Welcome to TriHealth

HIMSS
Nicholas E. Davies
Award of Excellence
Case Studies
August 1, 2018

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

TriHealth Awards for Clinical Quality, Technical Excellence and Employee Engagement

Healthcare Information and Management System Society (HIMSS) Analytics Electronic Medical Record (EHR) Adoption Model Stage 7 **Awarded to TriHealth July 2014**

TriHealth successfully **recertified** as HIMSS Stage 7 in **December 2017**

Advanced Quality Outcomes

Presented by:
Lori Baker, MSOL, MSW, LSW
Director Senior Services and Post-Acute Network
Martha Tillson, R.N., BSN, Manager Application Solution Center
Barb Dam, R.N., BSN Nurse Liaison for Post Acute

Local Problem

Over 125 SNF in Cinti market, TriHealth does not own any SNF

Collaborate with highest quality local SNF to achieve triple aim

Capture data was manual in the beginning which was time consuming

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

DLS1

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

TriHealth

Slide 8

DLS1 Update Colorectal as the Perferred Service Line to font 26 to match the other heading.

Smith, Diana (Trihealth), 7/22/2018

What is TriHealth Advanced Quality Outcomes Program (AQO)

Design

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

Workflow and Solution Design

- Multi-disciplinary team leverage physician leadership team
- Matrixed partnership with clear goals and objectives for the program

- Guiding principles to leverage core systems
- Standardized documentation
- Scalable architecture
- Discrete data for reporting quality and compliance

Governance

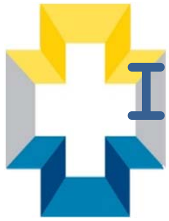
Solution Design

Implementation

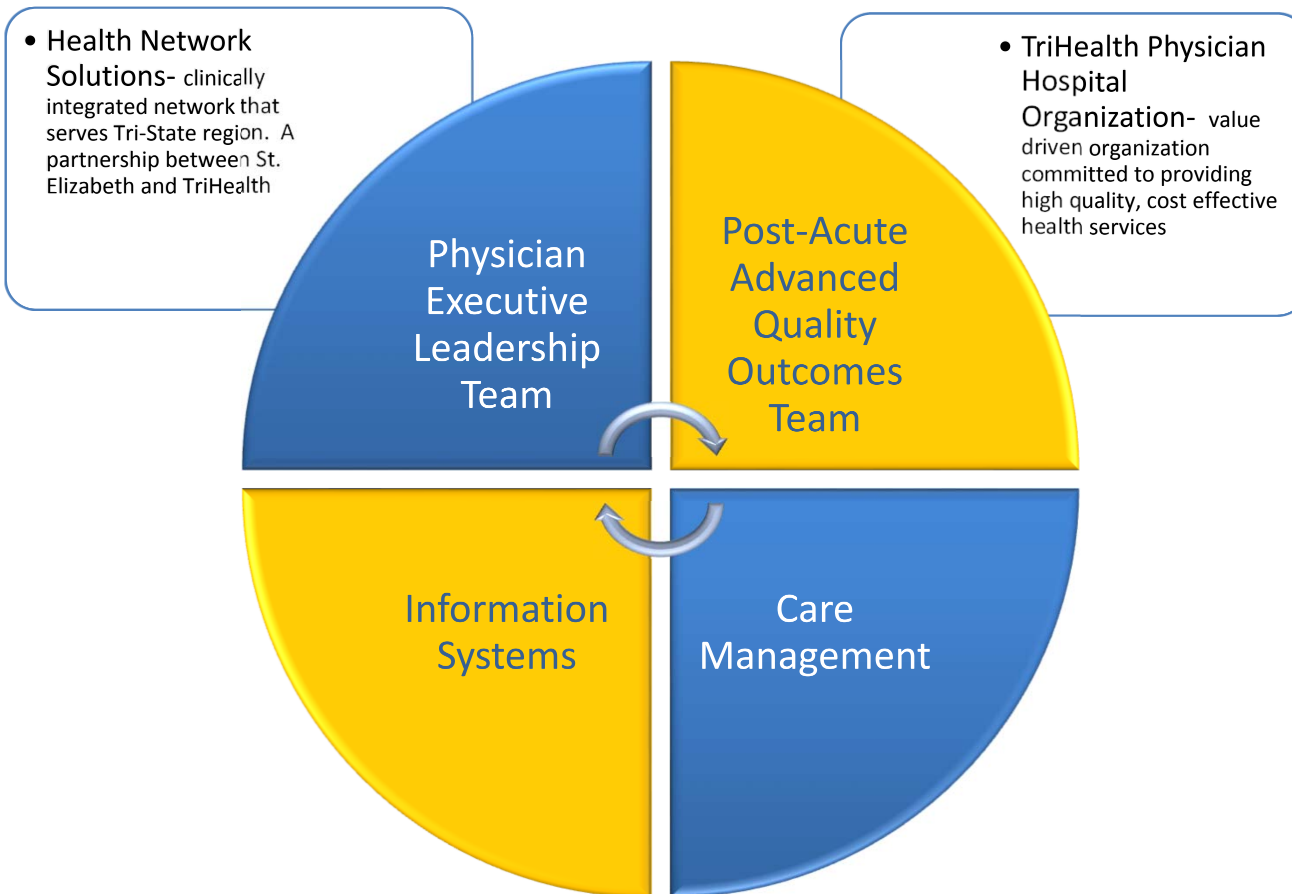
Barriers and Challenges

- Logistics
- Training and support
- Report cards for communicating performance

Legal barriers: HIPPA requirements
- High turnover at SNFs
- Connectivity to TH EMR



Importance of Team in Decision Making



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

Intended Project Outcomes

Design

- Increase communication with SNFs and Home Care partners
- Increase documentation compliance
- Decrease readmissions from SNFs
- 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

