## dispatchhealth



Partnering for Success
Innovative Acute Care Strategies to
Enable Residents to Age in Place

## **Session Agenda**

#### Introductions

Jacquie Owens – SVP, Elara Caring Sara Crate, Chief Commercial Officer DispatchHealth

#### **Company Overviews**

Elara Caring
DispatchHealth

#### Successful Partnerships

Pillars and Best Practices







#### **Our Mission**

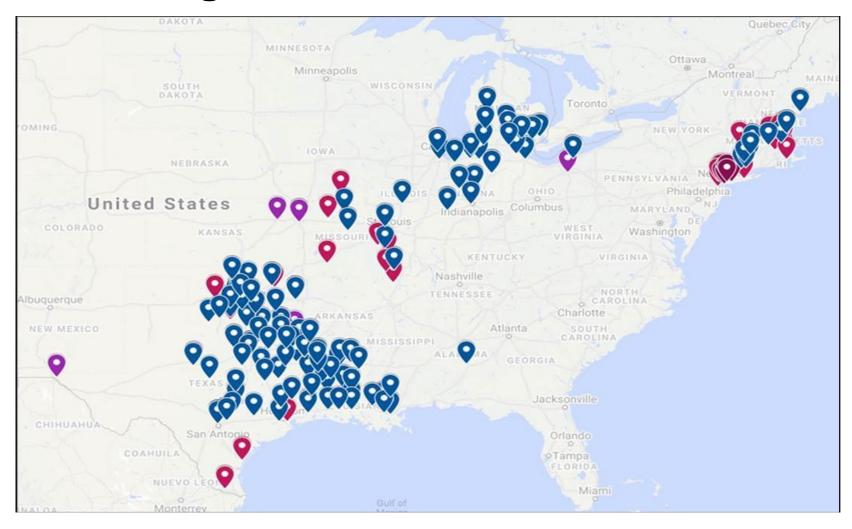
We believe the best place for your care is where you live.

We exist to deliver exceptional personalized healthcare services wherever you call home.

We do this by hiring compassionate people who believe in taking care of our patients, our clients, our care providers and each other. We strive to foster personal development and empower a collaborative team approach to ensure we are delivering the **right care**, **at the right time and in the right place**.



