POST-ACUTE CARE

Insights, Future Trends, Strategy Considerations

Cathy Barr
Senior Vice President and Chief Operating Officer
HealthEast

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HEALTHEAST

- HealthEast is an integrated system of preventive, primary and secondary care services which serves the Twin Cities' East Metro and Western Wisconsin.
- Established 1986, proudly celebrating 30 years as a system
- Unified four hospitals (representing different religions and care philosophies) that had been competitors for over 100 years. Collaboration led to successfully serving our community. (Midway ultimately closed in 1997)
- CMS four-star rating (short-term acute care hospitals) 2016
- Leadership transformation after 40 years

KATHRYN CORREIA

President and CEO

- January 2012
- ThedaCare
- Lean expertise
- Lean’s role in the success and sustainability of health care
- Moving from volume to value
- Improve processes and performance and increase the value we bring to patients, employees and communities. Deliver benefit, remove burden.

President and CEO

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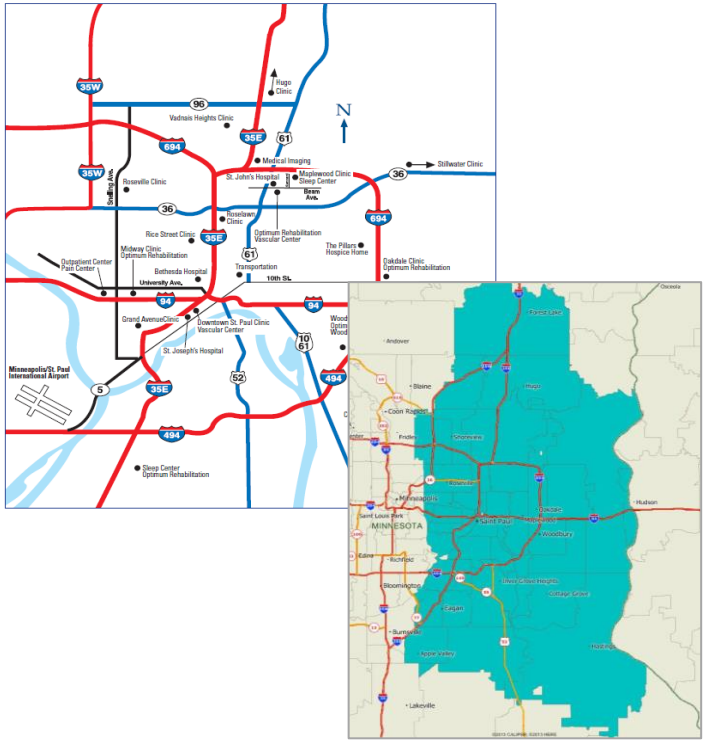
WHERE WE ARE LOCATED



