



# Hospital Without Walls: New Opportunities for CBOs

A webinar in partnership with the Administration for Community Living, consultant Tim McNeill and the Council on Aging of Southwestern Ohio.

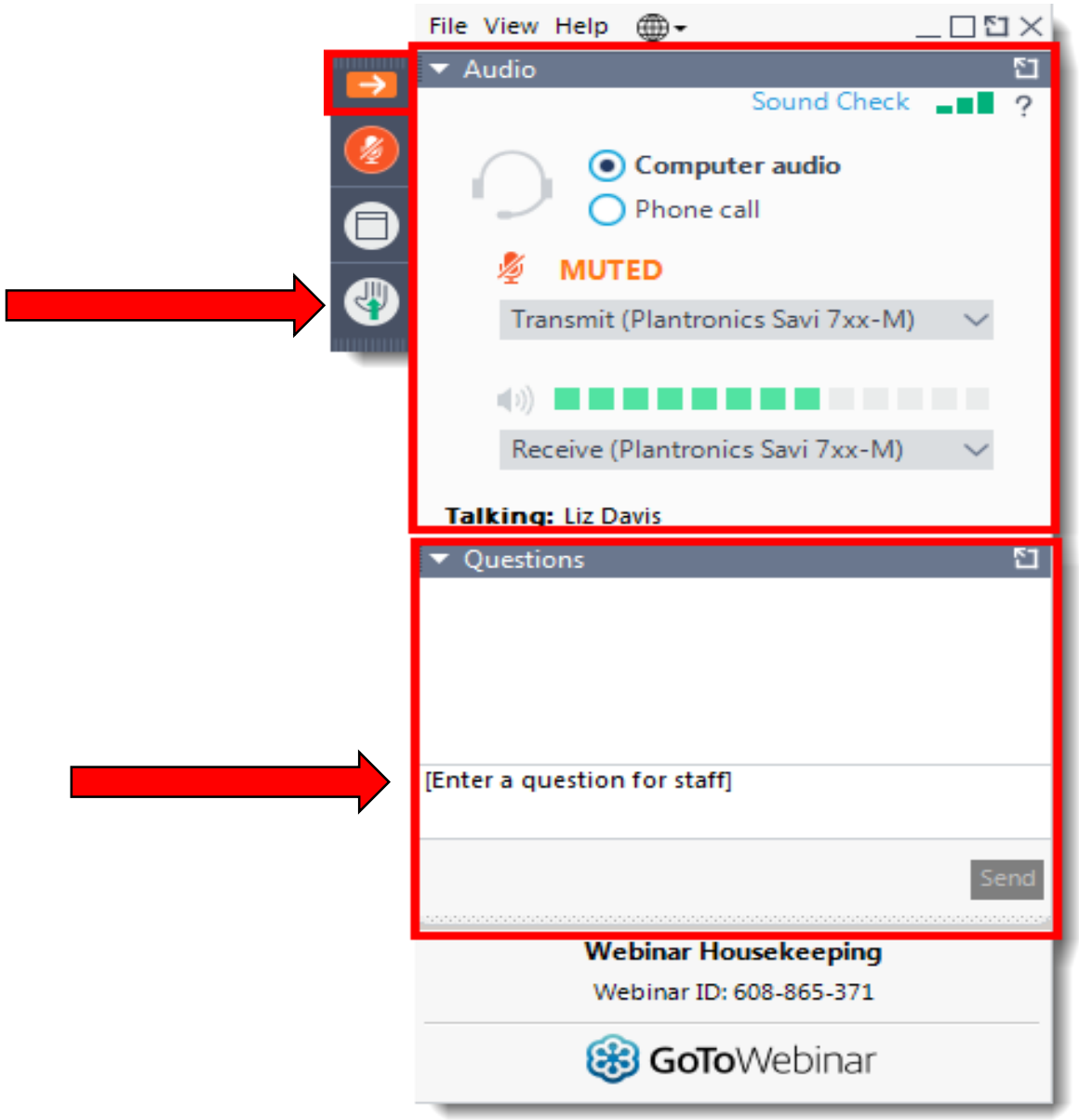
April 16, 2020

# Agenda

- Introductions and housekeeping
- Framing the opportunity
- Details about Hospitals without Walls and opportunities for Community-Based Organizations (CBOs)s
- Area Agency on Aging (AAA) experiences with Hospital without Walls
- Q&A

# Webinar Instructions

- **Audio options**
  - Use your computer speakers, **OR**
  - Dial in to the conference call
  - All participants are muted
- **"Questions" box**
  - Q&A session will be at the **end** of the presentation, but feel free to submit your questions at any time during the presentation. Click on the dropdown arrow icon " ▼ " to pop out the questions box where you can type and submit your questions.



