Post Acute Care (PAC)

- Range of services delivered after discharge from hospital
- Acuity of patient and intensity of care no longer requires hospital level care but further treatment is needed to return patient to baseline status
- Significant majority of patients who use PAC are >65 y/o on Medicare
- 42% of Medicare beneficiaries discharged from hospital with PAC services
- Average daily census may be 2-3 times that of hospital

PAC providers

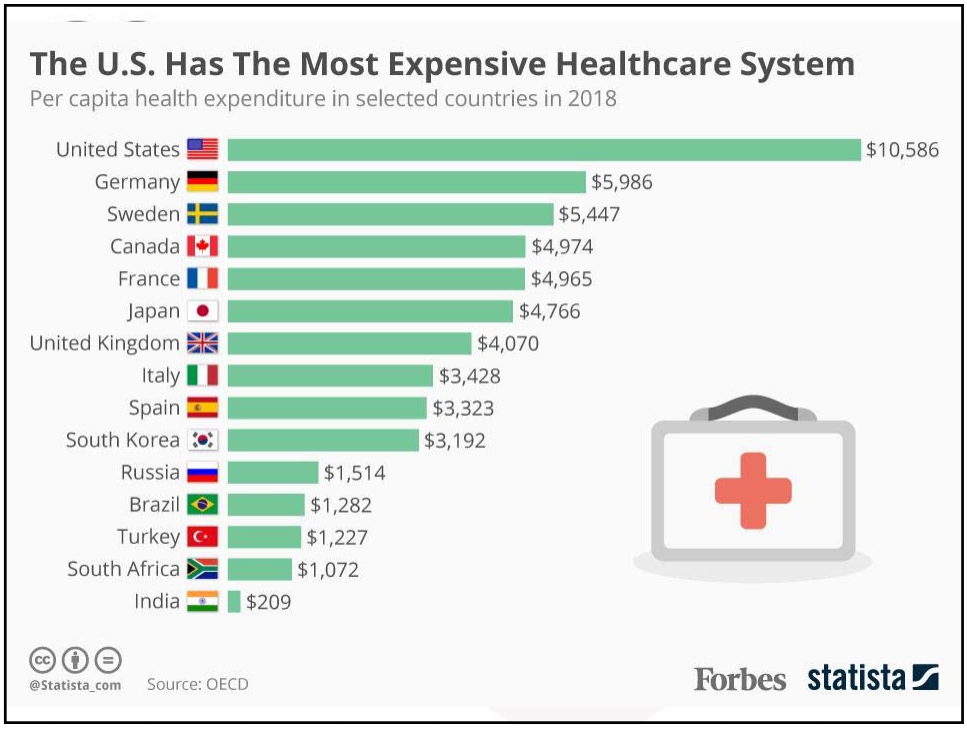
- Covered under Medicare A benefit
- Large and diverse group
  - Skilled nursing facilities (SNF), home health agencies (HH), Long term care hospitals (LTCH), inpatient rehab facilities (IRF), hospice
- Historically smaller reliance on private insurance as a form of payment
- PAC is transforming from a “discharge disposition” to a significant part of continuing care for the patient

Key Strategies in Transformation of PAC

- Develop system that provides the right care, at the right time, for the right patient
- Standardized and objective care pathways
- Connectivity of electronic medical records and technology across continuum of care and includes all providers
- Evaluate options of build, buy, or partner to meet PAC needs
- Develop population health framework to support continuum of care of patient
- Achieve goals of Triple Aim- improve patient experience (including quality and satisfaction), improve health of population, reduce per capita cost healthcare

