CarePort®
powered by WellSky®

The 5 Levers of Value-Based Care

Achieving Success Across the Continuum

VBCExhibitHall.com

Educational Webinar Series

CarePort® powered by WellSky®

Today's speaker

Michael Ipekdjian, MBA-HM, BSN, RN, SANE, PHRN, NREMT

Head of Clinical & Solution Architecture
CarePort, powered by WellSky

Michael Ipekdjian, MBA-HM, BSN, RN, SANE, PHRN, NREMT, has extensive experience in nursing, case management, and managing value-based care initiatives. Mike was introduced to the CarePort solutions during his time as the Director of Transitional Care Management at Holyoke Medical Center, a subsidiary of Valley Health System, where he oversaw the health system's care coordination department.

CarePort is the largest end-to-end care coordination network that exists today and is growing rapidly

130,000
Providers

1,000
Hospitals

~25M
Referrals

14M
Lives Impacted

1/3
Post-Acute Referrals

Leverage CarePort for **complete visibility into the patient journey**

CarePort Care Management

Optimize care transitions with an EHR-agnostic, cloud-based solution

CarePort Referral Management

Receive and respond to all patient referrals electronically

CarePort Guide

Guide post-acute care selection and help patients choose high quality care

CarePort Connect

Manage patients across care settings with real-time data and care transition alerts

CarePort Insight

Evaluate patient outcomes and post-acute provider performance metrics

CarePort Transition

Create, manage and send post-acute referrals embedded directly within your EHR

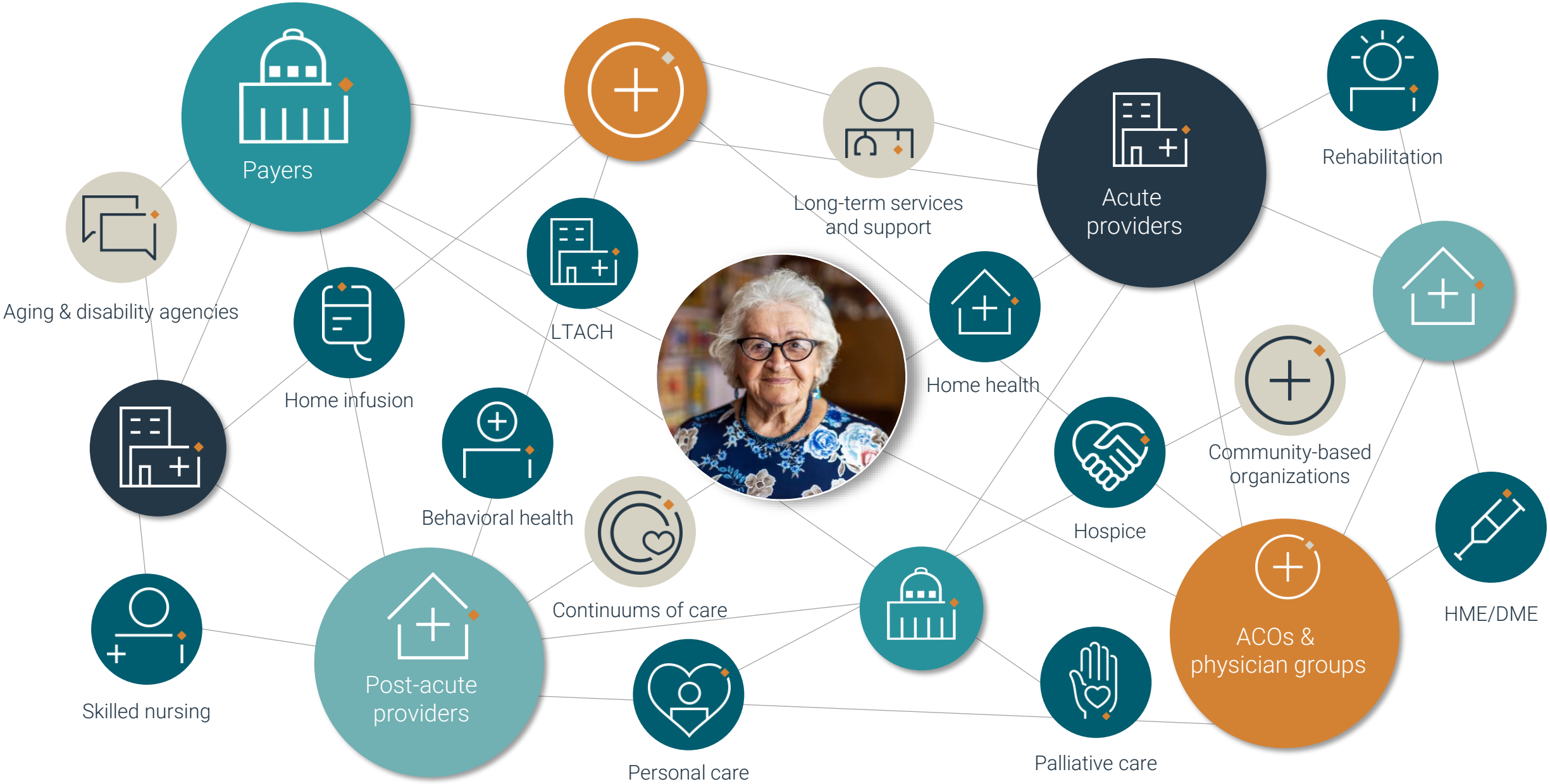
Today's healthcare system is **adapting, evolving and shifting.**

