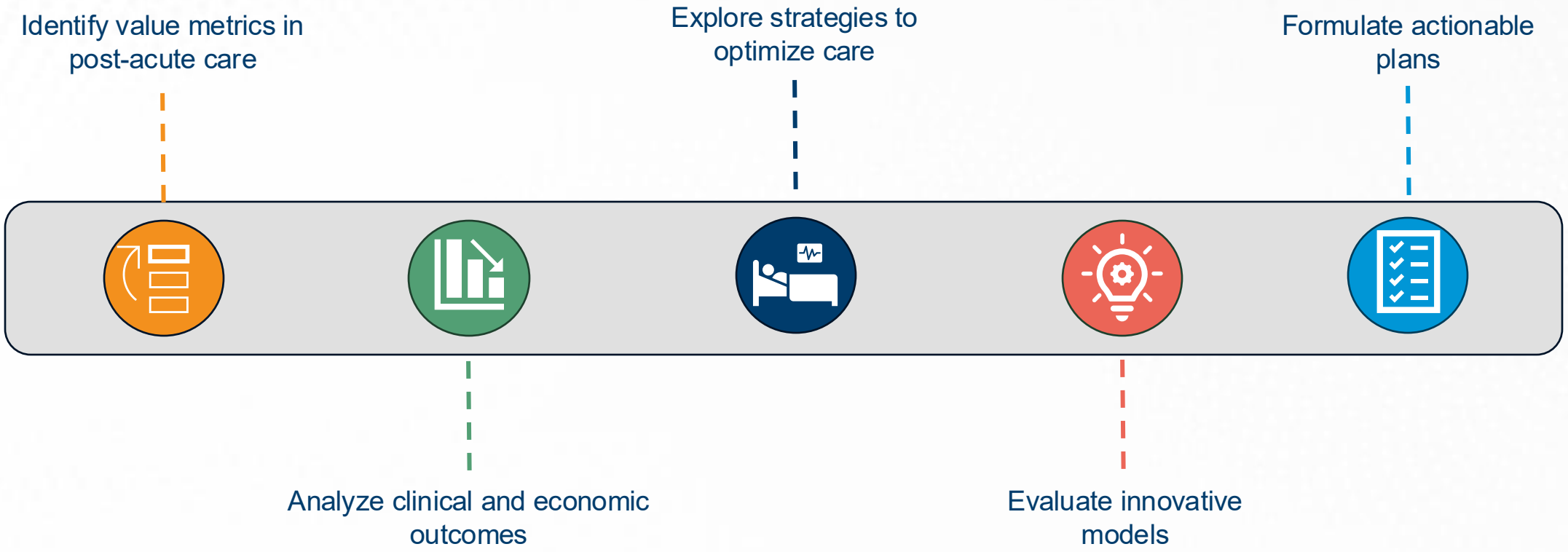