Barriers in PAC continuum

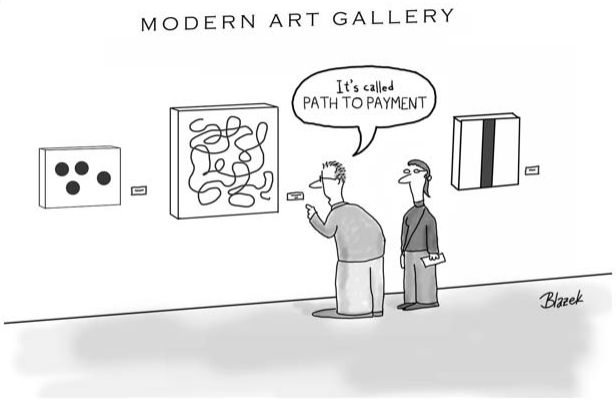
- Siloed system of care
- Placement reflective of bed availability
- Poor visibility into quality/cost metrics and medical records among PAC providers
- Foot in 2 camps
  - Reimbursement still significantly driven by volume (FFS) but value-based and bundle initiatives rising
- Incentives not aligned
- Varying levels of electronic and clinical capability
- Leadership, expertise, resources limited
- Vendor management
- Competitors
- Status Quo



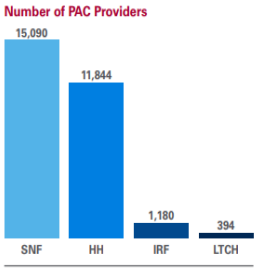
Healthcare System Challenge

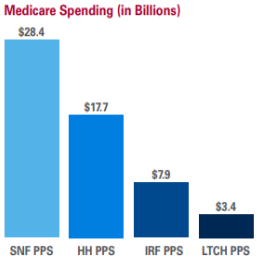
Success in PAC requires developing and operating continuous care health systems in order to optimize patient transitions from one appropriate care setting to another seamlessly with the correct medical information and education and at the lowest cost.

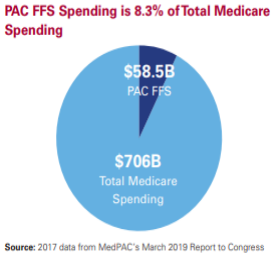
Responsibility and accountability of PAC network without authority



Post-Acute Care Stats







Source: 2017 data from MedPAC's March 2019 Report to Congress

Impact of Skilled Nursing Facilities

Historical Data

Clinical Episode	% of Episodes that go to SNF	SNF Cost as % of Total Episode Cost	Avg Episode Cost with SNF	Avg Episode Cost w/o SNF	SNF ALOS	SNF Avg Cost per Day
AMI	21% (42/201)	39%	$45,717.27	$17,502.24	25	$530.16
CHF	33% (193/581)	40%	$37,226.81	$17,027.55	23	$502.47
Overall	30%	40%	$ 38,744.26	$17,165.53	23	$507.90

*Important to note that some episodes had multiple SNF stays

Source: CMS Historical Claims Data File for CHF/AMI BPCI-A Episodes
Timeframe: January 1, 2014-December 31, 2016

PAC

Primary determinant of episode spend around hospitalization

Growth rate greater than inpatient

Variation in spend 68-230% between Medicare FFS beneficiaries and private insurers in similarly matched groups

Increasing variation infers unnecessary/wasteful care

The patient's diagnosis should dictate the treatment (evidence based medicine) not differences in practice by an individual provider or hospital

Lack of evidence to suggest increase spend for PAC reduces readmission or recovery to baseline

Suggests opportunity to reduce spend and improving quality without negatively impacting care

Legislation focusing on Waste and Standardization

2013

Budget Act 2013

- Overhaul to LTCH payments

2018

Balanced Budget Act 2018

- Redesign HH payments

2014

Improving Medicare Post Acute Care Transformation (IMPACT Act) of 2014

- Went into effect 11/29/2019
- Requires standardized discharge planning including goals of care, interoperability, and improved patient access to their records
- Prospective Payment System 2024

CMS Inpatient Prospective Payment System (IPPS)

1 in every 5 Medicare beneficiaries is hospitalized 1 or more times each year

Hospitals are paid under the Inpatient Prospective Payment System (IPPS)

- Flat rate based on average LOS and charge for a specific diagnosis
- Payment reduced if penalties assessed

Value Based Purchasing (VBP) Payment Adjustment

- Scores are based in part on patient satisfaction and post-discharge spending (efficiency)
- Vulnerable to PAC providers spend

