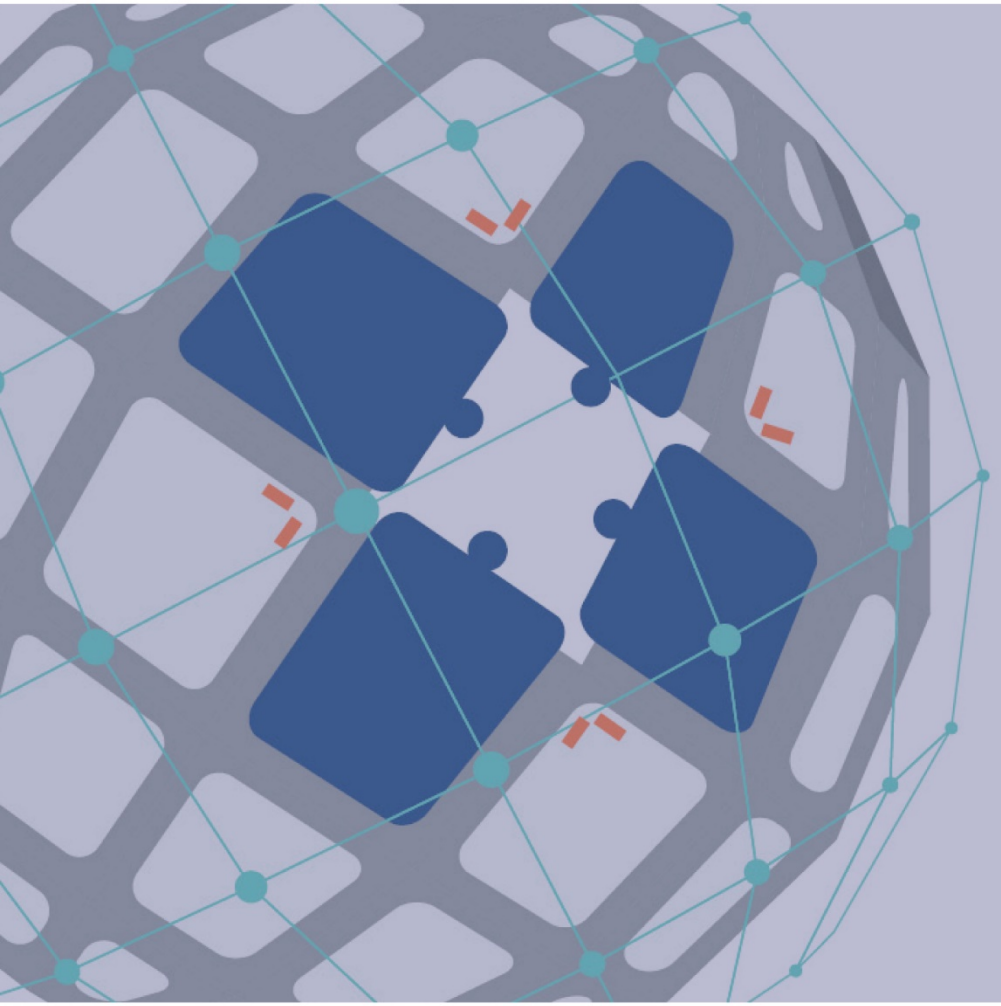

Managing to the New Medicare Patient

Driving New Care Delivery Models with Post-Acute Data Transparency

Presented by:
Gina Markwell, LNHA and Phyllis Wojtusik, RN

Housekeeping

- Speakers will present for approximately 45 minutes
- Q&A will take the remainder of time
  - You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar
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- Webinar is being recorded
  - Slides and recording will be available on the NAACOS website within 24 hours. You will receive an email when they are available

Today's Speakers

Gina Markwell, LNHA

Director, Post-Acute and Transitional Care
Triad Healthcare Network

In her role, Gina manages the integration of technology platforms into transitional and post-acute care delivery workflows to achieve quality patient outcomes that empower patient choice, while improving care transitions. With a focus on ensuring the right care, at the right place, and at the right time, Gina drives the advancements of improving the continuum of care and establishing strong value-based care programs.

Phyllis Wojtusik, RN

Executive Vice President, Health Systems
Real Time Medical Systems

With over thirty-five years of health care experience, Phyllis draws on her experience as a Registered Nurse in acute care, ambulatory care, and post-acute care to bring vital input and client-side perspective into the development of Real Time's Interventional Analytics solutions. A true expert in the field of long-term care, Phyllis is also an integral part of Real Time's coordinated care effort, working to bring skilled nursing facilities, ACOs, and health systems together for the benefit of the patient.

