Direct Admission Program

HealthSouth Rehabilitation Hospital of Toms River, New Jersey
• **Introduction of Presenters**
  - Patty Ostaszewski, MS, BSN, RN, CRRN, LNHA, Chief Executive Officer
  - Beth Lynch, MS, CCC-SLP, Associate Administrator
  - Julie Hormilla, RN, Senior Liaison, Marketing Coordinator
  - Padma Adusumilli, MD, Medical Director

• **Company and Hospital Overview**

• **Direct Admission Program**
  - Patient Referrals
  - Admission Criteria and Candidate Profile
  - Potential Diagnosis
  - Program Development Considerations
  - Benefits for Patients and Hospitals

• **Volume and Outcome Data**

• **Case Studies**

• **Summary**

• **Comments and Questions**
Encompass Health | A Leading Provider of Inpatient Rehabilitation and Home-Based Care

- ~60% of EHC’s IRFs have an EHC home health location within a 30-mile radius.*

Portfolio as of December 31, 2017
- Inpatient Rehabilitation Hospitals (“IRFs”)
- Home Health Locations
- Hospice Locations
- 7 Future IRFs**
- 36 States and Puerto Rico ~37,900 Employees

Inpatient Rehabilitation - 12/31/17
- 127 IRFs (42 are Joint Ventures)
- 31 States and Puerto Rico
- ~29,400 Employees
- 22% of Licensed Beds†
- 29% of Medicare Patients Served†

Key Statistics - Full-Year 2017
- 171,922 Inpatient Discharges
- ~$3.2 Billion in Revenue

Largest Owner and Operator of IRFs
4th Largest Provider of Medicare-Certified Skilled Home Health Services

Home Health and Hospice - 12/31/17
- 200 Home Health Locations
- 37 Hospice Locations
- 28 States
- ~8,500 Employees

Key Statistics - Full-Year 2017
- 124,870 Home Health Admissions
- 4,870 Hospice Admissions
- ~$783 Million in Revenue
OUR PURPOSE
We believe integrated care delivery across the healthcare continuum is critical to achieving the best outcomes for patients. We exist to provide a better way to care that elevates expectations and outcomes.

THE ENCOMPASS HEALTH WAY

<table>
<thead>
<tr>
<th>Set the standard</th>
<th>Lead with empathy</th>
<th>Do what’s right</th>
<th>Focus on the positive</th>
<th>Stronger together</th>
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</thead>
<tbody>
<tr>
<td>We are committed to going above and beyond, never settling for anything less than excellence. We pride ourselves on being industry leaders and challenge ourselves to continuously improve.</td>
<td>We start with empathy, taking the time to understand the physical, mental and emotional needs of each other and those we support. We listen, make deep connections and engage on a personal level to better serve others.</td>
<td>We do the right thing the right way, no matter how difficult, even when no one is looking. We’re not afraid to have hard conversations. If we make a mistake, we acknowledge it, proactively find a resolution and make it right going forward.</td>
<td>We have a positive spirit and find the light even in the most difficult situations. We bring our whole self to work. We celebrate successes and inspire others to create meaningful impact.</td>
<td>We believe our individual strengths make us stronger together. We take accountability for our actions, connect across teams and lean in to get it done – at all levels of the company.</td>
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Specific Information Regarding Our Hospital

- Joint Commission Certified for Disease Specific Care for Brain Injury Rehabilitation, Cardiac Rehabilitation, Advanced Inpatient Diabetes Care, Pulmonary Rehabilitation, Stroke Rehabilitation and Wound Care.

- Nationally Ranked in the Uniform Data System (UDS) Top 10% of Rehabilitation Hospitals for 11 Years.

- HealthSouth Toms River is consistently ranked in the top quartile of HealthSouth’s Clinical Ranking. This ranking reflects patient’s functional progress, patient experience score, discharge to community, and re-admission rate.

- Achieved Encompass Health rigorous criteria for 2018 Stroke Center of Excellence.

Specialized Treatment Team:
- 100% Certified Case Managers (CCM)
- 43 Certified Rehabilitation Registered Nurses (CRRN)
- Numerous Therapist certifications including Vestibular, Lymphedema, Cardiac and Neuro Rehabilitation
Direct Admission Program: Patient Referrals

- Home
  - Patient clinically identified by primary care physician or home health professional

- Emergency Department & Observation Units

- Surgery Centers

- Physician Office

- Assisted Living Facilities

* No 3 day qualifying stay required *
* Community Need *
* Gaps in care options for patients *
Direct Admission Program: *Admission Criteria*

- Rehab diagnosis and goals.
- Patient requires multiple therapy disciplines (1 must be PT or OT).
- Patient must reasonably be expected to participate in therapy and benefit significantly.
- Requires supervision of a rehab physician who conducts face to face visits at least 3 days per week, as well as the need for medical management in an inpatient setting.
- Safe discharge environment and plan.
Direct Admission Program: **Patient Profile**

- Patients with a functional decline from baseline
- Patient has a rehab diagnosis
- Medical need to be “in-patient”
- Cognitively alert in order to participate in therapy
- Must be willing and motivated with realistic goals
- Referred from Home Health company, Emergency Department, or Primary Care/ Specialty Physician office.
Direct Admission Program: *Potential Diagnoses*

