# Post-Acute Providers “Partnering” with Acute Care

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Ohio Living

HIMSS
CENTRAL & SOUTHERN OHIO *Chapter*

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# Ohio Living

FAITH + COMPASSION + COMMUNITY

## 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

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# Ohio Living

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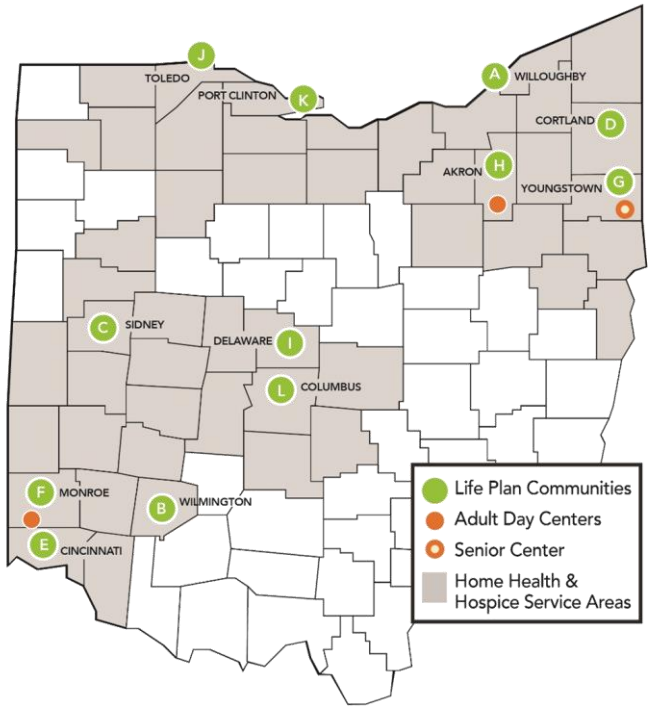


## Life Plan Communities

**A Ohio Living**
**Breckenridge Village**
**440.942.4342**
36851 Ridge Road
Willoughby, Ohio 44094

**B Ohio Living**
**Cape May**
**937.382.2995**
175 Cape May Drive
Wilmington, Ohio 45177

**C Ohio Living**
**Dorothy Love**
**937.498.2391**
3003 West Cisco Road
Sidney, Ohio 45365

**D Ohio Living**
**Lake Vista**
**330.638.2420**
303 North Mecca Street
Cortland, Ohio 44410

**E Ohio Living**
**Llanfair**
**513.681.4230**
1701 Llanfair Avenue
Cincinnati, Ohio 45224

**F Ohio Living**
**Mount Pleasant**
**513.539.7391**
225 Britton Lane
Monroe, Ohio 45050

**G Ohio Living**
**Park Vista**
**330.746.2944**
1216 Fifth Avenue
Youngstown, Ohio 44504

**H Ohio Living**
**Rockynol**
**330.867.2150**
1150 West Market Street
Akron, Ohio 44313

**I Ohio Living**
**Sarah Moore**
**740.362.9641**
26 North Union Street
Delaware, Ohio 43015

**J Ohio Living**
**Swan Creek**
**419.865.4445**
5916 Cresthaven Lane
Toledo, Ohio 43614

**K Ohio Living**
**Vineyard on Catawba**
**419.797.3100**
3820 E. Vineyard Village Drive
Port Clinton, Ohio 43452

**L Ohio Living**
**Westminster-Thurber**
**614.228.8888**
717 Neil Avenue
Columbus, Ohio 43215

## Ohio Living Home Health & Hospice

24-hour Referral Line 855.579.4967

**Greater Akron 330.873.3468**
1815 West Market Street, Suite 303
Akron, Ohio 44313
*Serving Cuyahoga, Huron, Lorain, Medina, Portage, Stark, Summit & Wayne Counties*

**Greater Cincinnati 513.681.8174**
25 Indiana Avenue
Monroe, Ohio 45050
*Serving Butler, Clermont, Clinton, Hamilton, Preble & Warren Counties*