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Learning Objectives

- Focus on clinical case types across care settings to drive new care delivery models
- Establish care standardization and outcome measures across entire PAC network – no matter where care is delivered
- Prioritize advance care planning initiatives

Medicare by the Numbers

- *Baby Boomers or “Boomers” are estimated at 73 Million
- *10,000 people per day turn 65
- *All Boomers will be 65 by the year 2023
  - Increasing projected Medicare Beneficiaries to over 80 Million
- **2019 Medicare Enrollment was 61,541,510
  - Traditional Medicare = 62.7%
  - Medicare Advantage = 37.3%
  - Increasing away from traditional Medicare by 1-2% each year

*https://www.census.gov/library/stories/2019/12/by-2030-all-baby-boomers-will-be-age-65-or-older.html#:~:text=The%20number%20of%20people%20age%2065%20and%20older,according%20to%20the%20Census%20Bureau's%20Vintage%20Population%20Estimates.

** CMS Program Statistics | CMS

Value-Based Care is *NOT* Going Away

"The Center for Medicare & Medicaid Innovation laid out a goal to get every Medicare beneficiary and a majority of Medicaid members in an accountable care arrangement within the next 10 years."

- Released Oct. 20, 2021: CMS White Paper on CMS Innovation Center's Strategy -
Driving Health System Transformation - A Strategy for the CMS Innovation Center's Second Decade

How will Boomers Change Health Care?

- Sheer Volume
  - Current health care worker shortages already exist
  - Drive toward digital solutions
- Healthcare Consumerization
  - Concierge like approach
  - Choices based on research and information from family/friends/social network– not just physician recommendation
- Information Transparency
  - Remove redundancy
  - Access information across settings even with disparate EHRs
- Long-Term Care (LTC) Initiatives
  - Home based care
  - Aging in place – desire not to be in LTC facilities

Let’s discuss our current state

Where should we be now or in the near future to prepare for the new Medicare patient?

TRIAD Health Network Overview

- Affiliated with Cone Health System in Greensboro, NC
- Manage and coordinate care for nearly 200,000+ patients in Alamance, Guilford, Randolph, Rockingham and part of Forsyth counties.
- Converting to DCE in 2022 from Next Gen
- In 2020, THN's performance results included:
  - $12.7 million in savings
  - 5.00% savings rate
  - 99.1% in quality

Program Highlights

- Bayada Home First transitions program with HH partner
- Mom's Meals- clinical condition friendly meal delivery
- Concierge program assisting with transportation and Rx pickup
- Partnered with home-based PCP company
- Paramedicine program
- Vynca ACP Platform
- Emmi Preventative Health Campaigns

Analyzing Your Population's Clinical Data

- What percentage of your population receives Medicare and Medicaid (Duals)?
  - How many are discharged to a skilled nursing facility (SNF)?
  - How many go directly into home health?

- What is the average age of your Medicare population?

- Are there trends in case-types?
  - Cardiac, Ortho, Sepsis, Pulmonary, other?

- What comorbidities or functional status get patients to a SNF?
  - Diabetes, CHF, COPD, debilitation etc.

Analyzing Your Population's Clinical Data, cont'd

- Are you utilizing a frailty score?
  - Identifying functional needs
  - Annual Wellness visit data
- Do you have a measure to evaluate functional improvement on SNF and home health discharge?
  - Quality measurement beyond readmissions and LOS
- Are you finding any outliers? If so, who?
  - Niche programming
- Does geography play a roll in patient placement?
  - Regionalized approaches
- How do physician practice patterns impact placement?
  - Aligning quality outcomes with practice patterns

Drive Value-Based Care Initiatives in the PAC Network

Clinically *manage* patients with Post–Acute Partners

- Identify high volume case-types and set standards of clinical care across all provider types/locations with same metrics for success
  - CHF, Sepsis, Pneumonia, Ortho
  - Clearly identify criteria for next level of care
  - Communicate length of stay standards to patients ***and*** post-acute providers
  - Readmission targets for home health and SNFs
  - Successful medication procurement on discharge and standardized medication education

Drive Value-Based Care Initiatives in the PAC Network, cont'd

Utilize technology and data transparency to drive adoption of standards

- Obtain Clinical Line of Sight into PAC Data
  - Embed clinical standards into daily process – plan of care, user defined assessments
  - Assess data at the patient and agency/facility level to continuously monitor outcomes and adjust strategies
- Utilize Telehealth as part of care delivery model
- Unblinded performance data shared with network
- Include standardized patient education for all care settings
- Ensure your partners make successful transitions of care and handoffs back to PCP's
- Discharge follow-up calls with standardized questions by case-types

Drive Value-Based Care Initiatives in the PAC Network, cont'd

Identify Intensive Needs population, *may not be high in volume but high in resource utilization*

- Programmatically Address Intensive Needs
  - Clinically complex
    - ESRD, End Stage heart failure, Multi-organ system failure, LVADs
    - Niche providers who get majority of volume, so they become experts in care
    - Monitor patterns and patient needs i.e. CHF
      - Have a scale?
      - Regular cardiology follow up
      - Access to low salt food
  - Socially Complex
    - Community dwelling with high number of positive SDoH - dual eligible
    - Identify/partner community resources
    - Include social work as standard case managers – follow through all settings

Collaborate with PAC Network to Meet SDoH Needs

- Consider social determinants of health (SDoH) as risk factors and employ community strategies to meet those needs. Partner and support community service providers and work with your network to ensure placement/acceptance of these high-risk populations.
  - Housing needs
  - Food insecurity
  - Transportation
  - Medication needs
  - Mental health and emotional needs

- Unless one facility/agency steps up to take these case-types spread the wealth
  - Serve the community
  - Mission oriented

Establish Advance Care Planning Processes

- Beyond code or no code
  - Feeding tubes
  - Aggressive treatment vs Palliative approach
  - Rehospitalization
- Consistent with lifestyle choices
  - Clearly identify decision maker
- Specific life circumstances clinical discussion
- Clear communication in non-urgent times
- Routine reassessment
- Palliative care team – essential as part of care team

Where do we go from here?
What will drive care in the next decade?

