Post-Acute Providers “Partnering” with Acute Care

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Chief Information Officer
Ohio Living

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Ohio Living
Life Plan Communities – Revenue 171M
Owns and operates 12 life plan communities throughout the state of Ohio.

**Choices include:**
- Apt, Brownstone, and villas -
- Independent Living - 1700 beds
- Assisted living – 550 beds
- Memory care
- Skilled Nursing Facility - 940 beds
- Rehabilitation
- Outpatient therapy

Ohio Living
Home Health & Hospice – Revenue 45M
Provides home and community-based services to adults in 48 Ohio counties.

**Services include:**
- Home health care 11,300 episodes
- Hospice – 325 avg. daily census
- ACO participation
- Palliative care
- Adult day centers
- Care management
- Caregiver services
- Home care
- Wellness clinics

Ohio Living
Foundation – Annual Giving 7M
Raises and manages funds to provide charitable support for the people, projects and programs of Ohio Living, with over $224 million raised since 1986.

**Donations support:**
- Capital projects
- Cultural enrichment
- Life care commitment
- Make It Happen
- Spiritual life
Ohio Living’s Organizational Focus

- Growing through Expansion of Services with Increased Residents and Clients Engagement
- Strengthening Ohio Living with Improved Resident/Patient Quality Outcomes and Satisfaction
- Attracting Talent
- Increasing New Partnerships
- Improving Financial Performance
Triple Aim

➢ Improving the patient experience of care (including quality and satisfaction)
➢ Improving the health of populations
➢ Reducing the per capita cost of health care.

Institute for Healthcare Improvement
Post-Acute Care Settings the NEW Focus for Hospitals within the “Continuum of Care”

EXHIBIT 5: Healthcare Continuum
### Market Forces Affecting Healthcare Today

<table>
<thead>
<tr>
<th>Consumerism</th>
<th>What do consumers want?</th>
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<tbody>
<tr>
<td>• Growing influence of consumerism</td>
<td>Changes under way with different Administrations – How will care models continue to change and how does it effect the care continuum?</td>
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</table>

<table>
<thead>
<tr>
<th>Care Coordination</th>
<th>Since 2010, health technology start-ups have raised $7.65 billion from Venture Capital firms. What technologies are changing a patient’s experience, care and cost?</th>
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<tbody>
<tr>
<td>• Transition to Value Based Care</td>
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<tr>
<th>Innovation</th>
<th>Is the exchange of patient data keeping up with demand?</th>
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<tr>
<td>• Growing Disruptive Innovation</td>
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<tr>
<th>Decentralized Care</th>
<th>Where will staff come from?</th>
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<td>• Interoperability, CommonWell, Care Quality, Transitions Alert</td>
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<tr>
<th>Job Market</th>
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<tr>
<td>• Robotics, Efficiencies, Competing for Employer of Choice</td>
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</table>
Specific Post-Acute Care Forces

➢ Patients want to be home – “The best life in the best place”
➢ Post-Acute Providers
  ➢ Are racing to get new patients and keep existing ones
  ➢ Looking to actively reduce costs – demonstrate they are able to compete
  ➢ Are partnering for Model 2 Bundles or leading with Model 3 Bundles to value-based (vs volume based) payments
  ➢ New Payment models are driving need for sharing financial risk and mutual savings
➢ Looking to create new alliances – becoming a “preferred provider” to manage treatment across multi care settings
➢ Diversifying brand to gain an edge over the competition – expanding SNF to include Rehab Therapy, Memory Care, Home Health, Chronic Care, ACOs and Hospice, Telemedicine
➢ Readmission penalties driving more integration of health systems with PAC providers – PACs are considered more than just a “downstream” provider
➢ Seamlessly transitioning in care & creating longitudinal care planning, which is driving a need for interoperability
➢ Developing a new breed of clinicians to monitor risk with a eye on quality
| 1. | A majority (64%) of SNFs used an EHR in 2016. |
| 2. | Almost one-fifth (18%) of SNFs used both an EHR and a state or regional health information organization (HIO). |
| 3. | Three out of 10 SNFs electronically exchanged (i.e., sent or received) key clinical health information. |
| 4. | SNFs that used an EHR and an HIO could send, receive, find, and integrate patient health information at higher rates than those facilities that used an EHR alone. |
| 5. | Nearly two-thirds (62%) of SNFs had information electronically available from outside sources at the point of care. |
| 6. | SNFs that used an EHR and an HIO had patient health information available from outside sources at the point of care at higher rates than those facilities that used an EHR alone. |
| 7. | No significant differences in adoption based on SNF size, Location- urban rural or Type of company – for profit/not for profit |
Challenges

Facing Post-Acute Care Providers

➢ How can we overcome the challenges of organizing the delivery care process to take advantage of our “Care Navigation” abilities?
  ➢ Interoperability standards in support of transitions in care are lagging
  ➢ HIE not always available
  ➢ Referral sources don’t always know their high risk patients
  ➢ CCD’s come as documents, not discreet data files

