2020 HCBS Conference

Care Transitions: Building on Lessons Learned During COVID-19

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Care Transitions: Building on Lessons Learned During COVID-19

- Care transitions before COVID-19
- Care transitions during the Public Health Emergency (PHE)
- Experience from the field

CARE TRANSITIONS BEFORE COVID-19

Care Transitions and Social Determinants of Health

- Between 40-50% of readmissions are linked to social problems and lack of community resources.

- In a study evaluating the home food environment of hospital-discharged older adults, 1/3 of participants reported being unable to both shop and prepare meals.

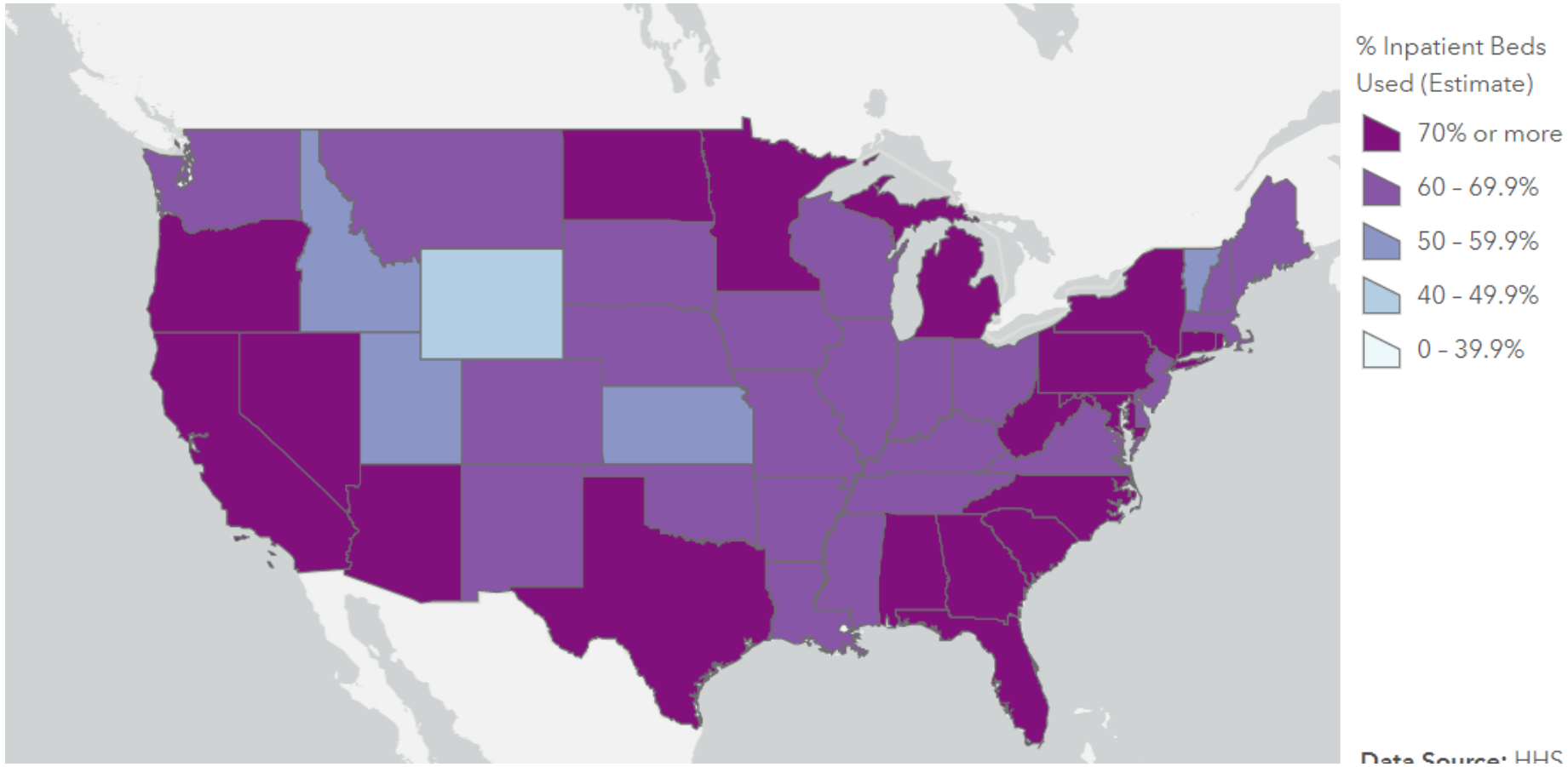
Proctor et al. (2000). Adequacy of Home Care and Hospital Readmission for Elderly Congestive Heart Failure Patients. Health and Social Work; 25(2): 87-96(10).
Anyanqu, Ucheoma O., Sharkey, Joseph R., Jackson, Robert T. (2011) Home Food Environment of Older Adults Transitioning From Hospital to Home. *Journal of Nutrition in Gerontology and Geriatrics* 30:105-121.

