

LeadingAge[™]
Maine & New Hampshire
Educate. Collaborate. Inspire.

COURAGE IGNITED



From Healthcare to Health

Population Based Cross-Continuum Programming



The Great Reset

From REACTIVE to PROACTIVE

Build a solid foundation for
change

ID acuity + needs of aging
population

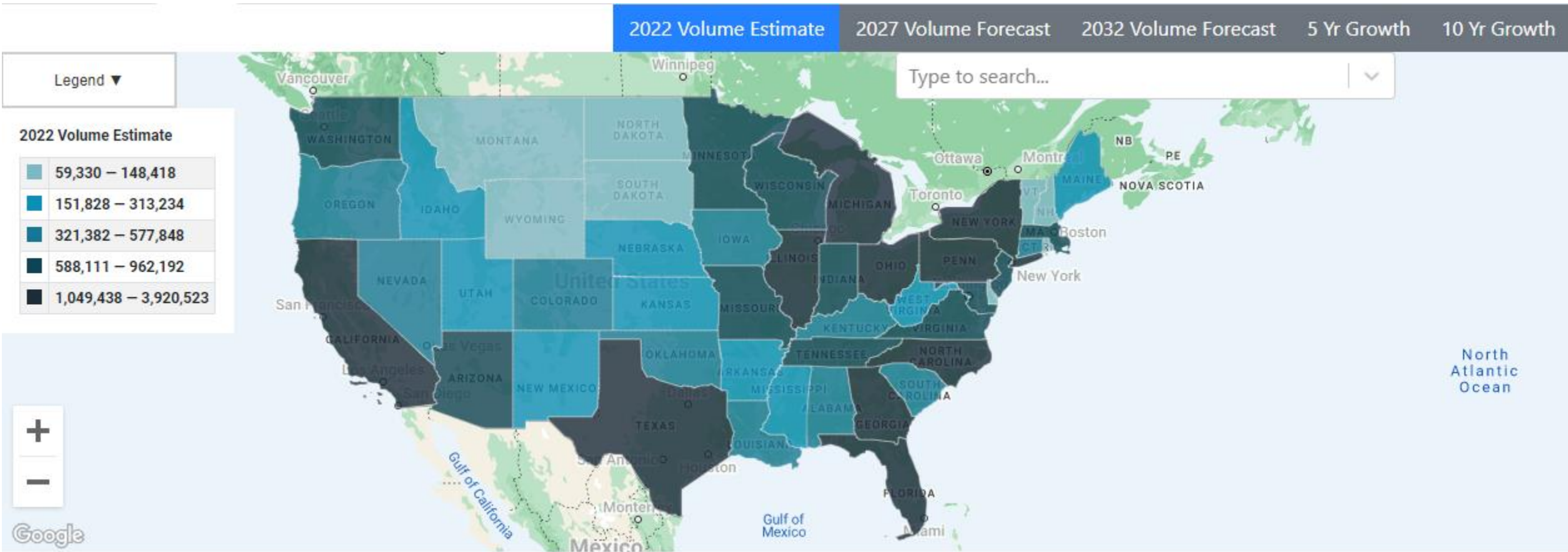
Multitude of offerings to meet vast
needs

