Building and Maintaining a Post-Acute Preferred Provider Network:

Advanced Quality Outcomes

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HIMSS
CENTRAL & SOUTHERN OHIO *Chapter*

Agenda

- TriHealth At A Glance
- Local Problem
- What is AQO
- Workflow Solution and Design
- Intended Project Outcome
- Workflow Design
- Value Proposition
- Next Phase of AQO
- Wrap Up and Questions

TriHealth At A Glance

- Four acute-care hospitals with 900 adult-staffed beds
- One short-stay surgical hospital
- Three free-standing outpatient surgery centers
- Over 140 outpatient service locations
- Over 150 physician practice locations
- Over 850 employed physicians
- Over 1,800 physicians on medical staff
- Over 12,000 employees

TriHealth

TriHealth Awards for Clinical Quality, Technical Excellence and Employee Engagement

HIMSS DAVIES AWARD WINNER

Watson Health 100 TOP HOSPITALS 2019

Watson Health 15 TOP HEALTH SYSTEMS 2019

HealthCare's most wired WINNER 2018
WINNER 2014 • WINNER 2015 • WINNER 2016 • WINNER 2017

Becker's Hospital Review
150 Top Places to Work in Healthcare 2019
#BECKERSTPTW19

LEAPFROG HOSPITAL SAFETY GRADE
A GRADE

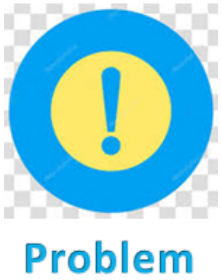
WORLD'S BEST HOSPITALS 2019
Newsweek
statista

MAGNET RECOGNIZED
AMERICAN NURSES CREDENTIALING CENTER

TriHealth Wins in Post-Acute

- HIMSS Davies Award Jan 2019 (presented at HIMSS)
- Post-Acute presentation at EPIC XGM May 2019
- QSS Mission Award for post-acute
- Nomination for the Dr. Richard Smith Leadership in Quality Award (Health Collaborative)
- Recognition from the Advisory Board (Washington DC) for Best Practice in sharing information with patients, SNF, Hospital about preferred providers

Local Problem

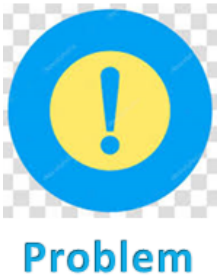


Over 180 SNF in Cinti market, TriHealth does not own any SNF

Collaborate with all SNF to improve quality local SNF to achieve triple aim

In the beginning capturing data manually which was time consuming but important to measure quality

Local Problem

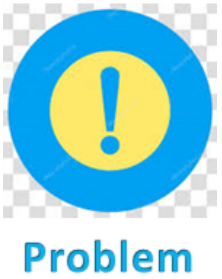


Historically data was based on perceived quality and we have moved to actual quality

We wanted to educate patients and team members throughout organization about value of network that was based on quality that was objective

An automated system was needed to track quality to develop and maintain a post-acute preferred provider network

Where We Started



	Jan - Dec 2015
Discharges to Preferred Providers	unknown
Post Acute Spend	$703/member
SNF Expenditure	$ 17,575,000.00
FTE Expense	$31,250

What is TriHealth Advanced Quality Outcomes (AQO)

AQO measures quality in post-acute for the management and determination of the preferred provider network that is based on objective quality data by:

- ✓ Monthly onsite contact with SNF and Educational Programming to share best practice every 6-9 weeks- attended by nursing leaders at SNF. Video-taped for education of all team members @ SNF
- ✓ Open discussions with all members of the treatment team to share data to improve network utilization
- ✓ AQO Monthly Meetings with SNF and HC to share best practice, communicate efforts, and share overall outcomes of the data
- ✓ Documentation within EPIC of quality metrics by disease for all patients discharged from TriHealth to SNF or HC data

Importance of Team in Decision Making

Design

- Health Network Solutions- clinically integrated network that serves Tri-State region. A partnership between St. Elizabeth and TriHealth

- TriHealth Physician Hospital Organization- value driven organization committed to providing high quality, cost effective health services

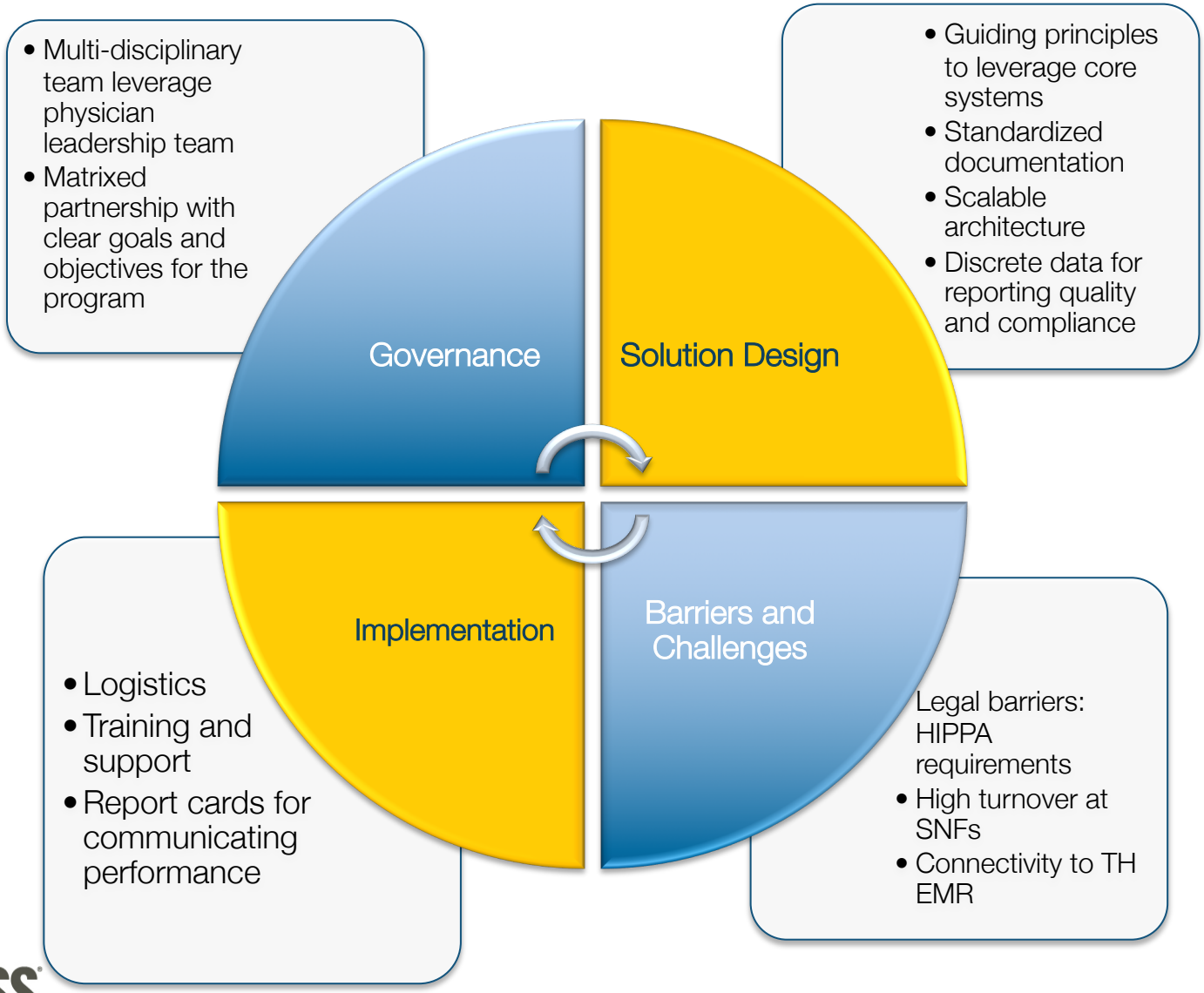
Multiple Teams work together for the development and ongoing management of the TriHealth Preferred Provider Network

Intended Project Outcomes

- Increase communication with SNFs and Home Care Companies
- Increase documentation compliance
- Decrease readmissions in post-acute
- Improve utilization of preferred partners who demonstrate better quality outcomes
- Increase shared savings
- Move from an environment of **perceived quality** to **data driven quality** performance for our patients
- Develop and manage a SNF/ Home care preferred provider network based on quality

