HSCRC / Post-Acute Collaborative / LTC Workgroup

Sharon McClernan, VP Community Services and Integration

Andrea Horton, Executive Director Clinical Post-Acute Operations

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LifeBridge Health: Providing a Full Continuum of Care

ACUTE CARE

- The Herman & Walter Samuelson Children's Hospital at Sinai — A LifeBridge Health Center
- Carroll Hospital — A LifeBridge Health Center
- Grace Medical Center — A LifeBridge Health Center
- Levindale — A LifeBridge Health Center
- Northwest Hospital — A LifeBridge Health Center
- Sinai Hospital — A LifeBridge Health Center

POST-ACUTE CARE

- Atlee Hill Skilled Nursing & Rehabilitation Center — A LifeBridge Health Partner
- FutureCare — A LifeBridge Health Partner
- avila home care — A LifeBridge Health Partner
- HomeCare Maryland — A LifeBridge Health Partner
- Baker Rehab Group — A LifeBridge Health Partner
- Levindale — A LifeBridge Health Center
- BridgingLife — Compassionate care for life's transitions
- PAPP Post-Acute Physician Partners
- LifeBridge Health Population Health

AMBULATORY SERVICES

- LifeBridge Health The Krieger Eye Institute
- LifeBridge Health Medical Group
- LifeBridge Health Outpatient Pharmacies at Sinai Hospital and Northwest Hospital
- LifeBridge Health Physical Therapy in collaboration with NovaCare Rehabilitation
- Carroll Occupational Health — Affiliated with Carroll Hospital Center
- LifeBridge Health & Fitness
- Nation's — Home Medical Equipment; Infusion at Home
- RadNet (Advanced Radiology)
- The SurgiCenter of Baltimore — A LifeBridge Health Partner

Additional Partners:

- Carroll County Digestive Disease Center
- Davita Carroll County Dialysis
- Ellicott City Ambulatory Surgery Center

HelloBrave by LifeBridge Health

URGENT CARE & TRANSPORTATION

- ExpressCare — A LifeBridge Health Partner — Urgent Care Centers
- Children's Urgent Care Pediatric Specialists
- Pulse Medical Transportation

SENIOR LIVING

- Springwell Senior Living Community — a LifeBridge Health Partner

PUBLIC HEALTH & COMMUNITY SERVICE

- A LifeBridge Health Group Center for Hope
- West Baltimore Renaissance Foundation
- Living Well @ the J
- VSP — A LifeBridge Health Partner
- The Family Tree
- #StrongerHearts — LifeBridge Health | American Heart Association. Life is Why

