Managing Patients through the Continuum of Care : Catholic Health and Covid-19

Catholic Health
March 10, 2022

Statewide Hospital-Home Care Collaborative for COVID-19 and Beyond

HCA EDUCATION AND RESEARCH

HANYS Always There for Healthcare

IROQUOIS Healthcare Association

Mother Cabrini HEALTH FOUNDATION

Support for this statewide collaborative training is provided through a generous grant from the Mother Cabrini Health Foundation.

Acknowledgement

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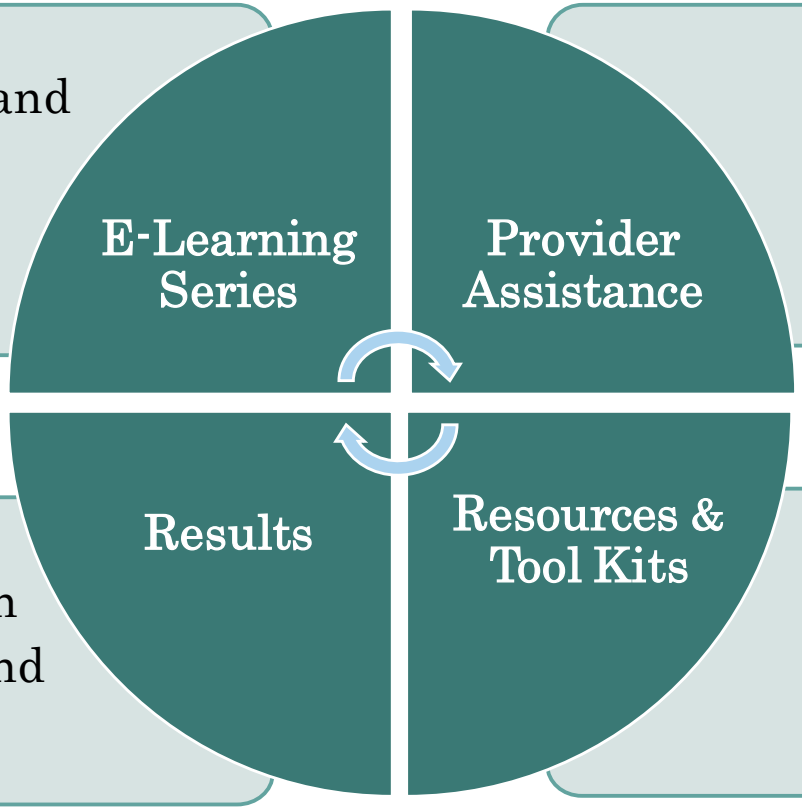
Thank you to the Foundation for its generous support.

Overall Goal and Components of Grant

Creation of a Hospital-Home Care Collaborative to advance statewide systemic collaboration in pre-acute and post-acute care for COVID and beyond.

- Live webinars
- Recorded for on demand access
- Additional recorded technical webinars
- Statewide summit



- Technical
- Operational
- Educational
- Workforce

- Reporting to Cabrini
- State Communication
- Policies needed around new models of collaboration

- Case Studies
- Collaboration Models
- Implementable Tools including Adaptable Blueprints

Catholic Health
&
COVID 19

Managing Patients Through the Continuum of Care

March 10, 2022

Catholic Health
The right way to care.

Catholic Health System

Introductions…

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Vice President of Operations for Long Term Care

Kimberly Peters: kpeters1@chsbuffalo.org

Vice President of Home Care Operations

Catholic Health System

Who We Are…

- A non-profit healthcare system founded in 1998 under religious sponsors in Western New York
- Patient-focused providers and services, dedicated to improving health and wellness in the WNY community
- Hospital system with SNF, primary care centers, imaging centers, home health and other community facilities

Catholic Health System

Who We Are…

Offering a full continuum of health providers, services and facilities across the Western New York region

- Six Hospitals
- Four SNFs (Sub-Acute/LTC)
- Home Care
- Independent and Enriched Living
- Pharmacy
- PACE
- Imagining Centers
- Laboratory Services
- Primary and Specialty Physician Practices
- Outpatient Rehabilitation Services
- Medical Rehabilitation Unit (MRU)

Catholic Health System

Our Mission: *(Why we exist)*

We are called to reveal the healing love of Jesus to all.

