ACOExhibitHall.com

Educational Webinar Series

Post-Acute Analytics: What's in It for My ACO?

PointRight®

A Net Health Company

Tuesday, August 31, 2021 | **Janine Savage,** VP, Product Management, Analytics and BI

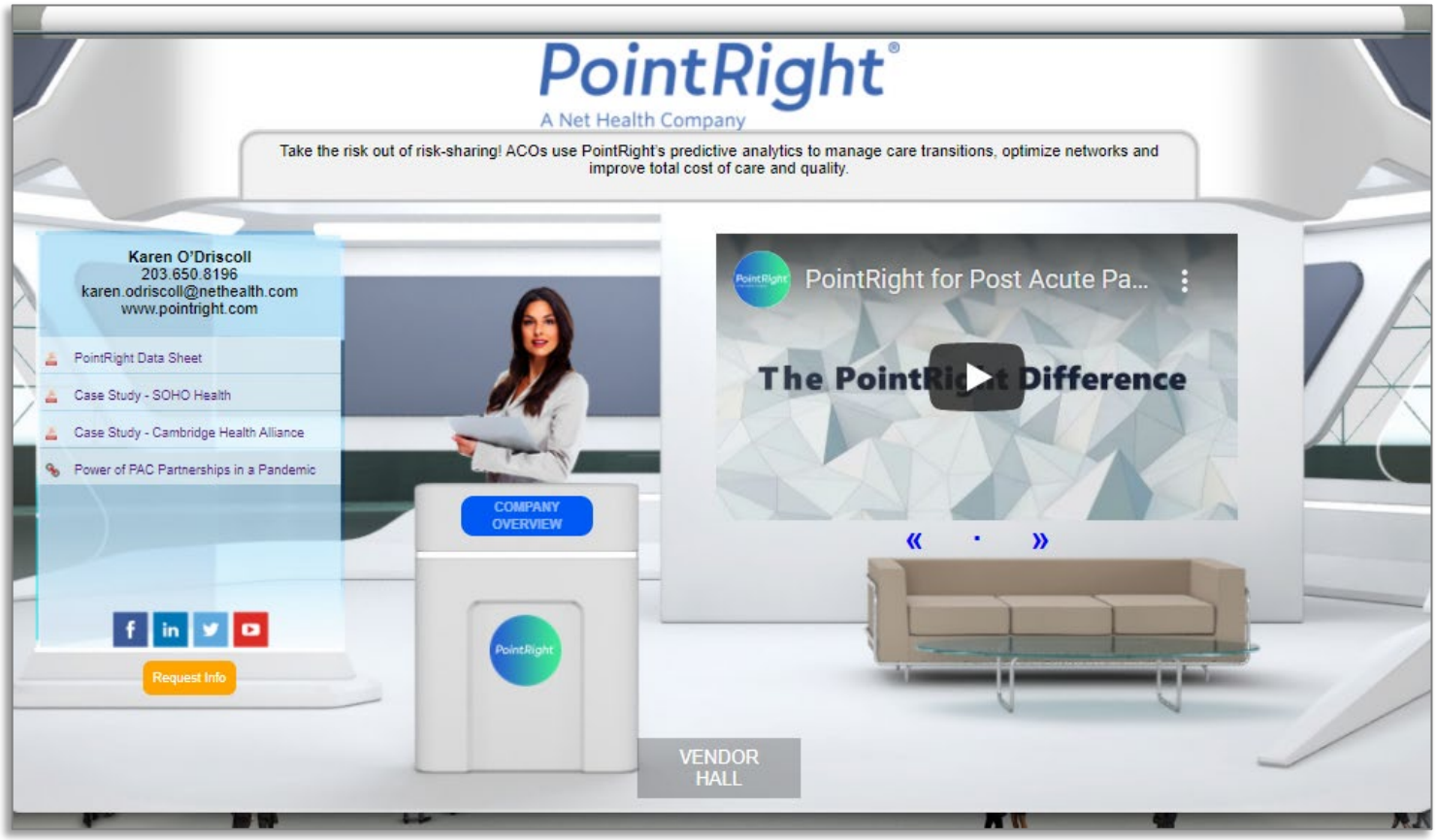
Welcome!

Intros

Garrett Schmitt
ACO Exhibit Hall

Presenter

Janine Savage
VP Product Management,
Analytics & BI



PointRight can be found in the
Population Health II: Software Tools & Data Analytics Exhibit Hall

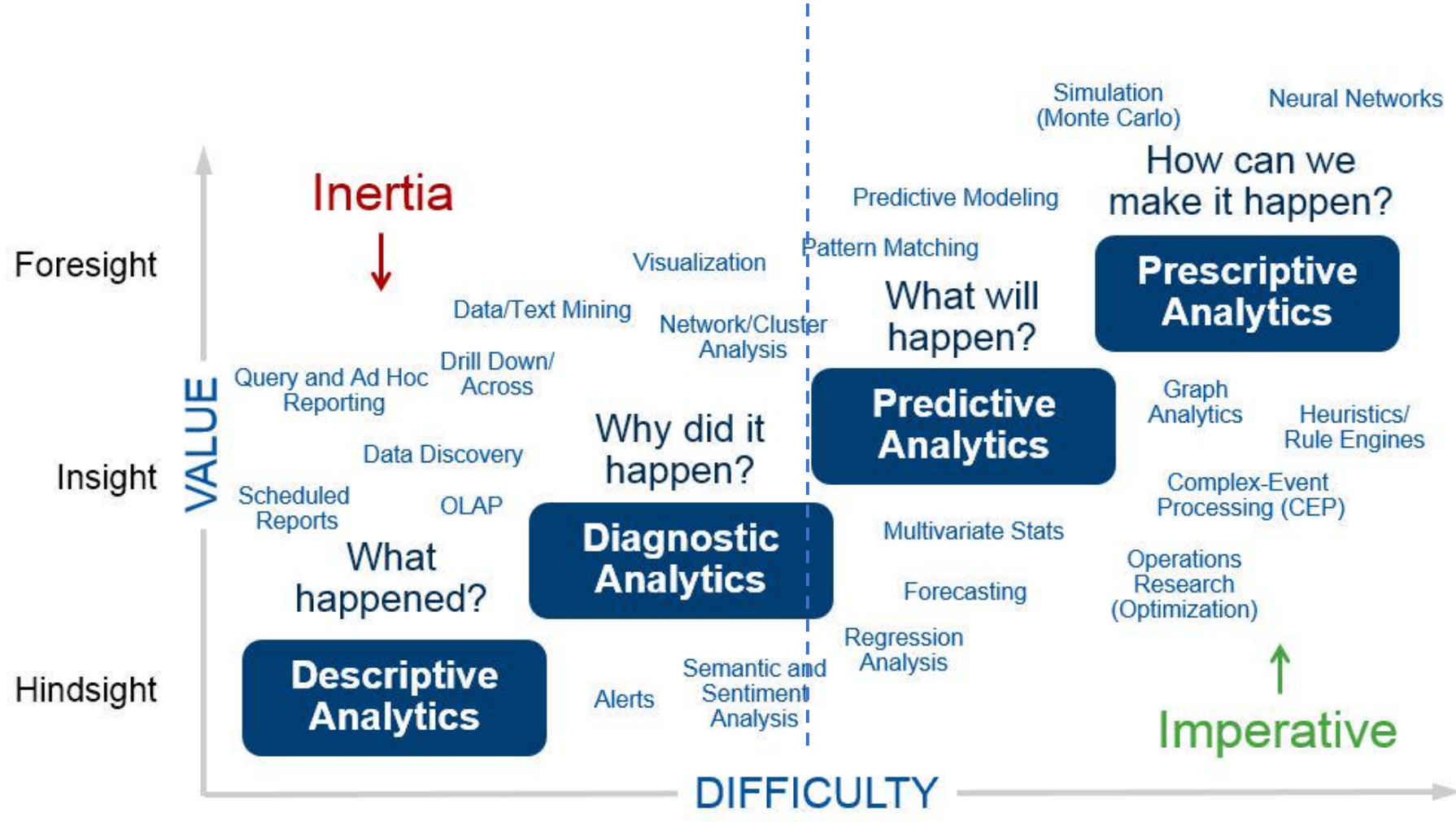
Today's Objectives

- Introduce types of Analytics in Post-Acute Care (PAC)
- Show how these analytics help you:
  - Build and sustain high-performing SNF networks
  - Prevent hospital readmissions and adverse events
  - Reduce total cost of care
  - Earn more shared savings

What is LTPAC?
Long-Term and Post-Acute Care

- Wide array of services ranging from institutional services provided in specialty hospitals and nursing homes, to a variety of home and community-based services healthit.gov
- Continuum of facilities, programs, and services
- e.g. Skilled Nursing Facility (SNF), Long Term Acute Care Hospital (LTAC), Inpatient Rehabilitation Facility (IRF), Home Health Agency (HHA), Home Care, Hospice, Assisted Living, Adult Care Facility, Senior Living, Life Plan Community or CCRC, PACE (Program of All-Inclusive Services for the Elderly), Adult Day Care, etc.