## **Elara Caring Overview**



16 States

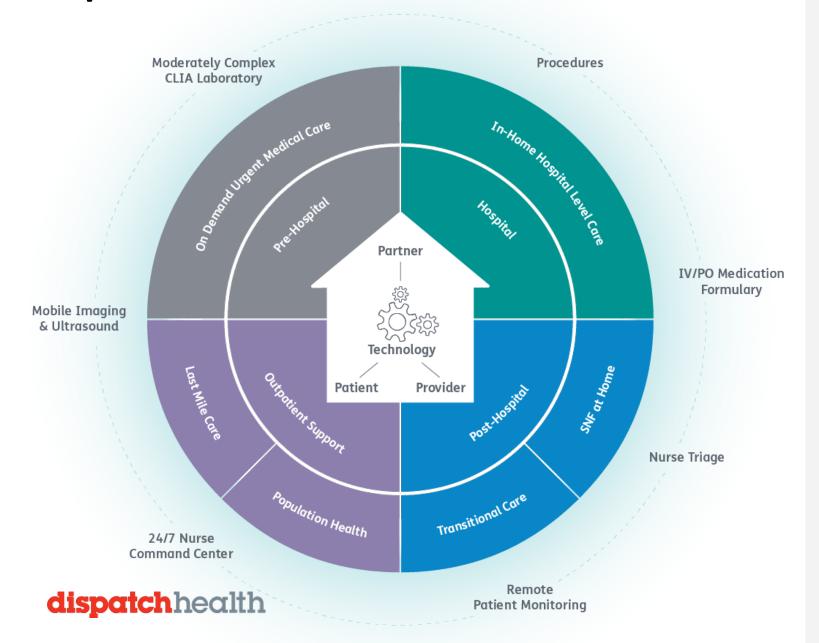
225 Offices

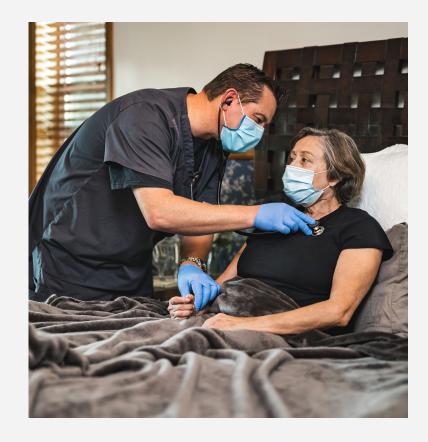
35,000 Team Members

60,000 Patients



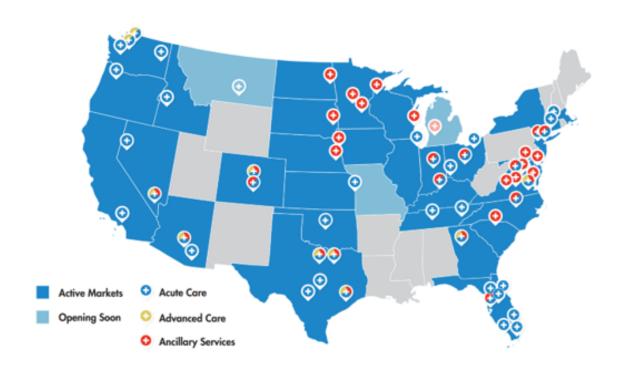
## **DispatchHealth Overview**





We bring the power of the hospital to the comfort of home.

## **DispatchHealth Experience**



**Patient Volume** 

Patient Satisfaction

Medical Cost Savings

## 100s of Thousands

Of patients treated in their home >1200 employed clinicians

**95 NPS** 

Net Promoter Score **95** (Healthcare Avg <30)

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\$1,100-1,500 net savings per acute care visit \$5,000-\$7,000 net savings per in-home hospitalization





































































