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Virtual COVID-19 Home Program

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A collaboration between Catholic Health Home Care and Primary Care Service Line

September 9, 2021

Acknowledgement

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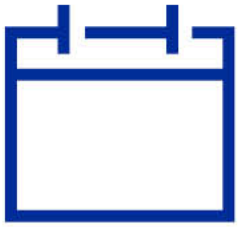
Today’s Agenda



1. Concept Origin
2. Goals and Targeted Outcomes
3. Team Members and Program Description
4. Implementation
5. Drivers of Success
6. Outcomes
7. Future Applications

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Overall Goal and Targeted Outcomes of Grant

GOAL

Develop an effective collaboration between Catholic Health Home Care and Primary Care designed to care for and manage patients at home during the COVID surge. Employing a patient-centric model, the primary goal of the project was to decompress the patient volume within system hospitals to allow for the management of the most acutely ill individuals while not compromising patient care and outcomes.

OUTCOMES

- Increased capabilities for in-home care of patients
- Avoid referrals or discharges to LTC facilities
- Prevention of avoidable admissions through collaborative strategies
- Improved support for acute care management through coordination of referrals and enhanced patient information provided at admission
- Optimization of successful discharge and transition to home
- Improved outcomes and health care cost efficiency
- Beyond COVID… a foundational, structural and lasting improvement in the coordination and operation of the health care system

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Principal Organizers

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Vice President Primary Care Service Line

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AVP Valued Based Care

Catholic Health Home Care and Good Shepherd Hospice

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Key Project Contributors

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Focus of Today's Presentation

PROGRAM DESCRIPTION

During the early COVID period, it was clear hospital admissions would increase and Catholic Health would be pushed to its capacity. We understood there was a clear need to design a process that would allow us to manage COVID-19 patients safely and effectively. Patient and family anxiety as well as provider variability in care made it difficult to send patients home safely because of a concern that sending patients home too early in their COVID illness would result in increased readmission rates and poorer outcomes.

An innovative program was developed by Catholic Health leadership designed to care for and manage patients at home during the COVID surge. Employing a patient-centric model, a collaborative partnership was expediently implemented among entities across the care continuum. The primary goal of the project was to decompress the patient volume within system hospitals to allow for the management of the most acutely ill individuals, while not comprising patient care and outcomes.

The target population was individuals with a primary diagnosis of COVID-19 who were oxygen-dependent with residual respiratory effects but who could otherwise be safely discharged from the hospital with careful clinical oversight.

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Programmatic Goals

- Determine the correct cohort of patient to enroll in this program
- Decompress hospitals' COVID-19 volume
- Coordination of discharge with:
  - ❖ Patient and family
  - ❖ Discharge Planners
  - ❖ Catholic Health Home Care team
  - ❖ Central Referral Office
  - ❖ Primary Care Provider and Staff
- Provide 24/7 access to a Catholic Health Home Care services
- Provide 24/7 access to a Catholic Health Primary Care Physician
- Provide 24/7 remote patient monitoring

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Planning Paradigm

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Initial Project Implementation (4/10-6/10/2020)

- “Trifecta Components of Care” comprised of a virtual physician visit, home health nurse visit, and implementation of remote patient monitoring within 24 hours of discharge
- Some patients opted for home health and remote patient monitoring services only
- A total of 372 people were the recipients of care in this program
  - 30-day hospital readmission rate of 0% among patients who agreed to all three components of the program (n = 128)
  - 30-day hospital readmission rate of 2.4% for those electing only home visits and remote patient monitoring (n = 194)
- Proved the value of a close partnership among physician and home health services across the care continuum

