WELCOME
TO THE
Post-Acute Care Collaborative
2019 National Meeting Series
Post-Acute Success in a Senior Care Market

A path forward in the managed care environment
Ongoing, active senior management now the norm

Majority of Medicare beneficiaries are in a model incentivizing management

Proportion of Medicare beneficiaries by program

Medicare, 2017

- Medicare Advantage: 33%
- Medicare ACO or Medical Home: 20%
- Medicare FFS: 47%

MSSP ACO assigned beneficiaries
In millions

- 2012/2013: 3.2 million
- 2015: 7.3 million
- 2018: 10.5 million

Medicare Advantage penetration
% of Medicare beneficiaries

- 2005: 13%
- 2011: 25%
- 2017: 33%


1) Fee For Service.
Updating the post-acute paradigm

Managed models create new goals and pressures for PAC providers

“ACOs essentially are a managed fee-for-service delivery model but, in the real world, are operating as Medicare Advantage plans”

Mike Cheek
SVP Reimbursement Policy
American Health Care Association

Care delivery expectations under managed models

- **Discharge disposition**
  Intentional focus on discharge to lowest cost appropriate care setting

- **In-setting utilization**
  External entities actively involved in patient care plan and trajectory

- **Downstream support**
  Responsible for supporting care transitions

- **Care in the community**
  Push to address non-medical, social determinants of health

## Intentional focus on low cost discharge setting

Vendor solutions targeting facility-based utilization

### Discharge disposition after acute care stay

<table>
<thead>
<tr>
<th>Facility Type</th>
<th>Historic Discharge Distribution</th>
<th>Algorithm-Enhanced Discharge Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>LTACH</td>
<td>6%</td>
<td>2%</td>
</tr>
<tr>
<td>IRF</td>
<td>10%</td>
<td>7%</td>
</tr>
<tr>
<td>Hospice</td>
<td>10%</td>
<td>10%</td>
</tr>
<tr>
<td>SNF</td>
<td>37%</td>
<td>30%</td>
</tr>
<tr>
<td>Home Health</td>
<td>37%</td>
<td>51%</td>
</tr>
</tbody>
</table>

### Vendor in Brief

Radial Analytics provides real time discharge decision support.

Data-driven algorithm emphasizes discharges to home health.

Source: Radial Analytics, accessed at [www.radialanalytics.com](http://www.radialanalytics.com); Post-Acute Care Collaborative interviews and analysis.
External entities intervening to influence key metrics

Health systems tracking SNF LOS, starting to pursue direct management

Sample length of stay analysis

<table>
<thead>
<tr>
<th>Condition</th>
<th>Estimated LOS</th>
<th>Cases</th>
<th>Expected days</th>
<th>Actual days</th>
<th>Difference in days</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHF¹</td>
<td>14</td>
<td>31</td>
<td>434</td>
<td>490</td>
<td>56</td>
</tr>
<tr>
<td>MJLE²</td>
<td>8.5</td>
<td>32</td>
<td>272</td>
<td>512</td>
<td>240</td>
</tr>
<tr>
<td>COPD³</td>
<td>11.5</td>
<td>12</td>
<td>138</td>
<td>173</td>
<td>35</td>
</tr>
</tbody>
</table>

Pressure for SNF to decrease LOS to improve value to system

Health system efforts to influence SNF LOS

- Data tracking and reporting to promote transparency
- Standards within preferred provider network guidelines
- Physician or NP-led SNFist model

1) Congestive Heart Failure.
2) Major Joint Replacement of the Lower Extremity.
3) Chronic Obstructive Pulmonary Disease.

Source: Post-Acute Care Collaborative interviews and analysis.
Truly investing in care transition capabilities

Unique components of UVA-Locus Health partnership

- **UVA investment in Locus Health**: Investment demonstrates strong partnership commitment
- **Locus Health access to UVA clinical data**: Allows direct interface between clinical data and analytics platform

Advantages for Locus Health product

- **Predictive analytics**: Incorporates clinical and historical utilization data to stratify UVA patients into risk pools and predict adverse post-discharge events
- **Timely clinical interventions**: Remote monitoring data detects when a patient’s data falls outside of a predetermined range, enabling clinical interventions that avoid symptom exacerbation
- **Post-discharge program alignment**: Collaboration between Locus Health team and existing follow-up supports, such as post-discharge clinics

40% Decrease in 30-day readmission rate

Source: University of Virginia Health System, Charlottesville, VA; Post-Acute Care Collaborative interviews and analysis.
University of Virginia Health System

- Based in Charlottesville, Virginia
- Multi-hospital academic medical center offering a variety of post-acute services including LTACH, SNF, and HH

- University of Virginia Health System (UVA) partnered with health care analytics and remote care solutions company Locus Health to reduce readmissions among UVA’s patients discharged to home.

- UVA’s strategic investment in the company allows for in-depth information sharing, including a direct interface between its clinical data warehouse and Locus Health’s analytics platforms.

- Demonstrated a 40% reduction in 30-day readmission rates among patients discharged to home and improved patient engagement.

Source: University of Virginia Health System, Charlottesville, VA; Post-Acute Care Collaborative interviews and analysis.
New avenues emerge to fund non-medical supports

Few plans move forward on tight 2019 timeline

**POLICY IN BRIEF**

**Chronic Care Act**

- Act expanded supplemental benefits to meet needs of chronically ill Medicare Advantage enrollees
- New benefits aimed to have a reasonable expectation of improving or maintaining the overall health of the enrollee

### New Supplemental Benefits Filed for 2019

**CMS PBP**

- **filings 2019**
- **N=2,047 filings**

<table>
<thead>
<tr>
<th>Benefit Category</th>
<th>Filings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nicotine Replacement Thx</td>
<td>49.4%</td>
</tr>
<tr>
<td>Caregiver Support</td>
<td>11.9%</td>
</tr>
<tr>
<td>Undefined Benefits</td>
<td>5.4%</td>
</tr>
<tr>
<td>Social Worker Phone Line</td>
<td>5.3%</td>
</tr>
<tr>
<td>Substance Use Mental Health</td>
<td>1.7%</td>
</tr>
<tr>
<td>Health Alert</td>
<td>0.5%</td>
</tr>
<tr>
<td>Home Palliative Care</td>
<td>0.4%</td>
</tr>
<tr>
<td>In-Home Support</td>
<td>0.1%</td>
</tr>
<tr>
<td>Non-Skilled Home Health</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

Population health changes PAC’s role in system

Post-acute care is an essential piece in the senior care continuum

Source: Post-Acute Care Collaborative interviews and analysis.
Looking for the future of Medicare management

CareMore model focuses on senior continuum, growth follows

**CareMore Health System**
- Integrated health plan and care delivery system serving 100,000+ patients across 8 states
- PCP-led model emphasizes preventative care; focused on high-risk chronically ill patients

**Timeline of organizational changes and growth**

- **1993**: Launched as a medical group in southern California
- **1997**: Restructured as an MA product focused on seniors
- **2011**: Acquired by Anthem, serving 50,000 beneficiaries
- **2014**: Expands to VA, TN; incorporates Medicaid
- **2016**: Expands to GA; serving 100,000 beneficiaries

CareMore Health System

- Based out of Southern California
- CareMore is an integrated health plan and care delivery system owned by Anthem, operates in eight states, and serves 100,000+ patients

- Care model designed to target high-risk, chronically ill seniors through focused care coordination, patient education and proactive disease management.

- Model of care centers on primary care, where the PCP and other clinicians manage and coordinate care for the patient and connect patients with an expanded set of supporting services focused on caring for the patient in their own home.

- CareMore patients see a significant decrease in per 1,000 bed days and readmissions compared to the Medicare average.

