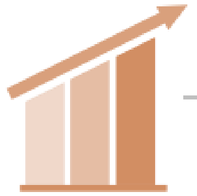
Advanced Care at Home

Kaiser Permanente
Advanced Care at Home Program

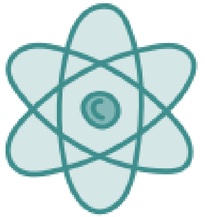
November 7, 2021

Multiple catalysts for a compelling opportunity

- The volume of patients who require acute care is growing



- On average, patients are older and have more diverse needs



- Hospitals can be capacity-constrained, unsafe, unpleasant

- Patients expect services on-demand and the technology exists

- We need to create capacity and capability without raising cost

The model: high-quality acute care at home

VIRTUAL HUB

The face of care + the brain that drives

- Sets and organizes care plan
- Monitors and connects with patient
- MD, PA, RN, Logistics Coordinator

SAFE WORKFLOWS

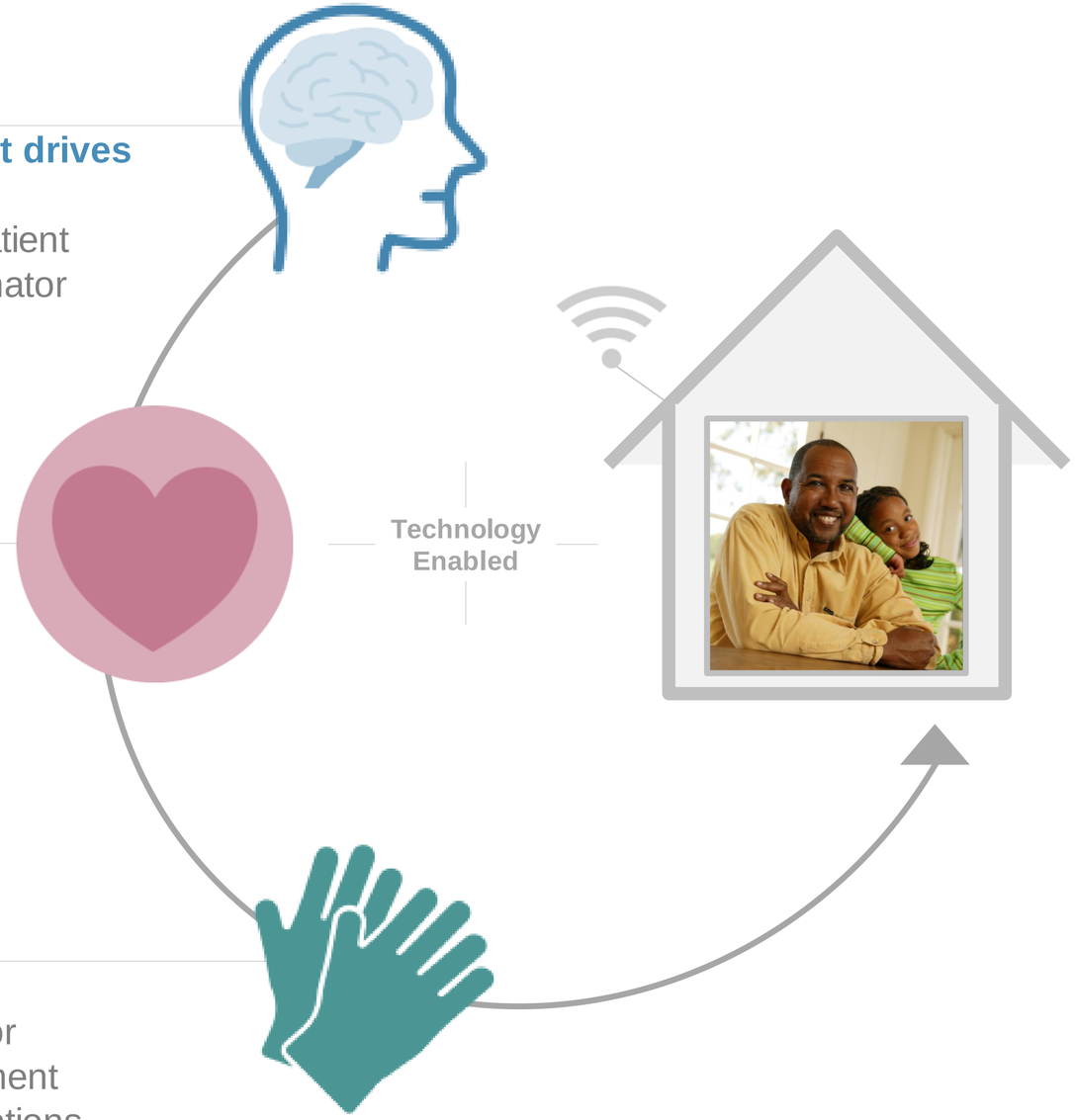
The heartbeat throughout

- Responsive, personalized care that prioritizes safety at every step

FIELD SERVICES

The hands that deliver

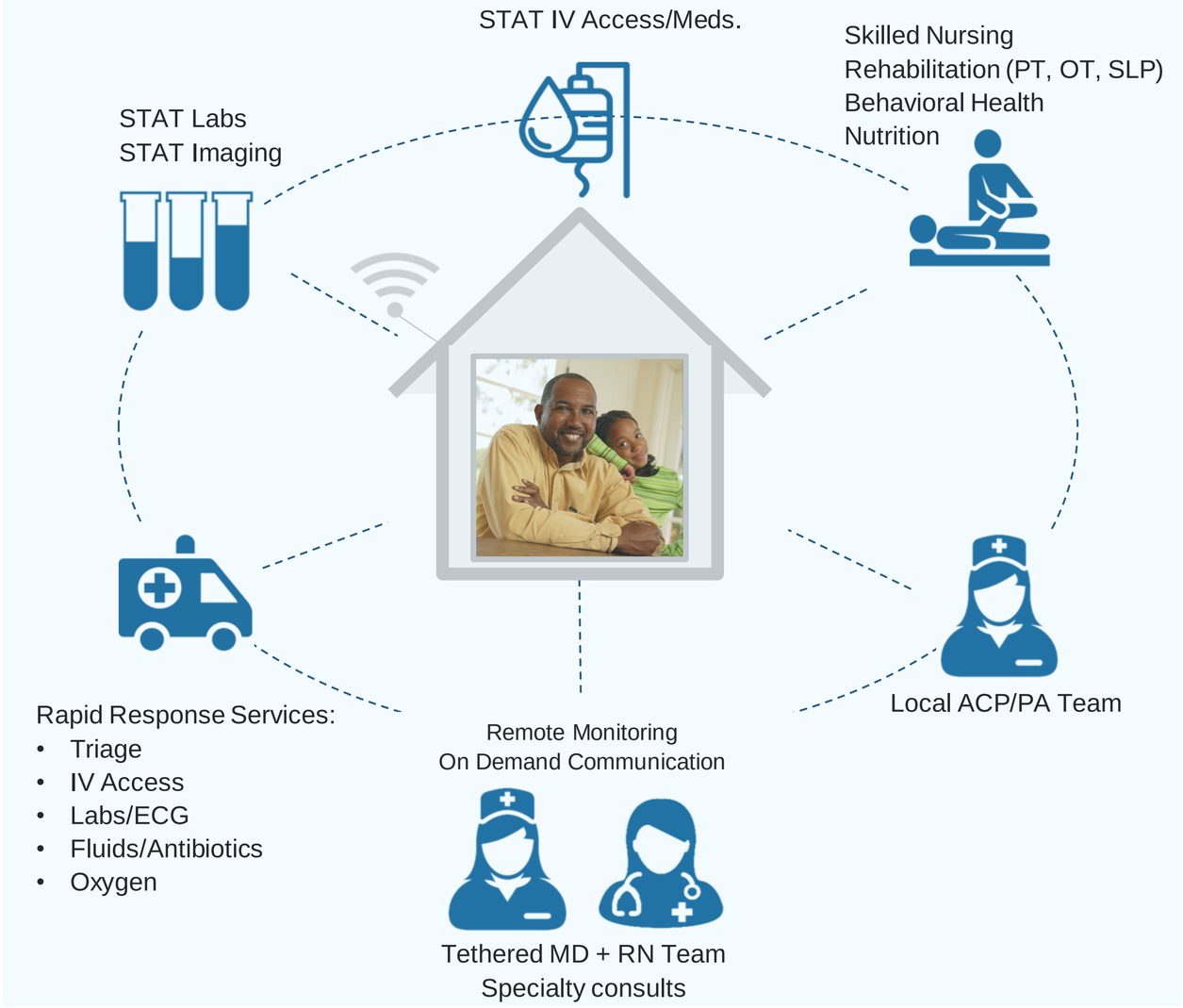
- A network of responsive vendor services, supplies, and equipment
- Skilled nursing, PT/OT, medications, DME, meals



Advanced Care at Home In Home Hospital Unit

Patient Referral to KP ACAH

- ✓ Qualifying DRG
- ✓ Meet Inpatient Criteria
- ✓ Clinical Stability Screen
- ✓ Social Stability Screen



Integration w/PCP

- ✓ Full recovery from medical episode
- ✓ New stable baseline

Replicating the capabilities of a brick-and-mortar hospital with in-home services.

