Trinity Health

Hospital – Home Care – Physician Collaboration Program

Public Health Law §2805-x

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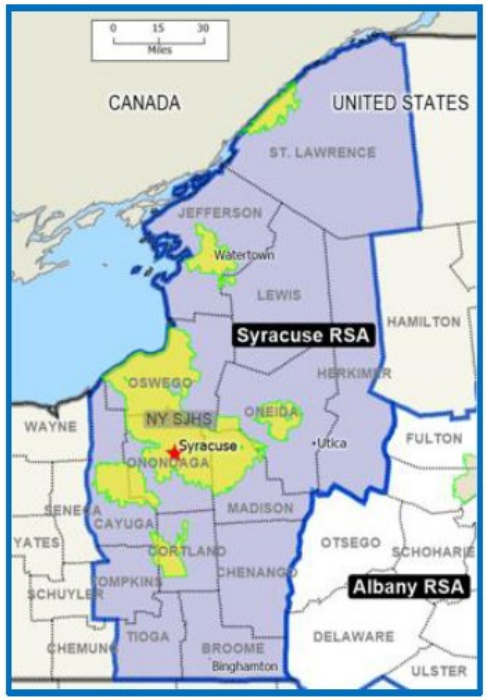
St. Joseph's Health – Syracuse

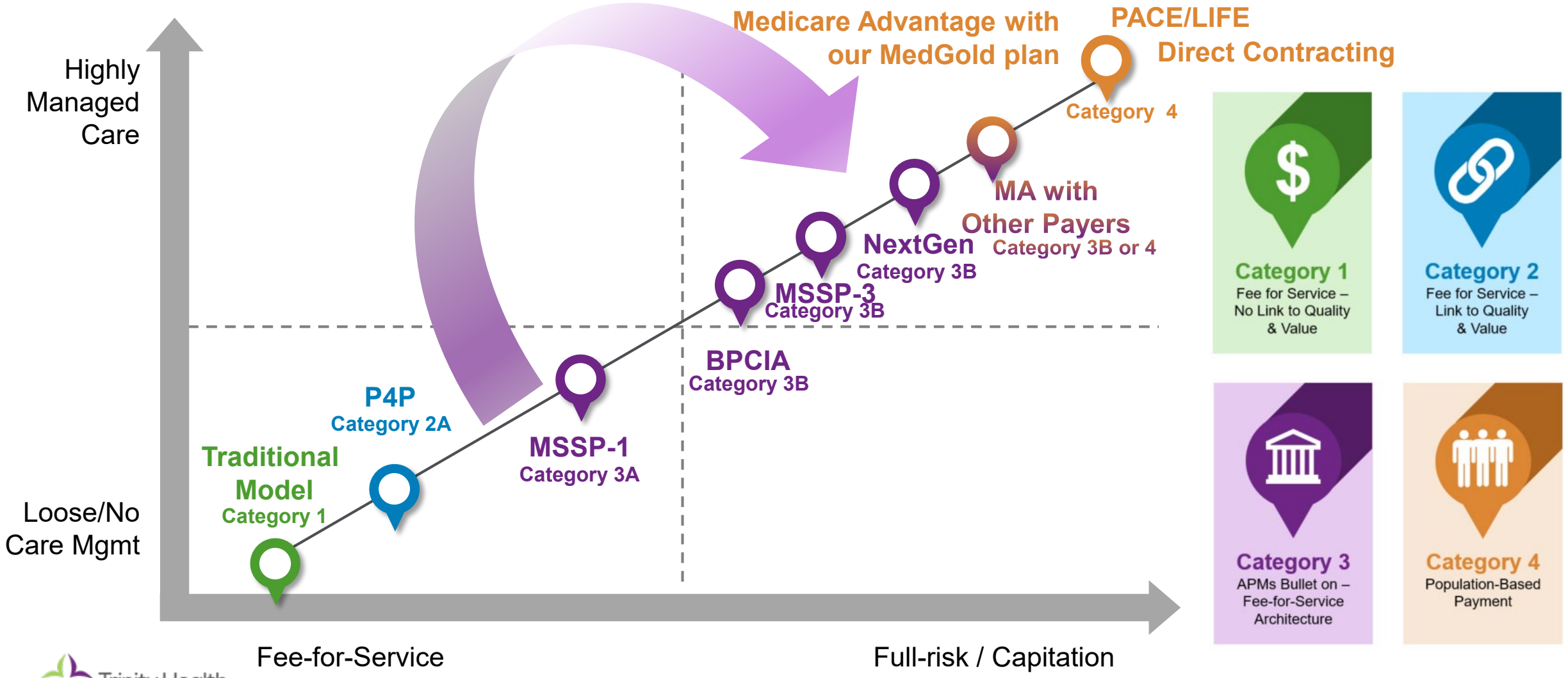


- Non-profit health care system based in Syracuse and a member of Trinity Health
- Magnet-recognized 451-bed Hospital with two (2) ambulatory surgery centers
- St. Joseph's Physicians – integrated multi-specialty group with over 70 primary care providers
- Certified Home Health Agency (Now managed by Trinity Health at Home
- NYS Certified Health Home (St. Joseph's Care Coordination Network)
- Clinically Integrated Network (CNY AIM) – Nine county area with over 1,200 providers

People-centered health system that delivers the Triple Aim for individuals, populations & communities

Listen	Partner	Make It Easy

