National Hospitalization Avoidance Program

Regency SouthernCare™
Hospice Services

Introduction

Regency SouthernCare Hospice is part of a family of home health, community care, and hospice care providers

Our Mission

To provide compassionate care and extraordinary service to the patients and families we serve

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Our Care Matters

- We are here 24/7/365
- We develop an individualized plan of care specific to each patient's needs and the wishes of the patient and family. The care plan includes physical care with pain and symptom management as well as emotional and spiritual support for the patient and family
- We provide continuous communication with our referral sources so they remain involved with their patients' plans of care and outcomes
- We strive for same day response to referrals, and 3-hour admissions
- We are dedicated to patient satisfactions and responsiveness to patient and family needs
- We are committed to clinical excellence and integrity, insuring our patients the highest quality of care and comfort

Our Program

National Hospitalization Avoidance Program

Our program provides appropriate coordination and care management techniques in order to avoid burdensome transitions.

We layer care management services upon the traditional hospice care model to specifically focus on:

- Reducing hospitalizations
- Improving patient and caregiver satisfaction levels
- Providing a feedback mechanism for a higher level of care delivery

Benefits of Our Program

- ✓ Kindred at Home – Hospice Division, including Kindred Hospice, has a 35% Lower National Live Discharge Rate*

- ✓ Patients participating in our Hospitalization Avoidance Program are **48.3% less likely to admit to the hospital** in the first 30 days of hospice care (i.e. revoke hospice for hospitalization when hospice could manage/ address the issue)

*PEPPER: Program for Evaluating Payment Patterns Electronic Report Q4FY2018, Release Apr 2019

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Basics of Our Program

- We layer telephonic support services with our traditional hospice care delivery to provide customer outreach to patients and caregivers. Our interactions focus on education needs and early identification of symptom management, and work in conjunction with our hospice care team

- Based on high risk stratification for Live Discharge by diagnoses, we engage with identified call schedules for lung cancer, Alzheimer's, CHF, COPD, and general diagnoses patients under routine care

Benefits of Our Program

- ✓ We identify our patients with high risk diagnoses as identified in our study, and implement best practices to avoid preventable live discharges and rehospitalizations
- ✓ We layer “Comfort Care Calls” to provide an additional layer of support and relationship for patients at high risk for live discharge and rehospitalization
- ✓ We engage our patients and their caregivers in “Call Us First” education for symptom and pain management
- ✓ The hospice agency ensures GIP contracts are in place so our patients may return for symptom management under the care of hospice without impacting readmission or mortality rates

The Study Behind Our Program

Development of Our Program

- Our program was developed as a result of an internal, multi-state study with hospital readmission data
- Based on the study 78% of hospital re-admissions were potentially avoidable
- Avoidable readmissions resulted in an excess cost of $3.39 billion to Medicare

Internal study was conducted by CURO Health Services; now Kindred at Home – Hospice Division