Connections to Services and Supports During Transitions

- Home Delivered Meals
- Nutrition Services and Counseling
- Personal Care/Homemaker/Chore
- Medication Management
- Home Injury/Risk Screenings
- Blood Pressure Monitor
- Care Management
- Benefits Assistance
- Transportation
- Pharmacy Delivery
- Assistive Technology
- Chronic Disease Self Management Programs
- Diabetes Self Management Programs
- Mental Health and Substance Misuse Programs
- Falls Management and Prevention
- Alzheimer's Programs
- Support Groups
- Socialization Activities
- Additional Options Counseling
- Home physician visits
- Housing
- Caregiver Support
- Handyman Services
- Respite
- Money Management Program
- Legal Services
- Exercise Programs
- Pet care

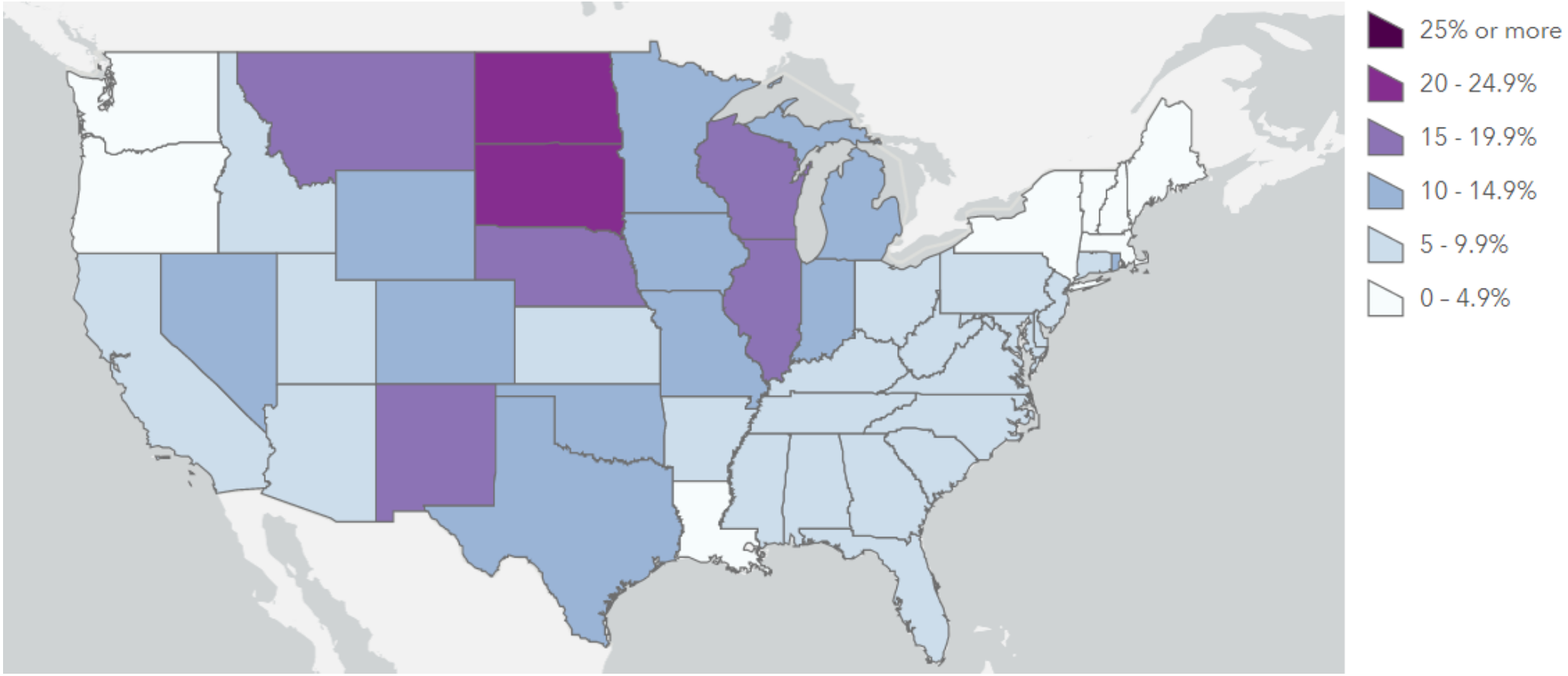
CARE TRANSITIONS DURING THE PUBLIC HEALTH EMERGENCY

