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Educational Webinar Series

VNS Health: Leveraging real-time data to optimize placements, maximize reimbursements, and improve collaboration

Tuesday, October 31 | 1:00PM ET

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Agenda

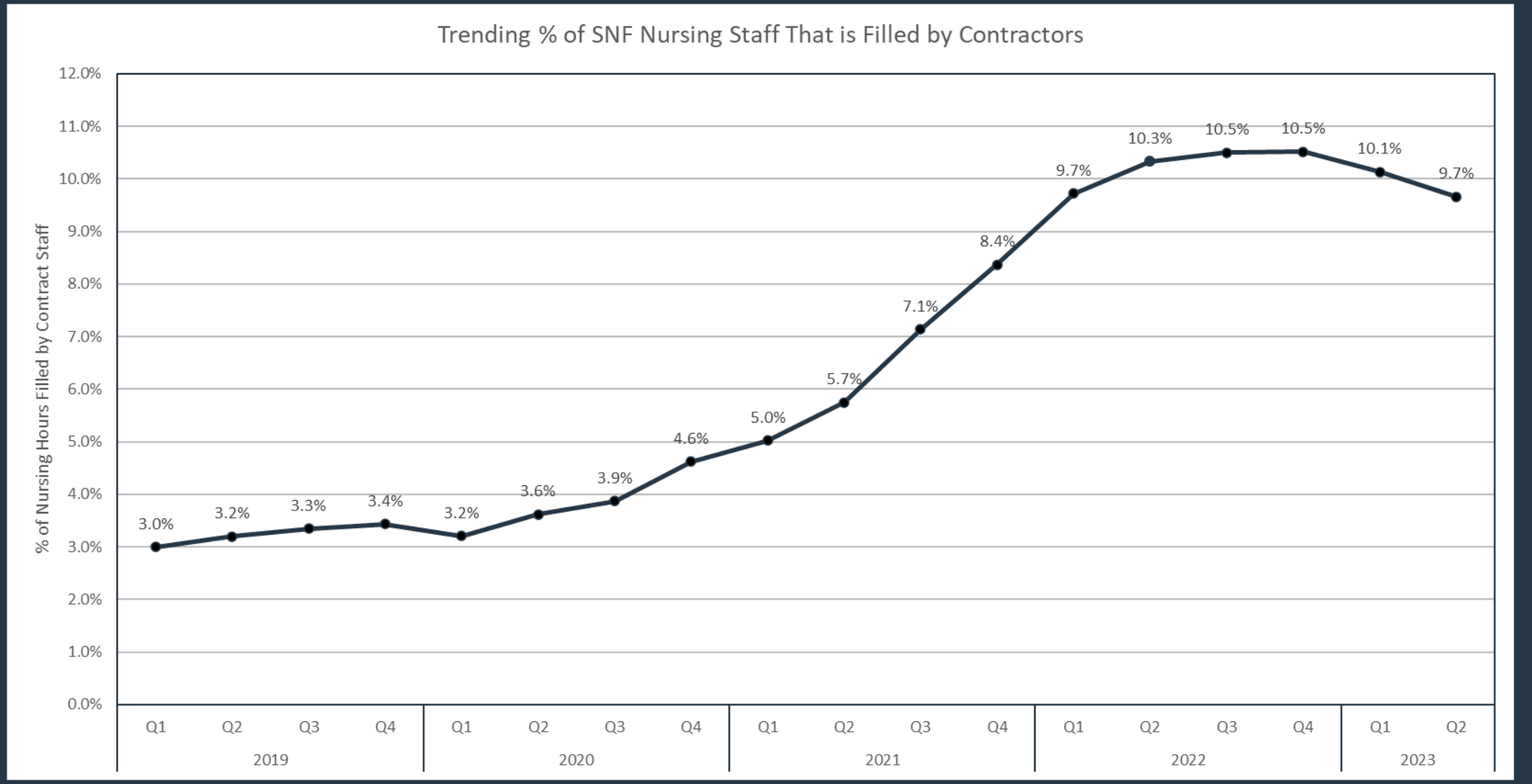
01 Industry-wide challenges & trends

02 Strategies for building a high-performing network and the metrics that matter

03 The VNS Approach

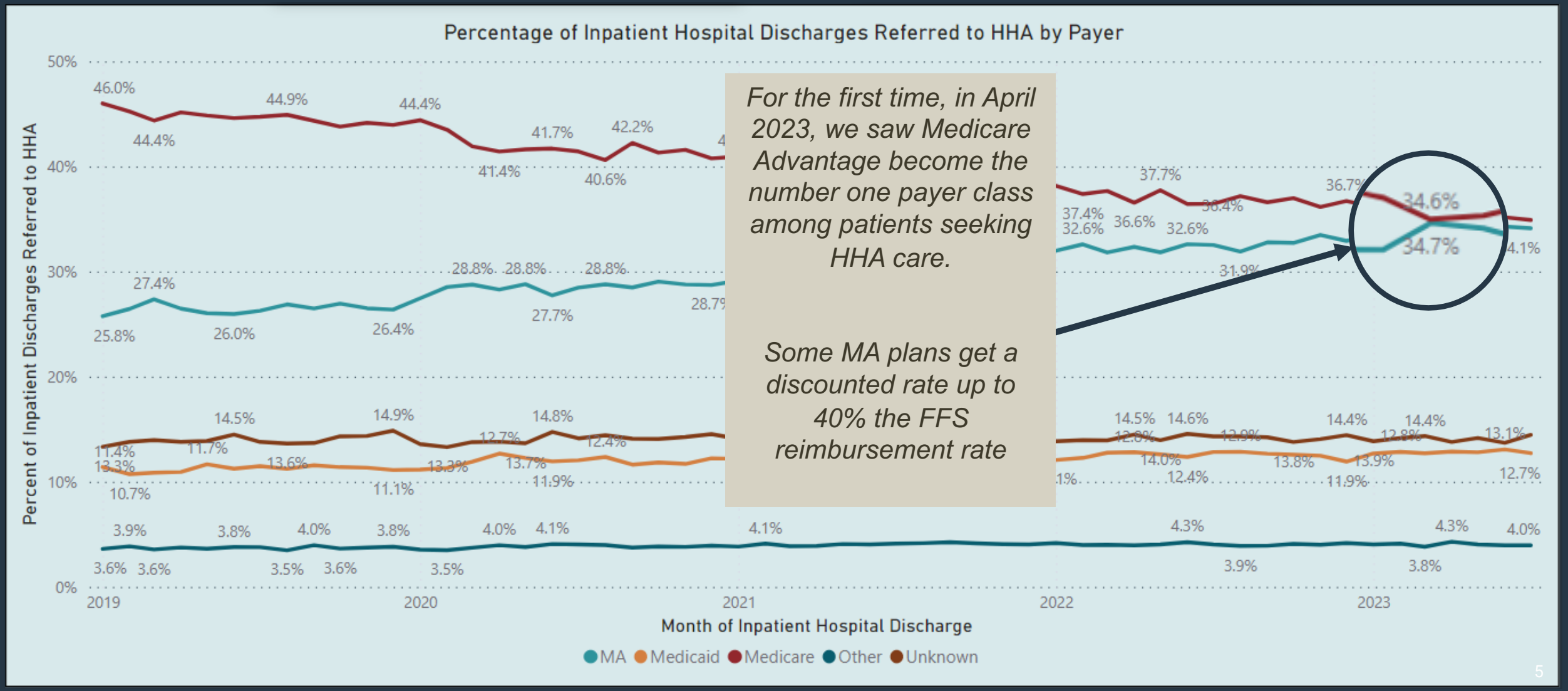
Industry challenges & trends

Staffing challenges continue



Contracted service costs can be as much as 4 times higher than employee costs

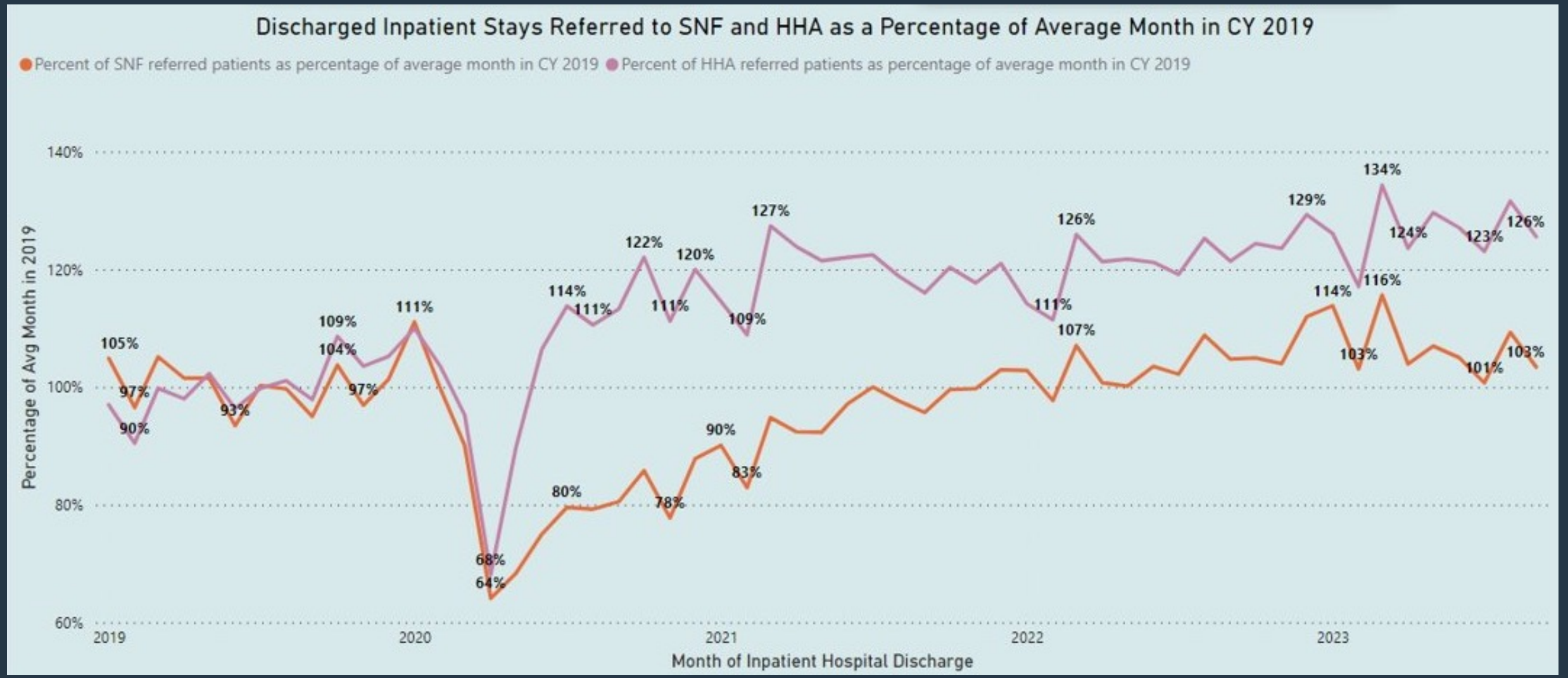
Growth of Medicare Advantage



For the first time, in April 2023, we saw Medicare Advantage become the number one payer class among patients seeking HHA care.

Some MA plans get a discounted rate up to 40% the FFS reimbursement rate

PAC Demand Recovery



Care transitions have never been more challenging/difficult

Hospitals are finding it **harder to place patients** in the face of rising demand for post-acute care

2x ↑ Average increase in number of referrals per patient sent to skilled nursing facilities (SNFs) and home health agencies (HHAs)