**Greater Cleveland 440.953.1256**
38879 Mentor Avenue, Suite A
Willoughby, Ohio 44094
*Serving Ashtabula, Cuyahoga, Geauga, Lake & Portage Counties*

**Greater Columbus 614.433.0031**
2740 Airport Drive, Suite 140
Columbus, Ohio 43219
*Serving Delaware, Fairfield, Franklin, Licking, Madison, Pickaway & Union Counties*

**Greater Dayton 937.415.5666**
6520 Poe Avenue, Suite 100
Dayton, Ohio 45414
*Serving Allen, Auglaize, Champaign, Clark, Darke, Greene, Logan, Miami, Montgomery, Preble & Shelby Counties*

**Greater Toledo 419.865.1499**
1730 South Reynolds Road
Toledo, Ohio 43614
*Serving Defiance, Erie, Fulton, Hancock, Henry, Lucas, Ottawa, Sandusky, Seneca & Wood Counties*

**Greater Youngstown 330.533.4350**
6715 Tippecanoe Road, Building E
Suite 201, Canfield, Ohio 44406
*Serving Ashtabula, Columbiana, Jefferson, Mahoning, Portage, Stark & Trumbull Counties*

## Ohio Living Foundation

P 614.888.7800 F 614.885.1201
1001 Kingsmill Parkway | Columbus, Ohio 43229

ACCREDITED CHARITY

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# 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