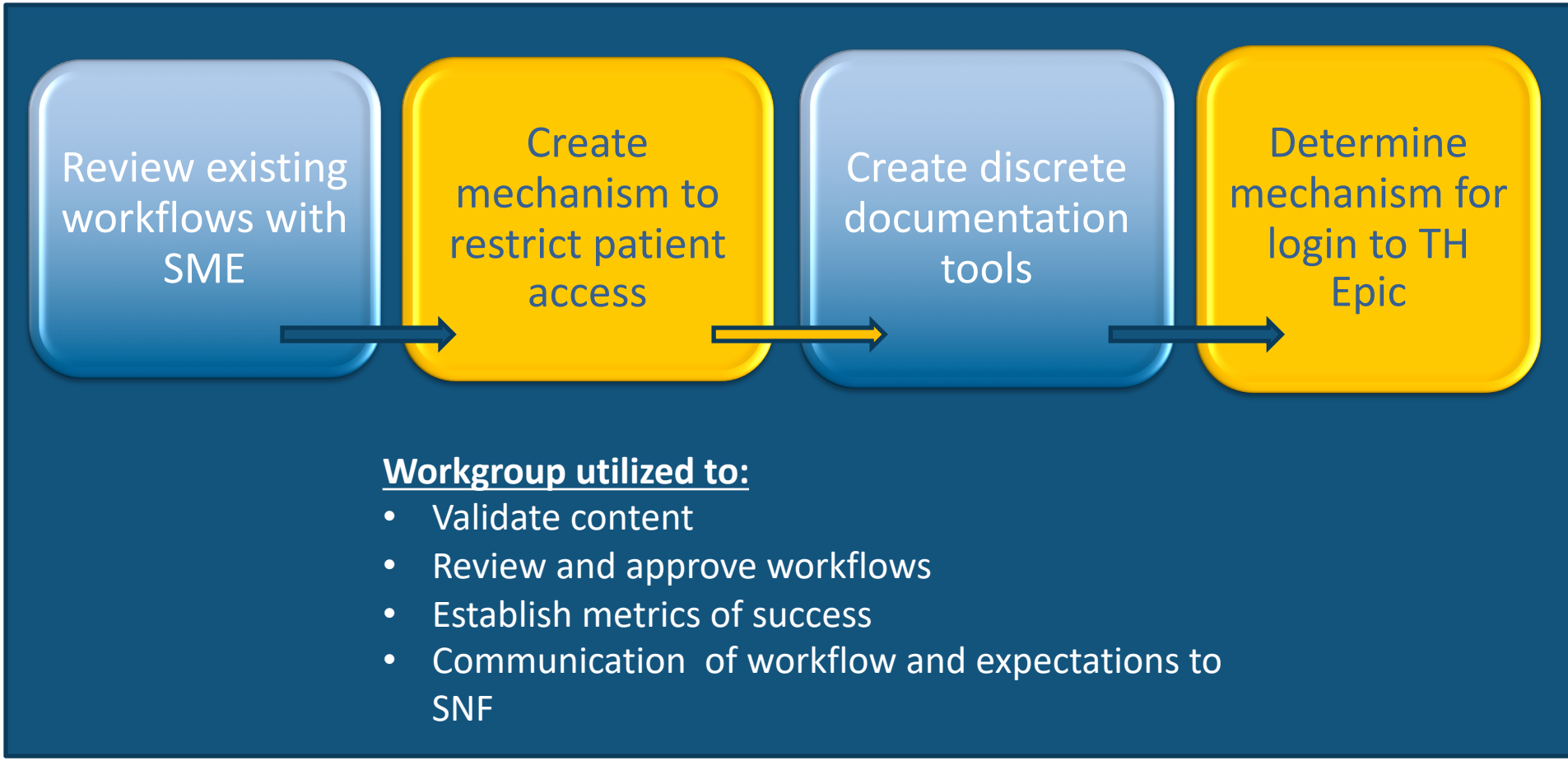
Workflow and Solution Design

Design



Process for Workflow Development

Design

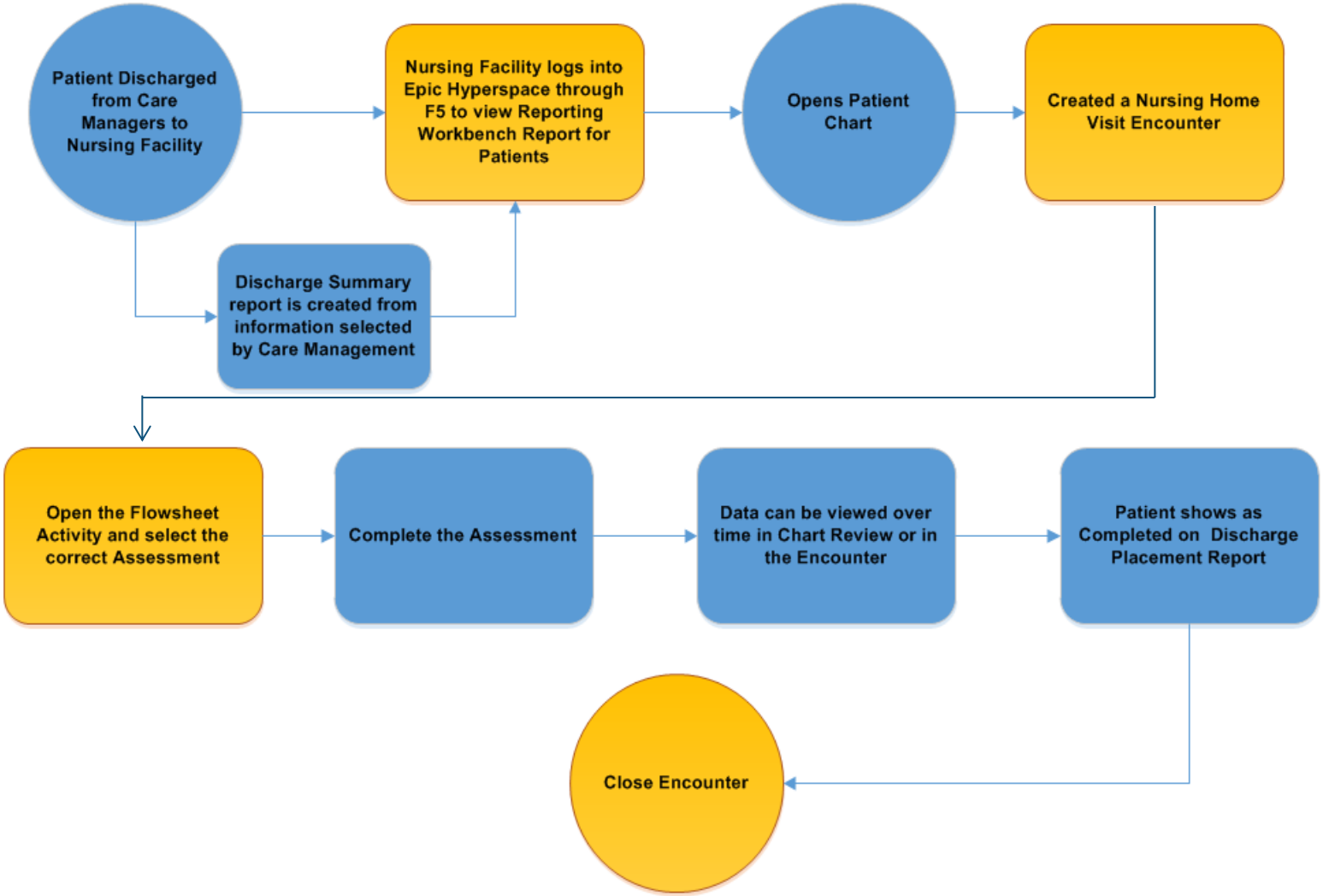


Workgroup utilized to:

- Validate content
- Review and approve workflows
- Establish metrics of success
- Communication of workflow and expectations to SNF

Workflow Design

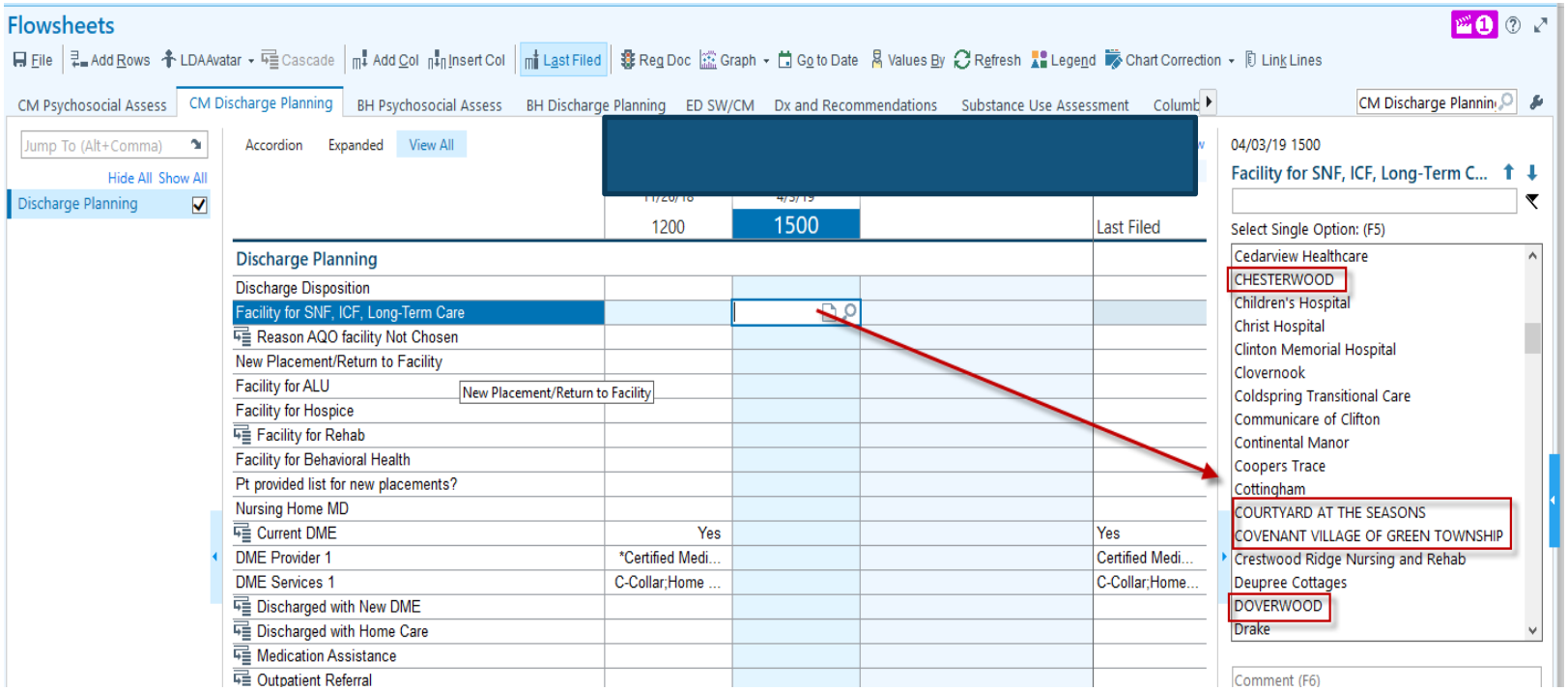
IT Tools



- Discharged from Hospital to SNF
- SNF Logs into TH Epic
- Reporting Workbench Report
- Create SNF Encounter
- Flowsheet Documentation
- Reporting Tools