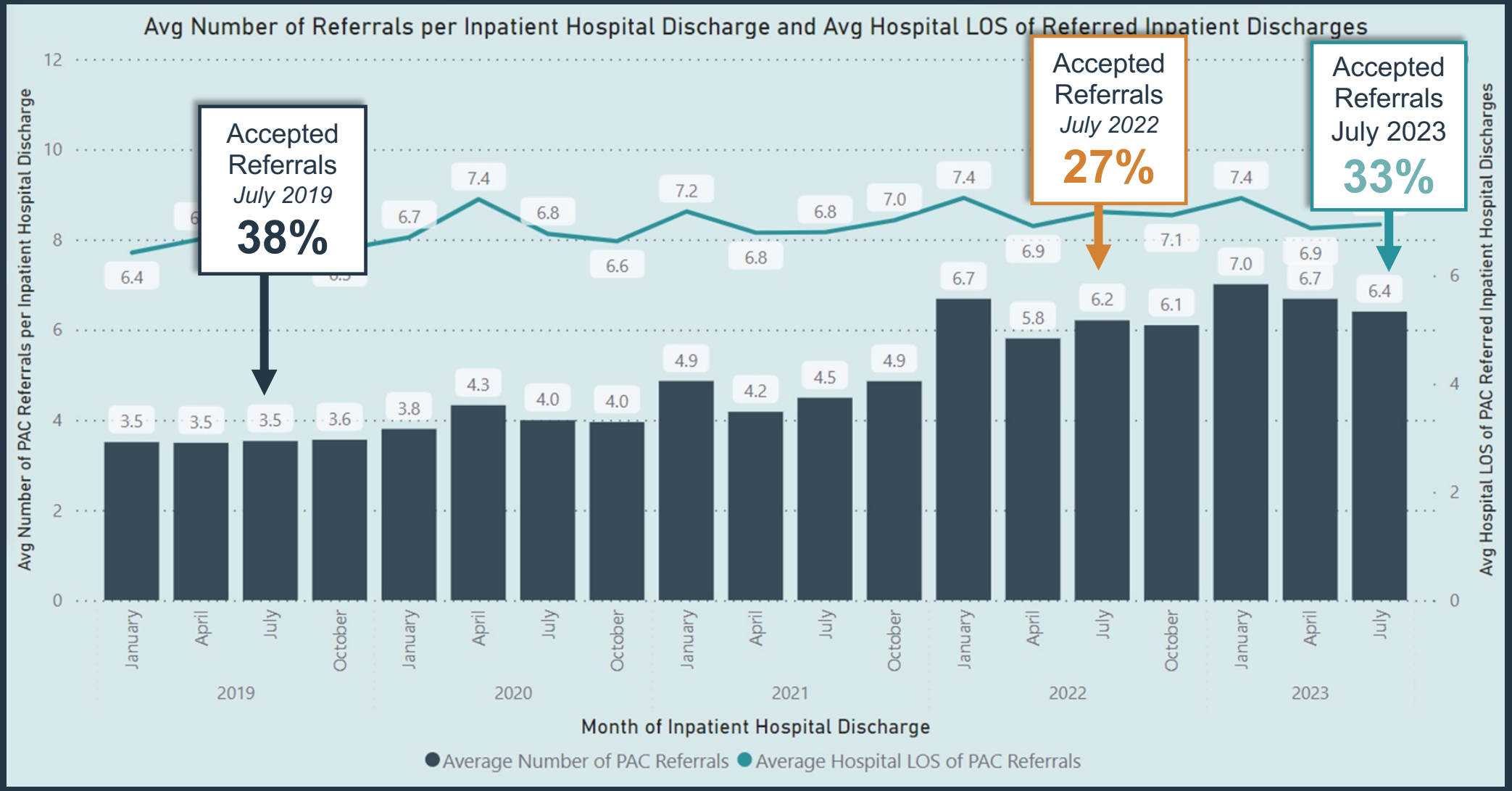
40% ↑ Increase in HHA rejection rates

Average length of stay in hospitals **remains high**

12% **longer stays among patients discharged to SNFs (2022 vs 2019)**

11% **longer stays among patients discharged to HHAs (2022 vs 2019)**

But transition trends are favorable



Hospital leaders have made clear that hospitals have needed to keep some patients longer than anticipated, only because post-acute discharge opportunities are scarce, given the staffing shortages and other factors.

The high-performing network and the metrics that matter

Post-acute care is critical to value-based care….

But there's still an extreme unexplained variance in quality among SNFs

NBER | NATIONAL BUREAU of ECONOMIC RESEARCH

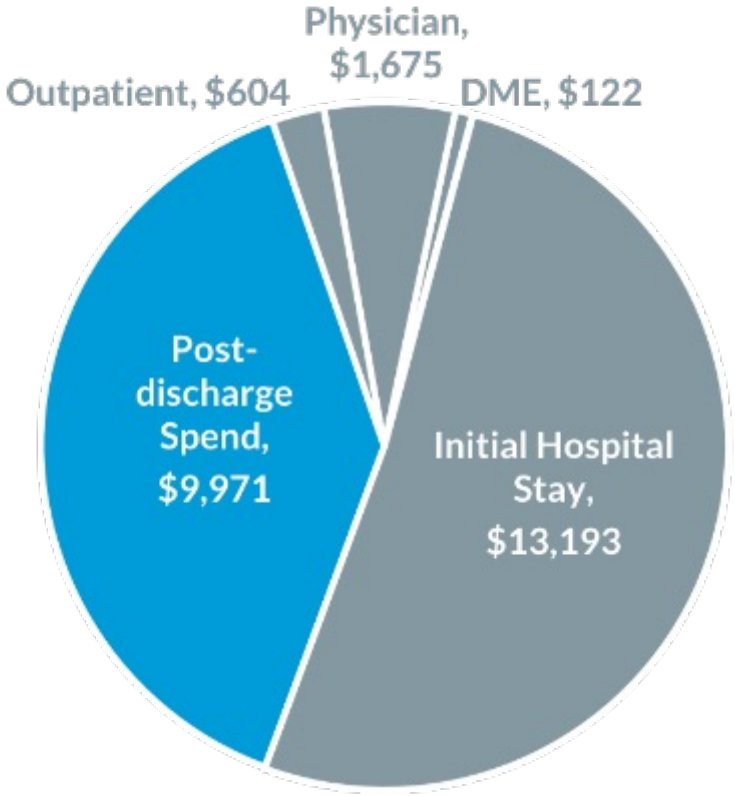
Paper published by NBER in August 2022 "Producing Health: Measuring Value Added of Nursing Homes" finds:

1. "compared to a 10th percentile SNF, a 90th percentile SNF is able to discharge a patient at the same health level about a week sooner"
2. "results point to the potential for substantial gains through policies that encourage reallocation of patients to higher-quality SNFs within their market."

Variance can lead to **poor quality** and **unnecessary cost**

Markets have **unique characteristics**

Technology is needed to facilitate **transparency**



Post-discharge spending drives **39% of spending per episode**

Value of joining a high-performing network

WellSky Client	SNFs in network	Avg monthly placements before Joining PPN	Avg monthly placements after Joining PPN	Relative Increase in Placements
Health System 1	35	11.9	18.3	153%
Health System 2	55	6.0	15	251%
Health System 3	12	4.1	12.4	305%
Health System 4	28	1.3	2.8	218%
Health System 5	51	1.2	1.9	154%
Health System 6	10	15.4	15.1	98%
Health System 7	20	8.8	15.5	177%
Health System 8	14	21.3	22.6	106%
Health System 9	9	1.5	1.9	128%
Health System 10	21	5.7	14.5	253%
Health System 11	19	16.8	19.8	118%
Health System 12	58	4.6	13.8	299%
Average	**27**	**8**	**13**	**188%**

