skilled nursing facility criteria based on functional status and Physical rehabilitation needs
- Meets skilled nursing criteria based on either
  - direct daily skilled care provision (ex. IV abx, wound cares)
  - Management and Evaluation of Care Plan (30.2.3.1)
  - 30.2.3.2 - Observation and Assessment of Patient's Condition (30.2.3.2)

SNF

- Functional complexity +/- medical complexity meeting skilled criteria for daily requirement
- Functional mobility with max assist of 1 or more

30.7 determination

Elevated Care at Home– Model of Care

- Community Paramedic transition visit
- Daily nurse or Community paramedic visits for the first 3 days of the episode
- Daily, and urgent tele-provider visits from physicians or nurse practitioners
- Urgent visits from community paramedics, nurses
- Same day set up and 24/7 Biometric monitoring with alerts and rounding; minimum twice daily
- 24/7 centralized nursing access and provider coverage
- Ancillary services: DME/oxygen, lab, imaging, respiratory therapy, and pharmacy support
- Physical therapy, occupational therapy, speech therapy, and social work as indicated

Elevated Care at Home Patient Demographics

n	2029
Age (mean (sd))	65.09 (14.59)
Sex (n(%))	
Female	962 (47.4)
Male	1067 (52.6)
Language (n(%))	
English	1860 (91.7)
Other	169 (8.3)
Patient declined/missing	0 (0.0)
Race (n(%))	
African American or Black	199 (9.8)
White	1672 (82.4)
Other	116 (5.7)
Patient declined/unknown/missing	42 (2.1)
Ethnicity (n(%))	
Hispanic/Latino	119 (5.9)
Not Hispanic/Latino	1880 (92.7)
Declined/Unknown	30 (1.5)
Payer source (n(%))	
Medicare	1066 (52.5)
Medical Assistance	280 (13.8)
Private	667 (32.9)
Missing/Uninsured/Other/Declined)	16 (0.8)

Hospital ALOS (mean (SD))	8.20 (7.20)
Oxygen requirements (n (%))	1216 (59.9)
Readmission risk LACE + (mean (SD))	63.05 (12.31)
APR-DRG SOI (n (%))	
None (0)	0 (0.0)
Minor (1)	65 (3.2)
Moderate (2)	188 (9.3)
Major (3)	740 (36.5)
Extreme (4)	1036 (51.1)
APR-DRG ROM (n (%))	
None (0)	0 (0.0)
Minor (1)	124 (6.1)
Moderate (2)	205 (10.1)
Major (3)	635 (31.3)
Extreme (4)	1065 (52.5)
Sit to Stand (n (%))	
No hands on assistance needed (0-1)	1355 (66.8)
Hands on asssistance needed (2-3)	88 (4.3)
Total Assistance (4)	7 (0.3)
Not reported	579 (28.5)

*May 2020- January 2022

Elevated Care at Home Episodic Care

Patient Served	5200	*May 2020- October 2023*
Average Episode Duration	4.5 Days	**Most patients continue with Home Health skilled nursing at time of discharge*
Patient Experience	NPS 85	
30 day readmission rate	18.9%	**May 2022- January 2022*
30 day mortality rate	2.8%	**May 2022- January 2022*

Questions?

SNF at Home/Post-Acute Care at Home

November 2023

Swetha Gudibanda MD
Medical director HRC/ HaH
Marshfield Clinic Health system Center, Marshfield

Marshfield Clinic Health System

Marshfield Clinic and Contessa Have Partnered to Offer Home Recovery Care /Hospital at home model

Marshfield & Contessa launched Home Recovery Care in 2016 and have demonstrated significant outcomes. We have four different admitting models.

September 2019,we launched our SNF at home model.

