Seamless Transitions:
Navigating the Post-Acute Ecosystem

Summary: This session will explore the critical journey patients undertake through the post-acute continuum of care, encompassing transitions between skilled nursing facilities, home health services and hospice care. Attendees will gain insights into the challenges and best practices for ensuring seamless transitions, maintaining high-quality care, and supporting patients and their families at each stage.

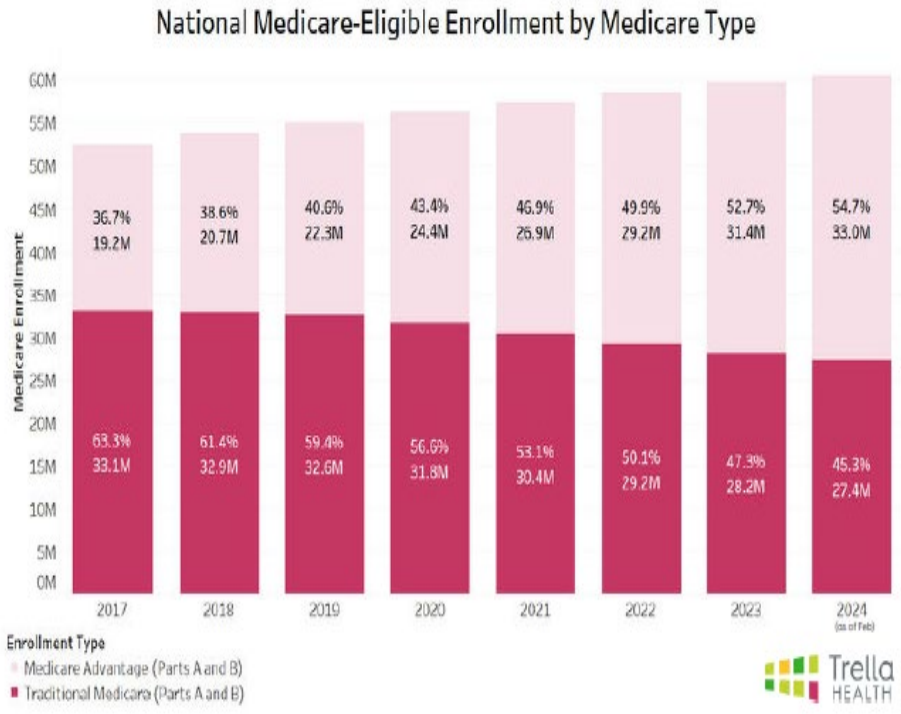
Presenting:
Nichole Shadle: Regional Director of Operations
Austin Hancock: VP of Operations – Home Health
Tommi Burchfield: VP of Operations – Hospice

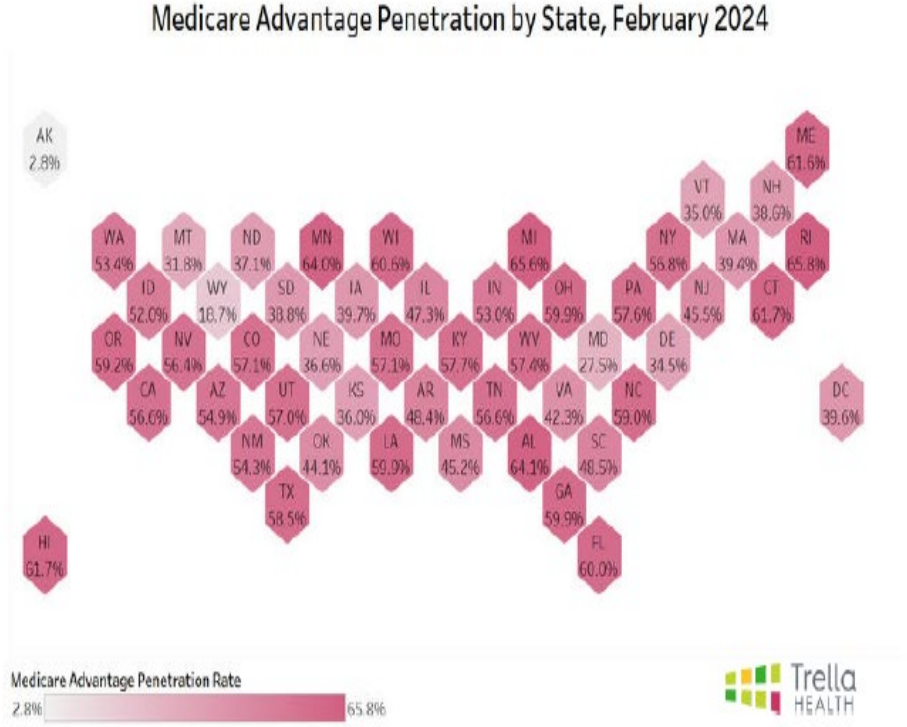
Advantage

Today's Agenda

- The Healthcare Landscape, 2025 and Beyond
- Creating a continuum of care network to better direct care to lower cost settings
- The importance of downstream partners and best practices for ensuring seamless transitions and high-quality care
  - Financial Benefits
  - Patient Outcomes
  - Patient Satisfaction

The Rise of Medicare Advantage Plans





Source: Trella Health

The Rise of Medicare Advantage Plans

In 2024, Medicare Advantage plans accounted for $462 billion (54%) of total federal Medicare spending

Research shows that Medicare pays on average more to MA plans for enrollees than traditional Medicare ($83 billion higher than traditional Medicare)

Due to increased spending, CMS has pushed MA Plans to mirror Medicare's Value-Based care model, tying quality and costs to reimbursement

Pennsylvania Total Enrollment and Market Share, June 30, 2024								
Insurer	**Pennsylvania**		**Philadelphia County**		**Allegheny County**		**Montgomery County**	
HIGHMARK GRP	3,709,823	29%	1,400	0%	968,521	62%	6,435	1%
INDEPENDENCE BLUE CROSS GRP	3,162,719	24%	1,085,108	55%	7,319	0%	608,615	66%
CVS GRP	1,599,614	12%	382,569	19%	77,567	5%	143,841	16%
UPMC HLTH SYSTEM GRP	1,271,747	10%	15,182	1%	359,515	23%	3,616	0%
Other Plans	3,247,623	25%	497,273	25%	157,779	10%	158,621	17%
Total	**12,991,526**	**100%**	**1,981,532**	**100%**	**1,570,701**	**100%**	**921,128**	**100%**
Source: Mark Farrah Associates' County Health Coverage™								

Advantage

Source: KFF.org

The Shift to Value-Based Care

In the traditional fee-for-service model, healthcare providers are reimbursed for each service they perform. This incentivizes volume but does not encourage best outcomes for the patient.