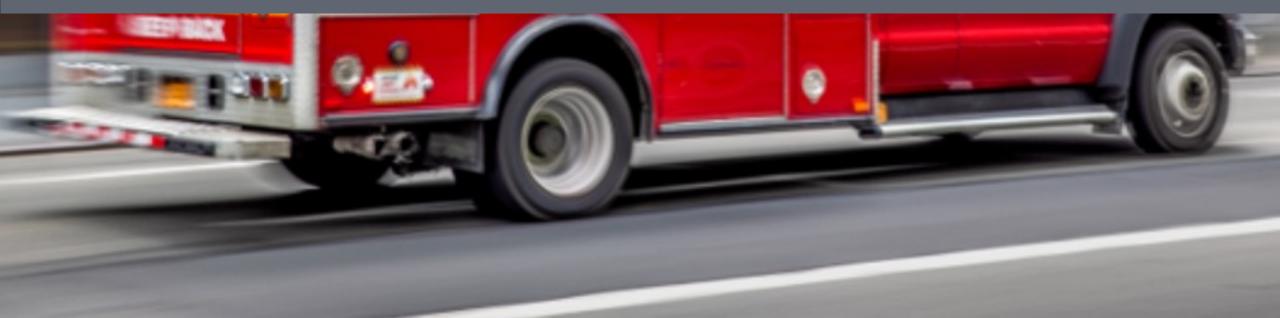


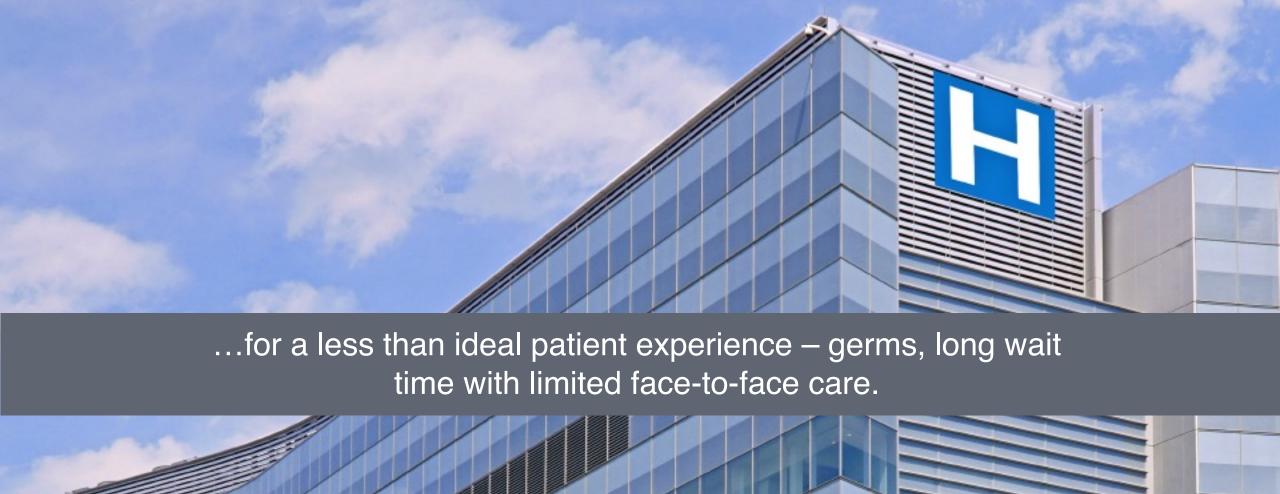


What happens when health situations arise that are urgent but not-life threatening, but beyond the scope of care you can provide in-house?



Typically, it's a stressful transport ...









What if there was another option to get same-day complex healthcare?

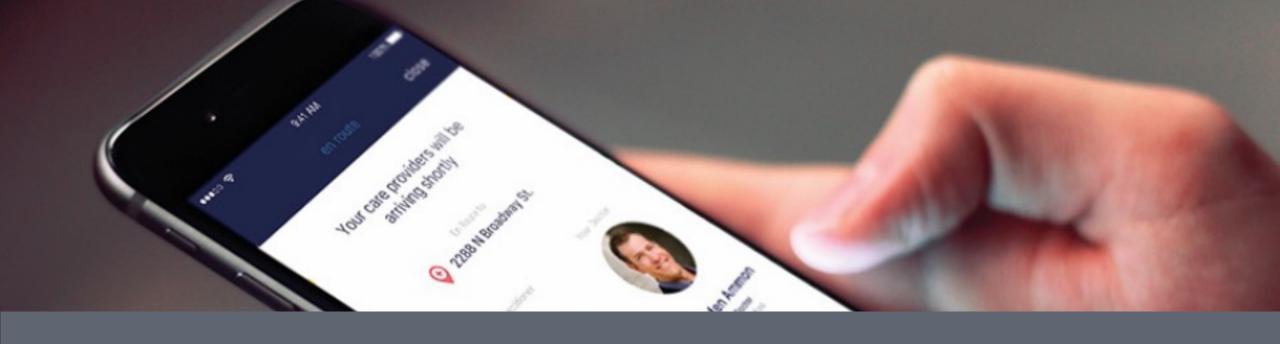




Focused on the people - the patients, providers, and the necessary tools.

Brought to a comfortable place.

