Addressing the COVID-19 Pandemic and Beyond: Post-Acute Care

Ascension

NAACOS Webinar
June 18, 2020
1-2 PM

Housekeeping

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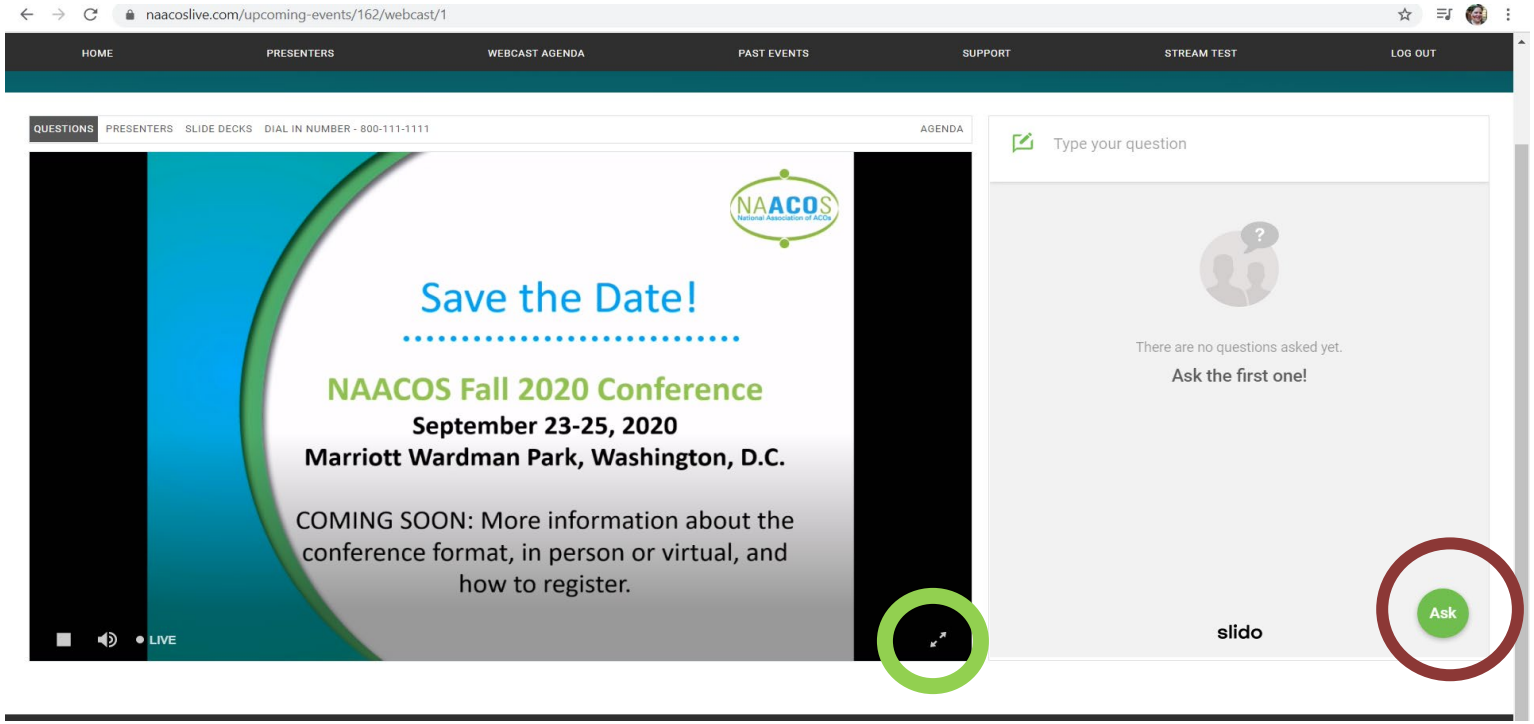

Format

- 60 minute session
- Brief introduction of speakers
- Each speaker will present for 15 minutes
- Questions will be taken after the last speakers finishes

Presentation Order

Tony Reed

Ronda Winans

Andrea Ortman

Panel Chair & Speaker

Tony Reed, Vice President, Population Health Strategic Solutions, Ascension Medical Group

- Vice President of Population Health Strategic Solutions, Clinical & Network services at Ascension Medical Group (AMG) and has responsibility for value-based health care programs and contracts for AMG. He also represents Ascension by serving as a speaker and member for several national organizations dedicated to accountable care and alternate-care payment models. Mr. Reed is on the board of directors for NAACOS and has presented at many conferences including The Leaders Board for Population Health Management, NAACOS conferences, The Hospital and Health System Association of Pennsylvania, xG Health Solutions, Inc and for the Marcus Evans Group. He is in his 23rd year of work in health care industry and his previous roles include, Chief Administrative Officer for the Keystone Accountable Care Organization and AVP of Accountable Care initiatives at Geisinger Health.