Range of at home support meets evolving needs

CareMore model emphasizes home- and community-based care options

Strategies to ensure chronic conditions are managed at home

NP-led disease management model
NPs monitor and screen patients to provide necessary care and make referrals to other settings

Remote patient monitoring at home
Biometric sensors are used to bring real-time health information to clinicians for intervention as needed

Home intervention SWAT team
Teams of clinicians and non-clinical support staff make house calls to reduce unnecessary hospitalizations

Ongoing management  Active intervention

Care centers connect patients to needed services

A one-stop-shop for senior care needs

- Preventative services
- Chronic disease management
- Mental health
- Podiatry
- Primary care

Benefits of care centers:

- Convenient location
  - Decreases likelihood of missed appointments

- Houses multiple services
  - Eliminates need for multiple appointments

- Consolidated patient records
  - Prevents duplication of efforts across providers

Source: CareMore Health, www.caremore.com/About/Clinical-Model.aspx; Post-Acute Care Collaborative interviews and analysis.
Extensivist responsibilities span full continuum

Consistent, coordinated care for highly complex patients

**Extensivist Role in Care model**

**Acute care**
- Oversees other medical specialists
- Ensures holistic treatment recommendations
- Reviews discharge preparedness

**Post-acute care**
- Eases transitions into new setting
- Works with care managers to map progress
- Determines post-discharge setting

**Home**
- Supports in home nurse with care plan
- Links high-risk patients to 24/7 nurse triage line

**Illustrative Extensivist Schedule**

**8:00 am – 11:00 am**
- Makes rounds at hospital, seeing an average of eight patients per day

**11:00 am – 12:00 pm**
- Multidisciplinary phone conference with case managers about patients currently in the hospital or skilled nursing facility

**1:00 pm – 4:30 pm**
- Two days per week: complete an average of eight visit types, hospital preoperative assessments for elective surgeries, hospital follow-ups, fall prevention program assessments, frailty clinic
- Two days per week: long-term care facility rounds
- One day per week: hospital admitting physician

CareMore model lowers utilization, increases quality

Investments in comprehensive support drive desired outcomes

**Inpatient bed days per 1000 patients**

<table>
<thead>
<tr>
<th></th>
<th>Medicare average</th>
<th>CareMore 2015</th>
<th>CareMore risk-adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>1,420</td>
<td>1,093</td>
<td>812</td>
</tr>
</tbody>
</table>

**Acute hospital readmissions**

<table>
<thead>
<tr>
<th></th>
<th>Medicare average</th>
<th>CareMore 2015</th>
<th>CareMore risk-adjusted</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>17.9%</td>
<td>13.9%</td>
<td>10.3%</td>
</tr>
</tbody>
</table>

Physicians, plans looking to advance the model

Senior management innovations popping up nationally

ConcertoHealth
- Integrated care delivery model targets frail, elderly, and dual-eligible patients
- Reported 30.3% year-over-year reduction in hospital readmission rate

Walgreens and Humana
- Operates senior-focused primary clinics in Walgreens stores
- Provide holistic care through services like diabetes education and community support

Oak Street Health
- Aims to serve “healthcare deserts” where seniors struggle to find doctors
- Reduced hospitalizations by 40% among peer Medicare cohorts

Landmark Health
- Offers in-home medical, behavioral, and palliative care support
- Expanded to serve patients in 13 states

ChenMed
- Focuses on improving access to PCPs for underserved seniors
- Showed admission rates 28% lower than Medicare average

An expanding senior care landscape

New critical pieces of the senior care continuum

<table>
<thead>
<tr>
<th>Role in senior population management</th>
<th>Home-and community-based care</th>
<th>Primary Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offer services, including non-medical, in the home setting to promote preventative care</td>
<td>Manage and coordinate care for seniors across the continuum</td>
<td></td>
</tr>
</tbody>
</table>

Challenges to care delivery

- Lack of reimbursement for services
- Investment often necessary to create new offerings

Example service offerings

- Telemonitoring
- Home-based post-discharge visits
- Community-based support services

- Geriatric primary care expertise needed
- Must operationally connect to other services

- Geriatric primary care models
- Home-based primary care

Source: Post-Acute Care Collaborative interviews and analysis.
Emerging pieces of the senior continuum

Areas of focus for today’s conversation

**Home and community-based care**

1. Evaluating the range of care at home options
2. Avoiding duplication on at home management investments

**Primary care for the senior population**

3. Integrating senior care expertise into population health
4. Managing populations without a primary care infrastructure

Source: Post-Acute Care Collaborative interviews and analysis.
Care at home essential to forward-looking models

Payer and provider goals coalesce on home environment

**Total cost of care goals**
- Shift patients to cost-effective care settings
- Meet a wider array of patient needs
- Avoid preventable admissions

**Provider strategic goals**
- Appeal to patient and family preference
- Succeed under value-based models
- Capture new revenue streams

Incentives align across the industry to prioritize care at home

Source: Post-Acute Care Collaborative interviews and analysis.
Home-based care innovation happening outside FFS

Total home health discharges
Medicare FFS, 2014-2017

<table>
<thead>
<tr>
<th>Year</th>
<th>Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015</td>
<td>4.2 M</td>
</tr>
<tr>
<td>2016</td>
<td>4.1 M</td>
</tr>
<tr>
<td>2017</td>
<td>4.1 M</td>
</tr>
</tbody>
</table>

Representative member questions about home care, 2018

“Can you tell me about programs aimed at enhancing patient satisfaction by treating patients in the home?”

“How should we evolve our home and community service portfolio?”

“Can you help me evaluate the possibility of starting a program where doctors attend to patients in their homes as part of post-acute care?”

“Is Medicare Advantage paying for private duty or home care? How are people using it? Are people innovating their models based on this?”

Source: CMS, Advisory Board analysis; Post-Acute Care Collaborative interviews and analysis.
Growing spectrum of services provided in the home

Emerging services capitalize on low cost appeal of home

Admission avoidance

Ongoing management

Pre-acute care

Certified home health
Serves Medicare qualifying patients post-discharge

Community care management
Supports discharged seniors living in community

Telehealth support
Aids high-risk chronic condition patients remotely

Home-based primary care
Helps seniors with high-risk of no-show

Hospital at home
Treats appropriate hospital admits at home

Source: Post-Acute Care Collaborative interviews and analysis.

1) Managed Care Organizations.
Best Home Healthcare eyes medication reconciliation

Added service targets universal referrer, payer challenge

Keys to Home Health Medication Therapeutic Management (MTM) Advantage Model

**Dedicated Staffing**
On-staff clinical pharmacist integrated into home health team to provide pharmacy support for eligible chronically ill patients

**Coordination with Primary Care**
Pharmacist connects with patients’ PCP to develop customized drug plan and perform medication reconciliation

**Patient Engagement**
Pharmacist educates patients on medication usage, promotes adherence, and identifies strategies to reduce medication costs

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**MTM Program Drives Savings, Reduces Errors**

- **$400-**
- **$1200**
  - Average yearly savings to patient

- **2.9**
  - Drug problems identified per patient by MTM Team

Source: Best Home Healthcare Network, Chicago, IL; Post-Acute Care Collaborative interviews and analysis.
Best Home Healthcare Network

- Based in Chicago, IL
- Best Home Healthcare Network offers a variety of in-home care services including pharmaceutical consultation, chronic disease care, and full range of therapies

▶ Medication Therapeutic Management (MTM) Advantage program utilizes an in-house clinical pharmacist who coordinates with patients’ primary care provider to develop a customized drug schedule

▶ Providers ask eligible patients with multiple chronic conditions if they would like to receive this service; a nurse and pharmacist meet with the patient to perform medication reconciliation and educate the patient about adherence, side effects, and costs

▶ On average, this service saves patients $400-$1200 in medication costs annually; the team identifies an average of 2.9 drug therapy problems per patient

Source: Best Home Healthcare Network, Chicago, IL; Post-Acute Care Collaborative interviews and analysis.
Home visit model enhances post-discharge clinics

Ochsner program provides improved visibility, patient convenience

Start high-risk post-discharge program
Target MA/ACO patients with LACE+ score >55 for clinic appointment

Patient compliance to clinic visits proves problematic
50 to 60% of targeted patients schedule an appointment; 15 to 20% no-show rate

Home visit option introduced to decrease no-shows

NP role critical to program
• Eliminates need for PCP approval to prescribe medicine, treatments
• Requires 5 visits per day to break even financially

Home-based visit informs NP duties
• Medication reconciliation
• Digital home monitoring
• Caregiver education

200 Seniors in the pilot program for over 30 days
20.5% Decrease in 30-day readmission rate compared to patients opting out of program

Source: Ochsner Health System, Baton Rouge, LA; Post-Acute Care Collaborative interviews and analysis.
Ochsner Health System

- Not-for-profit health system based in Southeast Louisiana
- Operates 11 hospitals across the state, as well as inpatient rehab, skilled nursing, and home health

▶ Ochsner implemented a post-discharge home visit option for high-risk seniors in response to high levels of no-shows for post-discharge clinic visits.

▶ The program is aimed at patients with a LACE score of 55 and over, with social determinants of health also taken into consideration; eligible patients decide to accept either a post-discharge clinic visit or home visit. If patients accept a home visit, an NP performs the encounter.

▶ The 200 patients in the home visit program for more than 30 days achieved a 20% decrease compared to high risk seniors not enrolled.
Telehealth makes old services new again

BAYADA program provides initial nurse visit and ongoing monitoring for heart failure patients

Initial visit
- RN visits after patient is transferred home

HRS/Vivify\(^1\) installed
- Scalable technology
- Focus on education/engagement

Call center monitoring
- RNs and LPN staff
- Backend monitoring

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**Initial program details**

- **45** Initial cohort of patients in program
- **2** Markets where the pilot program will launch in 2019

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1) HRS and Vivify are remote monitoring technology vendors.

