Fairview

Presentation to

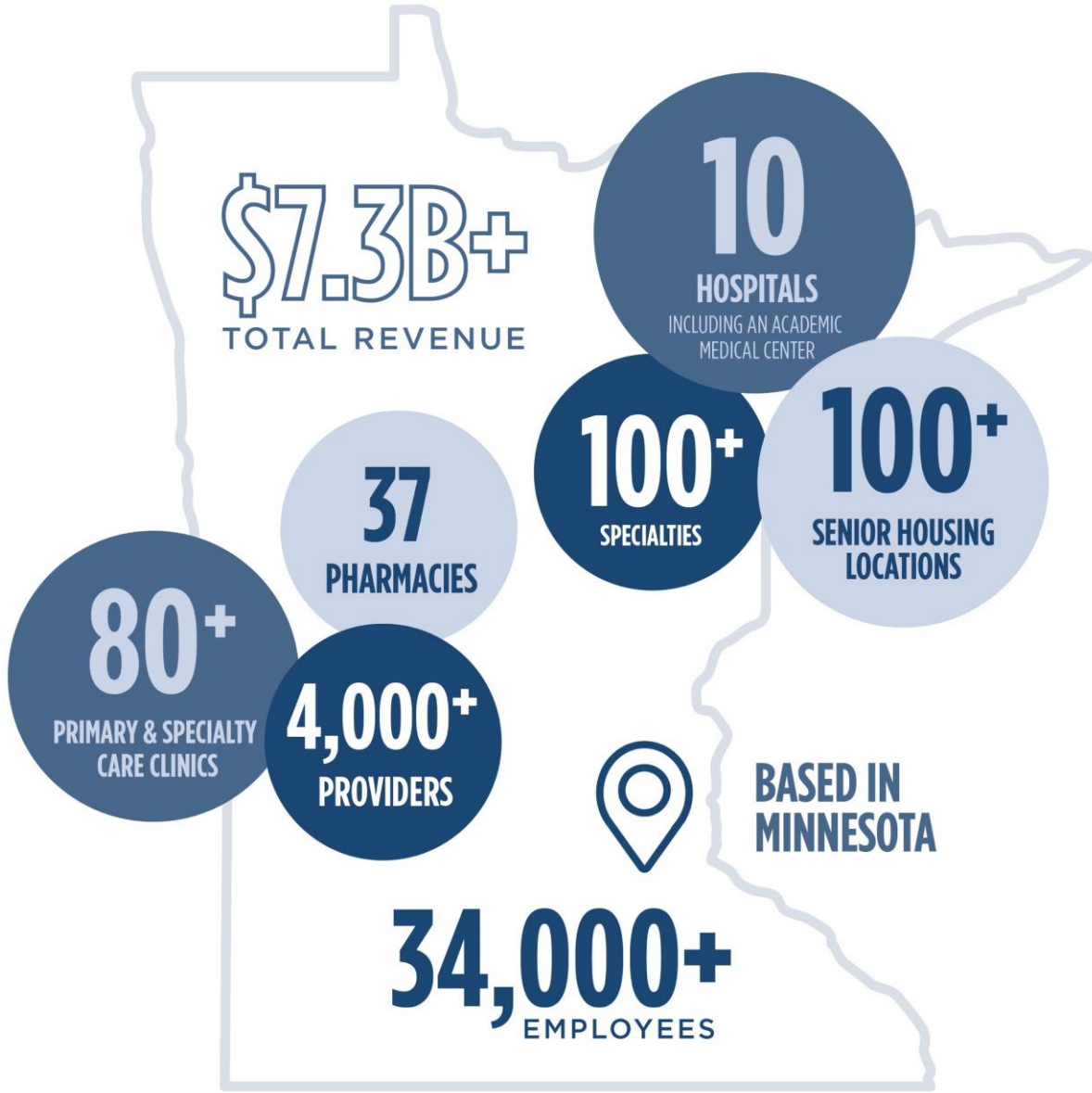
Legislative Task Force on Aging

July 10, 2024

About Fairview

A Full Spectrum of Services:

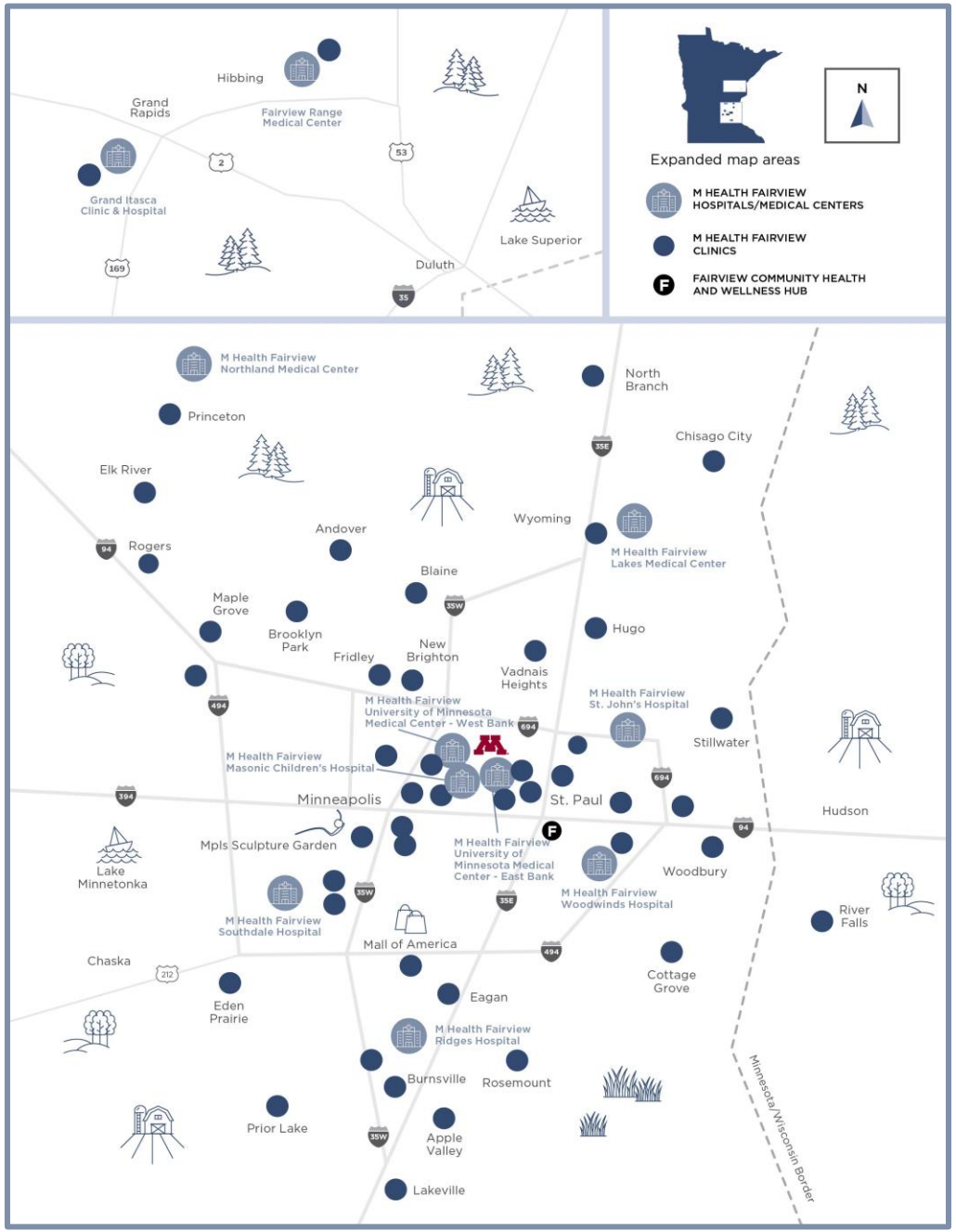
- Based in Minnesota
- 10 hospitals, including an Academic Medical Center
- 80+ primary and specialty care clinics
- 37 pharmacies
- 100 + senior housing facilities
- 100+ specialties
- $7.3B+ total revenue
- Network of 4,000+ providers
- 34,000+ employees
  (4th largest employer in Minnesota)



As of December 31, 2023

Fairview Has The Largest Healthcare Geographic Footprint in Minnesota

As of December 31, 2023



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M Health Fairview Geriatrics

Who We Are:

- 32 Advanced Practice Providers (Nurse Practitioners and Physician Assistants)
  - APP Driven Care Model
- 7 Physicians
  - Consultation with APPs
- 2 University of Minnesota Department of Family Medicine and Community Health Faculty Geriatricians
- Geriatric boarded Medication Therapy Management Pharmacist
- Part Time Orthopedic APP
- Part Time Mental Health APP
- 5 Triage Registered Nurses
- 12 Team Coordinators