# Webinar Instructions

**Handouts**

- Handouts can be downloaded from the bar located below the Questions bar
- Click the arrow to expand the handouts section
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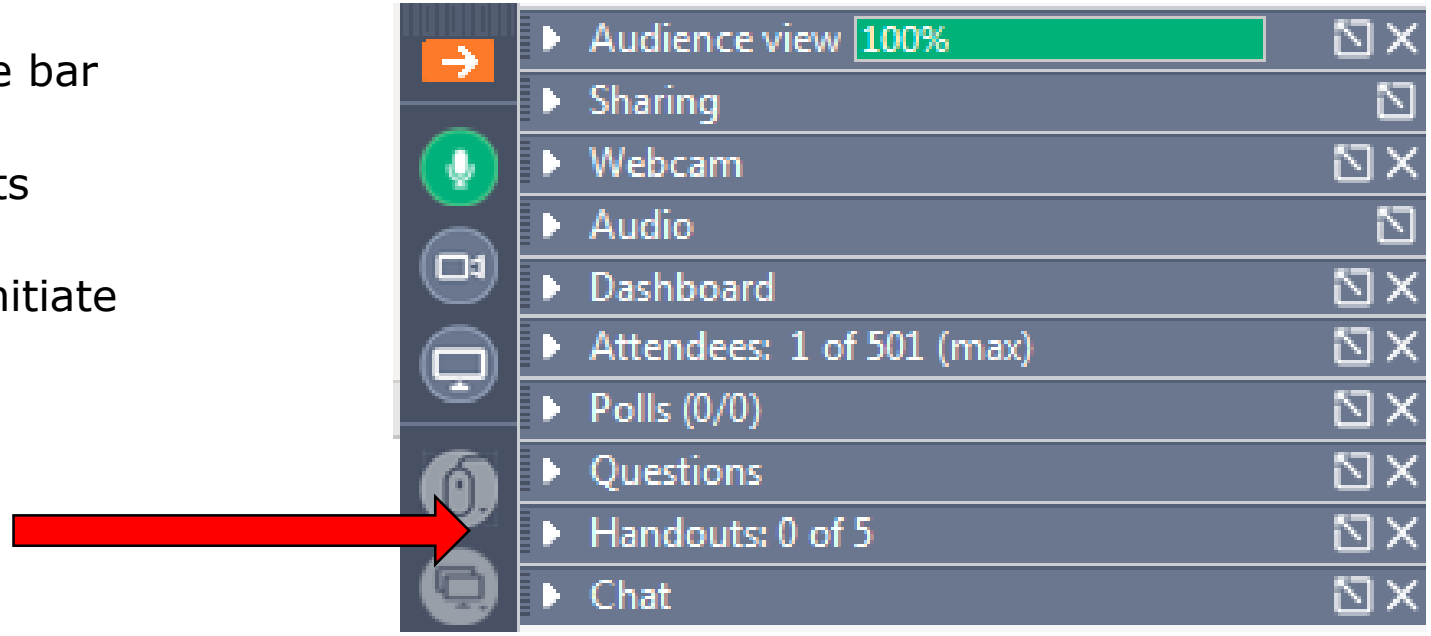


# Speakers

**Kelly Cronin**
Deputy Administrator,
Center for Innovation and Partnership
U.S. Administration for Community Living

**Tim McNeill**, RN, MPH
Consultant,
U.S. Administration for Community Living

**Suzanne Burke**
President and CEO
Council on Aging of Southwestern Ohio (COA)

**Ken D. Wilson**
Vice President of Program Operations
Council on Aging of Southwestern Ohio (COA)

# FRAMING THE OPPORTUNITY

**Kelly Cronin**
Deputy Administrator, Center for Innovation and Partnership
U.S. Administration for Community Living

# COVID-19 Flexibilities under the Public Health Emergency Declaration

## Opportunities for CBOs

1. Public Health Emergency Declaration
2. Impact of the Crisis on High-Risk Pop.
3. Hospital Without Walls Initiative/ Expanded Telehealth
4. Experience from the Field

# POLL QUESTION # 1

Which of the following responses best describes your organization?

- Area Agency on Aging
- Center For Independent Living
- UCEDD
- Protection and Advocacy System
- Non-profit community-based organization
- Other (please enter in the chat)

# Public Health Emergency Declaration

- March 13, 2020:  President Trump declared a national emergency related to COVID-19
- Secretary Alex M. Azar II, Secretary of Health and Human Services, issued a Public Health Emergency pursuant to section 319 of the Public Health Service Act, as a result of confirmed cases of 2019 Novel Coronavirus (2019-nCoV)
  - Available: https://www.phe.gov/emergency/news/healthactions/phe/Pages/2019-nCoV.aspx
- CMS issued a series of COVID-19 Blanket Waivers, last updated 04/15/2020
  - Available:  https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

# HHS Issues Blanket Waivers

- All Blanket Waivers are Retroactive to March 1, 2020
  - Blanket Waivers are in effect through the end of the emergency declaration
  - Broad Range of Waivers that impact several aspects of the the healthcare delivery system
- Waivers provide the healthcare system to adjust to the changing needs of the population resulting from the COVID-19 emergency
  - Waivers apply to services provided to any Medicare or Medicaid beneficiary – regardless of a COVID-19 diagnosis or potential diagnosis
- Stark and Antikickback Statute Waivers from OIG
- Medicare Advantage and Commercial health plans are encouraged to adopt the same provisions in the Blanket Waivers