National Hospital Readmission Data

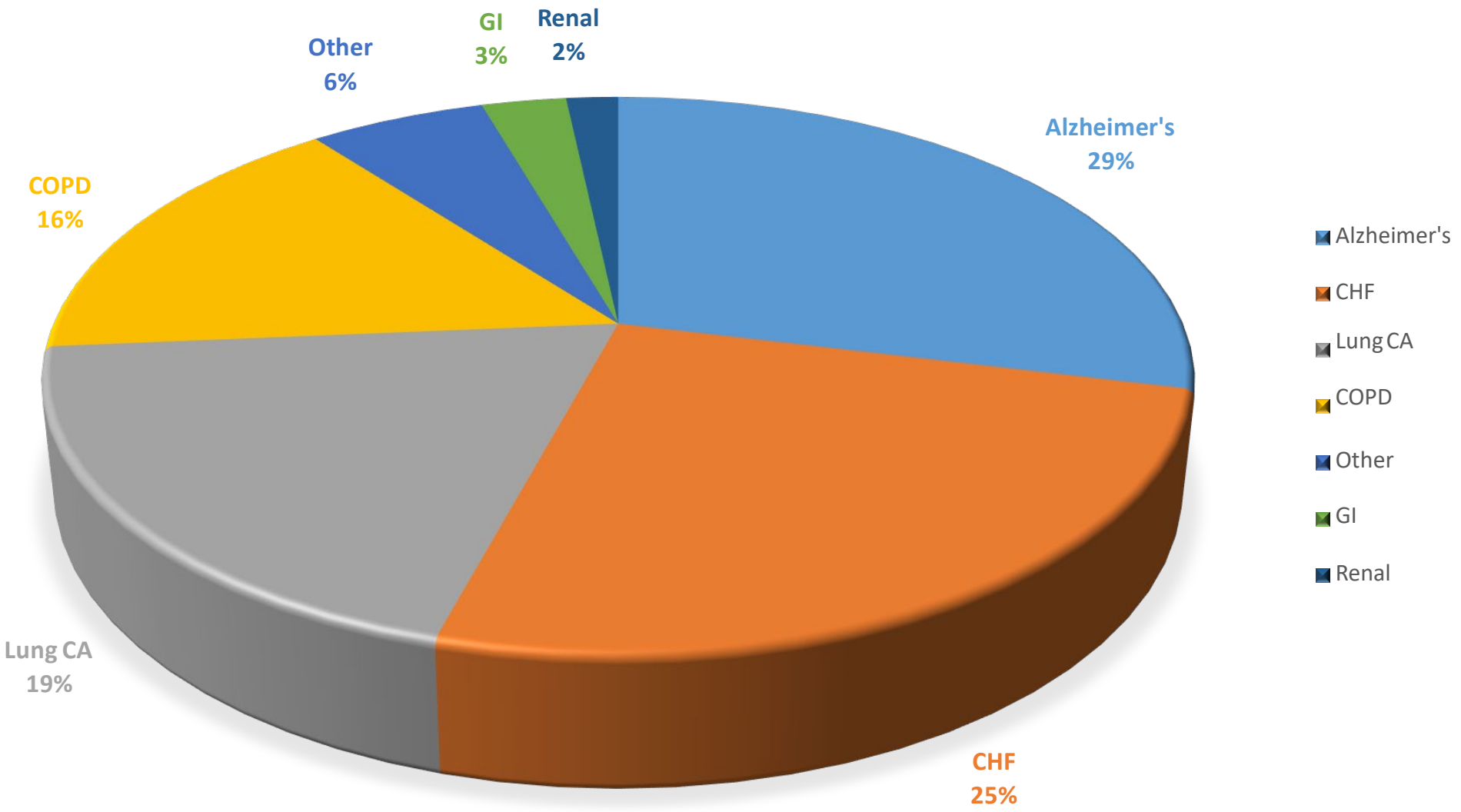
- **20%** of Medicare beneficiaries are rehospitalized within 30 days
  - Avg expense to the hospital---$11,200
  - Avg Medicare payment---$10,352
- **67%** of Medicare patients discharged from a hospital were re-hospitalized or died within the first year after discharge
- **26.9%** of Heart Failure patients were readmitted to the hospital within 30 days
- **22.6%** of pulmonary disease patients were readmitted within 30 days
- **50%** of patients rehospitalized within 30 days after a medical discharge to community did not visit PCP or physician

NEJM: Rehospitalizations Among Patients in the Medicare Fee for Service Program (2009)

Research Actions

- Medicare and our parent company statistics for the live discharges nationally, regionally, and by state
- Analysis identified high risk states stratified the reasons for company live discharges
    - Clearly define discharge reasons in EMR to allow for better root cause analysis
    - Develop education to reduce live discharge rate for low performing agencies
- Identified the characteristics of the patient population that are most predictive of a potential live discharge
    - Diagnosis
    - Length of stay
    - Days of benefit period with highest rate of dc by diagnosis