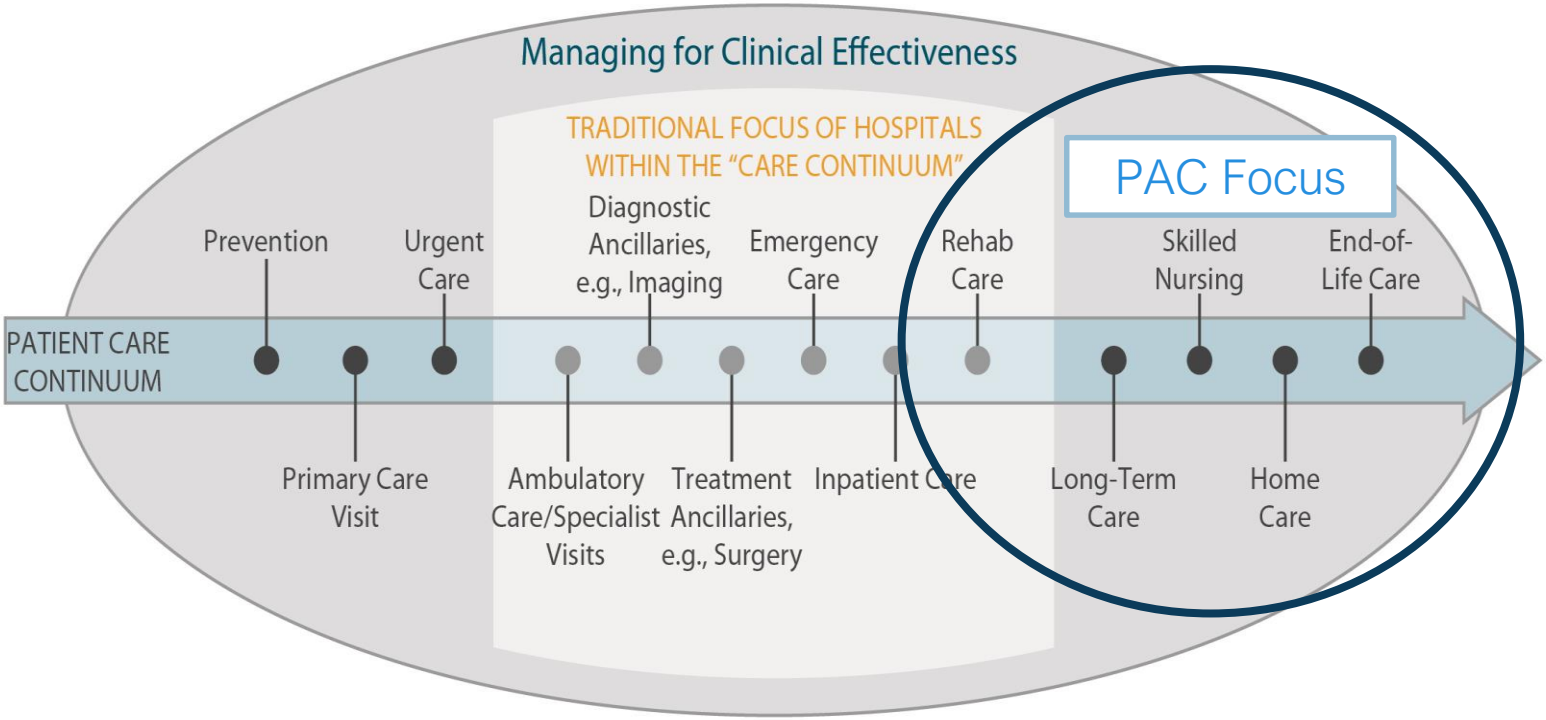
# Triple Aim

- 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

**Consumerism** — What do consumers want?

- **Growing influence of consumerism**

**Care Coordination** — Changes under way with different Administrations – How will care models continue to change and how does it effect the care continuum?

- **Transition to Value Based Care**

**Innovation** — 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?

- **Growing Disruptive Innovation**

**Decentralized Care** — Is the exchange of patient data keeping up with demand?

- **Interoperability, CommonWell, Care Quality, Transitions Alert**

**Job Market** — Where will staff come from?

- **Robotics, Efficiencies, Competing for Employer of Choice**