M Health Fairview Geriatrics

What We Do:

- Onsite primary care for ~ 2200 residents living in nursing homes and assisted living facilities

- Onsite medical care for ~ 540 short term rehab patients
  - Helping to manage transitions of care and bridging their hospital to home path

- Care provided to patients at almost 50 unique locations/campuses that include short term rehab unit, long term care facilities and assisted living facilities

Challenges:

- In last five years we have seen patient volume being served by geriatrics team drop by almost 20 percent

- Care coordination is more time intensive with this population because of need to coordinate across medical records, with staff, families and other decision makers.

Combined: Advantages

Fairview + EBENEZER

Combined resources and expertise in 1995

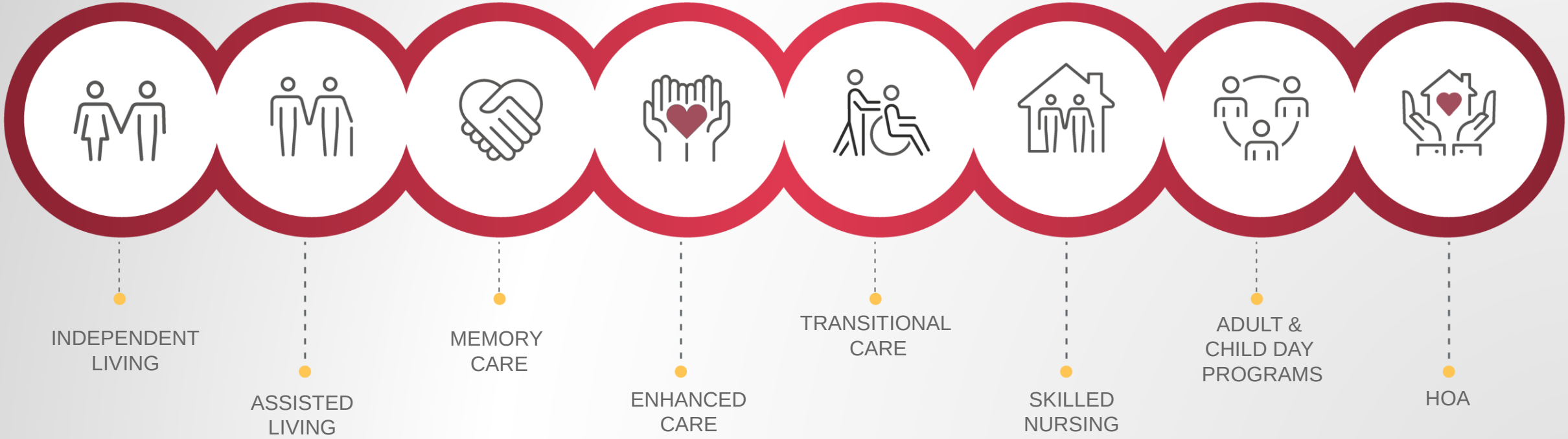
IMPROVED HEALTH MONITORING AND MAINTENANCE

EFFICIENCIES IN RECORDS MANAGEMENT

INCREASED BENEFICIAL PARTNERSHIPS & RESOURCES

Physicians, Hospitals and Medical Centers, Primary Care Clinics,
Specialty Care Clinics, Retail Pharmacies, Health Plans, Home Care & Hospice,
HPC (a Group Purchasing Organization focusing on Health Care, Hospitality, Business and Construction)

Living options and services



Ebenezer Management Services (EMS)

EBENEZER

Minnesota's largest senior housing operator

- **10,000** lives touched daily
- **60+** co-ops & condos in MN, IA, NE, WI
- **7** subsidized affordable housing buildings in MN
- **37+** stand-alone AL and MC communities
- **7** LTC communities
- **5** TCU
- **5** Adult Day
- **4** Childcare Programs

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Fairview Partners

Continuing to live in your own home is important.
We are dedicated to helping individuals live in their own home by ensuring they receive the help they need to keep living independently.

