Continuing Education Disclosure

Trent Butler, LHC Group

1. I have no relevant financial relationships with any ACCME-defined commercial interest* to disclose.
2. I will not discuss off label use and/or investigational use in my presentation.
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SKILLED PLACEMENT PROGRAM
OBJECTIVES

• Describe the coordination of clinical and social support factors to ensure the home is the appropriate environment for discharge

• List factors to consider for safe and effective placement in the home post-acute discharge

• List the services and levels of care comparison for traditional home health, complex home health, and skilled placement

• Describe how new payment systems are encouraging better skilled nursing facility and home health collaboration

• List the steps necessary for improved collaboration and seamless transition of care from SNFs to home health

• Discuss how various clinical and therapy programs result in improved outcomes, decreased costs, and decreased re-hospitalizations when combined with proper placement and improved collaboration
OVERVIEW

• Hospital discharge planners have traditionally discharged approximately 20% of their patients to skilled nursing facilities (SNFs).

• Many SNFs will not or are reluctant to accept patients with respiratory symptoms.

• Patients and families refuse or are reluctant to discharge to a SNF due to real or perceived risk of infection. This has been underscored during and due to the COVID-19 pandemic.

• Data shows that the cost of skilled nursing care can be 3 to 4X greater than that of home healthcare.

We see a sizeable opportunity to care for higher acuity patients in the home at a lower total cost – producing equal or better outcomes.
SKILLED PLACEMENT - DEFINED

• Our *Skilled Placement Program* is a coordinated effort by LHC Group and our hospital partners to help ensure that *clinically appropriate patients* are discharged to home health.

• In many cases, internal factors such as case burden or false assumptions regarding quality of care lead to an inefficient reliance on skilled nursing facilities as the “most correct” discharge option.

• This program requires coordination of clinical and social supports in order to ensure that the home is a safe and appropriate environment for the patient to receive skilled nursing care.

• Factors include consideration for caregiver readiness, DME, medication availability and reconciliation, and meals.
PROGRAM REQUIREMENTS

Hospital Partner
- Must have an engaged, collaborative relationship with Care Management/Discharge Planning at partner hospital. Program requires highly coordinated effort for patient identification and confirmation of admit by LHC Group.
- Discharge process coordinated by an LHC Group care transition coordinator with hospital EMR access.

Patients/Caregivers
- Only patients who are appropriate for home health are admitted to program.
- Confirm presence of caregiver in the home.
- Ensure cognitive ability to use phone/video (or caregiver’s ability to do so).

Payor Source
- Discharge process coordinated by an LHC Group care transition coordinator with hospital EMR access.
- Home health initiation of care within 24 hours.
- Immediate authorization by payor necessary to facilitate timely discharge for patients in this program.
SKILLED PLACEMENT:
Our national data indicates that 20-30% of patients discharged to SNF were recommended as home health appropriate.
PATIENTS **NOT APPROPRIATE** FOR THE SKILLED PLACEMENT PROGRAM

**FACILITY APPROPRIATE**

- Genuine need for in-person, 24-hour nursing.
- Home is not structurally appropriate based on care needs or condition (e.g., second floor walk-up).
- Need for frequent MD/NP rounding.
- Clinical interventions that are not appropriate for the home setting, such as complex ventilator management and complex medication titration.
- Caregiver unavailable (either family member not present, or without means to hire caregiver) to meet ADL needs (e.g., toileting, transferring, basic hygiene).
- Inability to meet basic necessities (e.g., food, water, medications).
# LHC GROUP CAPABILITIES

