HENRY FORD HEALTH®

Driving Excellence in Health Care through Post-Acute Care Initiatives

Gloria Rey PA-C; MPH

Director Post-Acute Care

Henry Ford Health/Populance

Henry Ford Health Overview

Full Continuum of Services

- 13 Hospitals
- Eye Care, Pharmacy, and Other Healthcare Retail
- Multispecialty Centers
- Primary and Urgent Care Centers
- 3 Behavioral Health Facilities
- Health Insurance
- Clinical Integrated Network
- Home Health Care, Hospice, & Hospital at Home
- Population Health

Employees

Among Michigan's **largest** and most **diverse** employers

>50,000

Valued Team Members

Nearly 6,000

Physicians & researchers from Henry Ford Medical Group, Henry Ford Physician Network and Jackson Health Network

A Leading Academic Medical Center

It is one of the nation's leading academic medical centers, recognized for clinical excellence in cancer care, cardiology and cardiovascular surgery, neurology and neurosurgery, orthopedics and sports medicine, and multi-organ transplants.

>4,000

medical students, residents and fellows trained every year across 50+ accredited programs

>2,000

research projects engaged in annually

HENRY FORD HEALTH

HENRY FORD ENTERPRISE

Henry Ford Health...

...is a care delivery organization that provides clinical services across the care continuum

2.5 million+
Lives Served

50,000+
Team Members

6,000+
Physicians & Researchers

13
Acute Care Hospitals

550+
Locations in Michigan (Primary & Virtual Care, Home Health, Eye Care, Retail, Pharmacy)

Populance...

...is a population health services company that works with organizations to improve outcomes and experience while reducing cost

500,000+
Value-based Lives Served

170+
Team Members

90,000+
Shared HFH/HAP Lives

Health Alliance Plan...

...is a health insurance organization that offers a range of affordable insurance products and is a formal risk-bearing entity

400,000+
Lives Served

800+
Team Members

50,000+
Network Provider Partners

Plans
Commercial (employer & individual), Medicare, Medicaid, Self-funded

populance

$13 Billion in Revenue

New Regions

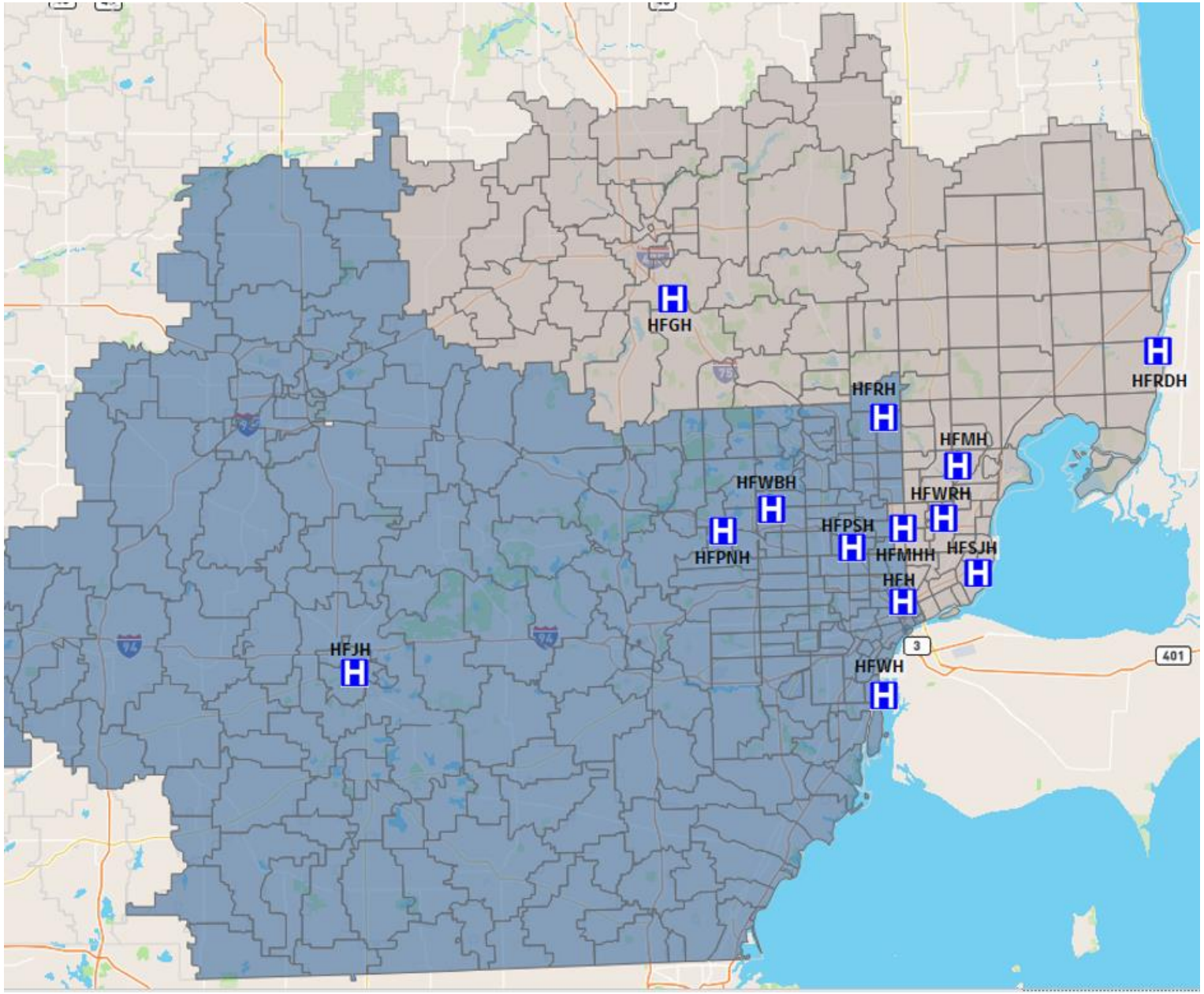
Legend

HF Hospital

Region

East

West



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Advancing Fairness in Healthcare

- Fairness ensures similar access to healthcare for all populations
- Post-acute care initiatives can reduce disparities in operational and performance outcomes
- Standardized metrics can help addresses barriers in underserved communities
- Data-driven strategies help identify and close gaps in care
- Collaborative/Standardized care models promote inclusive patient support

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Henry Ford Health
Post-Acute Care Strategy

Patient Care

- Post Acute Care Surveillance Team

Hospital Support

- Referral Analysis/Management
- Inpatient Case Management

Network Management

- Post-Acute Network Program Manager
- PAN/Local Meetings
- Scorecard Development
- Quality Reports
- Analytics
- Hospital Relationships

Program Development

- Virtual Specialist Program
- Discharge Workflow Improvement (ex. Dialysis, Referral)
- Pharmacy Delivery Program
- Mosaic ACO Administrative Support

Patient Care Journey: From Admission to Post-Acute Resources

Patient admitted to hospital for acute care and stabilization

In-hospital treatment and multidisciplinary care coordination

★ Discharge planning initiated early with case management team

★ Transition to post-acute care provider based on patient needs

★ Enhancing post-acute services and quality of care

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Objectivity for Post-Acute Partners

Networks

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Requirements for All Post-Acute Network Providers

Submit	Submit ADT feeds to MiHIN or CarePort
Attend	Attend 75% of Post-Acute Council Meetings
Attend	Attend one quarterly market meeting at the local hospital
Place	Place at least 20pts in building(SNF)/50(HHC)/10 pts (Hospice) in company in last 6mths
Maintain	Maintain at least 5 of 10 on scorecard
Work	Work collaboratively with Transformation Project Specialist and PACS team
Respond	Respond to Quality Concerns
Ensure	Ensure Post-Acute Network and Post-Acute Provider Continuing Care Agreement

Metric	Goals
30 Day Rehospitalization Rate (ADT)	> 22%
Short Stay CMS LOS	< 26days
CMS Star Rating	>=3
Adjusted CMS 30 day Readmission Rate	< 23%
CMS Penalties – Last SNF Survey	<= $50 000
Adjusted Total Nursing Hours	>= 4.0
% High Risk Patient Placements (Hold)	<=25%
Referral Acceptance Rate	>=50%
Complex Payer Placement Rate (MCAID/MCAID HMO/Pending)	>=10%
Average Time to Definitive Answer	<= 120min
Medicare Beneficiary Spend	<0.9