Our 2025 Vision: *(What we are striving to do)*

As your trusted partner, inspired by faith and committed to excellence, we lead the transformation of healthcare and create healthier communities.

Our Values: *(What we believe in)*

Reverence, Compassion, Integrity, Innovation, Community, Excellence

Managing Patients through the Care Continuum

Objective:

- Develop system focused care deliver models to manage capacity and deliver the highest quality patient care
- Collaborate across the continuum to manage capacity
- Ensure safe, appropriate discharges and transition patients to the appropriate level of care
- System collaboration and community partnerships to operationalize a COVID care delivery model

Continuum of Care
COVID 19 Collaboration

COVID 19: System Call to Action

- March 2020: COVID Response team to evaluate and manage the COVID impact
- 700+ associates signed up to work on the COVID response team across the continuum
- Drive through testing sites at all of our hospitals to lead the COVID testing initiative
- Utilization of Call Center to rapidly assess all associates with a COVID exposure
- Medical tents outside the Catholic Health ERs to triage patients to the right level of care

COVID 19: System Call to Action

- Purchasing and Supply Chain teams worked to acquire, distribute and conserve necessary PPE
- Conversion of the St. Joe's Campus into a centralized COVID 19 hospital
- Care Management coordinating timely discharges, patient transfers across our hospital sites and post acute care (SNF, Home Care)
- Community partnership to develop the first COVID 19 post acute site
- Development of Community Application

Care Coordination Across the Continuum

- Daily cross continuum huddles to discuss/brainstorm on complex cases
- Level of care hand offs between Care Management, Network Screeners, Liaisons and Site Leadership
- Barriers to level of care transitions reviewed
- Communication to manage capacity surges and promote safe and appropriate transitions of care

Transition to the Community

Community App Telehealth Virtual Program

Population

- COVID patients screened in ED - did not qualify for an acute care stay or for certified home care services

Why?

- Monitor and educate COVID-19 patients to achieve better outcomes

Transition to the Community

Community App Telehealth Virtual Program

Process:

- Information given while in the ED
- CHS Call Center contacted patient to set up app
- Telehealth dept. notified with patients agreeable to program
- RN contacted patient to set up appointments
- Patient completed “survey” through app daily reporting temperature and symptoms
- RN performed 7 virtual visits over a 14 day period for assessment and education
- Any decline in condition---follow up with MD or referred back to ED

Transition to the Community

Community App Telehealth Virtual Program

Outcomes:

- Major payer reimbursed for 7 visits per patient
- Small population agreed to program
- Only 1 admission to acute care

Barriers:

- Data reporting
- Patient “Buy In”
- ED Involvement

COVID Post Acute Care Unit

St. Joseph Post Acute Center (SJPAC)

- COVID–only skilled nursing facility- first of its kind in NYS, and possibly the nation.
- Opened under an 1135 waiver for an alternate care site.
- We leased a near-by vacant 120 bed nursing home.
- Approved for 80 patients, with the site availability for an additional 40-bed unit.
- Operated in partnership with The McGuire Group (TMG)- our Network Partners.