Plan + invest for the future

C H A N G E
C

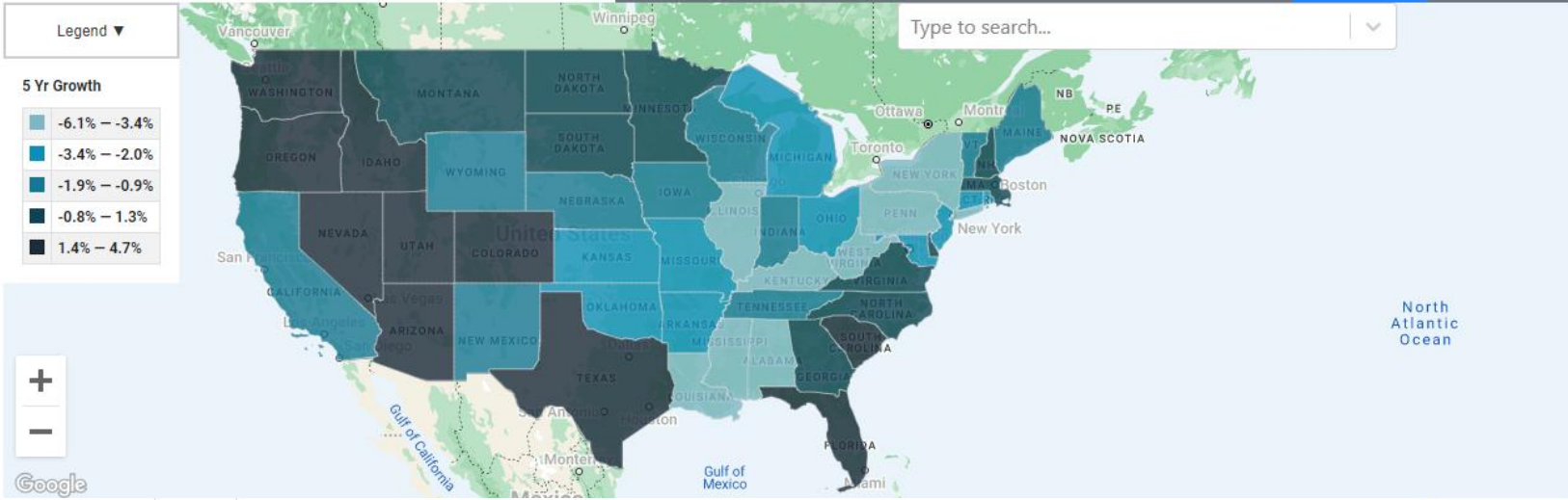


Current Population Over 65



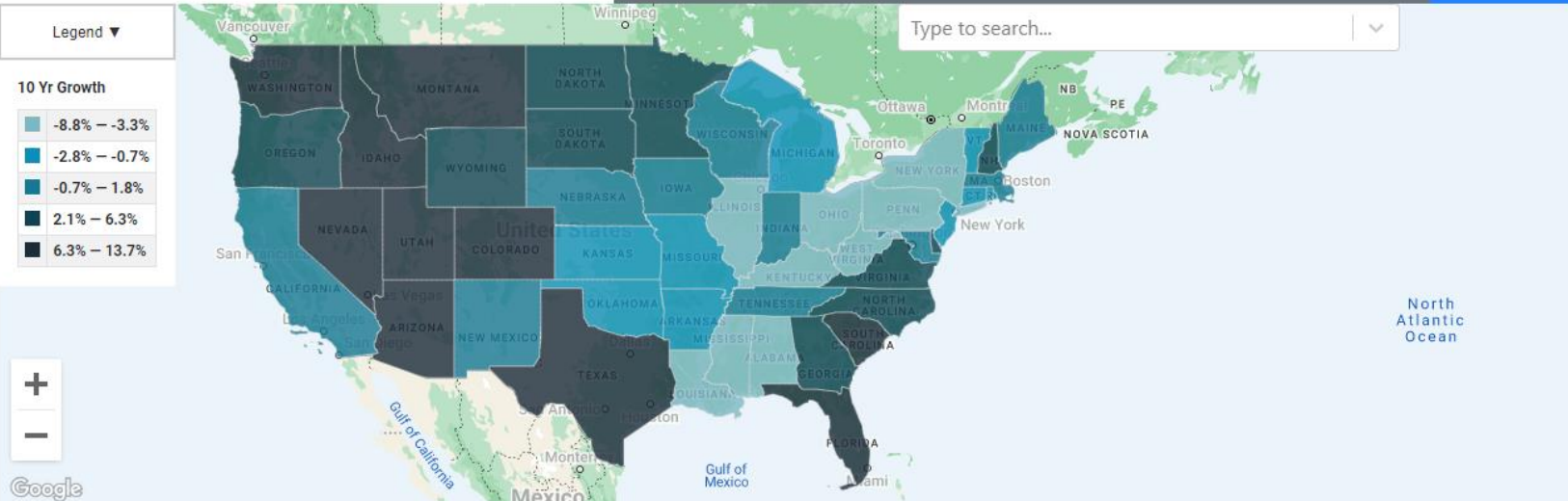
5 Year vs. 10 Year 65+ Population

2022 Volume Estimate 2027 Volume Forecast 2032 Volume Forecast 5 Yr Growth 10 Yr Growth



5 year growth:
ME .9%
NH 1.3%

2022 Volume Estimate 2027 Volume Forecast 2032 Volume Forecast 5 Yr Growth 10 Yr Growth



10 year growth:
ME 1.8%
NH 6.3%

The Acuity + Occupancy Equation

Thoughtful Level of Care Placement with Focus on Wellness + Lifestyle Offerings

Preventative Health Services

Ancillary Services + Partnerships

Integrated H+W Models

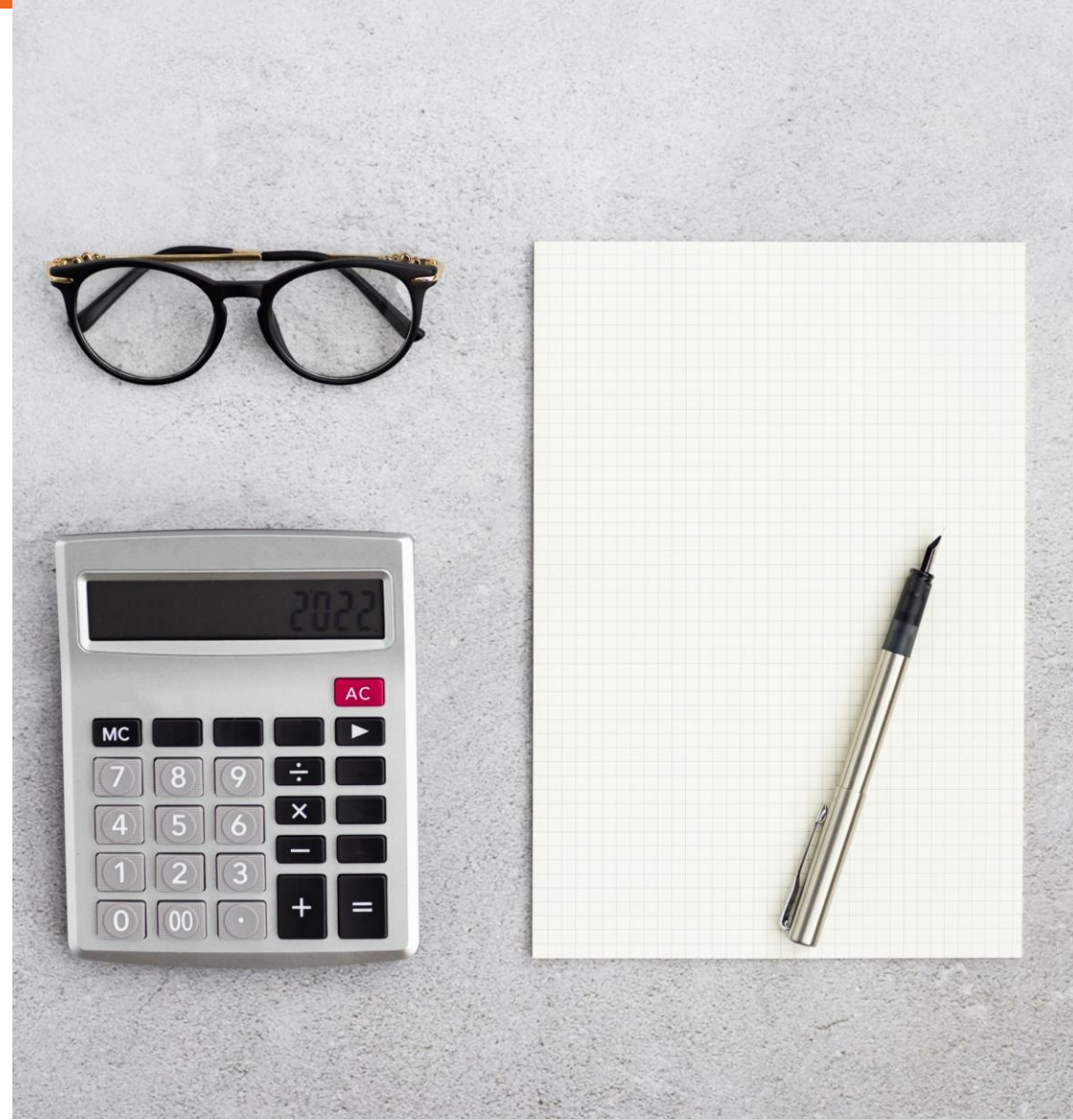
Purposeful Marketing Shift

- Help independent adults “aspire to retire”
- Promote the benefits of community vs staying home
- Combat loneliness & improve social lifestyle

Create a “One Stop Shop” Community

- Lifestyle offerings that appeal to all
- Ease of Access to Care
- Maintain a sense of PURPOSE

Understand the financial impact + success drivers
of YOUR occupancy formula



Population Health Management: *Success*

Recipe for

Customized Approach to Holistic Care

Education/Health Literacy
Participation in well-journey +
healthcare plan
Caregiver + family support

Collaboration of Care

Thoughtful + purposeful
coordination of care professionals
and offerings
Proactive ID of needs
Enhanced Coordination of Care =
Effective Cost Management



Consideration of Social Determinants of Health

Overcome barriers that may exist:
language, socio-economic, access to
healthcare, nutritional support,
environmental, education

Operation *THRIVE*

Data analytics/EMR offerings to drive
support + offerings
Continuous quality improvement
Measure Effectiveness, Revamp Process,
'Rinse + Repeat'
Retain within your 'Health System'!