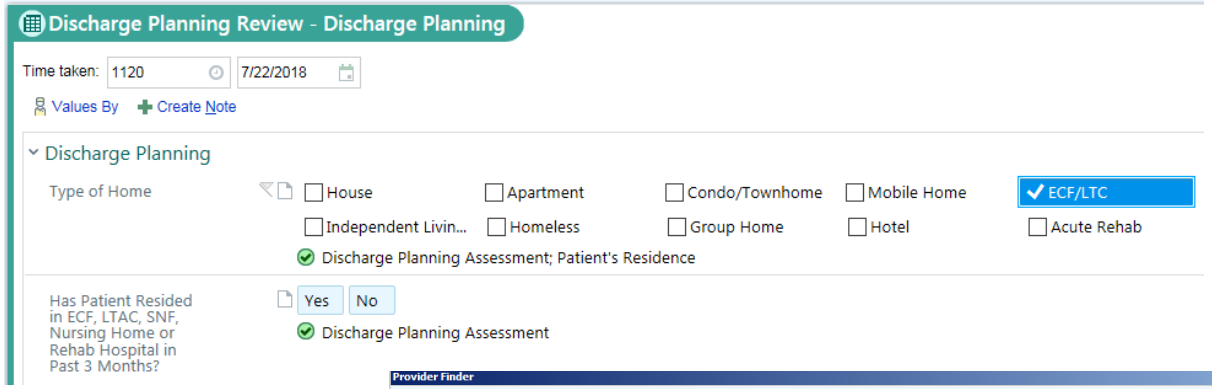
Clinical Workflow
Social Worker/Care Management

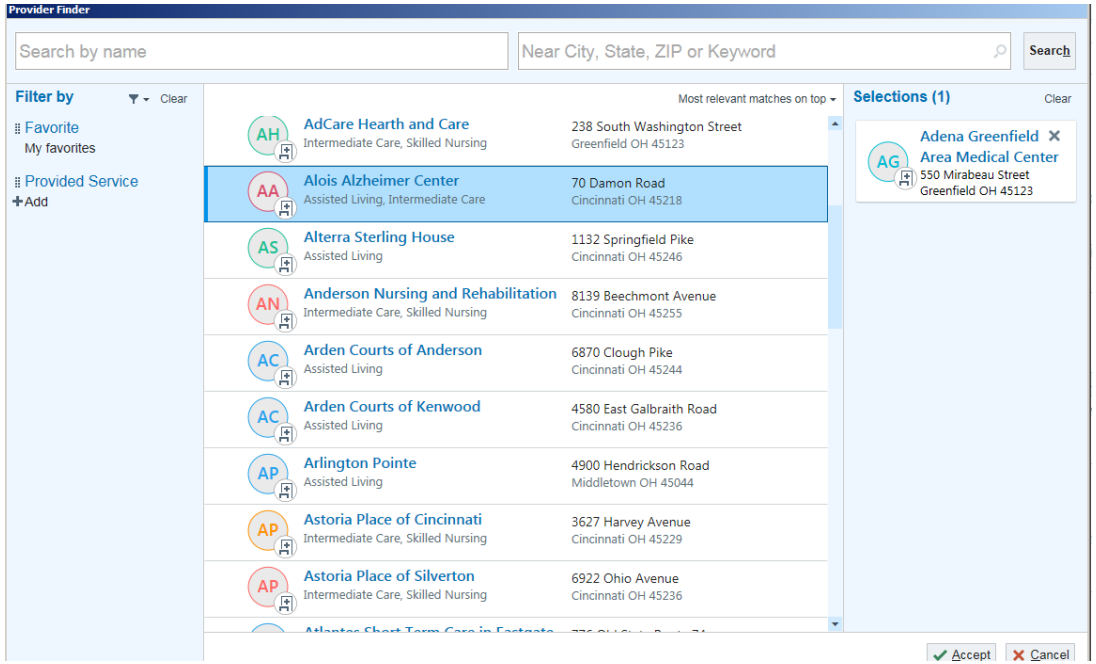
- Care Managers Documents Discharge Assessment to Trigger Clarity Report
- To help Inpatient Care managers know who the Preferred Providers are, All Preferred providers are capitalized in EPIC



Clinical Workflow
Social Worker/Care Management

IT Tools





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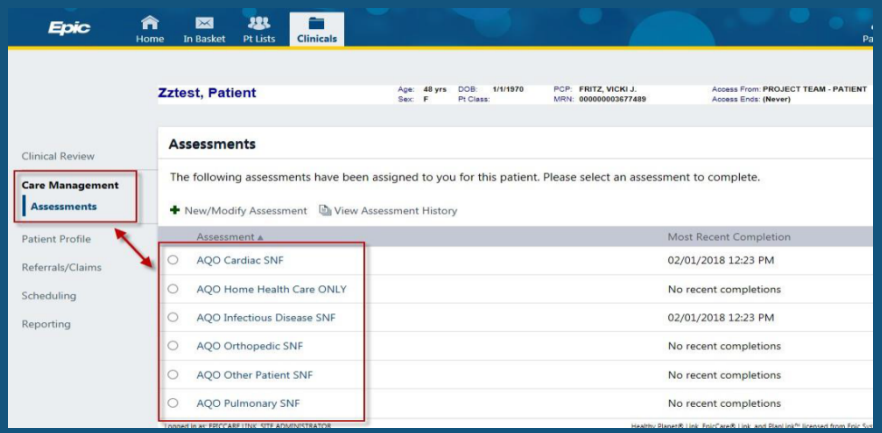
IT Helps Make Documentation as easy as 1,2,3…

IT Tools

#1 Log into TH EMR

#2 Locate DRG specific assessment



#3 Document on patient

- Discharged from Hospital to SNF
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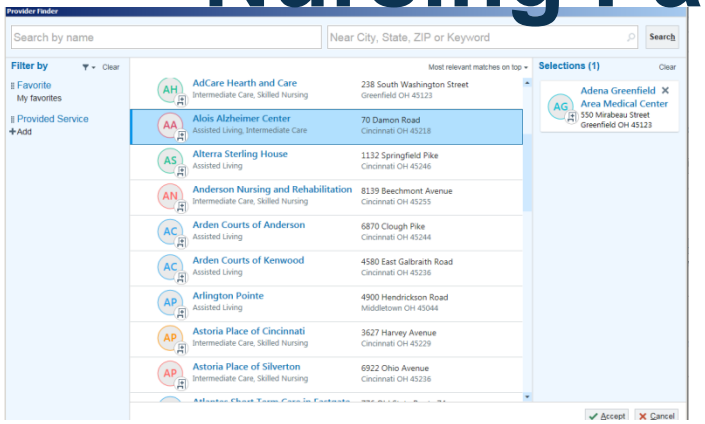
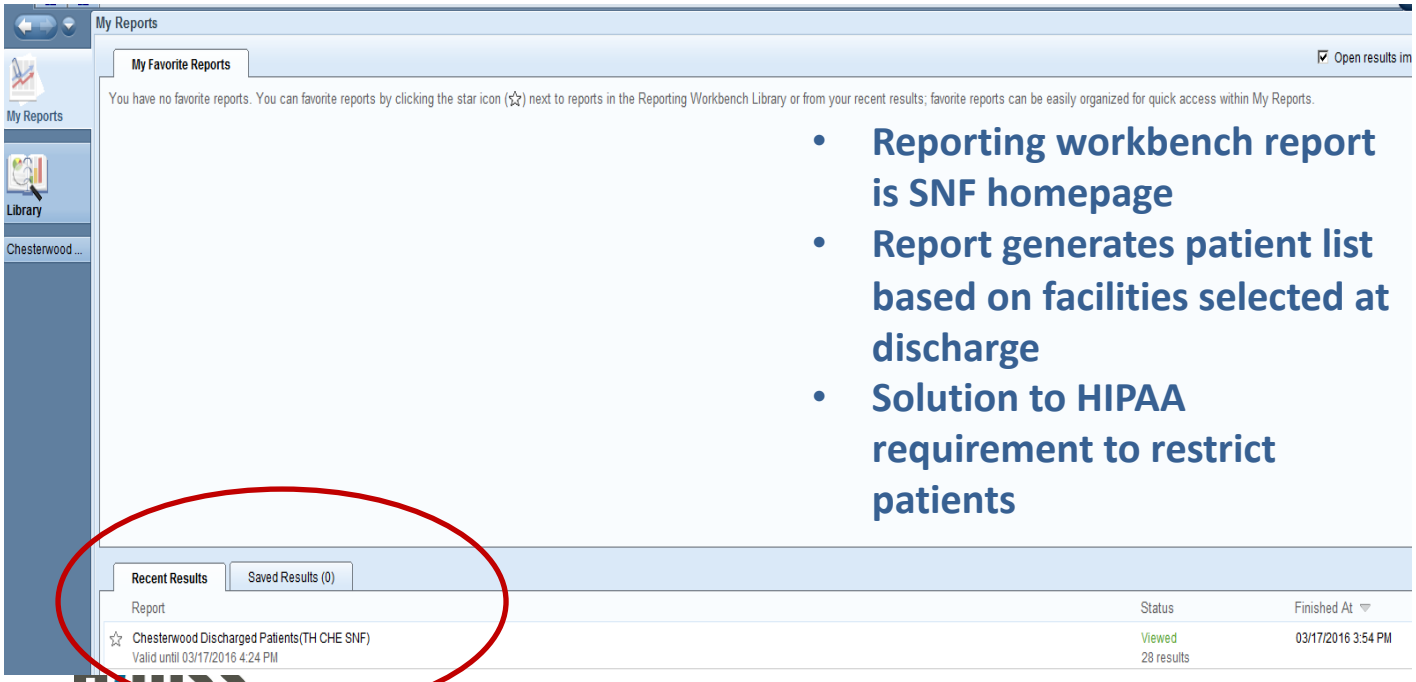
Clinical Workflow – Skilled Nursing Facility