Key Diagnoses for Live Discharge



Taken from Study Data presented March 2018

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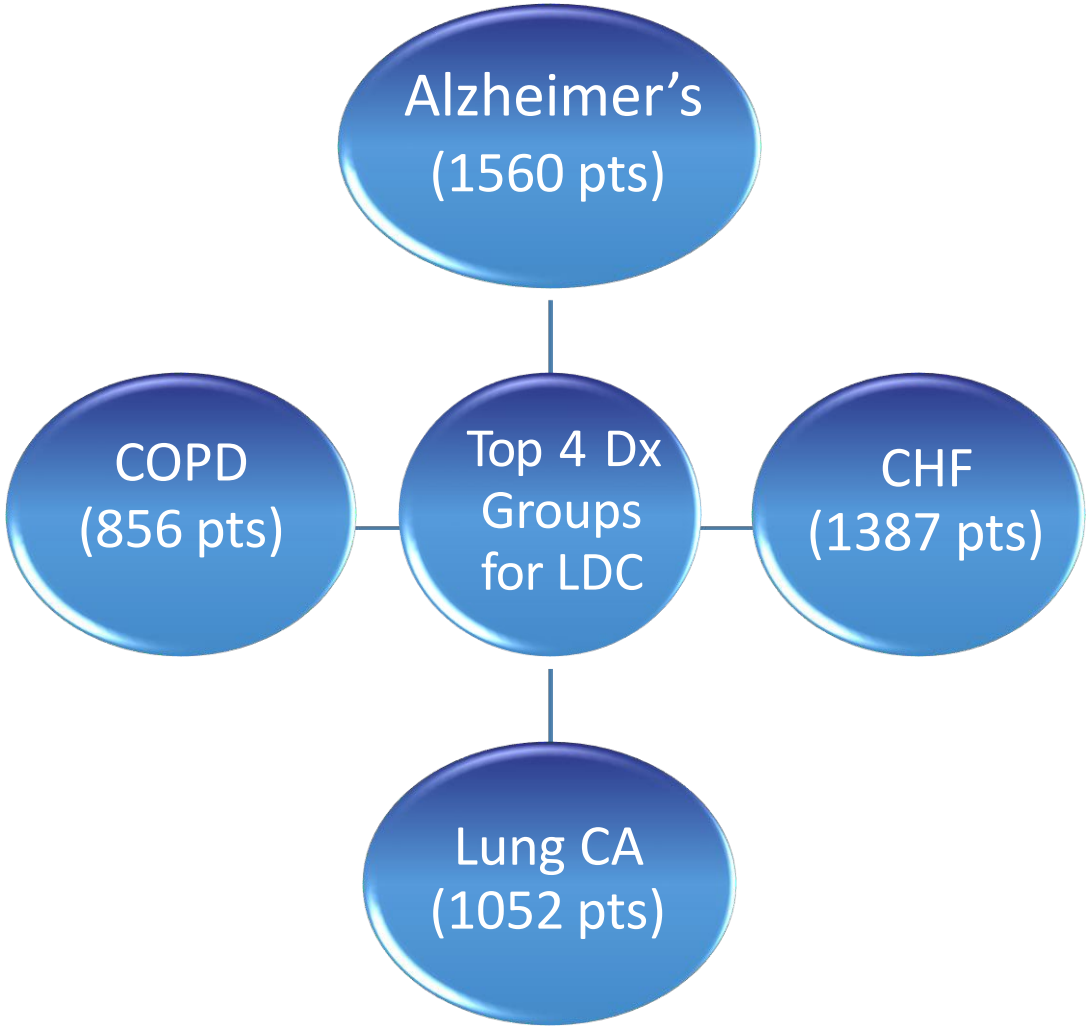
Top Diagnosis for Live Discharge

- 5,428 Hospice Live Discharges Reviewed
- Top 4 Diagnosis Groups Identified
- 60% of Top Diagnosis Groups had a pulmonary diagnosis in nature
  - CHF
  - Lung CA
  - COPD