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# 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 3Bundles 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

# Highlights
# Electronic Health Record Adoption and Interoperability among U.S. Skilled Nursing Facilities in 2016

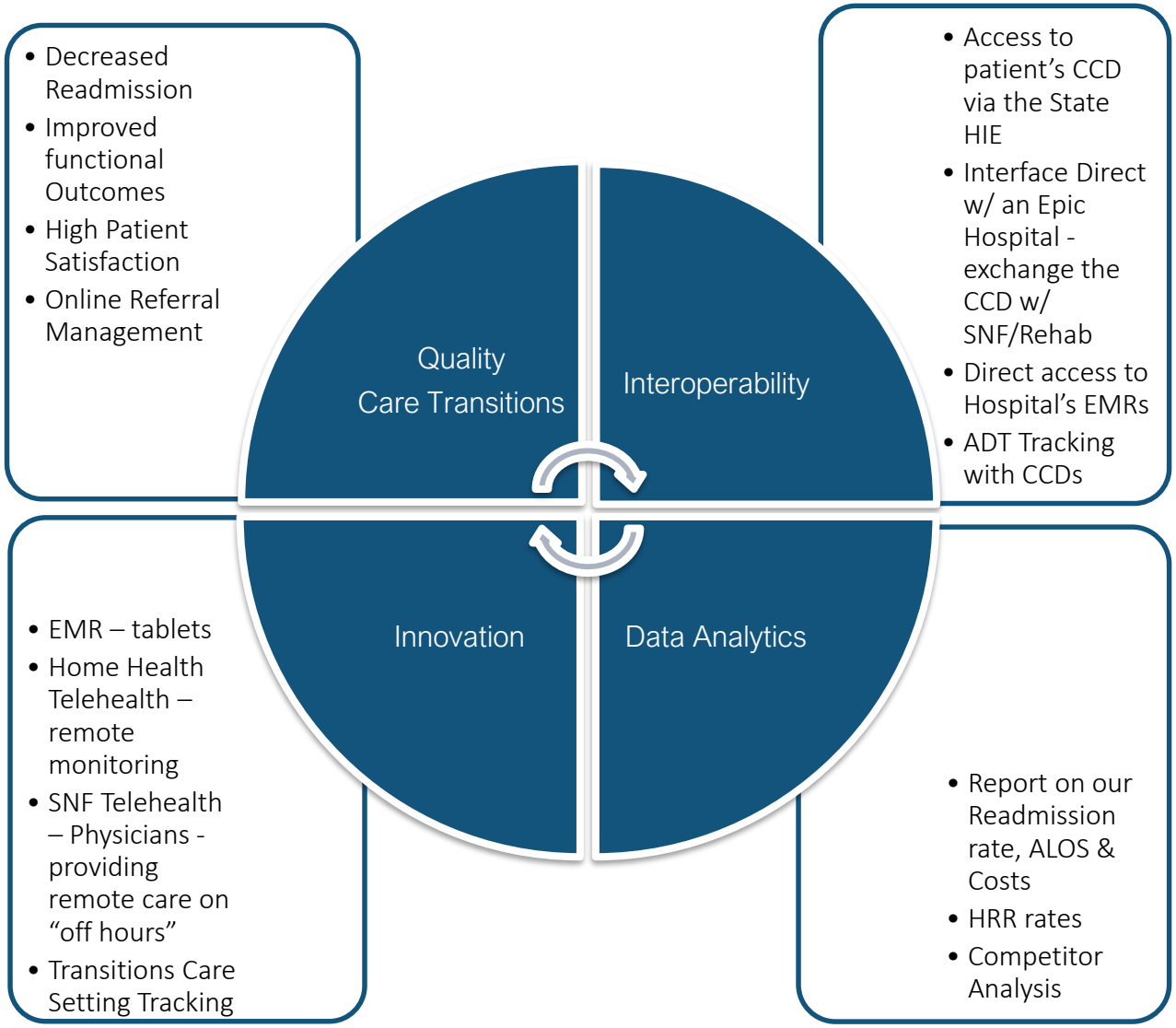
1. A majority (64%) of SNFs used an EHR in 2016.
2. Almost one-fifth (18%) of SNFs used both an EHR and a state or regional health information organization (HIO).
3. Three out of 10 SNFs electronically exchanged (i.e., sent or received) key clinical health information.
4. SNFs that used an EHR and an 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