SNF Post-Acute Network

- Updates
  - January
  - July
- Date Range of Data
  - Previous 6 months from launch
- Inclusion Criteria
  - Score of 5 or greater

Metric	Goals
Historical Quality Patient Care Star Rating	>=3
Historical Quality Timely Initiation of Care	>=90%
HCAHPS Patient Survey Star Rating	>=3
Acute Hospitalizations within first 60 days of Home Health	<=16%
Urgent Unplanned ED Visits Without Admission	<=10%
Medicare Beneficiary Spend per Episode, Compared to HH Facilities Nationally	<=95%
% High Risk Patient Placements	<=25%
Referral Acceptance Rate	>=50%
Complex Payer Placement Rate	>=10%
Average Time to Definitive Answer	<= 120min

Home Health Care Post-Acute Network

- Updates
  - April
  - October
- Date Range of Data
  - Previous 6 months from launch
- Inclusion Criteria
  - Score of 5 or greater

Metric	Goals
Rating this Hospice	>=85%
Willing to Recommend this Hospice	>=85%
Hospice and Palliative Care Composite Process Measure	>=93%
Observed Hospice Visits in the Last Days of Life	<=65%
Hospice Care Index	<=9.0
Observed Late Live Discharges (% Live Discharges)	<=35%
% Per Beneficiary spending (US Dollars)	<=10%
Observed Skilled nursing minutes on weekends (% minutes)	>=20%
Referral Acceptance Rate	>=50%
Average Time to Definitive Answer	<= 120min

Hospice Post-Acute Network

- Start date – April 1, 2024
- Updates
  - April
  - October
- Date Range of Data
  - Previous 6 months from launch
- Inclusion Criteria
  - Score of 5 or greater

Henry Ford SNF Post-Acute Network – Q3 2025

July 2025– December 2025

SNF Scorecard

Updated 06/24/2025

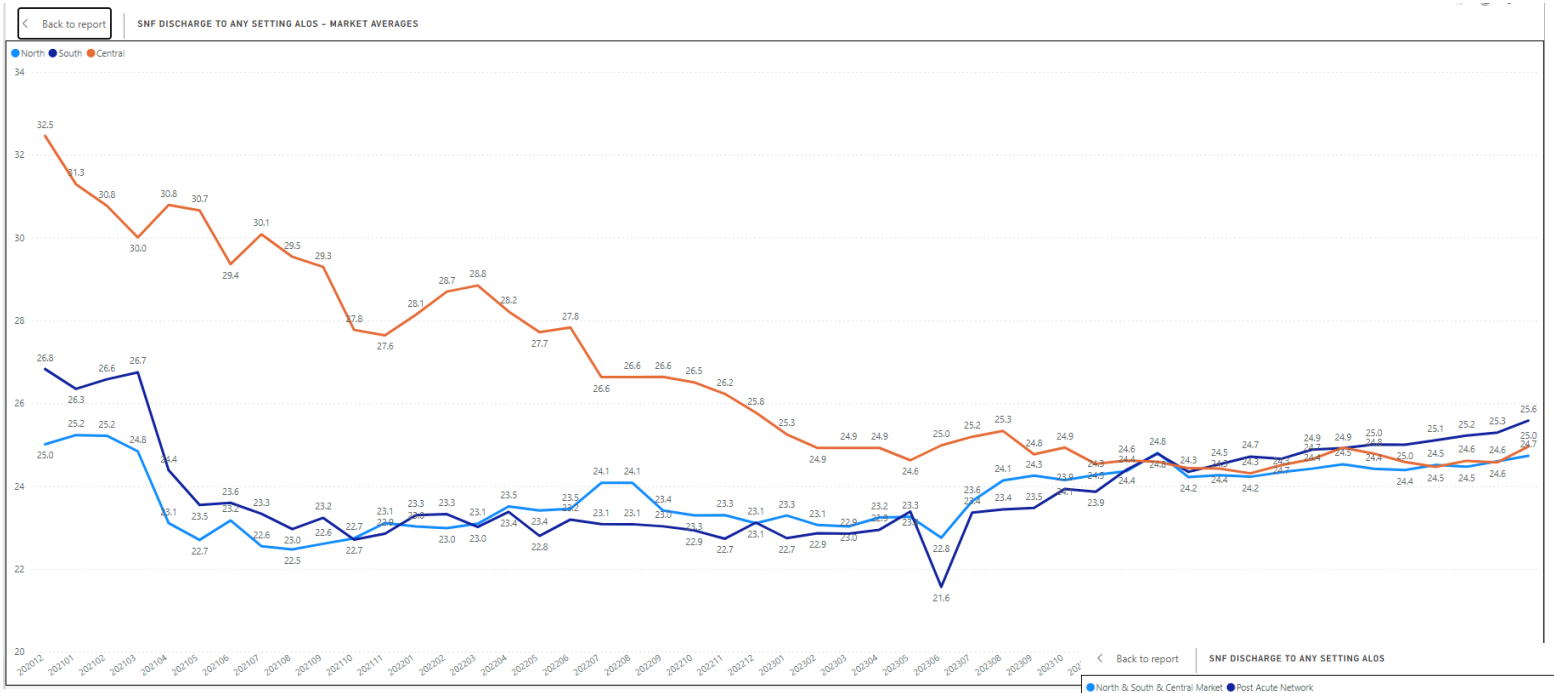
Careport statewide metrics as of 05/31/2025, 12-month look-back period (green)

Aggregate HFHS referral data for 12/01/24-05/31/25 (yellow)

Metrics included in the Total Score: 30 Day Rehospitalization Rate, Short Stay LOS, CMS Star Rating, CMS 30 Day Readmit, CMS Penalties, Nursing Hours, Medicare Spending Per Beneficiary, Referral Acceptance, Medicaid Placement, Average Response Time.