188%

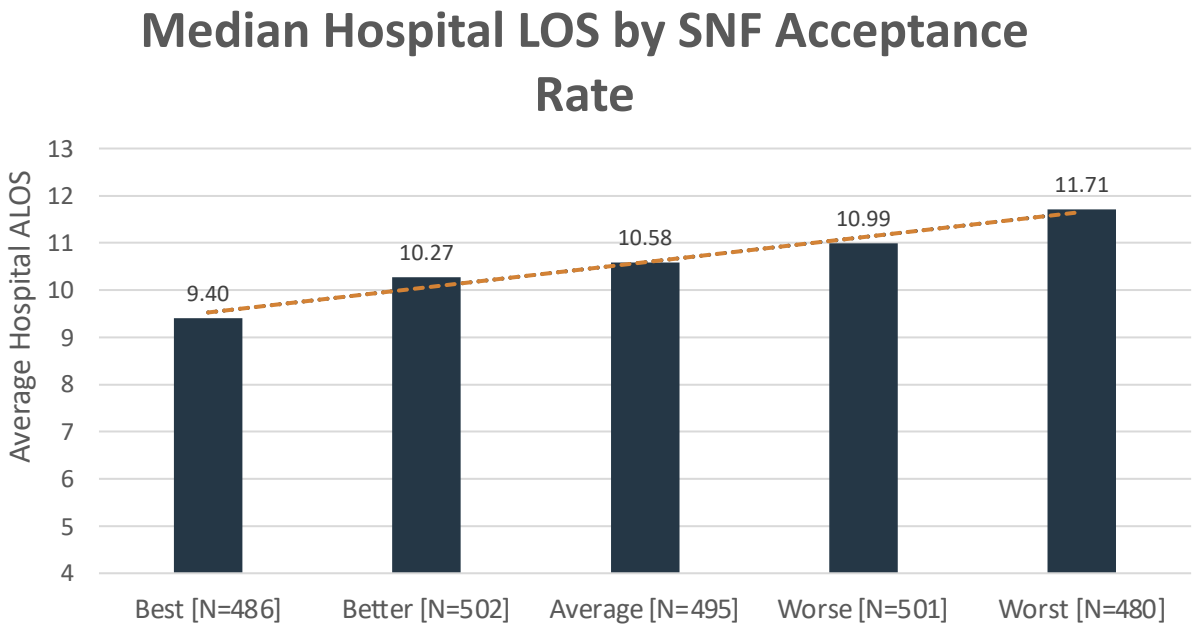
avg increase in placements to new members of high-performing PAC networks

*Analysis based on Guide clients that have a defined high-performing network in place and that have recorded changes to network overtime.

How in-network SNF providers compare to market

Quality Measure	Average difference between in-network and out-of-network providers
Overall CMS Star Rating	0.5 stars
Rehospitalization	2%
Discharged to Community Rate	2%
ALOS for Patients Discharged to Community	3.9 days

Beyond the standard quality measures



Skilled Nursing News

TECHNOLOGY

How Guardian Healthcare Sparked 125% Growth in Referrals

By **Alex Zorn** | January 30, 2022

"We've nearly doubled our-short-term, short stay patients. Our referring partners basically said you respond quickly to every referral we send you if you can take it or not and it lets us know if we need to go hunt something else down so we've almost become the default provider of choice because they know they can get an answer from us very, very quickly," VP Guardian.

SNF Referral Performance Metrics

	Market Characteristics				Timely Communication and Placement Metrics			Acceptance Rates by Payer Type					
Provider ↑	Distance from nearest hospital	Preferred Provider	Referral Management Subscriber	Patients Referred	Median First Response Time	Acceptance Rate	Median Response Time For definitive response	Referred Medicare FFS Patients	Medicare FFS Acceptance Rate	Referred Medicaid Patients	Medicaid Acceptance Rate	Referred Medicare Advantage Patients	Medicare Advantage Acceptance Rate
Market Benchmark	**2.1mi.**	**60.0%**	**100.0%**	**2812.8**	18min	34.0%	19min	951	59.0%	570	7.0%	380	37.0%
Elm Health 018969759	1.5mi.	✓	✓	3,857	13min	60.0%	15min	1,929	62.0%	1,157	33.0%	771	61.0%
The Oaks Skilled Nursing 185103836	1.6mi.			3,851	10min	39.0%	55min	1,926	64.0%	1,155	40.0%	770	36.0%
Green Nursing Home 292995974	2.2mi.	✓	✓	3,443	10min	39.0%	55min	1,926	64.0%	1,155	[illegible]	770	36.0%
[illegible]	2.2mi.	✓	✓	1,901	[illegible]	33.0%	[illegible]8min	951	59.0%	570	[illegible]	380	37.0%
	2.8mi.		✓	1,012	18min	34.0	19min	506	59.0%	304	25[illegible]	202	34.0%

Over the last 12 months, Elm Health received most of the patient referral volume. This is probably as expected given that Elm Health is part of their network.

While Green Nursing appears to respond to referrals within 10 mins, that first response is just a placeholder. They wait much longer than the market average to give a definitive yes/no.

Oak Skilled Nursing is an out-of-network provider, but they have consistently accepted Medicaid patients while other preferred providers have refused.

The VNS Health Approach

VNS Health

Home Care and Personal Care

Hospice Care

VNS Health

Helping people to live, age and heal where they feel most comfortable – in their home, connected to their family and community.

