Transitions of Care

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Leading Edge Health Care, LLC

Tools to Reduce Readmissions

- Skilled Home Health Services (VNA)
- Private Duty Home Health
- Housecalls Physician Practice
- R.E.A.C.H. Program
  - Social Work Field Unit
  - Readmission Analysis Team
- Telemedicine Heart Failure Monitoring Technology
- Medication at Bedside Pre-discharge Delivery Service
- ED Readmission Prevention Case Managers
- Spiritual Care Home Volunteers
- Specialized Transition Action Team (STAT)
- E-discharge Readmission Tracking Software

Goals for Transitional Services

- Reduce preventable hospitalization
- Prevent hospital re-admissions
- Improve health outcomes
- Improve efficiency of care
- Reduce the cost of health care services
- Improve patient satisfaction
- Enhance Patient-First Culture
- Partner with community resources and other healthcare providers in a collaborative approach dedicated to improved patient outcomes

Costs to Hospitals

- Patient dissatisfaction
- Re-hospitalization risk and potential delays in discharge (average cost per day $1,500)
  - Average Length of Stay (LOS) 3-5 days
- Anticipated reductions in Medicare reimbursement related to re-hospitalizations within 30 days for certain DRG's.
- Increased costs of post-acute care

Healthcare Transition and Coordination Challenges

- Poor patient Home Environment.
- Insufficient family/friend support structure.
- Primary Care Physicians (PCP) rarely follow patients during an acute care hospitalization.
- Patients are largely unaware of what a Hospitalist is and how their care is coordinated while in the acute care setting.
- Hospitalists have difficulty coordinating and communicating with PCP.
- Hospitalists and PCP are oftentimes unaware of medications ordered by other physician specialists involved with patients care.

Healthcare Transition and Coordination Challenges *(cont.)*

- Large number of patients without insurance or limited financial resources.
- Challenges with timely follow up and coordination with PCP and specialists.
- Patient non-compliance issues with treatment follow up.
- Lack of available community resources.
- Failure of patients to follow up with physician visits or outpatient services after discharge.
- Failure of patient to secure prescription medication post discharge due to lack of financial resources or non-compliance.

Home Health
Skilled Services

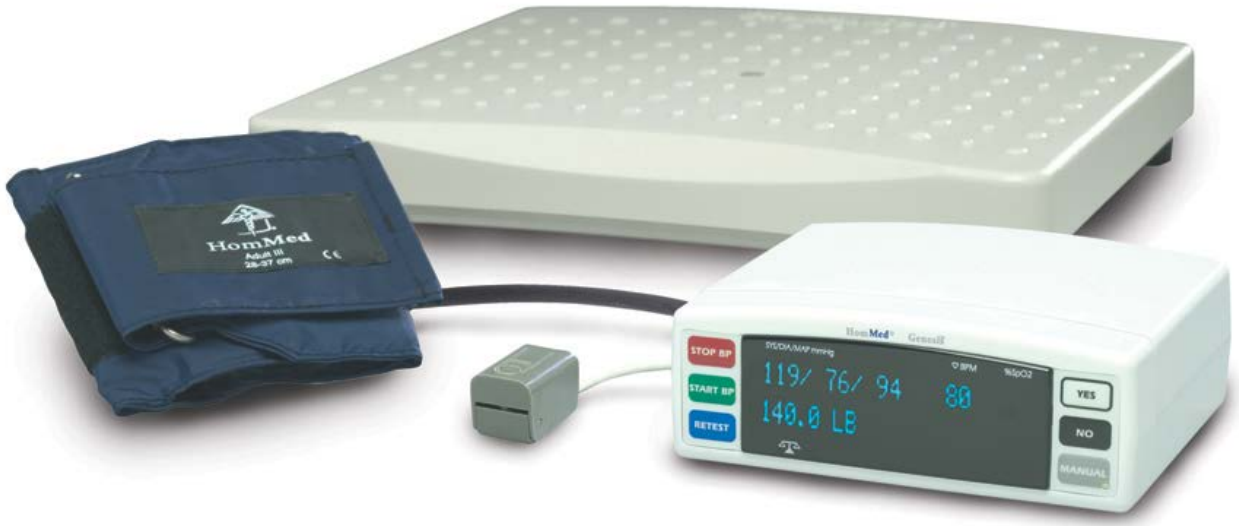
- Requires Physician Order.
- Patient must be considered "Homebound" to qualify for Skilled Services (considerable and taxing effort).
- Patient must require a skilled intervention that requires a licensed nurse or therapist to deliver services.
- Medicare covers above services (no co-pay currently).
- Insurance covers services (usually with co-pay).