Health Literacies

Enhancing Health Literacy for Better Outcomes

- **Empowered Decision-Making:** Improved health literacy empowers well-informed decision making, enhancing overall healthcare experiences.
- **Reduced Risk of Re-Hospitalization:** Enhanced health literacy reduces the risk of re-hospitalization by promoting better self-management + adherence to treatment plans.
- **Comprehensive Understanding:** Across various diagnostic groups patients gain a holistic understanding of their health issues.
- **Early Detection:** A well-informed approach enables early symptom recognition + timely medical attention.
- **Preventive Strategies:** Materials include prevention tips, promoting better health + quality of life.

HEALTHPRO HERITAGE
Health Literacy Resource Series: Understanding and
Managing Peripheral Arterial Disease (PAD)

HEALTHPRO HERITAGE
Health Literacy Resource Series: Understanding Sepsis

Sepsis is a life-threatening medical condition that can affect anyone. This comprehensive guide provides an overview of sepsis, its causes, symptoms, diagnosis, treatment, recovery, prevention, and when to seek immediate medical attention. For personalized guidance and information specific to your situation, consulting your healthcare provider is crucial.

Understanding Sepsis

Sepsis is a severe and potentially life-threatening response of the body to an infection. It can lead to organ failure and requires immediate medical attention. Sepsis can develop from various types of infections, including those in the lungs, urinary tract, abdomen, or elsewhere.

Causes of Sepsis

Sepsis is caused by the body's response to infection. Infections can result from various sources, including bacteria, viruses, fungi, or parasites. Anyone with an infection can develop sepsis.

Symptoms

The symptoms of sepsis may include:

- Fever or abnormally low body temperature
- Rapid heart rate and breathing
- Confusion or altered mental state
- Severe weakness or fatigue
- Organ dysfunction or failure

Diagnosis and Treatment

Diagnosing sepsis involves physical examinations, medical history, blood tests, and other diagnostic tools. Treatment may include:

- **Antibiotics:** To treat the underlying infection.

Health Literacy Resource Series: Understanding and
Managing Peripheral Arterial Disease (PAD)

affects the blood vessels
blood flow, primarily to the
of PAD, its causes,
ective management. For
our situation, consulting

the narrowing or blockage
legs and, less commonly,
sclerosis, a process where
blood flow and oxygen
ne factors contributing to

medical factors:
deposits in the arteries is the
ssure, high cholesterol,
heral arterial disease

changes and medical

, regular physical activity,
venting PAD.

ed to assist with urinary drainage
provides an in-depth overview of
, care and maintenance,
medical attention. For personalized
ation, consulting your healthcare

erted into the bladder through
is utilized when the normal urinary
al, allowing for the controlled and