Inpatient Trends

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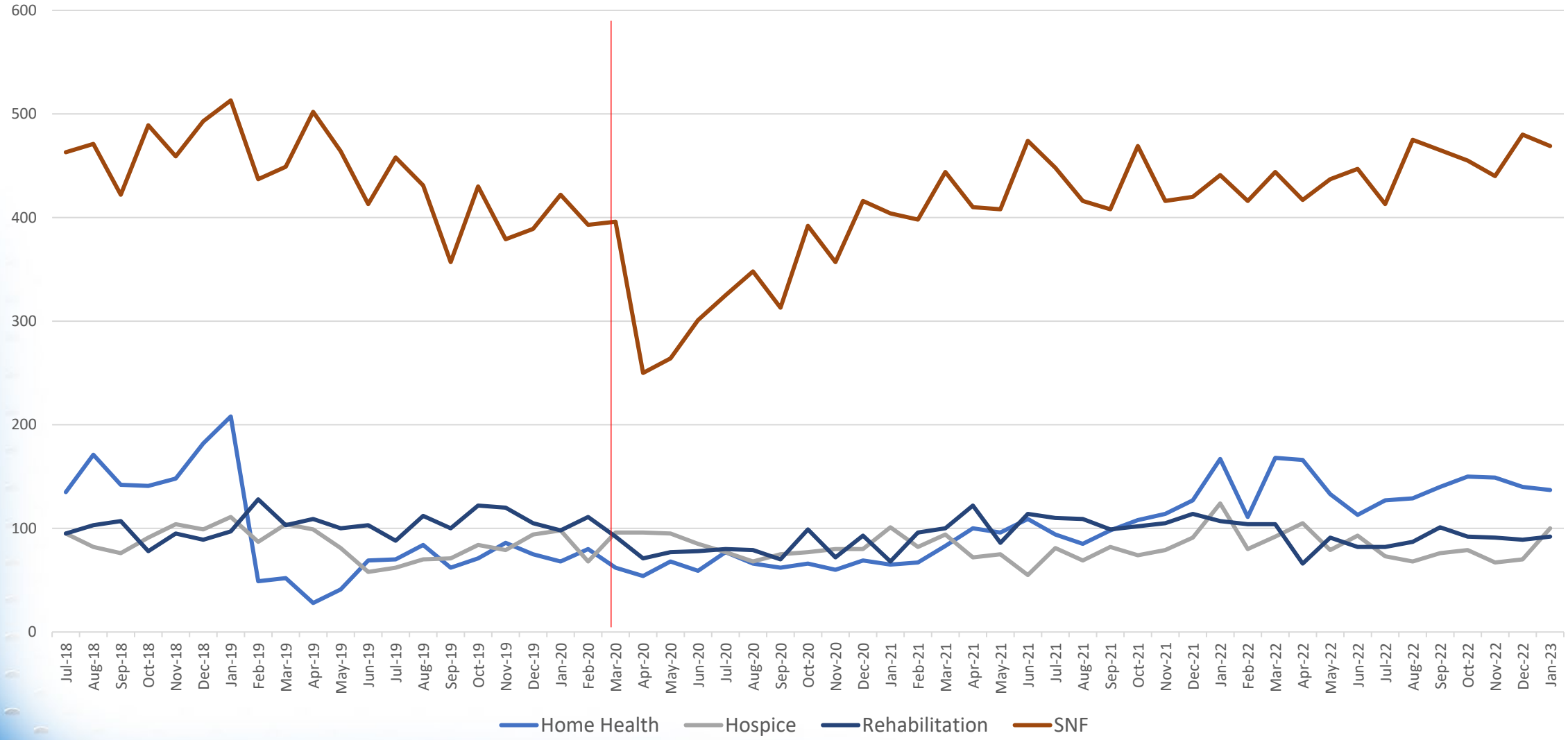
Inpatient Discharge Volume to Post-Acute Care - Carroll, NW, Sinai