Services Covered Under PACH (Post Acute Care at Home)

Care Delivery Team

- Nurses
- Therapists (PT/OT/ST)
- Pharmacists
- Personal Care Aides
- Virtual Doctors
- Pharmacy courier services
- Virtual care coordinators
- Social Worker
- Recovery Care Coordinator

Care Services Provided

- Around the clock skilled nursing care
- Around the clock home health aides/non-licensed caregiver support (if necessary)
- Virtual care from program MD
- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Social work support
- Labs
- Diagnostic Imaging (Ultrasounds, EKGs, X-rays, ECHO,Dopplers)
- Echocardiograms
- Arrangement of visits with subspecialists
- Supplemental oxygen up to 4 liters per NC
- Established CPAP/BiPAP patients
- Respiratory treatments
- IV Diuretics
- IV antibiotics (continuous and intermittent)
- IV fluids
- PD/HD patients with established treatment plan
- Wound care + wound VACS
- Intermittent catheterizations
- PICC & Mid lines

HRC's Modernized Approach to Care Delivery

Outcomes for Marshfield's PACH/SNF at home Model

QUALITY METRICS

0%	<11%	90%	100%
COMPLICATIONS OF CARE	ACUTE PHASE HOSPITALIZATIONS	PATIENT SATIFACTON	MEDICATION RECONCILIATION

OPERATIONAL METRICS

91%	100%
ACCEPTANCE RATE	TRANSITION TO HEALTH PLAN

Benefits of HRC Post-Acute Program:

- Improved quality outcomes
- Better patient and provider experience
- Decreased mortality, morbidity rates, falls, and infection rates

Clinical Outcomes in Post-Acute at Home:

25%

Reduction in 60-Day Readmissions[(1)]

(1): Mount Sinai CMMI Demonstration results: 91% acceptance rate, 27% reduction in 30-Day readmissions, 15 day average LOS.

Clinical Eligibility Guidelines for Post Acute Care at Home (PACH)

All conditions where patients can be treated safely at home, that require post-acute rehabilitation and would otherwise be appropriate for SNF level care

Illustrative Clinical Guidelines

- Adequate home support and is not a resident of a SNF
- Must meet utilization criteria for an SNF placement for SHP
- Non-ventilator dependent

. Absence of additional significant clinical factors not described above as determined by the treating physician

- Home safety (firearms, drug use, smoking & oxygen use) Proper utilities to support home care

Examples of Potential Patients

- Myocardial Infraction
- Sepsis
- Stroke
- Surgical Procedures
- Trauma

Top DRGs *Currently* Treated in PACH

Surgical	39%	Sepsis	6%
Pneumonia	11%	COPD	6%

HRC's Post-Acute Model Provides SNF-Equivalent Services to Patients Post-Hospitalization

15-20 days

40-45 days

ADMISSION (Following Hospital Discharge)	ACUTE PHASE (Patient's Home)	MONITORING (Patient's Home & Clinic)
Referring Provider (Hospitalist) • Initial treatment / triage **Inpatient Social Worker** • Patient referral to Pre-Auth Coordinator & RCC **Pre-Auth Coordinator** • Determines pt. meets SNF criteria	**Acute Care RN & Therapy** • Visits and treats patient daily • Performs clinical services as necessary (i.e. labs, imaging, infusion, and DME)	**Traditional PAC Services** • Home health/ nurses visits • PT / ST / OT **PCP/ Specialist** • In-person follow-up appointments and also arrange for tele video f/u apts
CONTESSA RECOVERY CARE COORDINATOR (RCC)		
• RCC located in the hospital • Identifies program patient's insurance and clinical eligibility • Conducts health & home assessment survey	• Oversees and coordinates care team • Monitors biometric data and care plan adherence (telehealth tablet) • Arranges clinical services as necessary (i.e. labs, imaging, infusion, and DME) • Submits "discharge" summary and final therapy assessment to care team	• Oversees and coordinates care team • Monitors biometric data and care plan adherence (telehealth tablet) • Executes the care plan (appointments, treatments) • Identifies gaps in care Social Worker • Connects patient and caregivers with community resources
Admitting Provider (HRC MD) • Completes admission note • Obtains patient's consent • Admission orders	**Admitting Provider (HRC MD)** • Rounds weekly "virtually" on the patient while acute care RN is in the home	**Health Plan Care Manager** • Ensures smooth transition of care

Telehealth System Allows Patient and Care Team to Easily Connect

Patients are equipped with a telehealth system allowing them to connect seamlessly with their provider, registered nurse and Recovery Care Coordinator