TriHealth

Process for Workflow Developm

Review existing workflows with SME → Create mechanism to restrict patient access → Create discrete documentation tools → Determine mechanism for login to TH Epic

Workgroup utilized to:

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

Clinical Workflow

Patient Discharged from Care Managers to Nursing Facility

Nursing Facility logs into Epic Hyperspace through F5 to view Reporting Workbench Report for Patients

Opens Patient Chart

Created a Nursing Home Visit Encounter

Discharge Summary report is created from information selected by Care Management

Open the Flowsheet Activity and select the correct Assessment

Complete the Assessment

Data can be viewed over time in Chart Review or in the Encounter

Patient shows as Completed on Discharge Placement Report

Close Encounter

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 M

IT Tools

Discharge Planning Review - Discharge Planning

Time taken: 1120 7/22/2018

Values By Create Note

Discharge Planning

Type of Home: House, Apartment, Condo/Townhome, Mobile Home, ✔ ECF/LTC, Independent Livin..., Homeless, Group Home, Hotel, Acute Rehab

Discharge Planning Assessment; Patient's Residence

Has Patient Resided in ECF, LTAC, SNF, Nursing Home or Rehab Hospital in Past 3 Months? Yes No

Discharge Planning Assessment

Provider Finder

Search by name | Near City, State, ZIP or Keyword | Search

Filter by — Clear
- Favorite: My favorites
- Provided Service: +Add

Most relevant matches on top

Provider	Services	Address
AdCare Hearth and Care	Intermediate Care, Skilled Nursing	238 South Washington Street, Greenfield OH 45123
Alois Alzheimer Center	Assisted Living, Intermediate Care	70 Damon Road, Cincinnati OH 45218
Alterra Sterling House	Assisted Living	1132 Springfield Pike, Cincinnati OH 45246
Anderson Nursing and Rehabilitation	Intermediate Care, Skilled Nursing	8139 Beechmont Avenue, Cincinnati OH 45255
Arden Courts of Anderson	Assisted Living	6870 Clough Pike, Cincinnati OH 45244
Arden Courts of Kenwood	Assisted Living	4580 East Galbraith Road, Cincinnati OH 45236
Arlington Pointe	Assisted Living	4900 Hendrickson Road, Middletown OH 45044
Astoria Place of Cincinnati	Intermediate Care, Skilled Nursing	3627 Harvey Avenue, Cincinnati OH 45229
Astoria Place of Silverton	Intermediate Care, Skilled Nursing	6922 Ohio Avenue, Cincinnati OH 45236

Selections (1) — Clear

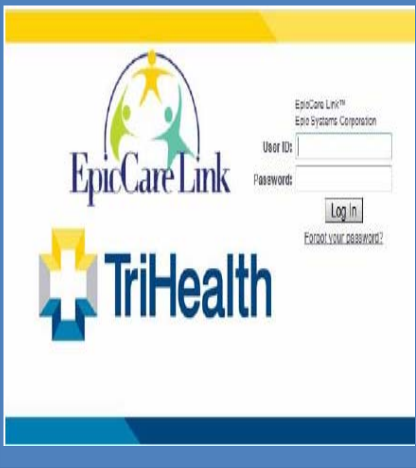
Adena Greenfield Area Medical Center, 550 Mirabeau Street, Greenfield OH 45123

Accept | Cancel

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

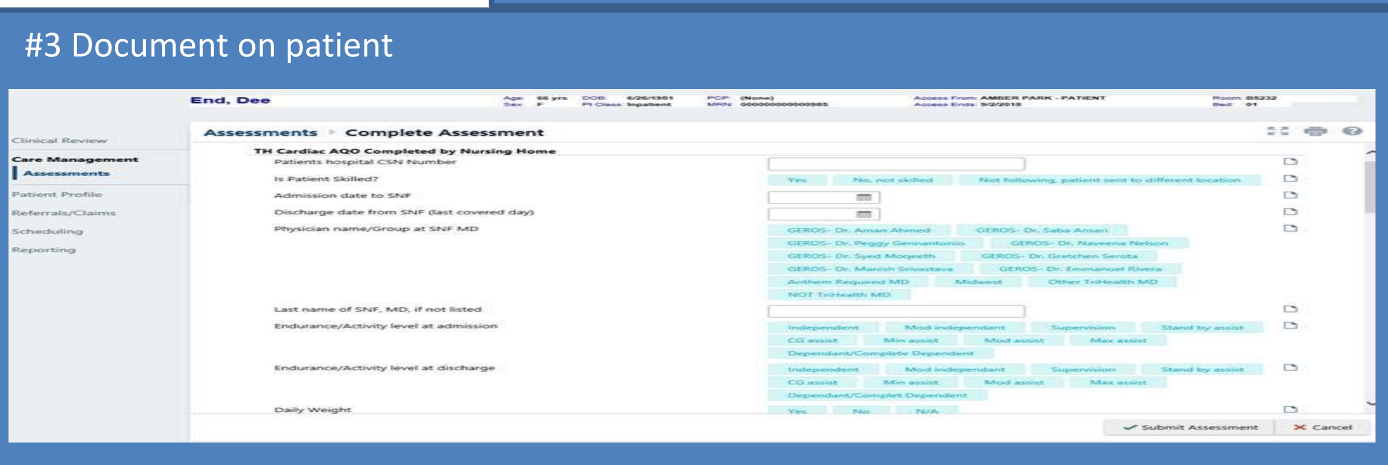
IT Helps Make Documentation as easy as 1,2,3…