Value-Based care is a care delivery model in which providers are reimbursed based on quality outcomes and reduced costs. Shifting the emphasis from volume to value. This encourages providers to foster collaboration with downstream partners

Key Benefits:

Improved patient outcomes
Cost savings for patients and providers
Increased patient satisfaction
Increased provider collaboration
Focus on preventive care
Data-driven decisions

Challenges:

Cultural Shift
Measuring Outcomes
Financial Risk

UPMC
LIFE CHANGING MEDICINE

BlueCross BlueShield

aetna™

Source: KFF.org

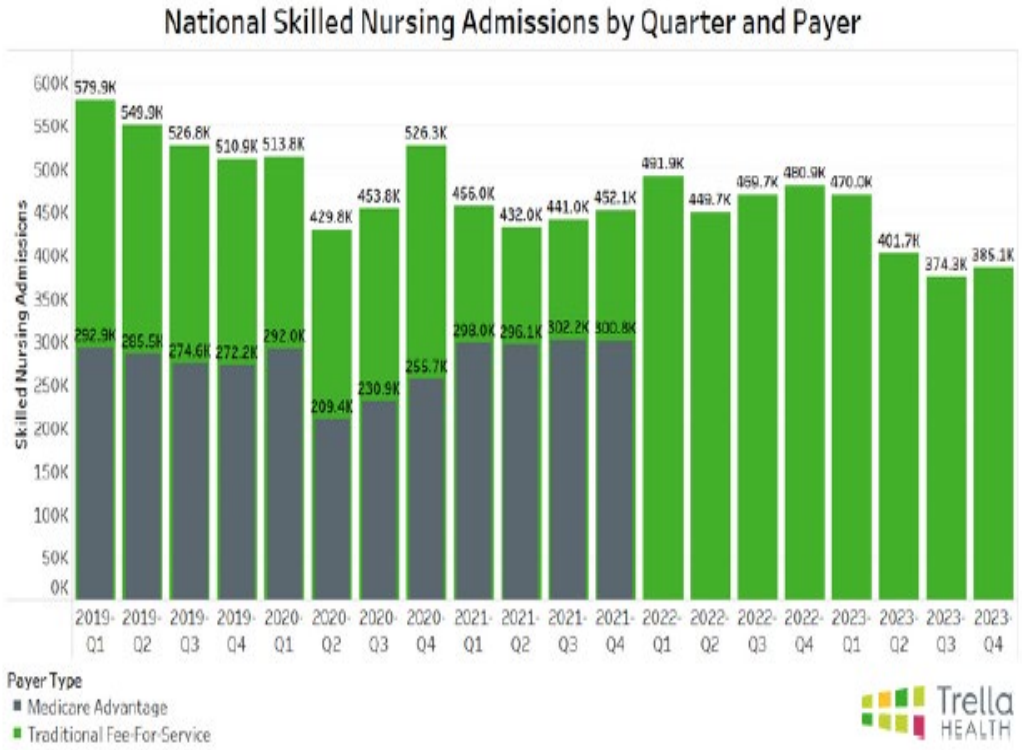
Controlling Costs: The Push to Home-Based Care

In 2025, up to $265 billion worth of care services for both Medicare and Medicare Advantage beneficiaries will shift to the home *(source: mckinsey.com)*

In 2024, Home Health admissions increased 8.7% and Hospice admissions increased 4.9%

Medicare Home Health 30-Day Payment: $2,010
Medicare SNF 30-Day Payment: $16,500

Key Drivers:
Patient Preference
Age in Place
Cost-Effectiveness
Technological Advancements
Covid-19 Impact



In 2023, Traditional Medicare SNF admissions decreased 14% and SNF utilization was 2% below the benchmark of 24%
PA SNF Admissions: -7.4% decrease and utilization rate of 22%