Paradigm Shifts in Post-Acute Care

- Data Transparency
- Acute and Post-Acute/Community Based Services as Driver of CIN/Shared Savings Program
  - Hospital at Home or SNF at Home
  - Outpatient Clinical Programs / Day Programs /"Pace" like
- Use of Home Monitoring and Smart Technology
- Changes in Long-Term Care
  - LTC providers getting into home and community-based services
  - Still will be a significant Medicaid population
  - Value-based care expanding
    - ISNPs
    - DCE's for LTC population

Post-Acute Data Transparency - Interoperability

The Unicorn

- Ability to see, import, utilize, and analyze data from any care location or setting
- Standardized, programmatic and clinical/social need-based assessment data across all settings that follow the patient
- Artificial Intelligence (AI)
  - Driving care protocols
  - Presenting next assessment points
  - Allowing for personalization of care

Post-Acute or Community-Based Focus for CINs

- Medical care will continue to advance with shorter hospital stays
- Majority of care will be delivered in community-based settings
  - Consumer driven
  - Concierge like services
- Choose Home Care Act
  - *89% of Americans support public investment in affordable home care services to help older adults with essential needs like bathing and dressing, medication management, transportation, and basic daily chores.
  - *86% say the government must make a bigger investment in services and care for seniors. This includes 92% of Democrats, 80% of Republicans, and 84% of Independents.
  - *83% support public investment in broadband internet to ensure equitable access for older adults who need this basic utility for telehealth and other care services, and to fight social isolation.

*Public Opinion Poll: U.S. Attitudes About Investing in Older Adults | LeadingAge

Post-Acute or Community-Based Focus for CINs

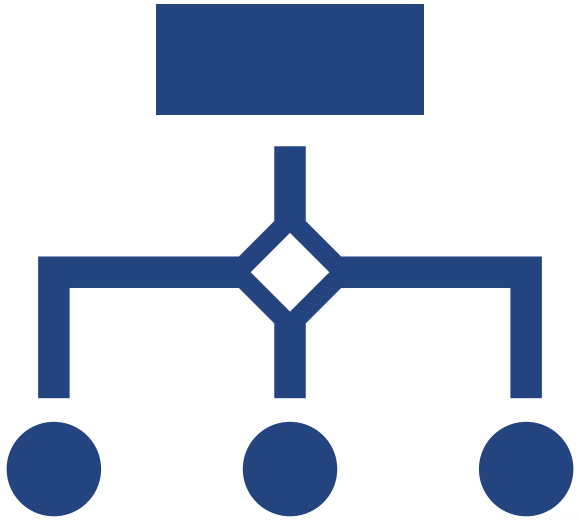
- Hospital at Home and SNF at Home*
  - Gaining traction and national support – Advanced Care at Home Coalition
    - Mayo Clinic, Medically Home, and Kaiser Permanente, joined today by additional members Adventist Health, ChristianaCare, Geisinger Health, Integris, Johns Hopkins Medicine, Michigan Medicine (University of Michigan), Novant Health, ProMedica, Sharp Rees-Stealy Medical Group, UNC Health, and UnityPoint Health.**
  - Driving community-based care delivery models and support companies
  - Payer/Provider models now advanced to take risk of program
  - Big tech entering the health care market
- "SNFs are at the greatest risk. SNF's occupancy rates continue to see record lows. Although the decline has slowed down, SNFs are evaluating what their next step is for survival. It would be a natural step for them to add the at home model."**

*Introducing the Advanced Care at Home Coalition - Medically Home

The SNF at Home Model and Home Care – Veterans Care Coordination™ (vcchc.com)

Long-Term Care Adaptation

- Long-Term Care providers changing their model
  - Not real estate or facility based only
  - Home Health and Hospice service delivery
  - Already seeing options to “join a community” but live at home
  - PACE like models beyond duals developed by DCE’s
  - AI and tech will play a big role in monitoring and service delivery as well as telehealth



Questions? Let's Discuss!

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Real Time Medical Systems is the industry-leading, KLAS Rated Interventional Analytics solution that turns post-acute EHR data into actionable insights.

Serving healthcare organizations nationwide, Real Time improves clinical and financial outcomes by reducing hospital admissions, accurately managing reimbursements, detecting early signs of infectious disease, automating antibiotic surveillance, and advancing care coordination through post-acute data transparency.
www.realtimemed.com