SNF Name	GeographicRegion	PostAcuteNetwork	30-Day Rehospitalization Performance - All Patients Observed Rate	SNF Admission to SNF Discharge - ALOS to Any Setting - All Patients	CMS Nursing Home Compare 5 Star Rating	Adjusted 30d Readmit Rate	MSPB Medicare Spending Per Beneficiary	CMS Penalities - SNF Last State Survey	Adjusted Total Nursing hrs/ resident day	Referral Acceptance	Complex Payor Placement Rate	Avg Time to Definitive Answer	Total SNFScore
			Goal <23%	Goal < 26	Goal >= 3	Goal <23%2	Goal <= .90	Goal <= $50,000	Goal >= 4	Goal >=50%	Goal >= 10%	Goal <=120	
AMBASSADOR, A VILLA CENTER	East	1	1	1	1	0	1	1	0	1	1	1	8
MEDILODGE OF RICHMOND	East	0	0	1	1	0	1	1	1	1	1	1	8
OPTALIS HEALTH AND REHABILITATION OF GROSSE POINTE	East	1	1	1	1	1	1	1	0	1	0	1	8
QUALICARE NURSING HOME	East	1	1	1	1	0	1	1	0	1	1	1	8
REGENCY AT CHENE	East	1	1	1	0	0	1	1	1	1	1	1	8
ST JOSEPH'S, A VILLA CENTER	East	1	1	1	1	0	1	1	0	1	1	1	8
WELLBRIDGE OF CLARKSTON	East	0	1	1	1	0	1	1	1	1	0	1	8
WELLBRIDGE OF GRAND BLANC	East	0	1	1	1	1	1	0	1	1	0	1	8
MISSION POINT NSG & PHY REHAB CTR OF HOLLY	East	0	1	1	1	1	1	1	0	1	0	-	7
MISSION POINT NSG & PHYSICAL REHAB CTR OF DETROIT	East	1	1	1	1	1	0	1	0	1	1	-	7
SHELBY HEALTH AND REHABILITATION CENTER	East	1	1	1	1	1	0	1	0	1	0	1	7
ST ANTHONY HEALTHCARE CENTER	East	1	1	1	1	1	0	1	0	1	0	1	7
THE ORCHARDS AT ROSEVILLE	East	1	1	1	0	1	1	0	0	1	1	1	7
THE ORCHARDS AT SAMARITAN	East	1	0	1	1	0	1	1	0	1	1	1	7
THE VILLAGE OF EAST HARBOR	East	1	1	1	0	0	1	1	1	1	0	1	7
FATHER MURRAY, A VILLA CENTER	East	1	1	1	0	0	0	1	0	1	1	1	6
LAKEPOINTE SENIOR CARE AND REHAB CENTER, L L C	East	1	0	1	0	1	1	0	0	1	1	1	6
MEDILODGE OF ST CLAIR	East	1	0	1	1	0	1	0	1	1	0	1	6
MEDILODGE OF STERLING HEIGHTS	East	1	0	1	0	0	1	0	1	1	1	1	6
MISSION POINT NSG & PHY REHAB CTR OF WARREN	East	0	1	1	0	0	1	0	1	1	1	-	6
OMNI CONTINUING CARE	East	1	1	1	1	0	0	1	0	1	1	-	6
OPTALIS HEALTH AND REHAB OF STERLING HEIGHTS	East	1	1	1	1	0	0	1	0	1	0	1	6
ORCHARD GROVE HEALTH CAMPUS	East	1	1	0	1	1	0	1	0	1	0	1	6
POMEROY LIVING STERLING SKILLED REHABILITATION	East	1	0	1	1	0	1	1	1	0	0	1	6
REGENCY AT SHELBY TOWNSHIP	East	1	1	1	1	0	1	1	0	1	0	-	6
SHELBY CROSSING HEALTH CAMPUS	East	1	1	1	1	0	0	1	0	1	0	1	6
SHOREPOINTE NURSING CENTER	East	1	1	1	0	1	1	0	0	1	0	1	6
THE ORCHARDS AT ARMADA	East	1	1	1	1	0	0	1	0	1	0	1	6
WELLBRIDGE OF FENTON	East	0	1	1	0	0	1	1	0	1	0	1	6
WELLBRIDGE OF ROMEO, LLC	East	1	1	1	1	0	0	1	0	1	0	1	6
BRIARWOOD NURSING AND REHAB	East	0	0	1	1	0	1	1	0	1	0	-	5
CARETEL INNS OF LINDEN	East	0	1	1	0	1	0	0	0	1	0	1	5
DURAND SENIOR CARE AND REHAB CENTER, L L C	East	0	0	0	1	0	1	1	0	1	0	1	5
FENTON HEALTHCARE	East	0	1	1	1	0	0	1	0	1	0	-	5
MEDILODGE OF SHORELINE	East	1	1	1	0	0	1	0	0	1	0	1	5
REGENCY AT ST CLAIR SHORES	East	1	0	1	1	0	0	1	0	1	0	1	5
THE ORCHARDS AT HARPER WOODS	East	0	1	1	0	0	0	1	0	1	0	1	5

PAN vs Market SNF LOS

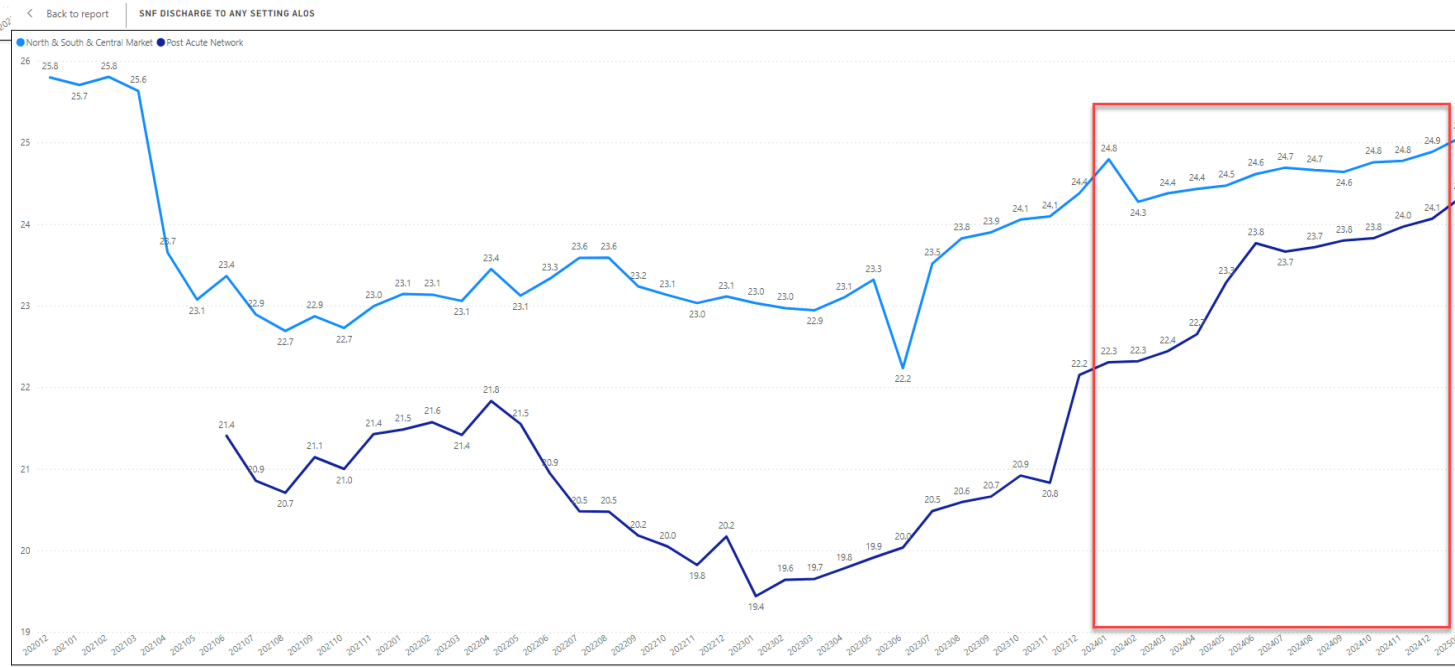


SNF LOS are lower in markets where we have a Post-Acute Network program

SNF LOS is about 1.3 days lower in facilities in our PAN than in the markets

Anticipated Cost Savings from Jan 1, 2024 to Dec 31, 2024 with 4868 placed referrals at PAN facilities =