Source: BRG Drive Analytics

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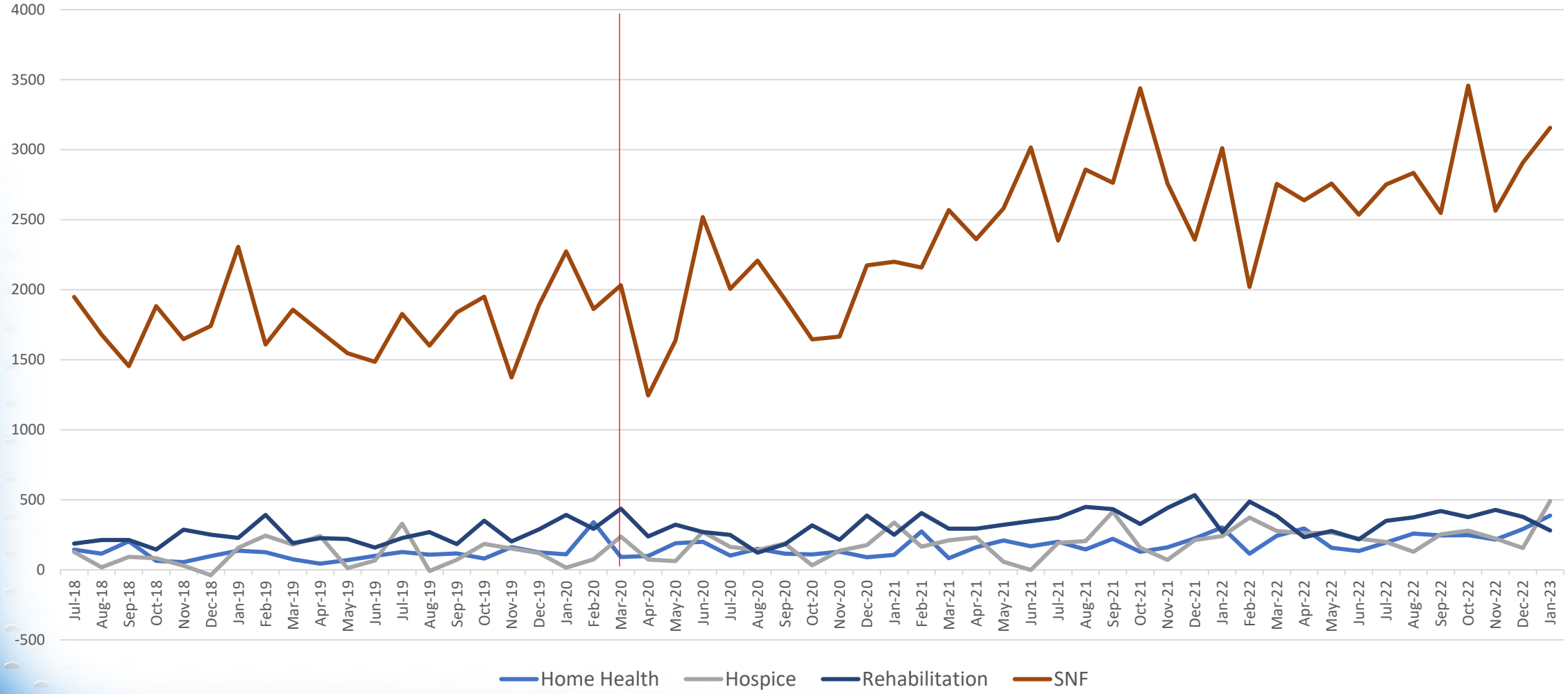
Inpatient Total Excess Days per Month by DC Disposition
Carroll, NW, Sinai



Source: BRG Drive Analytics

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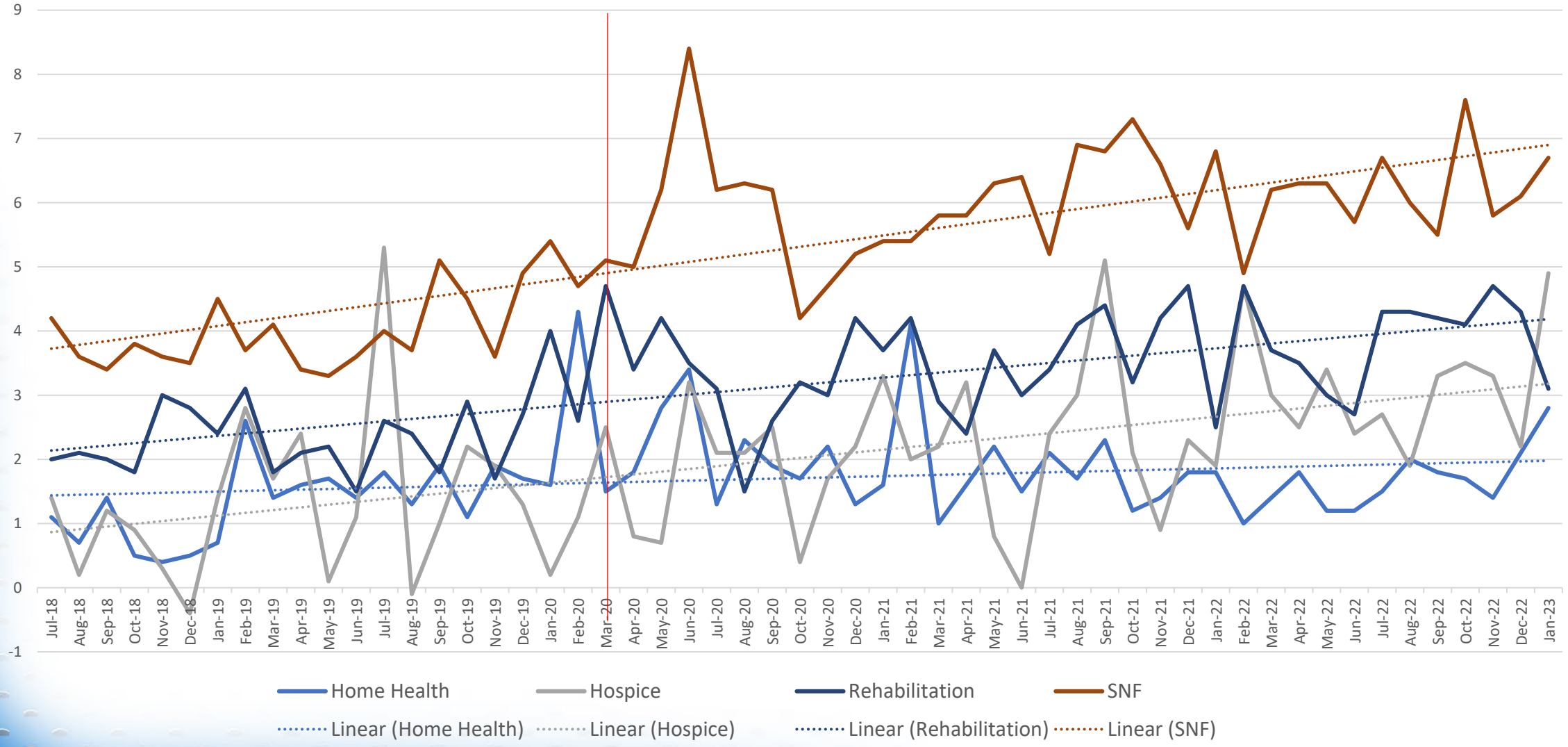
Inpatient Excess Days per Discharge Disposition - Carroll, NW, Sinai