The Gartner Analytic Continuum

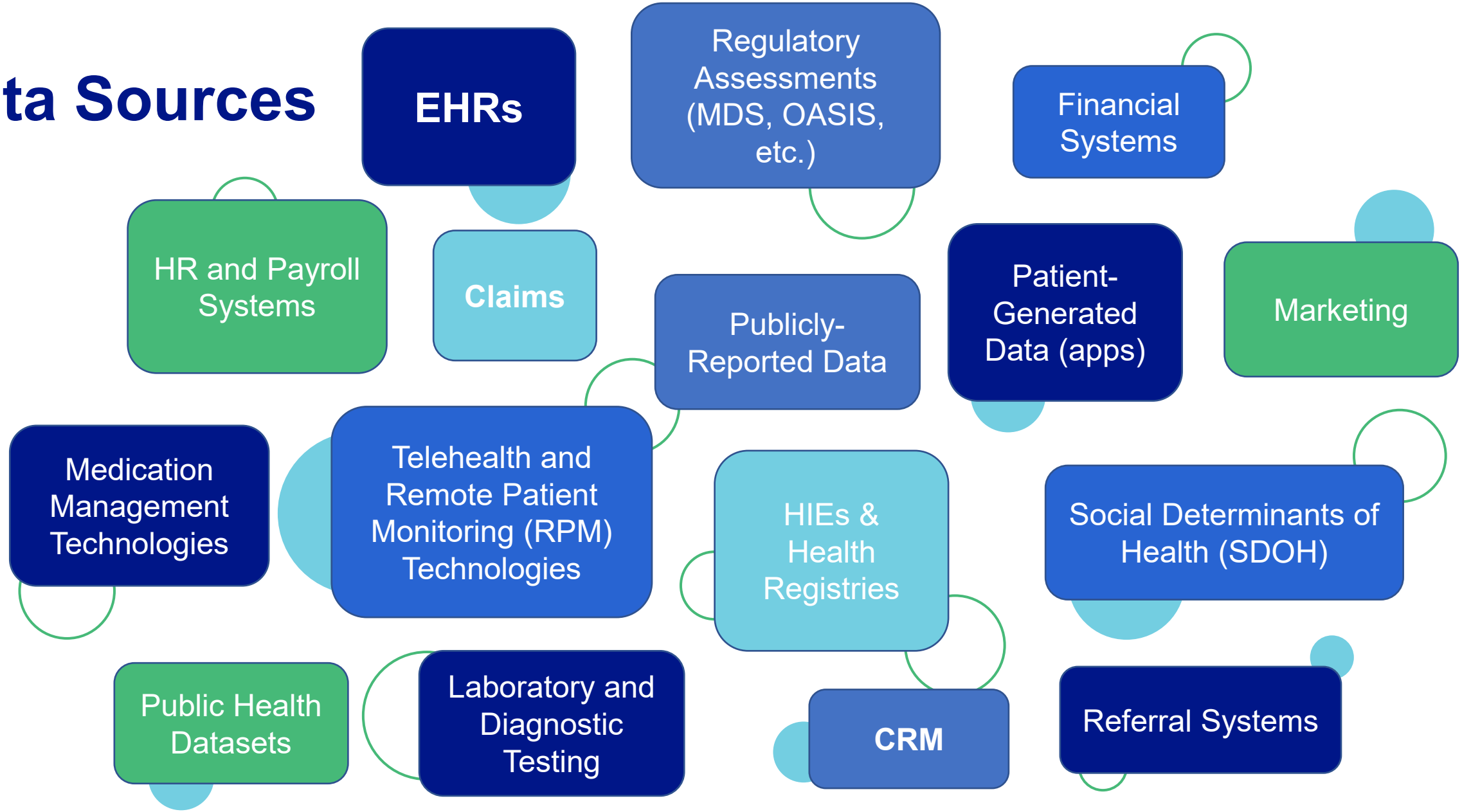


Gartner

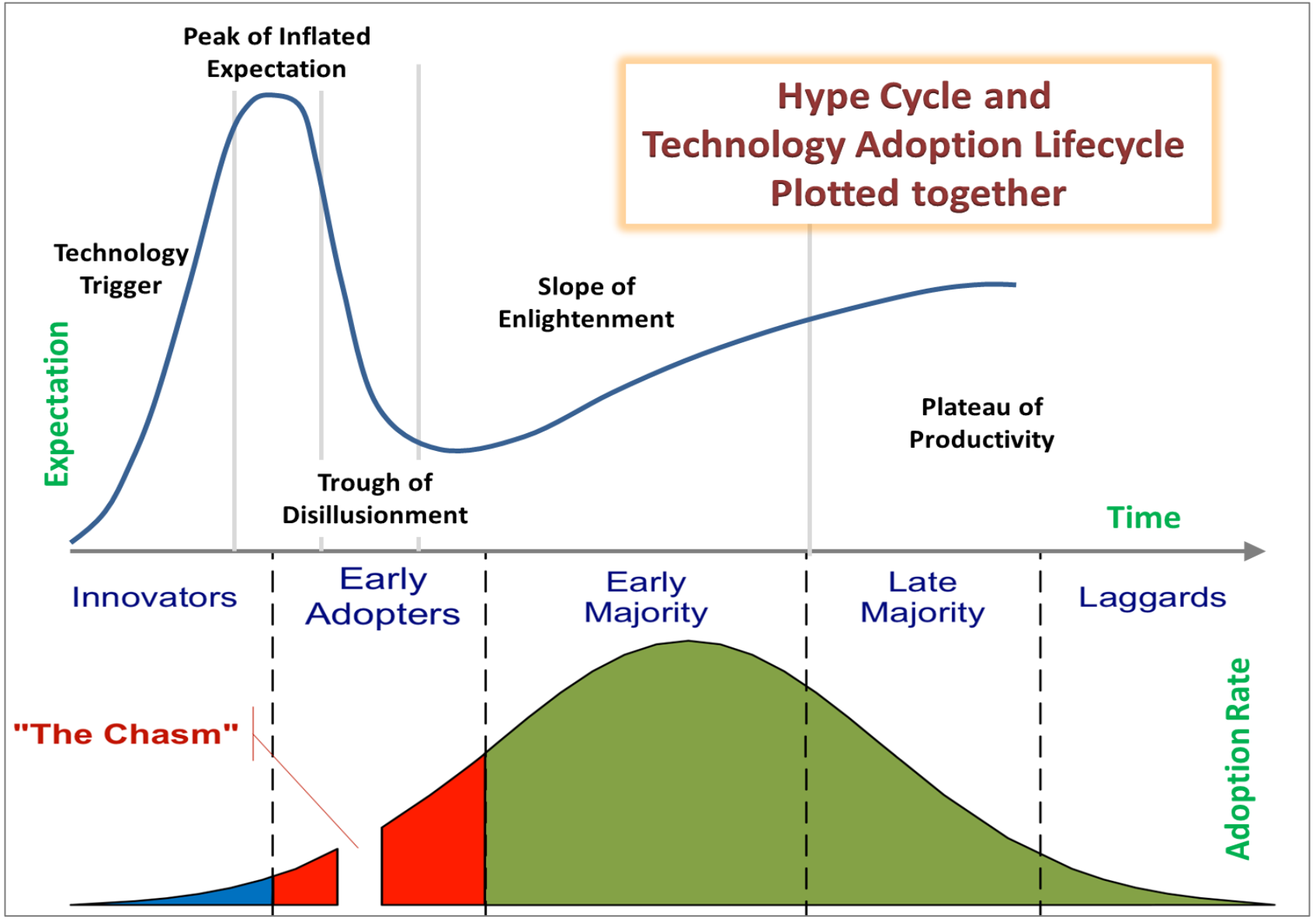
Application Areas for Healthcare Organizations