$3,164,200 savings



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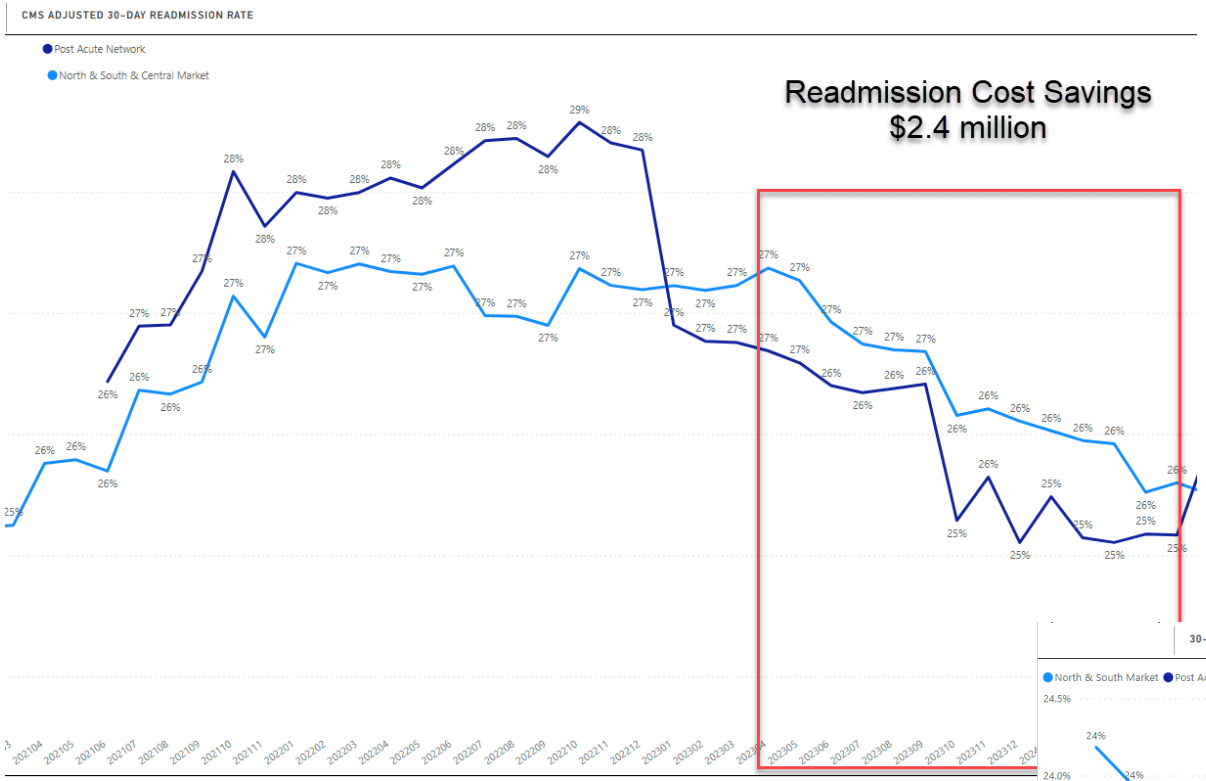
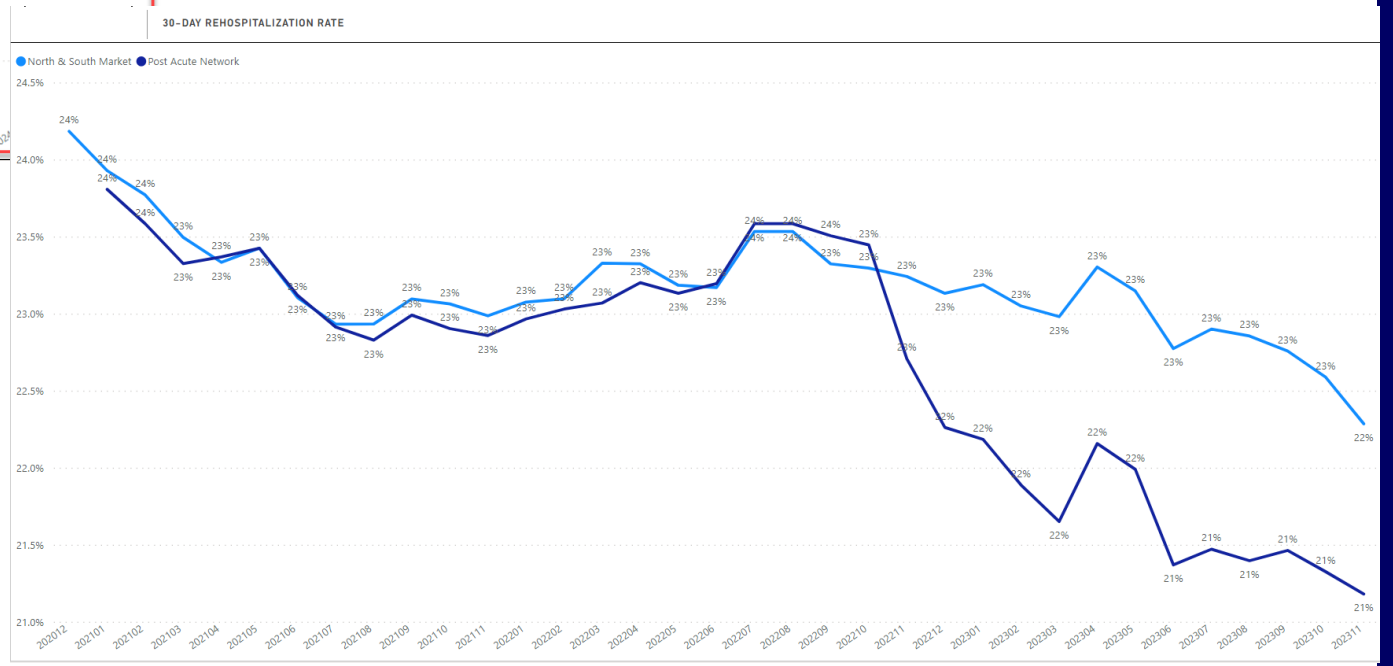
PAN vs Market Readmission and Rehospitalization Rate



30 Day CMS adjusted Readmission Rates lower in 2024 with an anticipated Cost Savings

$2.4 million



Rehospitalization Rates lower for facilities in the PAN then in the rest of the market

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Network Development Team

Integrated Cross-Functional Collaboration

- Local Post-Acute Meetings
- Quality Reports/Meetings
- SNF Tours
- Case Management Leadership Meetings
- On-site process coordination
- Training Sessions with Case Management teams
- Concerns and Quality Dashboard
- Post-Acute Expo
- Post-Acute Contact Database
- Website maintenance
- Contract Coordination
- On-Site Education Process

Next Steps

- Develop similar networks for
  - LTACH
  - IPR
  - Dialysis
  - Behavioral Health
  - Senior Living

- Standardize referral processes for the above dispositions as well

Patient Care Journey: From Admission to Post-Acute Resources

Patient admitted to hospital for acute care and stabilization

In-hospital treatment and multidisciplinary care coordination

Discharge planning initiated early with case management team

★ Transition to post-acute care provider based on patient needs

Enhancing post-acute services and quality of care

Patient Inclusion

Choice for Continued Care

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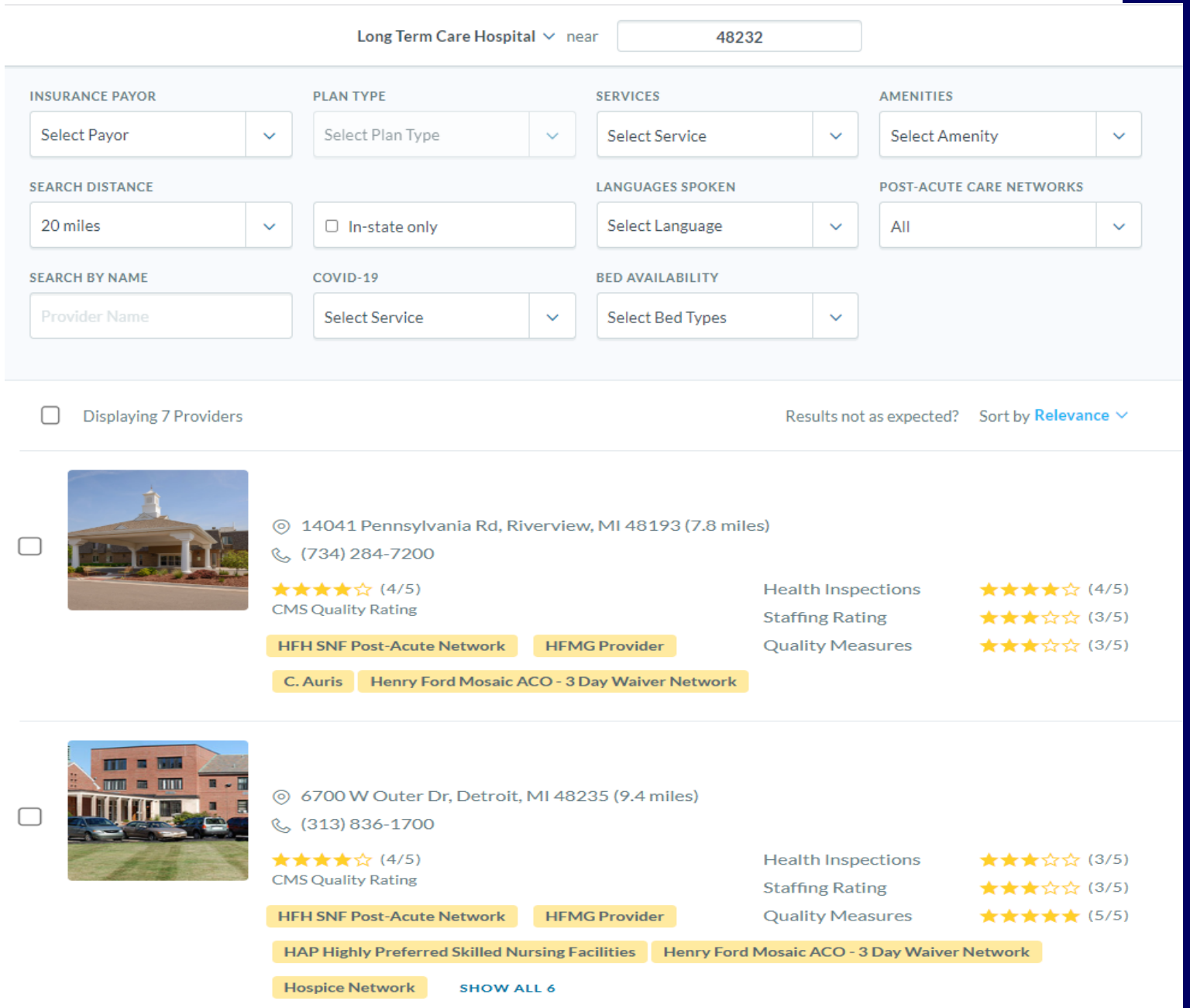
Patient Choice Guide Tool