Staffing **shortages**

- **90% of SNFs** are short staffed,
- **78% of nursing homes** are concerned workforce challenges might force them to close

Hospitals are finding it harder to place patients

- **32% increase** average number of referrals per patient **referred to SNFs**
- **42% increase** average number of referrals per patient **referred to home health**
- **15% increase** average number of referrals per patient **referred to hospice**

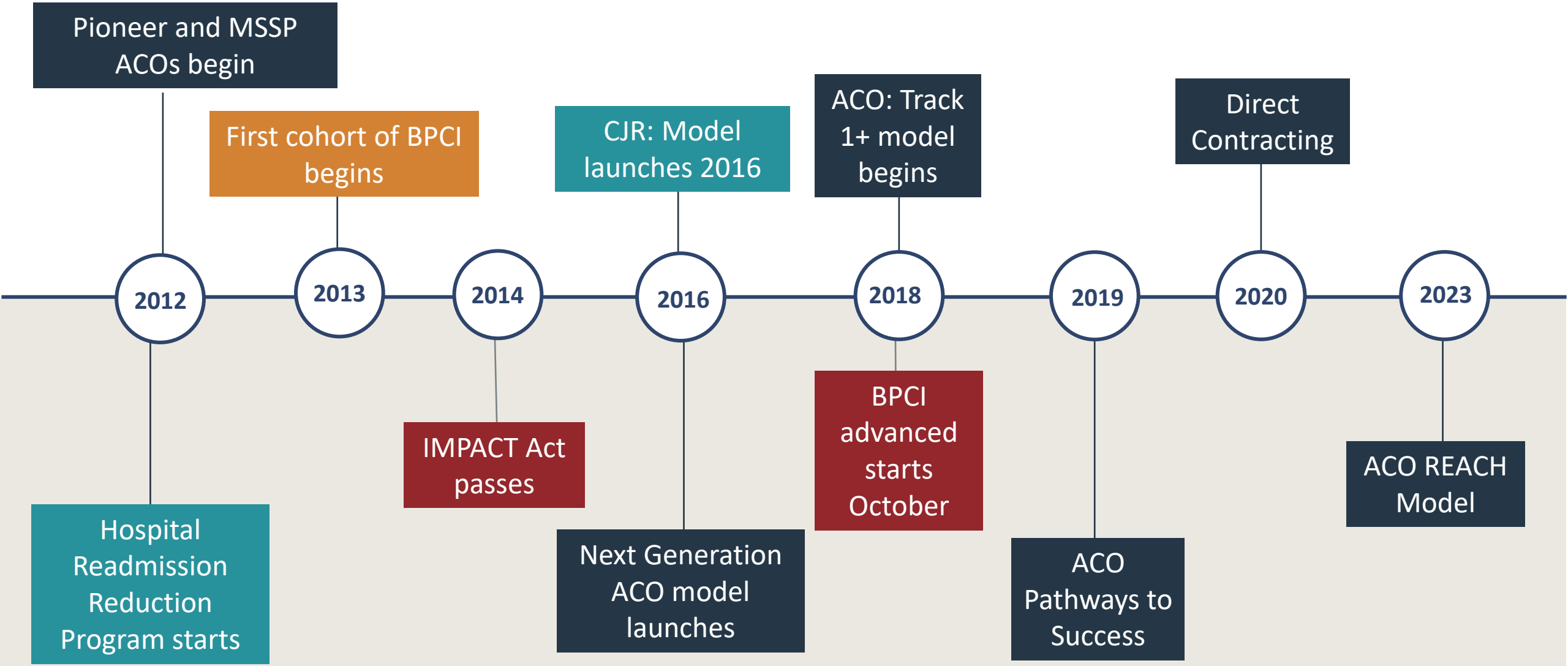

Payers
Aging & disability agencies
Home infusion
LTACH
Long-term services and support
Acute providers
Rehabilitation
Home health
Behavioral health
Hospice
Community-based organizations
Continuums of care
Skilled nursing
Post-acute providers
Personal care
Palliative care
ACOs & physician groups
HME/DME

Imagine a world where communication with post-acute providers is seamless?