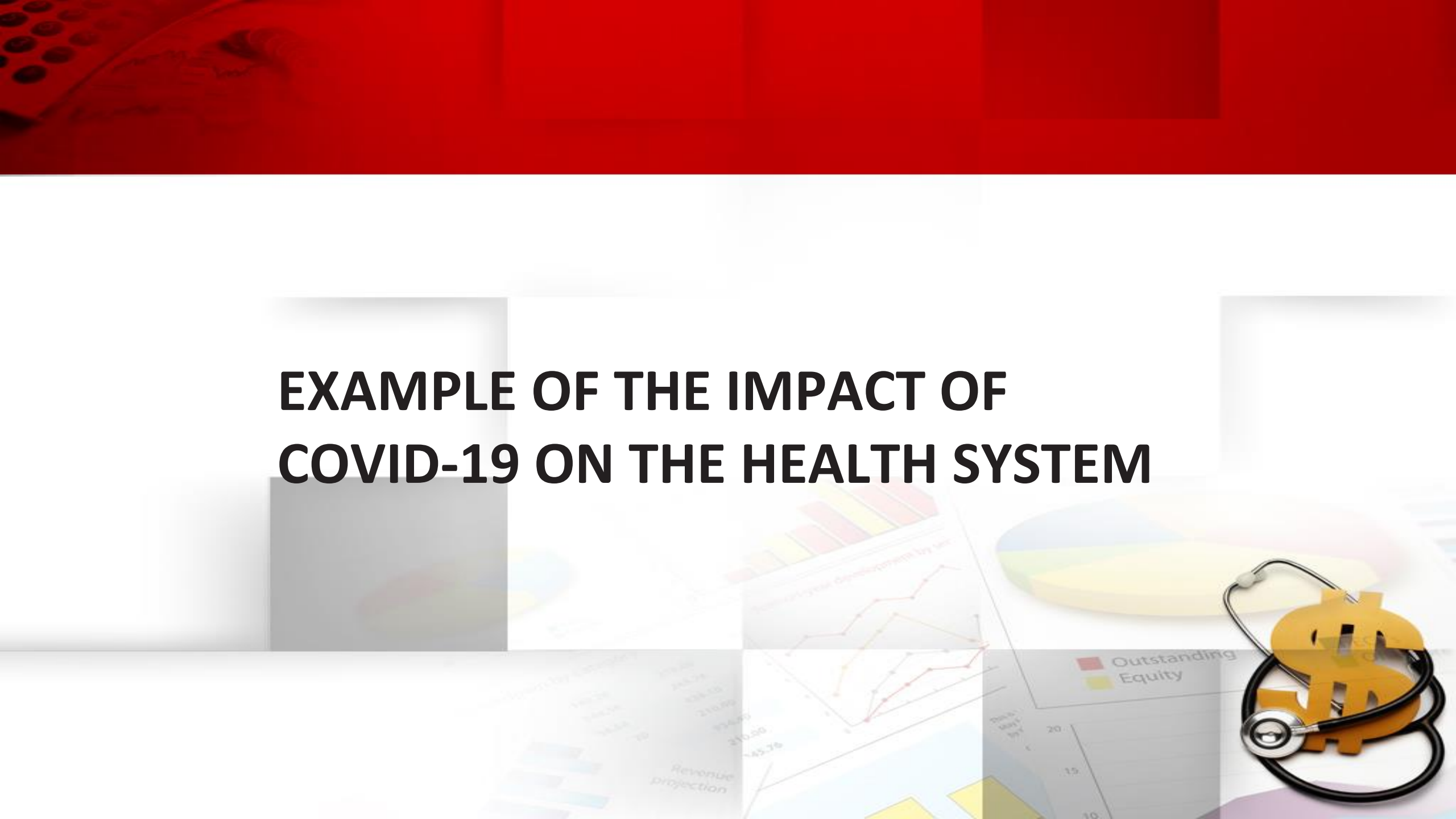
# Select List of Applicable Blanket Waivers

- Emergency Medical Treatment & Labor Act (EMTALA)
  - Hospitals and Critical Access Hospitals can screen patients at a location offsite from the hospital's campus to prevent the spread of COVID-19
- Limited Discharge Planning for Hospitals
  - CMS is waiving requirements and subparts at 42 CFR §482.43(c) related to post-acute services to expedite a safe discharge
  - 3-Day Eligible Stay Waiver for SNF admission
- Flexibility in Patient Self-Determination Act (Advanced Directives)
  - "CMS is waiving this requirement to allow staff to more efficiently deliver care to a larger number of patients."
- Expansion of Telehealth Services
- Expansion of Hospital Services "Hospital Without Walls"

# Potential Impact on the Aging & Disability Networks

- The Aging & Disability Networks provide supports for the highest risk population for COVID-19 mortality
- High-risk populations have limited access to healthcare and may require additional supportive services as the U.S. implements social distancing policies
- Increased instances of social isolation, loneliness, and depression
- Health system demand for increased access to community supportive services, for persons transitioned to a community setting, to support hospital surge capacity
- Limitations on the home-care workforce, as aides and caregivers begin to develop COVID-19 symptoms