Data Analytics Services, Technologies, and Methodologies

Data Sources

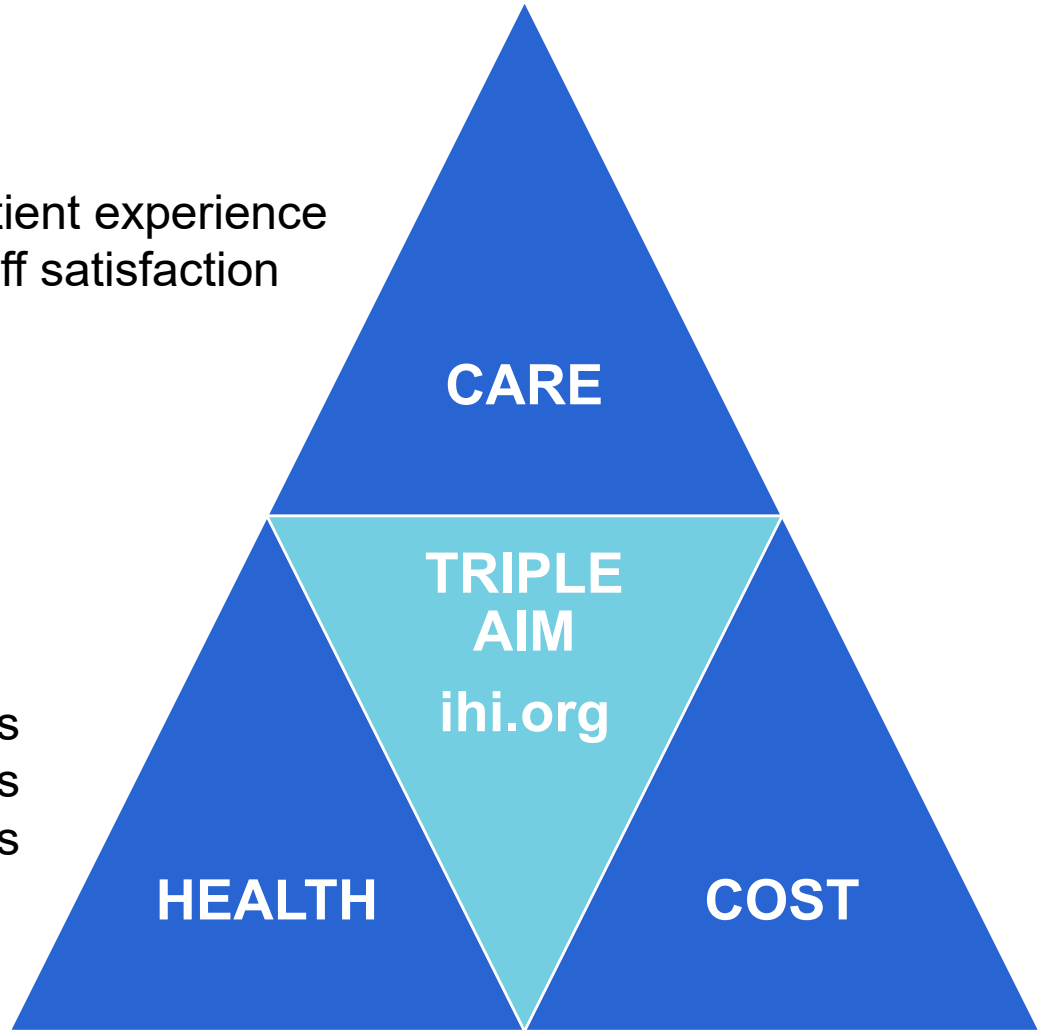


Analytics Maturity in an Organization



Potential Uses & Benefits of Analytics

Improve patient experience
Improve staff satisfaction



Improve outcomes
Prevent adverse events
Better manage populations

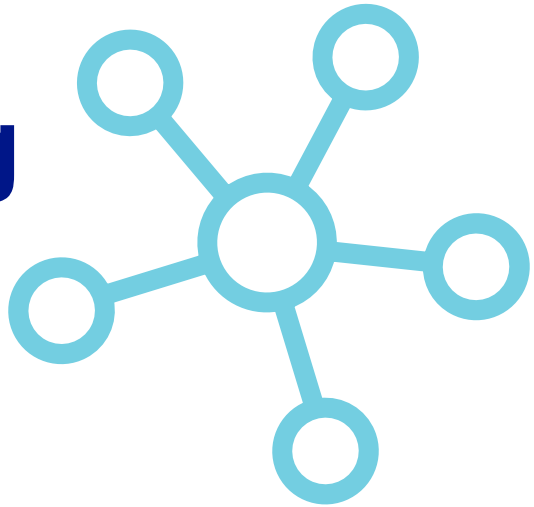
Compliant reimbursement
Impact total cost of care
- Manage risks
- Decrease readmissions
- Manage LOS and utilization

Increase operational efficiency
Improve overall financial health

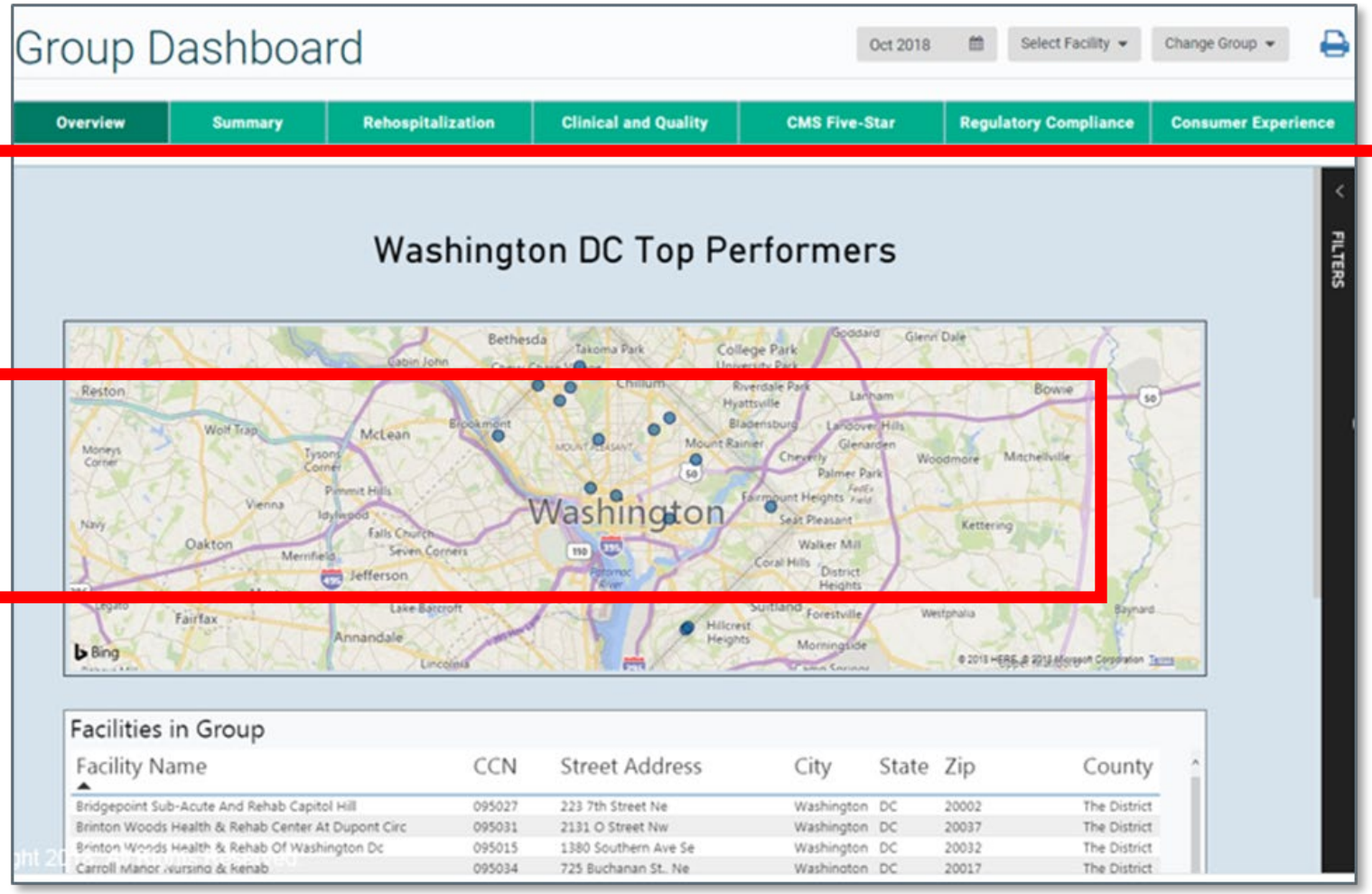
Analytics in Action:

How ACOs Are Using PAC Analytics

Build and Sustain High-Performing SNF Networks



Build Your SNF Referral Network



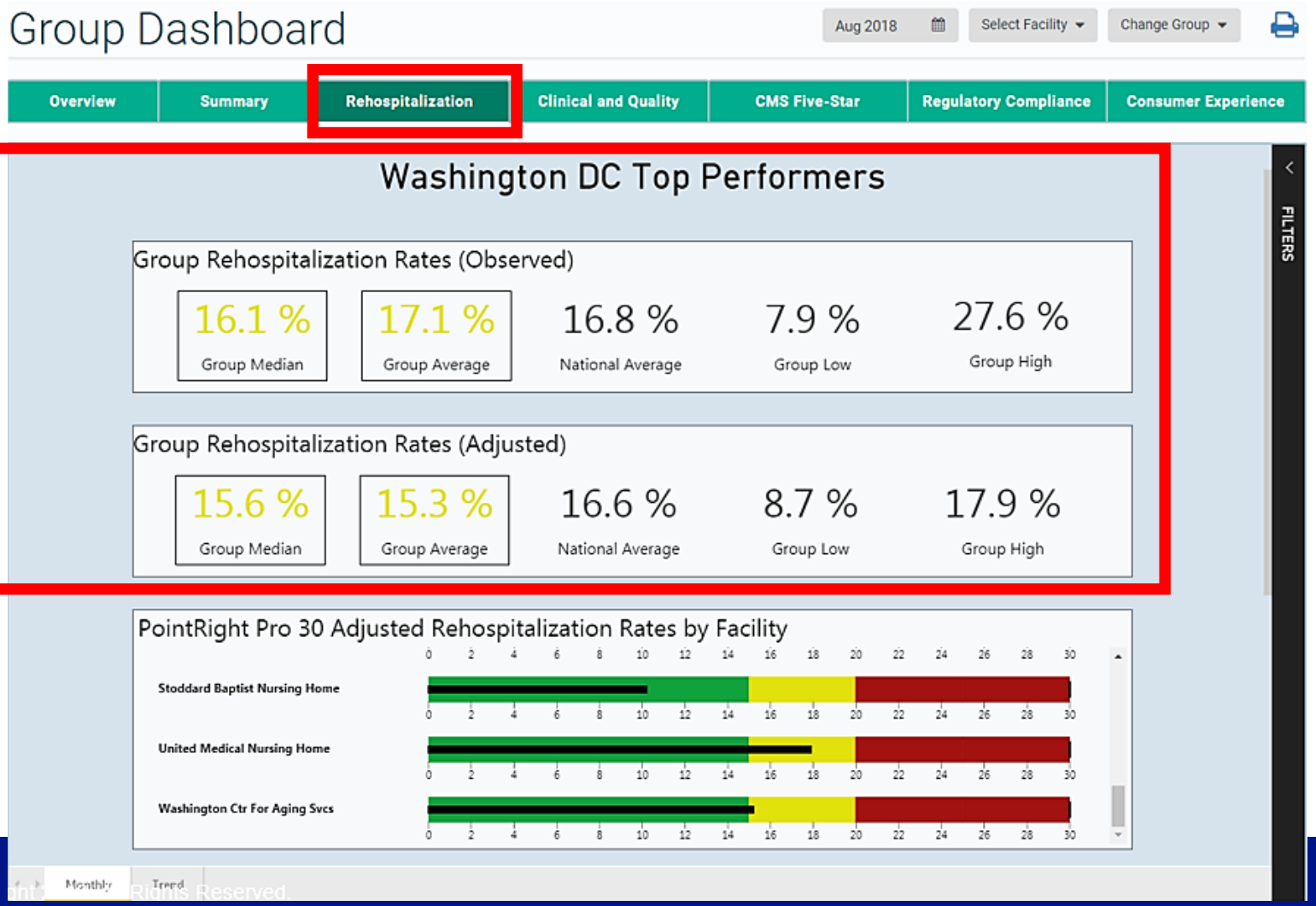
Review results in seven important domains

Select your service area for facility performance comparisons

Assess the Performance of Your SNF Network

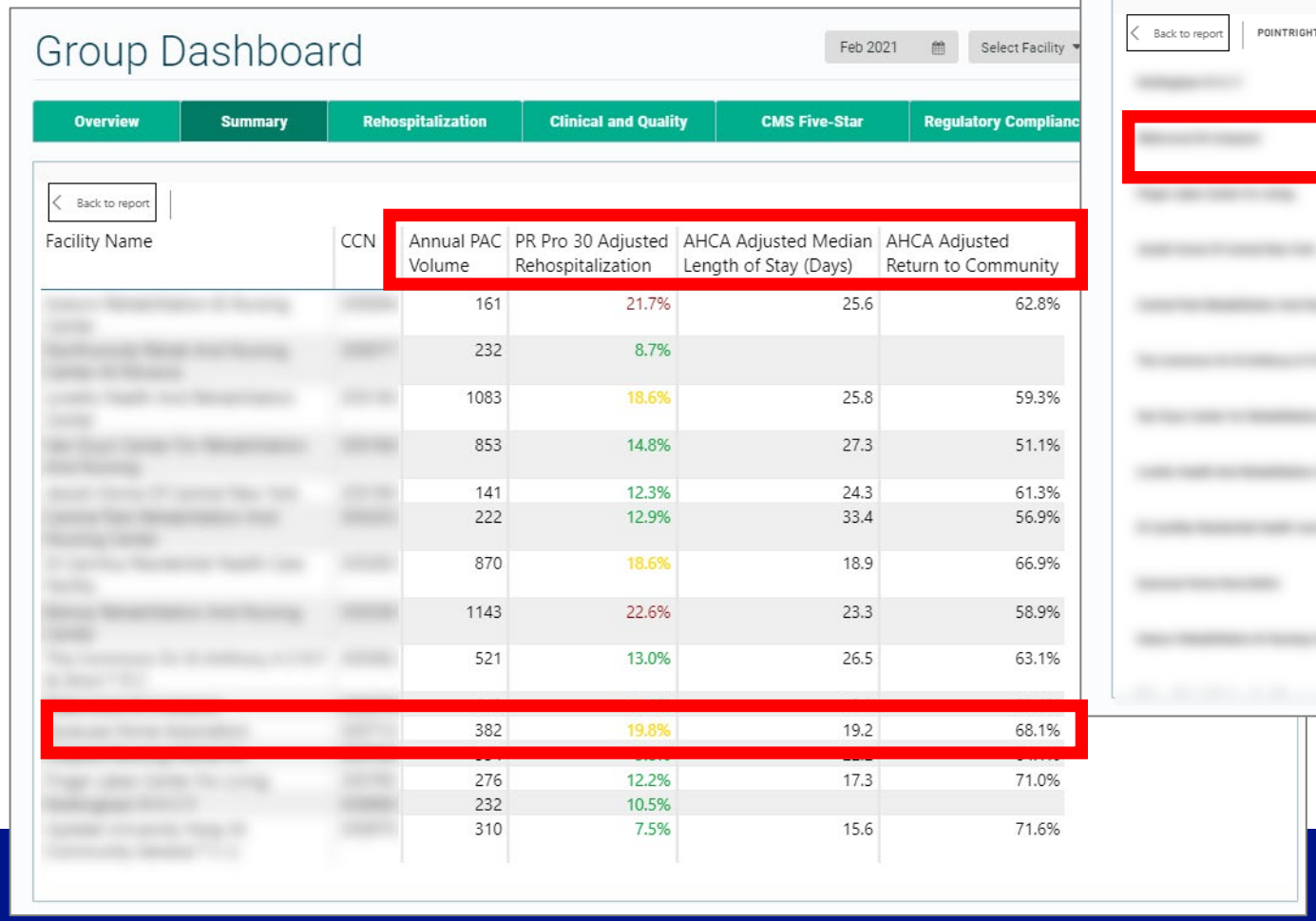
Group and facility comparisons:

- Identify strengths and areas for improvement
- Discover SNF best practices
- Identify areas for quality improvement initiatives