… a world where you have visibility into patient care across the continuum?

… a world where referrals and authorizations are processed electronically?

The industry is evolving to focus on managing patients across the entire continuum



2022 is the beginning of a new world of care coordination

Identify

Harness data

Integrate

As organizations prepare for participation in the ACO REACH Model in January 2023, this year presents an opportunity for continued innovation across the healthcare industry driven by the realities of COVID-19 and fueled by the constant need to improve access, quality, and the cost of healthcare in the US.

This enables us to create better treatments, better access and a more personalized experience for all participates.

The 5 Levers of Value-Based Care

1. Reduce emergency department utilization
2. Reduce hospital admissions
3. Identify the appropriate next site of care
4. Optimize SNF length of stay
5. Reduce hospital readmissions

One in five Americans visit the ED at least once a year, but approximately **two-thirds of these visits are avoidable** and could be treated in the primary care setting

Limiting the number of non-urgent ED admissions could save the U.S. healthcare system $32 billion annually.

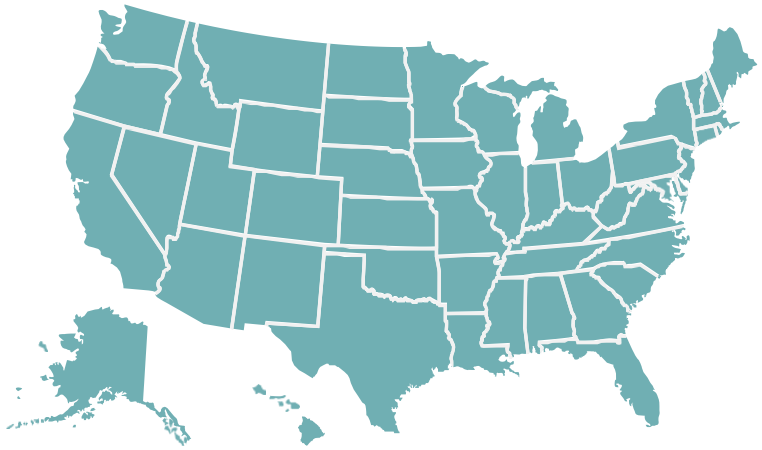
1

Reduce emergency department utilization

EDs are a costly site to receive non-emergent care, and knowing when to intervene before patients are admitted to the ED is crucial to reducing unnecessary hospital admissions and spending.

Common reasons why patients end up in the ED

- Lack of timely follow up care
- Medication errors or lack of medication compliance
- Failure to identify post-acute care needs
- Inadequate nutrition
- Lack of transportation to access care
- Infection



The U.S. population made 144.8 million ED visits costing a total of $76.3 billion in 2017.

Successful strategies for reducing ED utilization

Implement processes and systems to ensure your patients have care across the continuum from the hospital to the community

- Transitional care management programs
- Visibility into when patients are discharged & where they are discharged to
- PCP follow ups
- Implementing and managing programs to support patients long-term
  - Knowing who the patients are to ensure patients receive the right care at the right time in the right place

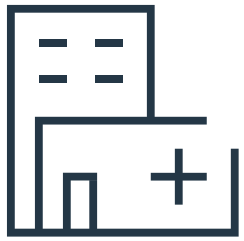
The average total cost for a hospital observation stay is approximately $8,100.

At approximately $2,600 per day, the average total cost for a hospital inpatient stay costs nearly $23,000.

2

Reduce hospital admissions – both OBS and INPT

The strongest risk factors associated with potentially avoidable patient hospital admissions include age, ethnicity, lifestyle, and access to primary care – among others.[4] Education, exercise/rehabilitation, and self-management have proven effective at reducing admissions among certain patient populations.



According to the American Journal of Accountable Care, patients treated in a home-based setting were significantly less likely to be admitted or readmitted to the hospital.

CarePort enables providers to better support patients' non-medical (social determinant) needs – such as food, housing, substance abuse, and mental health – to help reduce patient reliance on hospitals and EDs. CarePort seamlessly connects patients with local, commonly used community-based organizations (CBOs) and can provide these CBOs the ability to view and accept referrals electronically.