#1 Log into TH EMR



#2 Locate DRG specific assessment

#3 Document on patient



- Discharged from Hospital to SNF
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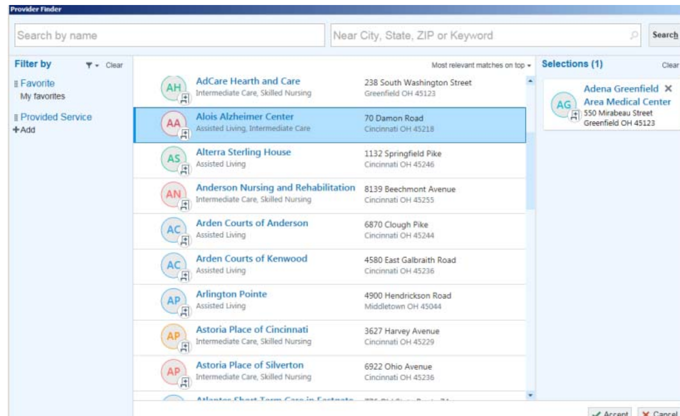
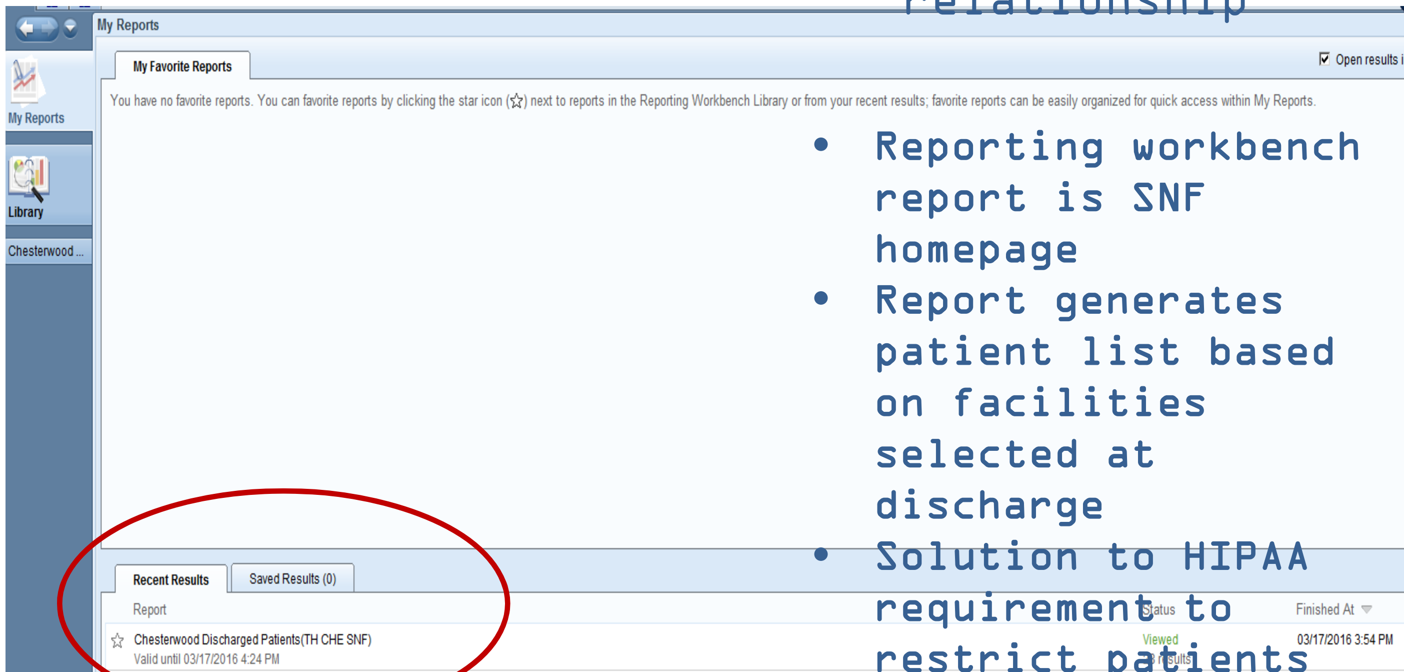
Clinical Workflow - Skilled Nursing Faci