# 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

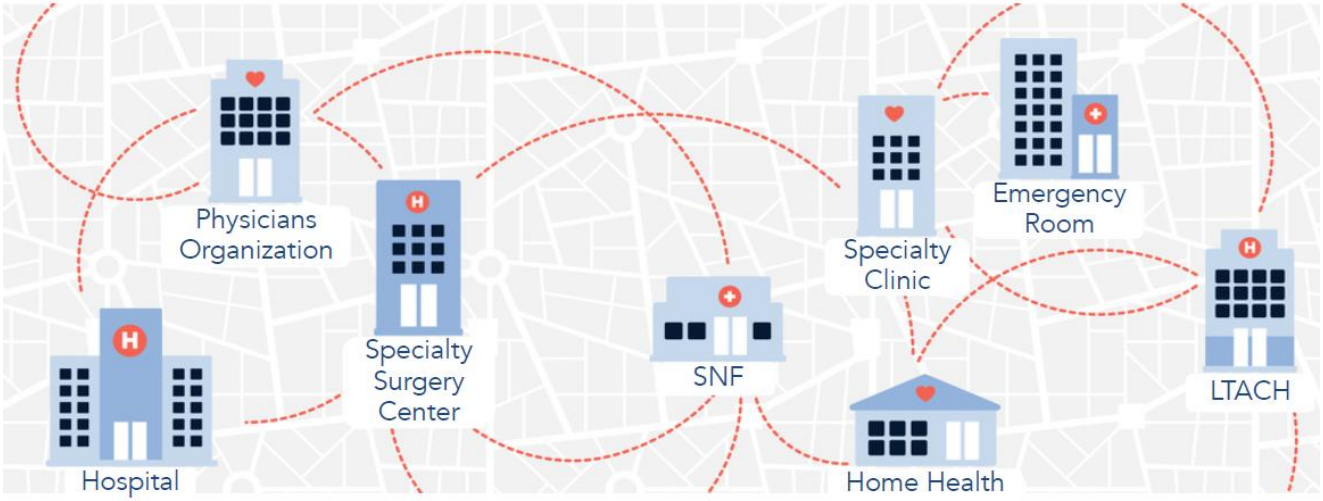
# Innovation in Post Acute

- **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

# Innovation…page 2

- 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

# Geographic Data Analysis

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

| Sender Facility | | | | | | Receiver Facility | | | | Receiver ALOS | | | Receiver Average Payment | | | Receiver 30-Day Readm. Rate | | | Receiver 30-Day Mort. Rate | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | [redacted] | [redacted] | [redacted] | 470-MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC | SNF | [redacted] | [redacted] | 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 | [redacted] | [redacted] | [redacted] | 470-MAJOR JOINT REPLACEMENT OR REATTACHMENT OF LOWER EXTREMITY W/O MCC | SNF | [redacted] | [redacted] | 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