Readmission Payment Adjustment

- CMS penalizes hospitals for high readmission rates
- PAC providers care for patients during high risk time for readmission post hospitalization

Why is PAC Important for Health Systems

Post-acute performance and spend increasingly impacts health system financial success in value-based reimbursement

Historical payment fee for service did not include PAC responsibility

Quality measures have been reported for several years, now cost included

Successful PAC outcomes are heavily influenced by individual PAC providers given there is significant variation in quality and cost

Methodist's Implementation and Coordination of a PAC Network

SNF Collaborative

Welcome to Methodist

Our Mission

Methodist Health System is committed to improving the health of our communities by the way we care, educate and innovate.

Your Care

Health care facilities with staff to provide ongoing skilled care and rehabilitation necessary for patients.

Outstanding Partnership

Business Case for Change

Above market utilization	Use LOS
Quality variability, despite volume	Readmissions ED visits
Growth in value payment contracts	ACO BPCI Private insurance

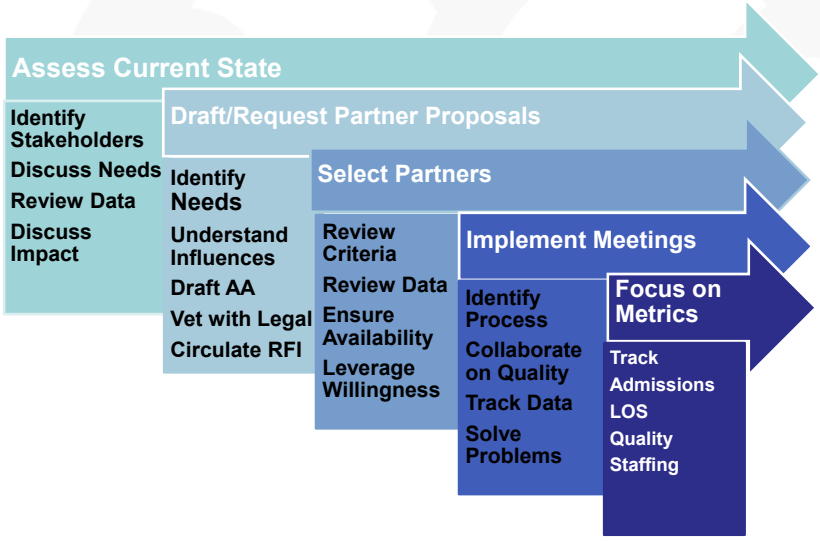
Opportunity for Reducing SNF Cost

- Two ways to reduce cost in SNF Utilization
  - Send less patients to SNF
    - Appropriateness criteria for SNF
    - Send more to HHC, home, and Hospice
  - Decrease SNF LOS
    - SNF UR

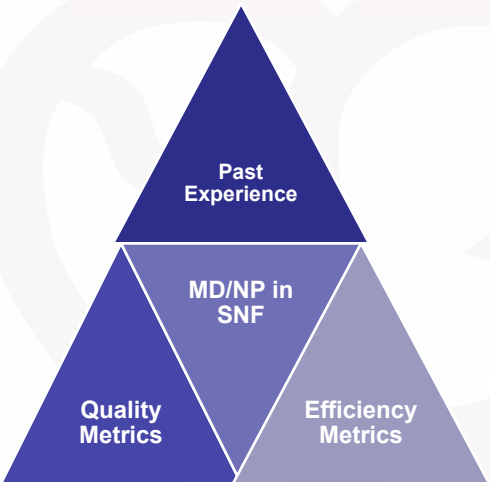
Overall Strategic Plan

- SNF Provider Program
- Home Health Network
- Pharmacy Partnerships
- ED Diversion
- Transitional Care Clinics

Post-Acute Care-SNF Roadmap



Initial Partnership Criteria



Reduce Variation by Formation Narrow Networks

- Health care systems are developing preferred provider networks with post acute providers who have high quality and efficiency
  - Maximize volume
  - Improve care management partnerships
  - Standard protocols for chronic disease to reduce variation in quality and cost
  - Limited resources to optimize post acute care as well as a new skill so restricted to those care partners who are most effective and efficient

Network Goals

A network of quality oriented SNF providers that adhere to identified service standards.