Solution design:
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

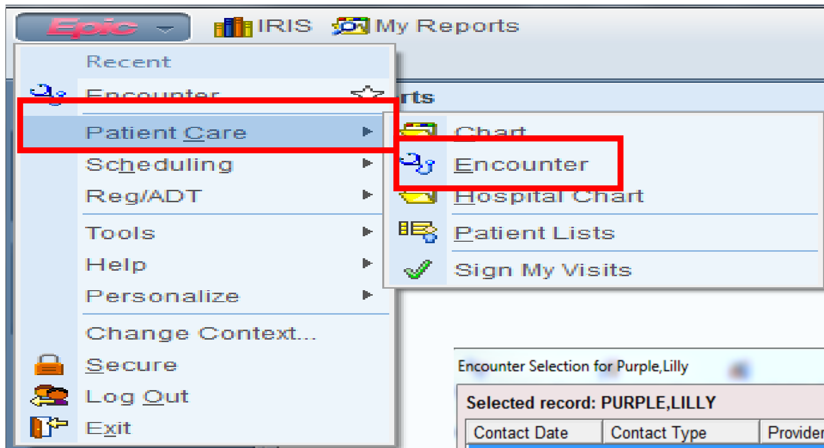
Reporting Workbench Report

Create SNF Encounter

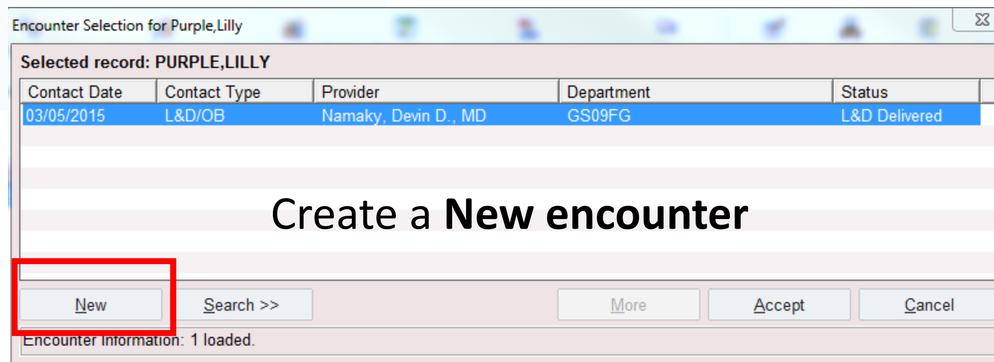
Flowsheet Documentation

Reporting Tools

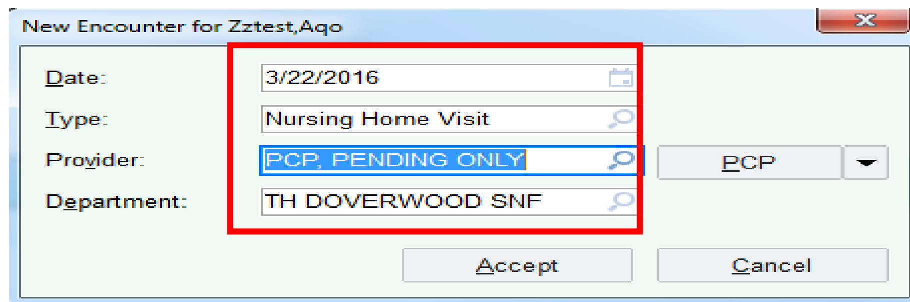
Clinical Workflow - Skilled Nursing Faci



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



Create a **New encounter**



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

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

Clinical Workflow - Skilled Nursing Faci

Flowsheets

File | Add Rows | Add LDA | Cascade | Add Col | Insert Col | Last Filed | Reg Doc | Graph

Wound AQO | Orthopedic AQO | Infectious Disease AQO | Cardiac AQO | Pulmonary AQO

Summary
Chart Review
Results Review
Flowsheets
Visit Navigator

Mode: Accordion | Expanded | View All

Admission (Current) from 1/15/20...

1/7/16 1400 | 4/28/16 1200

TH Wound AQO Completed by Nursing Home
Patients hospital CSN Number
Admission date to NH
Discharge date from NH
Length of stay in NH (in Amt of Day
Length of stay calculated in days
Physician name/Group at Nursing Home
Last name of nursing home MD, if not
Infectious disease MD/NP consulted from
Type of wound
Activity level at admission
Activity level at discharge

01/07/16 1400
Physician name/Group at Nursi...
Select Single Option: (F5)
(GEROS) Dr. Syed Mogueeth
(GEROS) Dr. Emmanuel Rivera
(GEROS) Dr. Manish Srivastava
(GEROS) Dr. Aman Ahmed
(GEROS) Dr. Gretchen Serota
(GEROS) Dr. Saba Ansari
(GEROS) Dr. Peggy Gennantonio
(GEROS) Dr. Naveena Nelson
Midwest
Other Trihealth MD
NOT Trihealth MD
Anthem Required MD
Comment (F6)

Flowsheets

File | Add Rows | Add LDA | Cascade | Add Col | Insert Col | Last Filed | Reg Doc | Graph | Go to Date | Values By | Refresh | Legend | Link Lines

Wound AQO | Orthopedic AQO | Infectious Disease AQO | Cardiac AQO | Pulmonary AQO

TH Wound AQO Completed by Nursin...
Discharge Status from Nursing Home
Readmission back to hospital
Follow up appointment made with PCP a...

3/22/16 1400

TH Wound AQO Completed by Nursing Home
Patients hospital CSN Number
Admission date to NH

03/22/16 1400
Patients hospital CSN Number
Comment (F6)

- 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

Emailed Excel Report

Epic Integrated Report

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

TriHealth

Clinical Workflow – Skilled Nursing Faci

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

Reporting Workbench Report

Create SNF Encounter

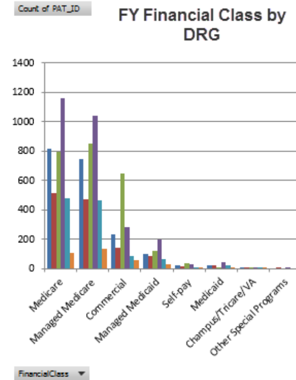
Flowsheet Documentation

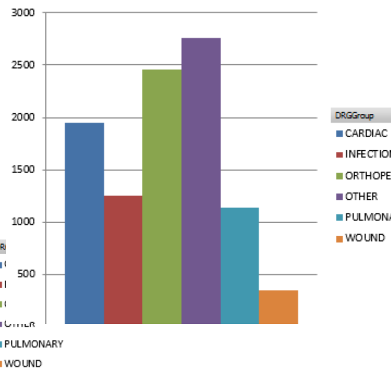
Reporting Tools

Data from 07/01/2017 to 06/30/2018

DocCompleted Yes

Count of PAT_ID Row Labels	CARDIAC	INFECTION	ORTHOPEDIC	OTHER	PULMONARY	WOUND	Grand Total
AMERICAN MERCY	915	375	245	1002	473	127	3137
CARE CONNECTION	185	114	434	321	139	49	1242
ALTERNATE SOLUTION	22	28	316	50	18	6	440
GEM CITY	67	40	170	85	29	14	405
SUMMIT ORTHOPEDIC HOME CARE	11	9	327	20	2	6	375
LODGE CARE CENTER	54	45	70	79	32	11	291
BROOKWOOD	45	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
CEDAR VILLAGE	23						
COVENANT VILLAGE OF GREEN TOWNSHIP	21						