State Hospital Bed Occupancy (as of 11/11/20)



https://protect-public.hhs.gov/pages/hospital-capacity

State Hospital COVID Bed Occupancy (as of 11/11/20)



https://protect-public.hhs.gov/pages/hospital-capacity

Importance of Hospital/Community Coordination During COVID-19

Likewise, the pandemic has illuminated the advantages of having provider offices, community health clinics, home care services, prehospitalization services (ambulances), **community services**, public health offerings and other parts of the care continuum coordinated with hospitals and health systems.

- June 2020 American Hospital Association

https://www.gnyha.org/wp-content/uploads/2020/06/AHA-TOOLKIT-COVID-19-Pathways.FINAL-20200611.pdf

Care Transitions During the Pandemic

- Increased demand for Hospital-To-Home transitions
  - HCBS
  - LTSS
  - Medicaid Waiver
- Skilled Nursing Facility (SNF) Diversion
- Care transitions intervention may need to extend up to 90 days

CARE TRANSITIONS TECHNICAL ASSISTANCE

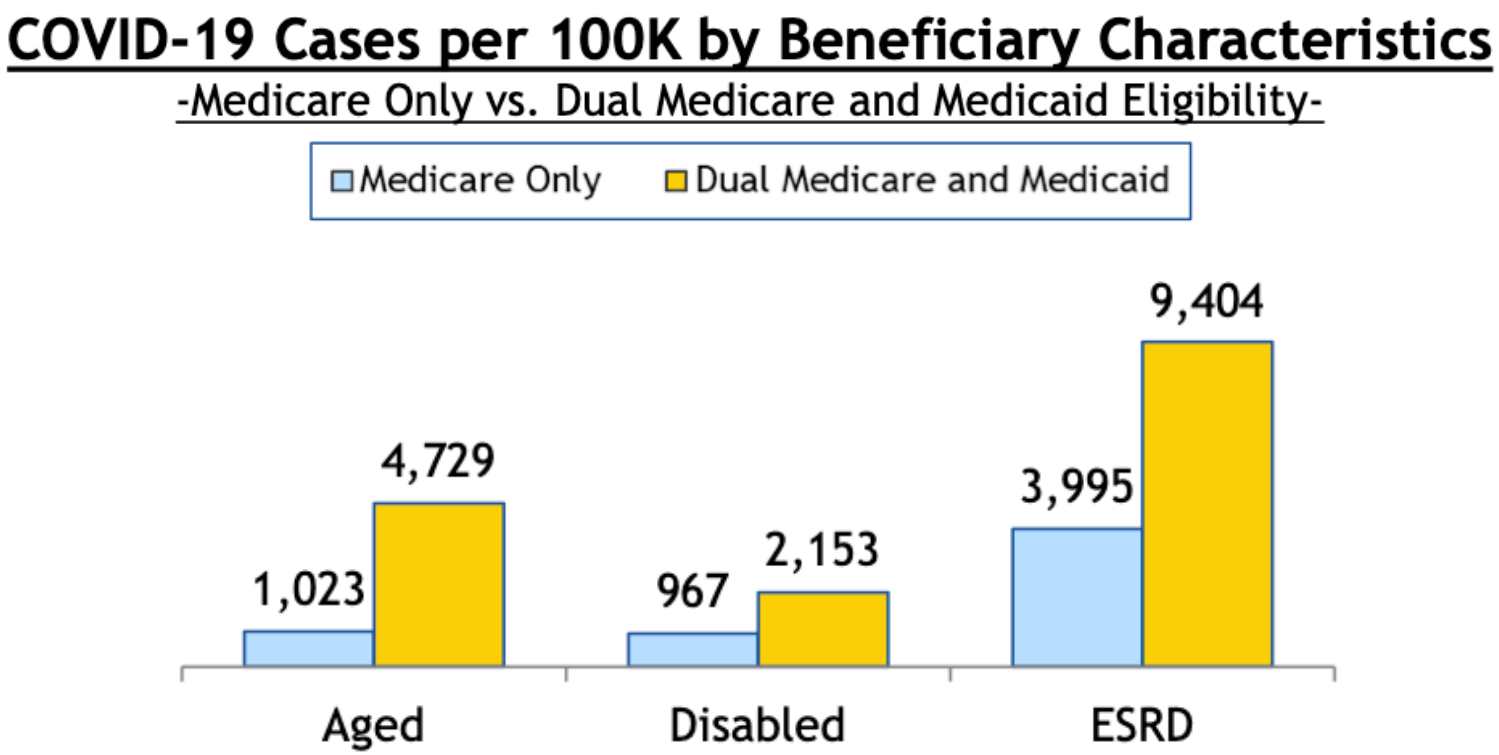
Frequent Technical Assistance Requests

- How to get started
- Best practices for securing referrals
- Target Populations
- How to modify care transitions during the Pandemic
- Hospital-To-Home transitions delivery model
- Integration of Care Transitions with Medicaid LTSS

Initiating a Care Transitions Program

- Policy References supporting Transitions
  - HHS and CMS policy guidance recommend that Hospitals coordinate with ADRCs, AAAs, and CILs to facilitate transitions for persons that require LTSS
- Demonstrate Value to the Healthcare Partner
- Develop a process to track the return on investment for the program – even when initiated with Grant funding