Source: BRG Drive Analytics

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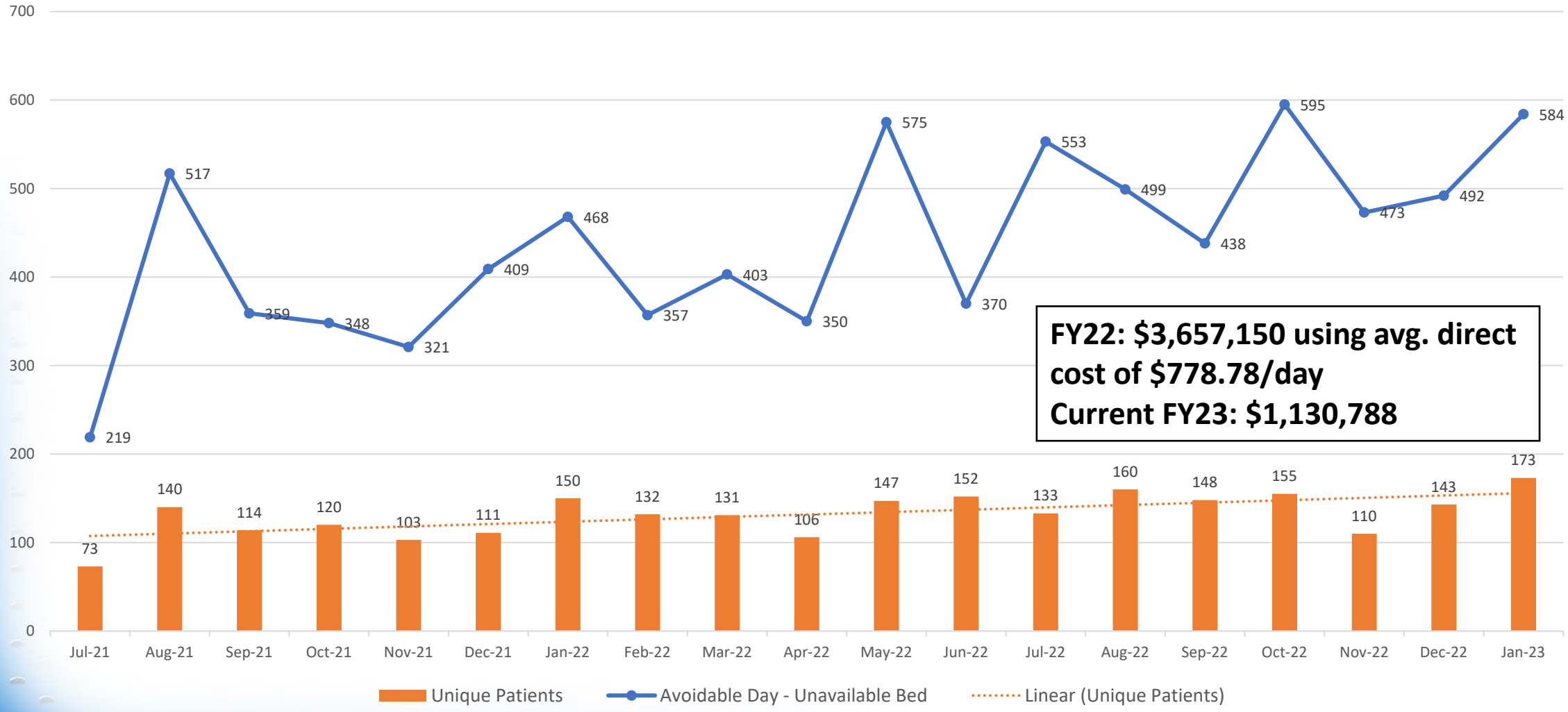
Avoidable Days - Unavailable Bed
Carroll, Northwest, Sinai