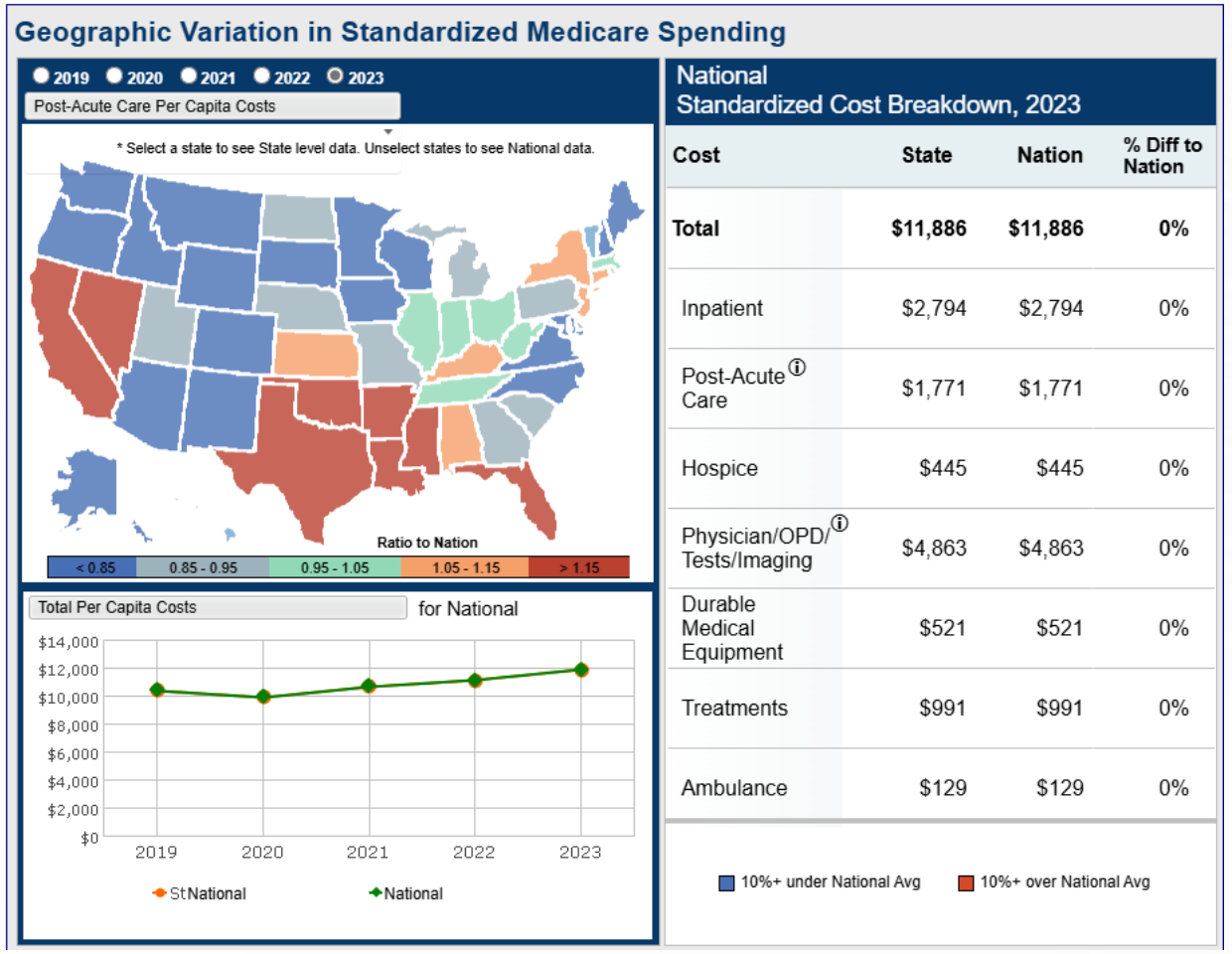
Unlocking Value in Post-Acute Care