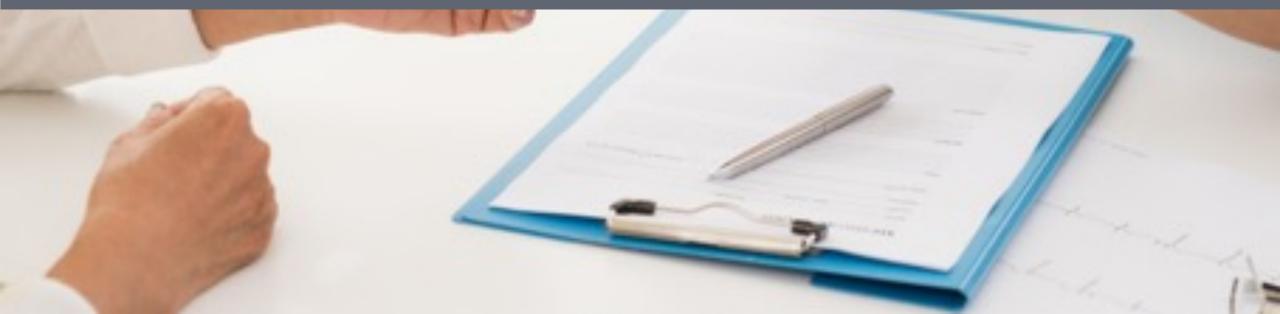




Backed by powerful technology at the core to drive quality, safety, efficiency....