Source: BAYADA Home Health Care, Moorestown, NJ; Post-Acute Care Collaborative interviews and analysis.
BAYADA

- Home health agency based out of Moorestown, NJ
- Serves communities in 22 states from 335 offices

- Implemented a telehealth remote monitoring program for heart failure patients in partnership with a managed care payer.

- The pilot program, designed to decrease unnecessary ED utilization, is set to launch in 2019.

- An RN completes an initial visit for patients and remote monitoring technology is installed. The RN or LPN continues ongoing remote monitoring for the patients.

Source: BAYADA Home Health Care, Moorestown, NJ; Post-Acute Care Collaborative interviews and analysis.
Targeted project portends broader collaboration

Provider and payers (and patient) benefit from HF telehealth

**Benefits for plan**
- Pilot program operated by a home-based care delivery expert
- Decreases total cost of care by preventing avoidable admissions

**Benefits for BAYADA**
- Develops a replicable skill set targeting a universally challenging population
- Opportunity to grow relationship with current or new partners

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**Study in Brief: Value of Telemonitoring and Telemedicine in Heart Failure Management (2017)**

- Systematic review of 12+ clinical trials and meta analyses comparing the effects of various telehealth technologies on heart failure patients
- Telehealth interventions shown to reduce mortality and readmission

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House call model utilizes community paramedics

Northwell Health targets homebound elderly with chronic conditions

Call center nurses support after hours care

ED
Refer patient to ED

Call Center
24/7 triage nurse select appropriate intervention

Send community paramedic for further evaluation

Telephonic support

Community paramedics complete home visit

Telemedicine enables physician connection
- Connect patients with physician or nurses
- Modify care plan, as needed

Provide baseline primary care support
- Administer medication, manage pain
- Perform diagnostics (e.g. blood glucose, vital signs)

$2.1M
Estimated savings after one year of program

Source: Northwell Health System, Great Neck, NY; Post-Acute Care Collaborative interviews and analysis.
Northwell Health System

- Health system based in Great Neck, New York
- Operates 18 hospitals, home care, hospice, SNF and rehab facilities, as well as a range of outpatient services

- Northwell found that seniors with complex conditions and functional impairments have frequent deteriorations in health status and difficulty getting to traditional primary care and specialty services. This leads to a reliance on ambulance transport, ED and hospital care.

- Community paramedics at Northwell are integrated into the House Calls program. The paramedics provide at-home interdisciplinary primary care to elderly patients, and help extend physician service into the homes of seniors requesting assistance.

- Estimated $2.1M cost savings after first year due to decreased utilization, specifically ED visits, avoided admissions, and reduced ambulance transports.

Source: Northwell Health System, Great Neck, NY; Post-Acute Care Collaborative interviews and analysis.
Mobile care team provides acute services at home

Staffing and communication key to program success

**Patient requirements**
- Residence in specific geographic area
- Targeted set of appropriate clinical conditions
- Require hospitalization, but meet social and medical criteria for at-home care

**Scope of services**
- 5 to 6 rotating physicians; 1 to 2 practicing at a time
- NPs, social workers, therapists, infusion trained nurses
- Paramedics help with high acuity events

**Staffing structure**
- 1 social worker or physical therapy visit per enrollment
- 5 to 6 rotating physicians; 1 to 2 practicing at a time
- NPs, social workers, therapists, infusion trained nurses
- Paramedics help with high acuity events

**Coordinated communication**
- Daily visit by physician or NP
- 1 to 3 RN visits per day
- 1 social worker or physical therapy visit per enrollment
- EMR shared with physician
- HIPAA compliant video calls between care team
- Care team huddles
- 24/7 access for patients

Source: Mount Sinai Health System, New York, NY; Post-Acute Care Collaborative interviews and analysis.
Mount Sinai Health System

- Integrated health system located in New York City
- Operates 3,535 beds across 7 hospital campuses and a medical school

- Hospitalization at Home (HaH) program provides patients with acute-level care in the home environment
- Staff of physicians, paramedics, and nurses work together to provide robust treatment for patients in the home, and remain communicative on treatment and the care plan via EMR, video calls, and team huddles.
- Since launching program in 2014, over 225 patients have been treated through MACT; 2 to 5 patients per day. The success of the program has led to the development of Rehabilitation at Home (RaH) focused on rehabilitation, medical and nursing services to replace a skilled nursing stay.

Source: Mount Sinai Health System, New York, NY; Post-Acute Care Collaborative interviews and analysis.
Growing spectrum of services provided in the home

Emerging services capitalize on low cost appeal of home

- **Admission avoidance**
  - Certified home health
    - Serves Medicare qualifying patients post-discharge
  - Community care management
    - Supports discharged seniors living in community

- **Ongoing management**
  - Telehealth support
    - Aids high-risk chronic condition patients remotely

- **Pre-acute care**
  - Home-based primary care
    - Helps seniors with high-risk of no-show
  - Hospital at home
    - Treats appropriate hospital admits at home

Source: Post-Acute Care Collaborative interviews and analysis.

1) Managed Care Organizations.
### Different stakeholders making similar investments

If you’ve seen one home-based care management model...

#### Common duplication in provider and payer home-based care programs

<table>
<thead>
<tr>
<th>Health plan</th>
<th>Hospital system</th>
<th>PAC provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN-led telephonic management</td>
<td>RN-led telephonic management</td>
<td>RN-led telephonic management</td>
</tr>
<tr>
<td>In-home visit within 30 days of discharge</td>
<td>In-home visit within 30 days of discharge</td>
<td>In-home visit within 30 days of discharge</td>
</tr>
<tr>
<td>Remote patient monitoring for targeted high-risk patients</td>
<td>Remote patient monitoring for targeted high-risk patients</td>
<td>Remote patient monitoring for targeted high-risk patients</td>
</tr>
</tbody>
</table>

Source: Post-Acute Care Collaborative interviews and analysis.
Health plans willing to delegate care management

Providers and plans looking to split functions for maximum efficiency

Overview of specific functions trusted to providers by plans

Care Management
- Medication management
- Patient education
- Care coordination
- PCP scheduling
- Predictive analytics

Utilization Management
- Prior authorization
- Formulary design
- Practice pattern analysis
- Referral management

Network Design
- Network composition
- Provider development
- Clinician education
- Attribution

Product Development
- Benefit design
- Marketing
- Product pricing
- Regulatory compliance
- Member services

Financial Management
- Actuarial analysis
- Risk aggregation
- Claims adjudication

**Plans Already Delegating**

**Plans Not Yet Delegating**

Source: Post-Acute Care Collaborative interviews and analysis.
An intentional focus on eliminating duplication

UW Health’s Transitions Coordination Committee breaks down siloes

**UW Leaders**
PCP, pharmacy, transitional care, home health, and ambulatory leadership

**Transitions coordination committee**

**NGACO¹ Partners**
ACO manager, partner hospital leaders, partner hospital home health managers

**Health Plan Partners**
Care management leadership, other plan leaders

**Goals of monthly committee meetings:**

**Connect the dots**
Improve communication and coordination for patient, program, and system processes

**Avoid wasted energy**
Prevent duplication of services and process for the benefit of patients and the organization

**Target key priorities**
Review ACO updates, TCM² coding, patient transitions, and discuss progress on committee initiatives

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1) Next Generation Accountable Care Organization.
2) Transitional Care Management.

Source: UW Health, Madison, WI; Post-Acute Care Collaborative interviews and analysis.

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Transitional care template consolidates view points

Solution creates streamlined patient care, aligns information for care team

Transitional template in EMR accessible by all, reducing duplication

Transitional care template in brief

- Conditions documented
  - Service/specialty program patient is enrolled in (Transitional care vs PCP clinic)
  - Family/caregiver information
  - Potential clinical red flags
  - Number of prescribed medications
  - Medication discrepancies
  - Recommended contact method for next follow up
  - Any future appointments

Source: UW Health, Madison, WI; Post-Acute Care Collaborative interviews and analysis.
UW Health

- Integrated health system headquartered in Madison, Wisconsin
- Operate a 505 bed hospital, as well as many other acute and post-acute facilities

► UW Health initiated their “connect the dots” group in 2012 to convene leaders at the organization who are involved in similar projects with similar goals to coordinate efforts on patient-facing workflows. The meeting occurs monthly for one hour with leaders across acute, ambulatory, and post-acute settings.

► One project targeted by the group was to reduce duplication on post-discharge telephonic follow up, which was being performed by three separate groups.