# EXAMPLE OF THE IMPACT OF COVID-19 ON THE HEALTH SYSTEM



# Example:  State of Maryland

Maryland.gov

Phone Directory  State Agencies

**Governor Hogan issues**
Stay at Home directive for Maryland

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Maryland

THE OFFICE OF
GOVERNOR LARRY HOGAN

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- Governor Larry Hogan
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- First Lady Yumi Hogan

**Stay Informed**

- COVID-19 Response
- Accountability Session 2020
- Redistricting Reform
- Renewable Energy Task Force
- Governor's Photos
- Intern Leadership Program

## Governor Hogan Activates Statewide Strike Teams for Nursing Homes, Enacts Order to Shut Down Unsafe Facilities

*Tours Field Hospital Site at Baltimore Convention Center*
*Directs Health Department to Provide Racial and Ethnic Breakdowns on COVID-19 Cases*
*Announces Designation of Baltimore-Washington Corridor as Emerging Hotspot by Federal Administration*

**Press Release Archives**

Select Month

# Maryland Governor's Actions to Support Nursing Homes

- "These strike teams will be activated in response to requests from nursing homes, local health departments, and Maryland Department of Health (MDH) infectious disease experts. There will be three types of teams:
  - Testing teams, to identify those in close contact with a confirmed case, and collect and send out specimens for the fastest test available.
  - Assistance teams, to quickly assess the situation on-site, determine equipment and supply needs, and triage residents.
  - Clinical teams, which will include doctors, nurse practitioners, and registered nurses from major hospital systems, tasked with providing on-site medical triage and stabilizing residents."

Available: https://governor.maryland.gov/2020/04/07/governor-hogan-activates-statewide-strike-teams-for-nursing-homes-enacts-order-to-shut-down-unsafe-facilities/

# Potential Impact on the Hospital

- Some hospitals have reported that nursing homes are reluctant to accept patients, unless they have at least two negative COVID-19 tests
  - In some markets, if the hospital cannot secure a test or if there are delays in obtaining results, the patient cannot be transitioned to a post-acute setting
  - Delays in securing discharges causes a reduction in the available beds needed to prepare for a potential surge of patients
- Some Area Agencies on Aging in Maryland have reported record increases in demand for community supportive services
  - MAC, Inc.; Salisbury, MD: "We have received 325 new referrals, in the past two weeks, for community supportive services and shelf-stable meals for patients leaving hospitals". Leigh Ann Eagle

# POLL QUESTION # 2

Have you seen an increase in requests to provide community supportive services to persons transitioning from Hospitals, short-term rehabilitation facilities, or long-term care settings, since the start of the COVID-19 emergency?

What has been the estimated increase in requests or call volume?

- No Increase
- 10%  - 20%
- 21% - 50%
- 51% - 100%
- Greater than double the number of requests (100%+)

# HOSPITAL WITHOUT WALLS INITIATIVE

# Overview

- “CMS is allowing healthcare systems and hospitals to provide services in locations beyond their existing walls to help address the urgent need to expand care capacity and to develop sites dedicated to COVID-19 treatment.”
  - Available: https://www.cms.gov/newsroom/fact-sheets/additional-backgroundsweeping-regulatory-changes-help-us-healthcare-system-address-covid-19-patient
- Hospitals can begin providing hospital level services to beneficiaries in alternative care settings – **While still receiving hospital payments under Medicare.**
- Ambulatory Surgery Centers can contract with hospitals or enroll as hospitals to provide hospital services and bill as hospitals

# Alternative Care Settings

- Hospitals Without Walls allows hospitals to provide hospital-level care in one of the following alternative care settings, depending on approved flexibilities at the State level
  - Hotels
  - Convention Centers
  - Dormitories (i.e., Assisted Living Facilities, Group Homes, etc.)
  - Inpatient Rehabilitation Facilities
  - Ambulatory Surgery Centers
  - Home
    - CMS Special Open Door Forum, April 9, 2020: Additional guidance is being drafted to address questions regarding including the home as an approved location.
    - Transcript of the Open Door Forum available: https://www.cms.gov/Outreach-and-Education/Outreach/OpenDoorForums/PodcastAndTranscripts

# Ambulance Transport

- Ambulances can transport patients to alternative locations for care
  - Physician's offices
  - Urgent care facilities
  - Dialysis treatment facilities
  - Federally Qualified Health Centers
  - Community Mental Health Centers

# Laboratory Specimen Collection

- Medicare will pay laboratory technicians to travel to a beneficiary's home to collect a specimen for COVID-19 testing, eliminating the need for the beneficiary to travel to a healthcare facility for a test and risk exposure to themselves or others.

# Opportunity for the Aging & Disability Networks

- Hospitals that are seeking to expand hospital level services, into community settings, will need to establish models to support the following activities:
  - Telehealth Services
  - Remote Monitoring
  - Room and Board
  - Meal Services
  - Case Management
  - Care Coordination
  - Discharge Planning
  - Transitional Care Management / Care Transitions

# POLL QUESTION # 3

Have you been approached by a health care system to be part of their response to COVID-19?