Learning Objectives



Why Post-Acute Care Matters Now

- Rising Healthcare Costs
- Shifts Towards Value-Based Care
- Increased Regulatory Scrutiny
- Patient Outcomes Tied to Care Transitions



Geographic Variation in Standardized Medicare Spending - State | CMS Data

Today's Speaker

Gloria Rey, PA-C, MPH
Director, Post-Acute Care, Populance

With over 20 years of experience, including 15 years as a practicing Physician Assistant, Gloria has more than a decade in leadership roles focused on transition of care. Passionate about improving patient outcomes by leveraging data, driving program development, and fostering community collaboration, Gloria's work centers on enhancing care processes and building innovative solutions that bridge gaps across the healthcare continuum.

Alex Brennsteiner, MHA

Interim Director, Clinically Integrated Network, Allegheny Health Network and Manager, Strategic Program Integration, Helion
Serving as Interim Director of Allegheny Health Network's Clinically Integrated Network (CIN) and as Manager of Strategic Program Integration at Helion, Alex brings 10 years of experience leading CIN governance and operations, post-acute strategy and partnerships and oversees operations for AHN's transitional care management technology vendor.

Stephen Rees, MD
Medical Director, Post-Acute & Transitional Care, Ochsner Health Network

As Medical Director of Post-Acute and Transitional Care, Dr. Rees drives the strategic initiatives Ochsner Health Network's, post-acute integrated network. Prior to joining OHN, Dr. Rees was Vice-President of Medical Affairs (VPMA) at Ochsner Lafayette General Hospital for 10 years. A physical medicine and rehabilitation physician in Lafayette, Louisiana, Dr. Rees contributes over 35 years experience in medicine.

Raphael Pransky
Vice President of Operations, Millennium Physician Group

Raphael serves as vice president of operations at Millennium Physician Group (MPG), where he leads clinical partnerships and on-demand care. Prior to MPG, he served as vice president at Redesign Health, where he led the launch of six active or acquired healthcare startups. Previously, he was a strategy associate at American Securities, where he partnered with portfolio company leadership on strategic projects. He began his career as a management consultant in Oliver Wyman's Health and Life Sciences practice. Raphael earned his MBA in Healthcare Management from Wharton and graduated with a bachelor's degree in Cognitive Neuroscience from the University of Pennsylvania.

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

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

populance

Ochsner Accountable Care Network

Ochsner Accountable Care Network proudly serves patients throughout the Gulf South.

Ochsner Accountable Care Network

60,000+
Medicare Lives Covered

3,200+
Physicians

$44.8M
Total Cost of Care Savings, MSSP, 2024

$32.9M
Shared Savings Earned by OACN, 2024

Top 1%
In Care Coordination, when compared to all ACOs in 2024

Ochsner Health Post-Acute Care Delivery

Providing holistic, individualized patient care across the continuum

Post-Acute Level of Care

Post-Acute Authorizations Process

Post-Acute Care Coordination (SNF & Home Health)

Inpatient Navigator

SNFist strategy/ Medical Directorship

Post-Acute Network Management

DISCLAIMER

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IDFS

About Helion & Allegheny Health Network

Health plan

Health plan with more than 4.4 million members

Allegheny Health Network (AHN)

14-hospital health system & Clinically Integrated Network

Helion

Post-acute network management

Helion is proud to collaborate with our clients:

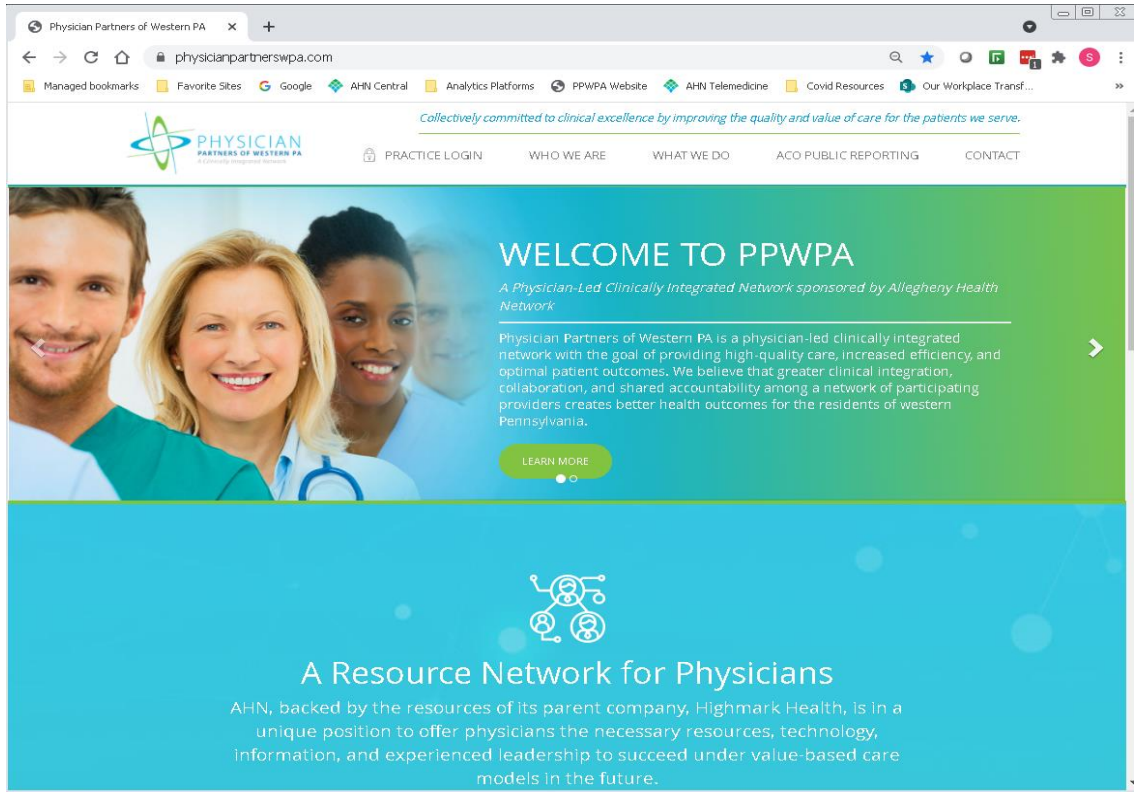
A national blended health organization headquartered in Pittsburgh, Pennsylvania, whose leading businesses support millions of customers with products, services and solutions closely aligned to the mission of creating remarkable health experiences, freeing people to be their best. Through this integrated health care delivery and financing system's payer arm, the health plans serve millions of members in Pennsylvania, West Virginia, Delaware, and New York. The provider arm of the IDFS offers a broad spectrum of care and services through 14 hospitals and more than 200 primary- and specialty-care practices in more than 300 clinical locations and offices.

The Physician Partners of Western PA, LLC

A Clinically Integrated Network (CIN)

A subsidiary of Allegheny Health Network

- Regional partnerships between physicians that are **collectively committed to improving the quality and efficiency of care delivered to the patient population it serves**.
- A scalable foundational platform that allows regional physicians to prepare for success as the payment and reimbursement environment evolves further into value-based models.



https://physicianpartnerswpa.com/

Clinical Priority Areas of Focus

Post Acute and Transitions of Care

- Post-discharge follow-up visits within 7 days
- Longitudinal care management for patients at high risk of readmission
- Provide the right care, at the right place, at the right time (e.g. virtual ED, Healthcare at Home)

Appropriate Utilization

- Engage patients on prevention, sites of care, and appropriate utilization
- Avoid unnecessary ED and specialist utilization
- Ensure patient-centered access to ambulatory care (same day, extended hours)
- Post-ED visit follow-up

High Risk and Chronic Condition Management

- Focus on high cost/high risk and rising risk patients
- Encourage enrollment in ECCM, Chronic Care Specialty Teams, palliative care for eligible patients
- PCPs/specialists collaborate to manage care for patients with chronic conditions (e.g. eConsults, care pathways)

Care Alignment

- Encourage patients to receive care through PPWPA providers
- Refer to PPWPA clinicians
- Encourage unattributed patients to establish with a PPWPA PCP

Risk Accuracy Capture

- Code to highest level of specificity to accurately capture patient complexity
- Address chronic conditions at all relevant encounters
- Leverage tools within the EMR to surface and address potential risk gaps

Pharmacy Interventions

- Generic prescribing
- De-prescribing
- Therapeutic interchanges
- Medication Adherence

Preventive Care

- Develop a preventive care plan
- Assess health behaviors & SDOH needs
- Screen early for high-risk/high-cost conditions (e.g. lung cancer screening, colorectal cancer)
- Engage patients in wellness and prevention

Quality Performance

- Address care gaps (e.g. Stars) at each visit
- Conduct pre-visit planning and care team huddles
- Proactively outreach to patients

About Helion

We are a healthcare technology and services company that helps payers cultivate high-performing networks while empowering providers to operate at their best — and in doing so, help patients heal better. Our end goal is health and healing in the home, but our solutions create value along a broader part of the healthcare continuum.