Speaker Introductions

Ronda Winans, Director of Continuing Care Clinical Integration, Trinity Health

- Ronda serves as the Director of Continuing Care Clinical Integration for Trinity Health, one of the largest multi-institutional Catholic health care delivery systems in the nation, serving more than 30 million people across 22 states. In this role, she works with Trinity Health's Clinical Integration, Population Health and Care Management national teams and the leaders of our regional Clinically Integrated Networks to develop, integrate and ensure high performance of an effective continuing care network to support success in Alternative Payment Models. In this role, she also collaborates with Trinity Health Continuing Care National Health Ministry to align goals, measure outcomes and close gaps. Ronda excels at identifying and spreading best practices that deliver both clinical and business outcomes across the continuum. After over twenty years in health care, first as a clinician and then progressively through healthcare delivery system management, Ronda knows the clinical drivers of operational success in integration and value-based care. She has assisted Trinity's 16 Clinically Integrated Networks with developing and aligning their high performing SNF networks and in her short time with Trinity Health demonstrated measurable results in reduction of SNF utilization and LOS, resulting in more care in the home and patients returning to home sooner. Ronda holds a clinical MS degree in physical therapy from Grand Valley State University and a MBA in executive management from University of Toledo.

Speaker Introductions

Andrea Ortman, Vice President, Care Management & Post Acute Care
Geisinger Health

- Andrea joined the Geisinger Health Plan in 2011 serving as a Registered Nurse Case Manager with a focus on Post-Acute Care Management. In her role Andrea developed a progressive model of care to manage inpatient post-acute management for approximately 200,000 insured lives. The model included deployment of Registered Nurses and licensed therapists at bedside to evaluate patient progression and manage concurrent review resulting in reduced readmissions and well-managed length of stay for skilled nursing facility, acute inpatient rehabilitation and long-term acute care hospital. In addition to managing the post-acute utilization for Geisinger's integrated health system Andrea has also served as leader of Geisinger's home infusion pharmacy and utilization management for Keystone Accountable Care Organization post-acute services. Currently Andrea serves as the Vice President of Care Management and Post-Acute Care leading both the discharge planning and hospital utilization review teams.

Due to the COVID-19 pandemic, ACOs can benefit from a standardized process for discharging inpatients recovering from COVID-19 and inpatients who have not been infected with the virus to the safe next level of care

Components of Successful Post Acute Discharge Planning

About Ascension

Millions served annually

150,000
Associates

15.1 million
Physician office & clinic visits

2,600+
Sites of care

150
Hospitals

8 MSSP ACOs
194,000+
Attributed lives

645,000
Surgeries

85,000
Births

813,000
Discharges

53
Ascension
Living senior
care sites

9,000
Employed
providers

Ascension

Financials (as of Nov. 2019)