TELEHEALTH PLATFORM

- **High resolution audio/visual capabilities**
- **Biometric data monitoring** (data is pushed into native EMR)
  - Blood pressure
  - Pulse
  - Pulse oximetry
  - Glucose
  - Weight
- **Virtual stethoscope**
- **Contessa specific assessments**
- **Patient health summary**

VIRTUAL ASSESSMENTS

- **Virtual rounding with Admitting Provider**
  - Acute Care RN in home during rounding
- **RCC coordinates scheduling for patients / providers**
- **24/7 on-call coverage:**
  - Admitting Provider
  - Acute Care RN
  - RCC
- All providers document in native EMR systems
- Telehealth platform data pushed to other provider EMRs (as system capability allows)

Benefits

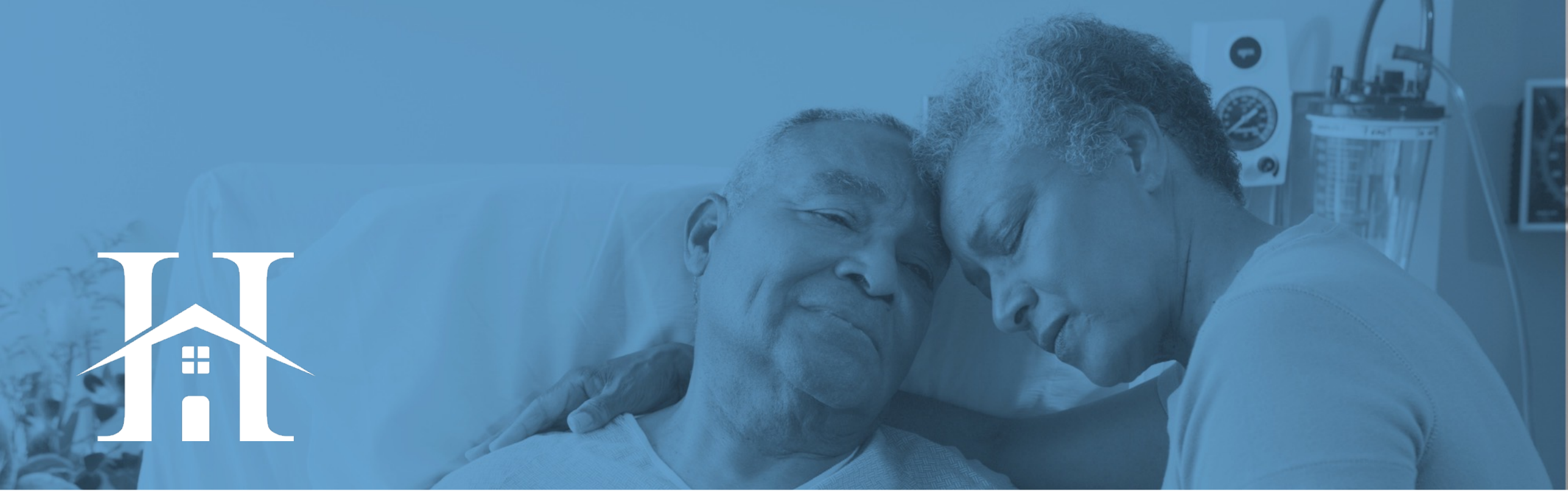
Patients	Hospital/Health Plan	Providers/RN
High Acuity SNF level rehab care at home without contributing towards their Nursing home days.	High Acuity Value based care at reduced costs	Flexibility to providers / nurse work hours
Patients receive all services, under bundle payment	Contracted bundle payment model.	autonomy
	Saves 15-30% reduced cost per episode.	
	Decreased readmission rates Increased patient satisfaction rates.	
	Overcome nursing homes bed and staff shortages	

Challenges

Patients	Health plan	Home health	Technology
Preference for hands-on, in person care by physician	Many health plans don`t offer hospital at home program to their members	Staff shortage - RNs and ancillary staff	Poor access to internet or cellular connectivity
Lack of family support			
Prefer privacy / avoid RNs at home			
Not comfortable with technology			

Thank you

Marshfield Clinic Health System



QUESTIONS

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