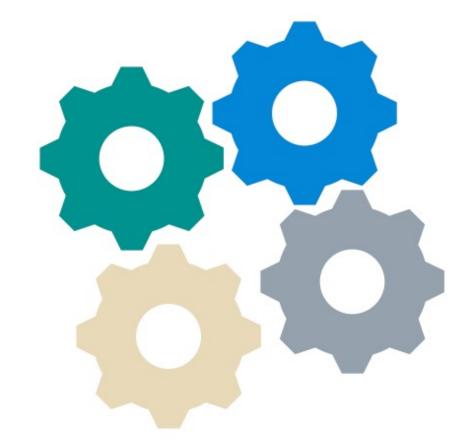


## Elara and Dispatch help Seniors Avoid Unnecessary ER Visits



## What Defines a Successful Partnership?

**Aligned Goals** 



Communication

Innovation & Growth

Collaboration



## Emergency Care Challenge - Billions Wasted in Unnecessary Care



Avg 30 Day ER bounce back rate for the same complaint

20%

Potentially avoidable senior living admissions cost more than

\$4 billion annually



Percentage of nonurgent ER visits

40%



Percentage of discharged inpatients that bounce back to the ER

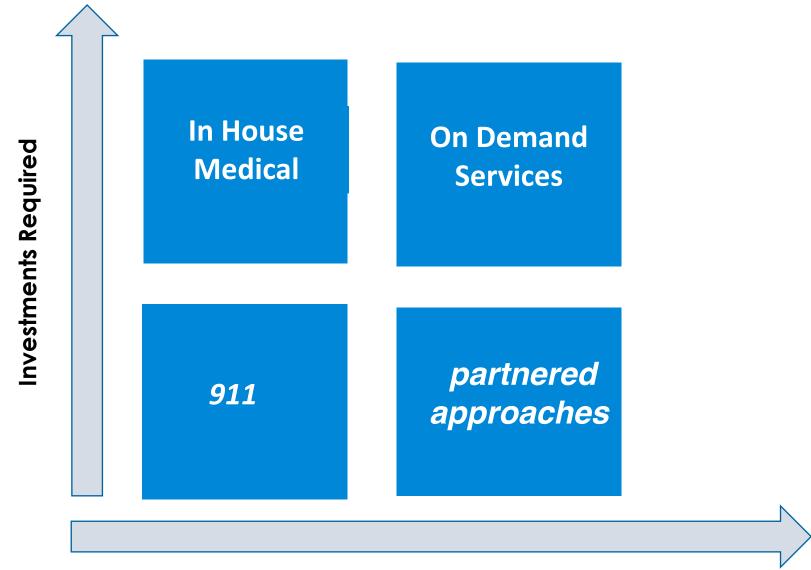
25%



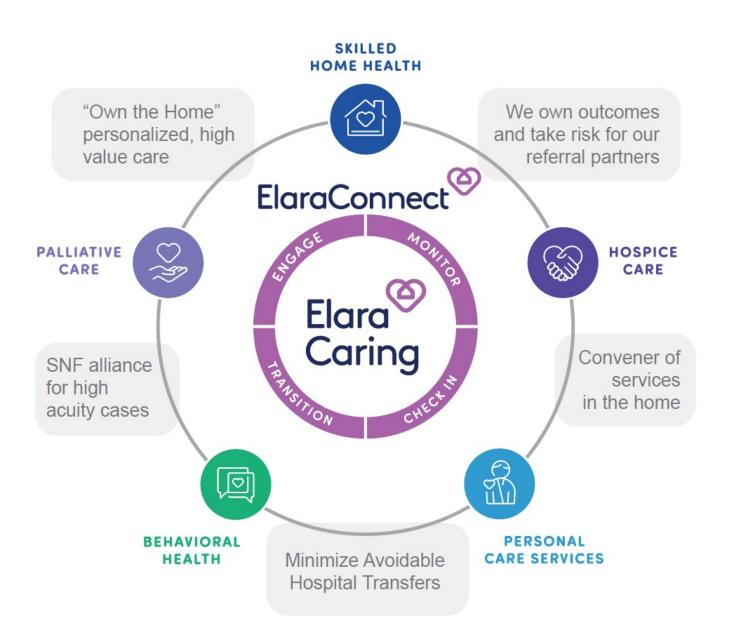




## **Options for Acute Care Available Today**









## Hospitalization Prevention

#### **Circle of Caring**

Designed to meet your patients' unique in-home care needs.

#### **ElaraConnect**

High touch and ongoing patient communications and follow-up.

#### **Call Us First**

24/7/365 Help Line for patient or caregiver questions or concerns.

DispatchHealth Team: Experienced Providers

Connecting Care



**Nurse Practitioner or Physician Assistant** 

On-scene care delivery

Care coordination responsibility

Emergency room experience

Prescriptive authority



**DispatchHealth Medical Technician** 

EMT trained

Helps with procedures/labs

Drives car, so NP/PA can document

clinical notes



**ER** physician

On-call

Virtual capabilities



## Collaboration

## Building programs together

For a program to be deemed valuable to our partners, they need to align to the patients needs, the specific population care gaps, and both organizations values/missions. Those are unique to each and based on data and trends identified.

Our partners may want to customize existing programs or collaborate to build a new program. This is one of the great ways we can ensure patient needs or population needs are met.



- Let's meet! Whether in-person or over the phone, discussing what makes sense and developing a partnership is key.
- Let's share data! Analyzing, patient dx, hospital costs incurred, LOS, provider/hospital discharge trends, etc.
- Let's develop terms! We will work with you to ensure we memorialize our partnership that supports both parties intent, needs, and wants.
- Let's educate! Each party educating their respective team members on the program(s) is key to ensuring success



## **How the Partnership Collaboration Works**

#### **CALL DISPATCHHEALTH**

- For urgent but not life-threatening conditions or injuries
- Well suited for patients who struggle with access to care / mobility issues

 Available in most markets from 8 am - 10 pm, 7 days a week, including holidays

## SAME-DAY COMPLEX MEDICAL CARE

In the place seniors call home Average 50 minutes face-to-face





#### **POST VISIT**

- We call in prescriptions
- We send clinical notes to the patient's care team
- We handle billing with patient's insurance company





# Post Care – Connecting Care back to Elara and other stakeholders in the patient's care plan

Dispatch calls in prescriptions

We update the family doctor

And, we manage all insurance and billing



## Communication

# The key to successful long-term partnership

For a program or partnership to be successful, on-going communication is necessary.

Establishing a regular cadence of meetings or JOC is recommended in order to monitor the performance, navigate barriers, and identify need for change.

Data and outcome sharing is also necessary in order to determine success and fulfillment of program obligations by the parties.

- ✓ Let's determine appropriate meeting cadence!
- ✓ Let's identify the timeline for data sharing and/or data needs!
- ✓ Let's identify the proper point of contact in each organization for program needs!