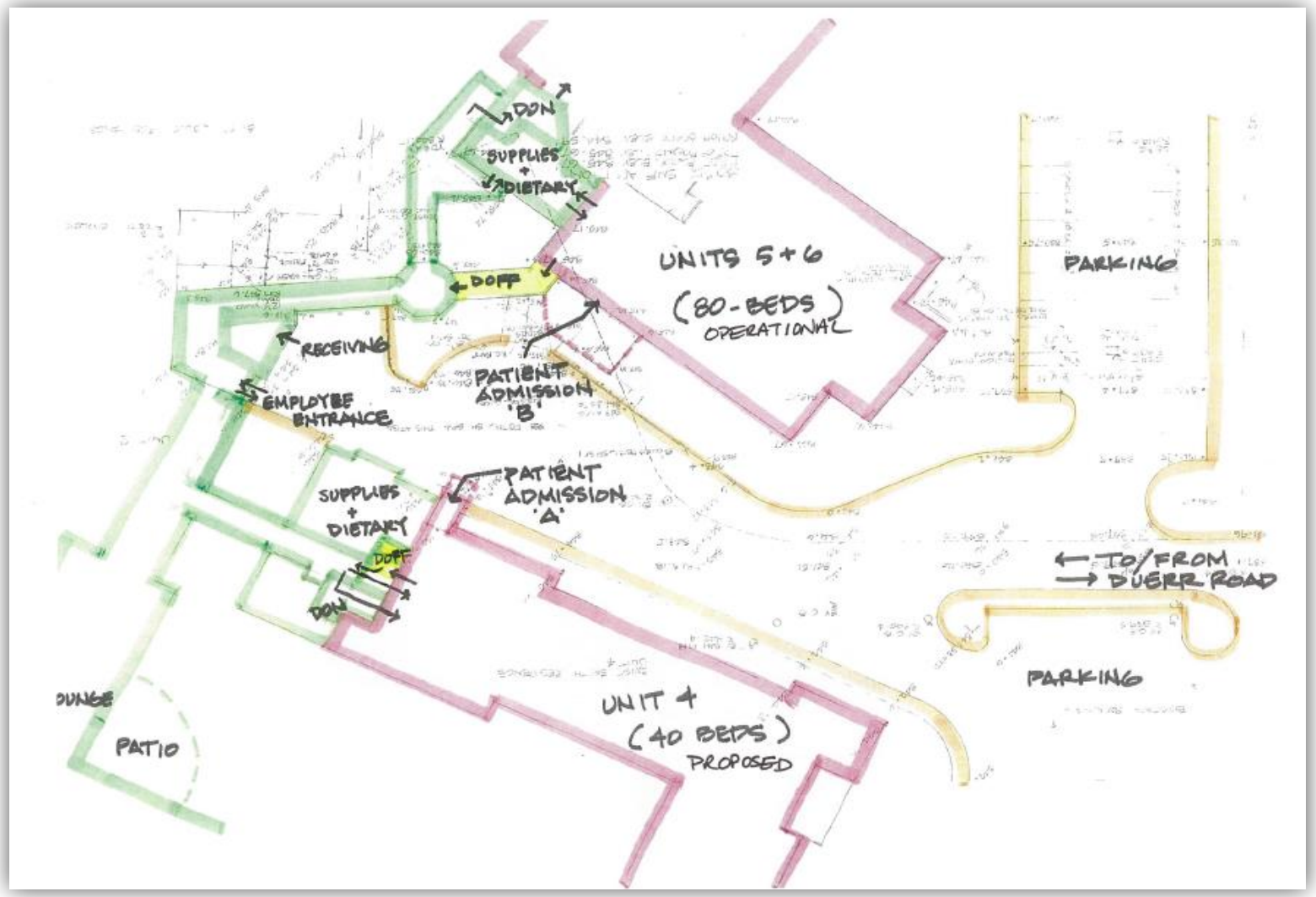
COVID Post Acute Care Unit

- Facility required significant repair work.
- These were expenses CH put forth, with no guarantee of reimbursement, to establish a safe discharge destination.
- From application to approval to opening, work accomplished in an incredible 13 days, during a covid lockdown.