Data from 07/01/2017 to 06/30/2018

DocCompleted Yes

Row Labels	Count of PAT_ID	Average of LoS
CARDIAC		
Female	957	5.470219436
Male	995	6.378894472
INFECTION		
Female	724	6.298342541
Male	528	6.948863636
ORTHOPEDIC		
Female	1628	3.014127764
Male	833	2.793517407
OTHER		
Female	1651	5.168382798
Male	1113	5.546271339
PULMONARY		
Female	719	5.207232267
Male	419	5.066825776
WOUND		
Female	203	4.832512315
Male	141	5.163120567
Grand Total	**9911**	**4.976995258**

EpicCare Link Login Requ

- 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

- 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

Site verification is due. Please verify the list of users is accurate.

Verify Now   Verify Later

- 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

How is the Preferred Provider Network Determined?

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 HC

OTHER Advance Quality Outcome Scorecard							
	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		

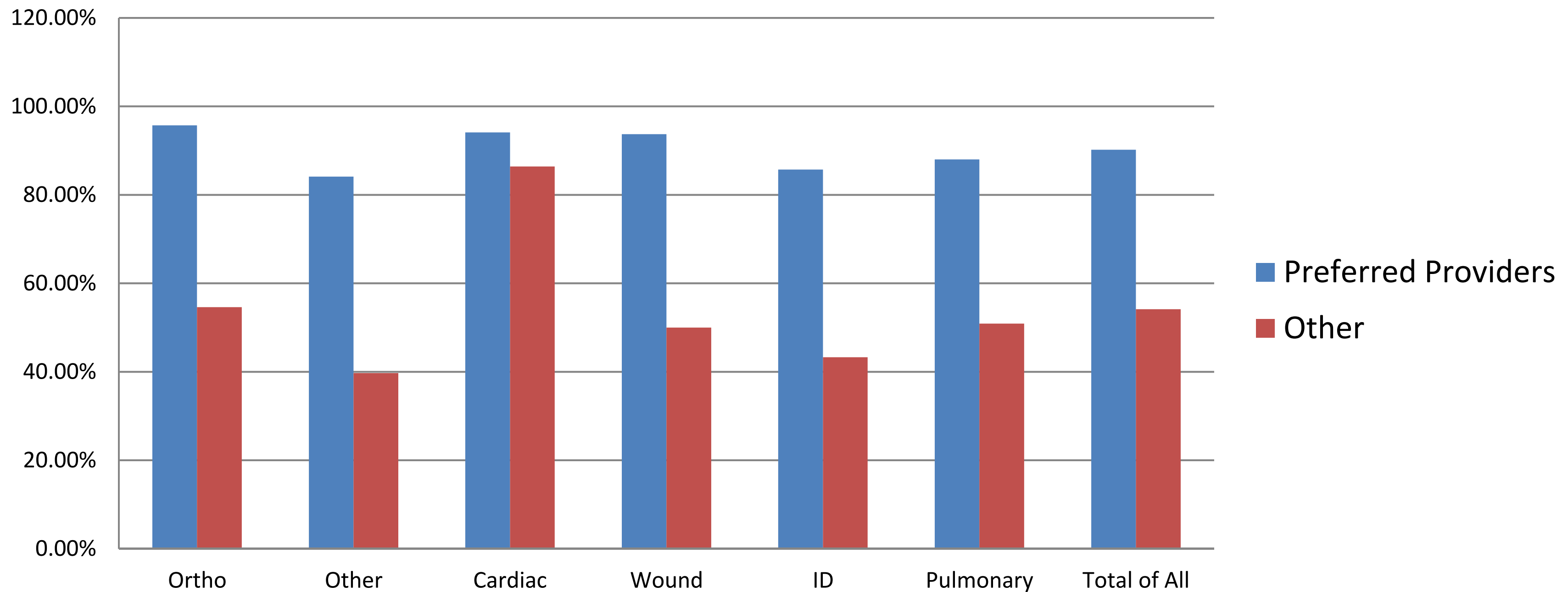
Project Status Indicator Key	
	Above the average for reporting SNF
	At average for reporting SNF
	Below average for reporting SNF