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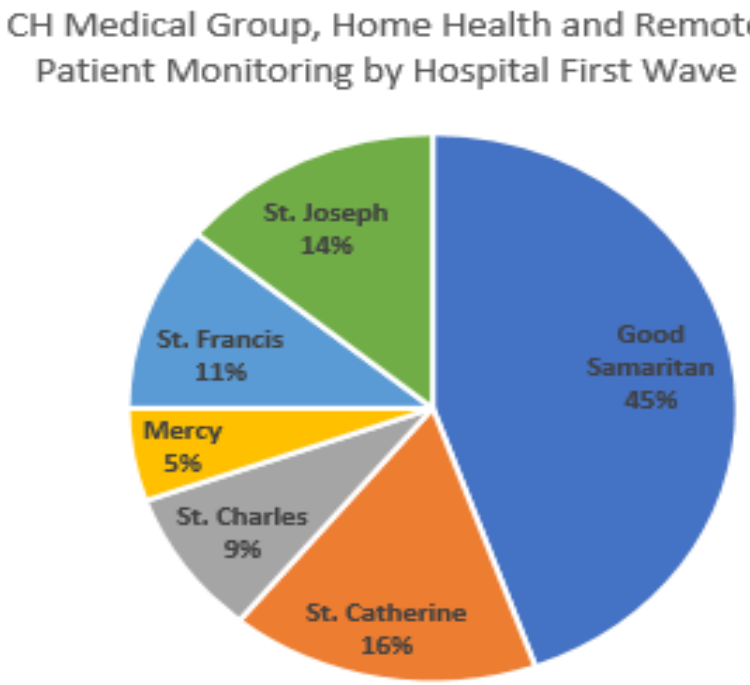
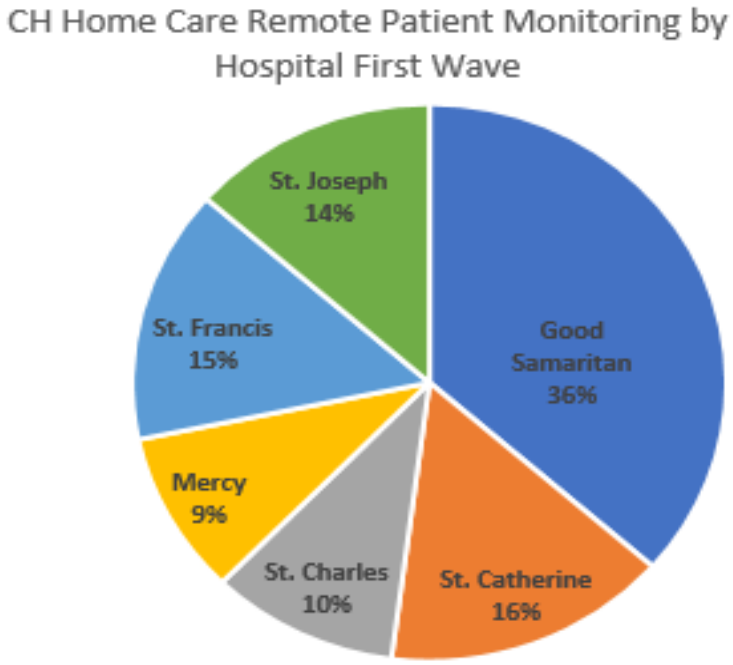
Initial Project Implementation (4/10-6/10/2020)



128 patients



194 patients

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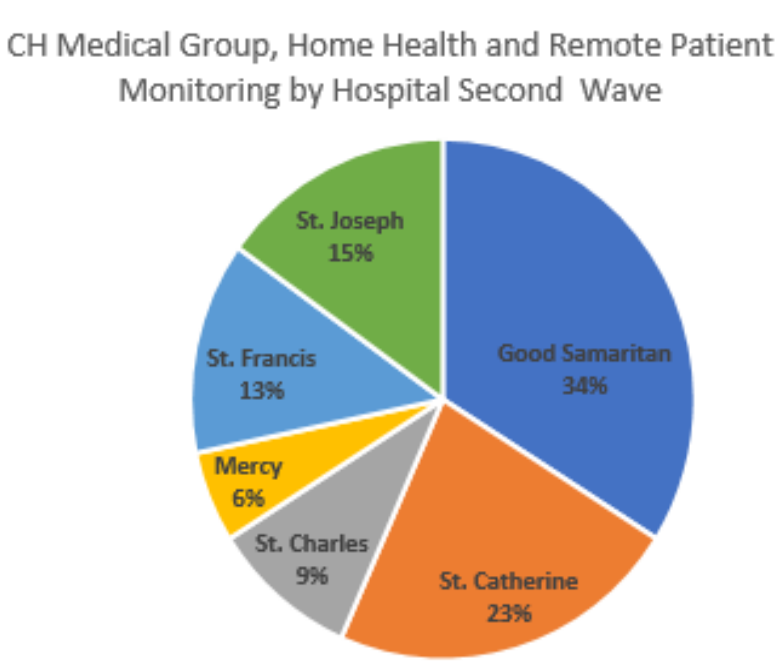
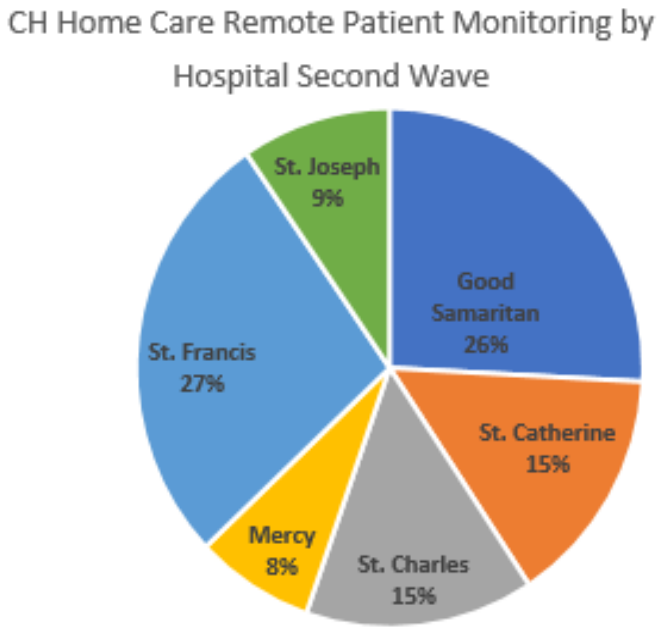
Second Surge (12/14/2020-4/14/2021)