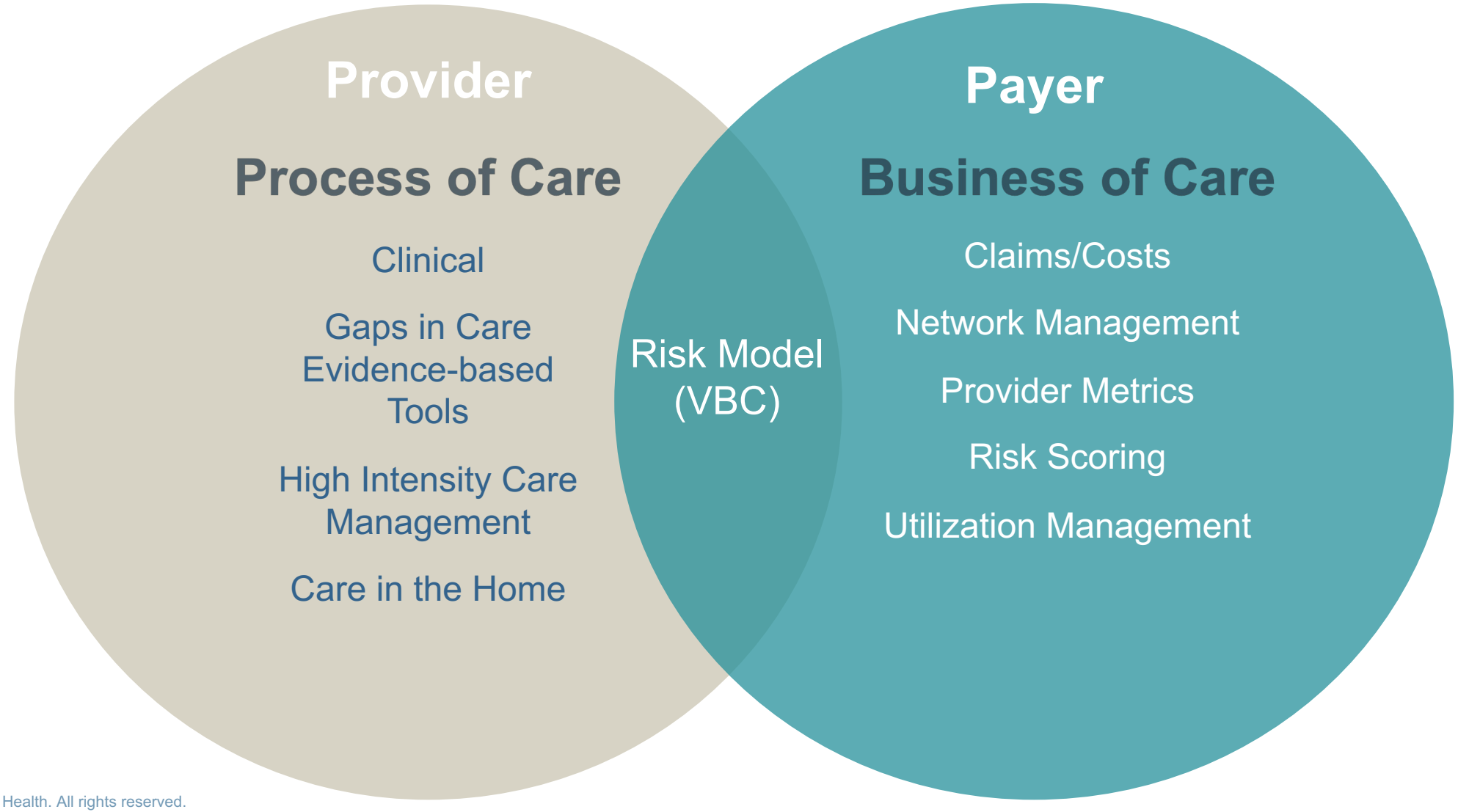
Behavioral Health

Health Plans

Care Management

Professional Solutions

The VNS Health Payvider Model



VNS Health care management program continuum

Impact of Programs

99%

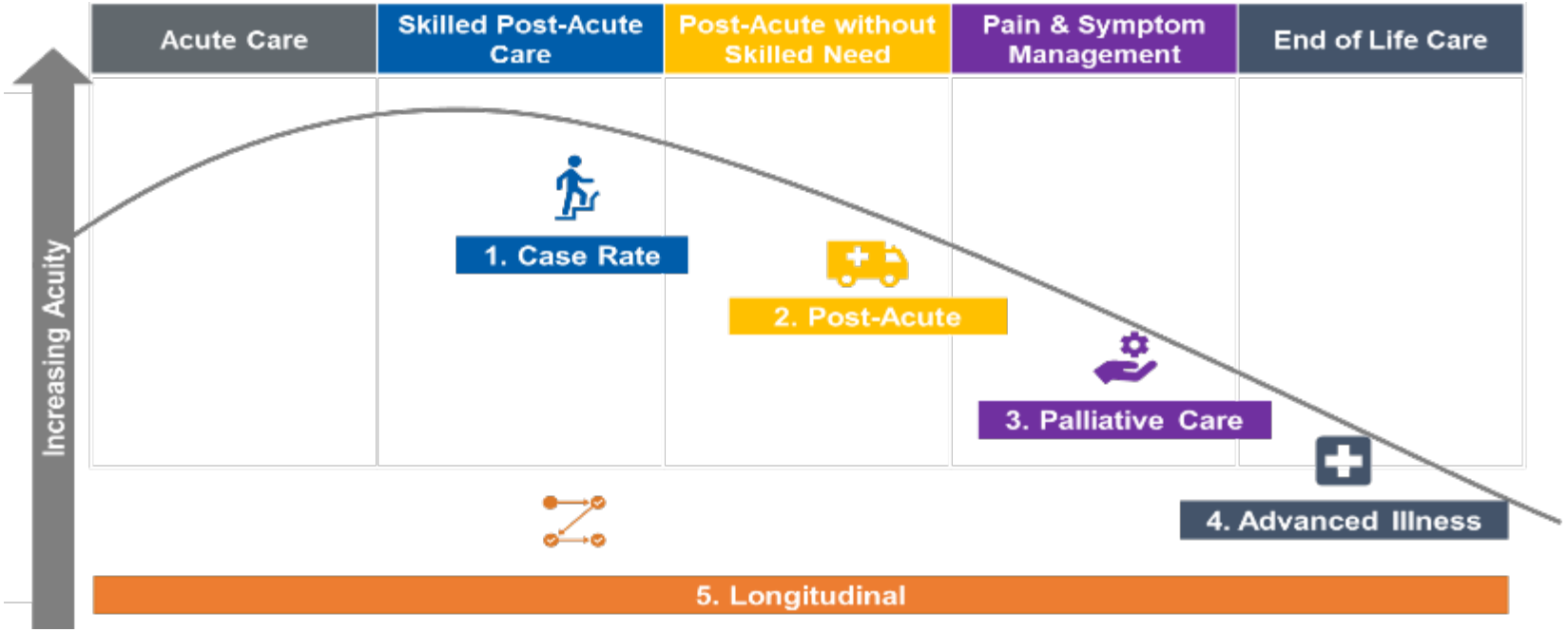
Compliance with 4 Medicare Stars HEDIS Measures