<table>
<thead>
<tr>
<th>CLINICAL/OPERATIONAL:</th>
<th>Traditional HH</th>
<th>Complex HH</th>
<th>Skilled Placement</th>
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</thead>
<tbody>
<tr>
<td>LHC Proprietary Utilization Mgmt tool based on historical optimal outcomes</td>
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<tr>
<td>Ongoing Case Mgmt including feedback to Physicians and Coordination of O/P appts</td>
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<tr>
<td>Coordinated DME Delivery &amp; Support</td>
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<td>Home Assessment for Safety &amp; Fall Prevention</td>
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<td>Patient Discharge Call Back Program</td>
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<td>Hospice and Palliative Care Bridge Program when appropriate</td>
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<td>Medication Reconciliation</td>
<td>x</td>
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<td>Teaching and Training on New Disease Processes or side effects of Medications</td>
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<td>Social Services, Depression Screening, and Cognitive Assessment</td>
<td>x</td>
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<tr>
<td>Wound Care</td>
<td>x</td>
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<td>Assistance with Home Vital Sign Monitoring</td>
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<tr>
<td>Therapies (PT, OT, ST)</td>
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<td>IV Therapy</td>
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<tr>
<td>Personal Emergency Response System</td>
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<td>Collecting and sending labs</td>
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<td>Mobile X-Ray coordination</td>
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<td>Diagnosis Specific Pathways (COPD, CFH, Sepsis)</td>
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<td>Home Assessment and Adaptive Set up</td>
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<td>Telemonitoring</td>
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<td>Weekly Interdisciplinary Case Conference</td>
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<td>Complete Nutritional Assessment (RN) and TPN</td>
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<td>Advanced Wound Care (Acute and Chronic), Wound Vac Mgmt</td>
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<tr>
<td>Therapy specific intervention, Low Vision or Central Nervous System Programs</td>
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<tr>
<td>Incontinence Therapy</td>
<td></td>
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<tr>
<td>Continuation of Diagnostic Specific Pathways with input from sub-specialists to carry out protocol</td>
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<td>Cardiac Infusion Patients who are stable, but requiring IV meds (Dobutamine/Amiodarone)</td>
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<td>LVAD</td>
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<td>Respiratory Support (In Home Oxygen, Home Nebulizer and Peak Flow, Pulse Ox Monitoring)</td>
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<td>In-home PostOp Customized Orthopedic program (Hips, Shoulders, Spine)</td>
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<td>Behavioral Health, Clinical Counseling and/or Tele-visit</td>
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## LHC GROUP CAPABILITIES (continued)

<table>
<thead>
<tr>
<th>Social Determinants of Health</th>
<th>Traditional HH</th>
<th>Complex HH</th>
<th>Skilled Placement</th>
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<tbody>
<tr>
<td>Ensure Medication is Available</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Basic necessities present or assistance available</td>
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<td>X</td>
<td>X</td>
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<tr>
<td>Confirm presence of a Caregiver in the Home (24 hour caregiver or SNF @ Home)</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Assistance with follow up appointments (telehealth as appropriate)</td>
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### Telehealth Readiness

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<th>Access to Phone or Device</th>
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<tbody>
<tr>
<td>Access to Wifi</td>
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<td>X</td>
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<tr>
<td>Cognitive ability to use phone/video, or caretaker ability</td>
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<td>X</td>
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<tr>
<td>Primary Language Spoken</td>
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</table>
Onset of negative payment adjustment (0.5% to 2%) by CMS for SNFs with re-hospitalization rate >= 20.524%.

Onset of positive payment adjustment (0.5% to 2%) by CMS for SNFs with re-hospitalization rate <= 16.78%.

Adjustments in the historical delivery of care... SNFs no longer paid by number of minutes of therapy provided (RUG Levels).
Objectives of Partnership

• Improved communication and collaboration across the post-acute continuum of care.
• Promote and improve continuity of patient care.
• Improved efficiencies with downstream and upstream referrals.
• Identification and communication of “high risk” patients.
Weekly Transitional Care Calls

- 10-15 minute weekly call for care collaboration between the SNF and home health agency (HHA)

- Attendees:
  - **HHA**: RTD, Executive Director (ED), Account Executive (AE)
  - **SNF**: Director of Rehab (DOR), MSW/Case Manager

- **Call Agenda:**
  - discuss patients referred from previous week
  - discuss upcoming patient referrals
  - discuss the clinical and functional specifics of patients identified as high-risk
  - collaborate on any staffing capacity issues
Components of Program

• Establish facility profile for both the SNF and HHA.

• Identification of point person for SNF and HHA.

• Establish referral flow processes downstream and upstream to promote seamless transition between providers.

• Enhanced communication with **weekly transitional care calls between SNF and HHA** to discuss pending admits and identify patients transitioning from the SNF that are at high risk for re-hospitalization.