Taken from Study Data presented March 2018

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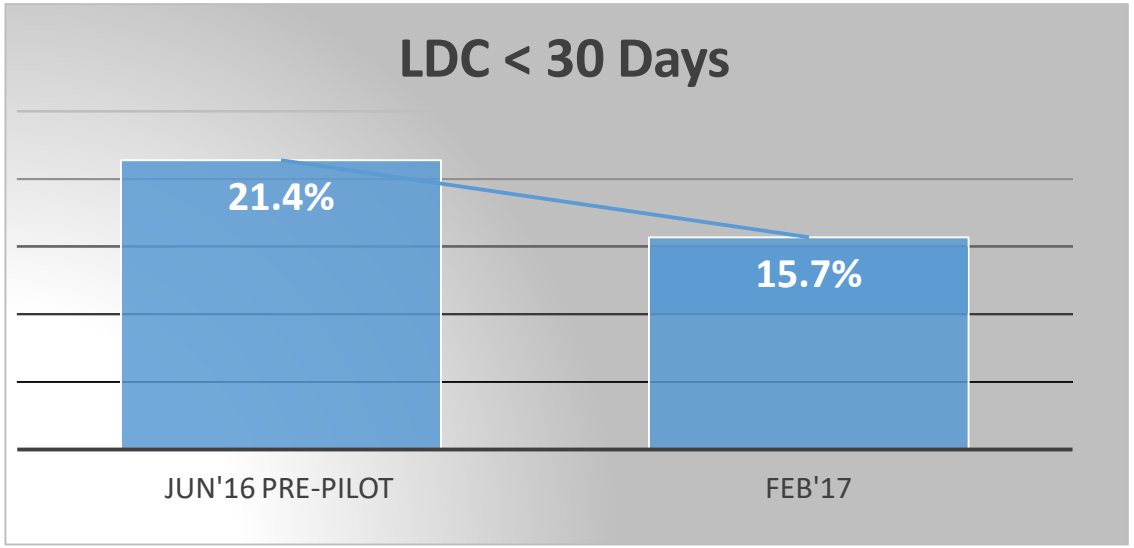
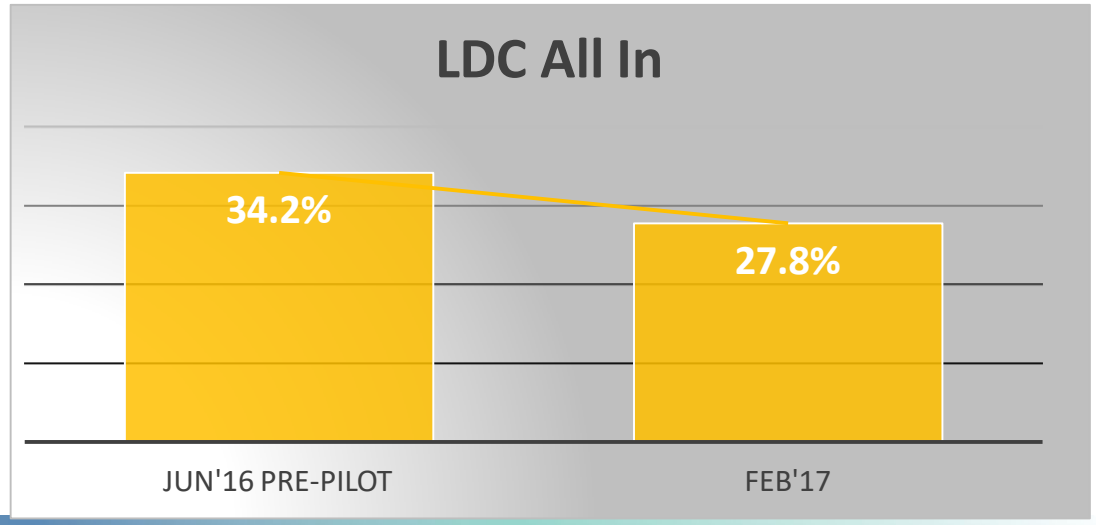
Multi-State Hospitalization Study Results

(June 2016 – February 2017)