Kaiser Permanente Advanced Care at Home

- 1,100+ patients to date
- Admits from ED and early hospital discharge
- Medicare & Commercial Payors
- 2 hubs: Portland, Northern California
- Urban/Suburban locales
- Acute + Restorative Phases of Care

<u>Early Outcomes Data</u>

- 0 sentinel events
- 0 mortality
- 1 HAI
- 9.2% 30 day readmission rate
- 6.7% 7 day return to care
- 4.9/5 average daily patient satisfaction

ADVANCED CARE at Home COALITION

Educating

Educating policymakers about the benefits and importance of advanced care at home services in today's health care landscape

Protecting

Protecting and extending current flexibilities beyond the COVID-19 PHE

Expanding

Expanding upon these flexibilities through the creation of a CMS Innovation Center model

- **14 Member Organizations**
- **Extension of flexibilities for advanced care services at home beyond the duration of the COVID-19 Public Health Emergency**
- **Creation of a Centers for Medicare and Medicaid Services Innovation Center model to test an advanced care at home delivery model**

Patient Story

Patient was a retired firefighter. He had been driving to his family's annual mountain get away when he developed septic shock from a leg cellulitis.

Patient Details:

- 64 yo male with severe obesity, a significant leg edema with chronic venous stasis, and recently uncontrolled diabetes (A1c from 6 to 10 in one year)
- Admitted after developing septic shock from a leg cellulitis
- Was just off pressors for 36 hours when admitted to ACAH from inpatient unit

Patient Course (6-day length of stay):

Patient Progress

- Patient status improved over acute phase.
- Team provided education on diastolic heart failure, lymphedema treatment (had leg edema since age 20), and diabetes management.
- Improved diabetes and blood sugars prior to discharge.
- Patient able to join his family on their annual mountain getaway.

Care Provided in the Home

- IV Ceftriaxone and IV Lasix daily
- Started on blood pressure medications and insulin
- Continuous engagement with nursing team and reminders—got patient into the habit of checking blood sugars daily.

Patient Feedback:

- Patient said he had never had this much time with his doctors face to face and been given so much education and empowerment regarding his health conditions

Thank you!

Henry Ford @ Home

AMA - IPPS

November 7, 2021

all for you

The Dawning of a New Era?

Can Mount Sinai be serious? The answer is a resounding yes. In fact, we couldn't be more serious.

Mount Sinai's number one mission is to keep people out of the hospital. We're focused on population health management, as opposed to the traditional fee-for-service medicine. So instead of receiving care that's isolated and intermittent, patients receive care that's continuous and coordinated, much of it outside of the traditional hospital setting.

Thus the tremendous emphasis on wellness programs designed to help people stop smoking, lose weight and battle obesity, lower their blood pressure and reduce the risk of a heart attack. By being as proactive as possible, patients can better maintain their health and avoid disease.

Our Mobile Acute Care Team will treat patients at home who would otherwise require a hospital admission for certain conditions. The core team involves physicians, nurse practitioners, registered nurses, social workers, community paramedics, care coaches, physical therapists, occupational therapists, speech therapists, and home health aides.

Meanwhile, Mount Sinai's Preventable Admissions Care Team provides transitional care services to patients at high risk for readmission. After a comprehensive bedside assessment, social workers partner with patients, family caregivers and healthcare providers to identify known risks such as problems with medication management and provide continuing support after discharge.

It's a sweeping change in the way that health care is delivered. And with the new system comes a new way to measure success. The number of empty beds.

1-800-MD-SINAI
mountsinai.org/myhealth

Mount Sinai

IF OUR BEDS

ARE FILLED,

IT MEANS WE'VE FAILED.