$40 billion
Total
assets

$2 billion
Care of the poor and community benefit

$25.3 billion
Total
operating
revenue

$560 million
Income from recurring
operations

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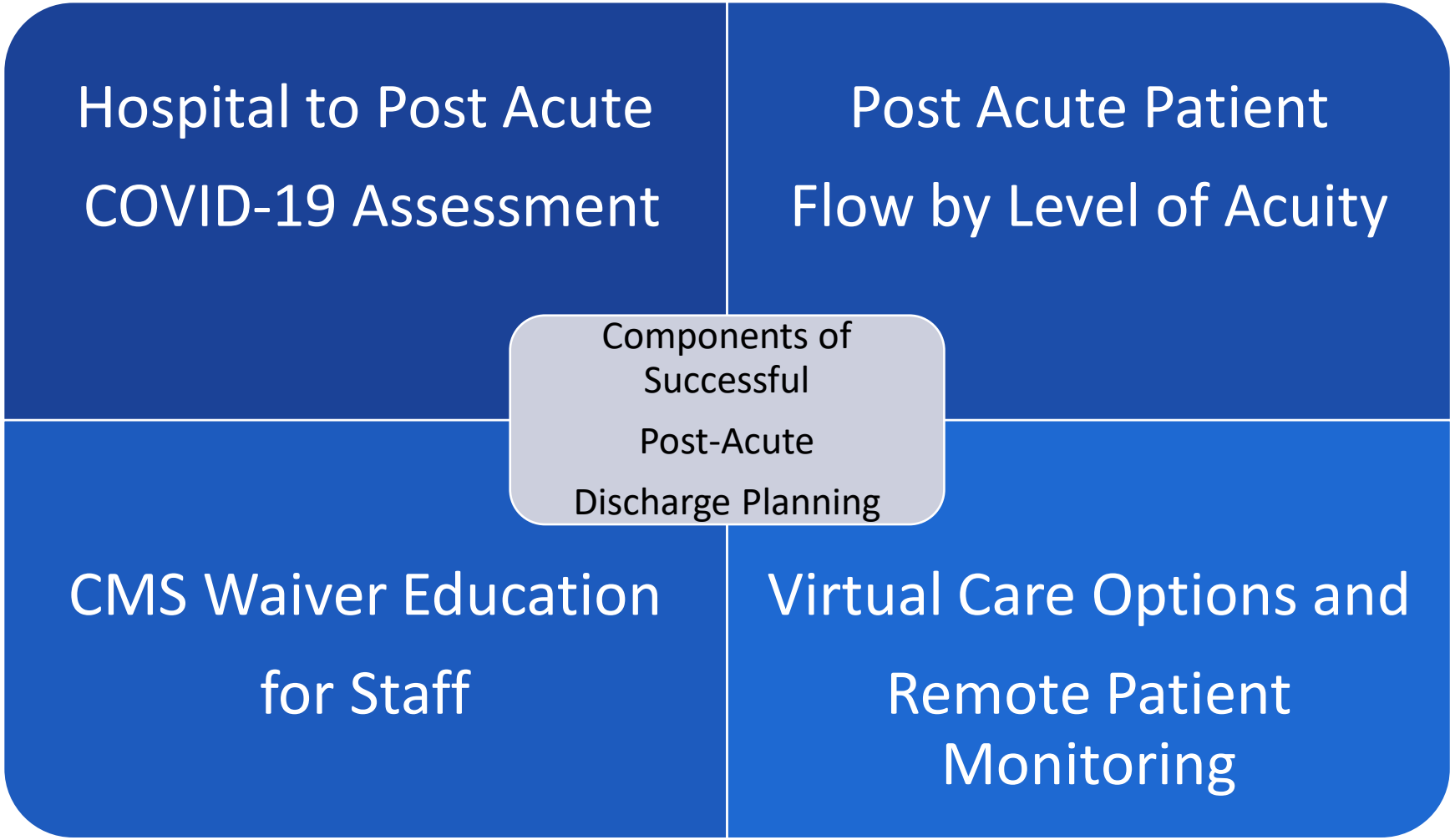

Components of Hospital to Post Acute COVID-19 Assessment

All hospitalized patients should be assessed for COVID -19 whether they presented with COVID-19 or not.

Assessment Components to Consider:

- **Was the patients laboratory tested for COVID-19?**
  - Documented date of test and result
  - What was the indication for testing?
  - In not tested, was patient assessed per CDC testing criteria?
- **Does the patient meet criteria for discontinuation and discharge of isolation requirements for person Under COVID-19 Investigation (PUI) and CDC Guidelines?**
- **Document respiratory history - Has the patient had a fever or Temperature of 100ºF and symptoms of lower respiratory illness (Cough, difficulty breathing, etc)?**
- **Is the assessments signed-off by the physician or the advanced practitioner who completed the post-acute clinical discharge assessment**
- **Assessment results must be communicated to the post acute facility**

Post Acute Patient Flow by Level of Acuity

- Adopt a “Home-First” Mentality
  - If home discharge is not an option follow guidelines to determine scope of services and top condition needs
  - Start from lowest acuity setting and work across settings to the highest acuity setting
    - Home, Home Health, Skilled Nursing, Acute Rehab, Long Term Acute Care Hospital (LTACH)

