SALUDE
THE ART OF RECOVERY

Guardian Home Health
an AccentCare® Company

A Post-Acute Care Model of Excellence:

The "Transitionist" Home Health Collaborative Model

Health systems and physicians are being held increasingly accountable for patient outcomes… outside the four walls of their facilities and offices. Hospital re-admission penalties and risk-sharing models such as the Centers for Medicare & Medicaid Services' bundled payments initiative and insurance plans' population health incentives create demand for better integration across the continuum of care to help improve clinical outcomes and patient experience while reducing costs.

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The Post-Acute Care Transition Challenge

Coordination across post-acute settings remains a challenge for our health care system. Lack of coordination often results in incomplete transfer of information, medication discrepancies, and patients and families who are unprepared for care setting transition.

Among older adults who are discharged from hospitalization to skilled nursing facilities (SNFs) for short stays, **22% require additional emergency department or hospital care within 30 days** of returning home.[1]

The Centers for Medicare & Medicaid Services (CMS) has identified studies which partnered healthcare providers to reduce re-hospitalization rates. Their results suggest that better coordination across the care continuum is beneficial for outcomes, as well as cost reduction related to avoidance of unplanned re-hospitalization.

Medicare cites a study demonstrating that when care coordination was utilized, the patients receiving such care had a lower hospitalization rate (15%), compared to the rate within the control group (20%). Similarly, in a CMS Care Transitions project, home health providers that employed specific strategies to care for patients (front-loading visits, identifying patients at highest risk, providing education and medication reconciliation), achieved a 4% absolute reduction in re-hospitalization rate. In yet another study in which a care transitions coordinator provided coaching, physician appointment scheduling, and patient/caregiver education, re-hospitalization rates decreased from 17% to 12%.[2]

Despite this trend toward integration across the care continuum,

only 7% of organizations' surveyed respondents call their patient care experience 'fully coordinated' between the inpatient, post-acute, and home settings.[3]

Vision for Collaboration

Salude, a preeminent transitional care and physical recovery facility in Atlanta, Georgia, opened in July of 2014 to deliver a unique upscale care experience in a state-of-the-art environment. Under the direction of Dr. Alan L. Wang, MD, SFHM, FACP and Chief Executive Officer, Salude supports recoveries from surgeries, trauma, acute exacerbations of chronic illness, infections, and other acute medical issues with a commitment to creating a positive in-patient experience while at Salude, as well as an equally outstanding and seamless experience during and after transition to home.

Guardian Home Health, an innovative home healthcare company, adept at serving complex patients, collaborates with Salude to ensure patient transitions are seamlessly integrated and well-aligned with the facility's model of care, thereby extending Salude's line of sight into the home.

In 2017, utilizing a "transitionist" clinical model and navigator service program in partnership with Guardian Home Health, 96% of Salude patients successfully completed their recoveries at home.

The success of this approach is credited to Salude's clinically integrated oversight, combined with Guardian Home Health's excellent patient outcomes reflected in its 4.5-star quality rating.[4]

Together the two organizations established the following as principles for the program:

- Emphasis on high quality, trust, and transparency
- Effective communication and sharing of complete and relevant patient information
- Creation of supporting care coordination protocols and processes
- Fostering of team relationships among clinicians, patients, and family caregivers
- Holistic and transparent approach to performance and outcome metrics
- Escalation protocols and processes to effectively manage any exacerbation in the home quickly and efficiently

Model of Care

The clinical integration design uses comprehensive communication during the patient's transition home to help eliminate confusion about condition, determine appropriate care, avoid medication errors, and prevent lack of follow-through on referrals. A Salude Nurse Practitioner (NP) and Medical Social Worker meet with the patient and family on the day of discharge to conduct a review of medications/medication reconciliation, ensure outpatient medical appointments are in place, and confirm that necessary home preparations are made. The NP makes an appointment to visit the patient at home within one week for the initial transitional care visit.

The Guardian Home Health Account Executive and Clinical Liaison work closely with Salude's social worker/discharge planner and the NP prior to the patient's discharge. Guardian Home Health's Clinical Liaison is a dedicated on-site resource, acting as the single point of contact to coordinate care with the Salude Transitionist Clinical Team. The Clinical Liaison streamlines the communication process to provide greater insight into the patient's ongoing clinical status, as well as the ability to more swiftly address a change in condition with real-time coordination with Salude's NP. This reduces time in addressing critical needs such as lab draws and medication changes that may help to avoid an Emergency Department visit.

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Clinical integration includes comprehensive communication and real-time coordination to help ensure positive outcomes.

Model of Care Overview

The integrated Salude and Guardian Home Health teams create a seamless, connected, and coordinated care continuum, including connection with primary care and facility-based care resources.