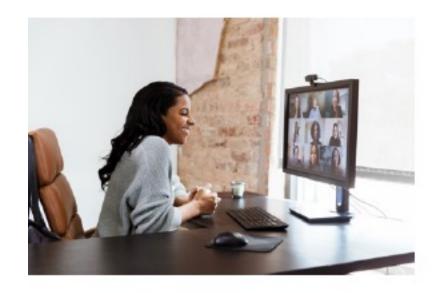
## **Sample Partnership Communication Cadence**

Meeting	Goal	Kindred attendance	DH attendance	DH lead
Monthly local branch meeting	Educate local home health staff on DH model and activation process	<ul><li>Local branch manager</li><li>All clinical staff</li></ul>	<ul><li>Local BDR</li><li>Market manager</li><li>Lead APP</li></ul>	Market Team
Monthly national business development meeting	Review utilization and outcome data. Ensure processes are working	<ul><li>Susan Prowse</li><li>Lori Witt</li><li>Sherri Raines</li><li>Lisa</li></ul>	Micheal Phillips	Micheal Phillips
Quarterly JOC	Review utilization and outcome data. Identify opportunities for increased alignment and partnership	<ul><li>Susan Prowse</li><li>Lori Witt</li><li>Sherri Raines</li><li>Lisa</li></ul>	Micheal Phillips	Micheal Phillips
Bi-annual regional education meetings	Education to all region teams. Update on new services and coverage area		<ul><li>Market Manager</li><li>BDR</li><li>Lead APP</li></ul>	Micheal Phillips



## Phase 1 – Local Leadership Kick-Off

District Director of Clinical Service, District Director of Operations, Executive Director, Department heads, & Visiting Providers









Weekly Cadence Set With DCO & Initial Intro to Leadership

2

Department Head Stand-Up, Staff Intros & Reference Guide 3

Care Team Meet & Greet



## Phase 2- Local Community Launch and Education







Resident Introduction, Events & Reference Guide

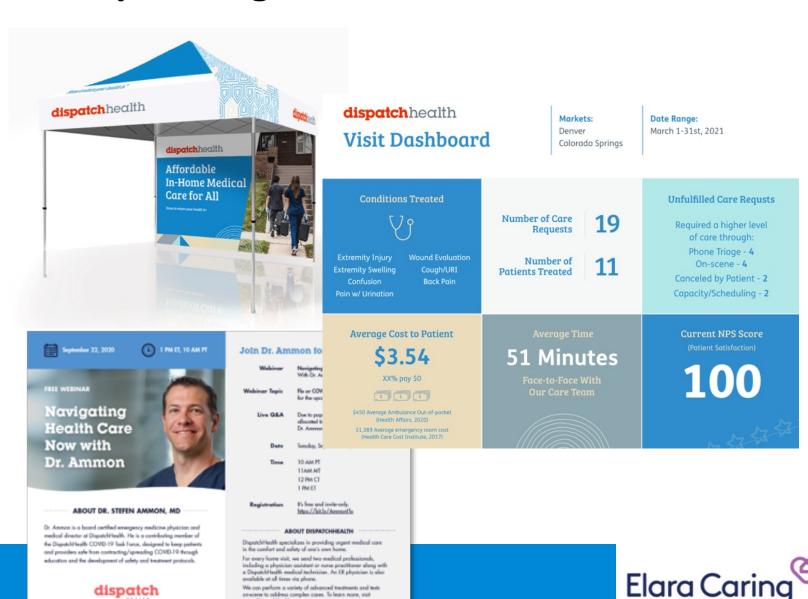
Family Letter & Engagement

Visiting Provider **Event/Dinner** 



## Phase 3 – Ongoing Partnership Management

- ✓ Regular quarterly KPI reporting
- ✓ Case review, feedback loop what's working, what's needs improvement?
- ✓ Continued education sessions
- ✓ Ongoing resident & family events
- Collateral refresh



We care where you are.

on-scene to address complex cases. To learn more, visit

www.DispetchHealth.com.

## Innovation

# Creativity fuels long-term success

As our partnership evolves, we can identify, analyze, and evaluate ways to improve or modify a program in order to bring value and improved outcomes to you and our mutual customers.