IT Tools



<u>Solution design:</u> Social Worker selected facility at discharge establishing patient relationship



- **Reporting workbench report is SNF homepage**
- **Report generates patient list based on facilities selected at discharge**
- **Solution to HIPAA requirement to restrict patients**

Discharged from Hospital to SNF

SNF Logs into TH Epic

Reporting Workbench Report

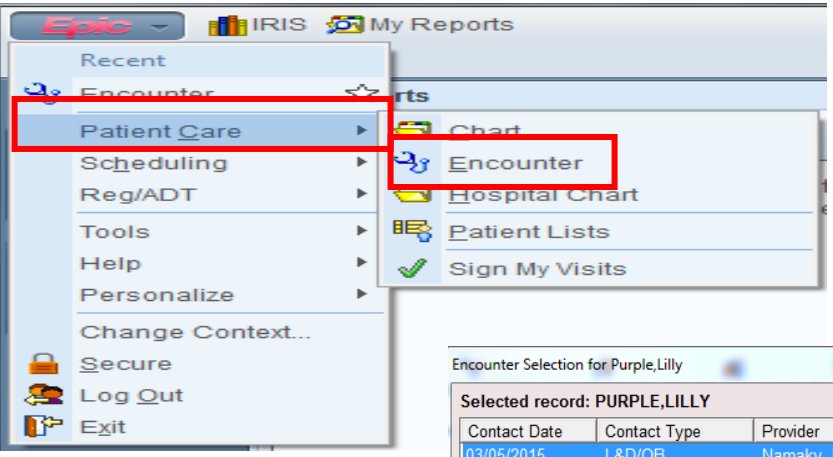
Create SNF Encounter

Flowsheet Documentation

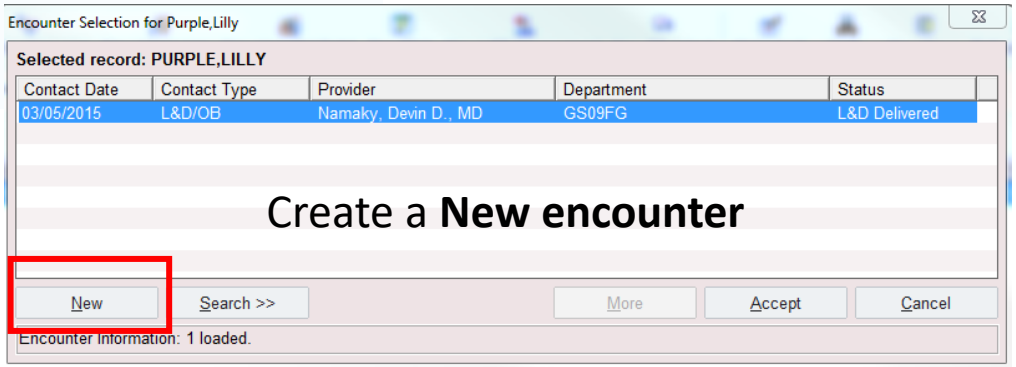
Reporting Tools

Clinical Workflow – Skilled Nursing Facility

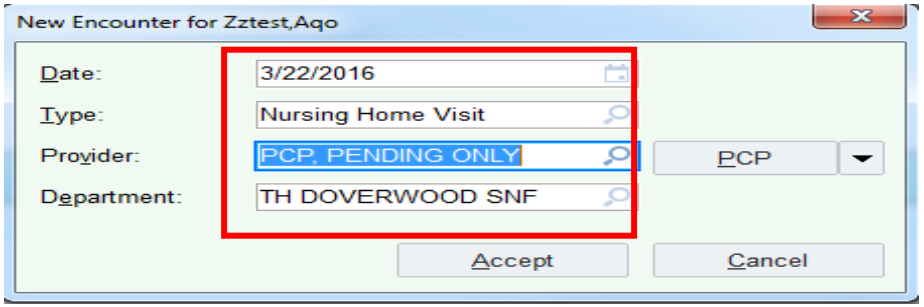
IT Tools



Select the EPIC button at the top left corner>**Patient Care**>**Encounter**



Select Nursing home visit as type. Facility name will appear in the department field



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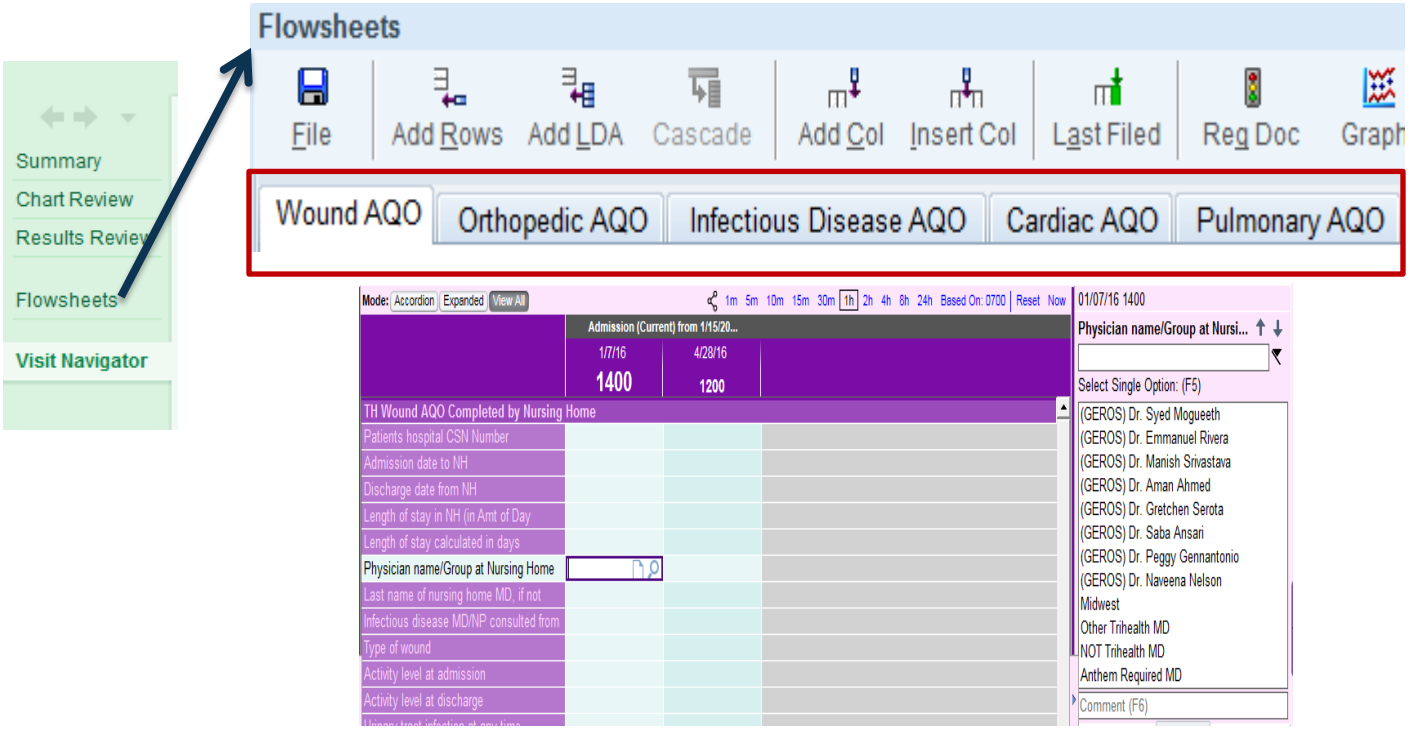
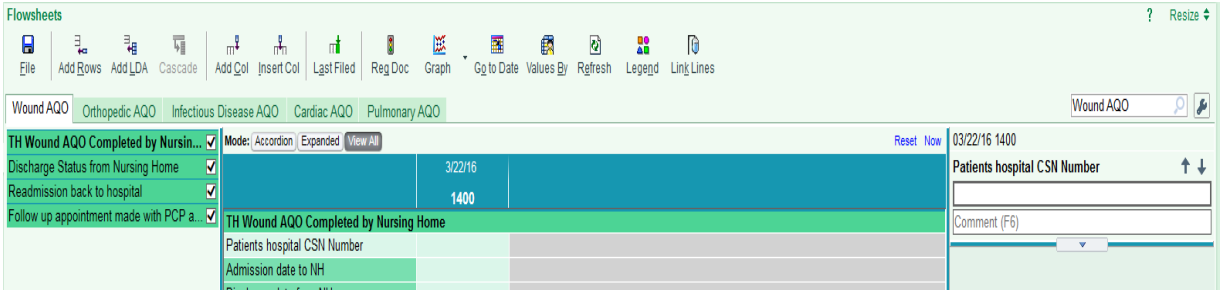
Clinical Workflow – Skilled Nursing Facility

IT Tools





- Discharged from Hospital to SNF
- SNF Logs into TH Epic
- Reporting Workbench Report
- Create SNF Encounter
- **Flowsheet Documentation**
- Reporting Tools