Through automated utilization management (UM), performance analytics, and end-to-end consultative support for payers and providers, it is a win-win for all.

Our mission and vision

Our mission: To transform healthcare by reimagining the home as the center for prevention and healing

Our vision: A future where the home becomes the core of the care continuum

Helion partnership with AHN optimizes transitions to post-acute care

There are six essential levers that enable AHN's post-acute care strategy

AHN PAC Strategy

Helion's Pillars of Work

1 Patient Level

- Assisting with **complex patient placement** issues.
- Participate in **Weekly Hospital Complex Case Calls.**

2 Operations

- Participant in **daily Throughput Huddles.**
- Partners with Quality and Case Management to provide **reporting and perform readmission reviews and root cause analyses.**

3 Action Planning

- Providing **reports and action plans** to hospital C-Suites.
- **SNF Site Visits** with Hospital Teams.

4 SNF Partnerships

- **Identifies prospective partners** and leads negotiations.
- **Reviews readmissions** & quality concerns with partners.
- Tracks referrals, placements, & denials for **program evaluation**

5 Transitions of Care

- **Optimizes technology** and partners with practices teams to bring together **effective workflow and technology enablement.**
- **CMS Bundles** Technology and Operational Support.

6 Program Development

- Clinical partner on Virtual Behavioral Health program.
- Developing and executing **PAC Partnership Strategy** and **Provider Integration Models.**
- **SNF Waiver Program Operational Support.**

Enabled through Data and Analytics

Millennium Physician Group at a Glance

We Are…

One of the largest independent primary care platforms in the country, complemented by a comprehensive set of services designed to support our PCPs and deliver great patient care.

Our Mission…

Connecting the best doctors, service and quality. Every patient, every time.

Demonstrated High Performance…

Millennium is a national leader in value-based care performance for 10 consecutive years, ranking among the top of all ACO participants in earned shared savings.

Resulting In…

High quality ratings and an exceptional patient experience

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Millennium Physician Group by the Numbers

~900
Physicians & Advanced Providers

100+
Specialists Across 25 Specialties

< 5%
Annual Physician Turnover

600+
PCPs

750,000+
Total Patients

89
Patient NPS

100+
Hospitalists

220,000+
Value-based Patients

17
Years Providing High-quality Care

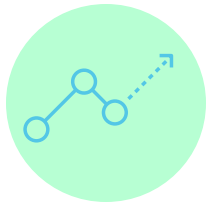
18

Millennium's Holistic Primary Care Support Model

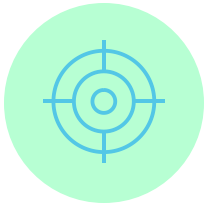
Ancillary Services
- Imaging
- Radiology
- Home Health
- Physical Therapy

Acute & Post-Acute Care
- Hospitalists
- Discharge Planners
- Transitional Care Coordinators

Wrap-around Care
- Home Visit APRNs
- Social Workers
- Pharmacy Support



Case Management
- Transitional Care Management Nursing
- Longitudinal Case Management



On Demand Care
- 24/7 Nurse Triage RNs
- Walk-in Clinics
- Virtual Care Clinic

Clinical Partnerships
- Chronic Kidney Disease
- Palliative Care
- Post-Acute Care

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Millennium's Post-Acute Care Strateg

MILLENNIUM PHYSICIAN GROUP
Your Connection to a Healthier Life

WellSky

M

Technology

CarePort Connect provides real-time information on MPG Patient status in the ER, inpatient, and post-acute settings

Network

Our High-Performing Network of SNFs and HHAs helps guide MPG patients to high-quality post-acute providers