- Post stroke, TBI, SCI
- Amputation
- Increasing debility, secondary to an acute illness, injury, or surgery
- Parkinson’s Disease
- Arthritis
- Previous stroke, with symptom exacerbation associated with acute illness, injury, or surgery
- Neurological disorders
- Pulmonary: COPD, pneumonia
- Cardiac disorders: CHF
Direct Admission Program: Admission Process

- First, discuss with patient & family
- Call admissions office or marketing rehab liaison directly
- Complete a referral form
- Provide demographics and medical information regarding the patient to the marketing rehab liaison

We take it from there!
- In-house assessment or contact with patient within 24 hours
- Follow up communication with referring doctor
- Final admission approval by physician at the rehabilitation hospital
Direct Admission Program: Development Considerations

• Need all Key Stakeholders involved
  o Medical Staff
  o Nursing and Therapy Teams
  o Rehab Liaisons: *specific to this program*
  o Referral Source Education to EDs, PCPs, Home Health Agencies, and the general community

• Communication
  o ED physician or PCP speaks directly to rehabilitation doctor and clinical liaison to gain as much accurate pre-admission clinical information as possible.

• Education
  o When the program is initiated, there may be a tendency for rehab physicians to increase diagnostic work up. Once the program is in place for a period of time, there will be a reduction in the amount of medical work up and associated expenses. This requires ongoing assessment, monitoring, and education.
## Outcomes and Volume

<table>
<thead>
<tr>
<th>Year</th>
<th>CMI</th>
<th>Volume</th>
<th>% of Volume</th>
<th>% D/C to Community</th>
<th>% D/C to Acute</th>
<th>% D/C to SNF</th>
<th>% RAND</th>
<th>PEM</th>
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<tbody>
<tr>
<td>2015</td>
<td>1.39</td>
<td>422</td>
<td>17.9</td>
<td>81.28</td>
<td>7.82</td>
<td>10.9</td>
<td>83.16</td>
<td>93.75</td>
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<tr>
<td>2016</td>
<td>1.47</td>
<td>454</td>
<td>19.62</td>
<td>80.4</td>
<td>10.79</td>
<td>8.81</td>
<td>81.5</td>
<td>80.44</td>
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<tr>
<td>2017</td>
<td>1.52</td>
<td>535</td>
<td>23.36</td>
<td>84.48</td>
<td>7.1</td>
<td>8.41</td>
<td>83.24</td>
<td>99.48</td>
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<tr>
<td>YTD 2018</td>
<td>1.48</td>
<td>219</td>
<td>25.85</td>
<td>77.16</td>
<td>7.3</td>
<td>15.52</td>
<td>82.65</td>
<td>82.79</td>
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<td>Overall</td>
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<tr>
<td>Regional</td>
<td>1.48</td>
<td>842</td>
<td>66.4</td>
<td>13.7</td>
<td>19.6</td>
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**Outcomes**

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<thead>
<tr>
<th>Year</th>
<th>D/C Acute</th>
<th>D/C Community</th>
<th>% Volume</th>
<th>Linear (% Volume)</th>
<th>Linear (D/C Community)</th>
<th>Linear (D/C Acute)</th>
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<td>2018 YTD</td>
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Facility: HEALTHSOUTH Rehabilitation Hospital of New Jersey

PATIENT SUMMARY
- Patient ID:
- Birth Date:
- Age at Admission: 71 years
- Gender: Female

CASE SUMMARY
- Admission Date: 12/13/2016
- Admission Class: Initial Rehab
- Admission:
- Impairment Group Code: 8.62 - Bilateral Knee Replacements
- Onset Date: 12/02/2016
- Etiologic Diagnoses: M17.0
- Discharge Date: 12/21/2016
- Discharge Living Setting: 06 - Home with home health
- Reporting CMG: A0805
- CMG: A0805
- Special CMG:
- Actual Length of Stay: 8 days
- CMG Expected LOS: 12 days
- Primary Pay Source: 02 - Medicare Fee for Service
Facility: HEALTHSOUTH Rehabilitation Hospital of New Jersey

PATIENT SUMMARY
Patient ID:
Birth Date:
Age at Admission: 81 years
Gender: Male

CASE SUMMARY
Admission Date: 09/06/2017
Admission Class: Initial Rehab
Admission:
Impairment Group Code: 6.2 - Osteoarthritis
Onset Date: 09/07/2017
Etiologic Diagnoses: M19.90
Discharge Date: 09/20/2017
Discharge Living Setting: 01 - Home
Reporting CMG: A1203
CMG: A1203
Special CMG:
Actual Length of Stay: 12 days
CMG Expected LOS: 14 days
Primary Pay Source: 02 - Medicare Fee for Service
Program strengthens local healthcare relationships, and provides alternate solutions for referral sources.

Assists local Emergency Departments with appropriate, timely, and safe discharges for a certain population of patients.

Enhances patient safety.

Reduces STACH re-admissions.

At the completion of the inpatient rehabilitation stay, discharge summary is sent to referring physician/PCP, and follow up appointments are scheduled accordingly.

Rehab liaison has formal document to close the loop regarding the patients clinical outcome.
Questions

Thank You