- Case Manager use this tool to be able to provide individual curated lists to patients
- Ensure your profiles are up-to-date
- Can be sent to patients/families electronically or printed and handed to them.
- Electronic version lets them peruse the profiles themselves like Hotel
- Tip sheet available upon request



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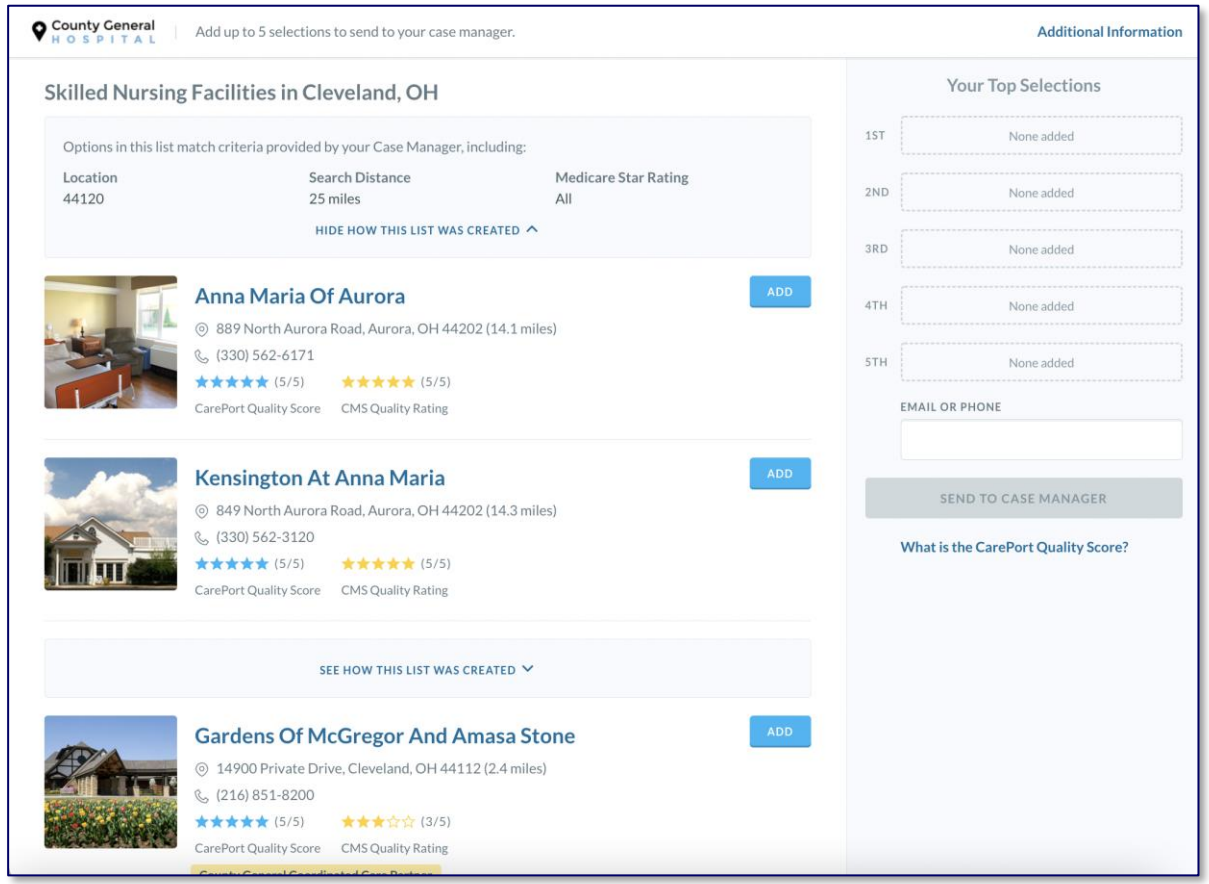
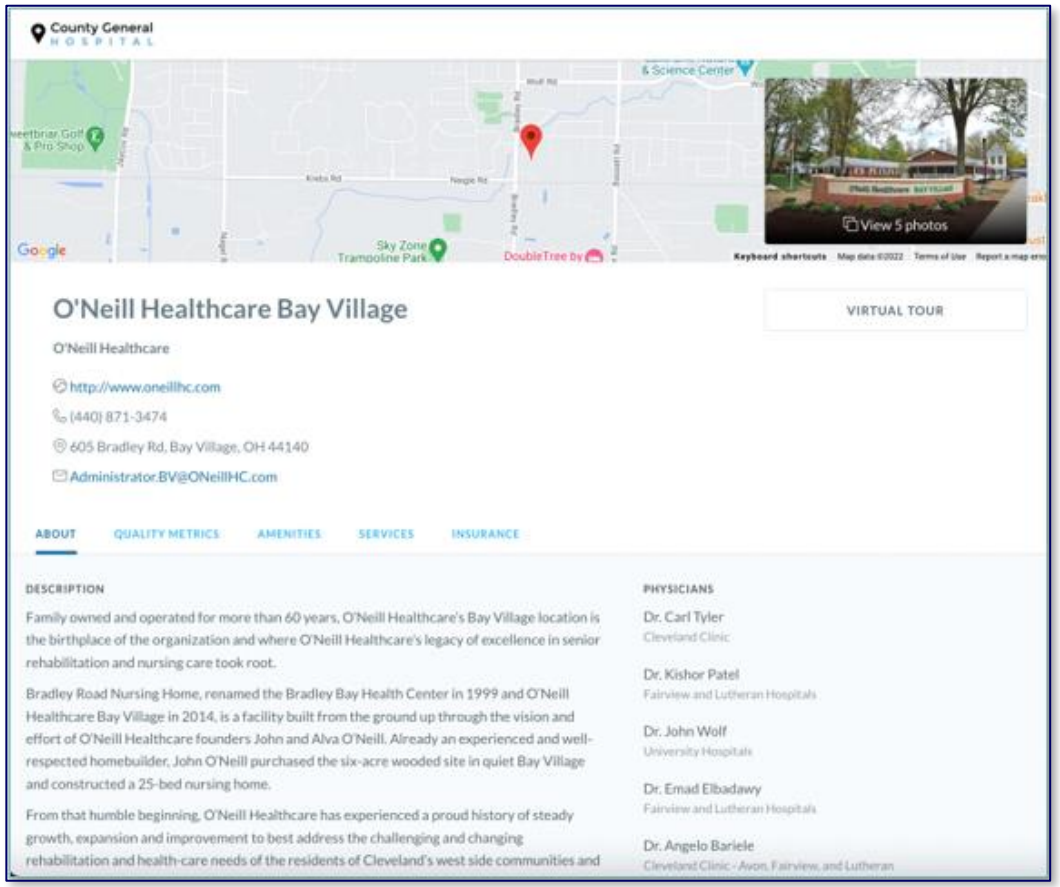
Patient/Family Perspective