- Yes, we are working with a hospital.
- Yes, we have been approached.
- No
- Does not apply to me at this time

# EXPANDED TELEHEALTH CAPABILITY

# Telehealth Benefit Expansion

- Telehealth services have been expanded nationwide – including in the beneficiary home
- The number of Telehealth approved services have been expanded to include an additional eighty (80) services
- Eligible Telehealth Providers:
  - Physicians and Non-Physician Practitioners
  - Psychologists
  - Licensed Clinical Social Workers
  - Registered Dietitians
  - Home Health Agencies
  - Hospice Providers

# Select Telehealth Codes Approved Nationwide

| CPT/HCPCS Code | Description | National Rate |
|---|---|---|
| 96156 – 96168 | Health Bhv Assessment/Interv | $99.97 |
| 97802 | Medical Nutrition Therapy Indiv | $38.25/15 minutes |
| 99496 | Transitional Care Management 7 day discharge | $247.94 |
| 99495 | Transitional Care Management 14 day discharge | $187.67 |
| 99497 | Advanced care plan 30 min | $86.98 |
| 99498 | Advanced care plan addl 30 min | $76.15 |
| G0108 – G0109 | Diabetes Self Management Tr. | $57.02/30 minutes |
| G0444 | Depression Screening | $18.41 |
| G0438/G0439 | Annual Wellness Visit | $172.87 - $117.29 |
| 99483 | Assmt & care plan cognitive imp | $265.26 |

# Sample Telehealth Supported Transitional Care Management Model

| CPT/HCPCS Code | Description | National Rate |
|---|---|---|
| 99496 | Transitional Care Management 7 day discharge | $247.94 |
| 99497 | Advanced care plan 30 min | $86.98 |
| G0444 | Depression Screening | $18.41 |
| G0506 | CCM Initial Plan | $63.52 |
| 99490 | Chronic Care Management 20 min | $42.22 |
| G2058 | Chronic Care Management non-complex additional 20 min | $37.89 |
| **Grand Total** | | **$496.96** |

# Policies Supporting the Model

- Chronic Care Management and Transitional Care Management can be billed during the same calendar month, for the same beneficiary, during the same episode of care
  - Effective January 1, 2020
  - Rule change not related to the Public Health Emergency
  - Care Management services can be rendered by a third-party entity under contract with the Medicare Provider operating under General Supervision
- Public Health Emergency allows for Transitional Care Management to be performed via Telehealth Nationwide – Including in the home and alternative care settings.
- Hospital Without Walls enables Hospitals and Physician practices to contract with CBOs to deliver Transitional Care Management, Chronic Care Management, and care coordination services reimbursable through the Medicare program

# Steps to Engagement – Assess the local impact

- Determine if there has been increased demand for supportive services originating from hospitals in your area
- Assess the impact of the COVID-19 emergency on at-risk populations in your area
  - Homebound persons with chronic conditions
  - Assisted Living Facilities
  - Congregate facilities
  - Skilled Nursing Facilities
- Determine if there have been changes in the discharge planning process at local hospitals and challenges with transitions of care

# EXPERIENCE FROM THE FIELD

**Suzanne Burke**
President and CEO
Council on Aging of Southwestern Ohio (COA)

**Ken D. Wilson**
Vice President of Program Operations
Council on Aging of Southwestern Ohio


# COUNCIL ON AGING

INDEPENDENCE. RESOURCES. QUALITY OF LIFE.

COA
Council on Aging

# WHO IS COA?

- State designated “Area Agency on Aging (AAA)” for Southwest Ohio
- Provide care management and home and community based services for over 25,000 individuals in our region
- Over 320 employees
- Budget of approximately $80 million
- Our core functions include:
  - ADRC
  - Care Management
  - Care Transitions
  - Levy Administrator

# WHO IS THE HEALTH COLLABORATIVE

- Nonprofit organization serving as the Greater Cincinnati and Northern Kentucky region's neutral forum for local stakeholders invested in the triple aim.
- Membership includes 30 hospitals and health systems, 150 long-term care facilities, and more than 100 business partners
- HealthBridge, a service line of The Health Collaborative, serves as the region's Health Information Exchange
- One unique component, of many, of The Health Collaborative is to bring together the region's health systems to improve quality through the evaluation of data. They have really done an amazing job of bringing together a group of competitors to improve health outcomes, improve quality and reduce costs.
- During our Community-based Care Transition Program (CCTP) process, they helped convene the health systems and were central to our ability to have our staff credentialed by the various hospitals, have direct access to EPIC, etc.