- 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 / [illegible] data

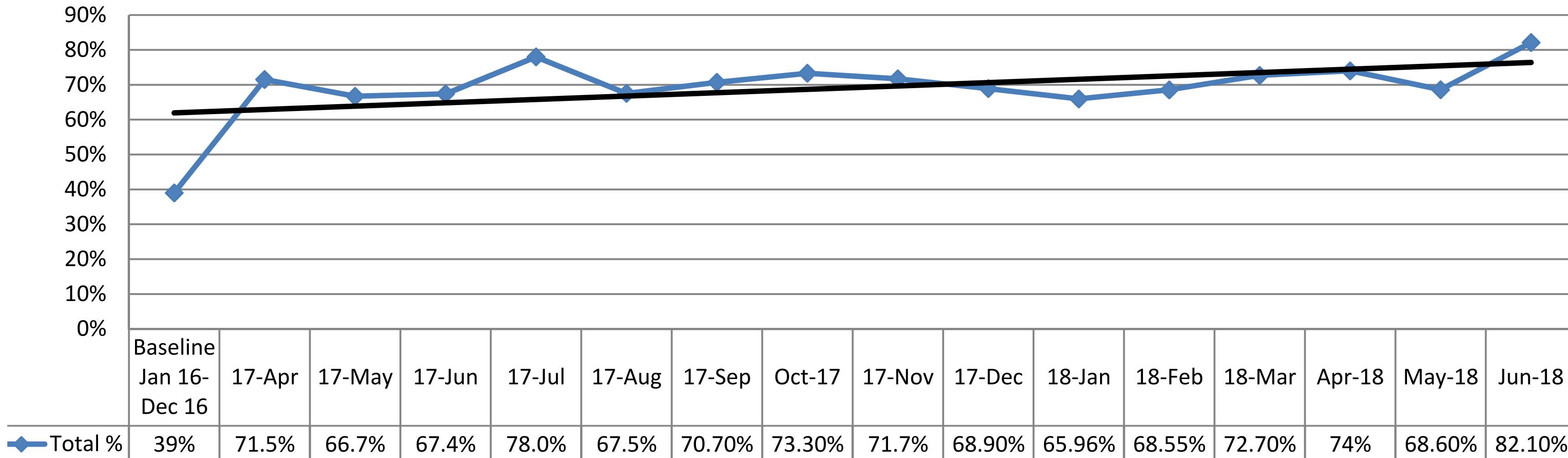
Documentation Compliance



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



	Baseline Jan 16-Dec 16	17-Apr	17-May	17-Jun	17-Jul	17-Aug	17-Sep	Oct-17	17-Nov	17-Dec	18-Jan	18-Feb	18-Mar	Apr-18	May-18	Jun-18
Total %	39%	71.5%	66.7%	67.4%	78.0%	67.5%	70.70%	73.30%	71.7%	68.90%	65.96%	68.55%	72.70%	74%	68.60%	82.10%

Increased Preferred Provider SNF Network Utilization to <u>over 80% Achieved</u> 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

New Medicare SNF Patients Discharged to Preferred Providers Demonstrates a Decrease in Readmissions

	% of Readmissions	Volume of Patients Discharged to TriHealth Preferred Provider SNF
April 17-June 17	15.19%	68.50%
July 17- Sept 17	15.56%	69.30%
Oct 17- Dec 17	16.80%	71.30%
Jan 18- Mar 18	13.59%	69.00%
18-Apr	11.63%	73.90%

Linear (% of Readmissions)

Our Preferred Providers had a 8.7% 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 - Page 33

Patient educational Tool – The Why

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	5.75% lower
Pulmonary	0.9 days shorter	9.86% lower
Advanced wound care	0.3 days shorter	18.56% lower
Cardiac	3.3 day shorter	4.95% lower

Results based on data collected during 2017–2018.

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, wheelchair)
- 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.com

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

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
- Advanced wound care
- Cardiac
- Infectious disease

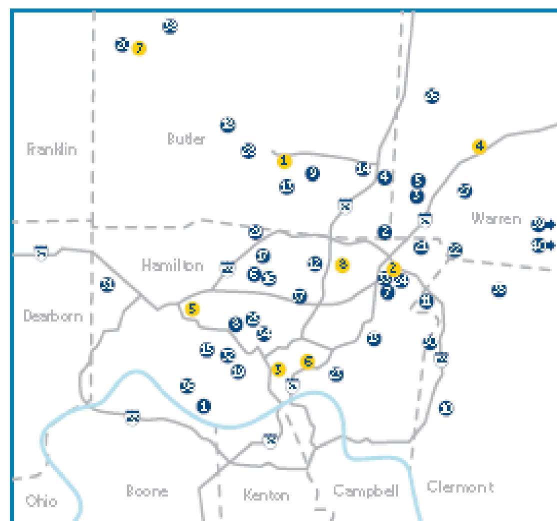
Facilities designated as Centers of Advanced Quality Outcomes have to meet strict standards of care including:

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

Educating Patients about preferred providers

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
7. McCullough-Hyde Memorial Hospital | TriHealth
8. TriHealth Evendale Hospital

KEY

A: Aetna Medicare Advantage
B: Anthem Medicare Advantage
C: Humana Medicare Advantage
D: Molina
E: UnitedHealthcare Medicare Advantage
F: CareSource

Butler County (OH)

4 Chesterwood Village
8073 Tylersville Road
West Chester, OH 45069
513 777 1400
A B C D E

9 Dovewood Village
4195 Hamilton-Mason Road
Hamilton, OH 45011
513 868 2266
B C D E

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

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

20 The Knolls of Oxford
6727 Contreras Road
Oxford, OH 45056
513 524 7990
A B C D E

28 Residence at Huntington Court
350 Hancock Avenue
Hamilton, OH 45011
513 863 4218
B C D E F

13 TriCounty Extended Care
5200 Camelot Dr
Fairfield, OH 45014
513 829 8100
A B C D E F

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

Clermont County (OH)

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

11 Florentine Gardens
409 Wards Corner Road
Loveland, OH 45140
513 630 1140
A B C D E F

30 SEM Haven
225 Cleveland Avenue
Milford, OH 45150
513 2481 270
C D

35 Venetian Gardens
1650 State Route 28
Loveland, OH 45140
513 722 0700
A C D E F

Clinton County (OH)

39 Laurels of Blanchester
839 Cherry St
Blanchester, OH 45107
937 783 4911
A B C D E F

Hamilton County (OH)

1 Bayley
990 Bayley Drive
Cincinnati, OH 45233
513 347 5500
A C D E

2 Brookwood Retirement
12100 Reed Hartman Highway
Cincinnati, OH 45241
513 605 2000
A B D E F

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

7 Courtyard at Seasons
7100 Dearwester Drive
Cincinnati, OH 45236
513 984 7273
A C D E

8 Covenant Village of Green Township
3210 West Fork Road
Cincinnati, OH 45211
513 605 3000
A B C D E

12 Glendale Place Nursing & Rehab Center
779 Glendale Milford Road
Cincinnati, OH 45215
513 771 1779
A B C D E

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

16 The Home at Hearthstone
8028 Hamilton Avenue
Cincinnati, OH 45231
513 521 2700
C D E F

17 Home at Taylor's Pointe
3464 Springdale Road
Cincinnati, OH 45251
513 741 4888
A B C D E F

19 Judson Care Center
2373 Harrison Avenue
Cincinnati, OH 45211
513 662 5880
C D E F

21 Lodge Nursing & Rehab Center
9370 Union Cemetery Road
Loveland, OH 45140
513 677 4900
24-Hour Admission Line 513 586 357
A B C D E