2.2X

Hospice Length of Stay

30 - 40%

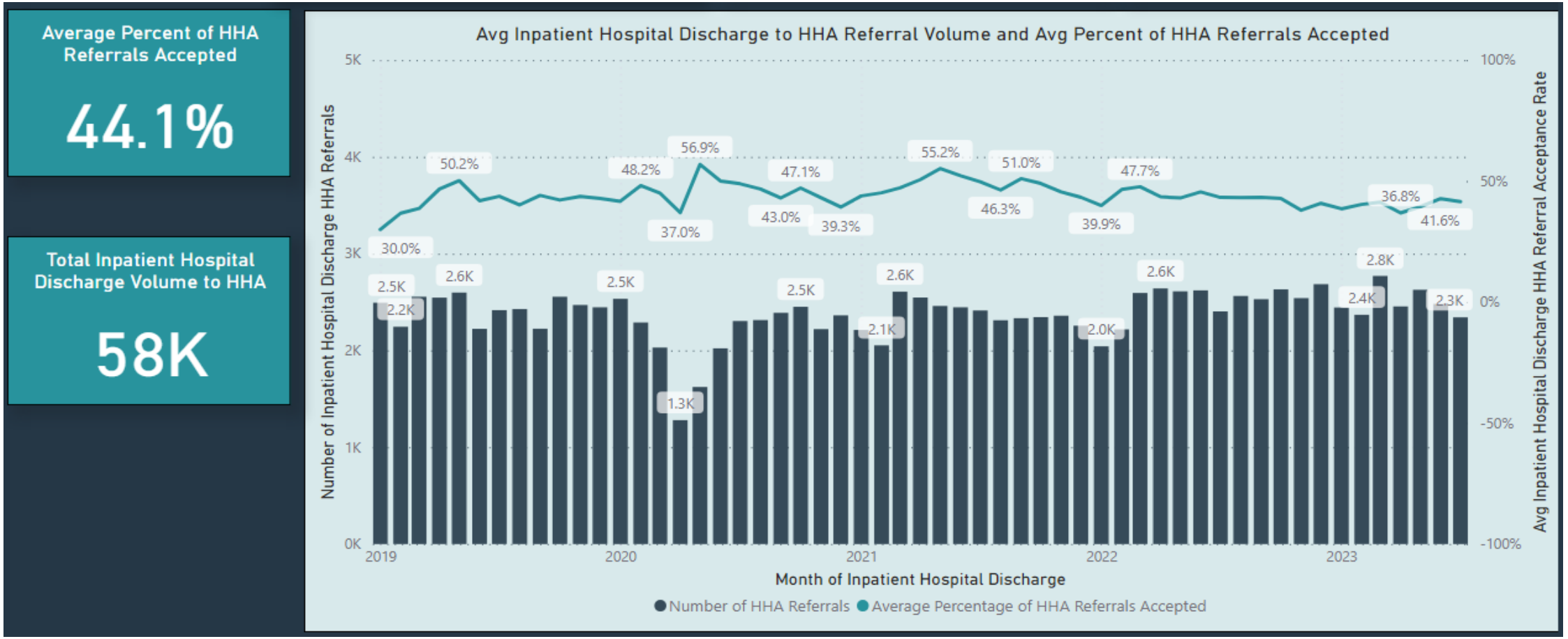
Reduction in Costs



Transitional		Palliative & Advanced Illness		Long-Term
Case Rate	**Post-Acute**	**Palliative Care**	**Advanced Illness**	**Longitudinal**
Members requiring skilled nursing and/or rehab	Members transitioning from hospital to community w/o skilled need	Members approaching end of life experiencing multiple medical crises and have not yet entered hospice		Members with most complex needs, often with multiple (6+) chronic conditions
60 to 90 days		End of life or transition to hospice		12-18 months or time in plan

Track regional trends

VNS is seeing an increasing trend in referrals in CY 2023 while maintaining a steady acceptance rate. This suggests market trends in Manhattan hospital referral region are different than CarePort national trends.



Program development

- Patients have low acuity level and moderately controlled comorbidities not receiving certified services
- Have community and care transitions' needs that would benefit from having a VNS Health Personal Care Initial Comprehensive Assessment performed by a Registered Nurse and a subsequent visit(s) with care management encounters for a 60-day episode.
- Patient must be independent, self-directing and/or have adequate caregiver support in the community to meet their healthcare need goals
- If any patient after an Initial Comprehensive Assessment is identified to have higher risk/acuity skilled needs, an outlined process will be implemented to communicate with the referrer and primary care provider for ongoing care and plan for authorization

Benefits

Benefit from a **care delivery of nursing visits** for symptoms and comprehensive assessment **coupled with care management** for the primary goal of safe care transitions during a 60-day episode of care