Advantage

Source: Trella Health

Addressing Industry Wide Challenges

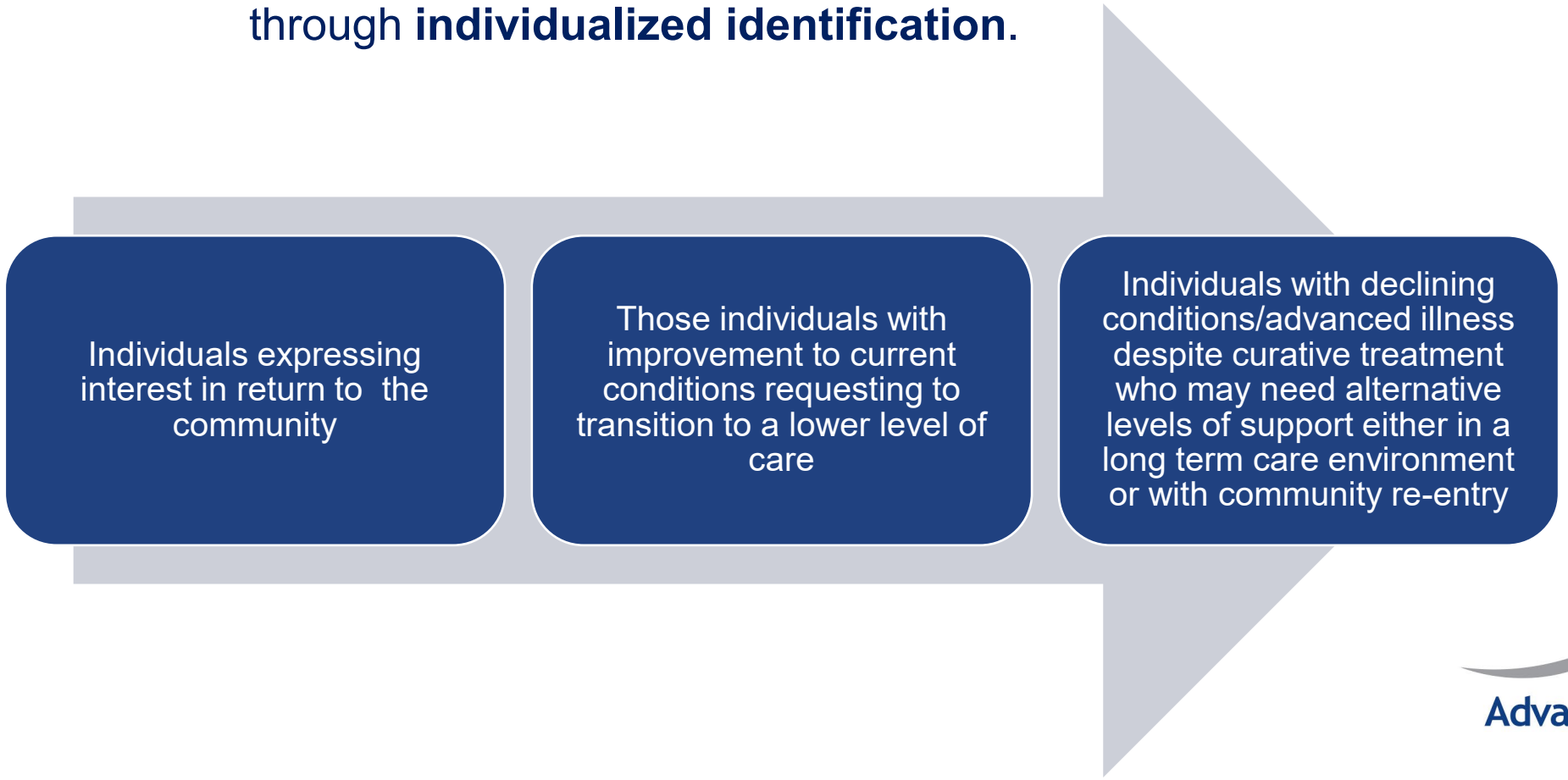
- Ever-Changing Insurance landscape
- Quality-Based care driving reimbursement opportunities
- Shorter LOS in the facility – The push to Home-Based care
- Discharge planning starts at Admission
- Lack of communication between facilities and downstream providers
- Staffing challenges effecting patient care
- Lack of transparency regarding patient outcomes

Advantage

The Role of Your Therapy Department

Bridging Person-Centered Care From Skilled Nursing Rehab to Care Continuum Collaborators

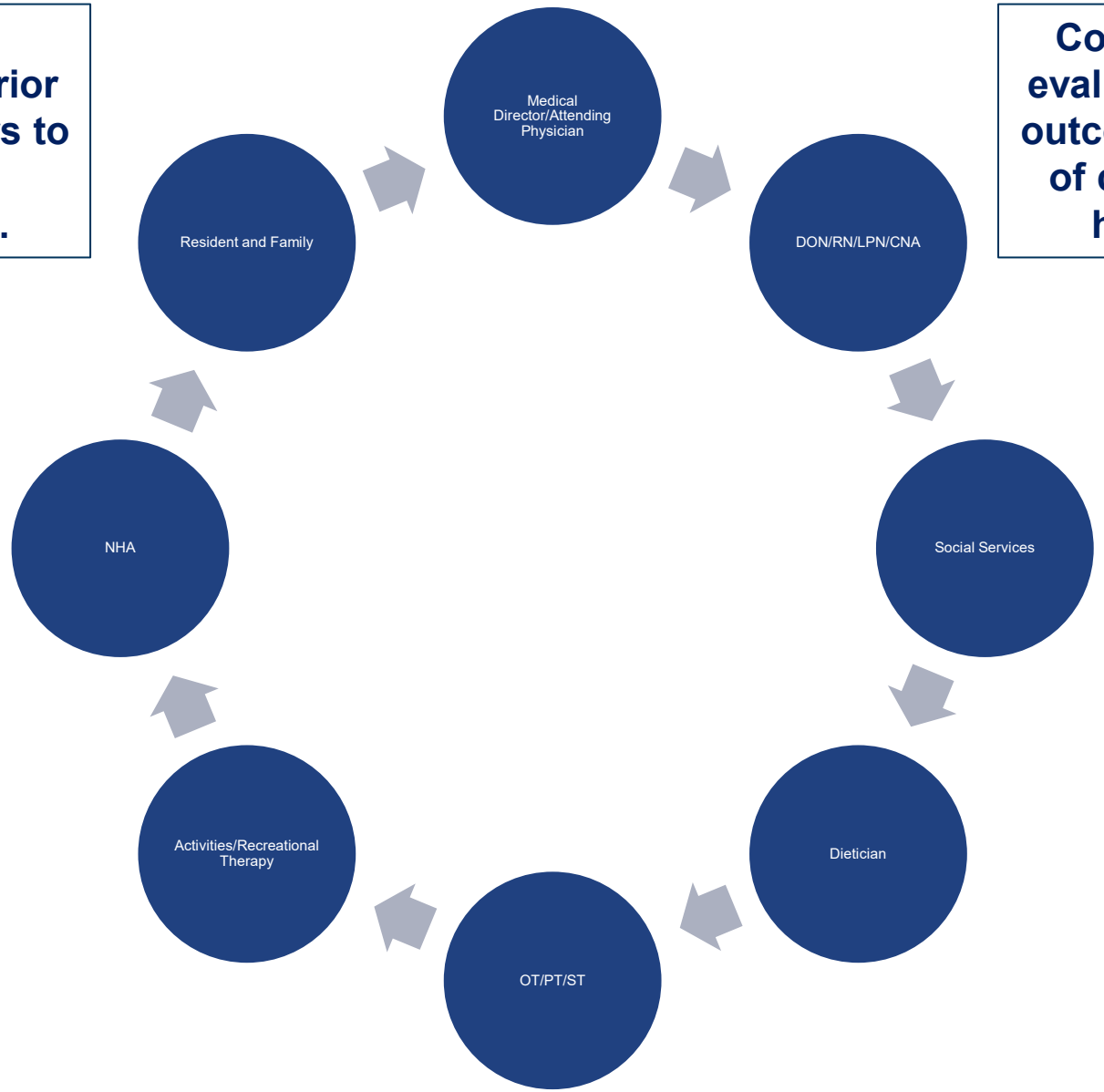
Approach to care starts day 1 of facility admission with support initiatives through **individualized identification**.