► An EMR transitional care template documents who called the patient, when, and the patient’s responses to ensure the information is available to all parties, but only one call was made to the patient.

Source: UW Health, Madison, WI; Post-Acute Care Collaborative interviews and analysis.
Two clear skills needed for senior population health

Opportunity exists to fill gaps in existing models

Primary care models

- Focus of physician groups and hospitals
- Basis for population health efforts
- May lack dedicated senior care expertise needed for complex cohort

Senior care models

- Focus of post-acute and senior care providers
- Senior population maintains distinct clinical needs
- May not employ or integrate directly with primary care physician groups

Source: Post-Acute Care Collaborative interviews and analysis.
Population health models often lack senior support

Lack of senior expertise can lead to gaps in geriatric care

Unique primary care needs of senior population

- Dementia care
- Loneliness and isolation
- Activities of daily living
- Dental health
- End-of-life decision making

Source: Post-Acute Care Collaborative interviews and analysis.
Cross-functional team assumes post-acute ownership

Baystate strategic PAC committee brings order, prioritizes efforts

Committee includes key positions from PAC and acute care

- SVP, Quality and Population Health
- VP, Strategic Planning
- President, VNA and Hospice
- Post-acute geriatrician

Representative topics for monthly committee meetings

- Post-acute network creation and utilization
- Developing care delivery strategy for high-risk groups
- Creating a complete senior population health infrastructure

Episodic management  Population health

Gap #1: Integration

Baystate Health

- Health system based in Springfield, Massachusetts
- Operates an academic medical center, two community hospitals, a health insurance company, and 250 physician practices

- Noticed a complex relationship and conflicts of interest between hospital and post-acute entities; created their strategic post-acute care committee (SPACC) to organize relationships around quality measures.

- Included both acute and post-acute stakeholders and instituted monthly meetings to discuss cross-setting problems and create solutions.

- Used the committee to create and sustain a SNF network, as well as develop strategies to track patients post-discharge and improve patient engagement.

Geriatric integration bolsters primary care

Interdisciplinary geriatric team focused on senior-specific needs

Demonstration embeds geriatric support in primary care office

Entities function as interdisciplinary care team:
- Creates accessible, efficient, and more relevant care for seniors, especially those with Dementia
- Promotes early recognition of cognitive decline
- Aimed at improving care management and transitions
- Established patient-healthcare team relationships

Initial results signal less fragmented care for program patients

2.9 Decrease in number of annual subspecialty visits per patient

2.3 Decrease in number of annual subspecialty visits per dementia patient

.2/.7 Increase in PCP visits for general and dementia patients, respectively

Senior management without a primary care investment

Interdisciplinary PACE model enables On Lok to expand mission

Care team assumes clinical, cost of care responsibilities

- Team members develop consensus on care plans; key decisions determined by best positioned team members
- PACE\(^1\) program leaders review utilization data, identify spikes, and determine if new protocols are needed

Care team responsible for developing clinical protocols focused on decreasing costs and maintaining quality

<table>
<thead>
<tr>
<th>1</th>
<th>15%</th>
<th>50%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Day shorter average length of stay compared to MA patients</td>
<td>Lower cost for PACE beneficiaries than traditional Medicare</td>
<td>Lower readmissions rate when compared to traditional Medicare</td>
</tr>
</tbody>
</table>


1) Program of All-Inclusive Care for the Elderly.
On Lok Lifeways

• Program of All-Inclusive Care for the Elderly based out of the San Francisco Bay Area
• Serves 1,400 elders in seven PACE centers and elders’ home with 700 full and part-time staff

► On Lok’s PACE program was initially developed in 1971 as an alternative to institutionalized care for the elderly.

► Utilize a large interdisciplinary care team including two primary care providers, nurses, behavioral health providers, occupational and physical therapists, dieticians, activity therapists, social workers, and personal care attendants and drivers.

► On Lok patients experience 50% lower readmission rates compared to traditional Medicare recipients, and less institutional care.

I-SNP model looks to monetize senior infrastructure

Model of care built on existing patient management capabilities

SeniorSelect’s nurse practitioner model ensures consistency of care

- **Staffing**: Consistent practices and staffing levels across all homes; NPs are responsible for working directly with facility operators

- **Management**: NPs cover and care for entire nursing facilities, including Simpra and traditional Medicare patients

- **Education**: Education is provided to every NP on Simpra’s model of care and goals

---

73
Number of homes Simpra Advantage operates in statewide

35%
Penetration among potential beneficiaries in first year

2,200
Estimated number of beneficiaries to date

Source: SeniorSelect Partners, Birmingham, AL; Post-Acute Care Collaborative interviews and analysis.
Senior Select Partners, Simpra Advantage

• SeniorSelect Partners and Simpra Advantage, Inc. are both based out of Alabama
• SeniorSelect Partners represents 28 long-term care providers. Simpra Advantage, Inc., a subsidiary of SeniorSelect Partners, is a Medicare Advantage plan

► SeniorSelect created an MA plan offering an Institutional Special Needs Plan (I-SNP) to address challenges of treating seniors in Alabama.
► SeniorSelect contracts NPs to offer care support to senior population. NPs are reimbursed based primarily on productivity with incentive payments determined by patient satisfaction scores, HEDIS measurements, and ED visits and hospitalizations.
► Within the first year of operations, Senior Select enrolled 35% of the eligible population, or approximately 2,200 individuals
Population health is challenging without PCPs

Three principles for post-acute providers to take the lead

**Population health management without primary care infrastructure**
Post-acute providers can manage specific senior populations without primary care investments, assuming they follow three principles.

1. **Buy-in across all leadership levels, including clinical ownership of financial results**
   From the top to the bottom, all leaders must be on board with strategic goals and operations under a risk model; clinical leaders must understand business implications of care decisions, and facility leaders update operations to reflect PMPM payments.

2. **Standardized, scalable care delivery model and interdisciplinary team**
   Strong and consistent care management that utilizes a wide range of clinical staff to develop an interdisciplinary team—in lieu of a large PCP practice; familiarity with, and adherence to, the care delivery model and standard clinical practices.

3. **Robust supporting infrastructure with select capabilities outsourced**
   Developing supports that are necessary or valuable to a longer-term vision, while identifying partners who can adequately fill in the gaps on capabilities (e.g., TPAs¹, PBMs², etc.) that you can not.

---

¹ Third-Party Administrator.
² Pharmacy Benefit Manager.

Source: Post-Acute Care Collaborative interviews and analysis.
Industry mega-mergers create new delivery model

Sanford Health acquires Good Samaritan Society

Sanford Health

- Headquartered in Sioux Falls, South Dakota
- Operates medical centers, clinics, and owned health insurance plan

$6 Billion

Combined value of Sanford Health following merger

Good Samaritan Society

- Headquartered in Sioux Falls, South Dakota
- Offers home-and community-based services, senior living facilities, and rehab/skilled care

Acquisition rapidly expands geographic range

ProMedica, HCR ManorCare also merge

A snapshot of the new ProMedica system

$7B Total value of combined entity

450 Assisted living, SNFs, hospice, and home health agencies

13 Hospitals in network

30 States covered by the combined entity

Integration unlocks new opportunities

“HCR ManorCare provides the platform to think differently about where healthcare services are delivered, particularly with respect to the aging of the population.”

Tom DeRosa
CEO at Welltower

A different-in-kind senior care model

Vertical integration with an eye on managing the premium dollar

Three key benefits of recent hospital-PAC mergers

Vertically integrated continuum
- Health system service offerings now include post-acute and senior care
- All entities incented toward system goals of lower utilization and improved care

Full range of senior-centered services
- Acquired services create emphasis on senior health, wellness, and management
- Enhanced footprint and capabilities to develop new clinical models

Expanded geographic coverage
- Larger system footprint and scale for future growth opportunities
- New or expanded patient pools for risk contracting or management

Source: Post-Acute Care Collaborative interviews and analysis.
Study evaluated impact of vertical integration

Results show increase in Medicare payments, improved patient outcomes

Advantages of increased acute and post-acute integration

Utilization changes to maximize acute and post-acute reimbursement

-0.74 days
Decrease in hospital length of stay

+4.64 days
Increase in SNF length of stay

Increased coordination reduces preventable readmissions from SNF

5.4%
Lower 30-day readmission rate for vertically integrated organizations

Shifting utilization patterns create the ability to control spending distribution

Picking the right identity for the right patient

1. **The post-acute performer**
   - Features a well-known brand that attracts appropriate patients—within the immediate market and beyond—for a defined set of services
   - Future investments focused on furthering clinical excellence and growing brand awareness

2. **The one-stop shop**
   - Offers a full range of post-acute offerings to capture a wide range of patient types and seamlessly coordinate care as patient needs evolve
   - Future investments focused on building out a set of comprehensive services and supporting patient care across those services

3. **The senior cohort manager**
   - Possess capabilities to manage defined senior populations through targeted payment models (e.g., I-SNP or PACE)
   - Future investments focused on operating dedicated business line for that distinct patient population, while remaining competitive for the core business

4. **The risk taker**
   - Positions the enterprise to maximize the percentage of patients that are under a direct management model (e.g., ACO or MA)
   - Future investments focused on creating a risk-based infrastructure and growing the number of covered lives

---

1) Institutional Special Needs Plan.

