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Tori Gaetani, RN, Director of Care Coordination, Testimony Presented to United States Senate Special Committee on Aging

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Senator Collins, Senator McCaskill, and members of the Senate Special Committee on Aging, my name is Tori Gaetani, I am the director of care coordination and I'm here today on behalf of EMHS Beacon Health our statewide CMS Pioneer Accountable Care Organization. I want to thank Senator Collins for the opportunity to speak with you today regarding our experience with the Pioneer ACO waiver of the requirement that Medicare beneficiaries spend three overnights in an acute care hospital in order to access the skilled nursing facility benefit.

I would like to begin with a brief overview of EMHS and our Pioneer ACO organization. EMHS is a not for profit comprehensive healthcare system serving the entire state of Maine. EMHS members include general acute care hospitals, critical access hospitals, a psychiatric hospital, home care providers, hospice providers, nursing facilities and air/ground transportation. EMHS was selected as one of the original 33 Pioneer ACOs. For EMHS our Pioneer ACO and population health services exist within a subsidiary of EMHS known as Beacon Health.

The Pioneer ACO program began in 2012 with just over 9,000 Medicare beneficiaries. We are now in our fourth year of the 5-year pilot program caring for nearly 29,000 Medicare beneficiaries and we accept both upside and downside risk for ACO Medicare service. Specifically we share in savings and accept financial risk when the overall cost of our care exceeds the annualized benchmark. We are proud of our ACO performance consistently ranking among the highest quality ACO networks in the country.

In 2014 we were approved by CMMI to participate in the Pioneer ACO waiver program for skilled nursing facility admissions. The waiver eliminates the three hospital overnight requirement for beneficiaries and allows us to admit qualified beneficiaries directly to a skilled nursing facility. Thus far 183 Pioneer patients and 14 qualified skilled nursing facilities, including swing beds at four critical access hospitals participate in our SNF waiver program.

Our participating SNF partners were required to have a quality rating of three or more stars under the CMS 5-Star Quality Rating System as reported on the Nursing Home Compare website, but have committed to quality of care measures beyond the Nursing Home Compare reports. Our SNFs now offer our patients admissions 24/7 access to allow for safe transitions no matter the time of day or night. This was not easy feat – it required a true spirit of collaboration between Beacon Health, the qualified skilled nursing facilities, and hospitals creating a truly seamless transition across the care continuum for our patients.

In order for me to share personal anecdotes about how the waiver is improving quality of life for our patients, I first have to share the nuts and bolts of the process we developed in order to make the most of our opportunity and provide with their healthcare.

First off Beacon Health established a care coordinated process for approval of patients to qualify for the SNF waiver admission. We have nurse care coordinators embedded in all our primary care practices, as well as transitions of care nurses embedded in our hospitals and emergency departments. These nurses are in constant communication with each other the patient and their family and the patient's primary care provider and hospitalists making sure our patients don't fall through the cracks and are supported at every point of care.

Pioneer patients can be referred directly from a primary care practice, emergency department, or after one or two day stay in a hospital. But patients do have to be medically stable with a confirmed diagnosis; meaning their medical conditions don't require further testing for proper diagnosis also patients must not require inpatient hospital evaluation or treatment. Patients need to have an identified skilled nursing or rehabilitation need that cannot be provided as an outpatient or with home health services. After medical stability and skilled need is determined, the patient's primary care provider is contacted for approval of the plan to transition a patient to a SNF facility.

Patients and family are then given a choice of which facility they want to go to – we offer them a list of 14 which encompasses our state. Patients are never just sent to a SNF where they have to re-tell their story to another set of care givers. We call it a warm hand-off of care that consist of traditional nurse to nurse reporting, but also includes provider to provider outreach. This extra step ensures relationships are deepened and that all care teams have a 360 degree view of the patient.

The coordination of care process does not stop when a patient is admitted to a SNF facility. Our nurse care coordinators continue their relationship with SNFs throughout the patients' length of stay. They are included in the patient's plan of care and discharge plan. This personalized outreach is done on a weekly or as needed basis either in person or by phone. Care coordinators ensure patients SNF discharge summaries are received and communicated to the patient's primary care provider to make sure we are always supporting their smooth transitions of care to wherever the patients' next level of care need is. We offer our patients true seamless care across the continuum.