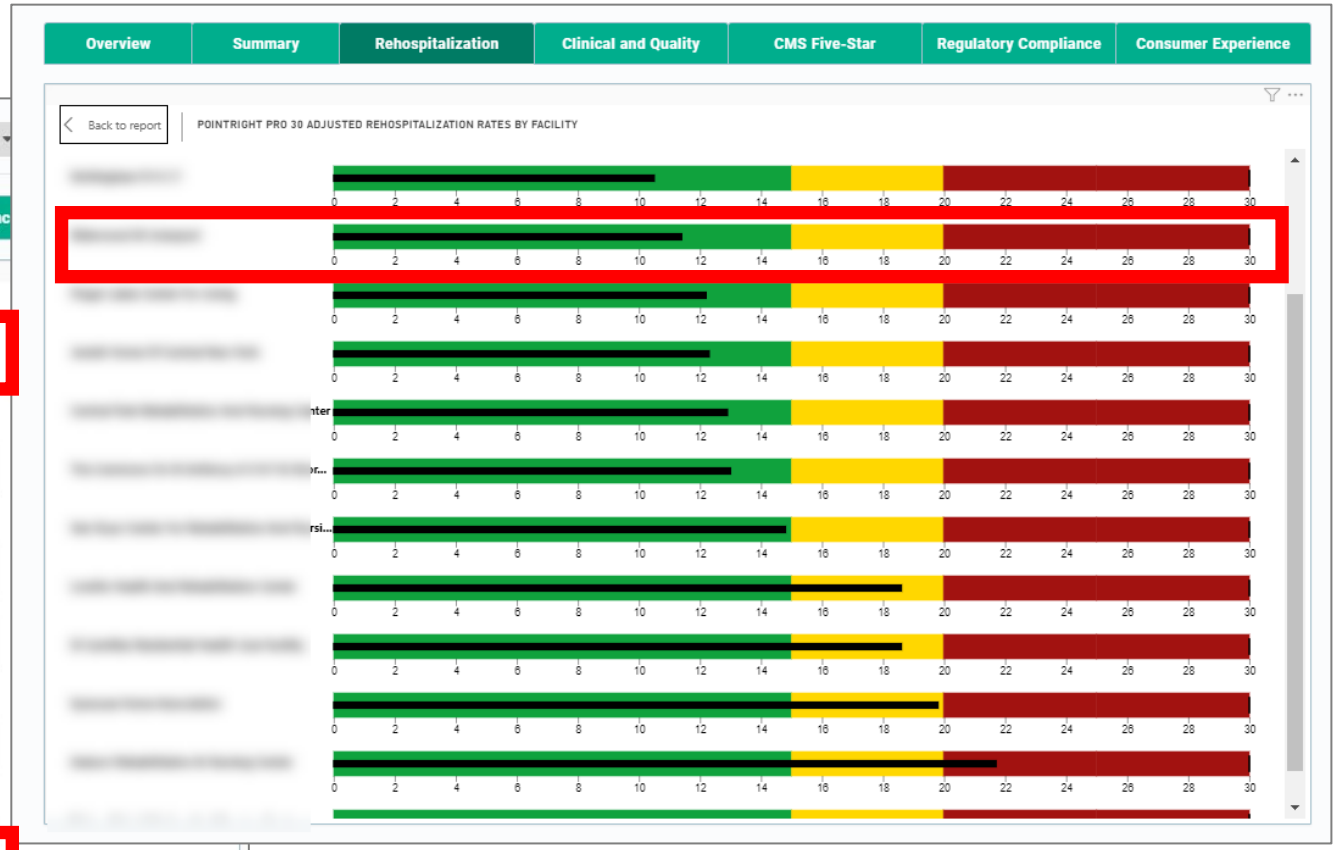


Understand a SNF's Key PAC Outcomes Compared to Others

Assess SNF post-acute care KPIs

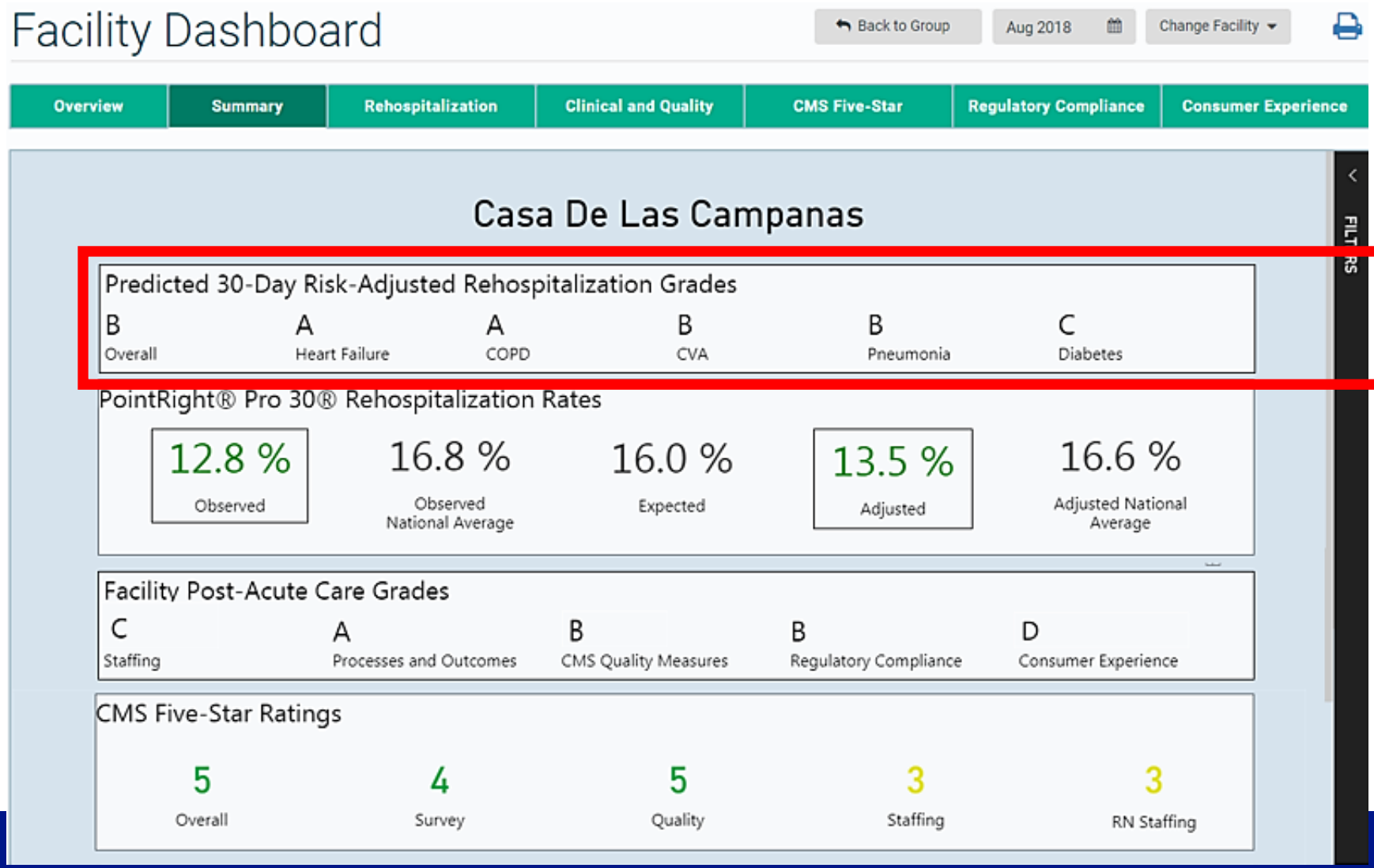


Facility Name	CCN	Annual PAC Volume	PR Pro 30 Adjusted Rehospitalization	AHCA Adjusted Median Length of Stay (Days)	AHCA Adjusted Return to Community
[redacted]		161	21.7%	25.6	62.8%
[redacted]		232	8.7%		
[redacted]		1083	18.6%	25.8	59.3%
[redacted]		853	14.8%	27.3	51.1%
[redacted]		141	12.3%	24.3	61.3%
[redacted]		222	12.9%	33.4	56.9%
[redacted]		870	18.6%	18.9	66.9%
[redacted]		1143	22.6%	23.3	58.9%
[redacted]		521	13.0%	26.5	63.1%
[redacted]		382	19.8%	19.2	68.1%
[redacted]		276	12.2%	17.3	71.0%
[redacted]		232	10.5%		
[redacted]		310	7.5%	15.6	71.6%