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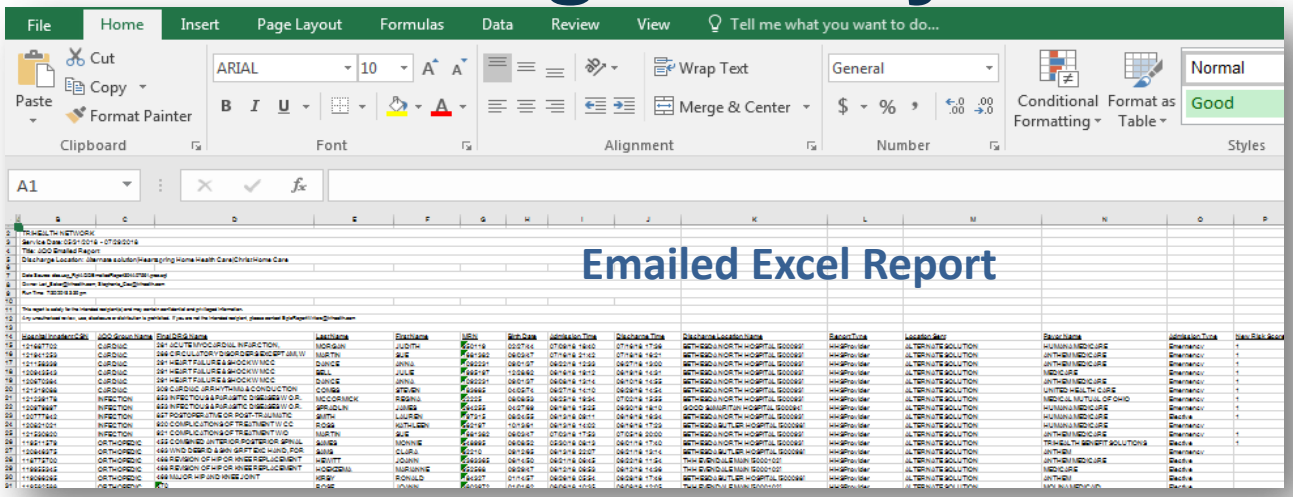
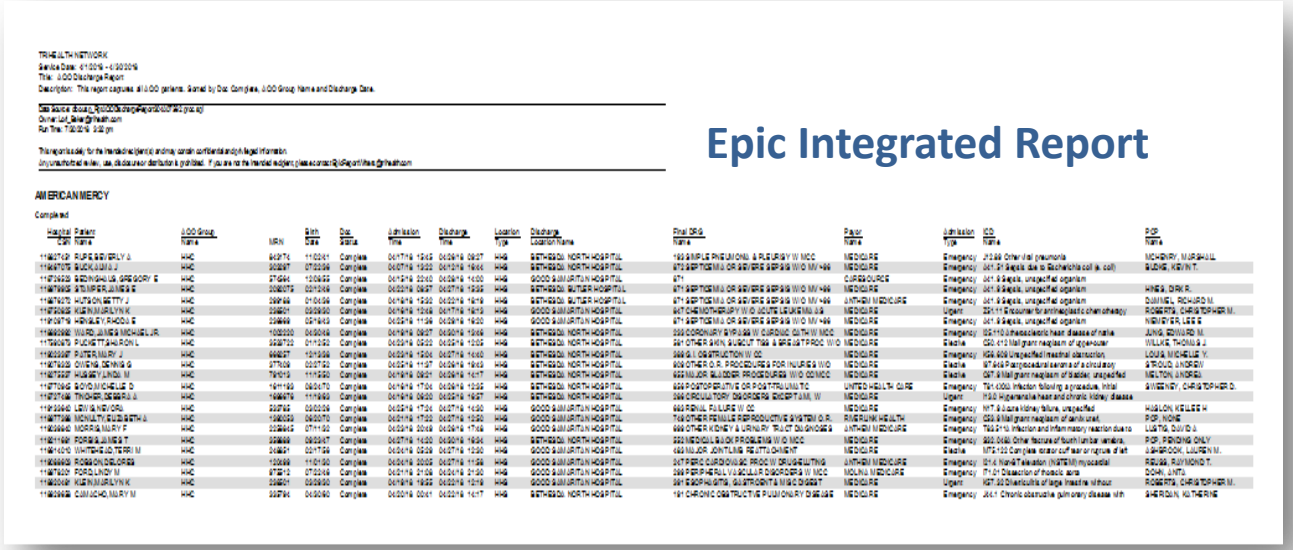
Clinical Workflow – Skilled Nursing Facility

IT Tools



Emailed Excel Report



TRIHEALTH NETWORK

Service Date: 4/1/2016 - 4/30/2016

Title: ADD Discharge Report

Description: This report captures all ADD patients. Sorted by Doc Complete, ADD Group Name and Discharge Date.

AMERICAN MERCY

Completed

Epic Integrated Report

- Discharged from Hospital to SNF
- SNF Logs into TH Epic
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- Flowsheet Documentation
- Reporting Tools

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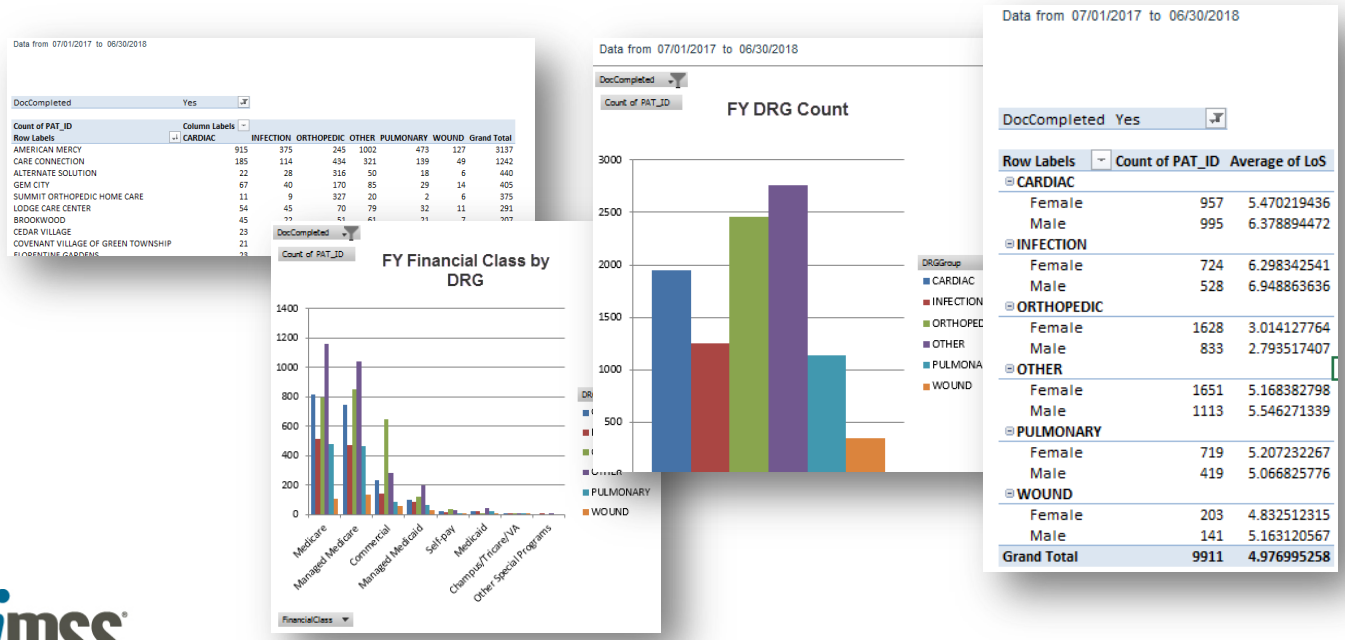
Clinical Workflow – Skilled Nursing Facility

IT Tools

Advanced Analytics

- Over 356 discrete data points available.
- Single report combines both hospital and SNF/HC data.
- Refreshes daily.
- Can pull data from any date range.
- Can be displayed in nearly any visualization platform.



Discharged from Hospital to SNF

SNF Logs into TH Epic

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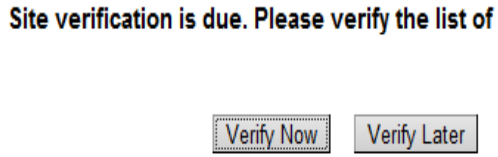
EpicCare Link Login Request

- The SNFs fill out a Login Request form. They either get this on the EpicCare Link website or we email them a blank copy.
- Form is completed and faxed back or securely emailed
- Identity Management team builds EMP record
- EpicCare Link team adds in Site Specific, Site Reports into Epic and activates record in PRD
- EpicCare Link contacts user with login information
- Users login using dual authentication through our Healthy Planet Link website

EpicCare Link Site Verification

IT Tools

- Every AQO site has a Site Administrator that can deactivate users at any time
- Per our Security Policy, every year the Site Administrators are required to verify all users at their site



- Once AQO site is verified it falls off our report to follow up on requirement.
- If requirement is not met after 30 days than all access at site is eliminated.
- In addition, site administrators notify our Information Systems Service Center to terminate team members as they leave the SNF organizations

Preferred Provider Network Determination

IT Tools

- **Submitted Quality Data thru AQO**
  - Source: Epic-SNF
- **Scorecard results of disease specific quality measures/utilization**
  - Source: Epic-SNF
- **Length of Stay in SNF**
  - Source: Claims data, Epic-SNF
- **Direct readmission rate/ED (30 days)**
  - Source: Epic-SNF
- **CMS CJR Navigant Data**
  - Source: Claims data
- **CMS MSSP HSN Data**
  - Source: Claims data/all diagnoses
- **Geographic areas**
  - Source: Network adequacy
- **IBM Modeler High Risk for Readmission**
  - Source: Epic