23 Marjorie P. Lee Community
3550 Shaw Avenue
Cincinnati, OH 45208
513 533 5014
A B C D E F

24 Meadowbrook Care Center
8211 Weller Road
Cincinnati, OH 45242
513 489 2444
A C D E

25 Ohio Living Llanfair
1701 Llanfair Avenue
Cincinnati, OH 45224
513 681 4230
B D E

29 Sanctuary Pointe Nursing & Rehab Center
11501 Hamilton Avenue
Cincinnati, OH 45231
513 648 7000
A B D E

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

32 Terrace View Gardens
3904 North Bend Road
Cincinnati, OH 45211
513 481 2201
C D E F

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

34 Twin Towers
5343 Hamilton Avenue
Cincinnati, OH 45224
513 853 2000
A C D E F

37 Wellspring Health Center
8000 Evergreen Ridge Dr
Cincinnati, OH 45215
513 655 5384
A C E

36 Western Hills Retirement Village
6210 Cleves Warsaw Pike
Cincinnati, OH 45233
513 941 0099
A B C D E

Highland County (OH)

40 Laurels of Hillsboro
175 Chillicothe Ave
Hillsboro, OH 45133
937 393 1925
A B C D E F

Warren County (OH)

3 Cedar Village
5467 Cedar Village Drive
Mason, OH 45040
513 754 3100
A B C D E

5 Christian Village at Mason
411 Western Row Road
Cincinnati, OH 45040
513 398 1486
C D

22 Loveland Health Care Center
501 North Second Street
Loveland, OH 45140
513 605 6000
A D E F

26 Otterbein Lebanon
585 North State Route 741
Lebanon, OH 45036
513 932 2020
B C D F

27 Otterbein Maineville
201 Marge Schott Way
Maineville, OH 45039
513 583 5161
A B D F

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.

Tracking quality for SNF Preferred Providers outperforming in Quality

Type Provider	Bisphosphonates needed and not started (goal lower) (source: EPIC)	Fall Prevention (goal lower) (Source: EPIC)	Falls tx to hospital for treatment (goal lower) (source: EPIC)	Readmission rate (source: HSN MSSP Data 30 day readmission)
Preferred Provider	6.3%	9.2% falls	1%	12.8%
Other	13.9%	12.2% falls	4%	14.72%

Additional Metrics collected from EPIC on Preferred Providers:

- ✓ SNF preferred providers managed pain significantly better than others
- ✓ Avg. of 73% of time MD appointment made prior to d/c from SNF
- ✓ 33.4% better management of pain

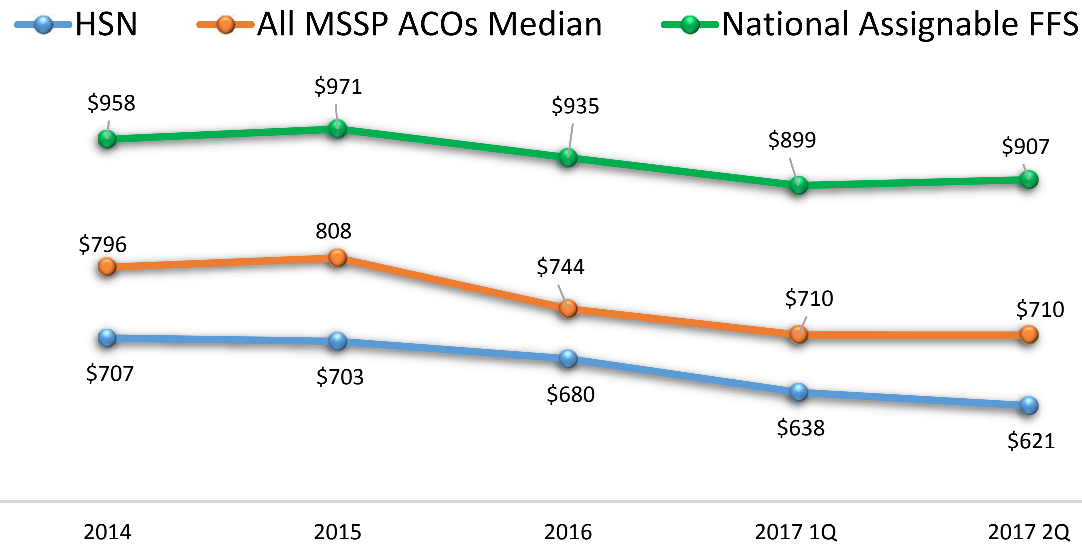
Source: EPIC
7/1/17- 3/30/18

Performance of Demonstrated Post-Acute Results

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).**

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

Reduced SNF Expenditure $2,050,000	Reduced Labor Expense $46,875
Reduced Readmissions 7% Cost Avoidance* $481,248	Total ROI $2,578,123

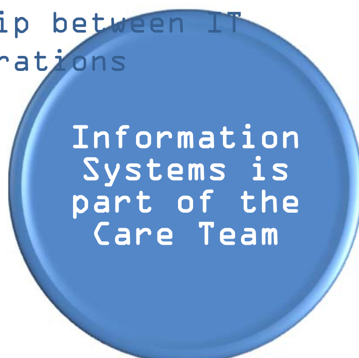
**TH average cost per readmission/all readmissions SOURCE: TH Decision Support Financial Data Warehouse