Overview of Services

1-3 face-to-face home visits (as needed) to address clinical RN or PT needs

Inclusion Criteria

Community referrals

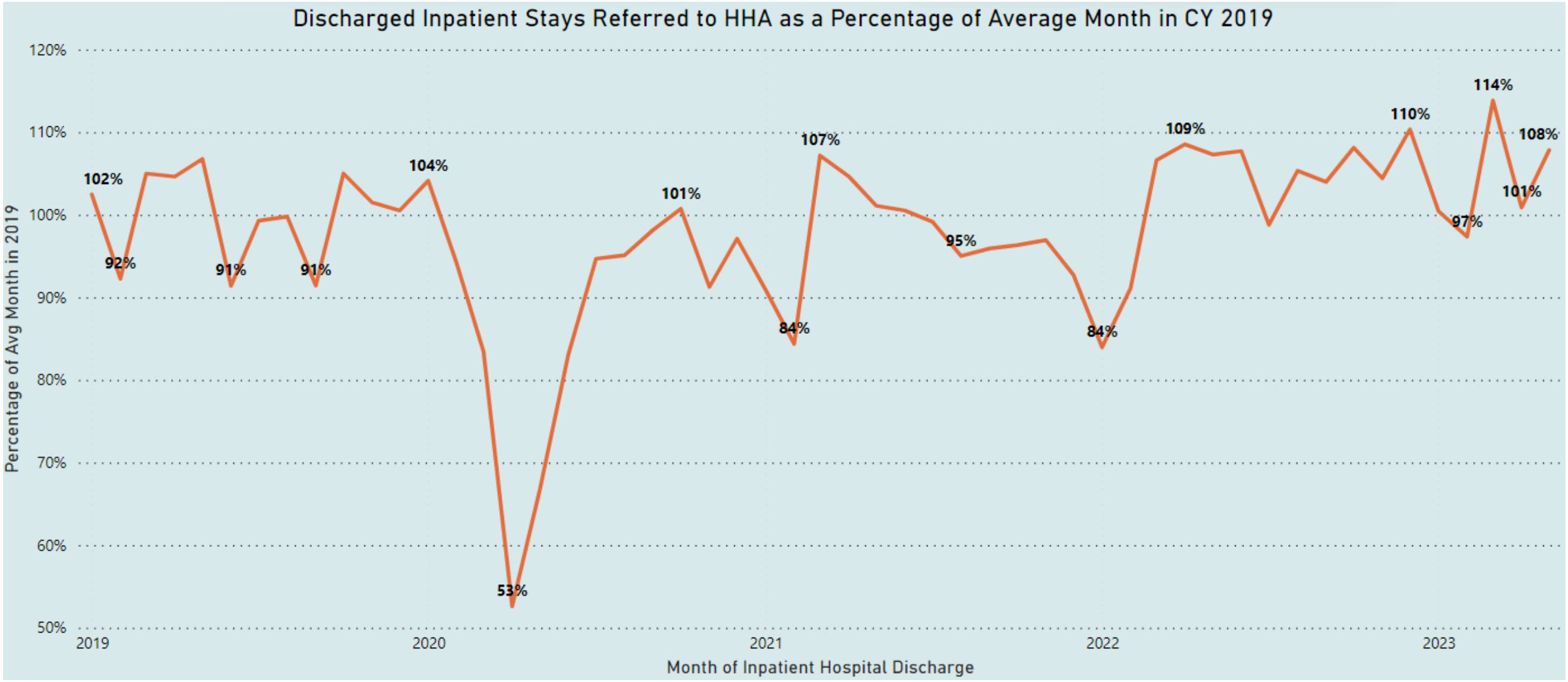
Health plan referrals

Hospital referrals

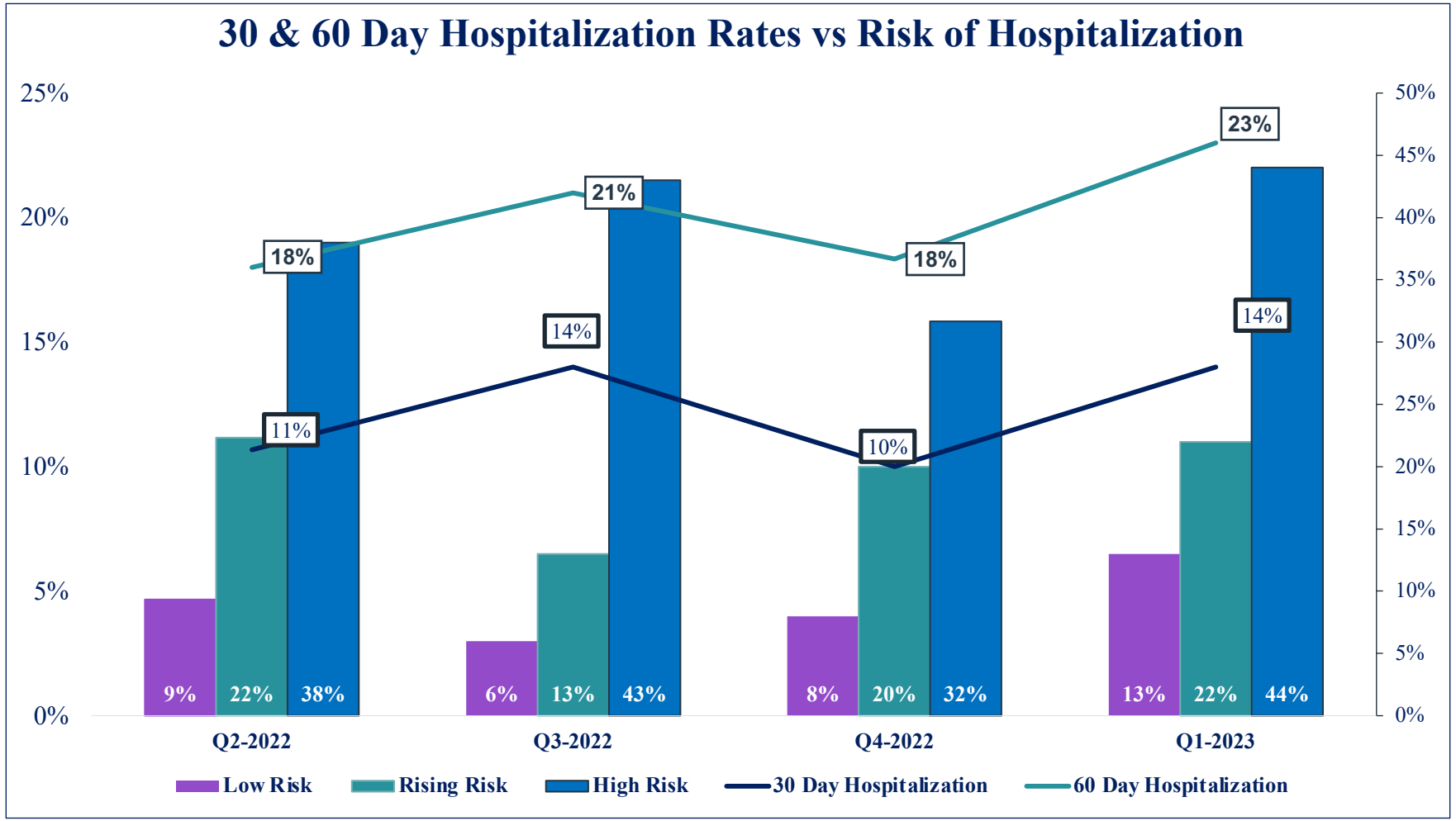
Track regional trends

15 Care Management Hospitals & Health Systems

126K Inpatient Hospital Discharges Referred to HHA



30-Day & 60-Day hospitalization metrics



Source: VNSNY CarePort Data

Making a difference: Health Plans Performance

Health Plan A

Medicare

Year	# of Episodes	Baseline	Actual Hospitalization Rate	Reduction in Hospitalizations
2017	5,917	35.6%	31.5%	-10%
2018	4,925	35.1%	30.3%	-14%
2019	5,387	35.1%	30.5%	-13%
2020	5,093	35.1%	29.3%	-16%