Sharing Performance SNF and Home Care

IT Tools

OTHER Advance Quality Outcome Scorecard							
[redacted]	Goal of SNF vs. the SNF in Region	Project Status	Score	Total Points for SNF (based on points possible)	Points Possible	Comparison SNF in Region	Overall Scores of Collected TriHealth Data from SNF
Total % of OTHER Readmissions to Any Hospital (Defined as patient had primary diagnosis of ortho DRG. Then readmitted to ANY hospital for ANY reason within 30 Days of the Ortho original DRG (Based on EPIC documentation from SNF)	Goal to be Lower		5%	5	5	18.55%	22.95%
# ED visits (counted as patient was sent to ED and RETURNED to SNF same day)(Based on EPIC documentation from SNF)	Goal to be Lower		0%	3	3	4.03%	5.46%
Average Length of Stay all OTHER (Based on EPIC documentation from SNF)	Goal to be Lower		15.72	5	5	17.6	18.35
HSN CMS Data (July 2016- June 2017) ALL Patient LOS	Goal to be Lower		16.30	4	4	20.00	20.00
HSN CMS Data (July 2016- June 2017) ALL Patient Total Cost	Goal to be Lower		$7,302.01	4	4	$9,378.00	$9,378.00
HSN CMS Data (July 2016- June 2017) ALL Patient ED Visits (30 Days)	Goal to be Lower		3.57%	4	4	7.19%	7.19%
HSN CMS Data (July 2016- June 2017) ALL Patient Readmission IN-DIRECT (during 30 day episode)	Goal to be Lower		10.71%	4	4	14.36%	14.36%
% of TriHealth/ GEROS as Primary Care In SNF	Goal to be Higher		55%	0	3	77.6%	75.07%
Total # Transfer at Admission	Goal to be Higher		6.1	0	1	6.02	6.22
Total # Transfer at Discharge			4.1				
Total Change in Transfer	Goal to be Higher		2	0	1	2.1	1.87
Endurance/Activity Level at Admission	Goal to be Higher		5.95	1	1	5.95	6.27
Endurance/Activity Level at Discharge			4				
Total Change in Activity	Goal to be Higher		1.95	0	1	2.07	1.86
Bisphosphonate Medications - Patient would benefit and med NOT started/ Pt Not on med			n/a				
Average UTI	Goal to be Lower		5%	1	1	7.26%	11.54%
Average Fall Score	Goal to be Lower		35%	0	1	19.20%	18.07%
Management of Pain	Goal to be Higher		1.05	1	1	0.76	0.61
Utilization of Preferred Providers for Home Care	Goal to be Higher		75%	0	3	80.00%	37.48%
PCP Appointment Made Prior to Discharge	Goal to be Higher		100%	2	2	77.78%	78.36%
Based on IBM Readmission Modeler, % of patients that were high risk for readmission.	Goal to be Higher		7.59%	0	2	15.82%	15.82%
Total Points				**34**	**46**		

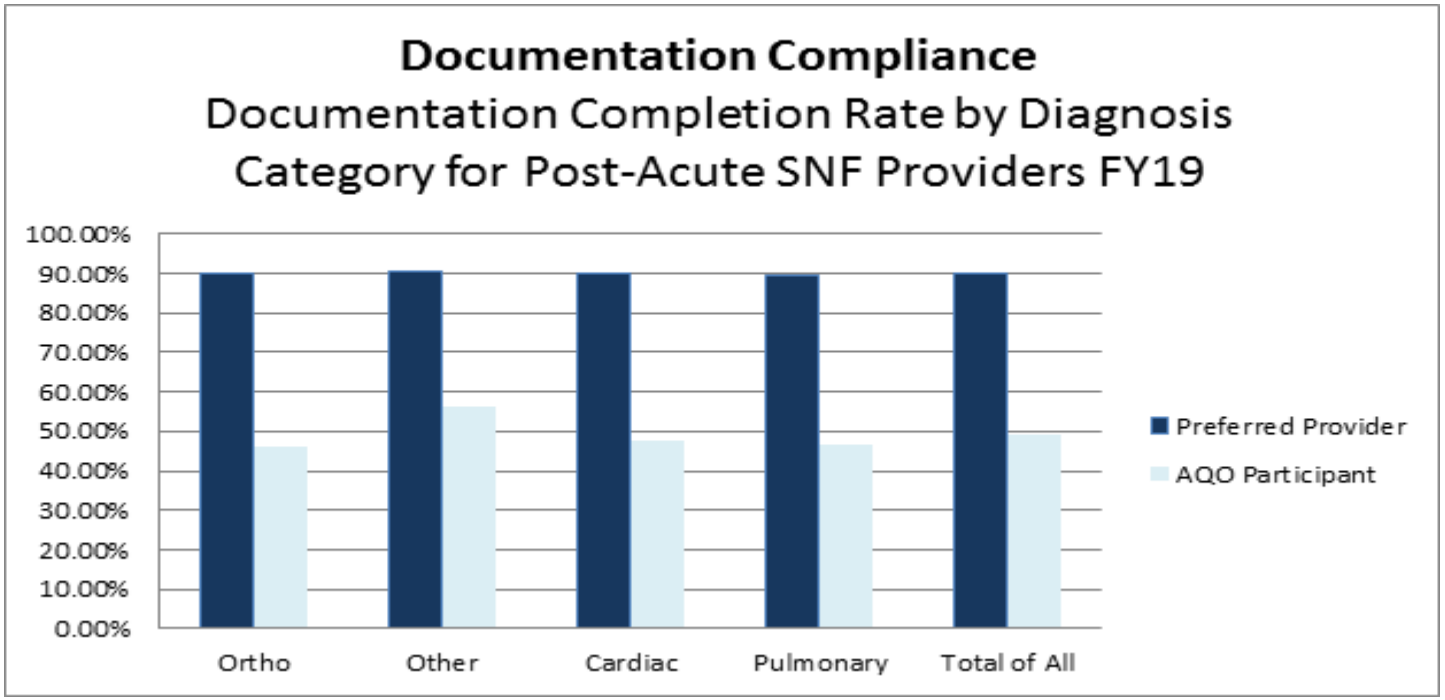
Project Status Indicator Key	
	Above the average for reporting SNF
	At average for reporting SNF
	Below average for reporting SNF

- On a Yearly Basis, Quality and Utilization data is shared with the SNF and HC.
- Comparison data is also shared to understand where there are opportunities to improve and where they are outperforming others in their market

Data Source is reported

- SNF and HC in TriHealth EMR/ EPIC
- MSSP / CJR claims data

Documentation Compliance



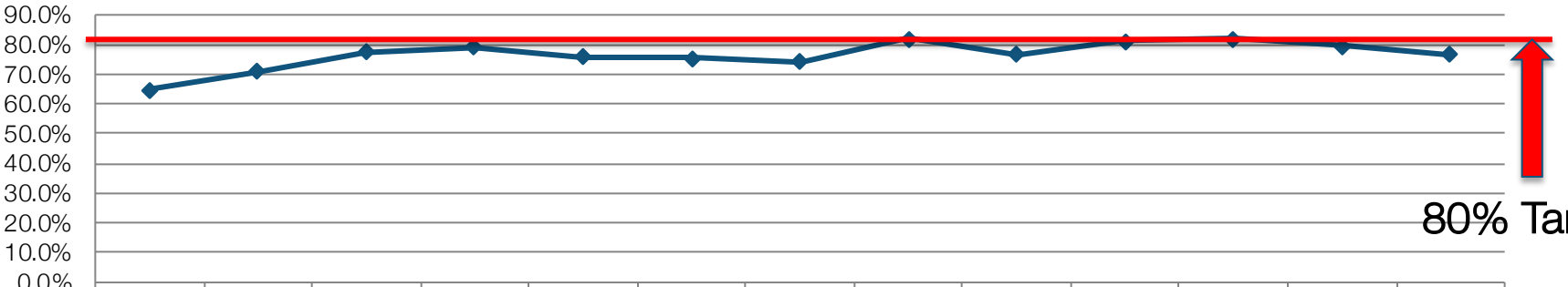
Post-acute Providers submit quality and utilization documentation within EPIC by disease category through secure web-based portal. **Preferred provider data demonstrates more engaged participation**

Source: EPIC

Utilization of SNF Preferred Provider Network

Value

All Insurance / All TriHealth Utilization of Preferred Provider
New SNF Placement Total



	Baseline July 2018-June 2018	Jul-18	Aug-18	Sep-18	18-Oct	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19
Total	65.0%	71.0%	77.6%	79.3%	75.9%	75.3%	74.1%	82.0%	76.7%	81.2%	82.1%	79.5%	76.7%