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Patient Care Journey: From Admission to Post-Acute Resources

- Patient admitted to hospital for acute care and stabilization
- In-hospital treatment and multidisciplinary care coordination
- Discharge planning initiated early with case management team
- Transition to post-acute care provider based on patient needs
- ★ Enhancing post-acute services and quality of care

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Post-Acute Care Surveillance Team

Post-Acute Care Surveillance Team (PACS)

- **Team Structure**
  - 1 Manager
  - 7 Discharge Planners (4 RN CM, 2 SW, 1 OT)
  - 3 Specialists

- **Action**
  - Follows ACO/HAP patients into SNF from hospital discharge
  - Manage data for ACO 3 Day Waiver CMS quarterly submission
  - Intervention based goals to discharge patients successfully to next level of care

- **Goals**
  - Schedule Follow-up Appointments
  - Reduce SNF LOS
  - Reduce Readmissions

Populations Covered

- Mosaic ACO
- HAP Commercial
- HAP Administrative
- HAP MA

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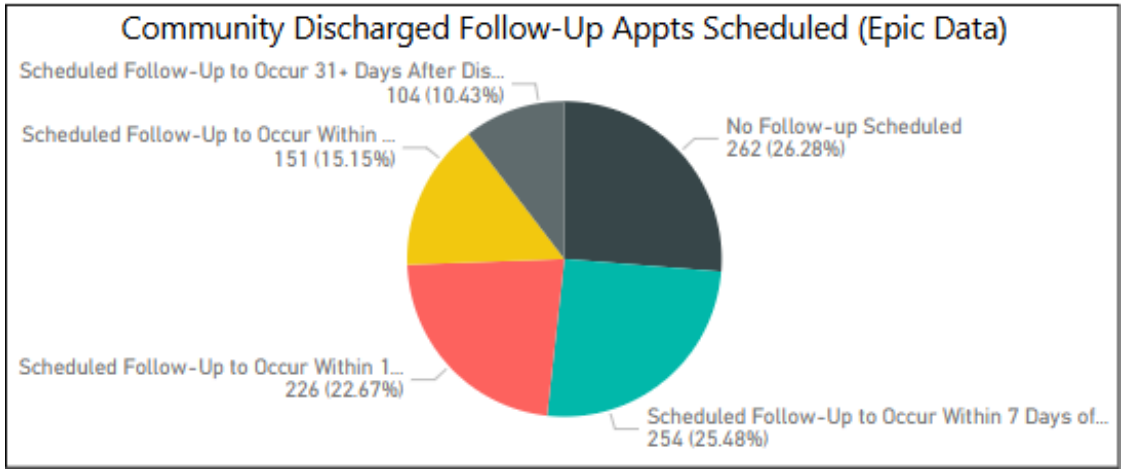
PACS 2024 Data

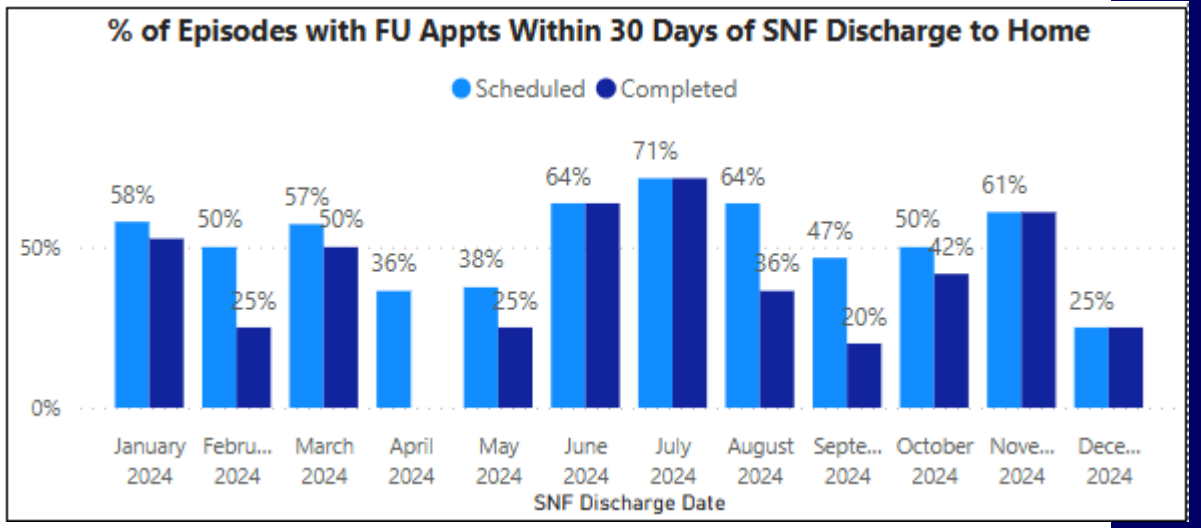
64% of pts discharged to community had PCP appointment set within 30 days



Community Discharged Follow-Up Appt Scheduled (Epic Data)

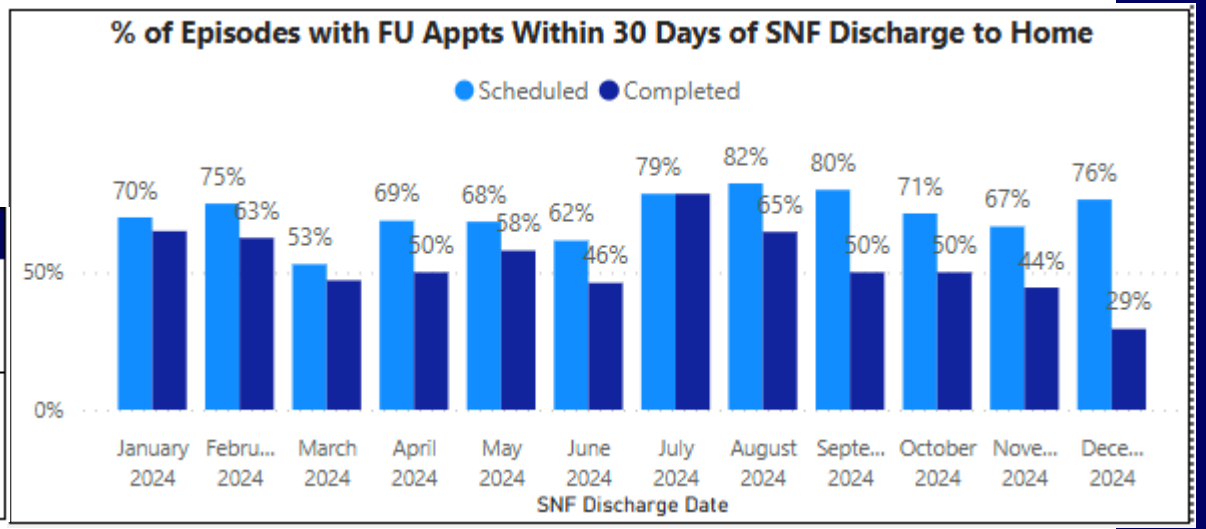
Follow Up PCP Visit
52.8%
Scheduled
40.3%
Completed