Source: Post-Acute Care Collaborative interviews and analysis.
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Post-Acute Care Collaborative

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Practice Manager
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Reducing Avoidable Acute Care Days

5 key delays hindering hospital to post-acute discharges
More coffee, faster service, more money

Efficiency is the key to financial sustainability

How coffee shops generate profit

Coffee sales - Time, resources per customer = Total profit

Volume
Price

Inefficiency
Redundancy

Profit margins

Source: Post-Acute Care Collaborative interviews and analysis.
Individual days add up to a big problem

- 25% of hospital days are avoidable
- 1.2 average number of avoidable days per patient
- 10.8 million avoidable days 2017-2018

Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.
Contextualizing avoidable days

What 10.8 million means in practice

Thousands of beds maintained to house avoidable patient days

10.8M = 29,590
Avoidable days
Hospital beds full for an entire year

Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.
Hospital bottom lines damaged by inefficiency

Health systems hurt by avoidable days, regardless of occupancy

Hospitals with high occupancy

Limited bed availability
Avoidable days reduce the number of new patients hospitals are able to admit

Hospitals with low occupancy

Unnecessary resource use
Avoidable days limit hospitals’ flexibility to scale down staffing and resource use as appropriate

Negative financial implications
Missed revenue from potential patients
Increased labor and facility costs

Source: Post-Acute Care Collaborative interviews and analysis.
For post-acute, a mixed picture

Avoidable hospital days offer both challenges and opportunities

Excess hospital days exacerbate financial troubles, but can also create incentives

**Challenge**

- Reduced reimbursement
  - Inability to quickly backfill empty beds reduces total reimbursement for post-acute settings

**Opportunity**

- Increased referrals
  - Post-acute providers who can help hospitals reduce avoidable days position themselves to solve a tangible problem

Source: Post-Acute Care Collaborative interviews and analysis.
Taking a closer look

Calculations for our analysis of avoidable acute care days

Methodology in brief

- Analysis uses data from CMS’ Standard Analytical Files (SAF) which include 100% Medicare FFS¹ claims data
- Utilizes GMLOS², which is determined by multiplying all of the length of stay values and then taking the Nᵗʰ root, where N is the number of values
- Includes Medicare FFS claims data from Q2 2017 to Q1 2018

Representative avoidable days calculation

\[
\left( \frac{4.2}{4.0} \right) \times 100 = 20
\]

- Average length of stay for a specific hospital or patient group
- National GMLOS for that patient group
- Patient volume for that specific hospital or group
- Avoidable days

¹ Fee-for-Service.
² Geometric Mean Length of Stay.

Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.
Avoidable days are ubiquitous across service lines…

<table>
<thead>
<tr>
<th>Service Line</th>
<th>Share of Avoidable Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopedics</td>
<td>23%</td>
</tr>
<tr>
<td>Cardiac Services</td>
<td>23%</td>
</tr>
<tr>
<td>General Medicine</td>
<td>24%</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>25%</td>
</tr>
<tr>
<td>Spine</td>
<td>26%</td>
</tr>
<tr>
<td>Thoracic Surgery</td>
<td>26%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>27%</td>
</tr>
<tr>
<td>Neurology</td>
<td>28%</td>
</tr>
<tr>
<td>ENT²</td>
<td>29%</td>
</tr>
<tr>
<td>Other Trauma</td>
<td>30%</td>
</tr>
<tr>
<td>Oncology/Hematology(Medical)</td>
<td>30%</td>
</tr>
<tr>
<td>Urology</td>
<td>31%</td>
</tr>
<tr>
<td>Vascular Services</td>
<td>31%</td>
</tr>
<tr>
<td>Gynecology</td>
<td>31%</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>32%</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>33%</td>
</tr>
</tbody>
</table>

*Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.*
...and also common among the majority of hospitals

On average, patients stay half a day longer than necessary

Share of avoidable days by hospital per 1000 cases

Medicare FFS, Q2 2017 - Q1 2018

n = 3,357 hospitals

Less than 500

29%

Greater than or equal to 500

71%

Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.
Excess hospital days not deterring readmissions

Longer hospital stays don’t correlate with lower readmission rates

**30 day readmission rates vs. avoidable days per 1000 cases**

*Medicare FFS, Q2 2017-Q1 2018*

n = 3,357 hospitals

1) Values greater than 40% not displayed due to outliers.

2) The coefficient of determination explains how much of the variability in the Y-variable can be explained by the X-variable. Values close to 1 indicate perfect correlation whereas values near 0 indicate no correlation.

R-squared value (coefficient of determination)$^2$ = 0.076

Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.
Post-acute discharges fraught with excess days

Discharges to PAC comprise a disproportionate share of avoidable days

Post-hospital discharge setting, all patients

Medicare FFS, Q2 2017 to Q1 2018

Share of days deemed avoidable, by discharge destination

Medicare FFS, Q2 2017 to Q1 2018

<table>
<thead>
<tr>
<th>Discharge Destination</th>
<th>Avoidable days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged to a PAC setting</td>
<td>39%</td>
</tr>
<tr>
<td>Discharged home¹</td>
<td>61%</td>
</tr>
<tr>
<td>Discharged to a PAC setting</td>
<td>76%</td>
</tr>
<tr>
<td>Discharged home¹</td>
<td>24%</td>
</tr>
</tbody>
</table>


Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.
All post-acute settings share the burden

Avoidable hospital days by discharge setting

*Setting-specific GMLOS*, Q2 2017-Q1 2018

<table>
<thead>
<tr>
<th>Discharge setting</th>
<th>Total number of inpatient days</th>
<th>Total number of avoidable days</th>
<th>Share of days deemed avoidable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>2,085,917</td>
<td>611,651</td>
<td>29.2%</td>
</tr>
<tr>
<td>LTACH</td>
<td>1,195,290</td>
<td>277,734</td>
<td>23.2%</td>
</tr>
<tr>
<td>Home Health</td>
<td>4,837,081</td>
<td>1,093,972</td>
<td>22.6%</td>
</tr>
<tr>
<td>IRF</td>
<td>2,080,198</td>
<td>468,271</td>
<td>22.5%</td>
</tr>
<tr>
<td>SNF</td>
<td>12,171,650</td>
<td>2,392,904</td>
<td>19.7%</td>
</tr>
</tbody>
</table>

Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.

1) Geometric Mean Length of Stay.
Uncovering barriers to timely transitions

Five major sources of delayed transitions

1. Difficult-to-place complex patients
2. Insurance preauthorization
3. Clinical complications at point of discharge
4. Misaligned discharge and intake times
5. Lack of available transportation

Patient’s stay in hospital unexpectedly extended

Source: Post-Acute Care Collaborative interviews and analysis.
Key resources to meet patients’ needs

Effective, timely transitions hinge on acute and post-acute settings providing the necessary care to address patient complexity and clinical requirements.

1. The Post-Acute Care Clinical Quality Compendium
   Understand how to deliver high-quality outcomes for various patient types, manage complex patients in the community, hardwire effective information exchange with post-acute settings

2. Pursuing Clinical Excellence in Post-Acute Care
   Promote safety, efficiency, and training for post-acute staff in advance of rising patient acuity in acute and post-acute settings

3. Managing the Tail End of Risk
   Learn strategies to identify complex patients in advance of post-acute transitions and offer appropriate support to manage them throughout their care episodes

Source: Post-Acute Care Collaborative interviews and analysis.
A creative way to ensure placement

Sometimes, paying for PAC placement is the most efficient option

Luna Health’s¹ PAC funding mechanism

Payment agreements established
Luna Health entered into a payment contract with five of their PAC partners

Patients identified
Patients—underfunded or without post-acute benefits—are flagged by case manager as unable to transition

Predetermined payment completed
Luna Health pays the contracted SNF a predetermined rate, based on patient severity, for patients flagged as unable to transition

Luna invests in post-acute care for ready-to-transition patients

“If a patient no longer requires inpatient services, you think about right care, right place…if you were to clear that bed and pay for the SNF bed, it provides access to others in need of tertiary and quaternary care.”