[4] https://www.rcpe.ac.uk/sites/default/files/purdy.pdf

Why is reducing observation stays important?

- **Financial impact** - Medicare reimburses hospitals 1/3 less on average for observation stays
- **Clinical impact** – Inappropriate patients could be taking up valuable bed space
- **Patient impact** – Medicare won't reimburse for SNF stays without a three-day inpatient admission and patients are responsible for a higher percentage of the cost of care received

Reducing observation stays and admissions from the ED is important for all hospitals and health systems – not just those in ACOs.

Technology to support whole person health

- Technology can enable providers to better support patient's non-medical (social determinant) needs — such as food, housing, substance abuse, and mental health — to help reduce patient reliance on hospitals and Eds.
- Technology connects patients with local, commonly used community-based organizations (CBOs) and can provide these CBOs the ability to view and accept referrals electronically.

The strongest risk factors associated with potentially avoidable patient hospital admissions include age, ethnicity, lifestyle, and access to primary care — among others.

Education, exercise/rehabilitation, and self-management have proven effective at reducing admissions among certain patient populations.

The Medicare Payment Advisory Commission (MedPAC) reports that the average SNF episode ($13,700) is 2.5x more expensive than a home health episode ($5,462).

3

Identify the next site of care post-discharge

Nearly 90% of Medicare patients discharged to post-acute care receive that care in a skilled nursing facility (SNF) or via home health care. However, costs vary greatly depending on the setting and level of care.[5] For example, the Medicare Payment Advisory Commission (MedPAC) reports that the average SNF episode ($13,700) is 2.5x more expensive than a home health episode ($5,462). To avoid potential overutilization of the SNF setting, many patients could instead appropriately receive home health care and recover successfully at a lower total cost.

Hospital and health system referral patterns vary greatly; some health systems only send patients to home health care, and some hospitals utilize SNF care for most patient discharges.

14%

Estimated reduction in post-acute care spend by using predictive analytics

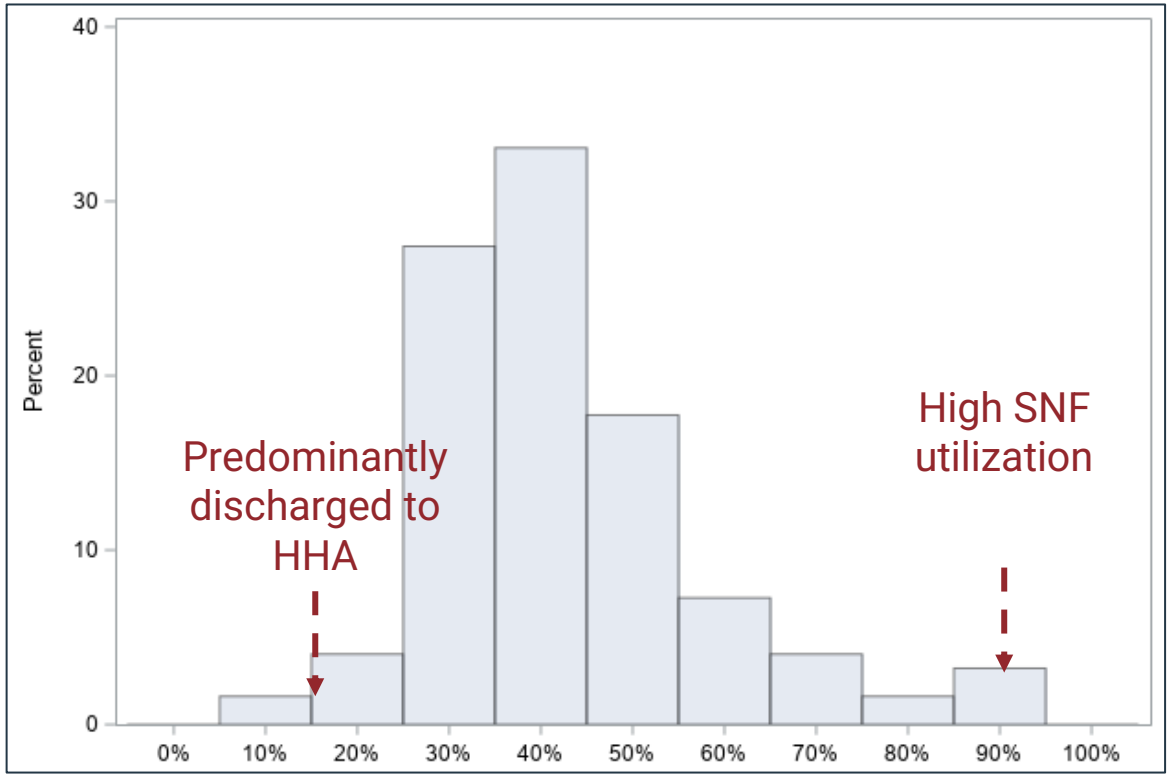
Hospitals and health systems vary greatly in where they send patients

Some health systems skew toward only sending patients home and some hospitals are utilizing mostly SNF care for a majority of patient discharges

?