HFPN



JHN

Follow Up PCP Visit
70.9%
Scheduled
54.4%
Completed



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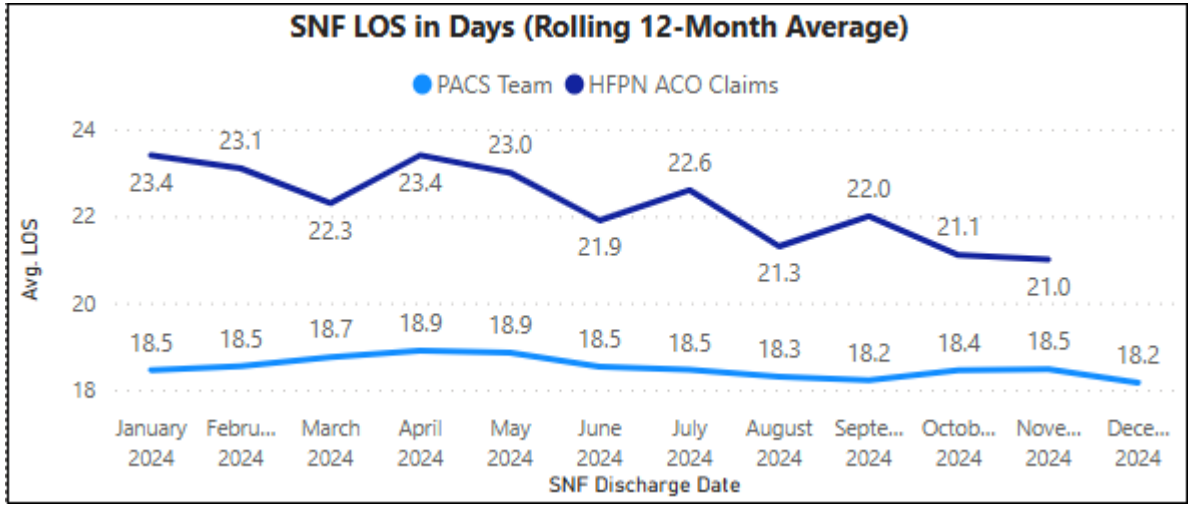
PACS 2024 Data

- **Average SNF Length of Stay reduction for patient managed by PACS team is 6 days = Cost savings of $3,130,385**

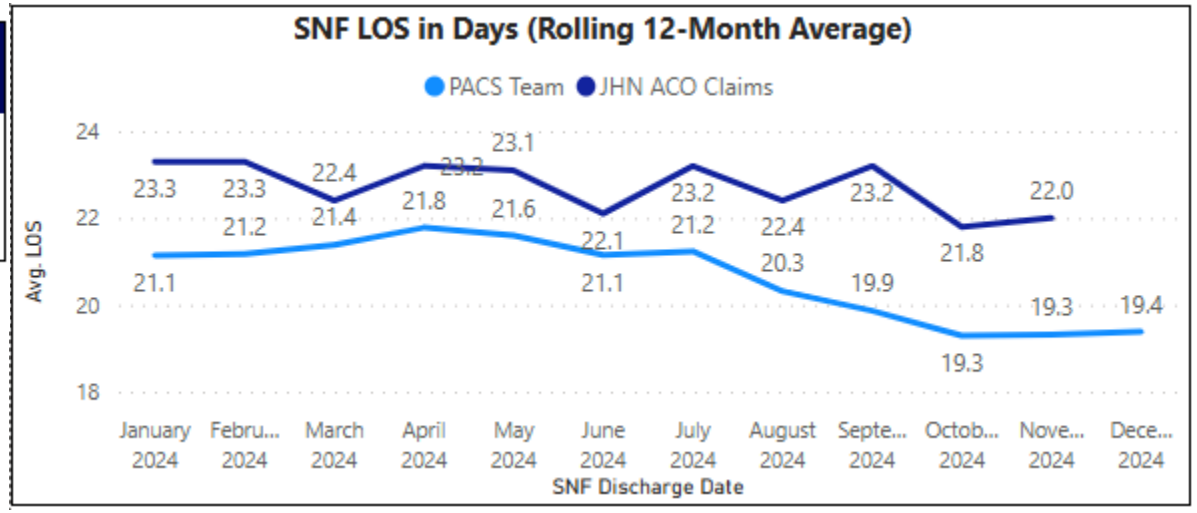


Avg. SNF LOS in Days
22.3
HFPN ACO Claims (Premier)
18.5
PACS Team

LOS Savings/Loss (SNF Spend)
$2,567,008.59

Average LOS in Days
22.73
JHN ACO Claims
20.6
PACS Team

LOS Savings/Loss (SNF Spend)
$563,377



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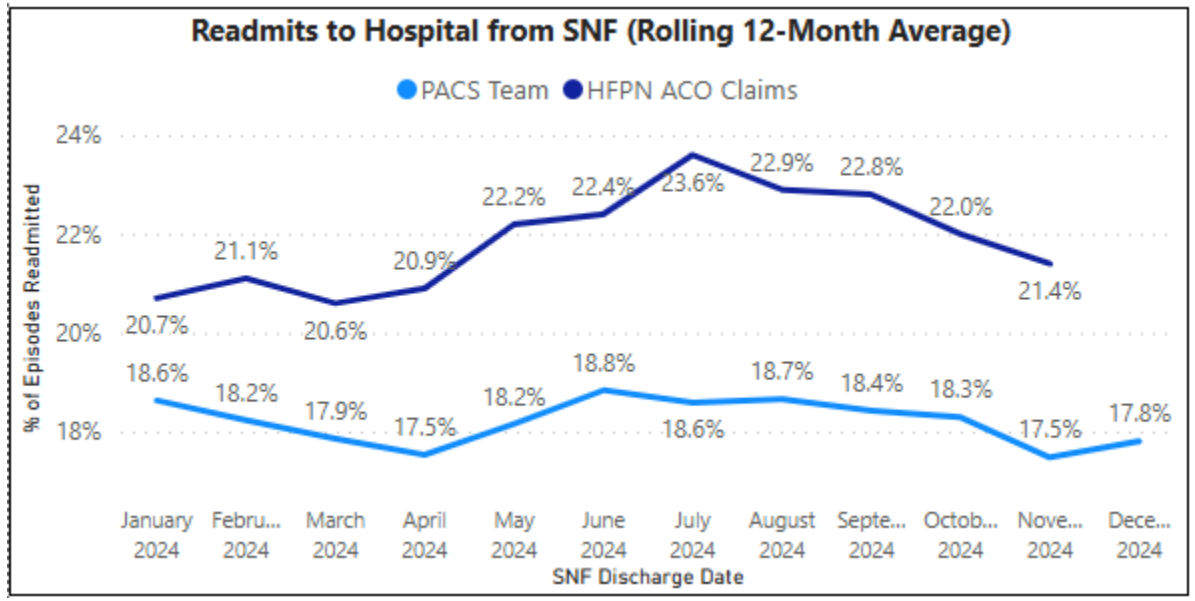
PACS 2024 Data

Average SNF readmission reduction for patients managed by PACS team is **3.3%**
Cost savings of **$1,385,987**

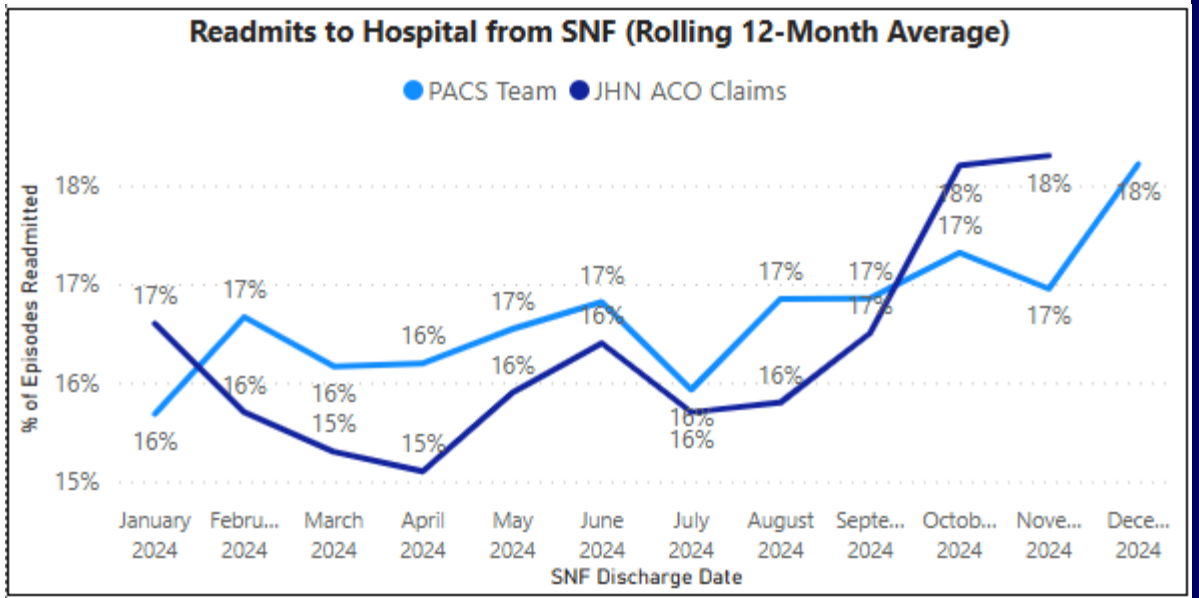


Readmissions
21.9%
HFPN ACO Claims (Premier)
18.2%
PACS Team

Readmissions Savings/Loss (Inpatient Spend)
$1,424,083

Readmissions
16.3%
JHN ACO Claims
16.7%
PACS Team

Readmissions Savings/Loss (Inpatient Spend)
($38,096)