AVP Care Transitions
Academic Health Center

¹) Pseudonym.
Luna Health

- Based in southeastern United States
- Multi-hospital system offering a variety of services including a comprehensive cancer center and partnerships with LTACHs

- Luna Health maintains a contracted payment system with 5 post-acute providers within their network where they pay to transition patients based on severity.

- Luna Health piloted the program in 2015 with 5 post-acute providers already in their network. After conducting internal data analysis, Luna Health determined that paying to transition patients lacking payer source was more financially advantageous than holding them in the hospital and created hospital access for patients waiting on a bed.

- Luna Health supports 20 to 30 patients per month under this model.

1) Pseudonym.
Eliminating preauthorization for specific patient groups

Negotiating with MA payers to bypass acute care stay reduces delays

Standard post-acute transition timeline

<table>
<thead>
<tr>
<th>Wednesday, day 1</th>
<th>Wednesday, day 1</th>
<th>Thursday, day 2</th>
<th>Monday, day 6</th>
<th>Tuesday, day 7</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>Acute care</td>
<td>Post-acute</td>
<td>Preauthorization</td>
<td>Post-acute</td>
</tr>
<tr>
<td>ED arrival</td>
<td>transition</td>
<td>care coordinated</td>
<td>obtained</td>
<td>transition</td>
</tr>
</tbody>
</table>

Aultman’s expedited post-authorization process

<table>
<thead>
<tr>
<th>Wednesday, day 1</th>
<th>Wednesday, day 1</th>
<th>Wednesday, day 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED</td>
<td>Direct transition</td>
<td>SNF submits</td>
</tr>
<tr>
<td>ED arrival</td>
<td>to SNF</td>
<td>insurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>authorization</td>
</tr>
<tr>
<td></td>
<td></td>
<td>after transition</td>
</tr>
</tbody>
</table>

Notable benefits

- Avoids unnecessary hospital stay
- Improves ED and acute care throughput
- Mitigates opportunities for discharge delays

Source: Aultman Health Foundation, Canton, OH; Post-Acute Care Collaborative interviews and analysis.
Post-authorization helps avoid an acute care stay

Aultman’s post-authorization process explained

1. **Patient identification**
   - ED social services flag patients that don’t need acute stay, and can’t safely transition home
   - Plan allows direct PAC transition for certain conditions like cardiac or medical respiratory

2. **SNF transition**
   - Partnering SNF admits patients around the clock
   - SNF postpones preauthorization until after transition

3. **Insurance authorization**
   - Insurance approves entirety of the patient’s SNF stay
   - Payer prevents unnecessary acute stay, hospital avoids potential readmission

70+ Acute care hospitalizations **avoided** in 2 years

100% Post-authorization requests **approved**

Source: Aultman Health Foundation, Canton, OH; Post-Acute Care Collaborative interviews and analysis.
Aultman Health Foundation

- Based in Canton, Ohio
- Multi-hospital system offering a variety of acute and post-acute services including LTACHs, home health, hospice/palliative care, skilled nursing care, and inpatient rehab

- Aultman Health Foundation directly transitions medical respiratory and medical cardiac patients from the ED to a partnering SNF, bypassing an acute care stay. The SNFs complete the preauthorization process after the patient begins care in the SNF setting.

- Aultman has piloted this program with three Medicare Advantage payers.

- The program has been in place since 2017 and Aultman has transitioned 78 patients under this model, with two readmissions in 2017 and zero in 2018. No post-authorization request has been denied by payers to this date.

Source: Aultman Health Foundation, Canton, OH; Post-Acute Care Collaborative interviews and analysis.
## Interdisciplinary rounds proactively surface issues

### Standard discharge rounds

<table>
<thead>
<tr>
<th>Delayed huddles</th>
<th>Discharge plans discussed late, often on the day of discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informal agenda</td>
<td>Meetings don’t include detailed discussions of every patient’s discharge plans and potential red flags</td>
</tr>
<tr>
<td>Inconsistent tracking</td>
<td>No formalized process to identify patients with delayed discharges and offer additional discharge assistance</td>
</tr>
</tbody>
</table>

### Maddox Health’s\(^1\) proactive rounds

<table>
<thead>
<tr>
<th>Early and regular discussions</th>
<th>Physicians meet daily to discuss discharge needs and send reports to discharge staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive agenda</td>
<td>Agenda includes a discussion of every patient’s discharge plan, dates, and areas of potential complications</td>
</tr>
<tr>
<td>Elevated assistance</td>
<td>Patients who fail to discharge by anticipated date are automatically flagged for additional assistance</td>
</tr>
</tbody>
</table>

### Decrease in time

15% Decrease in time from discharge order to actual patient discharge post implementation of rounds

---

\(^1\) Pseudonym.
Maddox Health

- Based out of Mid-Atlantic US
- Three-hospital network offering a variety of services such as a comprehensive cancer center, urgent care services, home care and hospice

- Maddox Health implemented daily interdisciplinary care rounds, meetings between physician, pharmacy, social worker, and nurse representative, to discuss discharge plans for each patient.

- The physicians meet in the morning to discuss discharge plans, anticipated discharge times, and discharge delays. All daily discharges that are completed are then logged into their EMR. The team reconvenes in the afternoon in a “huddle” to discuss progress, identify any additional discharge barriers, and elevate pending discharges for additional assistance.

- Maddox Health reduced the average time from discharge order to discharge by 15% after implementation.

1) Pseudonym.

Source: Post-Acute Care Collaborative interviews and analysis.
Reallocating staff to better meet hospital needs

Redstone Presbyterian Seniorcare shifts nurse staffing to match intake volumes

Pending Admissions  Nurse Staffing Shifts

**AM**

<table>
<thead>
<tr>
<th>AM</th>
<th>PM</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Pending Admissions AM]</td>
<td>![Pending Admissions PM]</td>
</tr>
</tbody>
</table>

**Nurse Staffing Shifts**

- **Morning nurse** reallocated to assist evening admissions
- **Telemedicine** offers clinical support for evening admissions

Physician and nurse led telemedicine

"We’re competing for those patients. If it’s hard for those patients to come to Redstone, they will go to the nursing home down the street."

Vicki Loucks, VP & COO
Redstone Presbyterian Seniorcare

Source: Redstone Presbyterian Seniorcare, Greensburg, PA; Post-Acute Care Collaborative interviews and analysis.
Redstone Presbyterian Seniorcare

- Based out of Greensburg, PA
- Offers rehab, hospice and palliative care, home health, and a variety of ancillary senior care services

► Redstone Presbyterian Seniorcare receives a significant number of intake requests in the evenings.

► Redstone restructured their Nurse Navigation department, reallocated morning staff to the evening shift, and implemented a physician and nurse supported telemedicine model to meet increased need for evening intakes.

► This has increased Redstone’s ability to intake patients later in the day and has helped improve relationships with upstream providers.

Source: Redstone Presbyterian Seniorcare, Greensburg, PA; Post-Acute Care Collaborative interviews and analysis.
Transportation investment key to timely transitions

Owned van fleet speeds up patient movement

Key components of a successful transportation program

- **Vehicles**: Operates five ambulances and four ambulettes
- **Payer source**: Billed to Medicare/Medicaid or private pay
- **Patient base**: Available to patients going to both Shiloh Care settings and other post-acute facilities

Potential roadblocks

- High cost of initial investment
- Competition from community ambulances

Shiloh Care solutions

- Ambulances are rented to other PACs, creating an additional revenue source
- Patients aren’t delayed, resulting in fewer bed vacancies
- Non-competitive intentions are communicated to ambulance providers to establish goodwill

1) Pseudonym.