The goals are:

1. High quality, efficient care
2. Timely access
3. Care coordination throughout the continuum
4. Positive patient experience

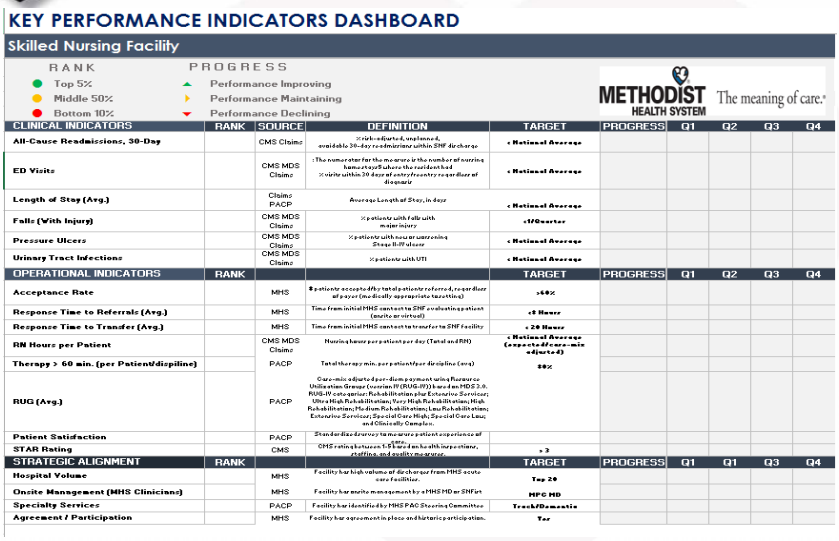
Partnership Objectives

- Communication enhancements
- Care management protocols
- Length of stay management
- Readmissions management
- Standardize transfers
- Mutual quality initiatives
- Data analytics

Selection of Partners

- Metro SNF providers sent materials
  - Council Bluffs to Fremont
- Vetted by internal stakeholders across health system in various roles
- 12 partners selected
- Pre-determined metrics guided process
  - Clinical, operational, and strategic
- Decision letters sent with follow-up plan

Metrics and Analytics



KEY PERFORMANCE INDICATORS DASHBOARD

Skilled Nursing Facility

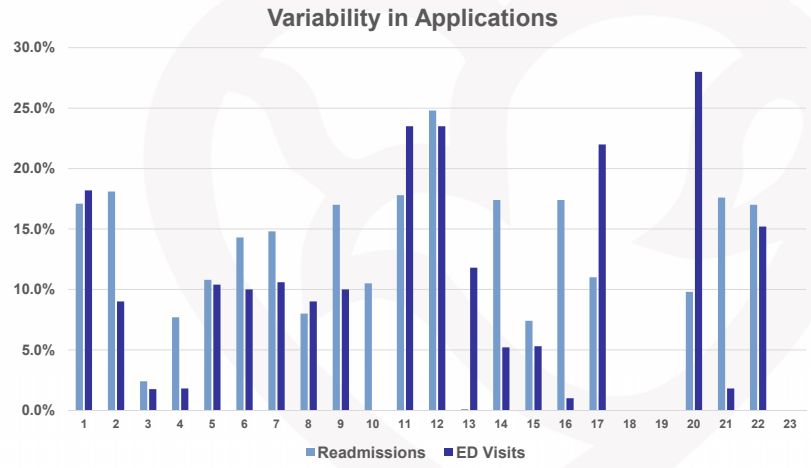
RANK
- Top 5%
- Middle 50%
- Bottom 10%

PROGRESS
- Performance Improving
- Performance Maintaining
- Performance Declining