We have advanced our APM strategy to take on greater accountability and create greater opportunity



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St. Joseph's holds $622M in cost of care accountability for 93K people

As of 1/1/21

	Annual Medical Cost	Attributed Lives
Medicare ACO – Syracuse Chapter	$200 Million	19,259
Commercial ACQA – with CNY Family Care	$250 Million	39,784
Bundled Payment (Episodes) for Care Improvement - Advanced	$25 Million	1,035
Medicaid Concordia (Super CIN) VBP – Fidelis	$147 Million	33,759

Our Approach

Prevent Unnecessary Hospitalizations

- Avoid Unnecessary ER Visits
- Avoid Unnecessary Admissions
- Manage Chronic Disease & Conditions

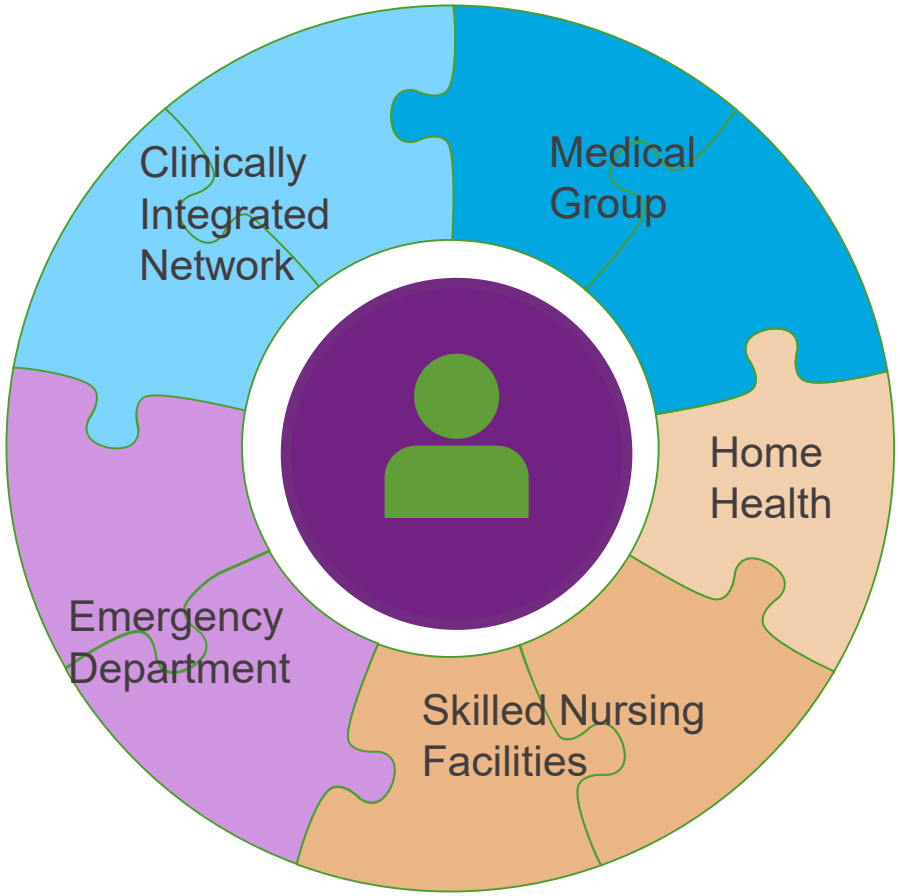
Reliable, High Quality Hospitalizations

- Improve Care Coordination Rate (High Reliability Hospitals)
- "Zero-Harm" - Reduce Hospital Acquired Conditions and Hospital Acquired Infections