FY22: $3,657,150 using avg. direct cost of $778.78/day
Current FY23: $1,130,788

Source: Cerner UM Data

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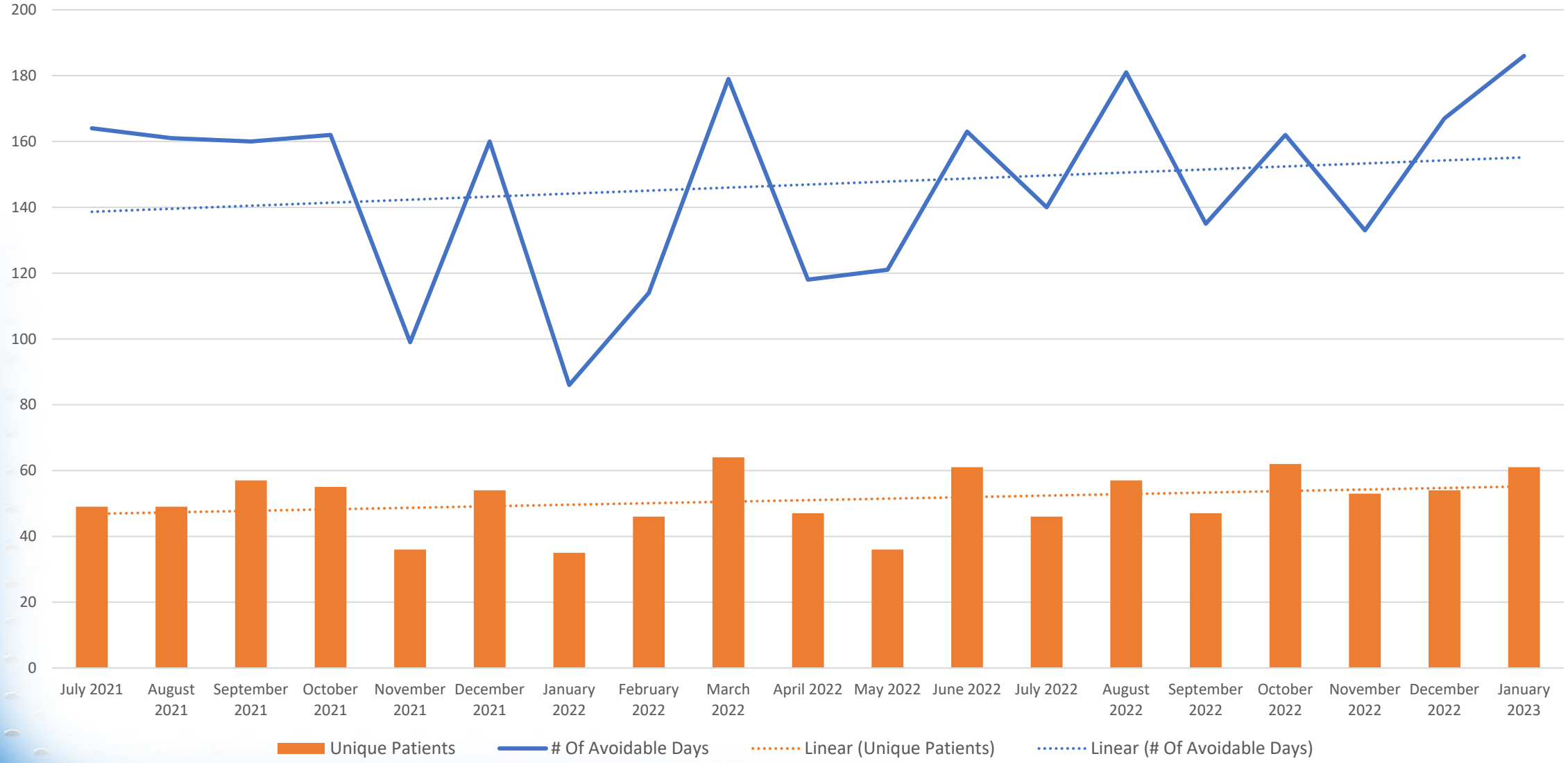
Avoidable Days – SNF Insurance Authorization