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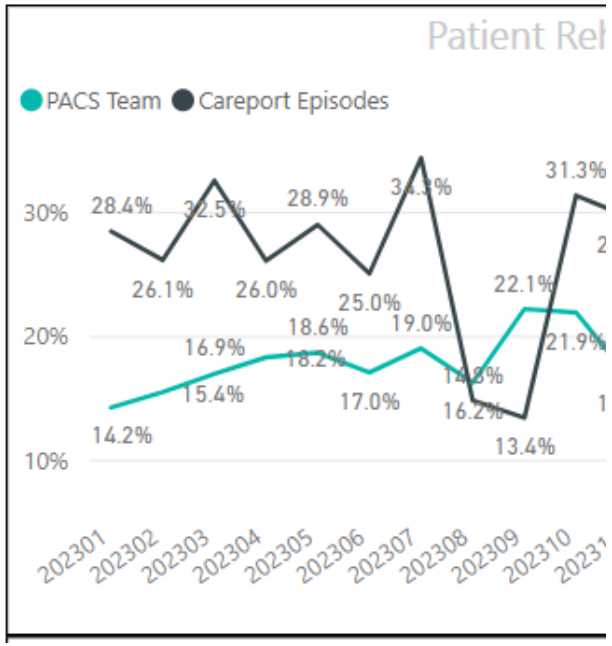
PACS Readm



SNF → Community

Michigan Value Collaborative

Blue Cross Blue Shield Blue Care Network of Michigan

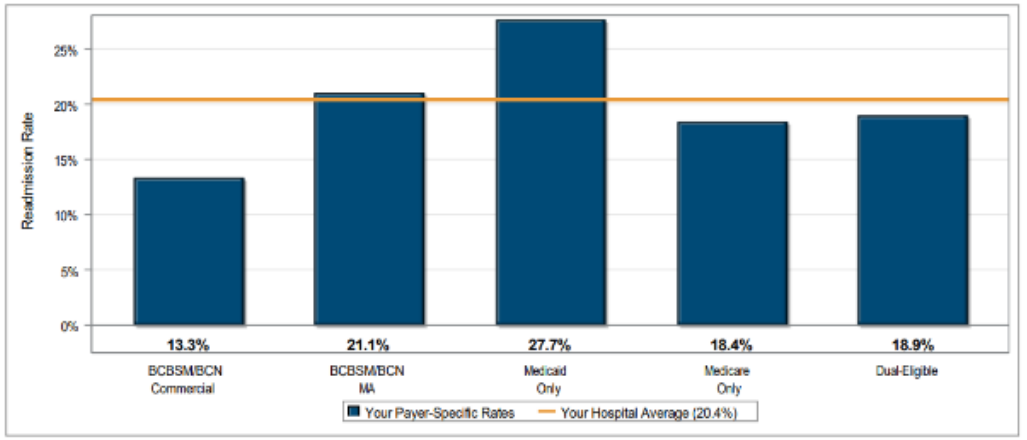
Nonprofit corporations and independent licensees of the Blue Cross and Blue Shield Association

Health Outcome Variation Report

Hospital A

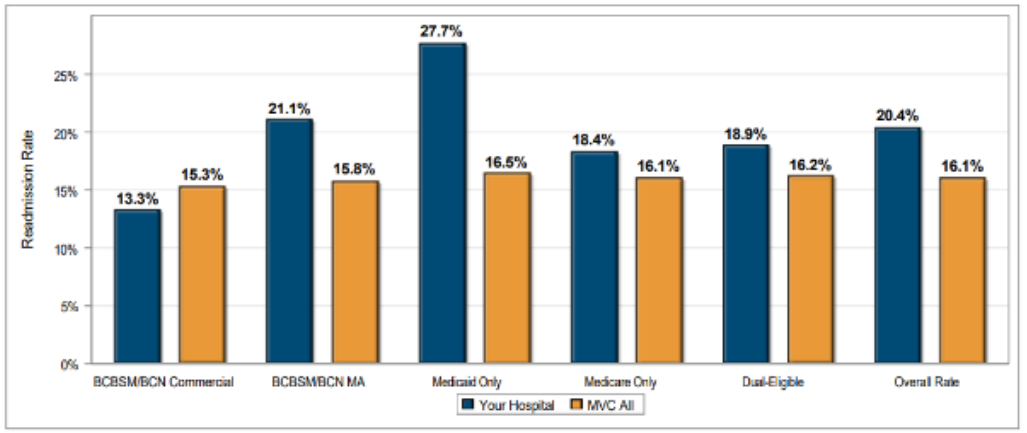
Risk-Adjusted 30-Day Readmission Rates for Your Patients by Payer in 2023

This figure shows readmission rates for each of the five considered payer groups and compares them to your hospital's overall readmission rate. Your hospital's overall readmission rate will be subtracted from each payer-level readmission rate to calculate payer-specific **absolute differences,** which are used in the index of variation calculation. This comparison highlights the payer group(s) with a readmission rate higher than your hospital's average readmission rate.



Risk-Adjusted 30-Day Readmission Rates by Payers in 2023 – A Comparison

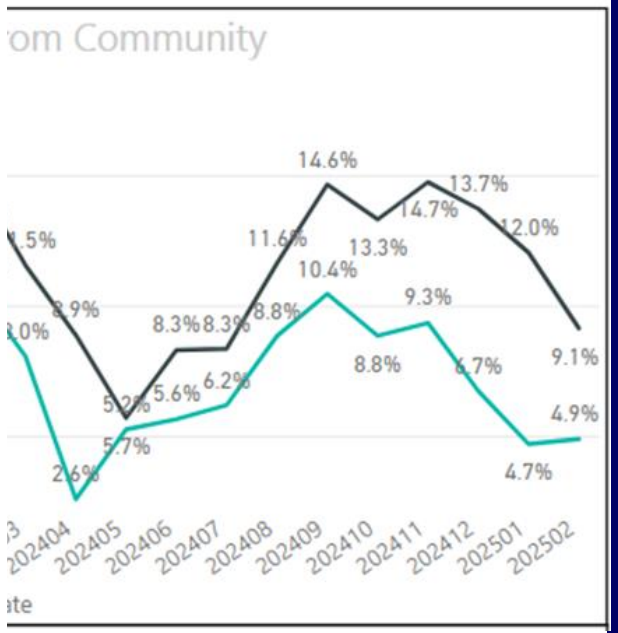
This figure assesses how your hospital's readmission rate, both across payer groups and overall, compared to the MVC All comparison group.



Data source: MVC 30-day inpatient episodes with index admissions 1/1/2023 - 12/31/2023 for BCBSM PPO Commercial, BCN Commercial, BCBSM PPO MA, BCN MA, Medicare FFS, and Michigan Medicaid

Report generated: 08/28/2025

SNF → Hospital



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PACS Readmission Rates

Reasons for Reduced Readmissions	Schedule Follow-up appointments based on anticipated date of discharge to ensure apt can be scheduled within 7-14days of discharge from SNF
	Coordinated enhanced interventions
	Increased communication with family
	Post-discharge follow-up calls
	Provide Patient Population specific interventions/resources

Post-Acute Care Resources

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Post-Acute Resources

Consistent Standardized Quantitative Metrics

HFH Post-Acute Website

Care and Concerns Process

Kudo's Process

Case Management services for VBC patients

Electronic marketing – Patient choice platform

Education Platforms

Showcases

Open Forum

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