Efficient Post Hospitalization

- Control Re-Admissions
- Minimize Avoidable SNF Days
- Manage SNF LOS
- Community Based Palliative Care

We are implementing interventions across the continuum to reduce preventable hospitalizations for our patients



- **Patient identification and stratification**
- **ED notification to CIN team via local Health Information Exchange (HIE)**
- **Same day/next day access in primary care**
- **Follow up visit with primary care post ED/acute/post-acute episode**
- **Ready access to urgent care during off hours**
- **Longitudinal Care Management for patients with chronic conditions**
- **Condition specific interventions (e.g. CHF clinics, COPD home care visits)**
- **Patient education including "sick day" plans**
- **Care management in the ED focused on avoiding the hospitalization including direct admit to a Skilled Nursing Facility (SNF waiver)**
- **Ambulatory pharmacy review and management to promote medication adherence and reduce polypharmacy**
- **Patients going home from ED or hospital with Trinity Health at Home + enrollment in Home Care Connect/remote monitoring when available.**
- **Enrollment in palliative care and even PACE where applicable for patients with advanced illness**

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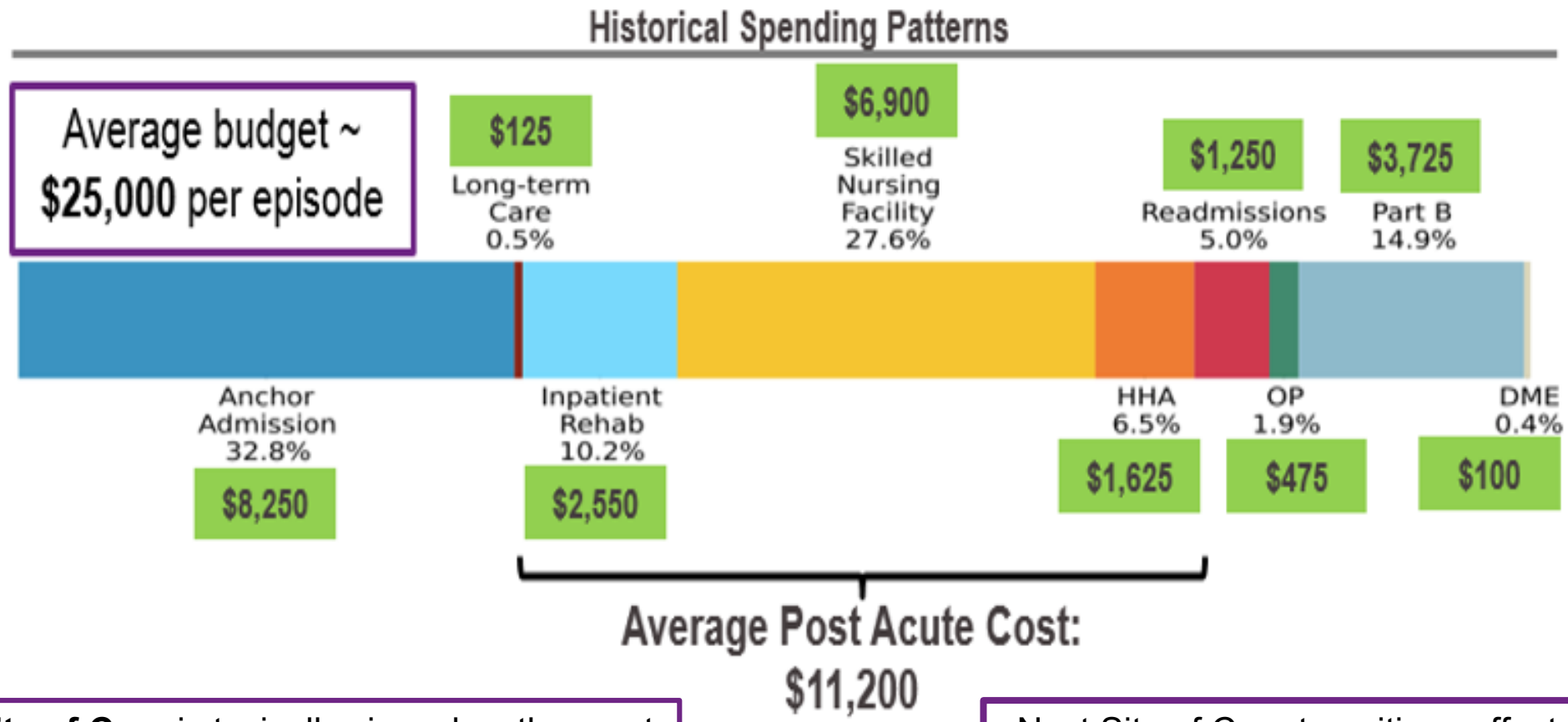
Participant Key Levers