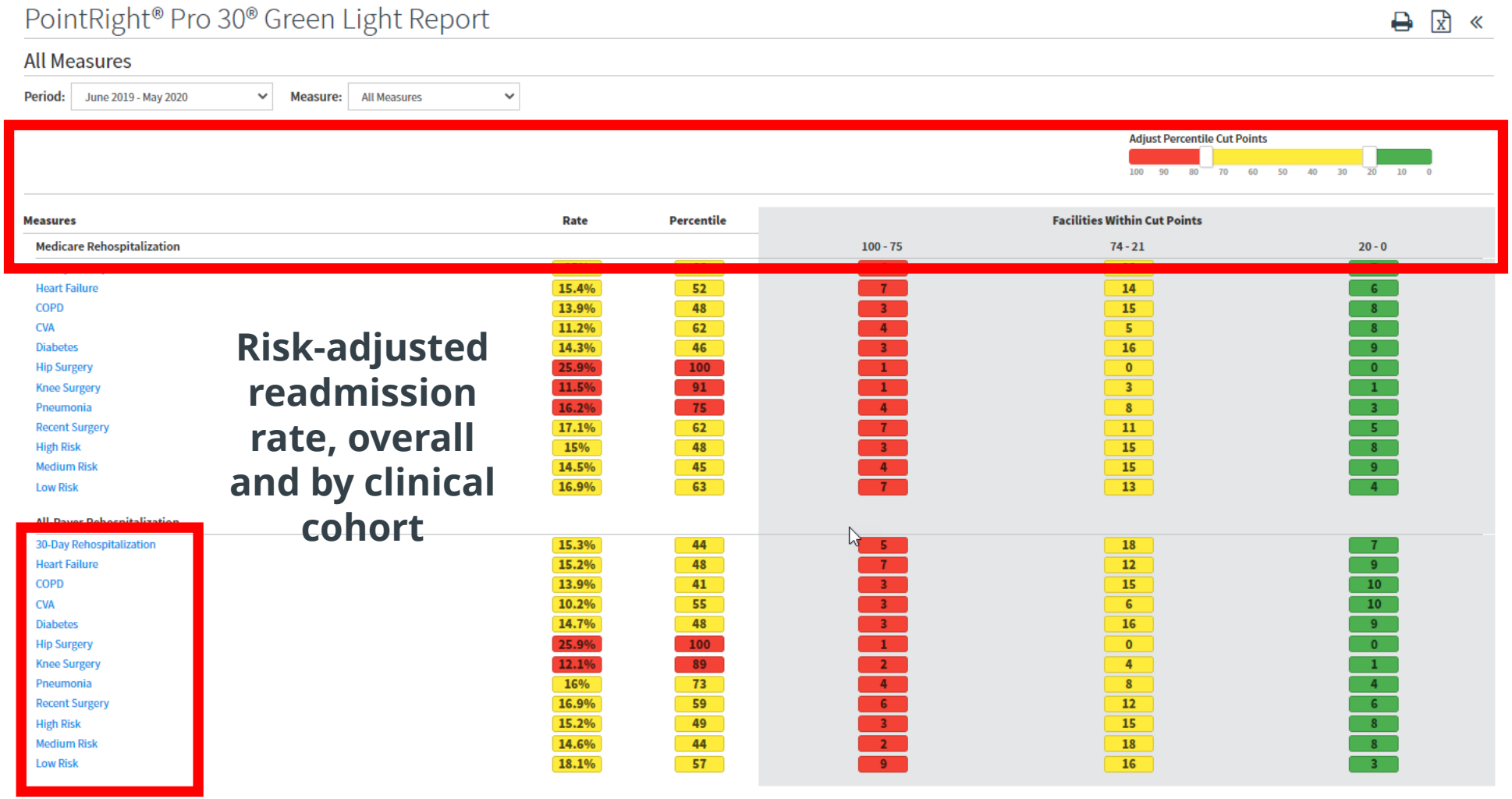
Prevent Hospital Readmissions

Evaluate Readmission Outcomes



View the facility's risk-adjusted grades for a valid evaluation of performance within the group

Benchmark Performance



PointRight® Pro 30® Green Light Report

All Measures

Period: June 2019 - May 2020 Measure: All Measures

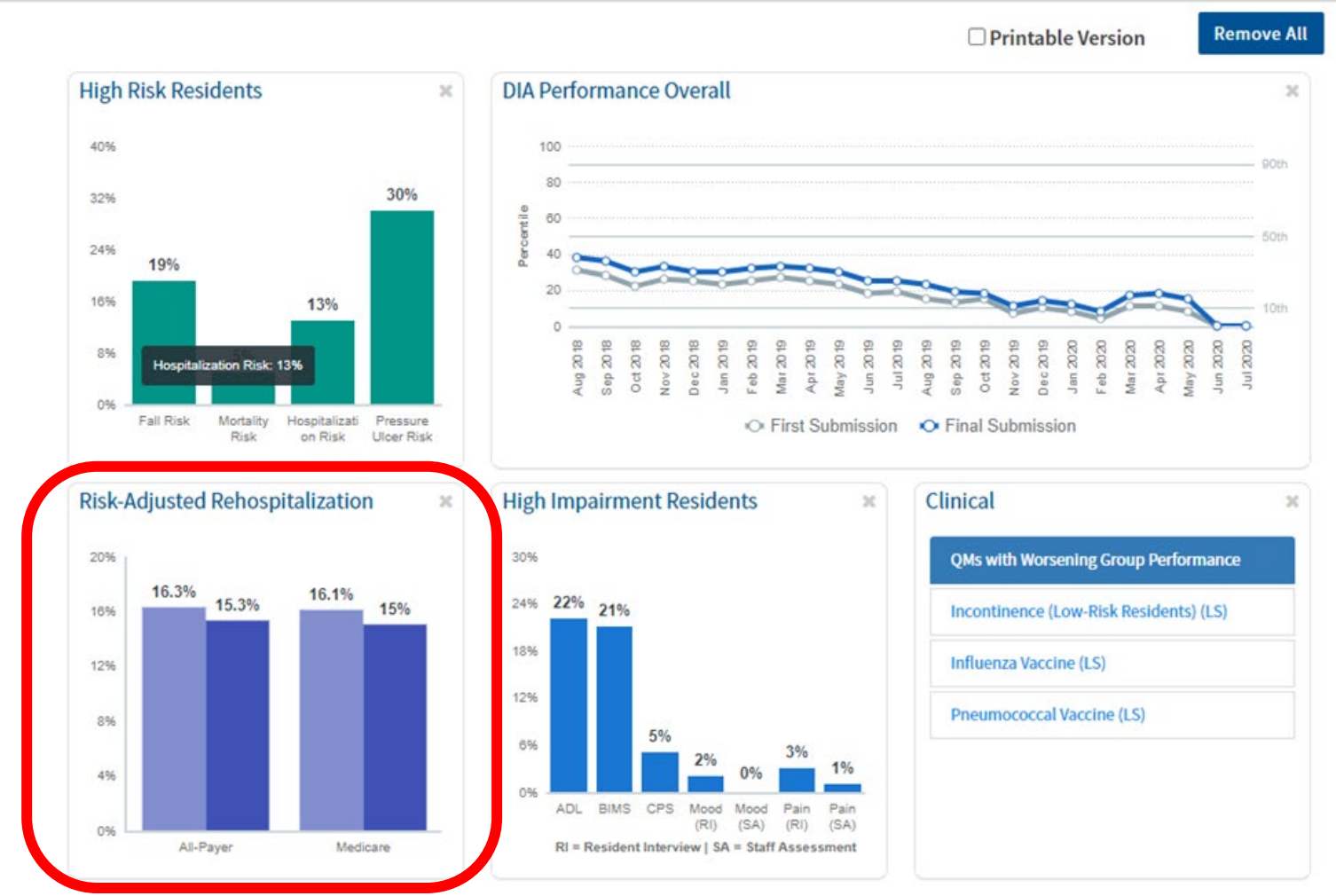
Adjust Percentile Cut Points

100 90 80 70 60 50 40 30 20 10 0

Measures	Rate	Percentile	Facilities Within Cut Points 100 - 75	74 - 21	20 - 0
Medicare Rehospitalization					
Heart Failure	15.4%	52	7	14	6
COPD	13.9%	48	3	15	8
CVA	11.2%	62	4	5	8
Diabetes	14.3%	46	3	16	9
Hip Surgery	25.9%	100	1	0	0
Knee Surgery	11.5%	91	1	3	1
Pneumonia	16.2%	75	4	8	3
Recent Surgery	17.1%	62	7	11	5
High Risk	15%	48	3	15	8
Medium Risk	14.5%	45	4	15	9
Low Risk	16.9%	63	7	13	4
All Payer Rehospitalization					
30-Day Rehospitalization	15.3%	44	5	18	7
Heart Failure	15.2%	48	7	12	9
COPD	13.9%	41	3	15	10
CVA	10.2%	55	3	6	10
Diabetes	14.7%	48	3	16	9
Hip Surgery	25.9%	100	1	0	0
Knee Surgery	12.1%	89	2	4	1
Pneumonia	16%	73	4	8	4
Recent Surgery	16.9%	59	6	12	6
High Risk	15.2%	49	3	15	8
Medium Risk	14.6%	44	2	18	8
Low Risk	18.1%	57	9	16	3