each designed for specific

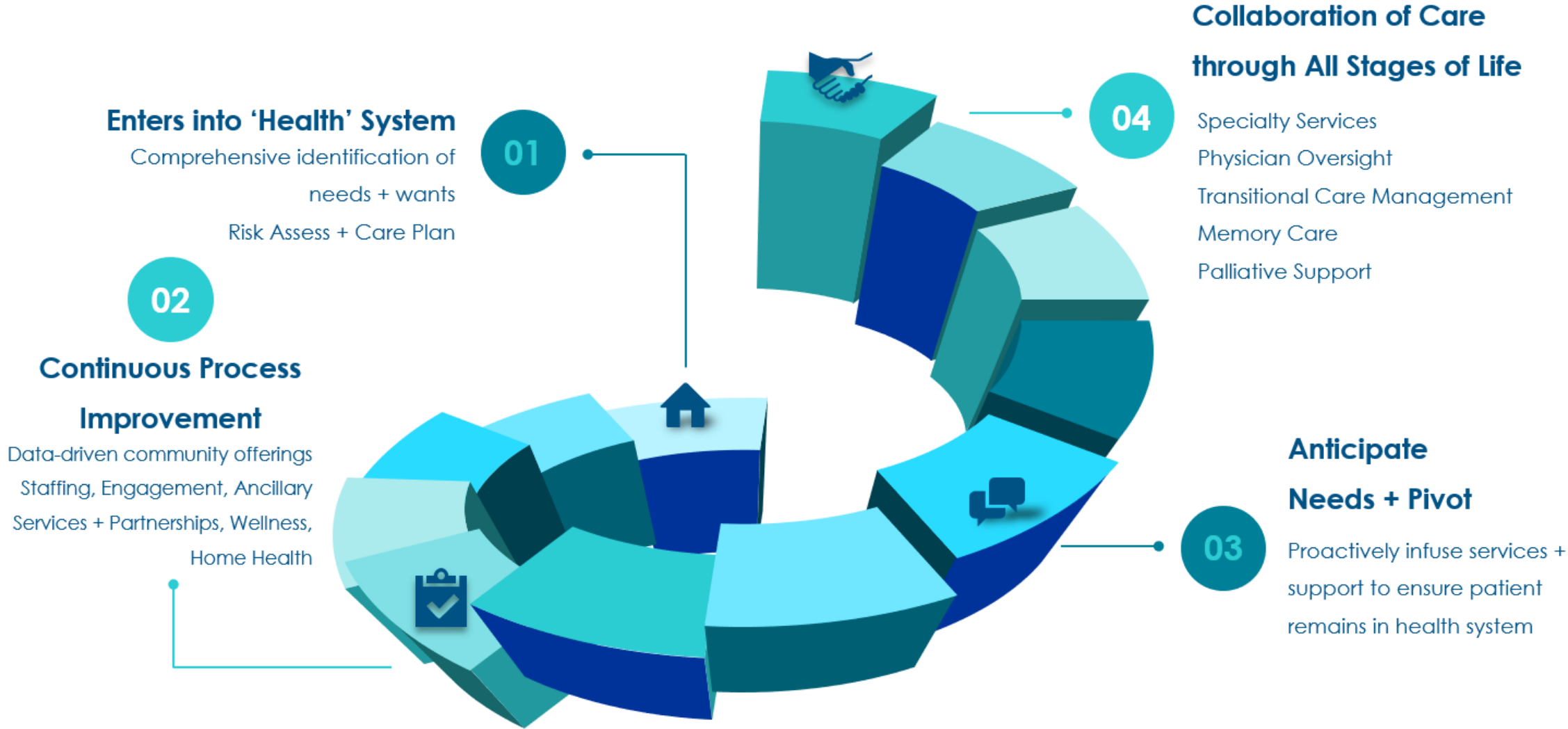
equipped with a small balloon
atheter in place within the
used for extended periods and

re inserted into the bladder
en removed. Intermittent
use, and it minimizes the risk of

through the lower abdomen
heters are an option when the

for men, these external
n and connect to a drainage
o prefer a non-invasive option.

Building Your Continuum



THE
FUTURE
IS
NOW

Disruptive Innovations to Senior Living

HEALTHCARE TO HEALTH

- Run TOWARDS the Change!
- Meeting Consumer Needs in a New Way
- To be the Uber, or the Taxi...
- Reframing Aging and Age
- Reframing Health Around Wellness
- Reframing Senior Care
- Farewell to Models of Dependency

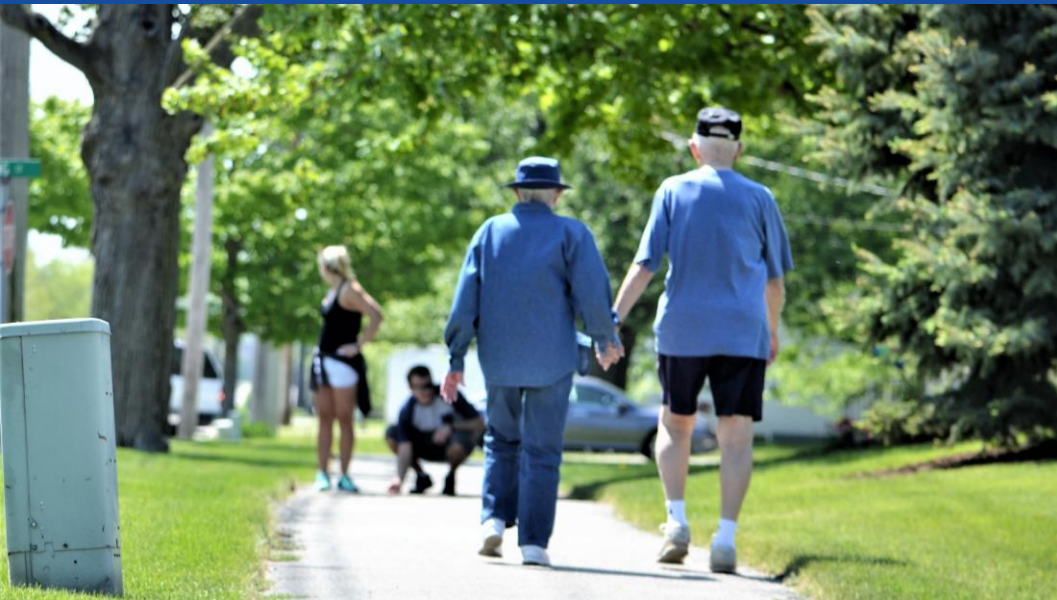


From Healthcare to Health

5-Step Action Plan



Where to Begin?