Advantage

Developing A Person-Centered Plan with Your Team

Comprehensive IDT assessment of needs prior to discharge and barriers to achieving a safe and supported discharge.



Comprehensive therapy evaluations with discharge outcome planning inclusive of caregiver training and home assessments.

Advantage

Success Strategies for Developing a Patient-Tailored Transition Plan

- Goals and Timeframe
- Team responsibilities/responsibilities of those assuming care at discharge
- Does Above Plan Align with resident preferences, strengths and needs?

- Engage Resident/Family/Community Caregivers
- Provide Information on Accessible Care and Safety Support
- Connect With Community Based Resources—**Your Downstream Partners**
  - **Home Health Provider**
  - **Out-patient Therapy Provider**
  - **In Home Out-patient Therapy Provider**
  - **Palliative Care Provider**
  - **Hospice Provider**

Achieving Success in your final Hand-Off

Best Practices to Achieve Excellence in Outcomes

- Discharge checklists inclusive of patient assistance needs and current functional status, DME recommendations
- Communication with community resources for meal and transportation assist
- Communication of Home Health, Outpatient and/or Hospice contact information with patient and family

Continuing That Connection

Care for Post-Facility Discharge

Established re-admission protocol for the facility and downstream partners

Check In Communication at 72 hours, 7 days, 14 days and 28 days

Advantage

Quality Assurance

Best Practices to Track Outcomes and Improve Processes

- Look for trending with hospital readmission rates
- Review satisfaction surveys for opportunity to improve patient hand off and communication
- Gather data and develop staff training to enhance services
- Schedule care coordination follow-discussions with downstream partners

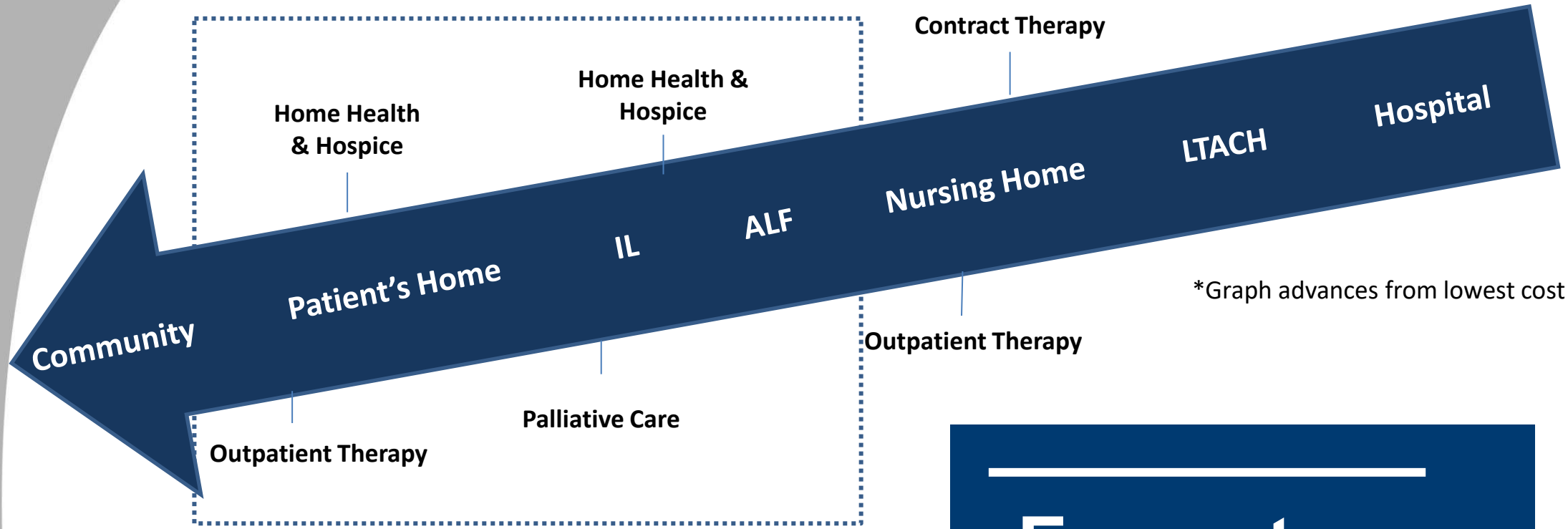
Advantage

The Importance of Downstream Partners

Advantage

Creating a Transitional Care Model with Downstream Providers – Home Health

- Ensure a smooth discharge to the most Cost-Effective Post-Acute Setting
- Streamline Continuity of Care for Patients & the Facility



*Graph advances from lowest cost to highest

Benefits of Downstream Partners

Highly specialized, patient centered, cost-saving interventions that ensure the right care at the right time in the right place.

Ecosystem

- Contract Therapy Services
- Outpatient Rehab
- Home Health
- In-Home Outpatient Therapy
- Palliative Care
- Hospice Care

Advantage

How To Do It

The Opportunity

Seamless & Specialized Patient Care	Collaborative & Transparent Partnership
Dedicated Transitional Care Coordinator	Facility-Specific Staffing Patterns
Coordinated Care Plans	Monthly Review Meetings
Specialized Care Pathways for High-Risk Diagnoses	Intelligent Data & Analytics
Patient Report Cards	Co-Marketing Capabilities
Plus! Skilled Nursing Admission Program	
Plus! Guaranteed 24-Hour Initiation of Care	

A Closer Look at

Program Features

Transitional Care Coordinator

How it Works

Ensuring a smooth referral handoff

Attending weekly care plan meetings

Meet with families and patients upon discharge to answer questions and address any concerns