Target Population



Disclaimer: All data presented in this update are preliminary and will continue to change as CMS processes additional claims and encounters for the reporting period. COVID-19 cases are identified using the following ICD-10 diagnosis codes: B97.29 (from 1/1-3/31/2020) and U07.1 (4/1/2020 and after). Medicare claims and encounter data are collected for payment and other program purposes, not public health surveillance, so caution must be used when interpreting the data. For additional details on data limitations, please see page 2 of this data update and view the methodology document available here.

Potential Pathways to Sustainability

- Hospital-To-Home Care Transitions Payers
  - Direct Contract with Hospital or Physician Group
  - Direct Contract with a Health Plan
  - Delegated Case Management contract
  - Medicaid Waiver
  - Medicaid Administrative Claiming
  - Money Follows the Person

Experience From the Field

Multnomah County

Lynn Schemmer-Valleau
Multnomah County
Community Services Team
Program Manager

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Resources

- ACL Technical Assistance Community: Care Transitions Webinars and Supplemental Materials

https://www.ta-cmmunity.com/tag/care-transitions

- ACL Technical Assistance Community: Integration of Health and Social Care (additional care transitions resources): https://www.ta-community.com/category/integration-of-health-and-social-care

Technical Assistance

If you have any additional questions or would like to ask for direct one-on-one technical assistance, please email the ACL care transitions mailbox:

ACLCareTransitions@acl.hhs.gov