2021	5,457	35.1%	30.0%	-14%
2022	5,011	35.1%	30.6%	-13%

Medicaid / HARP

Year	# of Episodes	Baseline	Actual Hospitalization Rate	Reduction in Hospitalizations
2017	4,547	30.8%	31.7%	3%
2018	3,164	30.8%	30.2%	-2%
2019	3,293	30.8%	27.8%	-10%
2020	2,668	30.8%	30.9%	0%
2021	2,866	30.8%	30.4%	-1%
2022	2,501	30.8%	30.0%	-3%

Health Plan B

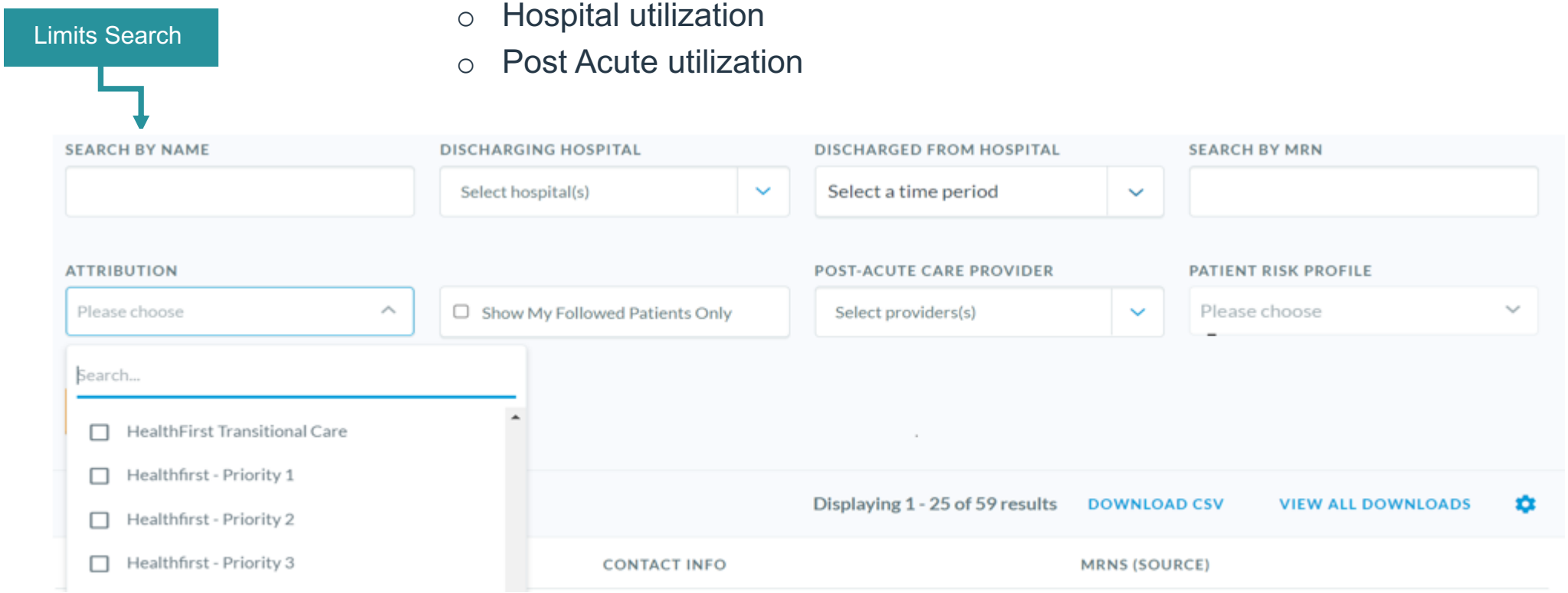
Medicare / Medicaid

Year	% Reduction in Readmissions
2020	-18%
2021	-25%
2022	-11%

CarePort Longitudinal Patient List: Search Engine

CarePort allows users to complete a client search utilizing various search filters to identify clients that care managers, transitional care associates and leadership can view utilization for, such as:

- Home Health utilization
- Hospice enrollment
- Hospital utilization
- Post Acute utilization

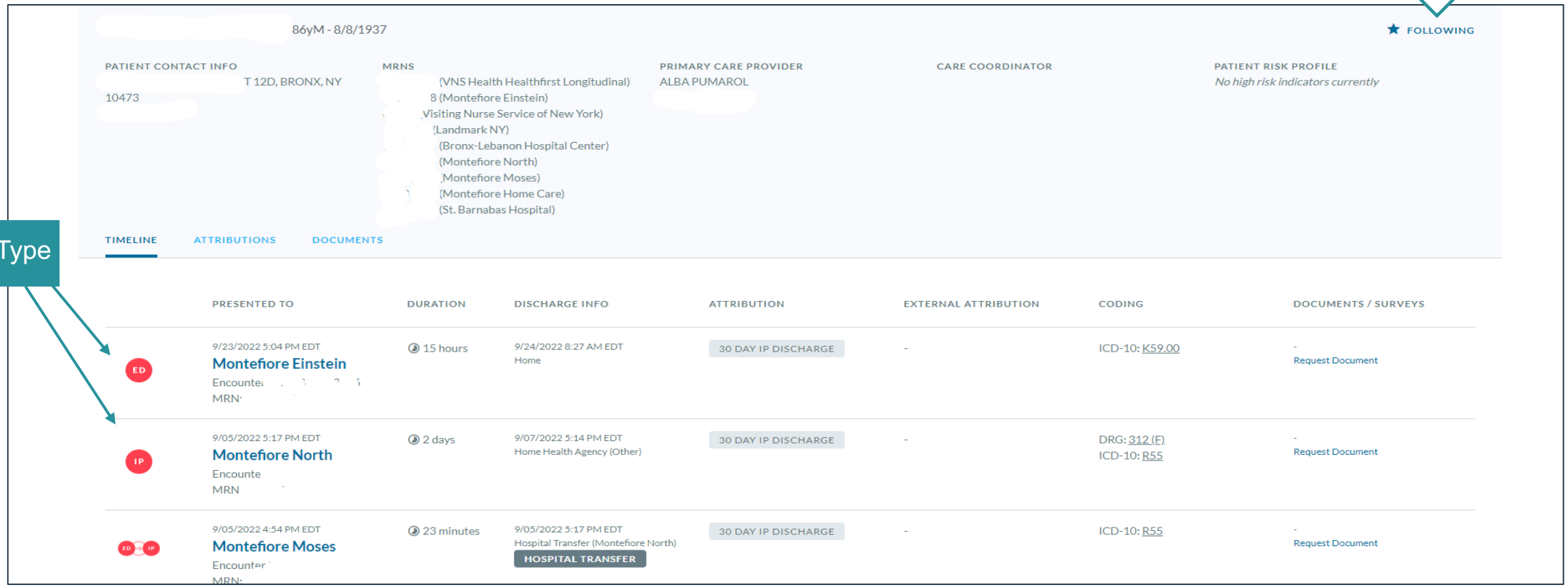


CarePort Patient List: Search Results

- Once a client is identified, one can view all data for that client and follow that client. The client is in active queue and the provider is notified of the client's utilization.
- CarePort solutions also allow for integrated facilities to attach documents related to the encounter.

Bolded star indicates client is being followed in active queue

Visit Type



CarePort Patient List: Impact on our Longitudinal Process

The Longitudinal Program's goal is to educate clients about how to improve their health status, to prevent or manage chronic illnesses and to improve quality of life.

- The early identification of hospital utilization can assist in the early identification of the need to increase surveillance for these clients. The goal is to identify gaps in care, identify precursors to hospital utilization and prevent readmissions.
- Once a client has been admitted and subsequently discharged, the Care Manager will:
  - Outreach to the client weekly for a total of 4 weeks
  - Ensure the client is maximizing available benefits – post-discharge meals, home health aides, home care
  - Ensure follow up appointments are made and completed
  - Establish need for any wrap-around services such as Remote Patient Monitoring, Nurse Practitioner visits, Pharmacy referrals, Nutritional referrals
  - Review discharge instructions and medication compliance

CarePort Patient List: Reporting

CarePort solutions allow for reporting on a group of clients and for a set timeframe, as noted below. Reports can identify:

- Clients with frequent utilization
- Overall utilization trends
  - Disease-specific
  - Client-specific
  - Facility-driven
  - PCP-driven

First Name	Last Name	DOB	Age	PCP Name	PCP Email	PCP Phone	Level of Care	Patient Class	Facility	Admit Date	Admit Time	Discharge Date	Discharge Time	Discharge Day of Week	Discharge Disposition
JOHN	Doe	8/29/1946	76	Dr Smith		7185551212	hospital	Emergency, Inpatient	New York Presbyterian - Allen Hospital	2/11/2023	11:34 AM	2/16/2023	1:15 PM	Thursday	Home
Mary	Smith	5/20/1984	39	Dr Jones		718-920-8888	hospital	Emergency	Montefiore Moses	2/11/2023	3:12 PM	2/11/2023	9:57 PM	Saturday	Home
Donald	Duck	5/20/1984	39	Dr Mouse		718-920-8888	hospital	Emergency	Montefiore Moses	2/28/2023	3:43 AM	2/28/2023	6:05 AM	Tuesday	E1
Mickey	Mouse	6/29/1943	79	Dr Wilson		718-563-0757	hospital	Emergency	Montefiore Moses	2/2/2023	3:47 PM	2/2/2023	9:16 PM	Thursday	Home

KEY TAKEAWAYS

- Consider non-traditional quality measures, like acceptance rates
- Continued challenges with PAC care transition friction
- Partnering with high-quality PAC providers delivers value to patients
- Value of real-time data to payvider & tools for care navigators
- Track demand and patient population changes to tailor care management programs
- Performance breakdown by payers and programs

Q&A

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Thank you

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