# BACKGROUND

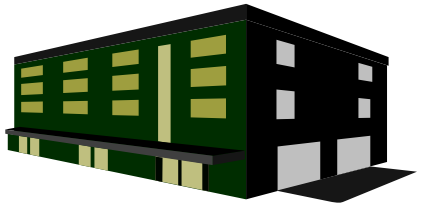
- COA was piloting care transitions with University Hospital in Cincinnati in 2010/2011
- In 2012, COA was awarded the CCTP funding.  COA formed a collaborative including a partnership with the Health Collaborative in Cincinnati as part of its CCTP structure
- The Health Collaborative served as a partner and convener and was able to assist COA in engaging hospital partners for CCTP
- When CCTP funding ended, COA utilized some federal and local funds to create a scaled down version of the CCTP program which we call Fast Track Home.  This program is in place in most of the large hospitals in Cincinnati
- COA is modifying out Fast Track Home model to address the emerging needs as a result of COVID19

# COA PLANNING FOR COVID19

- COA has been making planning preparations for COVID19 since January.
- Immediate priority was to ensure supply chain is available to ensure key services, such as home delivered meals, could be sustained.  Ex:  In anticipation of supply chain issues, COA delivered over 7,500 two week shelf stable meal boxes to all of our home delivered meal clients.
- More recently, our focus shifted to surge planning.  COA decided that we needed to be included in discussions surrounding daily discharge volumes during the surge to effectively plan for both our internal care management duties and our provider network capacity.
- Reached out to the Chief Medical Officer of The Health Collaborative to indicate we needed to be included in the loop for this data.
- He immediately included us into the planning process and a new workgroup to deal with discharge to home was created.

# MANAGING THE ELDERLY COVID19 PATIENT ACROSS SETTINGS - WORKGROUP FOCUS INITIALLY

Hospital



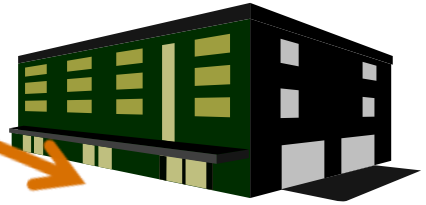
Nursing facility/ rehab

# MANAGING THE ELDERLY COVID19 PATIENT ACROSS SETTINGS - WORKGROUP FOCUS NOW

Hospital

Home

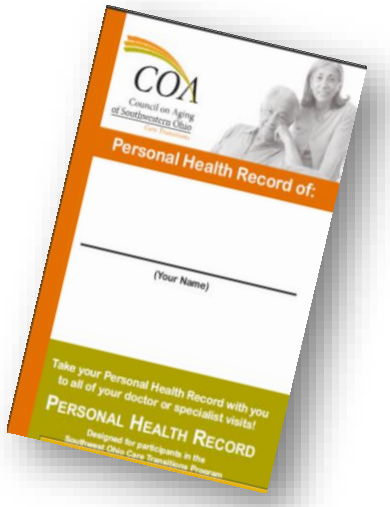
Senior Building



Nursing facility/ rehab

# COA'S FAST TRACK HOME MODEL IS BASED OFF COLEMAN'S FOUR PILLARS

- Medication self-management
- Use of a dynamic, patient-centered record: the Personal Health Record
- Timely primary care/specialty care follow-up
- Knowledge of red flags indicating condition worsening – how to respond
- PLUS fifth pillar of home and community based services



# FASTTRACK HOME (FTH)

- Innovative initiative implemented May 1, 2017 at UC Medical Center, Christ, and Jewish hospitals
- Enrolls seniors into Elderly Services Program (ESP) while in the hospital, combined with evidence-based Care Transitions model
- Services start at discharge and continue for up to 60 days
- Proven results.  COA is a national leader in reducing readmissions per CMS
- Funded with Federal Title III and local levy funding in Clinton and Hamilton Counties

# TRADITIONAL ELDERLY SERVICES PROGRAM SERVICE MODEL

- Call for services after home from hospital
- 2-3 weeks to assess ESP eligibility and set up in-home services
  - Benchmark from call to start of services is 20 days. State Medicaid programs take a couple months
- Result: many hospital patients must first go to a nursing facility.  Many others have readmissions because of difficult transitions home.

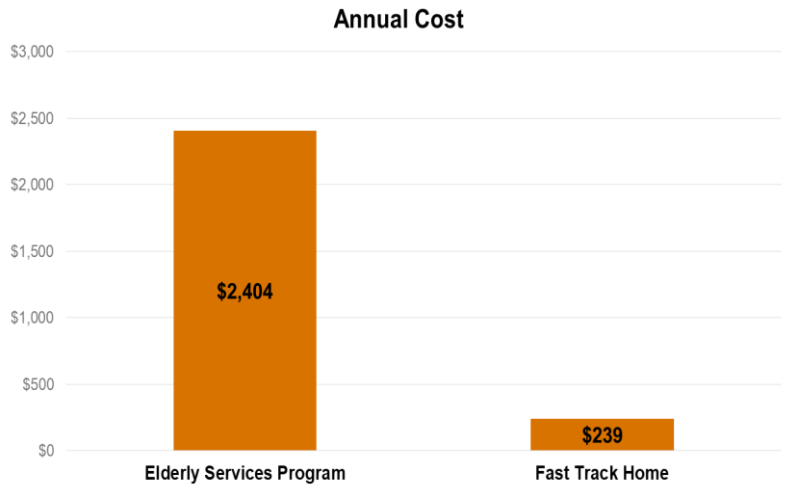
# FASTTRACK HOME PROCESS

- Coach works w/ hospital staff to identify eligible patients
  - Begin Coleman intervention
- Bedside assessment and FTH enrollment
- If needed, at home services arranged prior to discharge
- Coleman intervention coaching continues 3 days post discharge
- Long term services and supports evaluated for ongoing needs.