	Primary Care	Specialists	Acute Care Hospital	SNF/Rehab
Access	Great access to Primary Care [same day appts, extended hours, telehealth, proactive care management (CCM/LCM & referral to SJ CCN)]	Refer to Primary Care (primary care engagement)		
Quality	Annual Wellness Visits (Super Visits, Clinical Condition Documentation Improvement) & Quality Measures (and preparation for eCQMs)	"Efficient and efficacious" Office Administered Drugs	Zero Harm (high reliability hospitalizations)	SNF Zero Harm (high reliability SNF/Rehab admissions)
Readmissions	Transitional Care Management (within 5 days of discharge)	Transitional Care Management (within 5 days of discharge)	Best Practice "After Hospital Care Plan" (Med Rec, Post-discharge follow up, After Visit Summary & Teach-back to patient)	Readmission Avoidance
Right Place, Right Time		"Right" Site of Service Selection	ED Admission Avoidance (ACSC Admissions) & "Think 'Home' First"	SNF Optimal LOS
Keep it "in network"	Refer to "in network" Specialists	Keep services "in network" (think "Zero Harm Hospitals")	Refer to Post Acute Care Network & Utilization of 3-day SNF waiver	
ACP	Advanced Care Planning	Advanced Care Planning	Advanced Care Planning	Advanced Care Planning

Historical Spend for Episode of Care (CMS)



Next Site of Care is typically viewed as the most important lever because of its early identification of patients in an episode and its significant influence on the 90 at-risk days post-acute.

Next Site of Care transitions affect episode cost and patient satisfaction. Appropriate transition decisions allow for targeted **Skilled Nursing Facility Length Of Stay** and **readmission** management.

Post-Acute Clinical Levers for Success

if We ensure post acute care is provided in the least restrictive environment and provide safe transitional care

THEN: We will reduce avoidable all cause readmissions, reduce avoidable ED utilization, increase primary care engagement and patient satisfaction, and achieve shared savings within value-based agreements

Tactics

- Optimize Post-Acute Care (PAC)
- Utilize Transitional Care Management (TCM)
- Coordinate Emergency Department (ED) Care

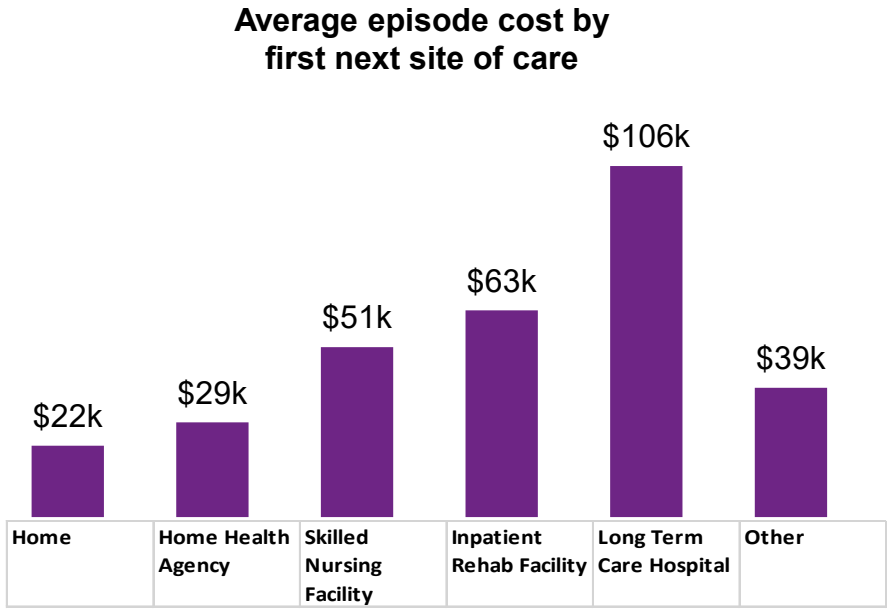
Expanding our CHHA services will assist St. Joseph's Health in meeting the objectives of the "Triple Aim" (Better Health, Better Care, Lower Costs) through improved access to home care services and effective/standardized patient management across our nine county clinically integrated network. This will promote care coordination and high value care in the communities that we serve.

Lever 1 - The Next Site of Care Discussion Addressing "Why Not Home?"