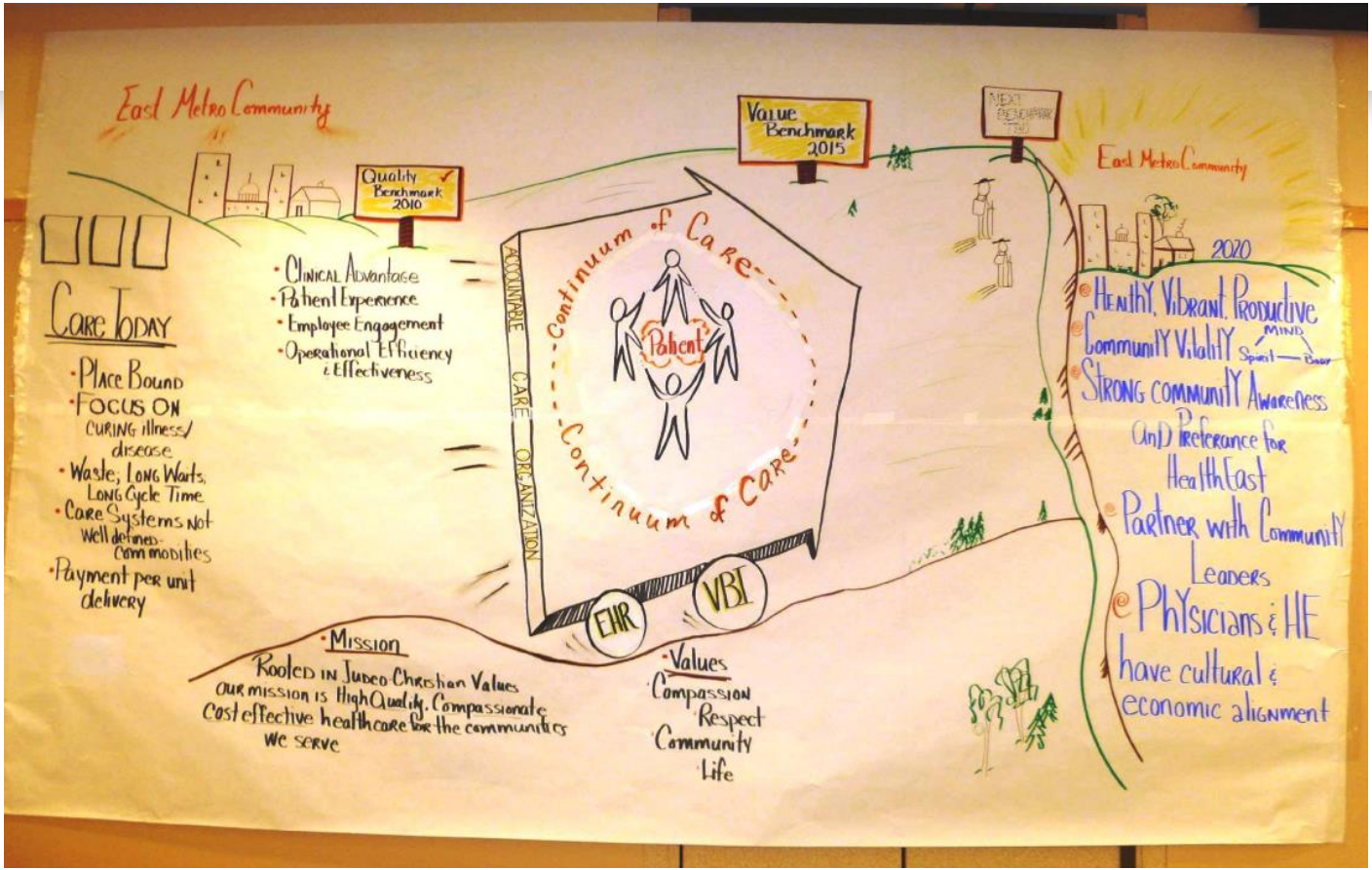
- HealthEast is a full-service provider serving a diverse and widespread area in the Twin Cities East Metro – St. Paul neighborhoods and suburban communities
- 1.1 million residents - 63 languages
- 14 primary care clinics
- Four award-winning hospitals (one LTACH)
- Multiple specialty centers
- Comprehensive wellness program
- Home health and Hospice
- Community outreach
- Partnerships (MHCA, MVNA, VNAA, Fazzi, Cerenity, Lake Superior Quality Innovation Network through Stratis Health to reduce readmissions and improve the coordination of care for Medicare beneficiaries.)

COMING IN 2017…

- HealthEast Medical Center – Maplewood | Multispecialty Center
  - Primary Care
  - Ambulatory Surgery
  - Specialty Care
  - Pharmacy
  - Radiology

Provide integrated care
Disciplines united under one room
Create effortless experiences for patients

INTENTIONALITY EASES BURDENS AND BRINGS BENEFITS TO OUR PATIENTS



GUIDING OUR WAY

Mission
We are called to improve the health of our neighbors.

Vision
Optimal health and well-being for our patients, our communities and ourselves.

Values
Customer First | Act with Courage | Trust and Confidence | Joy

Spiritual Philosophy
HealthEast remains committed to a ministry of compassion and healing in a way that respects the dignity of every person and honors his/her faith, culture and community.

FROM SILO TO SYSTEM

HealthEast Operations: Short-term Acute Care, Post-acute Care, Community Services, Ambulatory Services, Shared Services

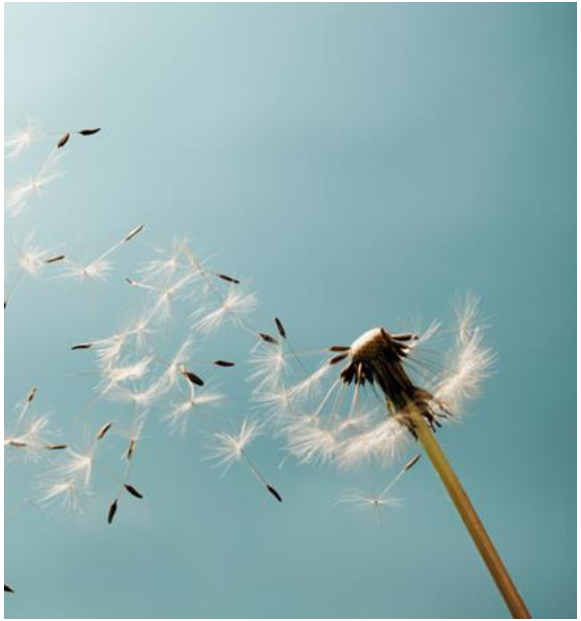
Old Measured success through market share; business model based on *volume*