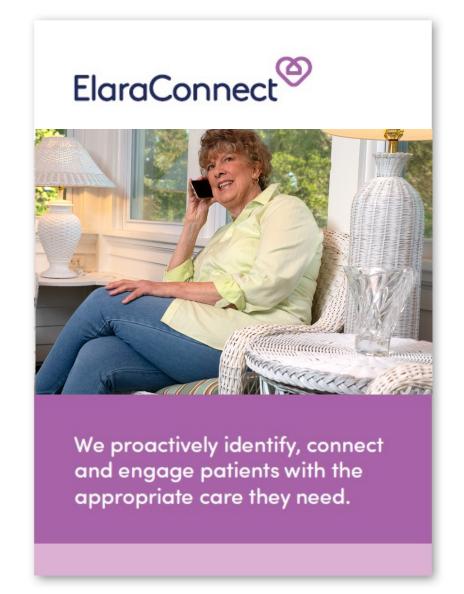
Innovation is necessary to ensure continued success. As more data is gathered, health policies change, the healthcare landscape changes, and the health of the population changes, we can work together to once again develop value programs that continue to meet the needs of the population.

- ✓ Let's evaluate member/patient data!
- ✓ Let's develop new metrics!
- ✓ Let's create new payment methodologies!
- ✓ Let's develop new programs!





### **Telehealth and Added Care Support Programs**



## Engage

Our Engage program provides personalized and interactive automated phone calls paired with timely manual calls that assess for significant changes in health status and alert appropriate professionals to contact the patient.

## Monitor<sup>®</sup>

Our Monitor program is for the top 10% at-risk population. It utilizes specialized devices and offers a mobile app for timely remote monitoring of vital patient health parameters and status.

### Check In®

Our Check In program starts after discharge from Skilled Home Health to provide personal follow up. This program bridges the healthcare gap to help patients get the care they need in a timely fashion.

## Transition

Our Transition program works closely with the Skilled Home Health team to assess patients for decline and identify patients who could benefit from and be eligible for hospice to ensure an easy transition.



833.GoElara Elara.com/refer



#### 2021 ElaraConnect Outcomes

### **Monitor Program**



5% Improvement in 30-Day Hospitalizations

Program averaged **12.0%** 30-day readmissions compared to risk-adjusted **12.6%** projection from SHP, resulting in fewer hospitalizations



1000+ High Risk Patients
Impacted as Program Scaled

Program impacted more than 1000 high-risk patients in 2021, an increase from prior years.



20.1% More At-Risk than Non-Monitor Groups

Program averaged **3.55** average SHP risk scores compared to the **2.95** non-Monitor group, indicating Monitor took on more risk in 2021.

## **Check-In Program**



100k+ Conversations with Discharged Patients

Highest level of engagement on record in history of program, improving 48% from pre-COVID levels



10k+ Needs Identified with 5k+ Needing Skilled Care

Over 50% of community needs identified qualified for skilled care in their home



3k+ Successful Admissions for Skilled Care

2<sup>nd</sup> highest level of home health admissions in history of the program

## **Engage Program**



**30% Total Census Coverage and Impact** 

Increased census impact by **39**% year over year from end of 2020, reaching more of our high-risk census



45k+ Alerts Identified and Triaged Successfully

**30% increase** in alerts identified and sent to the branch, outpacing 2020 service levels and increasing interactions with high-risk patients



98.8% Alerts Triaged within 30 Minutes

Great results done fast, with massive improvement in speed of alert triage compared to 2020 service levels near 17% in 30 minutes



<sup>\*</sup>All program data measured across all payors within Skilled Home Health service line for calendar year 2021

<sup>\*</sup>SHP = Strategic Healthcare Programs. Source for 30-day rates, as well as risk for hospitalization data for the Monitor Program

<sup>\*</sup>Check-In and Engage Program data sourced from Medalogix

## **Question & Discussion**

If you'd like more information on our approach, contact:

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