HFHS Pursues Hospital at Home Program

- Population demographic shifts
- Value based care opportunity
- FFS financial opportunity
- Patient satisfaction
- Higher quality / better outcomes

“If we had a drug with that kind of outcome — if hospital-at-home were a drug and not a service delivery model — we would all be sitting on beaches in the Caymans counting our money,”

Dr. Bruce Leff

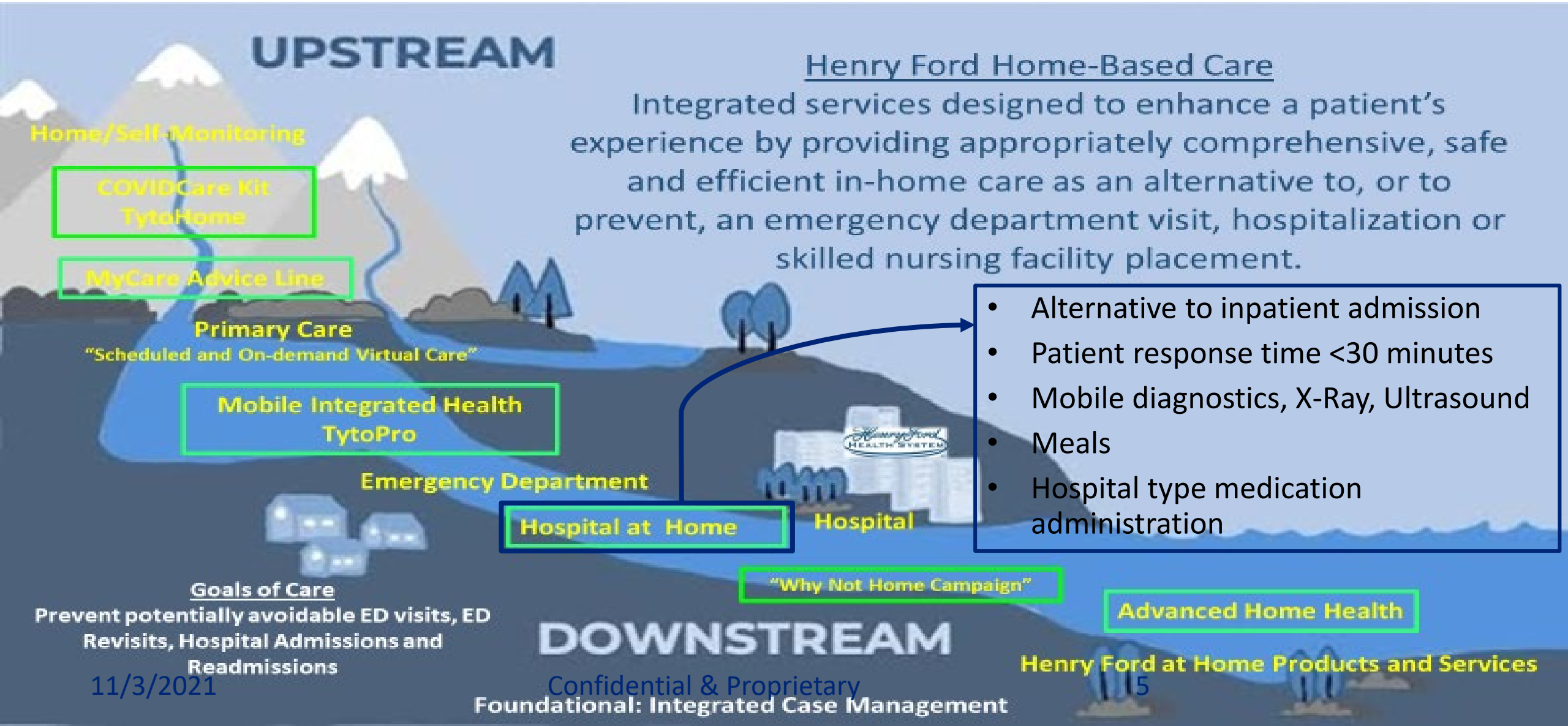
Johns Hopkins Center for Transformative Geriatric Research

Evidence-Based Care

Proof of concept: "Association of a Bundled Hospital at Home and 30-Day Post-acute Transitional Care program with Clinical Outcomes and Patient Experience" **JAMA Intern Med**. 2018: 178 (8): 1033-1040

Mt. Sinai Results	Hospital at Home	Inpatient Care
Number of patients	295	212
Patients eligible for H@H program	Approximately 10%	
Percent of patients accepting H@H	50%	
Patient Characteristics	Older, more functional impairment	
LOS	3.2 days	5.5 days
Readmission rate	8.6%	15.6%
ED return rate	5.8%	11.7%
SNF admission	1.7%	10.4%
Pt satisfaction high rating	68.8%	45.3%
Cost	*Not addressed in this case control study but others have shown lower costs due to shorter LOS and lower SNF utilization*	
Other	Higher ratings for communication, pain control	

Where does H@H fit in the Continuum of Henry Ford@Home?