Core integration points include:

- Guardian Home Health's on-site Clinical Liaison, working directly with the Salude clinical team
- Admission to care within 24 hours of discharge
- Front-loading of multi-disciplinary visits
- Assistance with transition to help ensure preparation of the home environment prior to discharge including available medical equipment, arranged services, and the alleviation of any home safety concerns
- Educational resources for patients and families regarding the home care benefit
- Coordination and communication between Guardian Home Health and Salude's Transitionist Clinical Team for 60 days post discharge
- Monthly partnership meetings as well as other opportunities to review service delivery, clinical outcomes, patient/family/staff satisfaction, and other facets of model optimization
- Monitoring of at-risk patients for return to Salude for care when appropriate

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1 Patient Discharge Planning

Social Worker
- All patients have discharge planning meeting
- Prepares for completion "face-to-face" at discharge to transition to home health

Nurse Practitioner
Meets patient and family on day of discharge and communicates with patient's PCP and/or specialist physicians
- Conducts review of medications with reconciliation
- Ensures outpatient MD appointments
- Makes appointment to visit patient within one week for transitional care at patient's home

Dedicated Onsite Clinical Liaison
- Onsite at Salude working directly with social worker and home visit NP
- Preparation for discharge and coordination for IV, DME, etc.
- Facilities planning home service

Transition to Home

2 Coordinated Care at Home

Nurse Practitioner
- NP home visit within one week for transitional care visit
- NP assists additional orders needed
- Triaging and management of complex cases

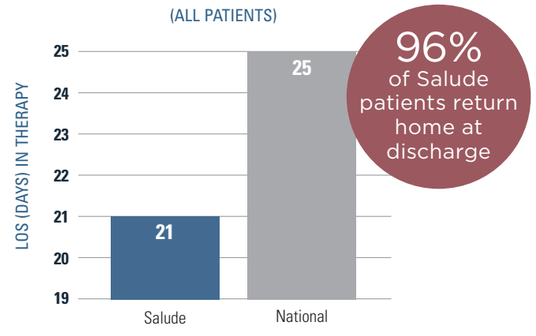
Home Health Team
- Admit to care within 24 hours
- Coordination with NPs in the management of patient care
- Individualized patient care plans
- Front-loading multi-disciplinary visits
- Proprietary RightPath® disease management and Palliative Care programs
- Tele-monitoring
- Weekly chart reviews
- Check-in calls
- Alert your Nurse® Zone Tool

Industry Leading Outcomes

Salude's composite patient satisfaction scores ranked 94% to 99% in 2017. Currently, with an average length of stay of only 21 days, Salude patients experience almost 11 percentage points greater improvement in Rehabilitation Outcome Measures. Over 96% of their patients return to a home setting at final discharge, and Salude's overall re-hospitalization rate for all patients is 11%.

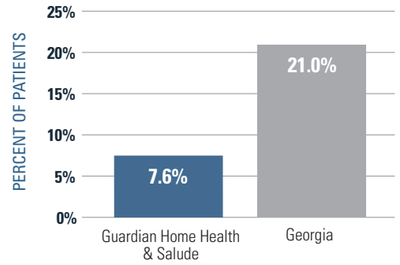
The 194 Salude patients admitted to Guardian Home Health's care from January 2018 through September 2018 had a 30 day re-hospitalization rate trending at only 7.6%[5] compared to Georgia's state average of 21%[6]. In addition, the emergency department utilization rate while on home health was 1.3%, compared to average rates of 3.1% in Georgia and 4.0% nationally.[7]

LENGTH OF STAY (LOS) IN THERAPY
(ALL PATIENTS)

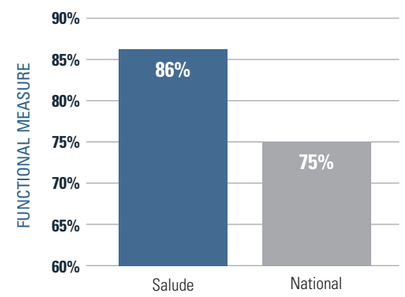


Data from Salude 2017

30 DAY RE-HOSPITALIZATION RATE

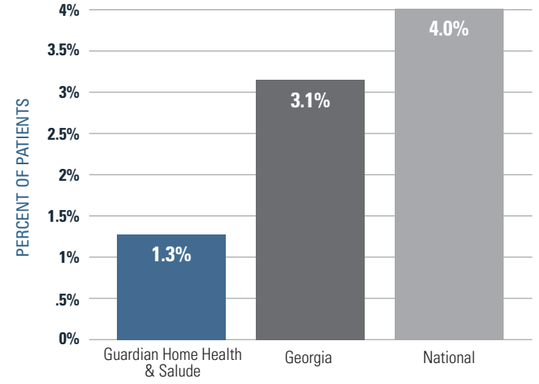


REHABILITATIVE OUTCOMES AT DISCHARGE
(ALL PATIENTS)