COVID Post Acute Care Unit: Before

COVID Post Acute Care Unit: After

COVID Post Acute Care Unit



COVID Post Acute Care Unit

- Contracted with The McGuire Group for core leadership and clinical staff
- Used a significant amount of agency personnel as well to meet staffing needs
- Meals were prepared offsite as the campus kitchen was not available to this project
- Contracted with area physician practice for Medical Direction and primary medical care

COVID Post Acute Care Unit

- Built out new “units” in Point Click Care for record keeping and billing
- Dedicated Admissions Coordinator & Discharge planner
- Admissions came exclusively from Catholic Health hospitals or CH nursing homes experiencing covid outbreaks

COVID Post Acute Care Unit

- Following 3 months of operation, CH took over facility operations and staffing
- Temporary closure was anticipated in the Fall 2020… and then the next wave hit
- In initial phases, patients required two negative tests to be transferred out to another SAR; most completed their SAR at SJPAC and would be discharged home, with or without home care services as warranted

COVID Post Acute Care Unit

- As COVID treatments evolved, so did our care protocols and length of stay was reduced
- Patients who were transferred from a nursing home were eligible for monoclonal antibody therapy

Transitioning to the Next Level of Care

- New CDC guidance helped with discharge planning an throughput
- Once ready for discharge, patients moved to the next step in the continuum
- Referrals were then made to the next appropriate level

COVID Post Acute Care Unit

- SJPAC discontinued operation on May 13, 2021, having cared for 693 COVID positive patients in need of continued care. Peak daily census was 78 in May 2020 and again in December 2020.

Transition to Home Care

Certified Home Care COVID Program

Population:

- COVID positive patients identified with a skilled need and homebound (if required)

Two Groups:

- Patients who agreed to the COVID Telehealth Program
- Patients who did not agree or did not have capacity for the COVID Telehealth Program

Transition to Home Care

Certified Home Care COVID Program

Process:

- Intake RN triaged —Telehealth or no Telehealth
- No Telehealth- Team/RN assigned - followed our Pneumonia Care Path (10 visits over 4 weeks and re-evaluated)
- Yes Telehealth – RN assigned; Telehealth Dept. notified
- RN picked up telehealth unit & necessary PPE for 1st open visit
- RN followed COVID Care Path (Pneumonia Care Path with virtual visits incorporated)
- Telehealth monitored patients vital signs daily
- RN performed 4 visits in first 7 days (2 face to face; 2 virtual)
- Overall RN performed 6 face to face visits; 4 virtual visits over 4 weeks; and re-evaluated

Telemedicine Utilization

Leveraged the CMS Public Emergency Telehealth waiver to manage COVID patients in the home care setting…