# of Patients: 5680
# of Calls: 20713
# of Contacts: 14704
Contact %: 71%
# of Locations: 77



YTD Diff
-26.6%



YTD Diff
-18.7%

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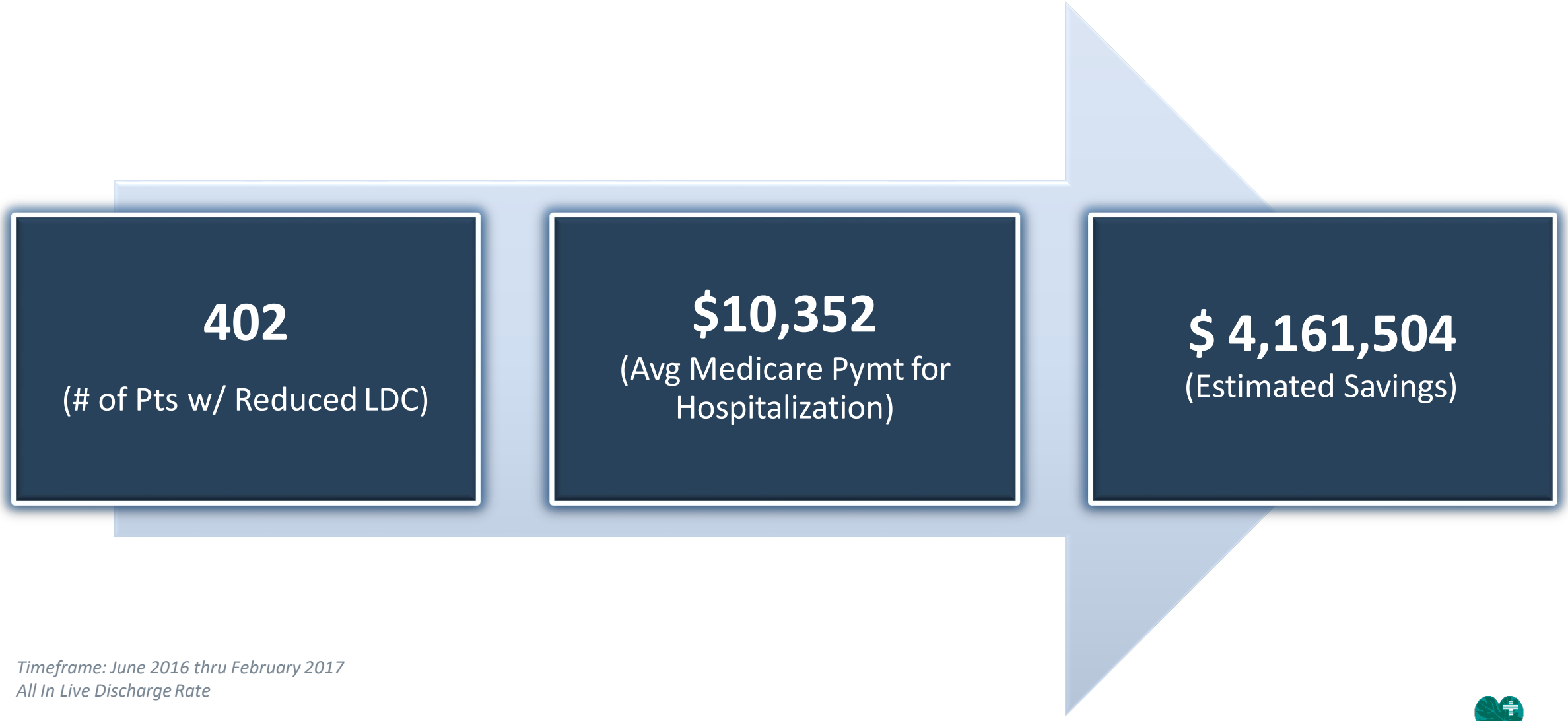
Hospitalization Study Financial Impact



Timeframe: June 2016 thru February 2017
All In Live Discharge Rate

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Summary

Summary

- ✓ We layer “Comfort Care Calls” (Our National Hospitalization Avoidance Program) based on statistical analyses to provide an additional layer of support and relationship for patients at high risk for live discharge

- ✓ Our Program demonstrates proven outcomes