Since May 2014, 399 Pioneer patients have been referred to the SNF waiver program. Of those patients, 183 benefited from the 3 day waiver and were admitted to a SNF. The majority of the patients that did not meet the qualifications were not properly aligned to the Beacon Health Pioneer program which made them ineligible, often times this meant their primary care provider was not a Beacon Health Pioneer. The other patients were not medically stable, without skilled need, or appropriate for home care or outpatient services.

The 3 Day Waiver program is working as we are connecting with patients in a way that makes sense to them. By no longer requiring a three night stay in a hospital in order to get the care they need to get back to their healthiest, patients are building a stronger connection with their primary care teams. Because of the Beacon Health integrated care coordination program our nurses were able to get 20 percent of the Pioneer patients into a SNF from the emergency department, seven percent went directly from their home, another seven percent went straight from their primary care practice. While another 44 percent were admitted after an observation stay and the remaining 22 percent went after a one or two night hospital stay. No matter how each patient was admitted, the common denominator is Beacon Health knew where the patient was, what their needs were, and we were able to advocate for their appropriate level of care.

Is Beacon Health making a difference by having a 3 day waiver program to better support the needs of our Pioneer patients? You bet we are. If you consider from a financial point of view we are providing a significant cost savings for Medicare. According to AHRQ the average hospital stay cost is $2300 per day and according to Medpac the average SNF cost per day is between $450 and $500. (AHRQ, 2012) (Medpac, 2014). One patient who avoided 3 nights in a hospital could save Medicare costs of approximately $5500.

Our patients though are the ones who are truly benefitting because of the waiver. For me and my team of care coordinators this is the best part of the story.

What does this all mean for beneficiaries? For Mr. Smith, an 86 year old gentleman who was living with his wife at home it's meant a better quality of life. Mr. Smith had found himself in the local emergency department for weakness and falls at home. The emergency department assessed him and sent Mr. Smith back home with home care services for physical and occupational therapy. However, Mr. Smith continued to fall at home so the homecare therapist contacted the patient's primary care provider to update them on the continued problems he was having and recommended more intense daily therapy.

The primary care practice reached out to Mr. Smith and asked him to come into the office for a visit. Mr. Smith and his family came in for his appointment when his provider saw a general overall physical decline, with increased weakness which was leading to his frequent falls. Mr. Smith, his family, and his provider wondered if the medications he was taking was contributing to his falls. They decided to make some adjustments to his medications and they also agreed some time in a skilled nursing facility for more intensive rehabilitation could support him living at home safe and independently.

The family took Mr. Smith to the SNF of his choice where he stayed and participated in therapy for 13 days. Mr. Smith returned home to his wife with out-patient services. Since Mr. Smith's discharge from SNF in March, he has had no falls, met his therapy goals and remains living independently at home with his wife. Mr. Smith was never admitted to the hospital, he got the appropriate level of care directly after a visit with his primary care provider.

Because of Mr. Smith and the countless other patients who continue to benefit from our program Beacon Health is looking to expand the number of participating SNF facilities to offer our patients more choices at approved facilities throughout our state, keeping patients as close to home and family as we can. We will

continue to communicate and educate patients, home health care, emergency departments, hospitals, and primary care providers regarding the SNF waiver eligibility to make sure all our Pioneer Medicare patients are offered the appropriate level of care that will improve their health outcome and overall quality of life.

The healthcare world calls it achieving the Triple Aim. Beacon Health sees it more as doing what is right for our patients. By always putting patient and family needs at the center of our care, Beacon Health is able to offer the right care, at the right time, in the right place. When you build strong relationships with your patients, they trust you and turn to you to support their health. We use best practices to guide our care plans coupled with our trusting relationships with our patients and have increased their satisfaction, improved outcomes, and lowered the cost of healthcare. Healthcare is personal and by partnering with our patients and their families we know what they need to be successful.

In conclusion we strongly urge the Senate Special Committee on Aging to recommend to Congress to eliminate the 3 hospital overnight requirement as an antiquated and artificial barrier for Medicare beneficiaries access to skilled nursing facility level of care. Trust us to know what is best for our patients and allow us to provide them with the level of care they need to get back to living their life.

References: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National (Nationwide) Inpatient Sample (NIS), 2003, 2008, and 2012

Medpac, A Data Book: Health care spending and the Medicare program, June 2014