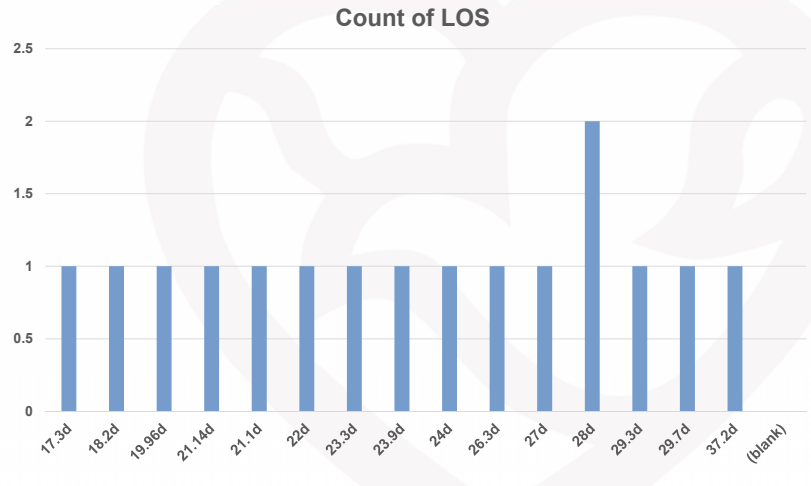
METHODIST HEALTH SYSTEM The meaning of care.

CLINICAL INDICATORS	RANK	SOURCE	DEFINITION	TARGET	PROGRESS	Q1	Q2	Q3	Q4
All-Cause Readmissions, 30-Day		CMS Claims	% risk-adjusted, unplanned, avoidable 30-day readmissions within SNF discharge	< National Average					
ED Visits		CMS MDS Claims	The numerator for the measure is the number of nursing home stays/where the resident had % visits within 30 days of entry/reentry regardless of diagnosis	< National Average					
Length of Stay (Avg.)		Claims PACP	Average Length of Stay, in days	< National Average					
Falls (With Injury)		CMS MDS Claims	% patients with falls with major injury	<1%/Quarter					
Pressure Ulcers		CMS MDS Claims	% patients with new or worsening Stage II-IV ulcers	< National Average					
Urinary Tract Infections		CMS MDS Claims	% patients with UTI	< National Average					
OPERATIONAL INDICATORS	**RANK**			**TARGET**	**PROGRESS**	**Q1**	**Q2**	**Q3**	**Q4**
Acceptance Rate		MHS	# patients accepted/# total patients referred, regardless of payer (medically appropriate transfers)	>60%					
Response Time to Referrals (Avg.)		MHS	Time from initial MHS contact to SNF evaluating patient (onsite or virtual)	<8 Hours					
Response Time to Transfer (Avg.)		MHS	Time from initial MHS contact to transfer to SNF facility	< 20 Hours					
RN Hours per Patient		CMS MDS Claims	Nursing hours per patient per day (Total and RN)	< National Average (expected/case-mix adjusted)					
Therapy > 60 min. (per Patient/discipline)		PACP	Total therapy min. per patient/per discipline (ave)	80%					
RUG (Avg.)		PACP	Case-mix adjusted per-diem payment using Resource Utilization Groups (version IV (RUG-IV)) based on MDS 3.0. RUG-IV categories: Rehabilitation plus Extensive Services; Ultra High Rehabilitation; Very High Rehabilitation; High Rehabilitation; Medium Rehabilitation; Low Rehabilitation; Extensive Services; Special Care High; Special Care Low; and Clinically Complex.						
Patient Satisfaction		PACP	Standardized survey to measure patient experience of care						
STAR Rating		CMS	CMS rating between 1-5 based on health inspections, staffing, and quality measures	> 3					
STRATEGIC ALIGNMENT	**RANK**			**TARGET**	**PROGRESS**	**Q1**	**Q1**	**Q3**	**Q4**
Hospital Volume		MHS	Facility has high volume of discharges from MHS acute care facilities	Top 20					
Onsite Management (MHS Clinicians)		MHS	Facility has onsite management by a MHS MD or SNFist	MPC MD					
Specialty Services		PACP	Facility has identified by MHS PAC Steering Committee	Track/Dementia					
Agreement / Participation		MHS	Facility has agreement in place and historic participation.	Tier					

