Integration of Care Services: Partnering With Places People Call Home

Thursday, March 8, 2018
11:15 AM – 12:30 PM
Dallas Ballroom E
Panelists

Anthony D’Alonzo  
BAYADA Home Health Care

Daniel Fagan  
National Church Residences

Hilary Forman  
HealthPRO Heritage

David McHarg  
Inspirit Senior Living

Maria Nadelstumph  
Brandywine Living

Rich Tinsley  
Stoneridge Partners
Audience Poll Question #1

Please Identify Your Professional Category:

1. SH Operator/Provider
2. SNF Operator/Provider
3. Both SH and SNF Operator/Provider
4. Non-Real Estate-Based Care or Service Provider
5. Health System or Insurer
6. Equity Investor or Debt Provider
About BRANDYWINE...

29 COMMUNITIES
6 STATES
OVER 3,000 RESIDENTS SERVED
BUILDING A Successful PARTNERSHIP... Lessons Learned

1. Find the Right Partner
2. Educate on Assisted Living as “Home”
3. Define the Scope of Services
4. Market The Partnership: Tell The “Story”
5. Track Quality Outcomes
Anthony D’Alonzo
BAYADA Home Health Care
About BAYADA Home Health Care

- 9 Specialty Service Lines
- 330 offices in 22 States
- Over 25,000 Home Health Care professionals (field and office)
- Over 31,000 clients served per week
- Over 4,000 clients reside in senior living settings across 13 states
Integrated Care in Action: Brandywine Living

Brandywine 9.6%

Six Locations with Integrated Care Model

National Rate* 12.5%

294 Admissions 114 ADC

Avg. Readmission Cost** $17,500

Health System Savings $157,500

*Strategic Healthcare Programs, 30-Day Readmission, 2017; shpdata.com
**Avalere Health, Readmission Market Average, 2017; avalere.com
What Does Integrated Care Look Like?

“Integrated Care” Provider

- Coordinated Services
- Dedicated Team
- Innovative Care Design
- Custom Analytics and Reporting

“Transactional” Provider

- Transactional Care Delivery
- Staff on Demand
- Routine Service
- Unknown Effectiveness
Poll Question #2

Please Choose One of The Following:

1) My Company is Beginning to Think about the Partnering Process

2) My Company is Currently Pursuing a Formal Business Relationship with a Non-Real Estate-Based Provider of Care

3) My Company is Currently Pursuing a Formal Business Relationship with a Real Estate-Based Provider of Care

4) My Company is Currently Engaged In a Formal Business Relationship with a Non-Real Estate-Based Provider of Care And Beginning to Collect Outcomes Data

5) My Company is Currently Engaged In a Formal Business Relationship with a Real Estate-Based Provider of Care and Beginning to Collect Outcomes Data
NATIONAL CHURCH RESIDENCES

- 309 Senior Apartment Communities / 20,129 units
- 4 Assisted Living Conversion Program (ALCP) Communities / 168 units
- 15 Family Housing Communities / 1,757 units
- 10 Permanent Supportive Housing Communities / 785 units
- 9 Residential Health Care communities
- 23 Home and Community Services Agencies / serving 2,844 clients
- 3 Adult Day Centers / 200 clients
HOME FOR LIFE™

with a Health System
Overall Spend for care was reduced by 15% leading to a reduction of $874,775.00
*The readmission rate was decreased by 57.5%*
NEW MODEL OF PROACTIVE RESIDENT ENGAGEMENT

ENHANCED SERVICE COORDINATION

YTD Resident Engagement
n=44,605 residents

<table>
<thead>
<tr>
<th>Month</th>
<th># Residents</th>
<th>Engagement Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr</td>
<td>34,674</td>
<td>83%</td>
</tr>
<tr>
<td>May</td>
<td>35,249</td>
<td>83%</td>
</tr>
<tr>
<td>Jun</td>
<td>35,816</td>
<td>83%</td>
</tr>
<tr>
<td>Jul</td>
<td>36,292</td>
<td>83%</td>
</tr>
<tr>
<td>Aug</td>
<td>36,730</td>
<td>83%</td>
</tr>
<tr>
<td>Sep</td>
<td>37,121</td>
<td>83%</td>
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</tbody>
</table>
A CARE MANAGEMENT TOOL FOR ASSESSING RESIDENT NEEDS

CARE GUIDE
A CARE MANAGEMENT TOOL FOR ASSESSING RESIDENT NEEDS

Severe VES 2015
n=1,025 Severely Vulnerable Residents

Severe VES 2016
n=1,410 Severely Vulnerable Residents

Severe VES 2017 YTD
n=1,828 Severely Vulnerable Residents

Chronic Conditions 2015
n=13,286 residents with one or more diagnosis

Chronic Conditions 2016
n=17,091 residents with one or more diagnosis

Chronic Conditions 2017 YTD
n=17,285 residents with one or more diagnosis

CARE GUIDE
This Preferred Provider Agreement ("Agreement") is entered into and effective as of ____________, 20___ (Effective Date) by and between ___________________________ ("Preferred Provider"), located at ________________, and ___________________________ ("Facility"), located at ________________ (each a “Party” and collectively, the “Parties”).

In consideration of the mutual promises and covenants hereinafter contained and for other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, Facility and Preferred Provider hereby agree as follows:

1. **Intent of the Parties.** Preferred Provider operates an organization that provides personal and/or health care services to individuals and Facility is a housing provider that provides housing to certain low-income individuals. High-quality personal and health care services are essential for the well-being of Facility’s residents ("Residents"), who tend to face challenges such as low income, lack of family support, poor health, and chronic illnesses. As such, Facility desires to enter into a collaborative relationship with Preferred Provider, who will be designated as a preferred provider of ________________ services at ________________.