Source: Post-Acute Care Collaborative interviews and analysis.
Shiloh Care

- Based out of Midwestern United States
- Multi-service post-acute provider offering skilled nursing care, post-acute rehabilitation, hospice, and home health services among other services

- Shiloh Care owns five ambulances and four ambulettes that transport patients out of the hospital and into their care.
- Shiloh Care invested in their own ambulances to mitigate transportation delays for patients relying on hospital or community ambulances.
- The ambulances also serve as an additional source of revenue as Shiloh Care offers transportation services to other skilled nursing facilities in their area.
Alternative transportation options available, for a price

Vendors stepping up to fill delivery system gaps

<table>
<thead>
<tr>
<th>Key Differentiator</th>
<th>Payment Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Uber Health</strong></td>
<td></td>
</tr>
<tr>
<td>Renown Health</td>
<td>Health system</td>
</tr>
<tr>
<td>Case managers order rides on UberHealth’s dashboard</td>
<td></td>
</tr>
<tr>
<td>• Options range from cars to wheelchair accessible vans</td>
<td></td>
</tr>
<tr>
<td>• Rides can be ordered instantly or scheduled up to a month in advance</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Key Differentiator</th>
<th>Payment Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Door-to-door transport</strong></td>
<td></td>
</tr>
<tr>
<td>FirstLight Home Care</td>
<td>Health system Insurance</td>
</tr>
<tr>
<td>Transport included in Readmission Rescue program</td>
<td></td>
</tr>
<tr>
<td>• Non-medical home care support (medicine pick up, DME supplies) also available</td>
<td></td>
</tr>
<tr>
<td>• Improves timely care access and adherence to care plan</td>
<td></td>
</tr>
</tbody>
</table>

Source: Renown Health, Reno, NV; FirstLight Home Care, Cincinnati, OH; Post-Acute Care Collaborative interviews and analysis.
CASE EXAMPLE

Renown Health

• Based out of Reno, Nevada
• Three-hospital network offering a variety of services including an urgent care center, lab services, x-ray and imaging services, primary care, and home health and hospice services

► Renown partners with UberHealth to provide patients with transportation out of the acute care setting into post-acute and home settings.
► UberHealth is a rideshare transportation service providing both scheduled and on demand medical transportation.
► As a part of this program, case managers can arrange Uber transportation, up to a month in advance, if a patient requires transportation services. The Uber Health drivers also provide door-to-door support.
► Renown has provided 2,024 rides over a 14 month period.

Source: Renown Health, Reno, NV; Post-Acute Care Collaborative interviews and analysis.
FirstLight Home Care

• Based out of Cincinnati, Ohio
• Offers a variety of non-medical home care services including companion, personal, and dementia care to seniors in over 240 US markets

► FirstLight Home Care offers Readmission Rescue services to hospitals. Part of this program includes services such as medication pick up, sitter services, and transportation support.

► FirstLight Home Care staff offer door-to-door transportation support and additional services like medication pick up and telehealth solutions for patients discharged from the hospital with FirstLight services.

► FirstLight is working with several payers and hospitals that will pay for the service due as a means of reducing readmission rates and improving discharge efficiency.

Source: FirstLight Home Care, Cincinnati, OH; Post-Acute Care Collaborative interviews and analysis.
Discover underlying sources of avoidable days

Introduction to today’s activity

Group exercise in brief

1. Within your small groups, **select a scenario** that contributes to discharge and intake delays | 5 minutes

2. Through discussions, **determine the underlying causes** of delays and **brainstorm related solutions** | 25 minutes

3. Reconvene with the larger group to **share overall findings** and learn how different groups addressed similar challenges | 30 minutes
Identify the root causes of delays

Example scenario: Ambulance transportation out of the hospital is delayed by several hours

1. Assess the underlying sources of delay
   For example:
   - Ambulance providers are overburdened due to lack of ambulances and licensed drivers
   - Patients are often discharged to facilities that are several hours away

2. Identify the responsible stakeholders
   For example:
   - Community ambulance providers are unavailable at needed times
   - Hospital discharge planners arrange transport late in a patient’s stay

3. Select 2-3 root causes for which to build solutions
   - Insufficient supply of ambulances
   - Limited driver availability
   - Patients discharge across a large geographic area

Source: Post-Acute Care Collaborative interviews and analysis.
Debrief with your peers

Topics to address with the full group

- **Strategies** identified to address challenges
- **Stakeholders** needed to implement strategies
- **Real world success** stories with identified strategies

Source: Post-Acute Care Collaborative interviews and analysis.
Seize the avoidable day opportunity

25% of hospital days are avoidable

1.2 Average number of avoidable days per patient

10.8 million avoidable days 2017-2018

Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.
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A Sustainable Model for Person-Centered Care

How to balance patient and provider needs
The gold standard: person-centered care

Post-acute providers promote a personalized experience

“Our centers have a **mission to consistently deliver high quality, person-centered care** with dignity, respect, compassion and integrity”

*Skilled nursing facility*

“We reinforce a message that **patients’ wishes and choices are respected and honored** throughout their lives under our care.”

*CCRC† and home care provider*

“It's the **patient-centered treatment policies**, state-of-the-art facilities and equipment, family-friendly environment, and supportive patient peer group.”

*Long-term acute care hospital*

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1) Continuing Care Retirement Community.
Practical realities limit person-centered care

Model is not always clinically appropriate or financially sustainable

What person-centered care looks like in practice

Example one:
A frail patient wants to go to the bathroom alone
Patient goes by herself, falls, and has to be readmitted

Example two:
All patients want to bathe at 8:00 PM every day
Provider spends significant resources changing staffing model to accommodate

Source: Post-Acute Care Collaborative interviews and analysis.
Post-acute environment creates unique challenges

Emotional burden, length of stay, and staffing differentiate PAC\(^1\)

Three factors affecting post-acute experience initiatives

1. Emotional burden
2. Average length of stay
3. Staffing

Family members and caregivers also have their own unique needs, which may not align with those of the patient

Source: Post-Acute Care Collaborative interviews and analysis.
The post-acute patient journey is difficult

Reality #1: Emotional burden

Post-acute care associated with aging and loss of independence

<table>
<thead>
<tr>
<th>Challenge</th>
<th>Potential for recovery</th>
<th>Sign of major life change</th>
</tr>
</thead>
<tbody>
<tr>
<td>In the long term, many post-acute patients won’t regain full functionality</td>
<td>Patients and families feel overwhelmed and frustrated by prognosis</td>
<td></td>
</tr>
<tr>
<td>Providers must manage expectations and help patients and families cope</td>
<td>Providers must educate patients and families about condition and lifestyle changes</td>
<td></td>
</tr>
</tbody>
</table>

Source: Post-Acute Care Collaborative interviews and analysis.
Extended stays present opportunities and challenges

### Reality #2: Average length of stay

**Average LOS\(^1\) by setting, in days**

<table>
<thead>
<tr>
<th>Setting</th>
<th>Q2 2017 – Q1 2018 Average LOS, in days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute care hospital</td>
<td>5.0</td>
</tr>
<tr>
<td>IRF</td>
<td>12.5</td>
</tr>
<tr>
<td>LTACH</td>
<td>24.0</td>
</tr>
<tr>
<td>SNF</td>
<td>24.7</td>
</tr>
</tbody>
</table>

**Impacts of longer LOS**

**Opportunity**

- More chances for staff to make a positive impression on patients and family members

**Challenges**

- Patients expect choices and amenities like they would have at home
- Patients want to build personal connections with staff members

---

1) Length of Stay.

Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.
Staffing realities leave patients feeling unsupported

PAC staffing is limited by regulatory environment, reimbursement

Low staff licensure
- Care teams differ significantly from acute care

- Hospital
  - Physicians
  - 24/7 RN coverage

- SNF and home health
  - Limited physician and RN coverage
  - LPNs¹ and aides

High staff turnover
- 2017 calendar year

- Hospital: 14%
- HHA: 37%
- SNF: 69%

Experience impact
- Patient and family perception of safety and quality
- Trust in care team and care process

Experience impact
- Organizational culture
- Consistency of care team

¹ Licensed Practical Nurses.

Source: Post-Acute Care Collaborative interviews and analysis.
Resources to help overcome staffing challenges

Low staff licensure in SNF

What to Expect from Post-Acute Care
Patient-facing cheat sheets

Three Things Direct Patient Care Staff Need to Know
Infographic and best practices

High staff turnover

The Guide to Reducing Turnover in Post-Acute Care
Toolkit

Home Health and SNF Turnover Benchmark Generator
Data

Source: Post-Acute Care Collaborative interviews and analysis.
The experience-expectation problem
Consumers expect both too much and too little from post-acute care

Patients expect more than we can give....

- A five-star experience that will make them feel like they’re at home
- To be able to see the same care team every day
- Physician coverage similar to the acute care setting

...but also less than we’re capable of

- “If I have to go to an assisted living facility, I’m completely giving up my independence”
- “I can’t trust these caregivers in my home”
- “These staff members don’t know anything about how to make me better”

Source: Post-Acute Care Collaborative interviews and analysis.
Who should drive decisions about patient care?