- Easy to implement as structure was in place
- Modification of workflow based on lessons learned
- 409 people were the recipients of care in this program
  - 30-day hospital readmission rate of 0% among patients who agreed to all three components of the program (n = 116)
  - 30-day hospital readmission rate of 3.1% for those electing only home visits and remote patient monitoring (n = 293)

Second Surge (12/14/2020-4/14/2021)



116 patients



293 patients

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Drivers of Success

- Explanation of the program to the patient and their families to alleviate fear and concern
- Warm handoff from Hospitalist to the COVID program physician
- True Transition of Care process review
- 24/7 availability of the Catholic Health Care Team
- Training of Primary Care Providers on management of COVID patients
- 24/7 remote patient monitoring
- Performance of a CH eVisit video conference with a provider within 24 hours of discharge
- Continued follow up of patients through televisits until discharge from the program
- Engagement of patients' family to participate in care
- Ability to address families' concerns about COVID
- Warm hand off from the program back to the primary care provider of record

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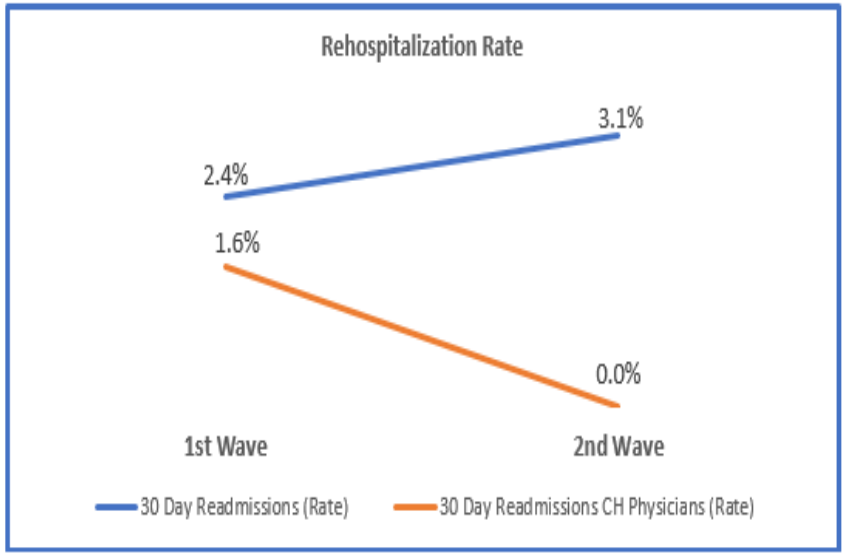
Program Outcomes

- The integration of new technology, improved provider access, with evidence-based practice guidelines can reduce 30 day rehospitalizations for patients with COVID-19
- The innovative use of shared resources can create an efficient healthcare delivery model
- Employing an interactive approach to care results in high levels of patient satisfaction