Post Acute Patient Flow by Level of Acuity

- Establish Post-Acute Admission Criteria using both normal criteria and COVID-19 criteria
  - Home - Patient stable enough for intermittent care, is there a caregiver, are household members low risk for complications from COVID-19, separate recovery area/room to reside without sharing immediate space with others
  - Skilled Nursing Facility – Provider order for skilled nursing, does SNF have separate admission area for COVID+ patients, has SNF confirmed they have adequate PPE and staff to provide care
  - LTACH – Physician written order, can the LTACH be an overflow option for the medical inpatients, can the LTACH perform its on COVID testing

Coronavirus Waivers & Flexibilities

In certain circumstances, the Secretary of the Department of Health and Human Services (HHS) using section 1135 of the Social Security Act (SSA) can temporarily modify or waive certain Medicare, Medicaid, CHIP, or HIPAA requirements, called 1135 waivers. There are different kinds of 1135 waivers, including Medicare blanket waivers. When there's an emergency, sections 1135 or 1812(f) of the SSA allow us to issue blanket waivers to help beneficiaries access care. When a blanket waiver is issued, providers don't have to apply for an individual 1135 waiver. When there's an emergency, we can also offer health care providers other flexibilities to make sure Americans continue to have access to the health care they need.

- # Educate Staff on CMS Waivers
  - Several Waivers have been approved on Medicare Patients with Part A & B
    - Home Health -NP/PA can sign orders, homebound definition expanded to included COVID-19 positive and at risk patients
    - Skilled Nursing - 3 day waiver rule
    - Acute Rehab – allow hospitals with IRF units to relocate patients within IRF's back to acute care
    - LTACH – relaxation of 25 day ALOS calculation to meet the demand of the national emergency

- Home Health Agencies (PDF) UPDATED (5/15/20)
- Physicians and Other Practitioners (PDF) UPDATED (4/30/20)
- Ambulances (PDF) UPDATED (5/15/20)
- Hospitals (PDF) UPDATED (5/15/20)
- Teaching Hospitals, Teaching Physicians and Medical Residents (PDF) UPDATED (5/15/20)
- Long Term Care Facilities (Skilled Nursing Facilities and/or Nursing Facilities) (PDF) UPDATED (5/15/20)
- Hospices (PDF) UPDATED (5/15/20)
- Inpatient Rehabilitation Facilities (PDF) UPDATED (4/30/20)
- Long Term Care Hospitals & Extended Neoplastic Disease Care Hospitals (PDF) UPDATED (4/30/20)
- Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) (PDF) UPDATED (4/30/20)
- Laboratories (PDF) UPDATED (4/30/20)
- End Stage Renal Disease (ESRD) Facilities (PDF) UPDATED (5/15/20)
- Durable Medical Equipment (PDF) UPDATED (4/30/20)
- Participants in the Medicare Diabetes Prevention Program (PDF)-UPDATED (5/14/20)
- Medicare Advantage and Part D Plans (PDF) UPDATED (4/30/20)
- State Medicaid & Basic Health Programs (4/30/20)
- Medicare Shared Savings Program Participants (PDF) (4/30/20)

Addressing the COVID-19 Pandemic and Beyond: Post-Acute Care

Virtual Care and Remote Patient Monitoring

- When the patient's home has been designated as the discharge destination, there are additional tools and capabilities, in addition to traditional in-home nursing, to help monitor and treat both recovering COVID-19 patients and non-COVID-19 patients.
  - Scheduled daily virtual visits
  - Urgent/acute virtual visits
  - Telehealth home monitoring equipment (pulse oximetry, blood pressure monitoring, etc)

Thank You

Trinity Health

COVID-19 Post-Acute Care (PAC) Management

Supporting PAC Transfers during the Pandemic

Ronda Winans, MBA, MS, PT
Director of Continuing Care Clinical Integration
Trinity Health

06/18/2020

We Currently Hold $10.4B in APM Cost of Care Accountability for 1.6M People

	Annual Medical Cost	Attributed Lives
Medicare ACOs	**$3.2** Billion	**276,000**
Medicare Advantage	**$1.6** Billion	**166,000**
Bundled Payment for Care Improvement	**$430** Million	**14,700**
Commercial & Medicaid	**$3.8** Billion	**955,000**
PACE / LIFE	**$323** Million	**4,000**
Colleague Health Plan*	**$1.0** Billion	**180,000**