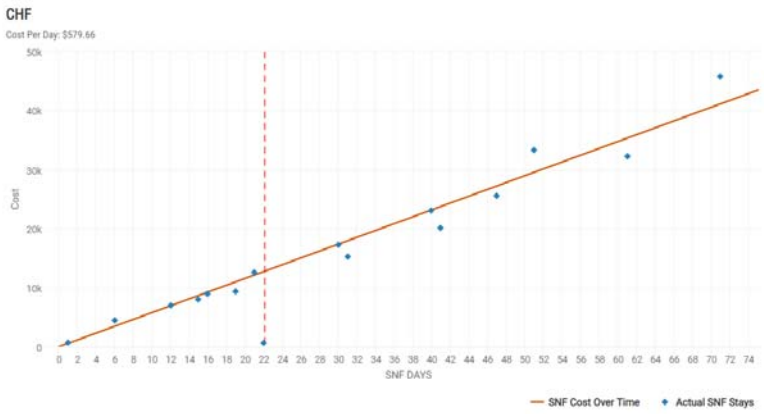
Quality Review



Efficiency Review



CHF SNF Costs



Partnership Philosophy

- Right care at the right time, for the right patient
- We need to transition our care from episodic to continuous
- We strive for and expect exceptional performance
- Change may be difficult but we can accomplish together
- Ongoing communication improves our network
- We are a data driven network
- Accountability supports change
- WE ARE BETTER TOGETHER

Methodist's Commitments

- Principal contact person for initiative
- Meetings on network performance
- Annually gather partners for education
- Data analysis and sharing
- Communication and problem solving
- Performance improvement partners
- Internal discharge support and standardization
- Care coordination

Provider Network Scripting

We want you to get the right care. There are many facilities to choose from, but we recommend you consider facilities in the Methodist Clinical Collaboration Provider Network of SNFs. A team of experts from Methodist selected these facilities based on their quality and the great care they give our patients. Methodist works closely with these facilities and many of our providers even provide care in the facilities helping resolve problems and communicating with your providers. These facilities are highlighted on this list, and the list includes quality metrics like star rankings (higher is better, and 5 is best). Please look through the information, and let us know your top 3 preferences from the list. Giving us 3 preferences helps us match the facility based on your insurance, timing of your discharge, or other needs. Although we recommend our Clinical Collaboration Network for good reasons, you can choose any of these facilities.

SNF Provider Commitments

- Data sharing and transparency
- Quality standards are your minimum
- Efficiencies are addressed
- Acceptance ratios and timeliness
- Communication on barriers
- Performance improvement participation

Agreement Commitments

- Patients accepted 7 days/week
- Patents transferred within 24 hours
- SNF accepts 60% of appropriate, referred patients
- SNF and PT communicate on plan
- SNF actively participates in scheduled meetings

SNF Network Quality Improvement

Marketing Partnership

Requirement of signed agreement

- Must remain in good standing in network
- Must remain **above** a 2 STAR facility
- Must disclose SNF as independent

Marketing must approve use of images

- Not defamatory, obscene, or libelous
- No infringement on intellectual property

PAC Strategy Completed

- Pre-work, implementation, build out
- PAC Network
- Performance Reporting
- Oversight
- Kick off/pilot
- Charter and Terms
- PAC providers access to Methodist EMR

PAC Network High Level Roadmap

Today *2020-2021*

Phase 1 | Phase 2 | Phase 3

1 Pre-Work Completed + Ongoing Operations

- Continue to work with subgroups to improve LOS, Readmissions, and Transitions
- Heart failure Protocol
- Weekly Huddles for SNF discharges
- ED Transfer Tool
- Utilization Review (UR) heart failure SNF stays
- Continue to create strong relationships with SNF partners

2 PAC Strategy In Progress

- Work Stream Plan + owners/champions
- Expand chronic disease-based protocols
- Milestone development
- Develop system level hospice program
- Continued partnership with Nebraska Health Information Initiative (NEHII) for real-time data analytics
- Decisions on vendor tools to improve transitions of care, readmission, identify rising risk patients, socioeconomic factors impacting health, patient and family education