“Build vs. Buy” Factors

- **“Buy” Options –** evolving market with many options: Joint Venture / Vendor / Co-Development Partner

- **Speed to Market:** Extensive infrastructure for home based care but limited capital/staffing bandwidth to launch a transformative project like H@H

- **Market Dynamics** – No established program in SEM in spite of ongoing efforts among multiple health system competitors. Suggests “high degree of difficulty”.

- **Capability** – Internal expertise exists as “fragments of knowledge” across multitudes of people. Implementation complexity is a major obstacle with need to draw subject matter experts from contracting/pop. health/IT/UM/rev cycle/clinicians/complex care/home care.

- **Scalability** - Are there services/resources available from a JV partner/Vendor to facilitate spread

Joint Venture Implementation

- **Contracting/Reimbursement:** Start with our own, provider sponsored health plan (HAP)

- **Patient Selection:** Small target population, establish proof of concept, build in reliability, insure absolute safety

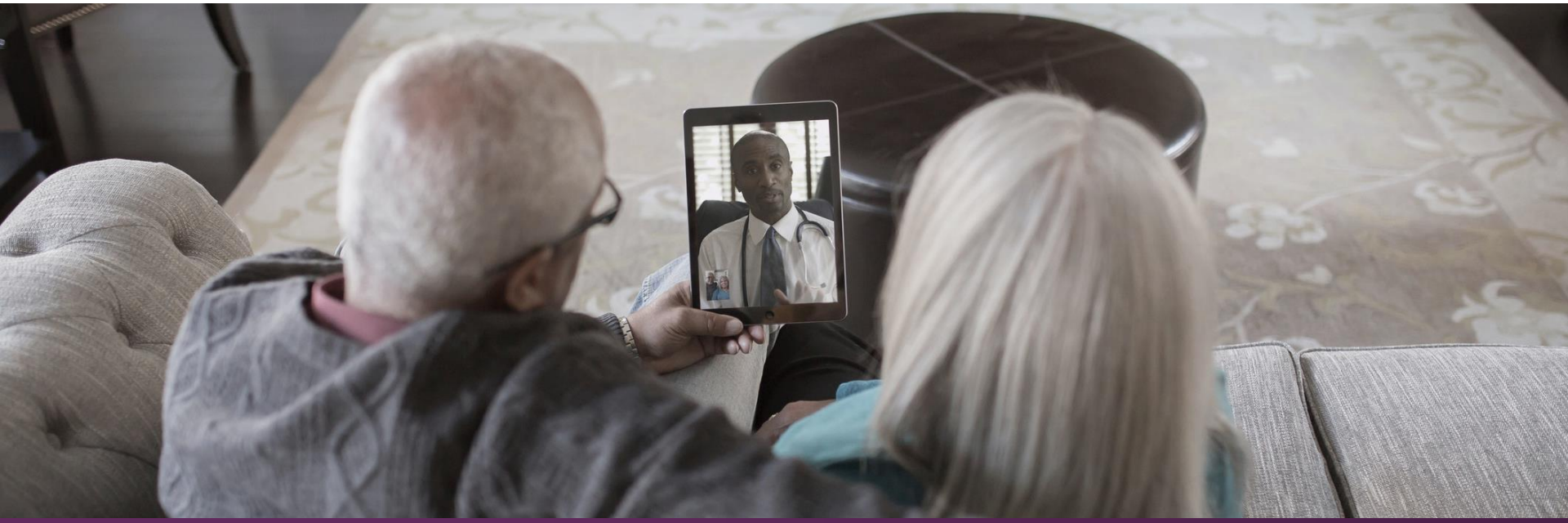
- **Management System:** Dedicated team, leverage existing expertise, JV board oversight, C-suite support

- **Physician Engagement/Inclusion:** Deploy vision, create inclusive model (pluralistic, team based) communicate results, build consensus