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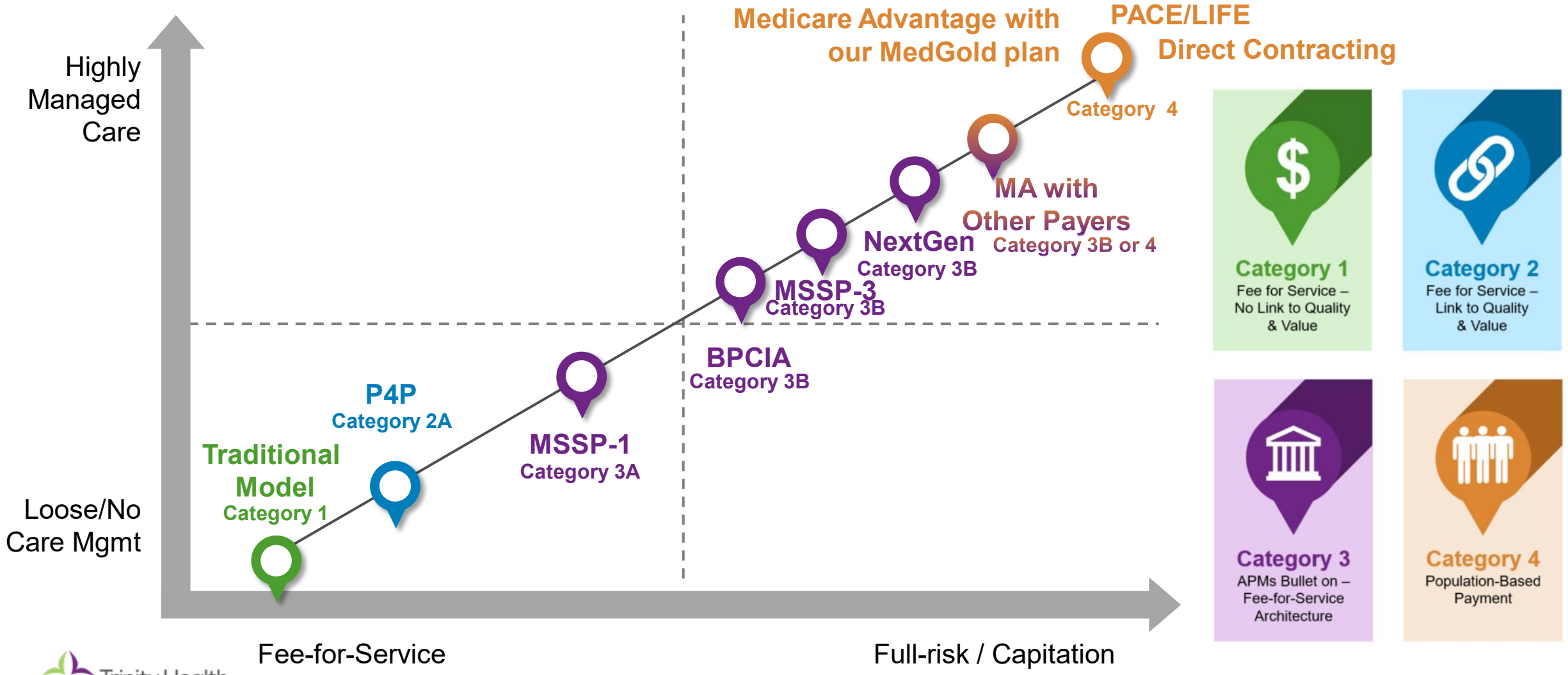
We are Advancing our APM Strategy to Take on Greater Accountability and Create Greater Opportunity



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Key Challenges Faced in Post-Acute Care Transfer Management

- Skilled nursing facility (SNF) acceptance policy; many initially not accepting COVID-19 + discharges
  - 2 consecutive negative COVID-19 tests
  - 14 days post-onset; 3 days fever free
- Long term care and Assisted Living unable to accept own patients back forcing hospital to “house” these patient types longer than expected
- SNF PPE Shortages
- SNF COVID-19 Test Access and delayed turnaround times
- Greater difficulty placing the usual hard to place (COVID + dialysis, COVID + behavioral health, etc.)