Telemedicine Utilization

In Home Telehealth Equipment

Wireless Scale

Wireless Pulse Oximeter

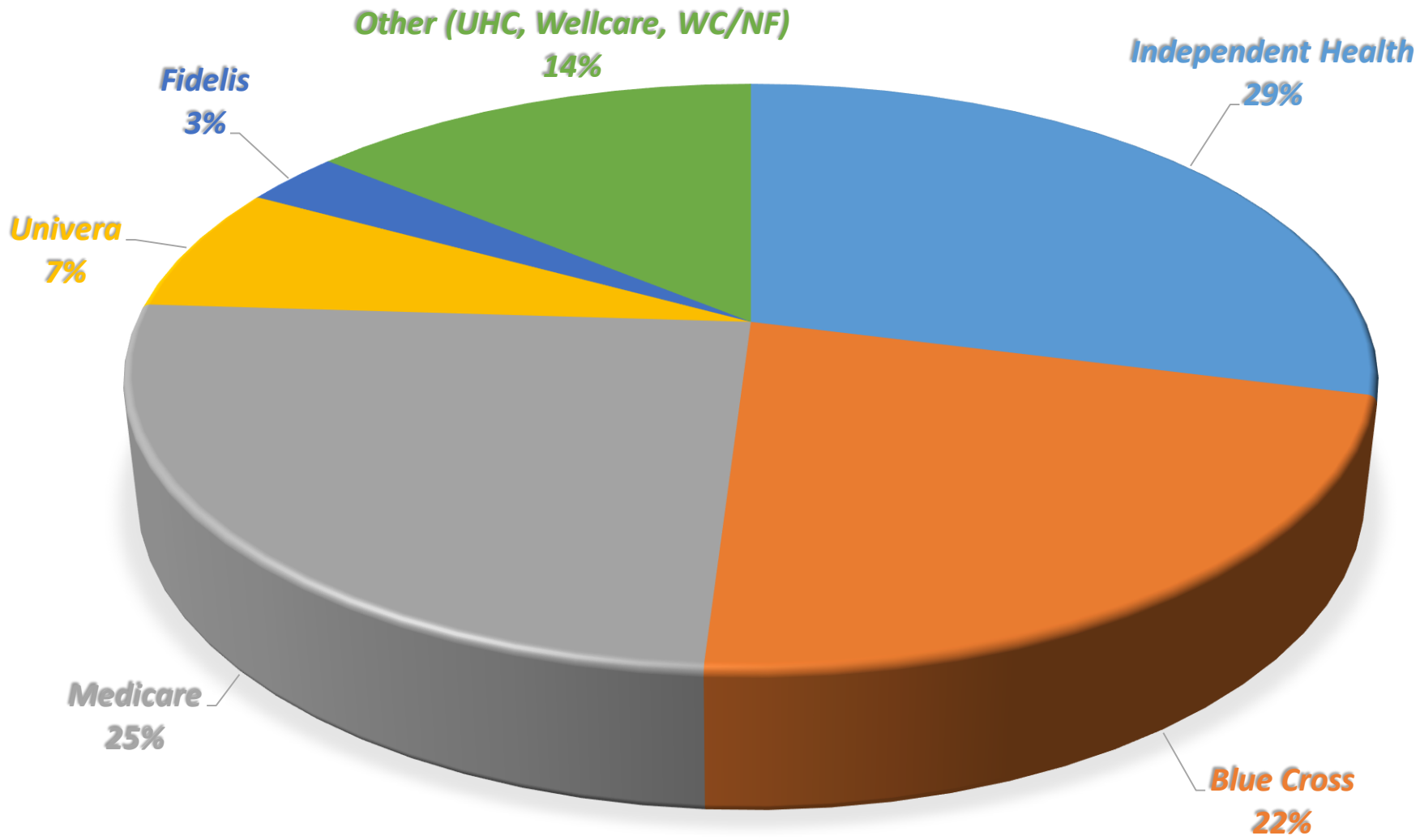
Wireless Blood Pressure Monitor

Wireless Tablet

Telemedicine Utilization: Payer Discussions

- Public Emergency Waiver opens payer dialogue to leverage reimbursement
- Major payers in WNY(Independent Health, Blue Cross, Fidelis, Univera, United Health Care and NYS Medicaid)
- Reimbursement/claim submission implementation, simultaneous with a COVID virtual visit care delivery platform