Finding the right balance between patient and provider priorities

**Provider-driven organization**
- Patient care plans are developed from standard care protocols
- Fixed dining and medication administration times
- Cost and quality, rather than patient preference, is the organization's top priority

**Patient-driven organization**
- Patients inform all decisions about care
- Staff respect patient choices, even if they disagree
- Organization works to achieve patient goals, despite other priorities

Source: Post-Acute Care Collaborative interviews and analysis.
Walk a mile in your frontline staff members’ shoes

Breakout activity instructions

1. Work in small groups to prioritize real-life patient and family requests and preferences into three categories:

   - **Always**: meeting this request would improve the patient and family experience without interfering with other organizational priorities
   - **Sometimes**: this scenario would only occasionally be worth the investment—it may improve the experience, but could also result in some other negative outcome
   - **Never**: fulfilling this request would not be in the best interest of the patient, family, or organization

2. Meet back as a large group to discuss lessons learned

30 minutes

10 minutes

Source: Post-Acute Care Collaborative interviews and analysis.
Meeting patient needs without changing staffing hours

Hospice of Northwest Ohio addresses patient needs before the weekend

Volunteers and team leads meet weekly to identify high-need patients

RN flags patient if he or she:

- Won’t receive a visit before the weekend
- Has had recent significant symptoms
- Is new to hospice care
- Has complex needs

Thursday meetings

Volunteers call each red flag patient to check on comfort, satisfaction

- Confidence in care over the weekend
- Current comfort or pain level
- Overall satisfaction with service
- Additional needs or questions

Source: Hospice of Northwest Ohio, Perrysburg, OH; Post-Acute Care Collaborative interviews and analysis.
Hospice of Northwest Ohio

- Community-based hospice provider based in Perrysburg, Ohio
- Manages patients at home, in nursing facilities, and at two freestanding hospice centers

▶ Developed a Thursday morning call system to proactively identify patients who may need a weekend visit.

▶ Each week, an RN team leads identify which patients are at high risk of needing a weekend visit, and volunteers will call the patients on that list on Thursday mornings.

▶ After the calls, volunteers fill out a summary document for staff, and staff will adjust their schedules to make additional visits prior to the weekend as necessary.

▶ This program has helped reduce the need for additional weekend staff and instill patient and family confidence in Hospice of Northwest Ohio’s services.

Source: Hospice of Northwest Ohio, Perrysburg, OH; Post-Acute Care Collaborative interviews and analysis.
Thursday calls prevent the need for after-hours visits

Staff identify and visit high-need patients prior to the weekend

Volunteer fills out summary document for each call

Team lead reviews, identifies which patients need an additional visit

Staff visit identified patients to address needs before weekend

Benefits of Thursday call system

Reduced the need for care team to make visits over the weekend

Reassures patients and families that they are safe and well cared for

Calls made and needs identified, 2018

838 Total calls answered in CY 2018

25 Patients indicated pain or discomfort

62 Patients had other needs that hospice could address

Source: Hospice of Northwest Ohio, Perrysburg, OH; Post-Acute Care Collaborative interviews and analysis.
Low-resource strategies to improve the experience

Balancing patient and provider needs

Assign an advocate to each patient

Equip patients to express their care preferences

Engage patients and families in improvement efforts

Process changes

Institutional change

Source: Post-Acute Care Collaborative interviews and analysis.
Assign a staff advocate to each patient

HCF Management’s constant caring ambassador program

Patients are matched with an ambassador at admission

Ambassador role filled by:
- Department heads
- Nurse administrators

What ambassadors do:

- Ask patient and family about their care experience
- Scan the room to identify any outstanding issues
- Address needs as able, otherwise elevate to administrator
- Report back challenges and solutions in team meetings

Benefits of regular check-ins with ambassadors

- Makes it easy for staff to proactively identify and solve service gaps
- Staff build relationships with patients and family
- Helps patients feel more comfortable and cared for

Source: HCF Management, Inc., Lima, OH; Post-Acute Care Collaborative interviews and analysis.
HCF Management, Inc.

- Skilled nursing and assisted living operator based in Lima, OH
- Operates 32 skilled nursing and assisted living facilities across Ohio and Pennsylvania

► Connects each patient with a Constant Caring ambassador, usually either a department head or nurse administrator, at admission.

► The ambassador will visit short term patients daily and long-term patients as often as the patient and family sees fit; ambassadors ask about their experience, scan the room for issues, and build relationships with patients and families.

► Ambassadors will report back the challenges and solutions they identified at team meeting every morning.

► The program has helped patients and families feel more connected to staff and equipped staff to proactively identify service issues.

Source: HCF Management, Inc., Lima, OH; Post-Acute Care Collaborative interviews and analysis.
Patient story booklet helps identify unique needs

Giving patients an outlet to express their preferences

Patient preference booklet process

Patients express what they value via a standardized question set at admission

Staff translate the list into a booklet that stays with each patient

Patient
- Adds goals to book as they change
- Uses book as a way to express themselves between visits through journaling or drawing

Staff
- Checks book at start of each visit
- References document to start discussions and develop ideas for activities the patient would enjoy

Questions asked at admission
- What activities that you currently are able to do bring you the most joy?
- What is something you used to enjoy doing but are no longer able to?
- Who is it most important that you stay in touch with at this time?

Source: Post-Acute Care Collaborative interviews and analysis.
CASE EXAMPLE

Jamesway Health\(^1\)

- Network of community-based hospice, palliative and home health care services

- Focused on helping patients achieve their personalized care and lifestyle goals during the last months of life.

- Creates a story booklet that stays with each patient, in which they can draw and write what they are feeling and what they want help with.

- Staff refer to the booklet during each visit and use it to spark conversation and identify new ways they can make the experience better for patients and families.

\(^1\) Pseudonym.

Source: Post-Acute Care Collaborative interviews and analysis.
Engaging patients and families in improvement efforts

Experience advisory councils give consumers a voice

**Spaulding Rehabilitation Hospital Cape Cod’s patient and family advisory council (PFAC)**

- Group made up of 9 patients and family members, 8 staff
- Meets at Spaulding every month for 90 minutes
- Spends time brainstorming how to improve the care experience
- Gives feedback to staff on potential new initiatives

**Sample experience council projects**

- Determining how to make patients and families feel more welcome at admission
- Helping translate clinical and quality information into patient friendly terms
- Providing input on upcoming renovations and facility design
- Developing new marketing material
- Starting new interest groups or programs for patients and families

Source: Spaulding Rehabilitation Hospital Cape Cod; Cape Cod, MA; Post-Acute Care Collaborative interviews and analysis.
Spaulding Rehabilitation Hospital Cape Cod

- Specialty rehabilitation hospital located in Cape Cod, MA
- Part of Partners HealthCare system

► Founded a Patient and Family Advisory Council (PFAC) to solicit feedback about the experience from staff, patients, and family members.

► The council, which consists of nine patients and family members and eight staff representatives, meets monthly for 90 minutes.

► Each meeting focuses on determining new ways they can improve the experience—through brainstorming sessions, giving feedback to staff on their initiatives, and breakout working groups.

Source: Spaulding Rehabilitation Hospital Cape Cod; Cape Cod, MA; Post-Acute Care Collaborative interviews and analysis.
How to run an effective experience advisory council

1. Establish a council structure
   - Set an agenda for each meeting
   - Use time to discuss problems, develop collaborative solutions
   - Focus on a new project at each meeting

2. Recruit staff, patient, and family advisors
   - Recruit from your existing base of volunteers
   - Host an information session for prospective advisors
   - Help new volunteers understand the purpose of the council
   - Teach advisors how to contribute productively to the group

3. Orient new volunteers
   - Set an agenda for each meeting
   - Use time to discuss problems, develop collaborative solutions
   - Focus on a new project at each meeting

4. Lead effective meetings

Based on the setting you work in and ability level of your patients, determine if you should start a:
- Patient/resident council
- Family council
- Patient and family council

For step by step guidance
Access Four Steps to an Effective Experience Advisory Council at advisory.com
What will you commit to changing TODAY?
What type of experience will you provide?

Senior leaders must set tone, guide organizations toward a practical goal.

Setting a vision for the patient and family experience

What would the ideal patient and family experience look like?

What roadblocks are in the way, and where should I focus?

How do I set a clear vision and keep my staff on track?

Source: Post-Acute Care Collaborative interviews and analysis.
Set an effective vision for your organization

An opportunity to reflect

1 “Top five” experience priorities

Example:

I want each patient and family that we care for to be:
• Greeted personally by me at the door
• Responded to within 10 minutes

2 Vision statement

Example:

We will provide a care experience that eases stress and makes patients and their loved ones feel comfortable throughout their stay with us.

Main points to consider when writing your statements

Think about the patient and family perspective—what is most important to them?

Be practical. Recognize the constraints we’ve talked about throughout the day.

Source: Post-Acute Care Collaborative interviews and analysis.
A sliding scale from provider- to patient-driven

Not a choice, but a continuum

Provider-driven organization

Patient-driven organization

Balance will depend on:

- Specific patient or family requests and preferences
- Health of business, ability to fulfill personalized goals
- Vision you set as an organization

Source: Post-Acute Care Collaborative interviews and analysis.
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