Going **Home** or **Home with Home Health Agency** when clinically appropriate can offer benefits to patients over being discharged to a Post Acute Facility.

- Lower risk of infection, falls, delirium, and skin conditions
- More privacy
- Less noise / better sleep
- Easier access to family and friends
- Enhanced patient and family satisfaction

The most appropriate next site of care can **reduce unnecessary costs** during the episode and ensure optimal **stewardship of a patient's Medicare Benefits**



Data from Oct 2013 – March 2014 (Claims Version 093014) – All Remedy Partners Phase I Providers (600+)

Home Care Role in “Why Not Home”

- Responsive to same day/next day need for care
- Ability to manage high tech needs of patients
- Intense rehab services in the home
- Ability to offer HHA services to support the patient and family
- Coordinate with acute care team to ensure needs of patient can be met
- Use of Remote Patient Monitoring through Home Care Connect with Trinity

Lever 2 - Leveraging Networks of high-performing post-acute providers drives success

Establish and Maintain Performance Networks

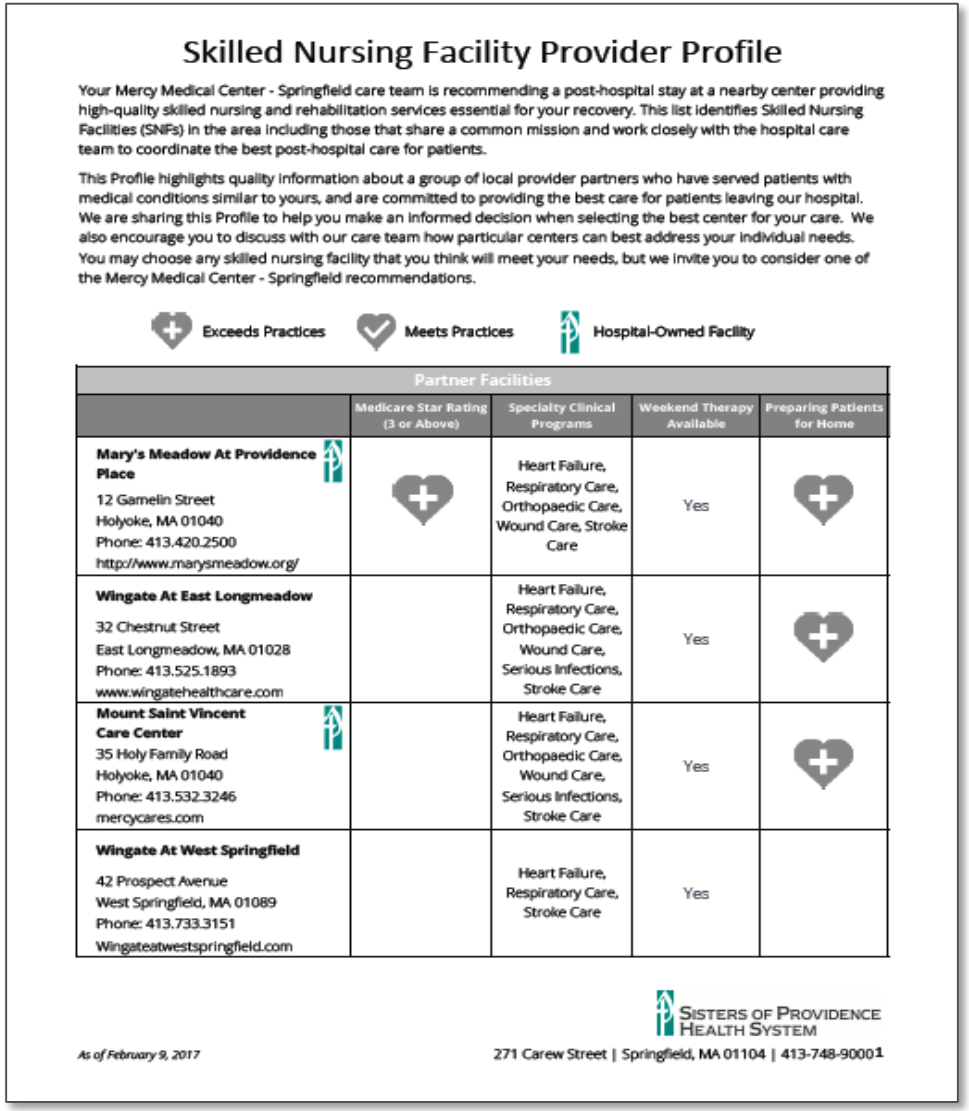
- Leverage quantitative and qualitative data to select providers
- Hold town halls to bring together Skilled Nursing Facilities, Home Health Agencies and other provider to discuss best practices
- Review data and drive performance improvement