Risk-adjusted readmission rate, overall and by clinical cohort

Focus in on Facility Performance



Address the Drivers of Facility Performance

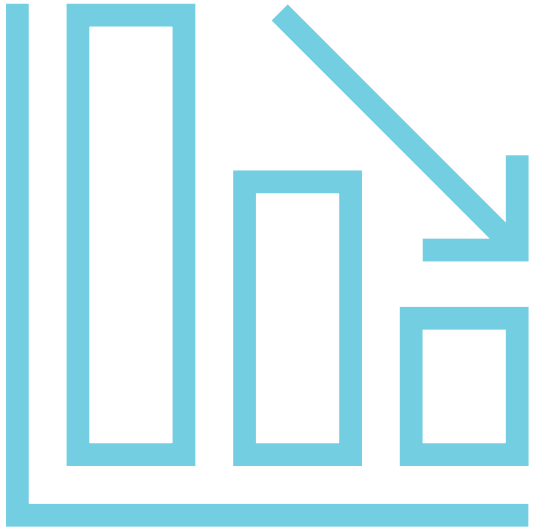
Medicare Rehospitalization Rates

OVERALL REHOSPITALIZATION			OBSERVED			EXPECTED	ADJUSTED		
Overall	Numerator	Denominator	Rate	PointRight® National Average	Percentile	Rate	Rate	PointRight® National Average	Percentile
30-Day Rehospitalization	55	257	21.4%	18.9%	69	21.3%	18.3%	15.9%	72

REHOSPITALIZATION BY CLINICAL COHORT			OBSERVED			EXPECTED	ADJUSTED		
Clinical Cohort	Numerator	Denominator	Rate	PointRight® National Average	Percentile	Rate	Rate	PointRight® National Average	Percentile
Heart Failure	17	55	30.9%	23.2%	84	27.6%	20.4%	16.2%	81
COPD	19	62	30.6%	21.0%	90	25.8%	21.6%	15.8%	87
CVA	8	42	19.0%	20.8%	44	19.2%	18.1%	16.2%	65
Diabetes	22	105	21.0%	21.8%	48	22.5%	17.0%	16.2%	58
Hip Surgery	0	0	⊘		⊘	⊘	⊘		⊘
Knee Surgery	2	3	⊘	10.4%	⊘	⊘	⊘	12.8%	⊘
Pneumonia	5	24	20.8%	24.5%	37	22.3%	17.0%	17.2%	51
Recent Surgery	12	53	22.6%	19.5%	71	20.0%	20.6%	17.1%	76

REHOSPITALIZATION BY RISK GROUP			OBSERVED			EXPECTED	ADJUSTED		
Risk Group	Numerator	Denominator	Rate	PointRight® National Average	Percentile	Rate	Rate	PointRight® National Average	Percentile
High Risk	26	63	41.3%	31.2%	89	35.8%	21.0%	16.6%	85
Medium Risk	19	128	14.8%	17.5%	33	18.8%	14.3%	16.4%	35
Low Risk	10	66	15.2%	10.0%	87	12.3%	22.5%	15.1%	86

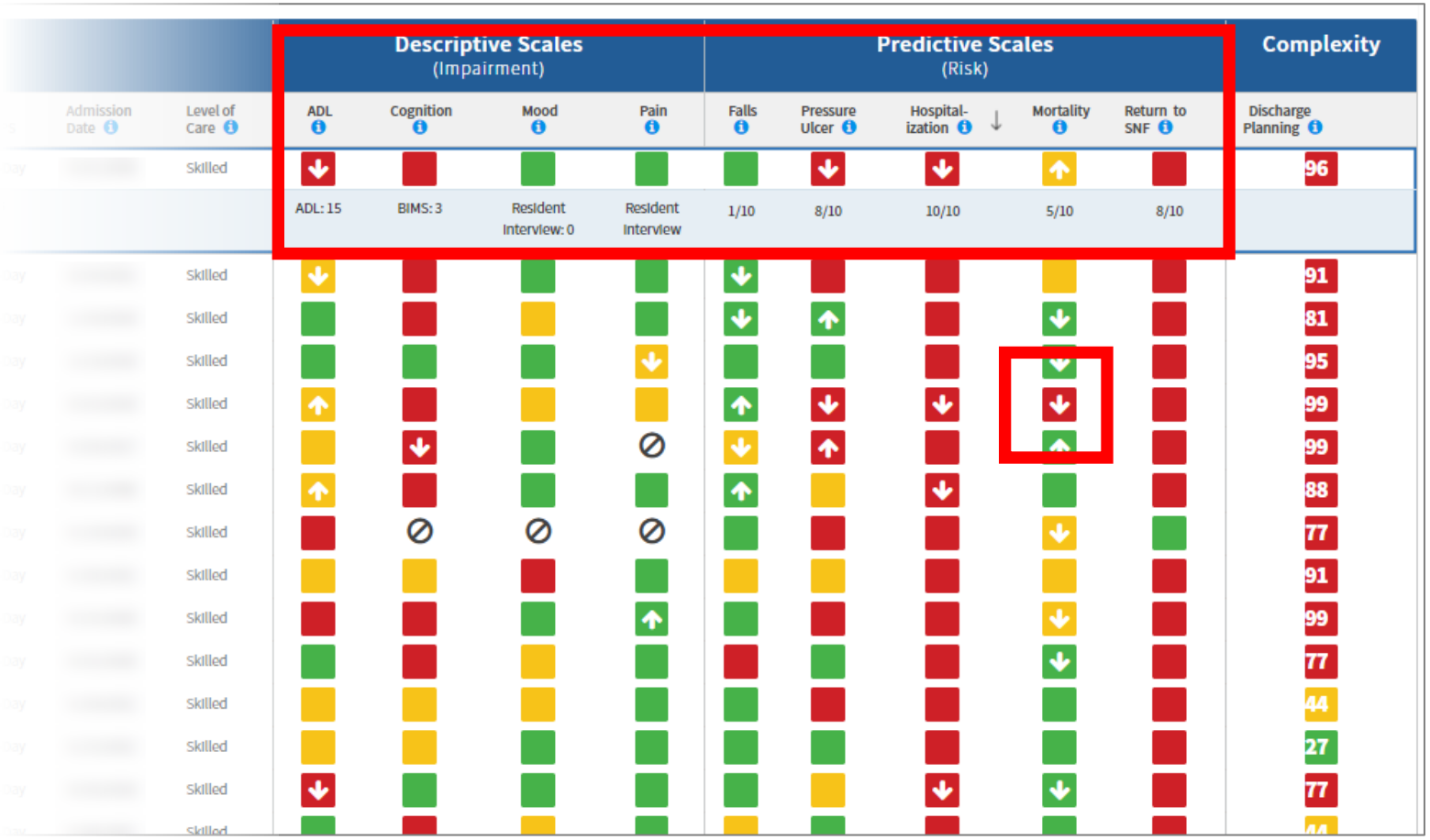
Reduce Total Cost of Care



Manage Patients at High Risk for Readmission

Prevent adverse events with predictive analytics

- Manage pressure ulcer, fall, and hospitalization risk
- Plan for successful discharge to Home & Community from the SNF
- Identify end-of-life for advance care planning



