CASE STUDY:
Building a Coordinated, Multidisciplinary Approach to Transitional Care

HealthPRO Client:

- 200+ dually certified beds
  - Short term: 60 beds,
  - Assisted living: 52 beds
  - Independent living: 115 units
- June 2015: Change from primary LTC to STR focus
- Marketplace: Highly competitive; two large hospital networks; significant managed care penetration
- Strategic Plan: Prioritize care redesign for post acute population
- HealthPRO implemented clinical pathway interdisciplinary taskforce

This community is now:

The #1 provider-of-choice for local hospital (BCPI, Model 2)

The #2 state-ranked provider for Regional managed care organization

HealthPRO® REHABILITATION

Care Redesign

Within 1st month of our partnership, HealthPRO established a "Clinical Pathway Interdisciplinary Taskforce." Under HealthPRO's guidance, this multi-disciplinary team developed a tangible **cross-continuum care coordination process** inclusive of:

- **Mandatory Credentialing Process for Physicians** to ensure timely interventions, adherence to established clinical pathways & consistent, interdisciplinary communication.
- **Multi-Disciplinary Admission Process** to ensure immediate review & evaluation of residents' conditions/needs & discharge plans.
- **Daily Rounds** for all short-term rehab patients.
- **Seven Multi-Disciplinary Clinical Pathways** in collaboration with Remedy Partners, local University Hospital (BPCI Model 2)
- **Risk Assessment Process using the** that identifies risk factors for re-admission.
- **Weekly Utilization Review** on all hospital BPCI patients with representatives from hospital, home health, physician
- **Follow-up After Discharge** to ensure safety, services in place and ongoing communication, to mitigate transitions back to skilled nursing versus to acute care.

Care Redesign

- Systems for improved tracking & analyzing of key clinical, functional& performance outcome measures.

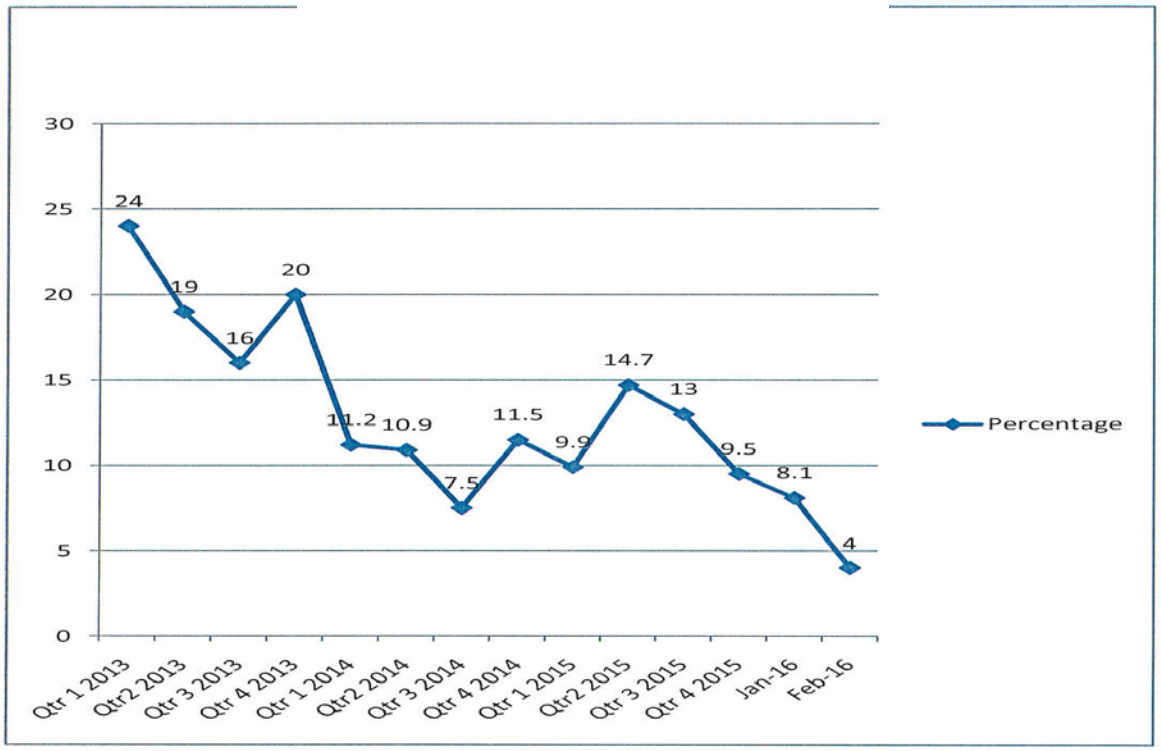
- Use of HealthPRO's proprietary Healthmax documentation and outcomes EMR was vital part of the process.

- HealthPRO committed to having the Therapy Team play an integral part in the culture change by playing an active role in the tactics listed above.

Impressive Results!