*Non-negotiable Clinical Programs and Partnerships to Ensure You are Building Upon a **Strong Foundation***

Assess Risk + Know the Opportunities

- Falls Programming
- Memory Care Programming
- Transitional Care Management

- Pharmacy
- Rehab/Therapy
- Wellness/Fitness
- Home Health

Advanced Clinical Programming:

UI, Parkinson's, Pain, Post-Operative Recovery, CHF/COPD, and MORE

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Wellness + Lifestyle Offerings in Action

Don't wait for illness or injury, engage in a proactive wellness process!



Assess Activity Offerings + Engagement Today!



Comprehensive Health and Wellness Assessment should be conducted upon move in and annually



ADD the six-dimensions of wellness into the offerings and prescribed based on the person centered care planning process



Wellness Plans should be person centered and focused on living an active lifestyles and engaging in place

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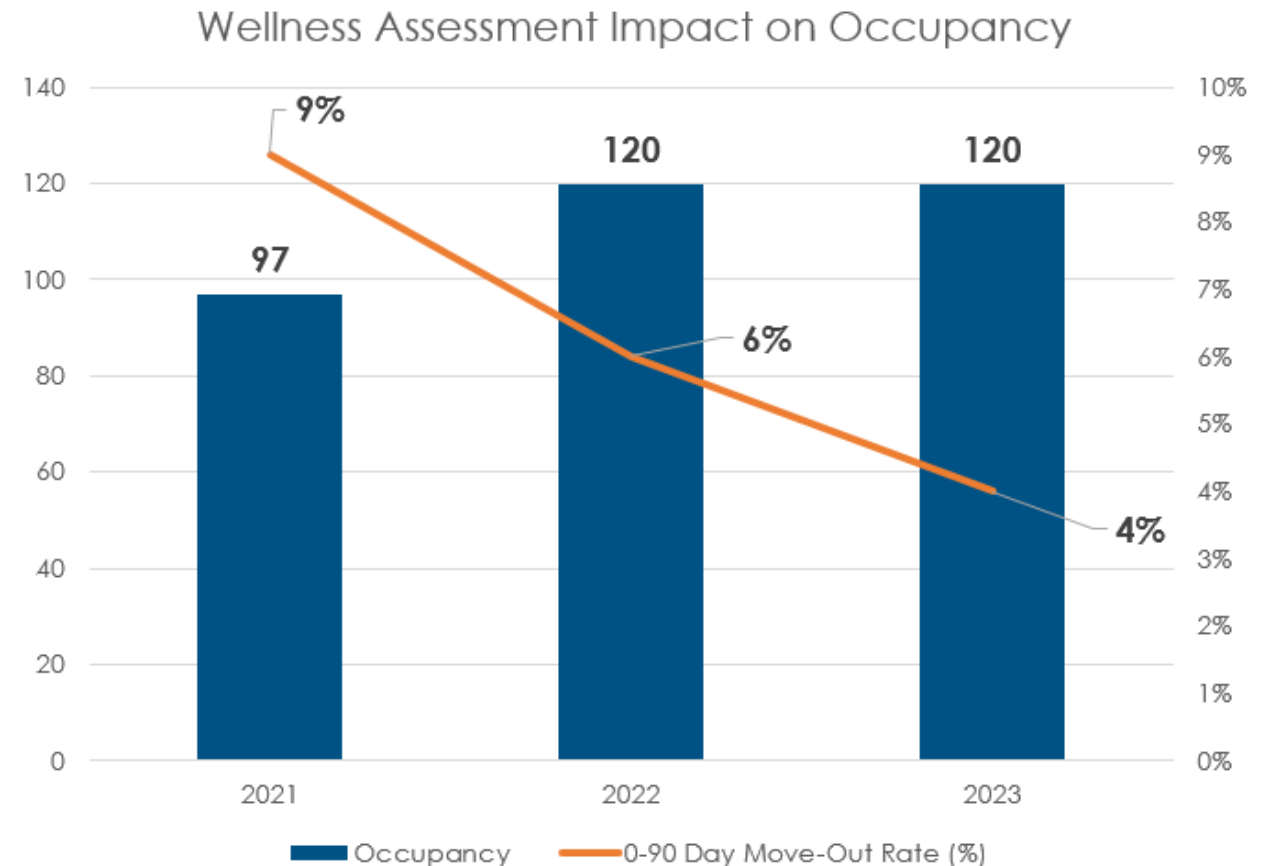
Proactive Wellness Assessments: on Occupancy