Clinical Services

Transitional Care Coordinators engage MPG patients in select inpatient facilities and SNFs to improve transitions of care

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Panel Discussion

Scorecards

Henry Ford SNF Post-Acute Network – Q3 2025

December 2024 – May 2025

SNF Scorecard

Updated 06/24/2025

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

Aggregate HHS 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 Penalties - 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	1	0	0	1	0	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	0	1	1	1	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	1	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

Ochsner Health: SNF Integrated Network Scorecard

key benefits:

- -pro-active planning for value-based care delivery
- -accountability for high-quality and patient outcomes
- -performance transparency
- -collaborative opportunities

Which Acute Hospitals are referring patients to my facility ? (Hospitals with volume >=11 in both years)

Rank	Top Index Hospitals (202..	Medicare Volume 2023	Medicare Volume 2024	Readm Rate 2023	Readm Rate 2024	ALOS (covered) 2023	ALOS (covered) 2024	Allow Per Diem 2023	Allow Per Diem 2024	Avg. Index DRG .. 2023	Avg. Index DRG .. 2024
Grand Total		58	73	27.59%	36.99%	27.4	22.5	$527	$538	1.597	1.910
1	names redacted	9	38	11.11%	39.47%	23.9	24.6	$540	$546	1.244	2.005
2		16	22	43.75%	27.27%	24.2	21.6	$529	$527	1.906	1.932
3		23		30.43%		29.8		$533		1.578	

Readmit % = Readmissions of beneficiaries who were **directly admitted** from acute stay.

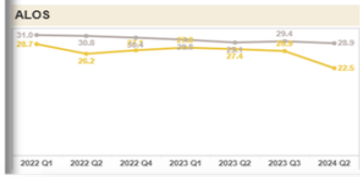
Yellow - Facility; Gray - OCH Network Average

	Selected Facility	Performance to Network		Ochsner Network Benchmark	State Average	Performance to State
Medicare Volume	73					
ALOS	22.45		<	29.66	33.84	
Readm Rate	36.99%		<	20.59%	22.61%	
ED Utilization	17.22%		<	12.56%	15.06%	
Avg. SNF Spend	$12,076		<	$17,303	$17,915	
MSPB Score	1.190		<	1.170	1.213	
Discharge to Community Rate	39.58%		>	40.00%	38.98%	
Pressure Ulcer	4.70%		<	2.90%	3.35%	
Avg. Index DRG Weight	1.910		>	1.766	1.747	
SNF Score	6.00		>	6.00	5.74	

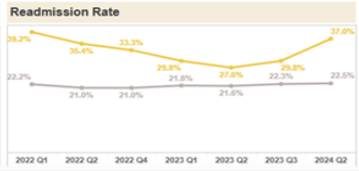
Select SNF Facility for Performance Trend

names redacted

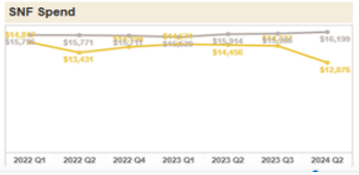
ALOS



Readmission Rate



SNF Spend



helion

Confidential and Proprietary

Once the data is exported, HIPAA protection becomes the user's responsibility

Sample SNF MA

Helion Market: Sample Market

Medicare Adv/Commercial

Ranking Period: 2024 Q2 to 2025 Q1

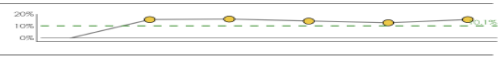
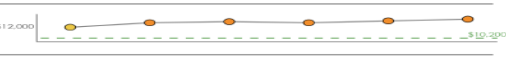
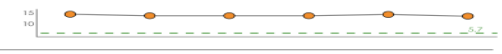
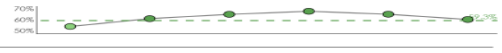
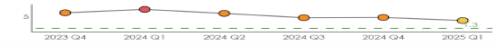
Sample SNF MA
BSID: 009999999
NPI: 9999999999