• Pre-discharge “welcome visit” to patient at SNF by AE (HHA) to decrease patient/caregiver anxiety and reinforce their expectation for pending transition from SNF to home.
SNF Facility Profile

• Provides the names and contact information for key positions in SNF (i.e. DON, Administrator, Medical Director, etc.).

• Identifies point person for facility.

• Identifies contact person for payor questions.

• Identifies contact person for clinical questions (i.e. primary diagnosis).

• Identifies contact after hours and on weekends.

• Identifies if SNF is participating in a bundle or ACO.

• Identifies “likes and dislikes” of the facility.
Home Health Agency Profile

• Provides the names and contact information for key positions in the HHA (i.e. Executive Director, Patient Care Manager, Account Executive, etc.).

• Identifies point person in the HHA.

• Provides contact information for after hours and weekends.

• Provides HHA key metrics:
  – ACH rate
  – Star rating: Quality of Patient Care
  – Star rating: Home Health CAHPS (Patient Satisfaction)
Goals of Partnership

- Decrease patient re-hospitalizations (ACH rate).
- Improve clinical outcomes and quality ratings for both the SNF and HHA.
- Improve patient/caregiver satisfaction and experience of care across the continuum of post-acute care.
These programs provide exceptional patient care and promote improved outcomes:

- Active Life Balance Care
- Continence Control Program
- Active Mind (Dementia Care)
- Low Vision Program
- Customized Orthopedics Program
- Senior Living/ALF Program
- Respiratory Recovery at Home
The Active Life Balance Care program ensures our patients get a comprehensive assessment of all systems that effect balance, including:

- vestibular
- oculomotor
- somatosensory
- musculoskeletal

Emphasis is on assessment & treatment of the vestibular system.

- If you are not assessing and treating the vestibular system, you are not providing the standard of care for a patient with balance issues.
Emphasis on treating incontinence using the Beyond Kegels Protocol and Roll for Control exercises.

- 5 exercises that combine to strengthen the muscles of the pelvic floor
- Agency orders personal care kits for patients to use to perform the exercise program

The program also includes: lifestyle changes (such as limiting caffeine, walking, proper hydration, etc.) as well as physiological quieting (relaxation techniques)

- Non-invasive evaluation and treatment
- Effective with all types of incontinence in women and men
- Research backs up the program’s effectiveness
Active Minds

Active Minds is our comprehensive program to work with patients who have dementia. The program emphasizes appropriate assessment and staging of a patient’s level of dementia.

• This allows our clinicians to utilize evidence-based strategies to provide more effective treatments.

• Once able to better understand a patient’s level of dementia, clinicians are able to utilize engagement strategies and tailor the care plans toward the patient’s existing abilities.

• Treatments often focus on traditional therapy items like gait, strengthening, and balance; but there is an emphasis on adjusting treatment interventions based on the patient’s dementia stage.
The Low Vision Program provides a unique opportunity to help low vision patients maintain independence in daily activities. In this program patients with acquired visual impairment diagnoses such as macular degeneration, diabetic retinopathy, glaucoma, or cataracts are instructed in the use of compensatory strategies to improve safety and performance of activities of daily living.

- OT-driven program.
- Emphasis on:
  - home environment adaptations
  - patient education
  - adaptive equipment needs *(low vision kits are available for the agencies)*
Senior Living/ALF Program

The Senior Living Program focuses on building mutually beneficial relationships with senior living communities.

- Program is tailored to the needs of the community
- Patient care is centered around Active Life Balance, Continence Care, Low Vision, and Active Minds
- Dedicated staff to the community (whenever possible)
  - Efficient for our staff
  - Builds strong relationships with residents and staff
• Fall reduction plan for the ALF’s is a key tool.
• May incorporate other clinical programs for patient treatment.
  – Continence Control Program
  – Active Life Balance Care
  – Active Minds Dementia Care
  – Low Vision Program
  – Customized Orthopedics Program
Respiratory Recovery at Home

• A comprehensive program that utilizes skilled nursing and therapy to help patients who struggle with respiratory conditions, neurological problems, or have limited functional independence due to decreased activity tolerance.

• May also utilize a variety of services such as oxygen weaning or devices such as a respiratory muscle training device (RMTD) or incentive spirometers based on the patient’s specific needs.
Questions?

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It's all about helping people.