Weekly/Monthly/Quarterly reporting back to the facility

Source: Associated Press

Facility Specific Staffing Patterns

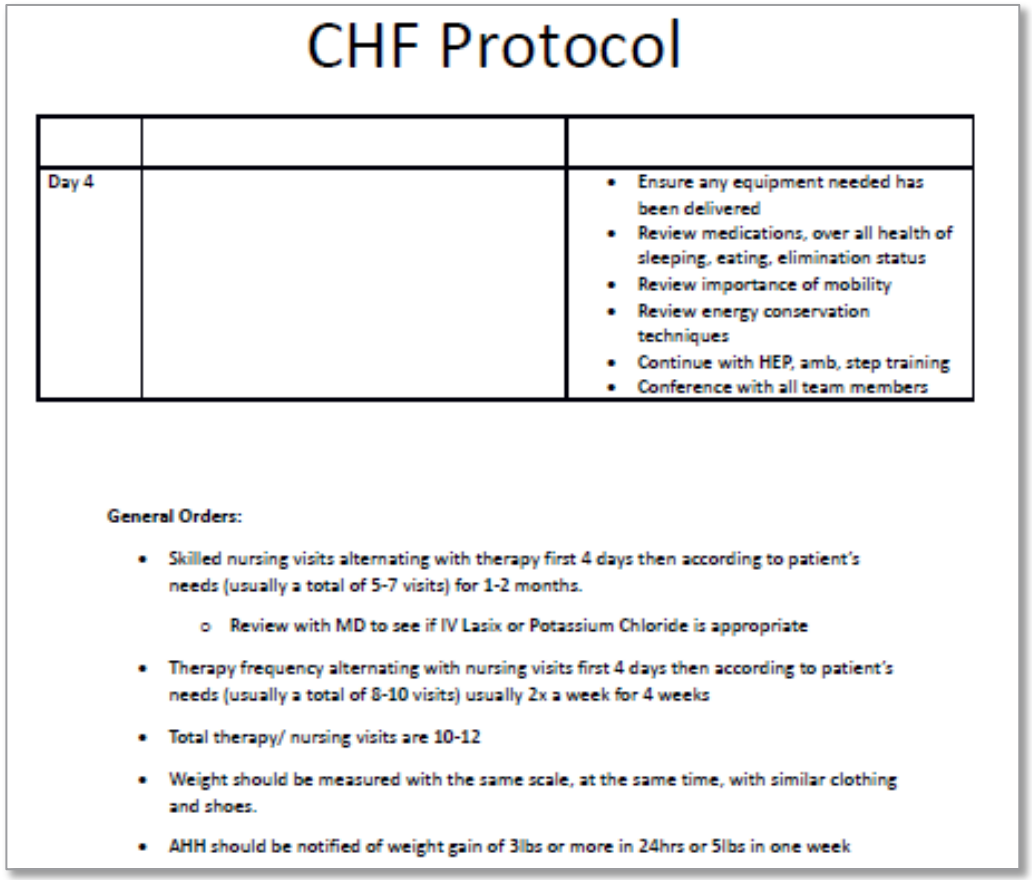
How it Works

- Continuity of Care
- Increased trust amongst the patient and caregivers
- Improved communication between the post-acute agency and the patient/facility
- Personalized Care
- Improved adherence to care plans
- Improved Patient Satisfaction
- Enhanced Patient Outcomes

Advantage

Specialized Care Pathways

How it Works



CHF Protocol

Day 4		• Ensure any equipment needed has been delivered • Review medications, over all health of sleeping, eating, elimination status • Review importance of mobility • Review energy conservation techniques • Continue with HEP, amb, step training • Conference with all team members

General Orders:

- Skilled nursing visits alternating with therapy first 4 days then according to patient's needs (usually a total of 5-7 visits) for 1-2 months.
  - Review with MD to see if IV Lasix or Potassium Chloride is appropriate
- Therapy frequency alternating with nursing visits first 4 days then according to patient's needs (usually a total of 8-10 visits) usually 2x a week for 4 weeks
- Total therapy/ nursing visits are 10-12
- Weight should be measured with the same scale, at the same time, with similar clothing and shoes.
- AHH should be notified of weight gain of 3lbs or more in 24hrs or 5lbs in one week

Evidence-based clinical care programs for Ortho, COPD, pneumonia, CHF, UTI & Diabetes

- **Developed in collaboration with hospitals and physicians to reduce readmissions**
- **Administered by trained and educated staff members**
- **Includes patient education, scheduled reporting, and more**

Advantage

Direct Admit Program

How it Works

Advantage Home Health *SNAP Program*

Facility Information:

Facility Name: _____

Address: _____

Phone: _____

Fax: _____

After Hours on call number: _____

Weekend on call number: _____

On call clinician name: _____

Clinical capabilities: _____

Main contact information:

Director of Nursing

Name: _____

On Call? ■ YES ☐ NO

Phone: _____

On Call Nurse Name: _____

Phone: _____

Director of Admissions

Name: _____

Phone: _____

Email: _____

Business Development & Marketing

Name: _____

Phone: _____

Email: _____

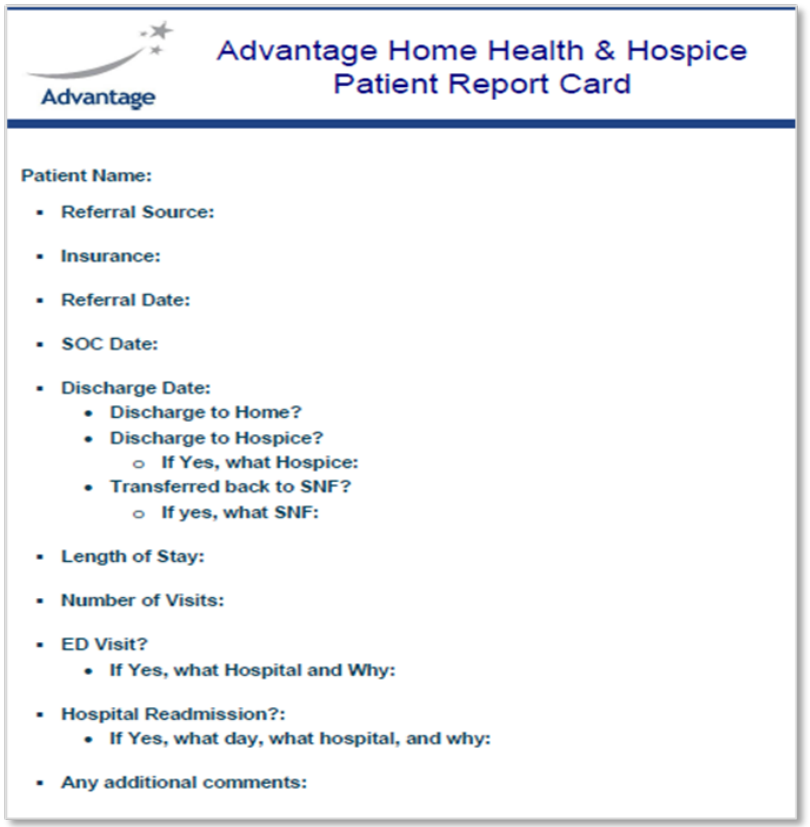
Please include any additional information down below:

Proven readmission intervention program

- 24/7 readmission coordination back to your facility, even on weekends & Holidays
- Patient/family coaching to ensure they call us first
- Has prevented more than 100 hospital readmissions since 2019

Data Driven Reporting

How it Works



Advantage Home Health & Hospice
Patient Report Card

Patient Name:

- Referral Source:
- Insurance:
- Referral Date:
- SOC Date:
- Discharge Date:
  - Discharge to Home?
  - Discharge to Hospice?
    - If Yes, what Hospice:
  - Transferred back to SNF?
    - If yes, what SNF:
- Length of Stay:
- Number of Visits:
- ED Visit?
  - If Yes, what Hospital and Why:
- Hospital Readmission?:
  - If Yes, what day, what hospital, and why:
- Any additional comments:

Patient Level Reporting

- Meet monthly to discuss patient specific data
- Accurate, timely, useful data for you + peace of mind for your patients and families
- Track hospital readmissions, ED visits, Length of Stay, Total visits, Timely initiation of care, etc.
- Root cause analysis in the "why"

Advantage

The Result

The Opportunity

Lower readmissions

Improved patient outcomes

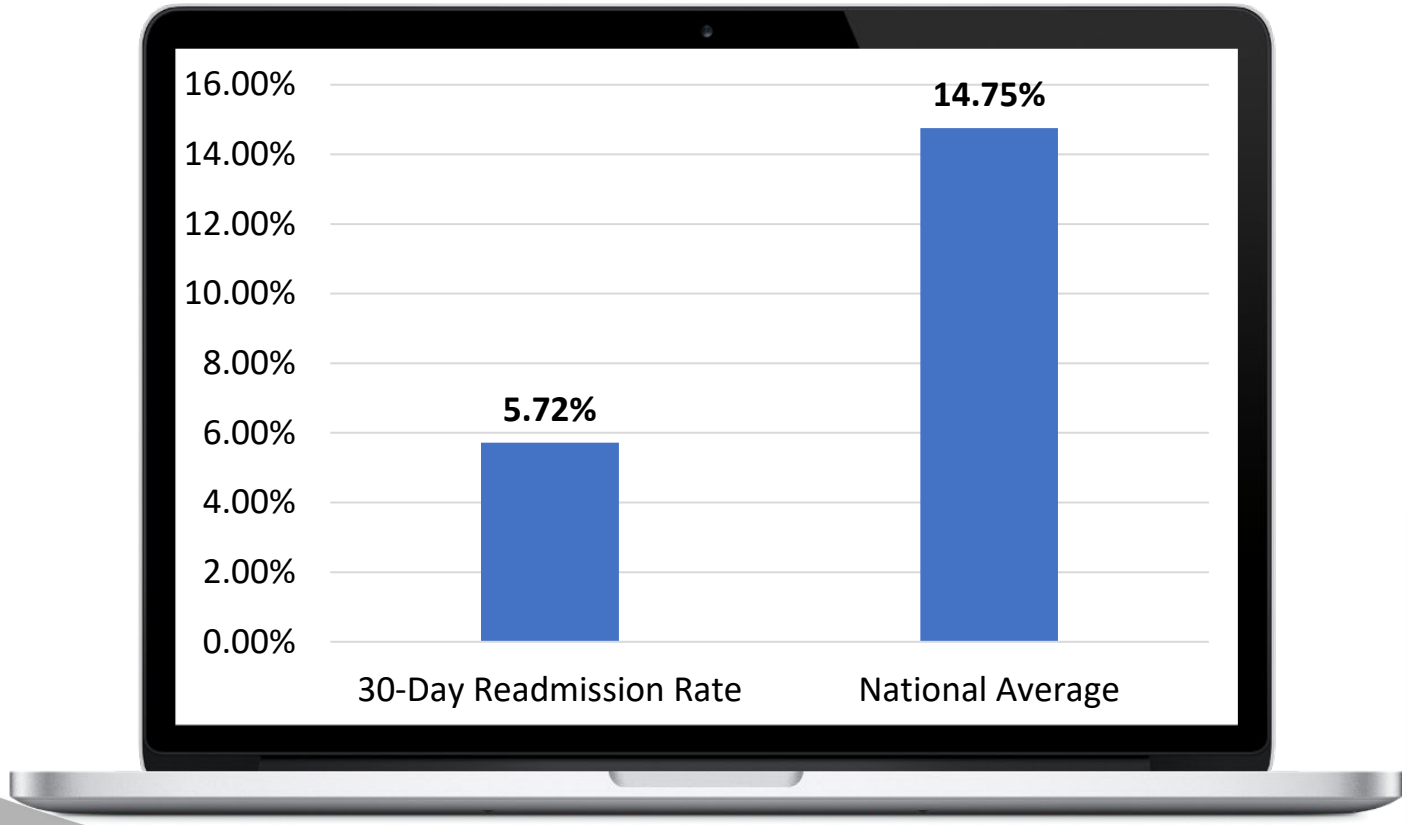
Higher patient satisfaction

Improved Value-Based Metrics

Advantage

Superior Outcomes

The Opportunity



30-Day Hospital Readmission Rate

Facilities who utilize a transitional care coordination model have a 30-day readmission rate 61% lower than the National Average