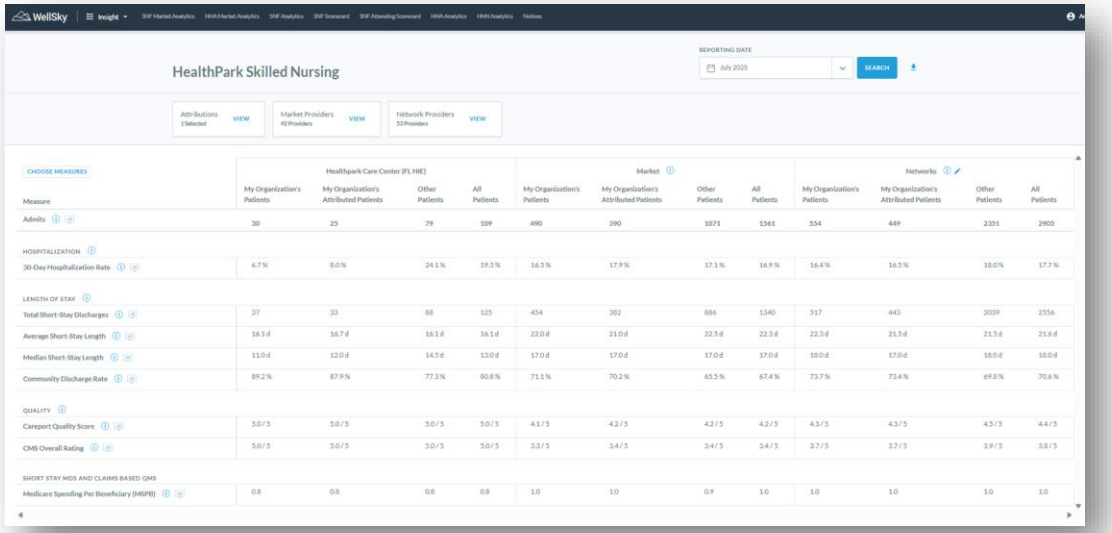
Overall Score 58%

Quintile	1	2	3	4	5
Hospital*	10.1%	13.4%	16.9%	20.8%	20.9%
MCC*	$10,200	$11,400	$12,300	$13,400	$13,401
ED*	5.7	8.5	12.5	16.4	16.5
PCP/SPEC	59.3%	55.6%	48.3%	42.5%	42.4%
Obs*	1.3	2.5	4.4	6.5	6.6