Manage LOS & Achieve Successful Discharge to Home from the SNF

Know and address key risk factors in plan of care

Resident Information								Descriptive Scales (Impairment)				Predictive Scales (Risk)					Complexity
Name	Room Number	ARD	OBRA	PPS	Admission Date	Level of Care		ADL	Cognition	Mood	Pain	Falls	Pressure Ulcer	Hospital-ization	Mortality	Return to SNF	Discharge Planning
Nibphefk, Fwunb	213-W	01/28/2021	Admission	5-Day	01/24/2021	Skilled		↑									50
Since Admission: 2 months Birth Date: 07/16/1921			At Level of Care: 2 months MRN: 1003418					ADL: 4	BIMS: 3	Resident Interview: 0	Resident Interview	10/10	3/10	4/10	2/10	8/10	

Hospitalization

HERE'S WHY High Risk

MDS Items that Contribute to Risk

- Entered the facility from an acute hospital (A1800)
- Bowel incontinence (H0400)
- Heart failure (I0600)
- Diabetes (I2900)
- Asthma, COPD, or chronic lung disease (I6200)
- 1 Stage 1 pressure injuries (M0300A)
- Oxygen (O0100C1, O0100C2)
- IV medications (O0100H1, O0100H2)
- Dialysis (O0100J1, O0100J2)

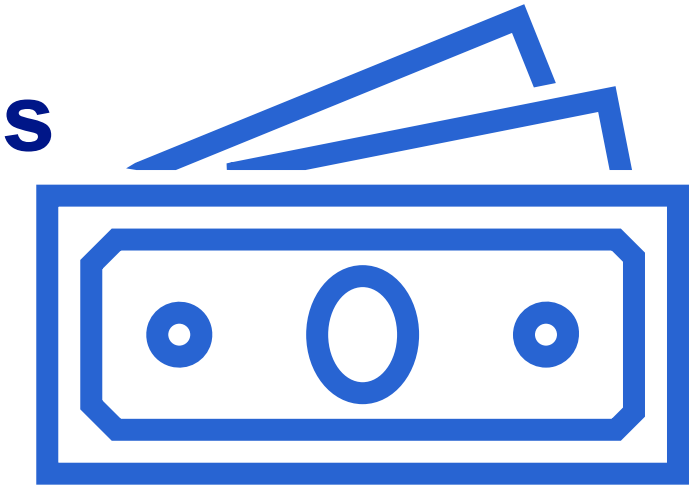
Discharge Planning: **50**

HERE'S WHY Moderately Complex

MDS Items that Contribute to Complexity

- Hearing highly impaired (B0200)
- Non-Alzheimer's Dementia (I4800)
- Antidepressant (N0410C)
- Bowel incontinence (H0400)
- Malnutrition (I5600)
- Altered consistency diet (K0510C2)
- PRN Pain medication (J0100B)

Earn More Shared Savings



Opportunities to Capture More Shared Earnings

ACOs can Reduce Total Cost of Care by Managing their SNFs Network

ACOS DO NOT EARN SHARED SAVINGS

50%

ACOs Did Not Earn Shared Savings in 2019

HIGH READMISSION RATES

23%

Hospital Readmission Rate for Some SNF Providers vs. 17% National Average

COSTS ARE CONCENTRATED IN HIGH-RISK PATIENTS

20%

Healthcare Expenditures From the Top 1% of the Neediest Patients

ACOS EARNINGS CAN BE SIGNIFICANT

$4M

Earned Shared Savings for a Long-term ACO

Improving ACO Performance

- $101.9 M Medicare savings for ACOs
- $57.8 M Earned Shared Savings for MSSP partners

> **PointRight brought so much transparency to a part of a patient's care continuum that was really not well understood by hospitals or providers."**
>
> *Lisa Trumble, CEO, SOHO Health*

Reduced Rehospitalizations

25% reduction in 30-day rehospitalizations YoY

Cambridge Health Alliance

Reduced SNF Length of Stay

14% reduction in Skilled Nursing Facility days

Cost Reduction

- **55% decrease** in SNF PMPY expenditure
- **13% decrease** in SNF costs

Shared Savings

- **$6.5 M in Shared** Savings for next generation ACO

Lourdes Health System

What's the value?
Ask end users and decision makers...

"All measures pertinent on one platform; perfectly differentiated."

"It's user friendly and provides the information I need quickly."

"Excels in development, implementation, and ongoing training…exceptional standards."

"Gives me actionable information on a daily basis."

"I believe we receive great support from the team and it clearly is making a difference."

"Products support monitoring and tracking of much needed quality information."

"All the benefits of data analysis, with no additional work required for input."

"Taking data to action is supported."

"Provides visual impact when we present results."

"Simplistic data analysis at the click of a button."

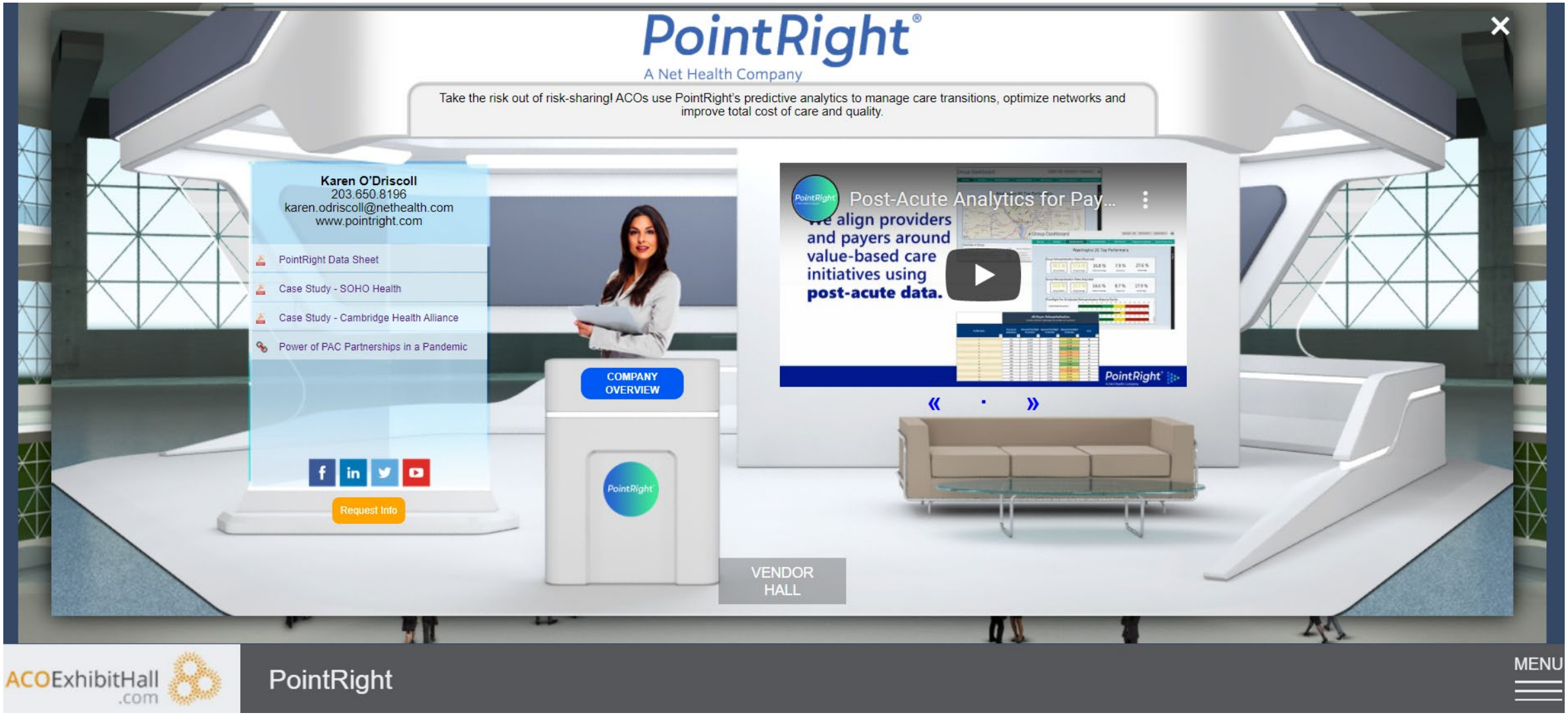
PointRight is by far the best in the industry in terms of nursing home analytics. It's the single source that hospitals and ACOs can use to get real-time, quality outcome data. You can drill down by disease, conditio quality measure—in any way you want to look at the data that's important to you. It's really the complete picture of nursing home quality and performance."

Rebecca Sweeney,

Associate Chief of Care Management at Cambridge Health Alliance

Q&A

Stop by our ACOExhibitHall.com Virtual Booth



Thank you!

Questions? karen.odriscoll@nethealth.com

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