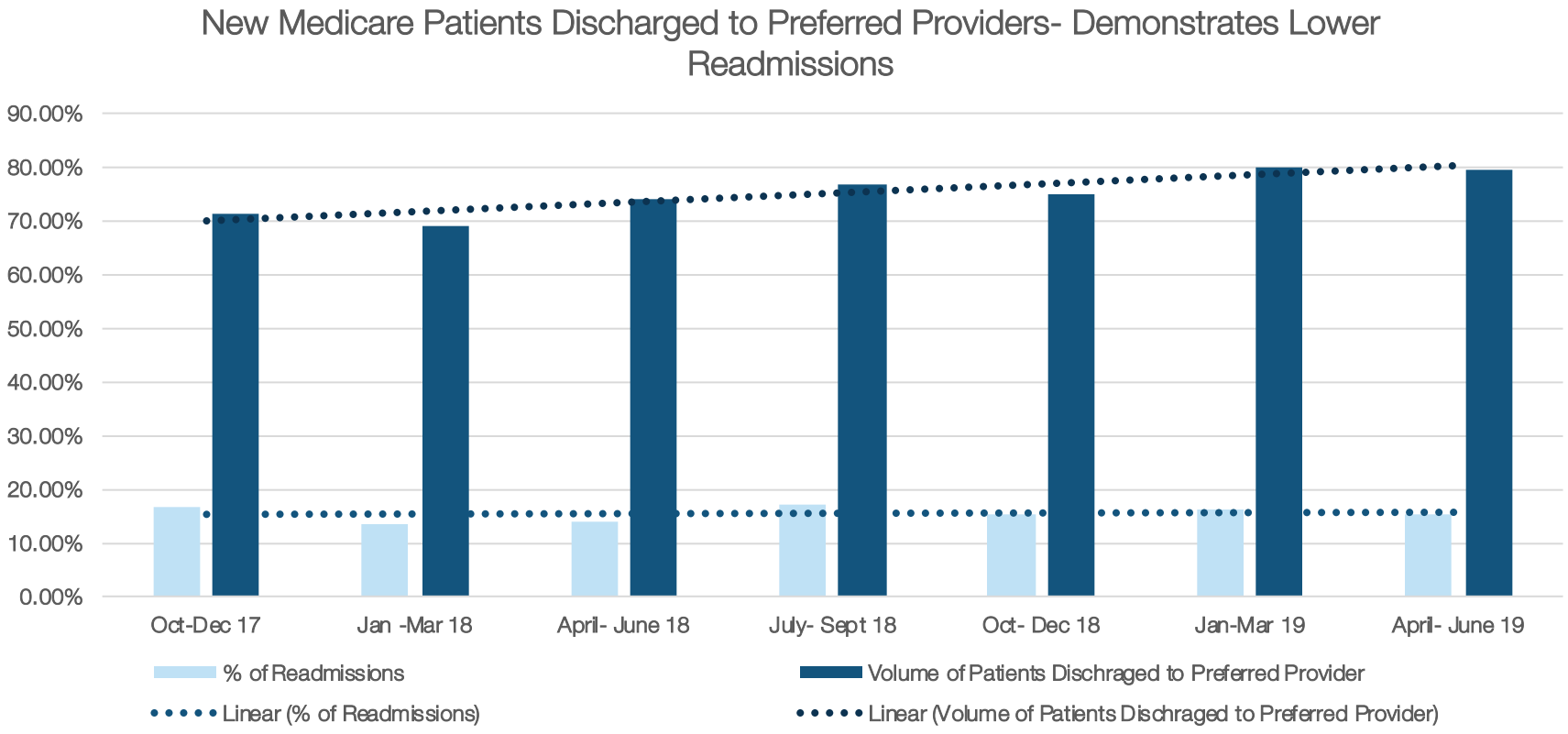
Increased Preferred Provider SNF Network Utilization to **over 78% FY 19 Achieved** by:

1. Developing educational document of value of preferred providers
2. Having CM document why network not selected- to ensure we are meeting community needs and that SNF Preferred Providers are taking all patients
3. Educating all areas about the performance of the preferred providers
4. Monthly monitoring of the use of the network

Source: EPIC

Decreasing Readmissions

As the % of patients discharged to Preferred Provider SNF Increased, Readmission Rates decreased **Data source: EPIC data warehouse**



Our Preferred Providers have a lower readmission rate than the CMS National Average demonstrating lower than the National Average readmission costs

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/SNFRM-Technical-Report-3252015.pdf

Educational Tool- Explaining the WHY

- Share THE WHY data with our patients about preferred provider outcomes
- Care Coordination and Providers utilize data to make referrals
- Utilize actual data to drive decisions versus perceived data

Skilled nursing facilities designated as Centers of Advanced Quality Outcomes demonstrated lower rates of infection as compared to other facilities along with the following:

Medical condition	Length of stay	Readmission rates
Orthopedics	1.8 days shorter	10% lower
Pulmonary	0.4 days shorter	7.52% lower
Cardiac	4.1 days shorter	2.71% lower
All other diagnoses	5 days shorter	0.25% lower

Results based on data collected during 2018–2019.

Let's prepare you for your short stay in skilled nursing care:

You are getting stronger and your goal is to get back to your prior functioning as soon as possible. That is our goal for you, too! **There are some differences between hospital and skilled nursing care that include:**

- You can expect to do more activities on your own.
- You will have less team members assisting you with your daily routine (remember you are getting stronger and this is GOOD! It will help get you back to your routine sooner).
- Doctors are available but not in the facility at all times. Your treatment team will ensure they are kept informed and reached, when needed. Changes in your condition will be promptly reported to your doctor. Many conditions can be treated right in the skilled facility without the need to transfer to the hospital.
- How long you will stay will depend on your personal progress and goals that are set by the treatment team.

What to bring:

- Three to five (3-5) sets of clothes (shorts/pants, shirts, undergarments, gym shoes, socks)
- Any equipment you used prior to your hospital stay (cane, walker, wheel chair)
- Copies of Health Care Power of Attorney, Insurance Cards
- Glasses, hearing aids, cell phone/IPad

Inpatient care coordinators

Bethesda Butler Hospital 513 893 8095
Bethesda North Hospital 513 865 1122
Good Samaritan Hospital 513 862 2567
McCullough-Hyde Memorial Hospital | TriHealth 513 524 5492
TriHealth Evendale Hospital 513 853 1868

TriHealth TriHealth.com

For more information about skilled nursing care, visit medicare.gov/nursinghomecompare/search.html

07 19

Let's get you back to your daily routine.

Together, we'll work to improve your health.

The road to recovery doesn't have to be traveled alone. TriHealth Institute specialists, hospitalists, geriatric physicians in post-acute and primary care physicians, in collaboration with other medical professionals within TriHealth, developed the Advanced Quality Outcomes Program to measure quality care in skilled nursing facilities in the following specialties:

- Orthopedics
- Pulmonary
- Cardiac
- All other diagnoses

Facilities designated as Centers of Advanced Quality Outcomes have to meet strict standards of care including:

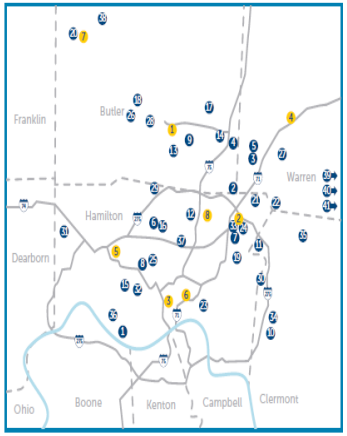
- Centers for Medicare and Medicaid (CMS) star rating of 3 or above
- Reduced patient readmission rates
- Improved patient recovery
- Low rate of infection

Tactics to Drive Outcomes

- Share data with our patients about preferred provider outcomes
- Care Coordination and Providers utilize data to make referrals
- Share with patients options available within their insurance provider that is a TriHealth preferred provider
- Utilize actual data to drive decisions versus perceived data

Centers of Advanced Quality Outcomes

Post-acute Network for Skilled Nursing Facilities



1. Bethesda Butler Hospital
2. Bethesda North Hospital
3. Good Samaritan Hospital
4. Bethesda Arrow Springs
5. Good Samaritan Western Ridge
6. TriHealth Rehabilitation Hospital
   513 601 0330
7. McCullough-Hyde Memorial Hospital | TriHealth
8. TriHealth Evendale Hospital

KEY

- A: Aetna Medicare Advantage
- B: Anthem Medicare Advantage
- C: CareSource
- D: Humana Medicare Advantage
- E: MYCARE Molina
- F: Mutual of Omaha Medicare Advantage
- G: United Healthcare Medicare Advantage

Butler County (OH)

4 Chesterwood Village
8073 Tylersville Road
West Chester, OH 45069
513 777 1400
ABDEFG

9 Doverwood Village
4195 Hamilton-Mason Road
Hamilton, OH 45011
513 868 2266
ABDEFG

17 Garden Manor
6898 Hamilton-Middletown Road
Middletown, OH 45044
513 424 5321
ABCDEFG

14 Heritagespring of West Chester
7235 Heritagespring Drive
West Chester, OH 45069
513 759 5777
24-Hour Admission Line 513 317 5460
ABDEFG

18 Jamestowne
1371 Main Street
Hamilton, OH 45013
513 785 4800
ABCEF

20 The Knolls of Oxford
6727 Contreras Road
Oxford, OH 45056
513 524 7987
ABCDEG

28 Residence at Huntington Court
350 Hancock Avenue
Hamilton, OH 45011
513 863 4218
ABCDEFG

13 Tri County Care Center
5200 Camelot Drive
Fairfield, OH 45014
513 829 8100
ABCDEFG

26 Westover Retirement Community
855 Stahlheber Road
Hamilton, OH 45013
513 844 8004
ABCDEFG

38 Woodland Country Manor
4166 Somerville Road
Somerville, OH 45064
513 523 4449
AG

Clermont County (OH)

34 The Atlantes
776B Old State Route 74
Cincinnati, OH 45245
513 399 6225
G

10 Eastgatespring of Cincinnati
4400 Glen Este-Withamsville Road
Cincinnati, OH 45245
513 752 3710
24-Hour Admission Line 513 543 8810
ABDEFG

11 Florentine Gardens
409 Wards Corner Road
Loveland, OH 45140
513 630 1140
ACDEFG

30 SEM Haven Health Care
225 Cleveland Avenue
Milford, OH 45150
513 248 1270
DF

35 Venetians Gardens
1650 State Route 28
Loveland, OH 45140
513 722 0700
ACDEFG

Clinton County (OH)

39 Laurels of Blanchester
839 Cherry Street
Blanchester, OH 45107
937 783 4911
ABCDEG

Hamilton County (OH)