State: 102 of 190 | Micro-Market: 2 of 5

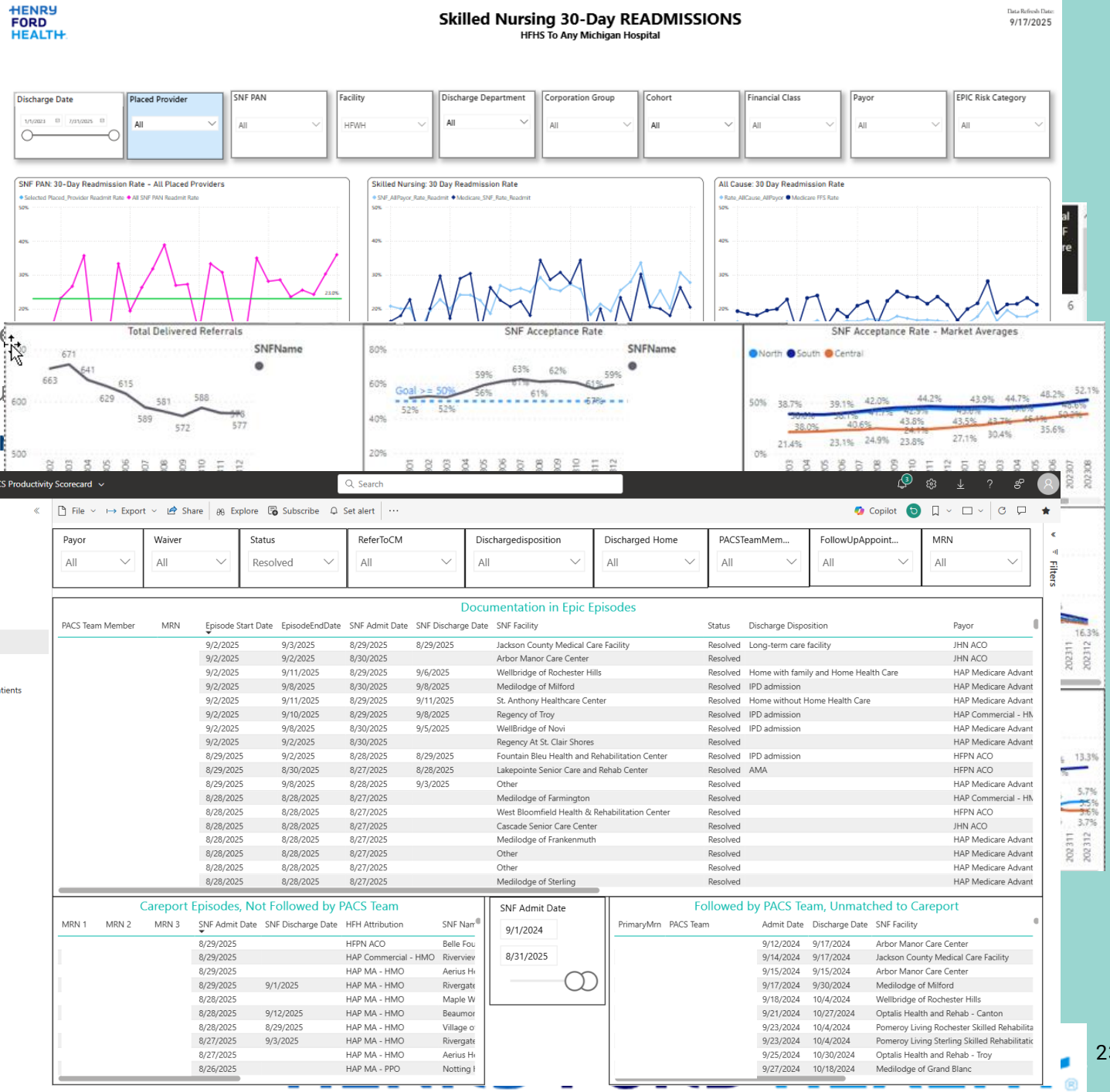
*Risk Adjusted

30-Day Hospitalization* 20% Weight Next Quintile: -2 %	15.4%	
30-Day MCC/Episode* 30% Weight Next Quintile: ($ 824)	$13,124	
30-Day OP ED per 100* 20% Weight Next Quintile: -1.0	13.5	
7-Day PCP/SPEC Follow up 20% Weight Next Quintile: 0 %	60.3%	
30-Day Obs Visits per 100* 10% Weight Next Quintile: -1.3	3.8	



Post-Acute Analytics

- Tools used to maintain Post-Acute
  - Productivity Reports (PACS Team)
    - monitoring real time and claims-based outcom
    - Error Reports – ensure validity of data and docu
  - Scorecards – SNF/HHC/Hospice
    - Automated
    - Interactive
    - Illustrative graphs for trends
  - Provider Readmission Reports
    - Allows SNFs to see % contribution of provide
  - Overall Readmission Reports
  - Predictive Analysis Reports



Action Plans & Final Thoughts

- ✓ Assess current metrics
- ✓ Identify gaps in transitions
- ✓ Engage partners across the care continuum
- ✓ Implement and iterate on data-driven strategies
- ✓ Post-acute care is a lever for success
- ✓ Value creation is both possible and measurable

Thank You