Source: Cerner UM Data

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PAC Initiatives

Previous

- Readmissions – Project RED, ED process, ED Handoff sheet
- Chronic Disease Pathways
- Data capture; Working toward narrowed network
- ECIP

Current

- **Post Acute Collaborative**
  - Calls twice a week to discuss difficult discharges
    - Remove barriers to get patients accepted
  - Readmission calls weekly to review opportunities for improvement
  - Monthly data on referrals, timeliness, LOS, quality to collaborative
- **Transitional Care Team**
  - Nurse Care Coordinators following high risk patients to facilities
  - Collaborate with facility team
  - Support transitions of care to and from facility

PAC Initiatives

- **Levindale**
  - Patients transferred from Sinai inpatient due to lack of accepting facility/placement
- **Biofourmis**
  - Remote patient monitoring platform; piloting with early discharge from hospital; PAC implications
- **Community Care Coordination Teams**
  - 10 to 20% of case load are facility patients
- **HomeCare Maryland- Hospital requested visits**
  - Single Case Agreements – other agencies refused
  - Dr. Ravi – Providing PCP services to sign 485
- **BridgingLife**
  - Palliative Care program development with FutureCare
- **Community Health Needs Assessment Support**

Observations in Process Improvement Efforts/Challenging Discharges

- Data gaps
- Instability of ownership/leadership
- Staffing of all disciplines
- Lack of geri-psych/memory care beds and treatment
  - Facility perception: ED/Hospital = easier geri-psych placement
  - The facilities that do “step up” often have the lowest CMS star ratings
- Infection Control/Isolation practices
- Lack of weekend accepting practices/resources
- SNF readmission reviews
  - Large majority are at the end of life
- “The Undesirable” placements

Future Engagement

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Engagement for Future Models

- **SNFs and ALFs engage in hospital efficiency measures**
  - Unnecessary ED utilization
  - Readmissions
  - Avoidable Days/Length of Stay
- **Be part of the same payor system or better align**
  - Same playing field
- **“Cherry Picking”**
  - CMI and social determinants of health should count for facilities willing to take higher acuity and complexity
- **Aging in Place/PACE**
  - Many families realize in the process HHC is not 24/7 and don’t have the ability to care give, but would prefer the patient be home
- **Palliative Care services and Hospice in facilities**
  - Need to address palliative payment model and Hospice room and board charges
- **People caught in the financial “gap”**

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