HSCRC/PAC/LTC Workgroup

Heather Kirby, Vice President and Chief Population Health Officer

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Long history of collaboration with PAC providers

- Launched a monthly Nursing Home Administrators meeting 28 years ago (SNF/LTC/ALF)
  - Individual facility/owner engagement on targeted projects
- Community primarily served by 8 in-county and 2 out of county facilities
  - At this point it is difficult to drive discharges based on collaboration and facility outcomes as individual facilities have varying degrees of readiness for different patient populations.
- Collaboration efforts have waxed and waned throughout the years; early success included a >25% reduction in SNF readmissions
  - Still perform well on hospital transfers including readmissions however there are clear opportunities for improvement
  - Partnered with Qlarant on a sepsis education project this fall with little to no interest

Current Experience

- Leveraging CTI, TCOC and QBR/Readmission policy as tools to drive collaboration
- Significant decline in SNF transfers during COVID, resulting in higher acuity discharges to Home Health
  - In the past 12 months we have experienced an increase in readmissions from home health
- Hospital LOS increasing for patients discharging to SNF/LTC/PAC settings (50% increase in patients with a LOS > 30 days)
  - Lack of Geri-psych or memory care beds
  - COVID and flu quarantine practices
  - Insurance authorizations
  - Access to bariatric beds/resources
  - Estimate 100+ SNF/LTC beds closed due to staff
  - Staffing challenges and complexity of resident's drive decisions to admit (avoid Friday or weekend admissions)
- Discharges to out of county facilities where we have no relationship or collaborative effort in place increased by 88%
- High turnover in facility staff, including leadership and ownership/operators delays or completely stalls collaboration

Targeted collaboration to improve patient outcomes & achieve strategic priorities

#1 - Levering care teams across the continuum

- Nurse Navigator/educator completes a “tuck-in” call 24 hours after facility admission to address any concerns or issues
- Heart Failure & Sepsis clinical protocols developed and integrated across the continuum
- Pharmacist providing medication reconciliation upon admission to SNF
- On site education to staff focused on early identification/warning signs of sepsis, infection prevention, advanced care planning, importance of complete and up to date MOLST, etc.
- Care management teams embedded in the primary care practices assist in securing follow up appointments with primary care upon discharge to home.
- Hospitalist service embedded SNFist in 3 local facilities; introduction to Five Star Physician Services 2015
- LTC COVID grant provided funding to:
  - Purchase I-pads, rolling carts and secure technology to launch tele-health visits with providers, including Frederick Health’s geriatric and supportive care team
  - 24/7 telehealth access to a Frederick Health provider to triage for treat in place prior to transfer
  - NPs rounding daily in facilities
  - Engage with the Maryland Patient Safety Centers “Clean Collaborative”

Targeted Collaboration to improve patient outcomes and achieve strategic priorities

#2 - Developing a quality driven preferred provider network

- Spent months with facility leaders developing the dashboard
- All facilities signed an Agreement with Frederick Health committing to completing the dashboard as designed w/understanding the dashboard would be used to develop our preferred provider network
- Difficulty executing due to data collection challenges, turn over, etc.
- Phase two transitioned to standard reporting from Qlarant
- Facilities continued to be challenged to operationalize data driven improvement efforts.
- Convened meetings with CRISP to encourage enrollment (engagement with CRISP included on the performance dashboard)

Targeted Collaboration to improve patient outcomes & achieve strategic priorities

#3 – Leveraging additional system resources to increase collaboration

- Reduce unnecessary hospital transfers at the end of life
  - 26 patients transferred to the hospital from SNF, expired within 24 hours.
  - Negative experience for patients and unfavorable impact on hospital mortality
- Launched a home-based primary service to ensure complex discharges to home health either from the hospital or from the facility have access to home-based primary care if needed.
- Transitioning to a partner who offers a comprehensive home based-primary care service positioned to scale the practice

Considerations/Opportunities

- Fundamentally agree with the concept of increasing accountability of SNFs/PACs in improving patient outcomes and reducing unnecessary cost, however:
  - Important to avoid any model that will increase the likely of SNF's cherry picking patients, as hospitals are already incredibly challenged to secure PAC placements for clinically and behaviorally complex patients.
  - Facilities who accept the most complex/challenging patients appear to be experiencing the most significant operational challenges however are the facilities most in need of additional resources to appropriately care for the residents they serve.
- Policy or Regulatory opportunities to consider:
  - Choose Home Act – provides patients the option to recover at home, with additional services versus going to a SNF
    - SNF benefit eligible
    - Traditional HH benefits + 30 coverage of expanded services to include: transportation, meals, medications, telehealth services and personal care services
  - Missed opportunity for appropriate hospice utilization due to room and board coverage
    - Reduce unnecessary hospital transfers and expensive, non-value add care at the end of life
    - Readmission rate for hospice < 1%

Expanding our efforts

- Continue efforts to drive facility specific improvements:
  - Working with Autumn Lake to integrate hospice team into the facilities
- Exploring pilot with Point Click Care to use clinical data from the EMR to identify early warning signs and improve outcomes
- Potential contract with local facility to provide a "direct bed" path to PAC from the community or emergency department
- Continue to partner with home health on providing wrap around services or additional resources to support patients who are appropriate for SNF, however choose to return home
  - Team huddle after admission to proactively address red flags
  - Private duty
  - Meals on Wheels/Moms Meals

Thank you for your time…