5.72%
30-Day Readmit

Creating a Transitional Care Model with Downstream Providers – Hospice

- Ensure a smooth discharge to the most Cost-Effective Post-Acute Setting
- Streamline Continuity of Care for Patients & the Facility

Care Across the Continuum

Curative Care	Palliative Care	Hospice Care
Driven by disease and response to treatment	Driven by symptoms and patient hopes and goals	Curative treatment has ended and focus is on comfort
Treatment prescribed by specialists with curative intent	Care coordination between all members of the healthcare team	Accessed towards the end of life
Disease progression and cure are primary area of focus	Holistic care for the patient/support of family are primary areas of focus	Holistic comfort care is provided by an interdisciplinary team and caregivers
Each treatment choice may have risks along with benefits to the patient	Palliative care can be provided along with curative treatment options	Focus on managing symptoms, pain and stress
Goal is to treat to cure or delay disease progression	Goal is to ease symptoms and help people enjoy life	Goal is to improve quality of life and support people and families

Hospice Length of Stay

Days of Care by Length of Stay in 2022

- 10% of patients were enrolled in hospice for two days or less.
- 25% of patients were enrolled in hospice for five days or less.
- 50% of patients were enrolled for 18 days or less.
- 75% of patients were enrolled for 84 days or less.
- The top 10% of patients were enrolled for more than 275 days.

Figure 15: CY 2021 days of care by length of stay, in days

Source: *MedPAC July 2024 Data Book, Chart 11-15*

Advantage

Location of Care

Average length of stay by location of care, as shown in Figure 17, was 98 days at a private residence, 109 days in nursing facilities, and 165 days in assisted living facilities. Median length of stay by location of care, shown in Figure 18, was 25 days at a private residence, 22 days in nursing facilities, and 55 days in assisted living facilities. The variance between average and median lengths of stay indicates that although some patients have long lengths of stay, most patients have short hospice stays.

Figure 17: Average length of stay by location of care, in days

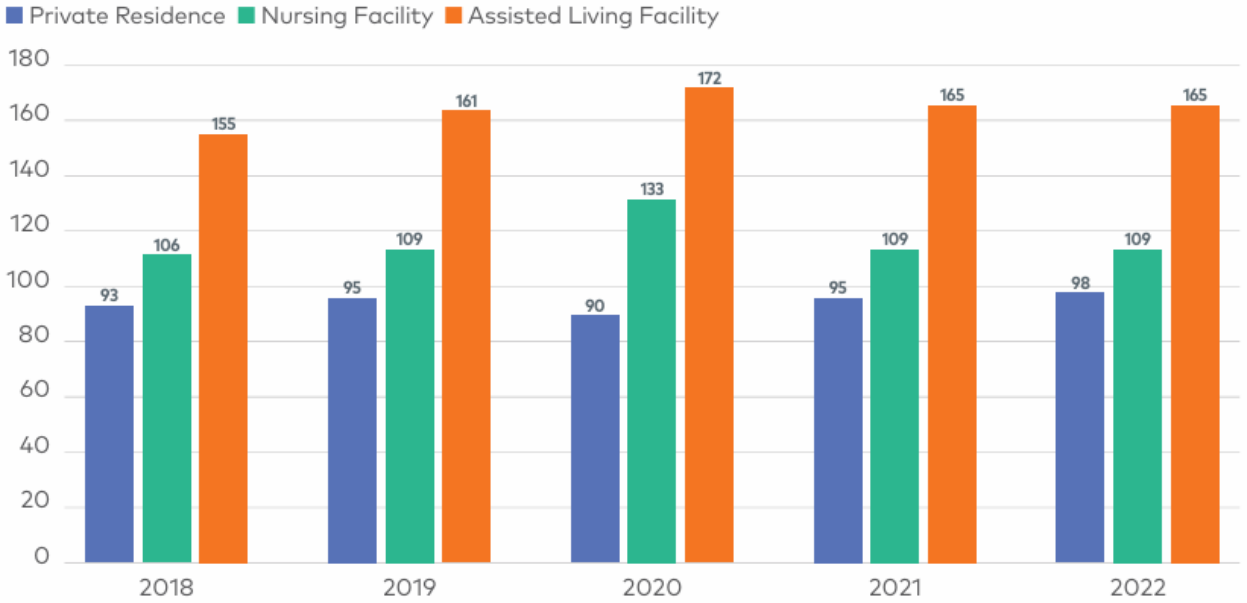
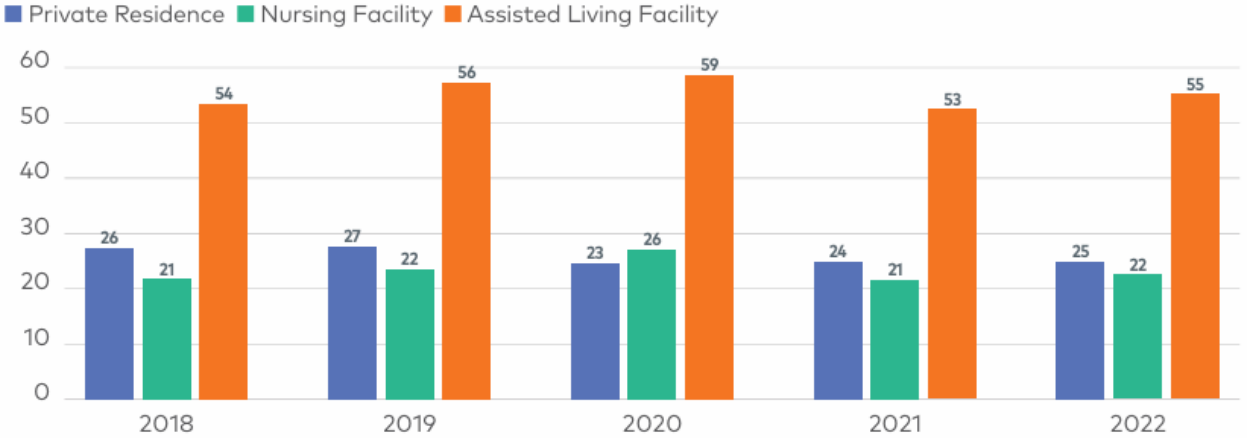