New Measure success through the *value* of our service and well-being of our patients

Then Silos: About *us* – Inward orientation

Now System: About the *patient* – Collaborate across services to optimize care

OUR VISION FOR THE FUTURE



Past

- Business model based on procedures and inpatient volume (heads in the bed)
- Measured success through market share
- Operated in silos
- Pay for sickness

Future State

- Optimal health for the East Metro population
- Measure success through service value and patient well-being
  - prevention and wellness
- Collaborate across services to optimize care
- Pay for chronic illness management and coordination

FUTURE FORWARD

- Focus, flow, innovation

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TRENDS

Population:

- 11+ million community-dwelling people in the US need long-term service and support
- 70 percent of those 65+ are expected to have a long-term care support or need
- Of this group, men have a 44 percent risk of needing nursing home care; women have a 58 percent risk of needing nursing home care
- The number of people 65+ will double between 2000 and 2030; currently there are seven potential family caregivers per adult. By 2030, there will only be four.
- By 2050, global life expectancy will increase by almost eight years.

Medicare:

- In 2015, Medicare paid providers/physicians $380 billion (was $362 billion in 2014)
- In early 2016, Health and Human Services announced that 30 percent of Medicare payments are now tied to alternative payment models that reward quality of care over quantity of services (i.e., ACO)
- By 2018, 90 percent of Medicare fee-for-service will be tied to quality or value
- Clear realization that shift to value-based payment is the future

GOVERNMENTAL LANDSCAPE, PART 1

- IMPACT Act overarching goals:

Unified system of payment

- Centers for Medicare & Medicaid Services (CMS) push for a site-neutral, value-based system spanning PAC settings

Stricter quality measures/data reporting

- Standardized
- Common definitions
- Exchangeable information

GOVERNMENTAL LANDSCAPE, PART 2

- **What**:
  - Health and Human Services quarterly performance reporting
  - MEDPAC prospective payment system