| Measure | Target * | January-16 | | February-16 | | March-16 | | April-16 | | May-16 | | June-16 | | July-16 | | August-16 | | September-16 | | October-16 | | November-16 | | December-16 | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % | Count | % |
| Data Integrity | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Chart Audit Discrepancies (# out of 40) | 0 | 1 | - | 0 | - | 1 | - | 0 | | 2 | - | 0 | - | 1 | - | | - | | - | | - | | - | | - | 5 | |
| SNF CCN Discharges | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Total OH patients discharged from SNF | N/A | 24 | - | 22 | - | 27 | - | 32 | - | 26 | - | 22 | - | 23 | | 0 | - | 0 | - | 0 | - | 0 | - | 0 | - | 176 | - |
| Total OH Medicare FFS patients discharged from SNF | N/A | 14 | - | 13 | - | 17 | - | 20 | - | 21 | - | 15 | - | 12 | | 0 | - | 0 | - | 0 | - | 0 | - | 0 | - | 112 | - |
| Length of Stay | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ALOS - All patients | N/A | 18.7 | - | 16.3 | - | 22.1 | - | 19.6 | - | 32.6 | - | 13.5 | - | 21.9 | - | N/A | - | N/A | - | N/A | - | N/A | - | N/A | - | 20.7 | - |
| ALOS - Medicare FFS patients | N/A | 19.0 | - | 15.4 | - | 22.5 | - | 17.4 | - | 19.2 | - | 13.8 | - | 21.6 | - | N/A | - | N/A | - | N/A | - | N/A | - | N/A | - | 18.0 | - |
| # Medicare FFS patients w/ LOS ≤ 21 days | ≥ 90% | 9 | 64% | 11 | 85% | 8 | 47% | 15 | 75% | 13 | 62% | 13 | 87% | 7 | 58% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 76 | 68% |
| Readmissions of patients discharged from OH acute setting *** | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| All payer 30-day, all cause readmissions to OH hospital only | ≤ 17% | 2 | 10% | 7 | 24% | 1 | 3% | 6 | 17% | 4 | 15% | 4 | 11% | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 24 | 13% |
| All payer 30-day, all cause readmissions denominator (index discharges only) | N/A | 20 | | 29 | | 32 | | 35 | | 27 | | 37 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 180 | |
| Medicare 30-day, all cause readmissions to OH hospital only | ≤ 17% | 1 | 13% | 5 | 24% | 1 | 5% | 6 | 25% | 2 | 10% | 3 | 12% | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 18 | 15% |
| Medicare 30-day, all cause readmissions denominator (index discharges only) | N/A | 8 | | 21 | | 21 | | 24 | | 20 | | 25 | | 0 | | 0 | | 0 | | 0 | | 0 | | 0 | | 119 | |
| Patients seen by physician or APN w/in 48 hours of admission | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | ≥ 80% | 21 | 88% | 19 | 86% | 18 | 67% | 25 | 78% | 21 | 81% | 18 | 82% | 21 | 91% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 143 | 81% |
| No | N/A | 3 | 13% | 2 | 9% | 8 | 30% | 7 | 22% | 5 | 19% | 3 | 14% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 28 | 16% |
| Blank | N/A | 0 | 0% | 1 | 5% | 1 | 4% | 0 | 0% | 0 | 0% | 1 | 5% | 2 | 9% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 5 | 3% |
| Patients scheduled to be seen by physician relevant to SNF stay within 7 days of SNF Discharge | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | ≥ 80% | 12 | 75% | 15 | 88% | 15 | 83% | 20 | 100% | 11 | 61% | 14 | 78% | 16 | 84% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 103 | 82% |
| No | N/A | 4 | 25% | 2 | 12% | 2 | 11% | 0 | 0% | 6 | 33% | 3 | 17% | 2 | 11% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 19 | 15% |
| Blank | N/A | 0 | 0% | 0 | 0% | 1 | 6% | 0 | 0% | 1 | 6% | 1 | 6% | 1 | 5% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 4 | 3% |
| # patients discharged (excludes dc disposition of 'hospital', 'expired', 'AMA','LTC','SNF') | N/A | 16 | - | 17 | - | 18 | - | 20 | - | 18 | - | 18 | - | 19 | - | 0 | - | 0 | - | 0 | - | 0 | - | 0 | - | 126 | - |
| Medication reconciliation completed for all patients at admission | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | ≥ 80% | 24 | 100% | 22 | 100% | 26 | 96% | 32 | 100% | 25 | 96% | 21 | 95% | 23 | 100% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 173 | 98% |
| No | N/A | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Blank | N/A | 0 | 0% | 0 | 0% | 1 | 4% | 0 | 0% | 1 | 4% | 1 | 5% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 3 | 2% |
| Medication reconciliation completed for all patients at discharge | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | ≥ 80% | 16 | 100% | 17 | 100% | 17 | 94% | 20 | 100% | 18 | 100% | 18 | 95% | 19 | 100% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 125 | 98% |
| No | N/A | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% |
| Blank | N/A | 0 | 0% | 0 | 0% | 1 | 6% | 0 | 0% | 0 | 0% | 1 | 5% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 2% |
| # patients discharged (excludes dc disposition of 'hospital', 'expired', 'AMA', & 'LTC') | N/A | 16 | - | 17 | - | 18 | - | 20 | - | 18 | - | 19 | - | 19 | - | 0 | - | 0 | - | 0 | - | 0 | - | 0 | - | 127 | - |
| # of patients referred to ED within 72 hours of admission | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| # Patients referred to ED ≤ 72 hours | ≤ 10% | 0 | 0% | 1 | 5% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 1% |
| # Patients referred to ED > 72 hours | N/A | 1 | - | 1 | - | 0 | - | 0 | - | 0 | - | 0 | - | 0 | - | 0 | - | 0 | - | 0 | - | 0 | - | 0 | - | 2 | - |
| OhioHealth patients discharged from SNF to home, community, or lower level of care in 60 days or less | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| # pts discharged to lower level of care ≤ 60 days | N/A | 18 | 75% | 19 | 86% | 20 | 74% | 24 | 75% | 21 | 81% | 17 | 77% | 21 | 91% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 140 | 80% |
| # pts discharged to lower level of care ≥ 60 days | N/A | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 3% | 0 | 0% | 0 | 0% | 1 | 4% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 1% |
| # pts discharged to other level of care | N/A | 6 | 25% | 3 | 14% | 6 | 22% | 7 | 22% | 5 | 19% | 4 | 18% | 1 | 4% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 32 | 18% |
| # pts discharge disposition blank | N/A | 0 | 0% | 0 | 0% | 1 | 4% | 0 | 0% | 0 | 0% | 1 | 5% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 1% |

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# PAC Future Strategies & Opportunities

- Strengthen our ability to partner with acute care hospitals and physicians – 0pen 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

# Acute/PAC Partnerships
## What to look for?

- 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