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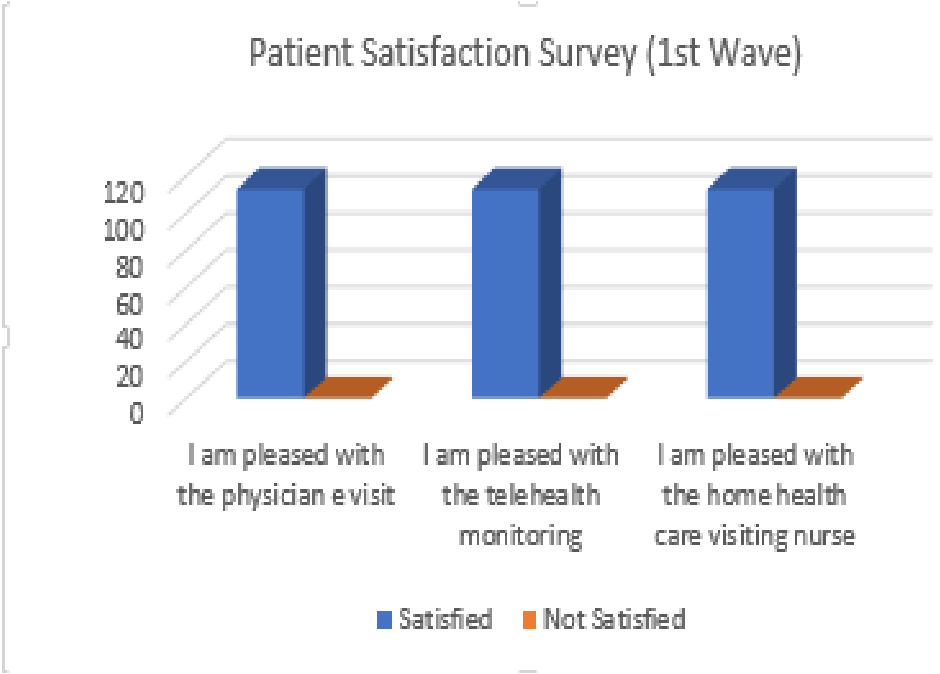
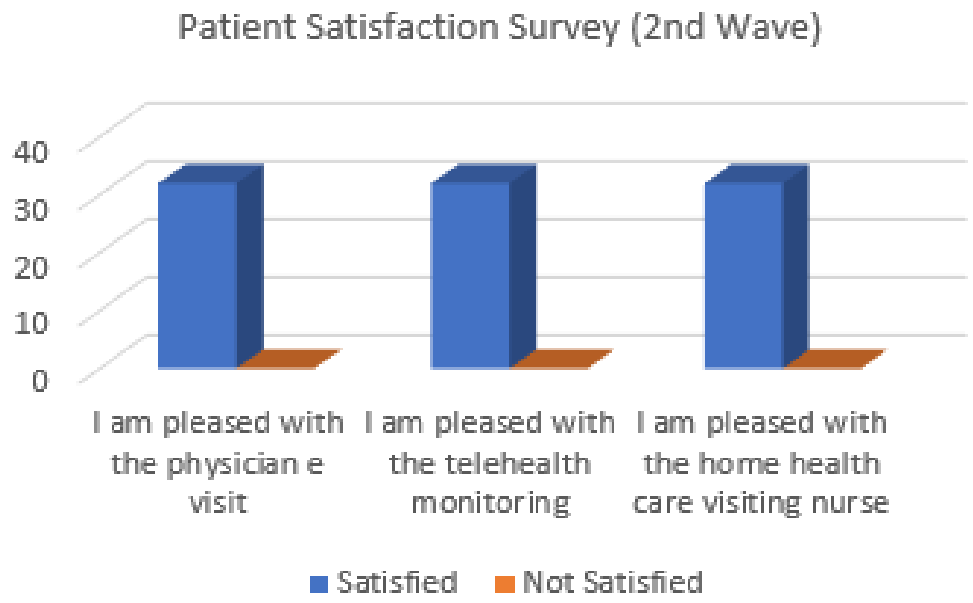
Patient Experience and Comments





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Lessons Learned

- Shared goals among system entities fosters collaboration and communication
- Collaborative care results in high levels of patient satisfaction
- Well-defined, clearly articulated shared processes support the provision of a true patient-centered model

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Sustainability and Replication

- Adapt and translate knowledge gained to other diagnoses which place patients at heightened risk for complications
- Evidence demonstrates early intervention and the combination of provider access, home health services, and remote patient monitoring can significantly reduce readmissions and improve patient satisfaction
- Hospital readmission rates remained similar between waves of the pandemic
- Project can be expanded to reduce readmissions for chronic diseases particularly those which fall within CMS penalty diagnosis groups
- Considerations may also include expansion of model to a hospital at home program, transition of care program, and provider home visits

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