➢ How can a patient centric information flow help to integrate the LTPAC into the Patients Continuum of Care?
  ➢ Longitudinal care planning needs to begin before discharge to Post acute
  ➢ Receiving higher acuity patients
  ➢ Need time data sharing to foster longitudinal care planning
Post Acute Care Strategies

- Decreased Readmission
- Improved functional Outcomes
- High Patient Satisfaction
- Online Referral Management

- EMR – tablets
- Home Health Telehealth – remote monitoring
- SNF Telehealth – Physicians - providing remote care on “off hours”
- Transitions Care Setting Tracking

- Access to patient’s CCD via the State HIE
- Interface Direct w/ an Epic Hospital - exchange the CCD w/ SNF/Rehab
- Direct access to Hospital’s EMRs
- ADT Tracking with CCDs

- Report on our Readmission rate, ALOS & Costs
- HRR rates
- Competitor Analysis

- Quality Care Transitions
- Interoperability
- Innovation
- Data Analytics
Quality & Care Transitions

Metrics
- 5 Star ratings – Patient Care Measures and Patient Satisfaction
- HRR – Below the National Average and significantly lower for specific populations
- Citations, Accreditations

Outcomes Measures Ratings & other Accreditations
- 5 STAR Improvement in Daily activities, pain levels, Dyspnea
- CARF – Commission on Accreditation of Rehab Facilities focused on Quality and results
- JCAHO – Inpatient Rehab Facilities
- OASIS - CQM home care reporting

Patient Experience of Care Star Ratings
- Satisfaction with overall care
- Percent of Patient who would recommend
- Survey response Rates
Innovation in Post Acute

➢ Telehealth

➢ SNF – Using a vendor with Diagnostic tele-health capabilities

➢ Home Health Implemented a system that provides the transfer of VS, weight, blood sugar, patient education, medication reminders

➢ Wearables
• Transitions of Care ADT Alert system

Coordinate Care Everywhere: To make the US health care the highest quality at the lowest cost by connecting providers to seamlessly coordinate care.
Interoperability

- Connecting through our State HIEs or Direct Exchange
  - Access to the CCD
- Exchanging with Hospitals directly
  - ADT transfer of care systems
  - Sending hospitalist billing file to the acute care billing system
- Hospitalists to “peek in” on patient at PAC facility

Post-Acute September 27, 2017
# Geographic Data Analysis

Medicare FFS Discharge Pathways, Patient Outcomes
Values less than 11 omitted per CMS' Data Use Agreement

| Facility Type | State | County | Provider ID | Facility Name | Grouping | Facility Type | Provider ID | Facility Name | Case Volume | Facility | County | Market | Facility | County | Market | Facility | County | Market | Facility | County | Market |
|---------------|-------|--------|-------------|---------------|----------|--------------|-------------|---------------|-------------|-----------|---------|--------|---------|---------|--------|--------|---------|--------|--------|---------|--------|--------|
| IP            | OH    |        |             |               |          | SNF          |             |               | 17          | 13.7      | 14.8    | 15.5   | $6,089  | $6,355  | $6,746 | null    | 7.1%    | 7.7%    | null    | 0.0%    | 0.0%    |
| IP            | OH    |        |             |               |          | SNF          |             |               | 13          | 11.4      | 14.8    | 15.5   | $5,453  | $6,355  | $6,746 | null    | 7.1%    | 7.7%    | null    | 0.0%    | 0.0%    |
### Preferred Provider Metrics

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<th>March-16</th>
<th>April-16</th>
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<th>June-16</th>
<th>July-16</th>
<th>August-16</th>
<th>September-16</th>
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PAC Future Strategies & Opportunities

➢ Strengthen our ability to partner with acute care hospitals and physicians – Open dialogue and share information

➢ Use data to strengthen our relationships for Quality Improvement Initiatives, predict and identify highest risk patients

➢ Foster gain sharing with acute hospitals and physicians to align incentives

➢ Leverage ways to use technology to smooth transitions in care

➢ Increase efforts to significantly reduce readmissions

➢ Increase Chance to manage acute hospitals PAC needs and population health management through new reimbursements for telemedicine
Ability to assist with development of new bundled pay culture as it evolves within your organization

Ability to collaborate with a Model 2 acute hospital

Exchanges data with the state HIE or with AC Partners directly

Experience with a learning culture that can apply insight of Analytics tools.
  - LACE tool for predictive models to avoid readmissions

Care Navigation and longitudinal care planning for case management

Applied Analytics – avoid inefficiency of “one size fits all” care
Are we there yet?

“Electronic medical records are, in a lot of ways, I think the aspect of technology that is going to revolutionize the way we deliver care. And it's not just that we will be able to collect information, it's that everyone involved in the healthcare enterprise will be able to use that information more effectively.”

Risa Lavizzo-Mourey, President and CEO of the Robert Wood Johnson Foundation