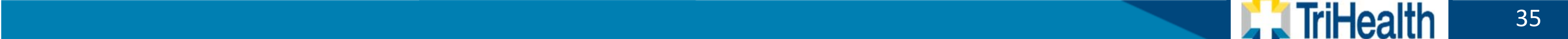
Keys to Success

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

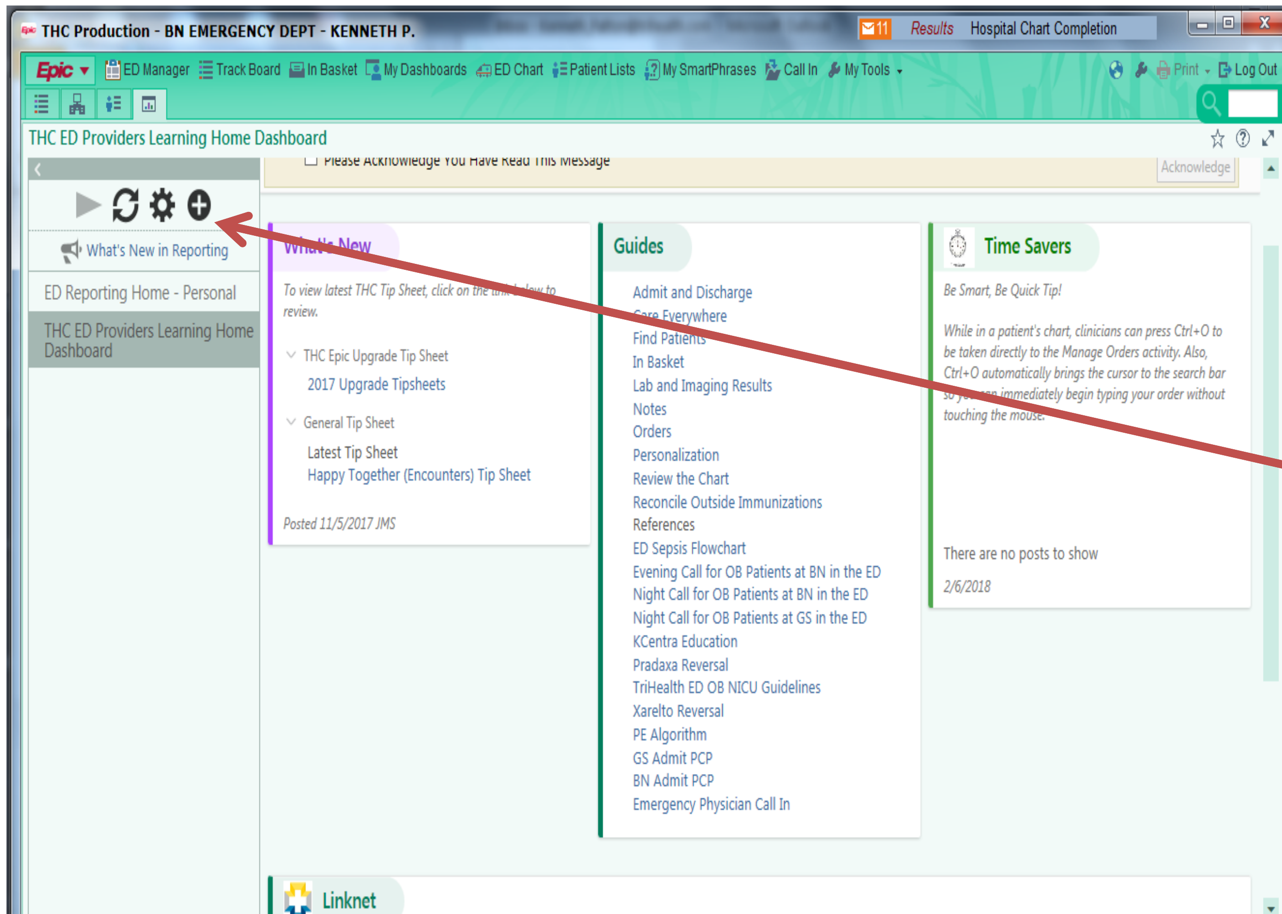
Data Analytics

- Claims data into Caboodle will allow us to automate the generation of annual quality report cards

Continue Education Programs

- RN visits SNF and HC meeting with key clinical team members to
  - Communicate and enhance best practices
  - Clinical education to decrease readmissions/ED visits
- Educational programs , organize, coordinate, arrange video, speaker set up

Improving Care and Reducing Avoidable SNF Admissions/Readmissions



Problem: During a recent ED Education between TH ED and SNF it was discovered that there was an opportunity to improve communication and knowledge of TH Team members about SNF capabilities

Solution:

- Task force of ED nurses, doctors, AQO Nurse, and SNF representatives to find better ways to communicate
- Educational tool created to be loaded to ED dashboard about SNF capabilities by location

Next Steps:

- IMPACT transfer document to align all SNF to using same information when transferring patients to TH ED

AQO Recognition

- Winner QSS Mission Award for post-acute
- Nomination for the Dr. Richard Smith Leadership in Quality Award (Health Collaborative)

Wrap Up

Problem

No affiliated SNF

Population Health - VBC

Need to lower cost/improve quality

Perceived quality

Vs. Data driven qualit

Design

Leverage core systems

Control patient access

Clinical end user involvement

Strong clinical governa

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 manua entry

S E R V E

serve
Our mission is to improve the health status of the people **we serve**.

excel
Excellence in quality, safety and service.

respect
Respect for all people, differences and spiritual heritage.

value
Value our time, treasures and talents through stewardship.

engage
Engage our people and community needs to improve health.