Figure 18: Median days by location of care, in days

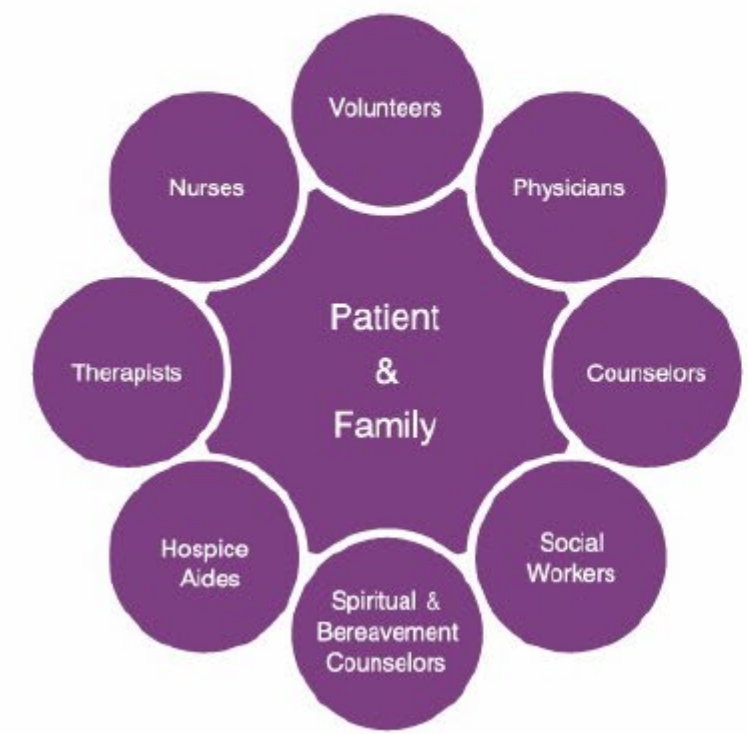


Source: *MedPAC July 2024 Data Book, Chart 11-15; MedPAC March 2022 Report to Congress, Table 11-7*

Advantage

Interdisciplinary Team Approach

Teamwork, Communication, Mutual Respect



- Holistic care based on patient goals
- Multi-level collaboration and communication
- 24/7 availability
- Individualized plan of care based on patient choice and goals
- Each team member is focused on improving the quality of life and delivering comfort within their discipline
- Offers bereavement support for the family after the patient passes

Hospice Condition of Participation- 418.100
Organization and Administration of Services

(c) ***Standard: Services.***

(1) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent with accepted standards of practice:

(i) Nursing services.

(ii) Medical social services.

(iii) Physician services.

(iv) Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling.

(v) Hospice aide, volunteer, and homemaker services.

(vi) Physical therapy, occupational therapy, and speech-language pathology services.

(vii) Short-term inpatient care.

(viii) Medical supplies (including drugs and biologicals) and medical appliances.

Signs of Patient Decline

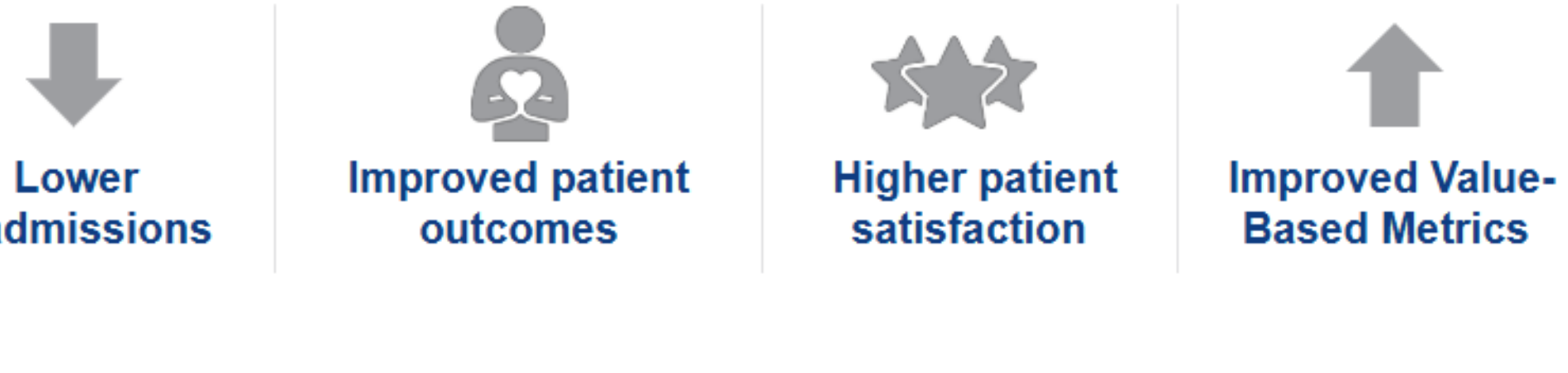
Functional Status	Nutritional Status
Increased occurrences of incontinence	Loss of appetite or anorexia
Decreased ability to perform ADLs	Change in weight
Decreased ambulation ability	Onset of or worsening in difficulty swallowing
Changes in memory, reasoning skills, or levels of consciousness	Changes in intake or output
Increasing muscle weakness	
Onset of pain and/or weakness	

Advantage

Benefits of working together:

- Integrated plan of care between hospice and facility
- Pharmacy, supply and equipment coordination
- Coordination and collaboration with staff who are caring for the patient or resident (including care plan meetings)
- Report to skilled staff on every visit
- Assistance in serving families
- Continuity through levels of care
- Orientation and training of staff in hospice philosophy and care
- Grief support available to staff members

Seamless Transitions:
Navigating the Post-Acute Ecosystem



Presenting:
Nichole Shadle: Regional Director of Operations
Austin Hancock: VP of Operations – Home Health
Tommi Burchfield: VP of Operations – Hospice

Advantage

Questions????

Advantage