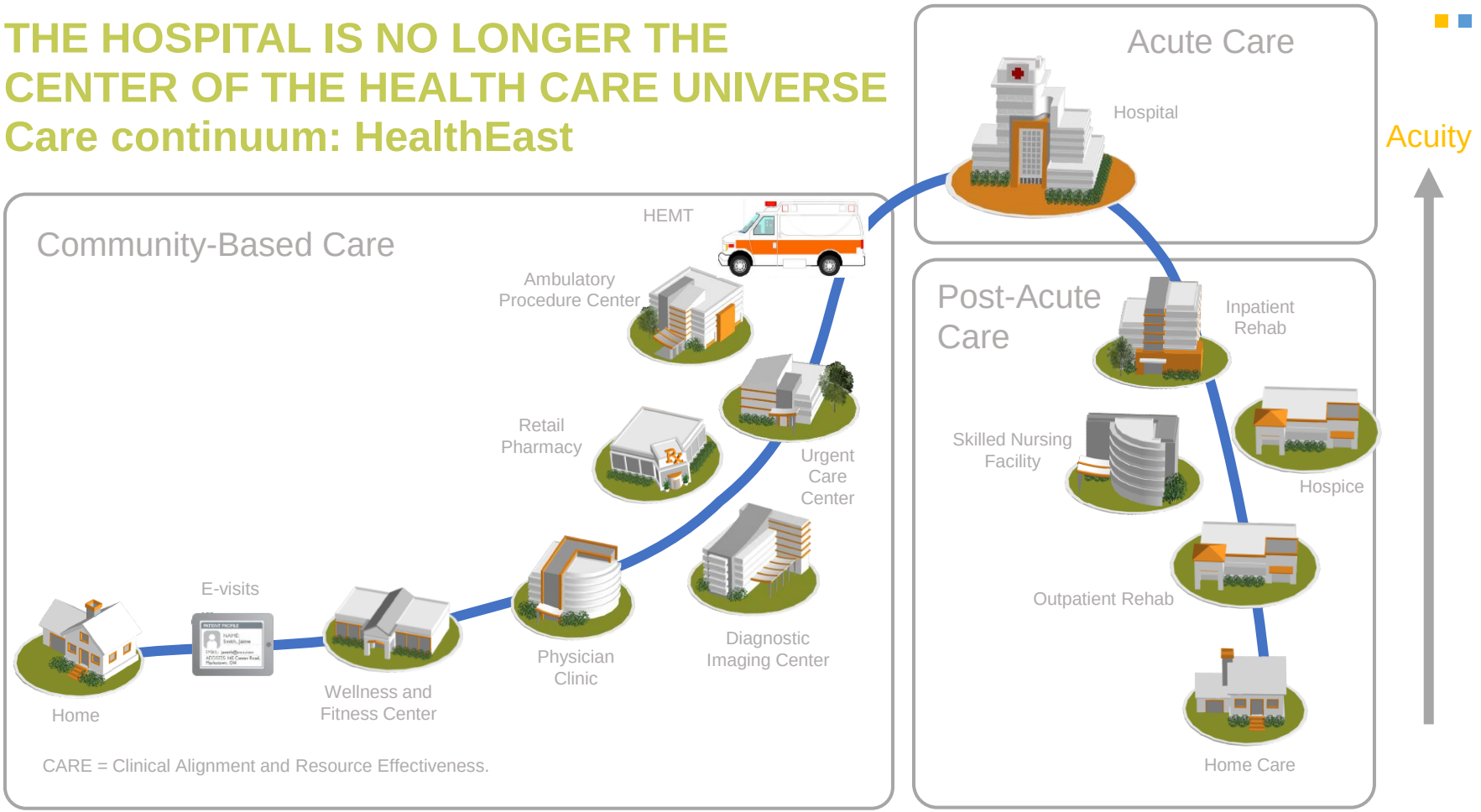
- **When:**
  - ***No later than Oct. 1, 2018***

    Mandatory standardized patient, quality and resource data reporting for SNFs, IRFs, LTACHs
  - ***No later than Jan. 1, 2019***

    Mandatory standardized patient, quality and resource data reporting for HHAs

THE HOSPITAL IS NO LONGER THE CENTER OF THE HEALTH CARE UNIVERSE

Care continuum: HealthEast



WHAT IS NEXT? STATUS QUO WILL NOT LAST!

- **Consumerism** cannot be underestimated
- Gradual transformation specific to **partnership** and **infrastructure**

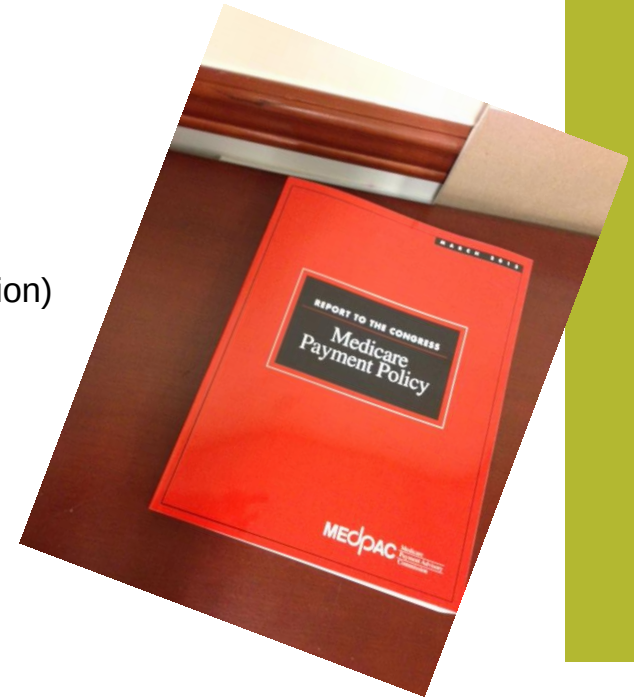
- **Longitudinal** care and **cross continuum** approaches
  - Team-based care
  - Focus on medical home
  - Practitioners working at the top of their license
  - Volunteer corps

- Align and leverage **financial** and **clinical models**
  - Risk-based contracts a sign of the times (payor and providers)
- **Technology solutions**

  *My*Chart and e-health virtual care

CURRENT SIGNALS LEADING TO MARKETPLACE ADJUSTMENTS:

- Bundling will lead to vertical integration.
- Providers own most PAC services.
  - When providers do not own these services they:
    - Form partnerships
    - Negotiate bundles together (scale and critical mass a consideration)
    - Align to quality and cost incentives/targets
- Outsourcing:
  - Exit business and partner with larger for-profit entities
    - Kindred
    - Baylor, Scott and White



WHAT SHOULD PROVIDERS CONSIDER? ALIGN, VENTURE, OR DO IT ALONE?