232 Preferred Providers Agreements in Place
The Power of Therapy Services Across the Continuum

HOME HEALTH
- Subcontracting options
- Needs of higher acuity patients
- Transition planning

OUTPATIENT
- Direct admits or patients from home health
- Preventative or high acuity services to address QMs

WELLNESS
- Preventative & maintenance therapy for risk areas
- Annual assessments to prevent decline
- Group & individual services

HOSPICE
- Quality-of-life-based services
- Education & training for family members

☑️ Track Outcomes
☑️ Prevent Re-Hospitalization
☑️ Progress Quality Measures
Developing a “Virtual Care Continuum”
Case Study: Stand Alone SL Community Brightview of Paramus (New Jersey)

Strategy
Fortify partnerships with vetted upstream & downstream providers

Therapy Services as the “Glue”
Same therapists at all levels = dedicated team to:
- Advocate consistency
- Optimal care delivery

Care Innovation
Option for SNF stay (lieu of rehospitalization)
Temporary discharge from SNF to Brightview before return to home

Census Trend
- February 2017: 75
- January 2018: 98.3

Preserve Census
Accountable to Resident Care
Timely & Safe Transitions
Hold "Preferred Partners" Accountable
Implementing a Partnership Approach

*Case Study: FP System (Large Portfolio of CCRCs) Sunrise Senior Living*

**Leverage outcomes…**
ALOS, Rehospitalization, Functional Metrics, Episodic Costs

**With network partners…**
Regional Hospitals, Conveners & Referral Sources

...To fortify ongoing alliances & ensure network inclusion.

Therapy Services as the “Glue”

- Care Innovation
- Right to a “seat at the table” based on proven success
- Quality service delivery *at all levels* & manage performance metrics

Get a Seat at the Table!

- Care Innovation
- Outcomes
- Collaboration

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**Care Innovation + Fiscal Strategy**

<table>
<thead>
<tr>
<th></th>
<th>SNF Versus Assisted Living Cost Comparison</th>
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</thead>
<tbody>
<tr>
<td>Room &amp; Board</td>
<td>SNF $117/day</td>
</tr>
<tr>
<td>Out-Patient Services</td>
<td>Assisted Living $138/day</td>
</tr>
<tr>
<td>Average Total Cost</td>
<td>SNF $6,762</td>
</tr>
<tr>
<td></td>
<td>Assisted Living $3,561</td>
</tr>
<tr>
<td></td>
<td>Assisted Living &amp; Home Health Services $5,628</td>
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</tbody>
</table>

Based on 14 Day LOS

Home Health $285/day

Assisted Living + Home Health Services
## From Then to Now

<table>
<thead>
<tr>
<th></th>
<th>Beds</th>
<th>Community</th>
<th>Employees</th>
<th>Revenue</th>
<th>Regional TM’s</th>
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<tbody>
<tr>
<td>One Year Ago</td>
<td>96</td>
<td>1</td>
<td>65</td>
<td>$2.6M</td>
<td>3</td>
</tr>
<tr>
<td>Now</td>
<td>485</td>
<td>6</td>
<td>340</td>
<td>$18.8M</td>
<td>7</td>
</tr>
<tr>
<td>Projected 2018</td>
<td>605</td>
<td>8+</td>
<td>~500</td>
<td>$22M</td>
<td>10+</td>
</tr>
</tbody>
</table>
ACUITY ANNUAL REVENUE $3.3M

(30% margin @ 8.5 cap)
53% of total value creation is attributable to acuity revenue

$11.64MM VALUE
7.6% INCREASE OCCUPANCY
58% INCREASE LOC REVENUE
39% VALUE CREATION (1 YR POST)
ACQUISITION COST: $56MM
STABILIZED VALUE: $78MM

85% ROOM RENTAL
15% ACUITY

Annual Revenue $22.0MM

THE OPPORTUNITY
CHOOSING THE RIGHT PARTNER - REHAB

- Experts in managing Rising Resident Acuity
- Experts in Geriatric Rehabilitation
- Strong interdisciplinary communicators with Nursing and our teams

OPTIMAL AGING

MEDICAL WELLNESS

FUNCTIONAL WELLNESS

SPIRITUAL WELLNESS

Michelle C. Odden, PhD, William Jen Hoe Koh, PhD, Alice M. Arnold, PhD, Bruce M. Psaty, MD, PhD, and Anne B. Newman, MD, MPH. “Health and Functional Status of Adults Aged 90 Years in the United States.” JAMA Internal Medicine, 20 March 2017, online.

- **TIMED UP & GO TEST**: 21%
- **CHAIR RISE TEST**: 25%
- **30-SECOND SIT-TO-STAND TEST**: 51%
- **BERG BALANCE SCALE**: 13%
- **PATIENT SPECIFIC FUNCTIONAL SCALE**: 73%

**TEST SIGNIFICANCE**
- Proven Test used to measure level of dependence, frailty, mobility and balance
- Proven test used to measure risk for falls, strength, and frailty
- Proven test used to measure risk for falls, strength, and frailty
- Comprehensive assessment of overall fall risk
- Proven test used to measure change in key items such as quality of life, functional ability and pain

*Figures are based on percentage of improvement*
Audience Questions

Please Take a Few Minutes to Complete Today’s Session Evaluation
Integration of Care Services: Partnering with Places People Call Home

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