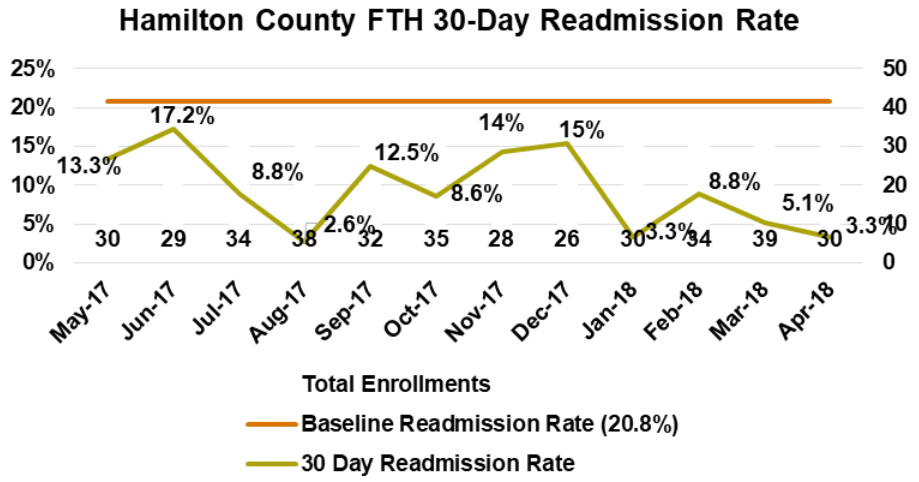
**Hospital assessment**

**In Home Coaching and Services**

# FAST TRACK HOME RESULTS







# BENEFITS

- Brings levy-funded program to more Hamilton County taxpayers – benefits seniors and their caregivers
  - Short term format allows us to serve  more individuals at a lower cost
- Supports COA's mission to help individuals remain independent in their homes and communities (prevents costly nursing home placements)
- Bridges gap between local health care system and home/community-based services
- Achieves Health Care Triple Aim: healthier people, better care, lower costs

# ADAPTING TO COVID19

1. Broadened FTH process to encompass all COA programs
2. Changed referral and coaching model
   - Dropped hospital coaching presence, added intake queue
   - Telephonic coaching protocols
3. Ramped up capacity - shifted staff resources, training and expanded days of operation to 7 days a week
4. Adapted provider capacity and service delivery procedures
   - Developed provider guidance and protocols
   - Expanded Home-Delivered Meals (HDM) availability 7 days a week, therapeutic meals
   - Durable Medical Equipment (DME), homemaking, personal care, Emergency Medical Response System (EMRS), and Transportation

# COUNCIL ON AGING'S
# COVID-19 RESPONSE
## Discharge planning process for hospitals and skilled nursing facilities

Council on Aging (COA) can support patients leaving hospitals and skilled nursing facilities during the COVID-19 surge. COA can provide meals, caregiver support, personal care and homemaking aides, medical transportation and more. See reverse for more details about available services.

**GUIDELINES FOR ELIGIBILITY**

*Note: There is NO income or insurance requirement. Medicaid patients will also be accepted.*

**Age Requirements**

- Butler and Clinton counties: age 65 and older Hamilton and Warren counties: age 60 and older

**Other Requirements:**

- The patient has an upcoming or recent discharge from the hospital or nursing facility.
- The patient does not require 24-hour supervision.
- The patient does not require two-person assist for transfers and supports. The patient is not leaving against medical advice (AMA).
- The patient has challenges with ADLs/IADLs which means they require additional support.

# COUNCIL ON AGING'S
# COVID-19 RESPONSE
## Discharge planning process for hospitals and skilled nursing facilities

**HOW TO MAKE A REFERRAL**

We know it's difficult to plan ahead during these times, but to the greatest extent possible, please complete referrals with as much advance notice as your processes allow -- ideally 24-48 hours in advance. This will give our staff time to set up the patient's required in-home services. However, referrals will be accepted up to 7-days post discharge.

**By Phone:** (513) 618-2313

**By Fax:** Send face sheet to (513) 725-1792

**By Email:** *FastTrack_Home@help4seniors.org*

**Contact your designated Council on Aging hospital liaison**

**Please include the following information with each referral:**

- Discharge planner name, contact information
- Patient name Patient date of birth
- Patient home number Patient discharge address Expected discharge date Insurance information
- Contact person, if different from patient
- Discharge Diagnosis (this could be different from admitting diagnosis)
- COVID-19 testing status: this will impact our service and PPE protocols and is recommended by Ohio Dept of Health (ODH) and Ohio Dept of Medicaid (ODM) in all transitions of care protocols
- Discharge instructions