COVID-19 Post-Acute Care (PAC) Transition Strategies

Trinity Health

COVID-19 PAC Strategy

- Strategy #1: Assessment of Landscape
- Strategy #2: Senior Leadership & skilled nursing facility (SNF) Weekly Touchbase
- Strategy #3: Logistics team hosting daily call with SNF to coordinate discharges
- Strategy #4: Acute Care
- Strategy #5: Local Public Health Connection

National SNF Providers – COVID-19 PAC Strategy

- Seeking to supplement skilled nursing facility (SNF) access for COVID-19+ admissions where our own Trinity Health SNFs either don’t exist or cannot accommodate
- First step was to evaluate where Trinity Health markets overlap with markets served by national SNF providers
- National SNF Providers reviewed:
  - Life Care Centers
  - HCR ManorCare
  - Genesis HealthCare
  - Sava SeniorCare
  - Ensign Group

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Market Overlap

HCR ManorCare

State	Ministry	# of Hospitals	# of Licensed Beds	HCR Affiliated SNFs within 50 Miles
CA	Saint Agnes	1	436	0
CT	THONE	4	439	0
DE	TH Mid-Atlantic	1	395	16
FL	Holy Cross	1	557	7
GA	St. Mary's	3	297	2
IA	MercyOne Clinton	1	249	3
IA	MercyOne Dubuque	2	307	3
IA	MercyOne North Iowa	2	360	0
IA	MercyOne Sioux City	2	478	1
ID	Saint Alphonsus	2	498	0
IL	Loyola & Mercy Chicago	4	1,448	9
IN	Saint Joseph	2	366	1
MA	THONE	2	382	0
MD	Holy Cross	2	514	12
MI	St. Joseph Mercy	5	1,822	13
MI	Mercy Health	3	716	1
NE	MercyOne Sioux City	1	23	0
NJ	St. Francis	1	238	18
NY	St. Peter's	3	1,014	0
NY	St. Joseph's	1	451	0
OH	MCHS	5	1,496	4
OR	Saint Alphonsus	2	74	0
PA	TH Mid-Atlantic	5	994	20
SD	MercyOne Sioux City	1	38	0
Overlapping Markets in 11 States				
for those states TH has -		37	9,877	110

Genesis HealthCare

State	Ministry	# of Hospitals	# of Licensed Beds	Genesis Affiliated SNFs within 50 Miles
CA	Saint Agnes	1	436	0
CT	THONE	4	439	25
DE	TH Mid-Atlantic	1	395	25
FL	Holy Cross	1	557	0
GA	St. Mary's	3	297	0
IA	MercyOne Clinton	1	249	0
IA	MercyOne Dubuque	2	307	0
IA	MercyOne North Iowa	2	360	0
IA	MercyOne Sioux City	2	478	0
ID	Saint Alphonsus	2	498	4
IL	Loyola & Mercy Chicago	4	1,448	0
IN	Saint Joseph	2	366	0
MA	THONE	2	382	19
MD	Holy Cross	2	514	27
MI	St. Joseph Mercy	5	1,822	0
MI	Mercy Health	3	716	0
NE	MercyOne Sioux City	1	23	0
NJ	St. Francis	1	238	33
NY	St. Peter's	3	1,014	1
NY	St. Joseph's	1	451	0
OH	MCHS	5	1,496	0
OR	Saint Alphonsus	2	74	4
PA	TH Mid-Atlantic	5	994	44
SD	MercyOne Sioux City	1	38	0
Overlapping Markets in 9 States				
for those states TH has -		22	4,548	182

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Drop Teams Strategy

- **Key Issues:**
  - Skilled nursing facilities (SNFs) are often ill-prepared for COVID-19
  - Access to testing can be an issue
  - Residents are transferred to the emergency department for testing or admitted and then the SNF cannot accept the patient back prior to 2 negative tests
- **Covid-19 Drop Team**
  - Offers a proactive approach to support care in congregate facilities preventing wide-spread illness and reducing mortality
  - Ease the burden of public health departments
  - Reduce unnecessary transfers to congested hospitals at or near surge capacity

Drop Teams Strategic Outcomes

- The overall outcomes targeted:
  - SNFs are better prepared for COVID-19+ patients and staff
  - SNFs are better able to engage with public health for rapid deployment of testing
  - SNFs feel well supported by the hospital team and hospital benefits from improved communication and the ability to prepare for surge
  - SNFs feel better prepared for care in place, which could impact hospital transfers and emergency department congestion

Trinity Health

Geisinger Health Post-Acute Transfers

Geisinger

June 2020

Andrea Ortman

VP, Inpatient Care Management and Post-Acute Care

Purpose

- Evaluate PAC transfers to hospital pre-transfer
- Review testing strategy
- Cohorting patients
- Continue to manage utilization – “Home First”