Payer Source Mix



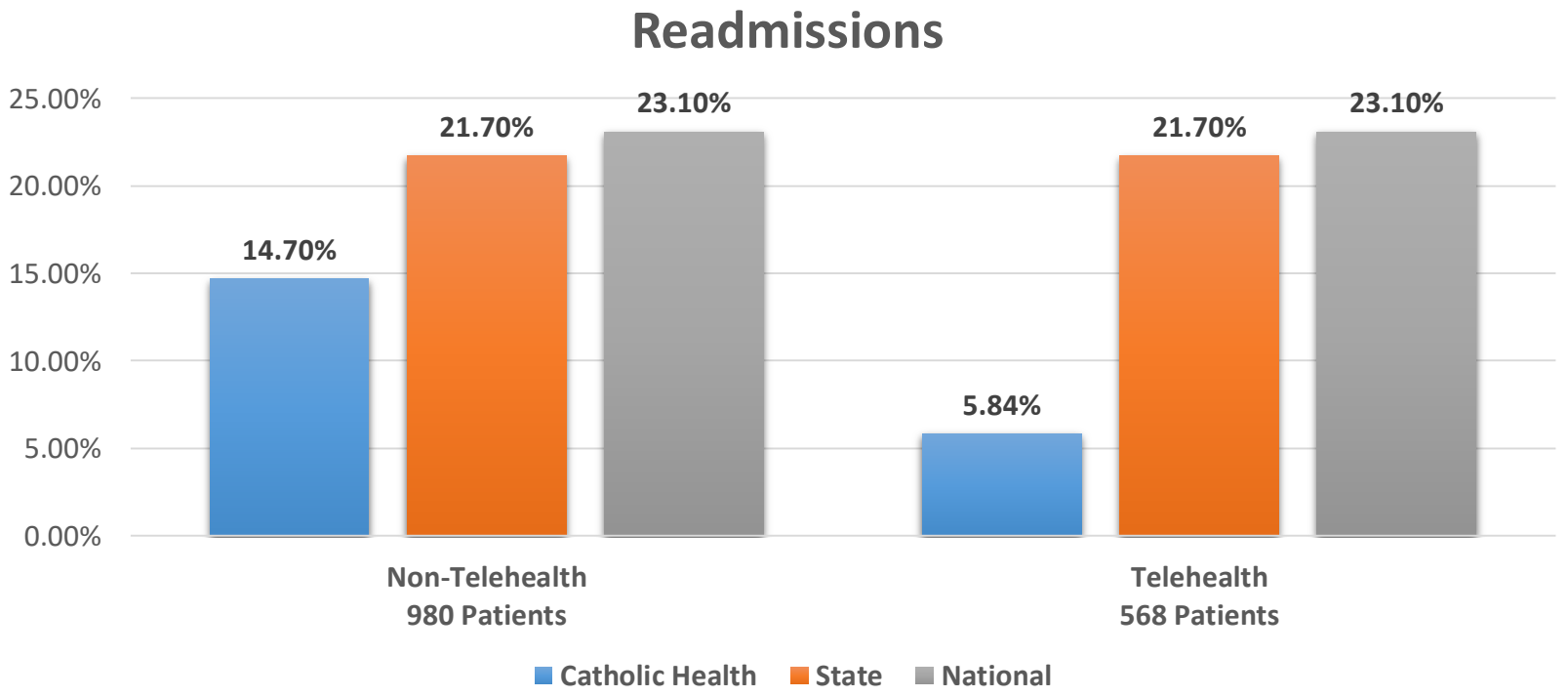
COVID Telemedicine Taskforce

- Executive orders to cease elective surgeries, resulting in reallocation of rehab staff
- Launched a “COVID Telemedicine Taskforce”
- Taskforce included a centralized operation center
- Operation center housed all telehealth units and was the centralized location for program staff
- Operation center managed exclusively by McAuley Seton Home Care clinical associates

Transition to Home Care

Certified Home Care COVID Program

Outcomes:



Conclusion: Lessons Learned

- COVID provided a platform for enhanced care collaboration, communication and teamwork throughout the continuum
- Promotion of community partnerships and creative approaches to managing patients outside the hospital walls
- Opportunity to launch innovative platforms of care delivery through the pandemic and beyond
- Opportunity for innovative, sustainable initiatives to gain traction

Thank you…

Next Scheduled Webinar Series

Name of Session	Collaborating Organizations	Date**
Collaboration of Care for patients with Mental Illness Across the Health system	Catholic Health Services of Long Island Mercy Hospital Catholic Health Home care	April 7
EPIC Integration	Montefiore Hospital Montefiore Home Care	To be determined

** All events are from noon to 1pm

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Important Links

RESOURCE PAGE

https://hca-nys.org/statewide-hospital-home-care-collaborative

https://www.iroquois.org/hospital-homecarecollaboration/

https://www.hanys.org/quality/patient_safety/

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