The Impact

- Doors opened in late 2020 amidst COVID
- Comprehensive H&W Assessments implemented Jan 2022 resulting in a **55% decrease in move-outs within the first 90 days since 2021!**
- YTD 2023: **45 Assessments Completed** resulting in **94 therapy tracks opened!**

Avg Cost of Assisted Living*: \$233/day
Preventing 5 move-outs/year results in
\$425K in revenue preservation

120 Unit Assisted Living Facility in Indiana



*SOURCE: National Investment Center for Seniors Housing & Care

Lifestyle Offerings: Enhance Your Life Enrichment

Take a Whole-Person Wellness approach to activity programming!

*Personalized, Meaningful + FUNctional
Activities that suits the needs of your
community*

Activities for all 6 Dimensions of Wellness

Diverse range of exercise classes

Special programming for all stages of dementia

Comprehensive training for activity staff

Strategic Scheduling of activities with
consideration for facility staffing

SUCCESS BY THE NUMBERS! CASE STUDY: NY

11.1 Implementation of SNF Activities Program in
New York!

12 FTE's in 11 units!

20% growth in program offerings (with more
coming!)

Attendance has increased by 50%

Inclusive of:

*Meditation • Dancing • Journaling • Spa Days • Pottery •
Jewelry Making • Knitting/Crochet • Spanish Club •
LGBTQ+ club • AND SO MUCH MORE!*

Leveraging Your FMD



Assessment

Internal & state requirements
Determine level of care & service plan
Move in & Annually
At any time of a change in function



Assessment Plan – Service Plan of Care

Document scheduled tasks
Provide interventions as appropriate
Track compliance



Unscheduled Services

Intervention Planning/ At risk
Timeline for prior level
Possible change in level of care & payment
Communication



Point of Care Tasks

Track service delivery & completion
Track compliance
Will show insight into unscheduled services/tasks

Meaningful Metrics: Understand the

Impact



Falls, Incident + Injury Metrics

WHY: Showcase impact of services on resident abilities

HOW: Care Coordinator, Resident Care Director



ALOS by Care Setting + Pt Risk Info

WHY: Highlight impact of services on successful aging + engaging in place

HOW: Billing Office + Transitional Care Team



Occupancy, Inquiry + Move In/Out Stats

WHY: Monitor impact of services on occupancy growth + “closing the back door”

HOW: Admissions + Marketing



Staffing Needs

WHY: Identify opportunities for strategic, collaborative solutions

HOW: Executive Director + Team

Redesigning Care: High Presence PCP Model



Physician Schedule: Rounding, Clinic Hours, Extender Presence

Annual Wellness Visits: Move In + Annual

Therapy + Wellness Coordination

IDT Risk Review Meetings

In House Treatment Model

Transitional Care Management

Transitional Care Management + YOU

A vital service that supports independent & assisted living residents

STRATEGIC APPROACH FOR SUCCESS

Transitional Care Management [TCM] is a package of services provided by a physician or NPP for patients that require moderate or high-complexity assistance with medical decision-making when transitioning from inpatient hospital, partial hospital, observation hospital status or skilled nursing facility to a patient's community setting.

INPATIENT HOSPITAL PARTIAL HOSPITAL OBSERVATION HOSPITAL SNF → AL / IL / CCRC

Why Provide TCM? TCM recognizes the importance of care coordination into focus, ensuring patient needs are met by consistent provider involvement. By providing TCM services, it allows financial capture for services often already rendered.

SENIOR LIVING ROLE

- Support PCP on TCM Codes
- Coordinate with PCP upon discharge from SNF/Hospital to Home/Home Health
- Utilize this opportunity to discuss direct admit into SNF
 - Discuss current advanced clinical capabilities
 - Coordinate communication with PCP

PREVENT BARRIERS TO TRANSITIONS!

