



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



I6 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





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 ...





...for a less than ideal patient experience – germs, long wait time with limited face-to-face care.





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....





...and at no-cost to your organization and a fraction of the cost for patients.



Elara and Dispatch help Seniors Avoid Unnecessary ER Visits



What Defines a Successful Partnership?

Aligned Goals



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



Percentage of discharged inpatients that bounce back to the ER



Annual 22.2 million 911 transports
 are unnecessary or inappropriate

17-25%



Options for Acute Care Available Today





Relative Value







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

SYMPTOMS

dispatchhealth



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

Elara Caring

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 | Local branch managerAll clinical staff | Local BDRMarket managerLead APP | Market Team |
| Monthly national business development meeting | Review utilization and outcome data. Ensure processes are working | Susan Prowse Lori Witt Sherri Raines Lisa | Micheal Phillips | Micheal Phillips |
| Quarterly JOC | Review utilization and outcome data. Identify opportunities for increased alignment and partnership | Susan Prowse Lori Witt Sherri Raines Lisa | • Micheal Phillips | Micheal Phillips |
| Bi-annual regional education meetings | Education to all region teams. Update on new services and coverage area | | Market ManagerBDRLead APP | Micheal Phillips |



Phase 1 – Local Leadership Kick-Off

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







1

Weekly Cadence Set With DCO & Initial Intro to Leadership Department Head Stand-Up, Staff Intros & Reference Guide

Care Team Meet & Greet

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Phase 2- Local Community Launch and Education



dispatch

(Community Name) a pleasant to turing our community a new healthcare option that allows but eacherite to perifie care they need quotely, and right hore the conflot of home Disputch/health delivers on demand medical care from cacro. I approv, seven days a week

Dispatch/Araith can treat a wide range of common to complex illnesses and injuries, such as unitary lead interdire (JPI), respiratory infections, Millipures, Ro, respectives, tempdration, autores and more. The medical Kis objects/Infectb brings to a patient visit contain rearis at or the scale and estimations. found in an ER, allowing the medical learn to perform a variety of advanced lears and teatments.

Departed health's brane call services can be requested by calling the sentences, via their riskin app or by visiting their website at dependmenth com.

When called, the caller will be asked to provide a few details about their illness to injury and conscientsmatory like their primary new provints's name, as soll as heir address

On everyon, Dispatric/Reality arrives within a few town. Carls resoluted learn consists plents a physician seastant or runne-practicities, along with a medical technican and on-call LR

Chapatchileath Takes Care of the Roat

Displacements we call it any prescriptions reason, update their patients according

Wethink our community will appreciate patting the care they need, right from home when an unexpected itraes or injury moury. Tolescontrons, visit Discontrolling/to turn. Negatable leaft is an in network provider with Neologra and monimage health insurance. The cost is the same as a

(Executive Director &ur Vielness Director Harry)

DEPARTMENTIC OPEN TEA SA WEEK | DATE OF THE



Family Letter & Engagement

Visiting Provider **Event/Dinner**

3



Phase 3 – Ongoing Partnership Management

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



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



We proactively identify, connect and engage patients with the appropriate care they need.

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.



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

2nd 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

*All program data measured across all payors within Skilled Home Health service line for calendar year 2021 *SHP = Strategic Healthcare Programs. Source for 30-day rates, as well as risk for hospitalization data for the Monitor Program *Check-In and Engage Program data sourced from Medalogix

Question & Discussion

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

Sara Crate Chief Commercial Officer Dispatch Health 503.403.9088 sara.crate@dispatchhealth.com

Jacquie Owens Elara SVP of Managed Care 208.830.1044 jowens@elara.com