Build Relationships and Ensure Continuity of Care

- Identify new Bundled Payment for Care Improvement patients entering preferred post-acute care sites
- Review weekly updates on patient status and targeted discharge date
- Establish communication and coordination expectations across the continuum

Drive Care Redesign and Process Improvements

- Drive adherence to **Episodic Length of Stay** guidelines
- Educate on and deploy care guidelines
- Assess and address causes of readmissions



Skilled Nursing Facility Provider Profile

Your Mercy Medical Center - Springfield care team is recommending a post-hospital stay at a nearby center providing high-quality skilled nursing and rehabilitation services essential for your recovery. This list identifies Skilled Nursing Facilities (SNFs) in the area including those that share a common mission and work closely with the hospital care team to coordinate the best post-hospital care for patients.

This Profile highlights quality information about a group of local provider partners who have served patients with medical conditions similar to yours, and are committed to providing the best care for patients leaving our hospital. We are sharing this Profile to help you make an informed decision when selecting the best center for your care. We also encourage you to discuss with our care team how particular centers can best address your individual needs. You may choose any skilled nursing facility that you think will meet your needs, but we invite you to consider one of the Mercy Medical Center - Springfield recommendations.

Exceeds Practices | Meets Practices | Hospital-Owned Facility

Partner Facilities	Medicare Star Rating (3 or Above)	Specialty Clinical Programs	Weekend Therapy Available	Preparing Patients for Home
Mary's Meadow At Providence Place 12 Gamelin Street Holyoke, MA 01040 Phone: 413.420.2500 http://www.marysmeadow.org/	✚	Heart Failure, Respiratory Care, Orthopaedic Care, Wound Care, Stroke Care	Yes	✚
Wingate At East Longmeadow 32 Chestnut Street East Longmeadow, MA 01028 Phone: 413.525.1893 www.wingatehealthcare.com		Heart Failure, Respiratory Care, Orthopaedic Care, Wound Care, Serious Infections, Stroke Care	Yes	✚
Mount Saint Vincent Care Center 35 Holy Family Road Holyoke, MA 01040 Phone: 413.532.3246 mercycares.com		Heart Failure, Respiratory Care, Orthopaedic Care, Wound Care, Serious Infections, Stroke Care	Yes	✚
Wingate At West Springfield 42 Prospect Avenue West Springfield, MA 01089 Phone: 413.733.3151 Wingateatwestspringfield.com		Heart Failure, Respiratory Care, Stroke Care	Yes	

As of February 9, 2017

Sisters of Providence Health System

271 Carew Street | Springfield, MA 01104 | 413-748-9000

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Lever 3 – Optimal recovery: Skilled Nursing Facility length of stay

- We have created a guide for each diagnosis as to the optimal length of stay in Skilled Nursing Facility
  - Goal for each discharge information session (also known as the Medicare Meeting in the Skilled Nursing Facility) is to discuss the estimated Length of Stay and barriers to achieving transition home in the time that the guide provides

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Lever 4 – Readmissions-both 30 and 90 day

- Historically we focused on the 6 diagnoses for Hospital Readmission Reduction Penalty (HRRP)
- The measure is All-cause, which helps us in the BPCI-A program significantly. This remains a 30-day evaluation, but we are responsible for readmission during the full 90 days episode
- Breakdown of readmissions for evaluation and Root Cause Analysis are 0-7days, 8-15days, 16-30days, 31-60days, and 61-90days*
  - Standard work is created based on time of readmission but most work is around Medication reconciliation, warm handover opportunities, and post discharge Physician office visit appointments

MIST – Mobile Integrated Services Team

- Home-based primary care team works collaboratively with SJ Physicians and SJHAH to serve our most frail, vulnerable, and truly homebound patients

- Patients are referred to the MIST by PCP, CHHA, ACO, acute care team, and Transition of Care team.