• Discharge planning

• Patient education

• Care coordination

GET THE MOST OUT OF YOUR TCM SERVICES

• Communicate with PCP

• Understand TCM codes

• Review discharge plan

Transitional Care Management

30 Day Worksheet

TCM Requirements for Post-Discharge Contact Deadlines:

2 Days Post DC: ____/____/____

7 Days Post DC: ____/____/____

14 Days Post DC: ____/____/____

Patient Name: _____

Patient DOB: ____/____/____

Discharge Date/Day: ____/____/____ M T W Th F Sa Su

Patient's Physician: _____

Contact Information: Patient Caregiver, Name: _____ Relationship: _____

Discharge Destination:

Home Family Member Home Non-Family Member Home Assisted Living Facility

Independent Living Facility Home Health, Agency: _____

Outpatient Center: _____ Rest Home Other: _____

Risk Assessment:

Problem medications Psychological Polypharmacy Principle diagnosis

Poor health literacy Patient support Palliative care Prior hospitalization

0-2 Triggers = Low Risk 3-5 Triggers = Moderate Risk 6-8 Triggers = High Risk

Consider Cognitive Assessment and Care Plan Services

Advantages

- Increased Care Coordination
- Provider Services Revenue Boost
- Physician Driven Program supported by IDT
- Consistent Provider Involvement
- Collaborative Discharge Planning Process
- Marketing Tools
- Reduced Hosp Readmission Rates
- Safe transition throughout the

Continuum CMS Promotes

+ Communication with patient or caregiver (phone, e-mail or in person) within 2 business days of discharge

PFS Final Rule expands concurrent billing codes; reduced from 57 to only 29 codes

Create a “Health Hub”

Attractiveness to ‘senior living’ is convenience of care + ‘One Stop Shopping’

Consider a model that provides that experience to patients *through strategic channel partnerships*

Greater Ease of Access + Increased Compliance to Care = Clinical + Operational Excellence

Transportation • Specialty Physicians (i.e. Cardiology, Orthopedic, Dermatology) • Pharmacy • Lab • Spa services • Nutritional support • Holistic Wellness Services • Skilled Therapies • Dental • Vision • Behavioral Health • Imaging • Remote Patient Monitoring • Telehealth Services •

Home Health



Interventions + Partnership

Checklist

Systems + Supportive Partners are
Crucial to Success



Telehealth + Physicians:

Annual Wellness Visits, Referrals to specialists, high presence in high acuity locations



Outpatient Therapy Programming and Quality Outcomes + Wellness Programming



Quality Home Health Services



Artificial Intelligence & Technology Integration

The Importance of Behavioral Health

4

Mental Health is HEALTH!

Accessible Support Services

- Psychiatric Evaluations, Medication Management, Therapy + Counseling, Staff Training
- MCR, MCD + Private Insurance billing option

Holistic Care Approach

- Depression, Anxiety, PTSD, OCD, Bipolar Disorder, Schizophrenia, Alzheimer's Disease, Dementia, Recent Life Changes, Antipsychotic Mediations + More

Integrate into Wellness Offerings

- Therapy Comprehensive Health & Wellness Assessments

Robust Care Team

- Increase Touchpoints
- Coordinated Care + Communication
- Build Your Village



Why TeleMental Health?



- Ease of access to quality care
- Antipsychotic medicine reduction
- Manage unwanted behaviors
- Alleviate staff burden amongst nursing + caregiver shortages
- Supportive documentation provided in addition to collaborating in care plan needs
- Provide necessary care to decrease risk of hospitalizations or move-outs
- Support for staff emotional well-being/mental health

Leveraging Tech + Data

Embracing Technology: Make it Work for YOU

Insights through machine learning & artificial intelligence

Changes & trends in behaviors

- Transportation
 - Dentist visits
 - PCP visits
 - Outside activities
- Wellness & activity participation
- Dining preferences
- “Medical Concierge”
- Communication to support seniors’ engagement
- Predictive analytics
- Wearables & RPM/RTM

Cubigo

VirtuSense

Aware

Owlytics

TouchTown

Forsite Solution

Tranquility Lifestyle Solutions

Leveraging Technology to Enhance Outcomes

Fall Prevention



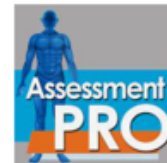
Tranquility Lifestyle Solutions



Resident Engagement + Wellness



Enhancing Therapy Outcomes



Remote Patient Monitoring



Additional Solutions



Shifting Mindsets



“What got us here, won’t get us there.”

–Marshall Goldsmith

Technology is required. It has a substantial impact on staffing, engagement & proactive care for long term success. Leverage the data available to you.

Becoming a destination for older adults who thrive. A place that feels like home but elevated. This will drive occupancy & financial stability.

Redesign purposeful partnerships that will drive holistic and collaborative resident care along with quality outcomes.

Shift away from a reactionary and healthcare driven model to a proactive, health and wellness model of care. Utilize all levels of care + resources to provide the **RIGHT CARE** at the **RIGHT TIME** in the **RIGHT PLACE**

THANK YOU

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