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HEALTH FAIRVIEW

EBENEZER

Fairview Partners Overview

LONG TERM CARE (LTC) AND ASSISTED LIVING (AL) CARE MODEL

Care Coordination for members who reside in partner facilities and receive on-site primary care by an M Health Fairview Geriatrics provider

Current Enrollment:

- 500 individuals living in LTC settings
- 300 individuals living in AL settings

COMMUNITY CARE MODEL

Care Coordination for members who receive their primary care from an M Health Fairview Clinic

Current enrollment:

- 4,000 individuals enrolled who are living in their own homes in community

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Community Care Coordination Model

- Comprehensive assessment w/in 30 days + med rec + PHQ
- Elderly Waiver screening
- PCA Assessment/Eligibility
- Care plan with individualized goal-setting
- Referrals placed for identified needs.*
- Care Plan communicated PCP
- Review insurance benefits, preventative care

- Regular communication with service providers
- Epic Healthy Planet & Compass Rose documentation
- PCC/PCP communication via EPIC
- Preventative care education & outreach

- CC follows member throughout ED, hospital, and/or SNF transitions
- Communication to receiving setting w/in 24 hours of all transitions
- CC attends SNF discharge planning conferences
- Direct admissions to SNF from home if necessary

***Members do have the right to refuse a home visit, however, they cannot receive certain services if the assessment is declined. Eighty-five percent of FVP members accept a home visit.**

Community Care Coordination Model

- Review care plan goals with member, revise as needed
- Review services and supports
- Assess for recent falls, preventative care needs, health status changes

- Assess for changes in:
  - ADLs/IADLs
  - Cognition
  - Health status
  - Social supports
  - Caregiver needs
  - ACP Status
- Updated POC with new/revised goals
- Adjust services as needed
- POC to PCP

- Death
- LTC move
- Care system change
- Health plan change

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Community Model Additional Services & Resources

- Geriatric Certified Pharmacist
- In-home advance care planning visits
- Interdisciplinary Team Case Reviews
  (MD, PharmD, RN, SW, CHW)
- Community Health Worker:
  Housing assistance, Gaps in Care outreach, advance care planning, community resources, MA paperwork
- Support Staff
  (schedule appointments, rides, assessment prep, post–visit referrals/authorizations)

What is Changing?

- **Patients are more acute and more complex**
  - More 65+ adults being admitted for hospital care
    - Just in our metro area hospitals, 38% of our inpatient discharges were for patients 65 years and older
      - Just in the last three years, we have seen 3% year over year increase
    - Comparatively at Grand Itasca Hospital and Clinic in Grand Rapids, 43% of inpatient discharges were for 65+ adults
  - In Primary Care over 20% of our attributed patients are 65 years and older
    - Statewide the percentage of population 65 and older = 16.6%
  - Medications are more expensive

- **Increased capacity challenges in post-acute settings across the state**
  - Not enough staff to meet needs in community, post-acute settings

- **Significantly longer delays with state/county processes for eligibility**
  - Longer timelines leave patients stuck in some settings

- **Rules and regulations were designed for patients of 15-20 years ago**

Challenges to Older Adult Health Care in Community

Transportation

Technology

Workforce

Discharge to Home

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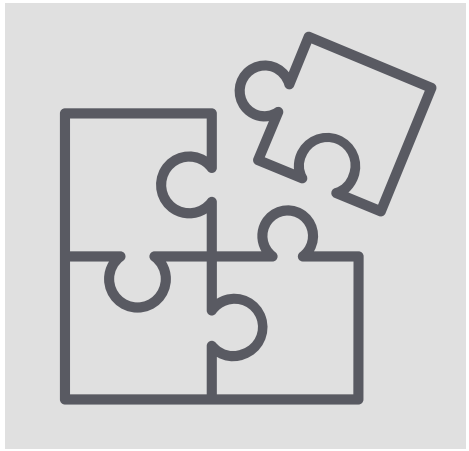
Opportunities/Recommendations for Innovation



- **Payment/Care Models that incentivize community settings and care coordination (i.e. Fairview Partners, PACE)**
  - Care coordination has limited reimbursement
- **Sustainable investment in transportation infrastructure**
  - Reimbursement not sufficient for non emergency medical transportation needs - particularly acute in Rural MN
- **Technology flexibility**
  - Telehealth and remote patient monitoring
  - Support for technology needs and education for aging adults
- **Centers of Excellence in post-acute care**
  - Not every facility can meet every need
  - Payment Models to account for facilities treating more complex patients (wound care, trach/vent, behavioral patients)

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Questions and Discussion

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President and Chief of Primary Care
Fairview Health Services

Jon Lundberg
President
Ebenezer and Fairview Senior Services

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