- **Integrated System Implications:** understand impact on hospital volumes, capital needs, staffing and redeployment, financial incentives

CONTESSA

HOME RECOVERY CARE



Contessa Overview

Prepared for Integrated Physician Practice Section (IPPS)
November 21, 2021

Hospital-at-Home Programs Have Proven Results But Have Failed to Scale

The clinical model has produced strong quality outcomes but has not scaled, largely due to the lack of a sustainable reimbursement model

Early Adopters

Johns Hopkins Medicine – The Johns Hopkins Hospital
Advocate Health Care
Partners HealthCare
Presbyterian
Marshfield Clinic Health System
VA
Mount Sinai

Mt. Sinai Research Study Results[1]

- Length of Stay ↓
- 30-Day Readmission Rate ↓
- ED Visit Rate ↓
- Transfers to SNF ↓
- Patient Satisfaction ↑

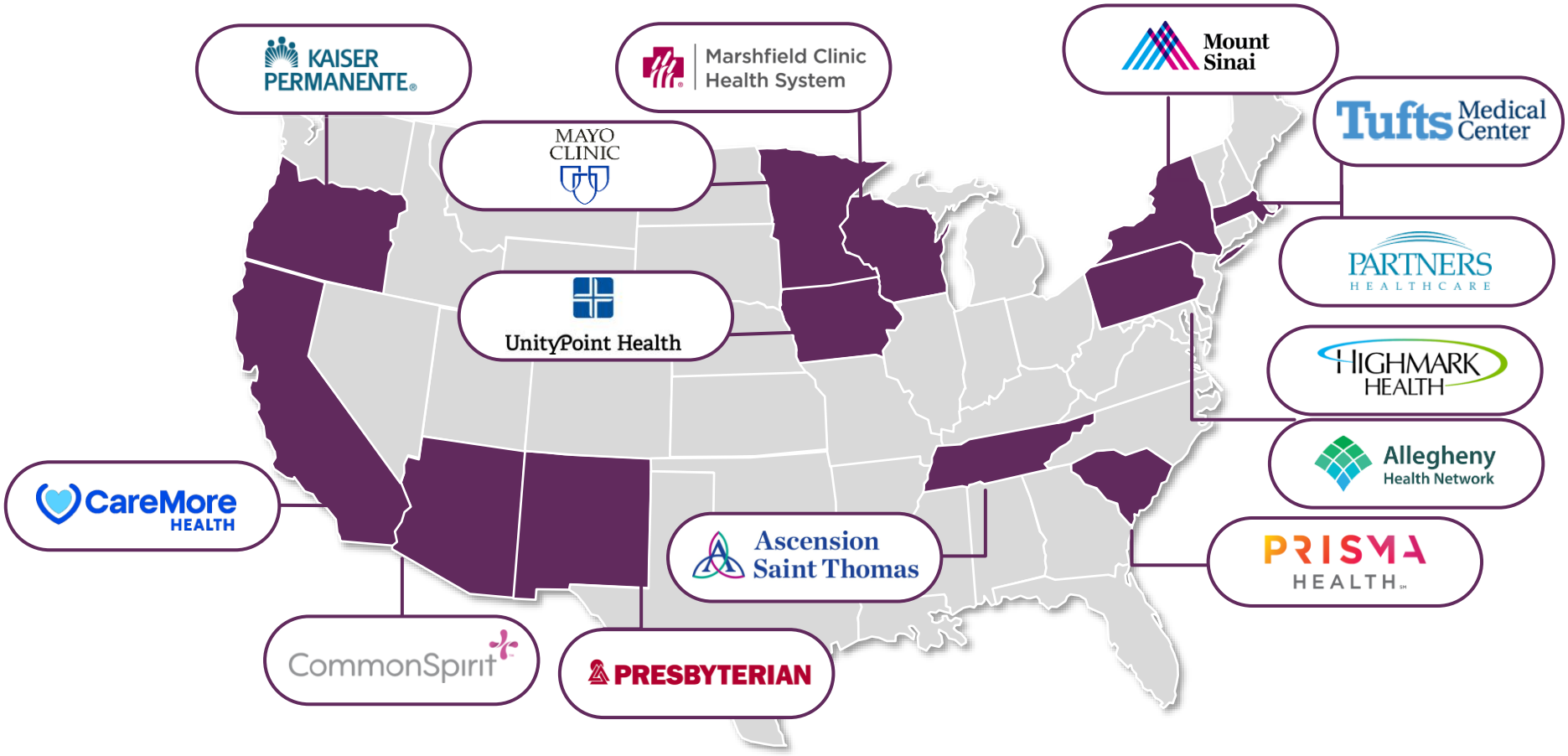
Previous Scalability Challenges

1. No use of telehealth
2. No form of reimbursement
3. No incentive for health systems to adopt if not at capacity or at risk
4. Limited number of addressable conditions
5. Inability to appropriately document