1 Bayley
990 Bayley Drive
Cincinnati, OH 45233
513 347 5500
ABDEFG

2 Brookwood Retirement
12100 Reed Hartman Highway
Cincinnati, OH 45241
513 605 2000
ABCEFG

6 Christian Village at Mt. Healthy
8097 Hamilton Avenue
Cincinnati, OH 45231
513 931 5000
ACDEG

7 Courtyard at Seasons
7100 Dearwester Drive
Cincinnati, OH 45236
513 984 9400
ACDEFG

8 Covenant Village of Green Township
3210 West Fork Road
Cincinnati, OH 45211
513 605 3000
ABDEFG

12 Glendale Place Nursing & Rehab Center
779 Glendale Milford Road
Cincinnati, OH 45215
513 771 1779
ABEFG

15 Hillebrand Nursing and Rehabilitation Center
4320 Bridgetown Road
Cincinnati, OH 45211
513 574 4550
BCEFG

16 The Home at Hearthstone
8028 Hamilton Avenue
Cincinnati, OH 45231
513 521 2700
ABCDEFG

21 Lodge Nursing & Rehab Center
9370 Union Cemetery Road
Loveland, OH 45140
513 677 4900
24-Hour Admission Line 513 518 6367
ABDEFG

19 Madeira Health Care
7885 Camargo Road
Cincinnati, OH 45243
513 561 6400
BDEG

23 Marjorie P. Lee
3550 Shaw Avenue
Cincinnati, OH 45208
513 871 2090
ABCEFG

24 Meadowbrook Care Center
8211 Weller Road
Cincinnati, OH 45242
513 489 2444
ACDEFG

25 Ohio Living Llanfair
1701 Llanfair Avenue
Cincinnati, OH 45224
513 681 4230
ABDEFG

29 Sanctuary Pointe Nursing & Rehab Center
11501 Hamilton Avenue
Cincinnati, OH 45231
513 648 7000
ABEFG

31 Shawneespring of Harrison
10111 Simonson Road
Harrison, OH 45030
513 367 7780
24-Hour Admission Line 513 314 4064
ABDEFG

32 Terrace View Gardens
3904 North Bend Road
Cincinnati, OH 45211
513 481 2201
CDEFG

33 Twin Lakes at Montgomery
9840 Montgomery Road
Cincinnati, OH 45242
513 247 1300
ABCDEFG

37 Wellspring Health Center
8000 Evergreen Ridge Drive
Cincinnati, OH 45215
513 948-2308
ADFG

36 Western Hills Retirement Village
6210 Cleves Warsaw Pike
Cincinnati, OH 45233
513 941 0099
ABDEFG

Highland County (OH)

40 Highland County SWING BEDS/SNF
1275 N. High Street
Hillsboro, OH 45133
937 393 6371
ABDG

41 Laurels of Hillsboro
175 Chillicothe Avenue
Hillsboro, OH 45133
937 393 1925
ABCDEFG

Warren County (OH)

3 Cedar Village
5467 Cedar Village Drive
Mason, OH 45040
513 754 3100
ABDEFG

5 Christian Village at Mason
411 Western Row Road
Mason, OH 45040
513 518 4436
ADEG

22 Loveland Health Care Center
501 North Second Street
Loveland, OH 45140
513 605 6000
ACFG

27 Otterbein Maineville
201 Marge Schott Way
Maineville, OH 45039
513 583 5161
ABCEF

For more information, contact an inpatient care coordinator. *(See brochure back.)*

Note about insurance coverage: Insurance providers offer multiple products. Please check with your insurance provider to ensure coverage prior to admission.

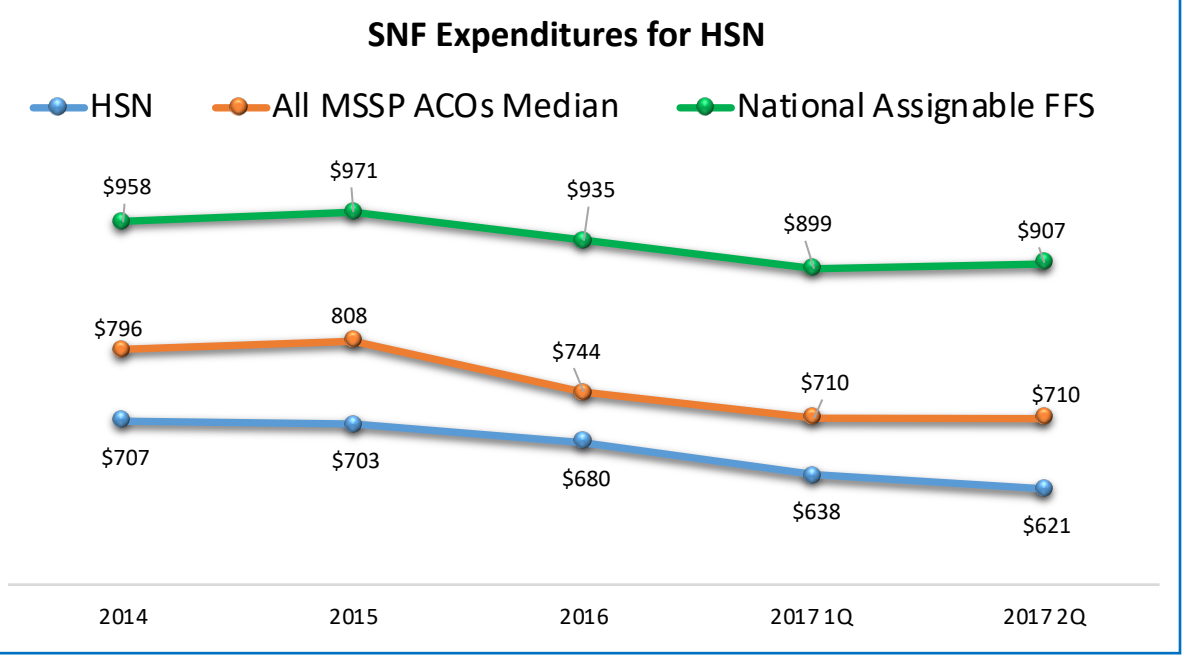
Performance of Demonstrated Post-Acute Results

Value

2016 SHARED SAVINGS PARTICIPANTS

In 2016, 134 (31%) ACOs achieved shared savings.

*** Reduced SNF expenditures by 18.3% ***



- ✓ Post acute spend
  - CY 2015 $703
  - CY 2016 $680
  - CY 2017 Q2 $621

  Savings $1,757,000
- ✓ SNF total cost decreased to almost $300 per member compared to CMS

Source: HSN 2017 Final Benchmark Report
Note: the All MSSP ACO trend is median.
***between benchmark year #3 (BY3) and performance year 2016 (PY16).**

Population Health

- All patients are given choice regarding
- SNF/HC placement-
  - ❑ Being a preferred provider doesn't guarantee referrals
  - ❑ Not being a preferred provider doesn't mean you WON'T get referrals
- All Preferred Providers for FY20 document on ALL medical conditions
- All Preferred Providers will be members of the TriHealth Physician Hospital Organization
- ALL Preferred Providers have SNF 3 stars/ HC 2.5 stars or higher with CMS avg for measurement period

Overall Project Outcomes

	Jan- Dec 2015	Jan- Dec 2016	Jan- June 2017
Discharges to Preferred Provider SNF	unknown	39%	82%
Post-Acute Spend	$703 / member	$680/ member	$621/ member
SNF Expenditure	$17,575,000	$17, 050,000 (svg $525,00 from 2015)	$15,525,000 (svg $1, 525,000 from 2016)
FTE Expense	$31,250	$15, 625	$0

2 Year Soft & Hard ROI for AQO

Value

Reduced SNF Expenditure
$2,050,000

Reduced Labor Expense
$46,875

Reduced Readmissions
7%
Cost Avoidance*
$481,248

Total ROI
$2,578,123

**TH average cost per readmission/all readmissions SOURCE: TH Decision Support Financial Data Warehouse

Keys to Success

Lessons

At TriHealth, there is a strong culture of partnership between all team members. The ability to work successfully in complex multi-disciplinary teams by valuing everyone's contribution is critical to the success our initiatives

Collaboration, on-going education, regular communication and a spirit of true partnership with the SNFs for improved care for our patients is paramount

At TriHealth, Information System is considered part of the care team. There is a close relationship between IT and Clinical Operations

Lessons Learned

- Explain the why of the value of the network to the entire organization involving all stakeholders to achieve strong results
- Continual process improvement is critical to success
- Meet in person with inpatient care management monthly for ongoing opportunities to improve results and share wins.
- Measure and report outcomes to the entire organization monthly including wins and opportunities to move results
- Quarterly share with each SNF/HC their performance and comparison data of the top performers to push all SNF/HC to improve utilization and quality and have monthly meetings to engage/ inform SNF/ HC
- Meet regularly with Preferred Providers to show successes and opportunities to improve. This is very helpful is driving performance of our SNFs
- We realized from SNFs that we needed to do internal education about what each SNF could/could not do. Don't underestimate internal education needs.

What's Next

1. Align post-acute preferred provider networks with insurance companies
2. TriHealth Senior Symposium Oct. 17 bringing together all post-acute providers for day long education for over 20 years
3. Work on connecting post-acute EMR-Point Click Care to EPIC to achieve triple aim

Wrap Up

Problem

No affiliated SNF

Population Health – VBC

Need to lower cost/improve quality

Perceived quality

Vs. Data driven quality

Design

Leverage core systems

Control patient access

Clinical end user involvement

Strong clinical governance

IT Tools

Identify patient population at discharge

Reporting Workbench Access

Standardized & discrete documentation

Reporting

Value

Reduced Readmissions

Reduced SNF Spend

Improved Quality Outcomes

Reduced cost for manual entry

TriHealth

HIMSS
CENTRAL & SOUTHERN OHIO *Chapter*