- Exquisite care management with PCP and other healthcare team members results in lower readmission rates and aids to relieve burden of case management from PCP offices as well as providing support to caregivers

POST ACUTE NETWORK & HOME CARE

- Post-Acute visits with provider
  - Collaboration between St. Joseph's Physicians and inpatient colleagues for process re-design for scheduling post-acute PCP visits for ALL shared patients
  - GOAL is to improve % of patients completing a PCP post-acute follow up visit within 7-14 days of facility discharge for all patients regardless of payer

- Heart Failure
  - Stoplight Tool - collaboration (among Heart Failure Coordinators, SJHAH, TOCNs, SJP, and ACO) to develop one comprehensive Heart Failure stoplight tool to be used across SJH – ambulatory settings, acute care, home care are now adopting for use
  - HF Clinic – workgroup established to improve identification of patients in need and referral process
  - Education module provided to SNFs in collaboration with acute HF Coordinator – education for caregivers and nursing staff within facility
  - Providing copies of tools and posters – requesting HF teaching be incorporated into ADL training
  - Vivify / diuretic protocol

POST ACUTE NETWORK & HOME CARE

- Development of Post-Acute Performance Network (PN)
  - Quarterly Town Hall meetings with SNF partners includes review of unblinded readmission data, baseline criteria for inclusion in PN (readmission rate of < 25%) , presentation of education modules/tools that can be used by SNFs for staff education
  - Expanding to include Home Care Agencies as well
  - Use of Quality of Care Profiles to highlight performance criteria
  - 1:1 Scorecard/Data reviews with partners
- Partnering with Home Care to:
  - Ensure safe transition of care
  - Decrease hospital and SNF LOS
  - Prevent Readmission
  - Participate in patient care conferences as needed
  - Accessibility of Home Care record for hospital/ACO/MD staff and hospital/MD record for Home Care staff

REAL TIME ALL CAUSE ACH and SNF READMISSION REVIEW (BKo)

- Readmission Review
  - Transitions of Care Team collaboration with acute care and ACO reviews sample of readmissions weekly
  - Includes Performance Excellence colleagues, Transition of Care Team, and now ACO

- MIDAS for readmission data collection
  - To improve tracking and trending of identified opportunities and action planning when gaps in care are identified
  - CHHA and TOCN staff use MIDAS platform to report risk events – especially those that appear to result/contribute to readmission
  - Collaboration across system is underway to consider approach to readmission reviews/action planning

Syracuse Chapter 2020 & 2021 ACO Performance Metrics

Metric	2020 Performance	2021 Performance	PY2021 "Big 3" Targets
Member Count	22,024	19,181	
Medical Cost of Care PMPM	866	877 (+1.2%)	
Acute Inpatient Care Coordination Rate (%)	41	38	
Acute Inpatient Admits/1,000	257	253	301
Inpatient Rehab and LTAC Admits/1,000	4	3	
All Cause 30-Day Readmits/1,000	51	41	
Readmission Percentage (%)	20	16	
ED Visits/1,000	316	334	360
SNF Days/1,000	1,824	1,892	1,549
SNF Admits/1,000	67	73	
SNF ALOS (in Days)	27	26	

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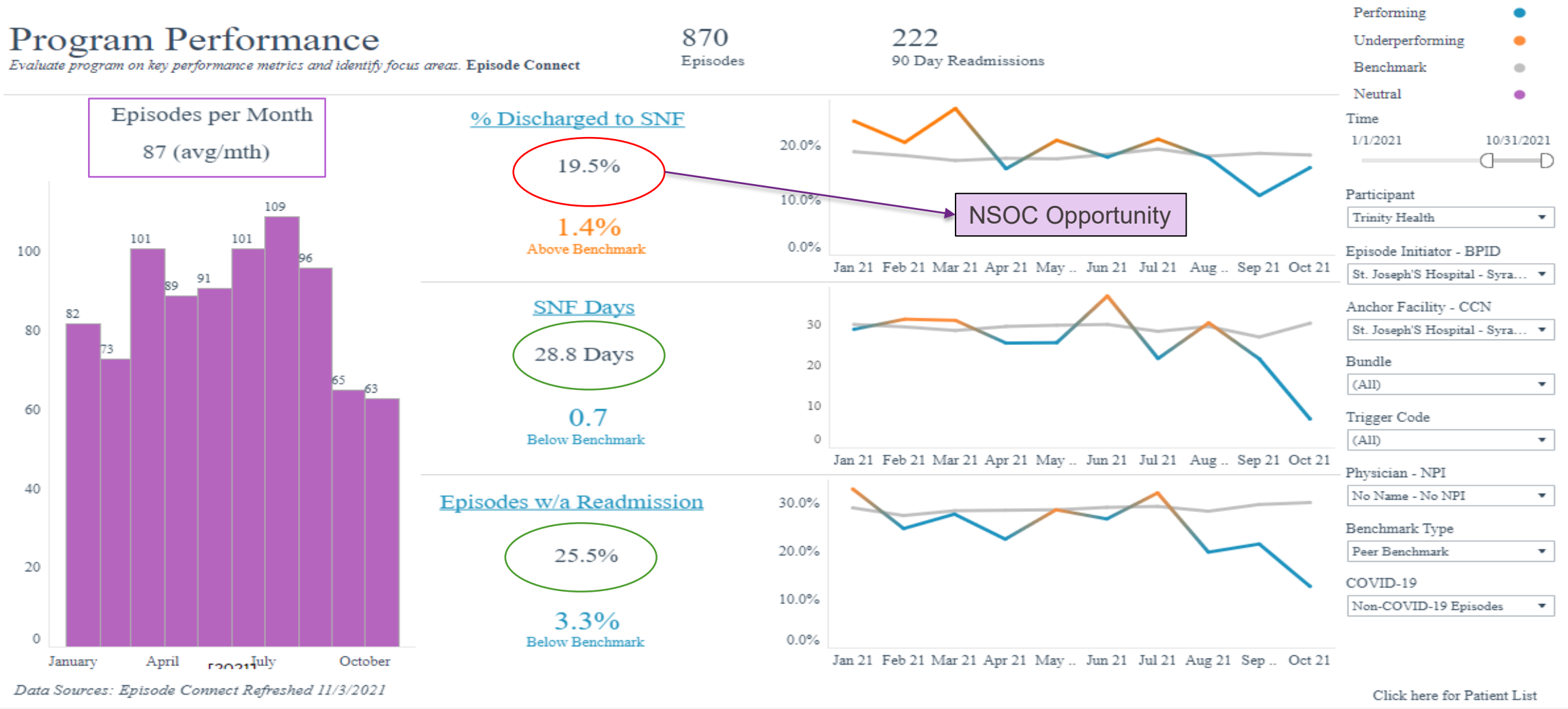
Improving BPCIA performance