Home Health
Non-Skilled

- No Physician Order required.
- Mostly home health aide services provided, rarely a skilled nurse or therapist.
- Homebound is not an issue, custodial care can be provided.
- Mostly private pay, no coverage by Medicare and limited coverage by Private Insurance and Medicaid.

Telemedicine / Telemonitoring

- Most Telemedicine / Telemonitoring consists of equipment to monitor weight, blood pressure, pulse, oxygen levels & blood sugars.



LEH Housecalls Program

- Program designed to serve as a bridge between Hospitalist and patients Primary Care Physician (PCP).
- Improves hospital discharge plan compliancy.
- Generally improves patient outcomes and care coordination.
- High level of patient and physician satisfaction.
- May be used long-term for homebound patients.

Medication Availability & Compliancy

- **Challenges**
  - Patient discharge delayed due to lack of resources for medications
  - Lack of insurance coverage & underinsured
  - After hours discharges
  - Compliancy issues
  - Lack of follow-up

- **Bedside Delivery (Pharmacy Partnerships)**
  - Medications delivered at bedside pre-discharge provides high level of patient satisfaction and reduces risk of re-hospitalization.

Discharge Support Services and Challenges

- Between seven million and ten million spent annually.
- Patient placements in SNF and ALF
- Homeless population compliancy
- Dialysis Services
- Medical supplies
- Increases in charity care as government services reduced.
- Significant increase in under-insured patients
- Durable Medical Equipment needs
- Miscellaneous costs, air ambulance, specialized equipment, etc.

R.E.A.C.H. Team

- R.E.A.C.H. represents Readmission Advocates Collaborating in Healthcare.
- Integrates the efforts of the Readmission Analysis and Field Support programs.
- Comprised of nurses, social workers, and case management technicians.
- Specially trained Nurses and Social Workers that interview patients re-hospitalized within 30 days to determine likely causes of re-admission.

R.E.A.C.H. Team

(cont.)

- R.E.A.C.H. strives to reduce the likelihood of readmissions by encouraging patients to utilize available community resources.
- Provides high level of patient and physician satisfaction.
- Pilot partnership between Health Care Providers and graduate MSW students.

STAT (Specialized Transition Action Team)

- **Challenges:**
  Develop creative interventions to reduce patient length of stay and reduce risk of re-hospitalization through comprehensive discharge planning.

- **Goal:**
  Quantify effectiveness of interventions, reduce length of stay and reduce risk of re-hospitalization and improve patient/family satisfaction.

- **Team Consists of:**
  - Administrator Transition Services
  - Corporate Manager Post-Acute Care
  - Corporate Manager Case Management
  - Discharge Support Manager
  - Physician Champions
  - Patient Business Representative
  - Regional Manager Home Health, Housecalls
  - Risk Manager
  - Spiritual Care / Hospice advisor
  - Field Unit Coordinator

ED Case Managers

- RN's stationed in hospital ED that are highly trained in utilization review and discharge planning interventions including comprehensive understanding of post acute care resources.
- Works with ED personnel to educate them on Transition Services programs available to prevent unnecessary admissions and potential re-admissions.

Spiritual Care & Volunteer Services

- Provides spiritual support as needed with access to many chaplains of various faiths.
- Coordinates Home Volunteers as identified by Discharge Team on behalf of Transition Services.

Tele-Housecalls

TELE-HOUSECALLS

BRING THE DOCTOR TO YOU

Tele-Housecalls features:

- *A nurse will come directly to your home, hotel or business*
- *A physician will assess your illness and will take appropriate action through the wonders of Telemedicine Technology*
- *Prescription delivered directly to your door*
- *All clinicians professionally screened and background checked*

When you feel the worst, you don't have to leave the comfort of your home, ***healthcare comes to you!***

"The patient will see you now doctor!"

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Any Questions?