- Health systems platforms for change:
  - Transition Management: flawless care transitions
  - Alignment of consistent strategic initiatives and metrics
  - Development of broad network that supports longitudinal care, non-Medicare services
    - Referral management mechanisms for PAC services
      - Cost, quality and consumer choice all part of the equation
- Acute care hospitals
  - Linkage Committee
- Community providers
  - MSHO, Medical Care for Seniors, Faith Community Nurse Network, private duty providers

FLAWLESS CARE

- The organization's overall flawless care score measures areas of performance at the entity, business unit and organizational levels by combining structure, process and outcome measure results to produce a single score.
  - **Home Health**
    - *Improve pain with activity at discharge*
    - *Admission to Acute Care*
  - **Hospice**
    - *Falls at night*
    - *Referral from SNF*

Flawless Care Scorecard

YTD	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug
10.38	3.77	8.65	10.87	25	13.34	21.39	14.61	19.82	18.49	15.27	-29.98	11.18

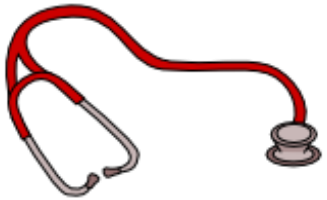
Measure Category	Measure	Baseline	YTD	Change
Brain and Spine	Access - Days until Third Available Appointment for Neurosurgery, Pain Clinics	22.62	19.12	15.49
Cancer	New Consults with Stage IV Cancer Referred to Palliative Care	4.35	4.85	11.42
Comm/Sr Outreach	Readmission Rate From SNF to Acute Care	11.39	11.88	-4.31
ED Outpt	Door to Diagnostic Evaluation by a Qualified Medical Personnel (Mean)	42	42.9	-2.14
ED Outpt	ED Head CT Scan Results for Acute Ischemic Stroke or Hemorrhagic Stroke who Received Head CT Scan Interpretation	53	87.5	65.09
ED Outpt	ED Mean Time to Pain Management for Long Bone Fracture	72	65.6	8.89
[illegible]	Mean Time [illegible] Arrival to ED Departure for Discharged ED Patients	197	193.9	1.57
Global IMM	Immunization for Influenza (1- March)	93	95.7	2.9
Heart Care	Heart Failure Follow-Up Within 5 D[illegible] of Discharge	47.83	43.14	-9.8
Heart Care	Heart Failure Order Set Usage	61.54	66.9	8.71
Home Health	Admission to Acute Care (60 days)	20.07	13.36	33.43
Home Health	Improvement in Dyspnea at Discharge	62.75	64.49	2.77
Home Health	Improve Pain With Activity at Discharge	61.39	67.03	9.18
HOP Acute AMI/CP	Aspirin at Arrival	97	97	0
HOP Acute AMI/CP	Mean time for Acute Coronary Intervention Transfe	65	59	9.23
HOP Acute AMI/CP	Mean Time to ECG	18.11	12.74	29.65
HOP Acute AMI/CP	Mean Time to Tx with Reason for No Fibrinolyt[illegible] (Mn.)	97.43	37	62.02
Hospice	Comprehensive Pain Assessment Comple[illegible]	45	88.87	97.48
Hospice	Falls at Night	80	31.55	60.57
Hospice	Hospice Referrals From SNF	15	15.04	0.29
Infections	Abdominal Hyste[illegible] y SSI	0.6	0	100
Infections	[illegible] SSI	6.8	6.7	1.47
Inpt ED Throughput	Mean time from Admit decision to time of departure from the ED for patients admitted to the hospital (Reported Measure)	78	86	-8.97
Inpt ED Throughput	Mean time from ED arrival to time of departure from the ED for patients admitted to the hospital (Reported Measure)	271	263	2.95
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