3 PAC Network Build-Out

Build-out will include:

- SNF Incentives/ Risk
- Established PAC Leadership
- Outcomes Analysis
- UR PAC strategy
- Three Day SNF Waiver Application
- Telehealth capabilities/ waiver
- Potential to expand to Home Health, Pharmacy partnerships, community paramedic program, SNF educational programs, community health worker program
- Continue to expand ER diversion, transitional clinics,

38

Telehealth

- Becoming important component of PAC
- Can reduce cost per episode and increase access to care, reduce ER use
- Anticipated increase adoption due to improved mobile technology and **more favorable government policies for payment**
- Demonstrated effectiveness for both acute care and chronic conditions
- Estimated $6 billion in reduced cost to U.S. companies
- 93% of patients who have used telehealth say it decreases their medical cost
- Only 15% of providers currently use telehealth
- Patient Centered

Opportunity Costs of Traditional Ambulatory Care

Opportunity Costs of Ambulatory Medical Care

Table 2. Time per Visit Seeking Care for Oneself, Other Adult, or a Child

	Seeking Care for Self	Seeking Care for Other Adult	Seeking Care for Child	All Adults Seeking Care for Self or Others
	Average minutes per visit (95% CI)			
All adult respondents	N = 2889	N = 530	N = 607	N = 3927[a]
Total time	115 (112-119)	139 (129-149)	128 (118-138)	121 (118-124)
Travel time	33 (32-34)	48 (43-53)	50 (45-55)	37 (36-39)
Clinic time	82 (80-85)	91 (84-99)	78 (71-85)	84 (81-86)
Employed adult respondents	N = 1339	N = 243	N = 400	N = 1925[a]
Total time	105 (101-109)	142 (127-157)	121 (108-134)	113 (109-117)
Travel time	31 (29-33)	45 (39-52)	50 (42-58)	36 (34-39)
Clinic time	73 (69-77)	97 (85-109)	71 (64-78)	77 (73-80)
All respondents				
Time face-to-face with physician[b]	21 (20-21)	21[c] (20-21)	18 (17-18)	20 (20-20)

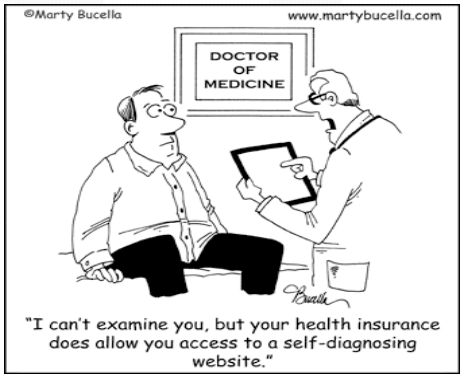
[a]Sum of individual visits exceeds total any visits, because a small number of respondents sought care for multiple people during their reported day.
[b]"Time face-to-face physician" was obtained from a separate data source, the 2003-2010 National Ambulatory Care Medical Survey (NAMCS) for adult, pediatric, and all visits.
[c]Because NAMCS does not indicate visits accompanied by another adult, the estimate for all adults is also used for accompanied adults.

Telehealth

HealthLeaders 1/16/2020

"MDLIVE LAUNCHES VIRTUAL PRIMARY CARE PLATFORM; CIGNA WILL OFFER PATIENTS VIRTUAL ANNUAL WELLNESS SCREENINGS"

Cigna has 12.5 million members



Rethinking Healthcare

- Newer Models of care to ensure patients get right care at the right time and right place
  - Hospital at Home
  - SNF at home
  - Uber and Lyft
  - Mobile Care
  - Community Paramedicine
  - Community Health Workers (CHW)
  - Remote Monitoring
- Improving EMR capability

  Artificial intelligence, natural language processing

HealthLeaders Briefing 1/20/20

"Uber and Lyft are aggressively pursuing ways to work with hospitals and health systems and see the healthcare business as a key growth area."

Big Picture & Future State

- High Quality
- Efficiently coordinated
- High satisfaction
- Effective
- Innovative
- ROI

Questions & Discussion