KEY TAKE AWAY: est. 1,035 - 1,200 episodes per year

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Four years of successful participation in Trinity Health Integrated Care ACO!

Year	THIC ACO Earned Savings (after sequestration)	Syracuse Chapter Share	Syracuse Chapter Expense Recovery	Syracuse Chapter Distribution (After Expense Recovery)	PCP TIN Distribution	CIN Distribution
PY2017	$12,406,622	$4,763,589	$1,778,000	$2,985,589	$1,492,795	$1,492,795
PY2018	$18,733,623	$6,366,378	$2,292,407	$4,073,971	$2,036,986	$2,036,986
PY2019	$13,720,667	$4,585,888	$3,437,124	$1,148,764	$574,382	$574,382
PY2020	$21,262,409	$6,768,653	$3,420,453	$3,348,200	$1,674,100	$1,674,100
TOTALS	**$66,123,321**	**$22,484,508**	**$10,927,984**	**$11,556,524**	**$5,778,262**	**$5,778,262**

VALUE PROPOSITION:

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BPCIA – Growth in program and Positive NPRA

Performance Period	# Episodes	Net Payment Reconciliation Amount	Savings Rate
PP1 (10/1/18 – 6/30/19)	313	$113,000	1.3% (through 2nd True Up)
PP2 (7/1/19 – 12/31/19)	304	$139,000	1.6% (through 2nd True Up)
PP3 (1/1/20 – 6/30/20)	311	$327,000	3.6% (through 1st True Up)
PP4 (7/1/20 – 12/31/20)	246	$358,000	4.9% (through initial reconciliation)
TOTALS	**1,274**	**$937,758**	**2.8%**

BPCIA IS A **FORCE MULTIPLIER** AND HOSPITAL'S BIGGEST BANG FOR BUCK OPPORTUNITY!
(BPCIA, ACO, Hospital Readmissions Reduction Penalty, STAR Ratings)

VALUE PROPOSITION:

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Barriers, lessons learned, future work

Barriers to greater success:

- Acuity of patients
- RN Staffing limiting availability of home care services
- Global pandemic limiting resources and in-person interaction with patients
- Overall health care system is still very much based on transactional care vs care management

Lessons Learned:

- Engagement of a Provider and or Executive Leader is essential
- Preferred networks with clear objectives and accountability
    - Develop shared goals/benefits for all involved to see the value of the participants

Future work:

- Improve understanding of regulatory and best-practice priorities, and care expectations across the continuum home care, ACO, ambulatory care, and transitions of care team
- Leverage EMRs to improve coordination and communication
- Improve data sharing and goal-setting among leadership across settings (e.g. TCM work, inpatient readmissions, SNF days, etc)