KEY TO ALIGNMENT

- Cross continuum from pre-acute to post-acute
  - Appropriate setting based on patient type
  - Partnership around high acuity/complexity
- “Get ‘er done” approach via network development or vertical integration
  - Form PAC networks
  - Scale/critical mass
  - Continuum-based services
- Social determinants critical to managing the elderly and diverse populations
  - Form PAC networks
  - Scale/critical mass
  - Continuum based services

HOME HEALTH AND HEALTH CARE SYSTEMS

- Health care systems will continue to invest in home health
  - Cost center versus profit center
  - Service line mentality
  - Prevent avoidable/unnecessary hospital admissions
- Home health can be:
  - “pivotal” mediator in managing care of the patient
- Given emerging complexity, consider critical care nurses, NPs or PAs for high-risk patients



64%

of Medicare beneficiaries readmitted within 30 days did not receive PAC services

MedPac report to Congress

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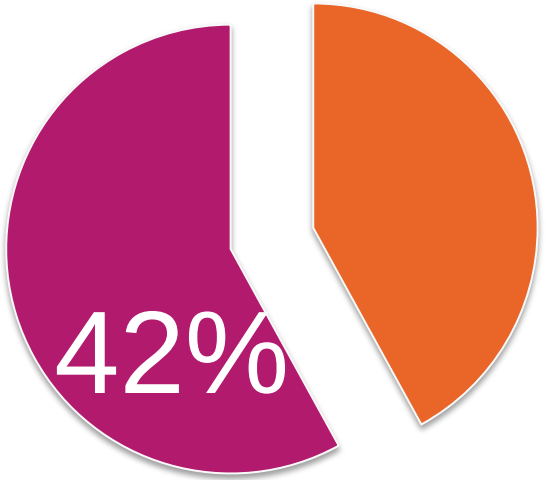
SKILLED NURSING FACILITIES AND AFFILIATION ARE IMPORTANT TO HEALTH SYSTEMS

- Cost
- Quality
- Affect STACH LOS
- Affiliated with brand and reputation



of respondents say skilled nursing is the PAC services area most in need of reform.

Source: Healthcare Intelligence Network (HIN) Report 2015

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NEXT STEPS FOR POST-ACUTE CARE

- Strengthen evidence base
- Increase patient-centered focus
- Streamline data collection requirements
- Improve hospital to PAC discharges
- Develop alternative approaches for low-volume providers
- Develop more effective risk adjustment methodologies
- Enhance regulatory relief

Trendwatch, American Hospital Association, December 2015

CONSIDER THIS:

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HOW YOU AND YOUR AGENCY IMPACT THE FOLLOWING AREAS?

- Episodic care with disease-specific focus
- Costs and value
- Enhancing and improving quality year over year
- Being good stewards of your resources
- Patient advocacy
- Full continuum approach and transition management
- Palliative Care (Home Care can help families identify goals of care, needs and limitations, with possible transition to hospice when needed. Also avoid readmissions or ER visits due to lack of items or services that Home Care could have provided).
- Non-skilled/non-Medicare services
- Linkages with medical homes (Home Care adds to the support a patient receives in the clinic. Improves management of overall condition.).

SUMMARY OF POST-ACUTE CARE INDUSTRY TRENDS

- Collaboration and integration
- Invest, not necessarily own, community services
- Partnership: an alternative for smaller providers
- Agreement of cost/quality metrics
- Innovative workforce alternatives

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FUTURE PLAY: INDUSTRY ASSOCIATION CONSIDERATIONS

Put head down and move forward using:
▶ Traditional pathway
▶ Education
▶ Networking
▶ Public policy

Consider additional options:
▶ Develop one, statewide home health voice
▶ Town hall meetings to increase consumer awareness (partner with MAHA, Leading Age)
▶ Participate in community grassroots efforts “Silos to Circles”
▶ Garner visibility with PR

INDUSTRY ASSOCIATIONS: MAKE SOME NOISE!

- Represent the industry locally and nationally
- Work to integrate care at the community level
- Partner with public health to impact community health ratings
  - Align resources and focus
- Partner with other industry organizations through
  - Conferences
  - Town hall meetings
  - Workforce planning
  - Education and training programs with local colleges
- Improve quality scores
- Get results through advocacy efforts including
  - Data
  - Patient stories
  - Video clips
  - Relationships

KEEP TRACK OF INNOVATION AND SHARE!