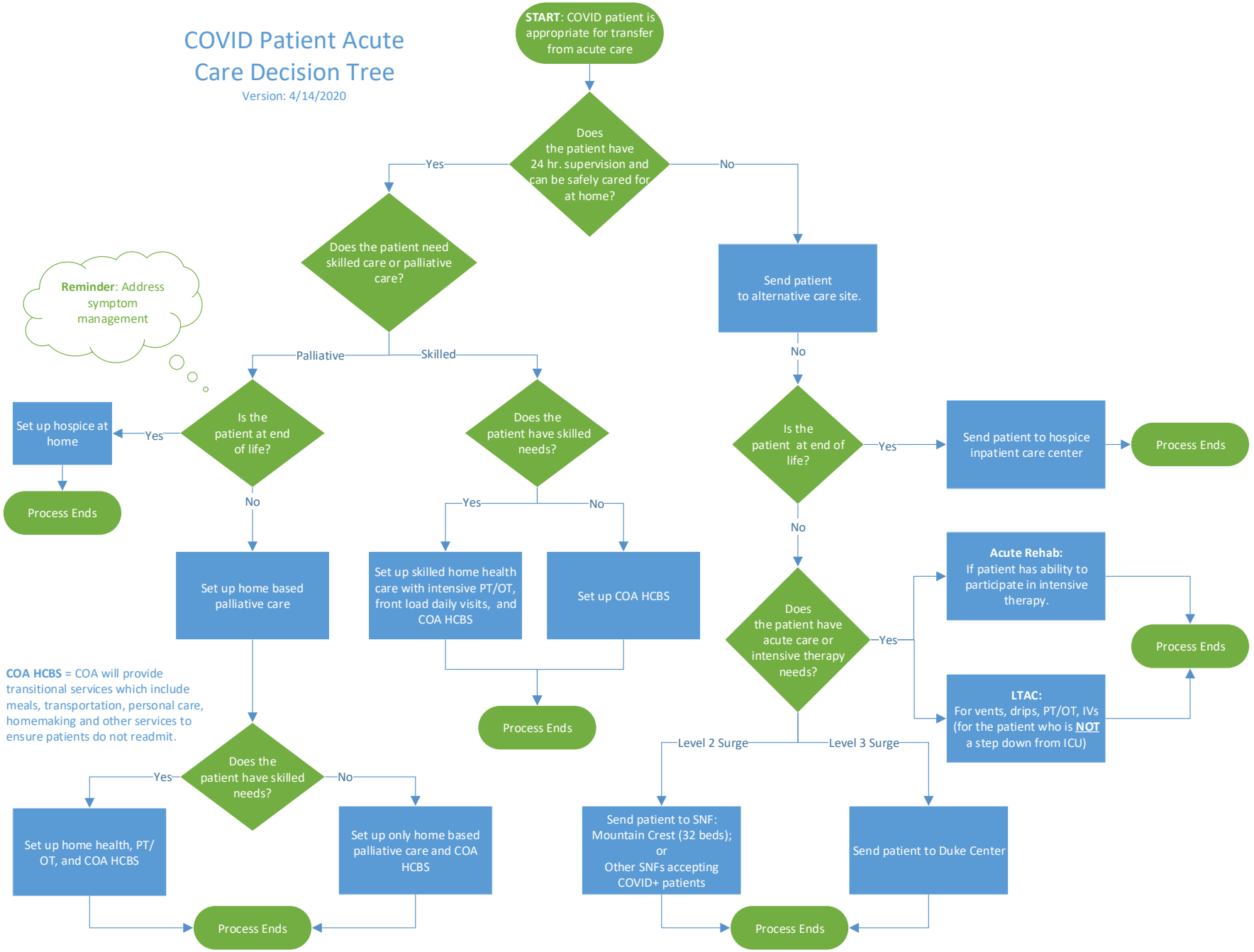
**Services and Supports Available through Council on Aging:**

- Telephonic care management including frequent follow up calls encouraging medication
- management and physician follow up Assessment of patient and caregiver needs
- Instructions and options for using telehealth applications for those patients who have access to an appropriate device
- Home-delivered meals
- Transportation to primary care physician appointments Telephonic caregiver coaching and support
- Durable Medical Equipment that is not covered by insurance
- Electronic Monitoring Systems
- Homemaking and personal care to fill any gaps not covered by caregivers and/or Medicare/Medicaid home health benefits

**Note:** eligibility for each service list above will be determined by a Council on Aging care manager.

# COVID Patient Acute Care Decision Tree

Version: 4/14/2020



# NEXT STEPS WITH SENIOR HOUSING

- Recognizing the unique risks in senior housing buildings & large numbers of at-risk seniors
- Establishing COVID testing protocols with senior buildings
- Resident quarantine and notification
- Service delivery protocols & communication
- Ensuring buildings are following prevention requirements
- Resident and management education
- Food and supply deliveries

# POLL QUESTION # 4

Are you currently partnering with physician offices to bill for care coordination, telehealth or care transitions during COVID-19?

- Yes
- No
- Does not apply to me at this time

# FINAL POLL QUESTION # 5

What topics would be helpful to hear more about on future COVID-19 related business acumen webinars/office hours?

- Scaling to meet demand
- Tele-health care transitions strategies
- Care management services
- Others? (Enter in the chat)

# Questions?