(1) Source: JAMA Internal Medicine – Association of a Bundled Hospital-at-Home and 30-Day Postacute Transitional Care Program With Clinical Outcomes and Patient Experiences.

Pre-Public Health Emergency in March 2020, Health Systems with Vast Geographic Footprint were Offering H@H Programs

Existing operators of Home Hospitalization programs had varying degrees of programs before the onset of the public health emergency



Home Hospitalization Programs Operating pre-PHE

CMS Announced the *Acute Hospital Care at Home* Program to Reimburse for Hospital at Home Services

Significant momentum has been demonstrated for hospital at home on the heels of the CMS waiver initiative with applicants operating 350+ acute care hospitals across the U.S.[1]

Health Systems Offering Hospital at Home

Marshfield Clinic Health System
GUNDERSEN HEALTH SYSTEM
Henry Ford Health System
CommonSpirit
Allegheny Health Network
Ascension Saint Thomas
PRISMA HEALTH
Mount Sinai
MICHIGAN MEDICINE UNIVERSITY OF MICHIGAN
Claiborne Memorial Medical Center
Mercy
VANDERBILT HEALTH
Cleveland Clinic
Stillwater Medical
Atrium Health
St. Bernards HEALTHCARE
Adventist Health
NORMAN REGIONAL Health System
Allina Health
OSF HEALTHCARE
Northwell Health
MultiCare
Northwestern Medicine Feinberg School of Medicine
PROMEDICA
MAYO CLINIC
BaylorScott&White HEALTH
SENTARA
HEALTH UNIVERSITY OF UTAH

CONTESSA

Current Contessa Health Hospital @ Home Partners

Other Hospital @ Home Operators

dispatch HEALTH
Medically Home

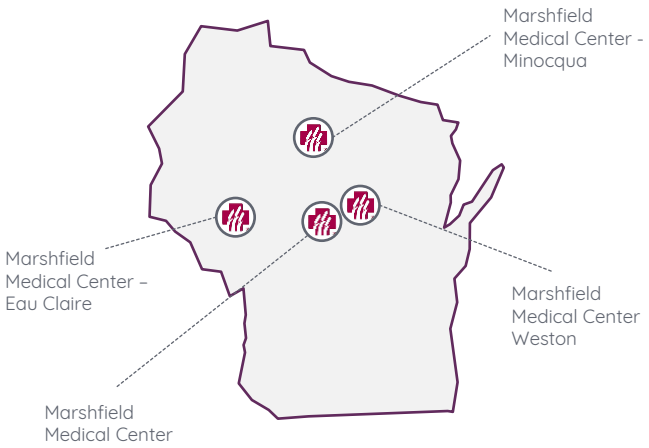
Provider Operated Hospital @ Home

Trinity Health
UnityPoint Health
PRESBYTERIAN

(1) Source: The American Hospital Directory (AHD)
(2) Source: Hospital@Home: The Future of H/C Brings Tailwinds for Hospitals & Home Health, Jefferies LLC

Current Hospital at Home Program Operations – Marshfield Clinic in Wisconsin

Marshfield Clinic | Home Recovery Care



Current Program Sites

2016 Program operations began in 2016

4 Currently operational at four admitting sites across the state of Wisconsin

Became the first to market with risk-based contracting with Medicare Advantage health plans

Contessa filled desire to have an operating partner for hospital at home program

Currently treat patients in multiple home care pathways including hospital @ home and SNF @ home

Partnership has demonstrated sustained success in a rural market

Hospital at Home Policy, Regulatory, and Managed Care Considerations

Considerable attention must be paid to create sustainable programs that are compliant with current regulatory standards, ultimately shaping future policy initiatives

Considerations

Licensure Requirements (Acute Care COPs vs. Physician-Based)

Reimbursement Structure (Site of Service has Statutory implications)

Managed Care / State Provider Accreditation (Nursing services in home)