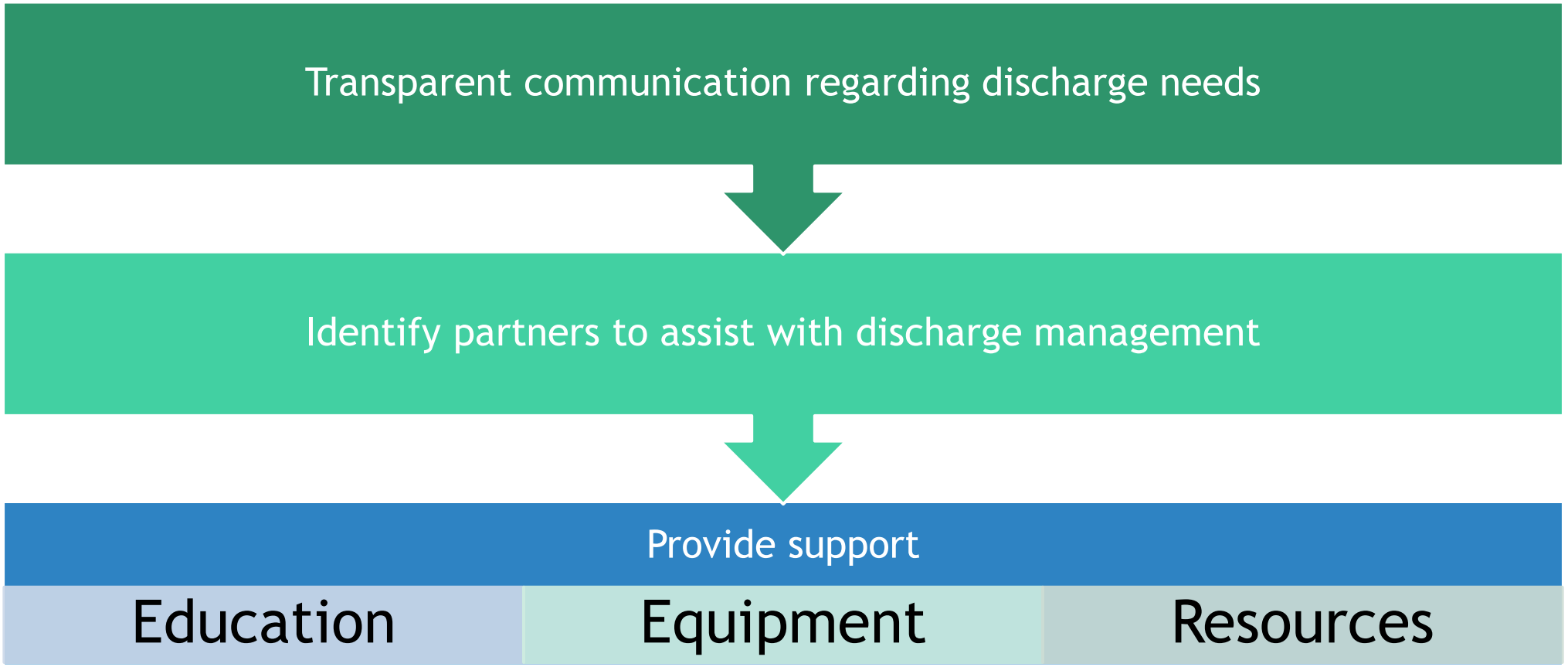
Triage Line

- Provide a central call center to assist skilled nursing facilities in evaluating need for transfer to acute medical center
  - 24/7 Nurse Triage
  - 24/7 Physician Triage
  - Provide recommendations to manage patients in place
  - Manage patient exposure to staff and other consumers for patients requiring additional evaluation

Testing Strategy

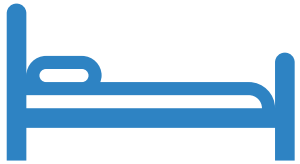
Monitor	Communicate	Assist
Continuously monitor updated guidelines from Center for Disease Control, Hospital Association of Pennsylvania to maintain up to date testing strategy	Communicate testing strategy to Physicians, Care Managers and PAC facilities	Assist facilities with management of testing needs

Cohorting Patients



Mobilize Patients

Nursing is the key!



Start small and work big

Out of bed for meals and daily hygiene activities

Ambulate short trips in the room

Consider use of technology (i.e.; iPads) to facilitate therapy treatements

Q&A

Thank You