Data from Salude 2017

PATIENTS' ED UTILIZATION RATES



RESOURCES

1. Mark Toles, Cathleen Colón-Emeric, Mary D. Naylor, Julie Barroso and Ruth A. Anderson (2016). Transitional care in skilled nursing facilities: a multiple case study. BMC Health Services Research, 1-2.
2. Home Health Claims-Based Re-hospitalization Measures Technical Report: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIQualityMeasures.html Jan 2017
3. Amy Compton-Phillips, MD & Namita Seth Mohta, MD (2016). Care Redesign Survey: Strengthening the Post-Acute Care Connection. NEJM Catalyst Insights Council
4. Centers of Medicare & Medicaid. January 2019. Claims data for 1/1/2017-12/31/17 and end-of-care OASIS assessments 4/1/17-3/31/18.
5. Salude and AccentCare's Outcome Data – Jan through August 2018. Data reflects the combined percentage of patients that were readmitted within 30 days of the hospital discharge date while on service with Salude and Guardian Home Health.
6. Percentage of short-stay residents who were re-hospitalized after a nursing home admission. CMS Nursing Home Compare: https://www.medicare.gov/nursinghomecompare/search.html
7. SHP ER Visits percentage - 2018 through September

SALUDE

Salude is a preeminent healthcare facility in Atlanta, Georgia, opened in July of 2014 to be the first-of-a-kind transitional care and physical recovery facility supporting recoveries from surgeries, trauma, acute exacerbations of chronic illness, infections, and other acute medical issues. It was designed and built with a focus on addressing every facet of a holistic and exceptional patient experience including clinical excellence as well as top-of-the-line hospitality. Salude takes a team-based patient- and family-centered approach, offering upscale cuisine that nourishes the body and promotes healing, superb rehabilitation services with state-of-the-art equipment, and individualized privacy to nurture the recovery process.

In a serene setting with stunning views and 64 all-private suites with over 330 square feet of space, chef-prepared cuisine, complimentary WiFi, and on-site concierge services, Salude is one-of-a-kind.

Additionally, the Salude's rehabilitation programs are supported by such appointments as an Aegis Therapies® in a 3,000 square foot state-of-the-art gym open seven days a week and an AlixaRx™ automated dispensing unit for medications.

Salude has a full-time Chief Executive Officer and Medical Director as well as three primary care groups, an infectious disease physician, a physiatrist (rehabilitation physician) and a wound care nurse on staff. Nurse practitioners are available seven days a week and community nurse practitioners are available for home visits after discharge.

GUARDIAN HOME HEALTH

Guardian Home Health is owned by AccentCare®, Inc., a nationwide leader in post-acute healthcare as well as specialized care management prior to acute episodes. Its wide variety of innovative services ranges from personal, non-medical care to skilled nursing, rehabilitation, hospice, private duty, and care management. Headquartered in Dallas, Texas, AccentCare has over 23,000 compassionate professionals in more than 190 locations across 14 states serving over 17,000 physicians and 2,000 facilities, regionally branded as AccentCare®, AccentCare® of New York, Accolade, Alliance For Health®, Doctors' Choice, Guardian Home Health & Hospice, Nurses Unlimited, Sta-Home, and Texas Home Health.

In addition, the company has over 30 regional strategic partnerships with insurance companies, physician groups, and major health systems, including joint ventures with Asante®, Baylor Scott & White Health, UCLA Health, and UC San Diego Health. AccentCare is the operator for these joint ventures under the respective brand names of AccentCare® Asante® Home Health, Texas Home Health Group, AccentCare® UCLA Health, and AccentCare® UC San Diego Health at Home.

AccentCare is committed to improving the quality of living with a mission to deliver consistently exceptional care for over 97,000 individuals, and their families, each year. Its approach to care, including proprietary RightPath® disease-specific programs, leads the industry in avoidance of unplanned re-hospitalizations, faster starts of care, and quality performance. Among its distinctions, AccentCare has a 4.3-star quality rating for legacy home health agencies, many of which have earned the HomeCare Elite® distinction. All hospice locations hold designations from the We Honor Veterans program and all legacy locations are accredited by CHAP.

COMMITMENT TO COMPLIANCE

A culture of compliance promotes transparency and integrity to better protect patients, customer partners and healthcare providers. In addition to addressing the "7 Elements of Compliance," AccentCare, Inc. utilizes:

- Third party monitoring of an alert/hotline
- Mandatory training for all employees and contractors
- Routine internal and third party audits of staff and processes
- Systematic QAPI programs, including tracked plans for corrective action

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