- Reduced Readmission Rate from 24 percent for the three months ended March 31, 2013, (“First Quarter 2013”) to 9.5 percent for the three months ended December 31, 2015, (“Fourth Quarter 2015”).
- Reduced average length of short-term rehabilitation stay from 28 days for the month of January 2015 to 15 days for the month of March 2016.
- Informed in February 2016 by local hospital and Remedy Partners
- : Ranked number one out of 20 regional skilled nursing facilities in BPCI Program SNF Performance Operational Metrics.
- Was selected in March 2016 as one of eight Preferred Providers by the local hospital network.

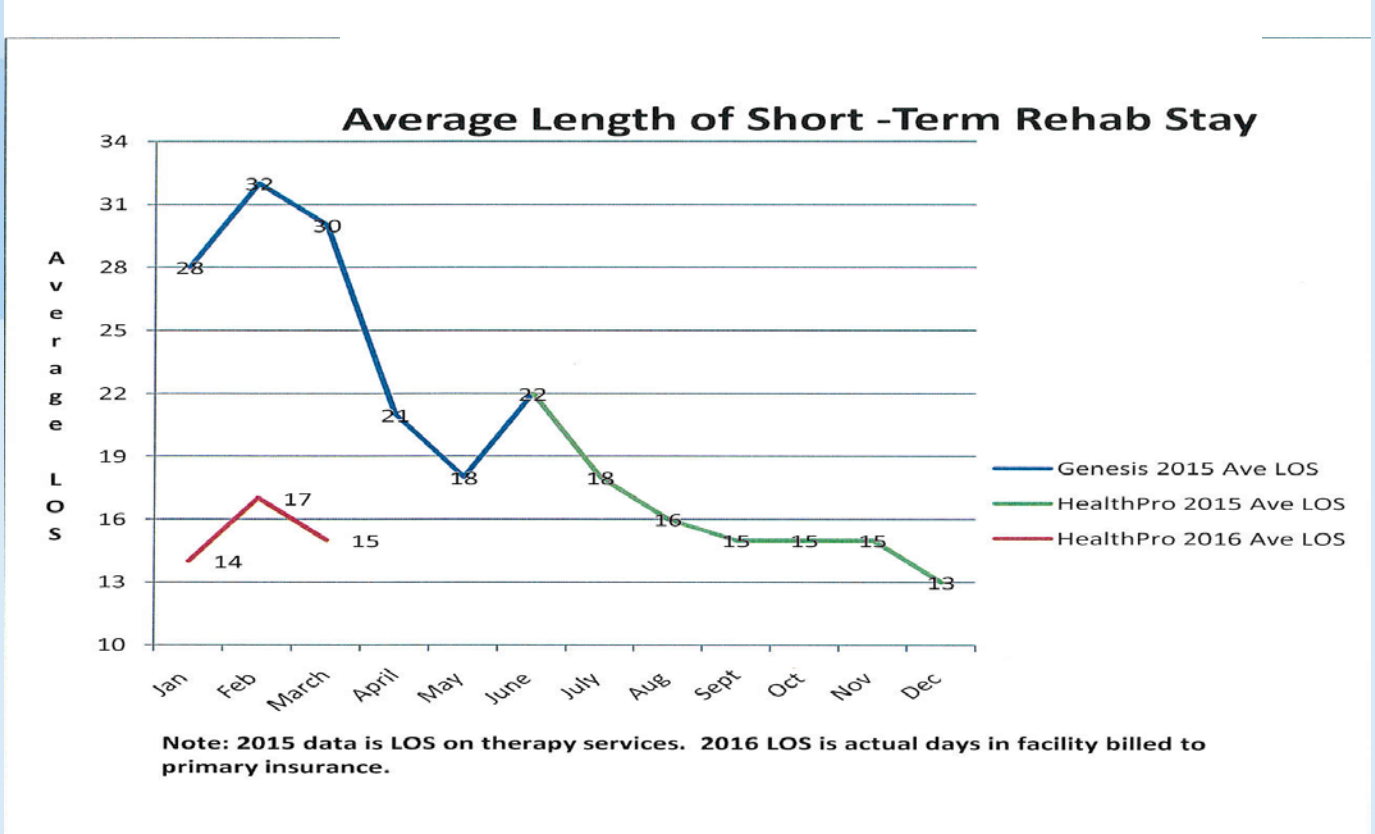
30 Day Readmission Rate



Non-risk adjusted re-admission rate acute discharges from the hospital to the SNF that readmitted to the hospital directly from the SNF within 30 days from the acute discharge.

*2nd and 3rd Qrt of 2015 % was skewed by a few Long term care residents with multiple re-hospitalizations. Either resident or family insisted on re-hospitalization despite facility and physician efforts to educate them that their needs could be met at facility.

Length of Stay



Note: 2015 data is LOS on therapy services. 2016 LOS is actual days in facility billed to primary insurance.