- Byline articles
- Develop poster presentations
- Attend conferences
- Quality, reform and access are hot topics
- Partner more effectively with Hospice and Palliative Care for reportable progress on innovation

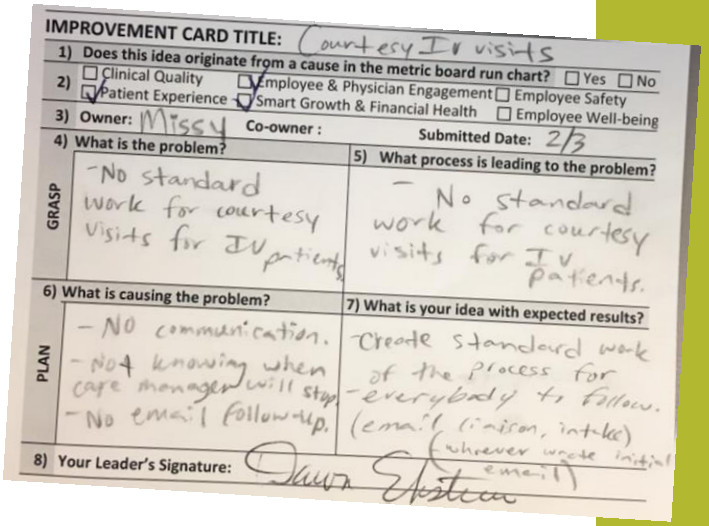
REAL-LIFE INTERNAL AND EXTERNAL PARTNERSHIPS

THE RELATIONSHIP OF LIAISONS & CARE MANAGERS

- Liaison partners with care managers in the three short-term acute care hospitals (STACHs)
  - Care manager will hand off the referral to the liaison
    - Liaison meets with the patient, checks the insurance, and facilitates a coordinated transition to Home Health.
    - Liaisons attend Care Management Value Based Improvement (VBI) huddles to look for improvement opportunities in hospital-to-home transitions.
    - We offered 13 open houses in August to capture real time feedback on what is working and identify improvement opportunities.
  - 80 care managers attended
  - Overwhelmingly positive feedback

AREAS OF OPPORTUNITIES

- **Care manager feedback generated 20 VBI cards and two A3 projects**
  - **Communication - Improve care coordination**
    - Care managers & liaisons – Improved communication (Skype, updates & e-blast)
    - Patients - New tailored program materials – e.g., instructions.
  - **Education – Increase awareness, ease of access**
    - Clinicians – Educate on program services and orders
  - **Courtesy visit – Ensure patient comfort level prior to discharge**
    - Improved process for additional nurse visit for home infusion


IMPROVEMENT CARD TITLE: Courtesy IV visits

1) Does this idea originate from a cause in the metric board run chart? ☐ Yes ☐ No

2) ☐ Clinical Quality ☑ Employee & Physician Engagement ☐ Employee Safety ☑ Patient Experience ☑ Smart Growth & Financial Health ☐ Employee Well-being

3) Owner: Missy Co-owner : Submitted Date: 2/3

GRASP

4) What is the problem?
- No standard work for courtesy visits for IV patients

5) What process is leading to the problem?
- No standard work for courtesy visits for IV patients.

PLAN

6) What is causing the problem?
- NO communication.
- Not knowing when care manager will stop.
- No email follow-up.

7) What is your idea with expected results?
Create standard work of the process for everybody to follow. (email (liaison, intake) whoever wrote initial email)

8) Your Leader's Signature:

Patient comment:

"I was a patient in your hospital and home care. I want to thank you for all of your help. You were all so kind and I appreciate it very much."

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FRONTLINE MANAGEMENT SYSTEM - LEAN

- **Using Lean and Value Based Improvement as framework**
  - Respect for people
  - Every person is a problem solver
- **Regular “huddles” foster visibility and real time thinking around “problems”**

Lean principles provide us with a system-wide framework of how we work together to improve the health and well-being of patients, communities, and ourselves.

AWARDS OF DISTINCTION/PUBLIC RECOGNITION

- ACHC (Accreditation Commission for Health Care) Certificate of Accreditation;

  July 15, 2015 – July 15, 2018
- SG2 Post-Acute Care Strategy (Integrations and Collaborations)
- *Preventing Falls, Saving* Lives, The Chairman's File, American Hospital Association
- Home Health Quality Improvement National Campaign Agency of the Month
  February 2015
- CMS Star Ratings system performance

  July 2015

THANK YOU / QUESTIONS

Presented by:

Cathy Barr, Senior Vice President and Chief Operating Officer

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