- Where does your organization fall?
- Do you know where you measure up against your peers?
- Do you know how your organization makes level of care decisions today?
- **Are you confident you're discharging patients to the right level of care?**

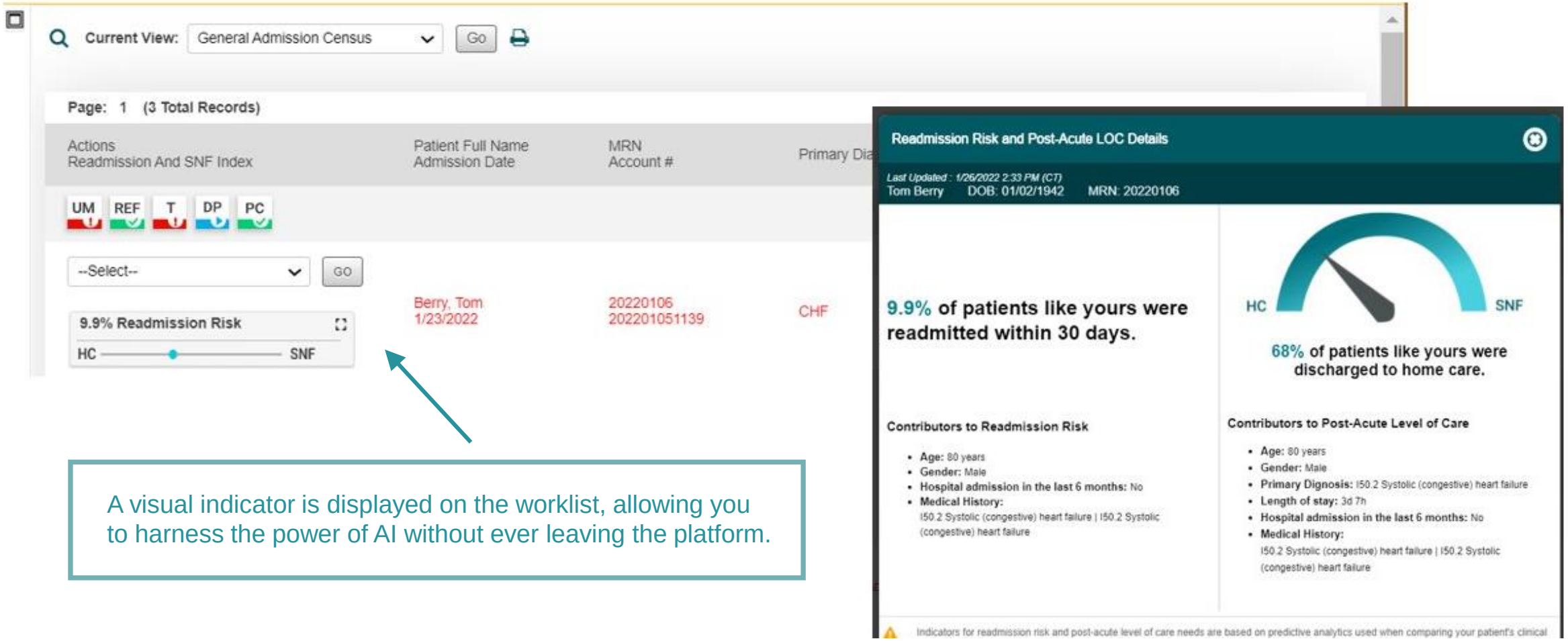
% of Patients Requiring PAC Care That are Referred to SNF



% of Patient Discharged to SNF over HHA

Readmission Risk & Post-Acute Level of Care indicators

Predictive analytics to determine a patient's likelihood of readmission based on patients with similar characteristics readmitted within 30 days.



A visual indicator is displayed on the worklist, allowing you to harness the power of AI without ever leaving the platform.

In the U.S., the average monthly cost for skilled nursing care range from $7,650 for a semi-private room to $8,700 for a private room.

4

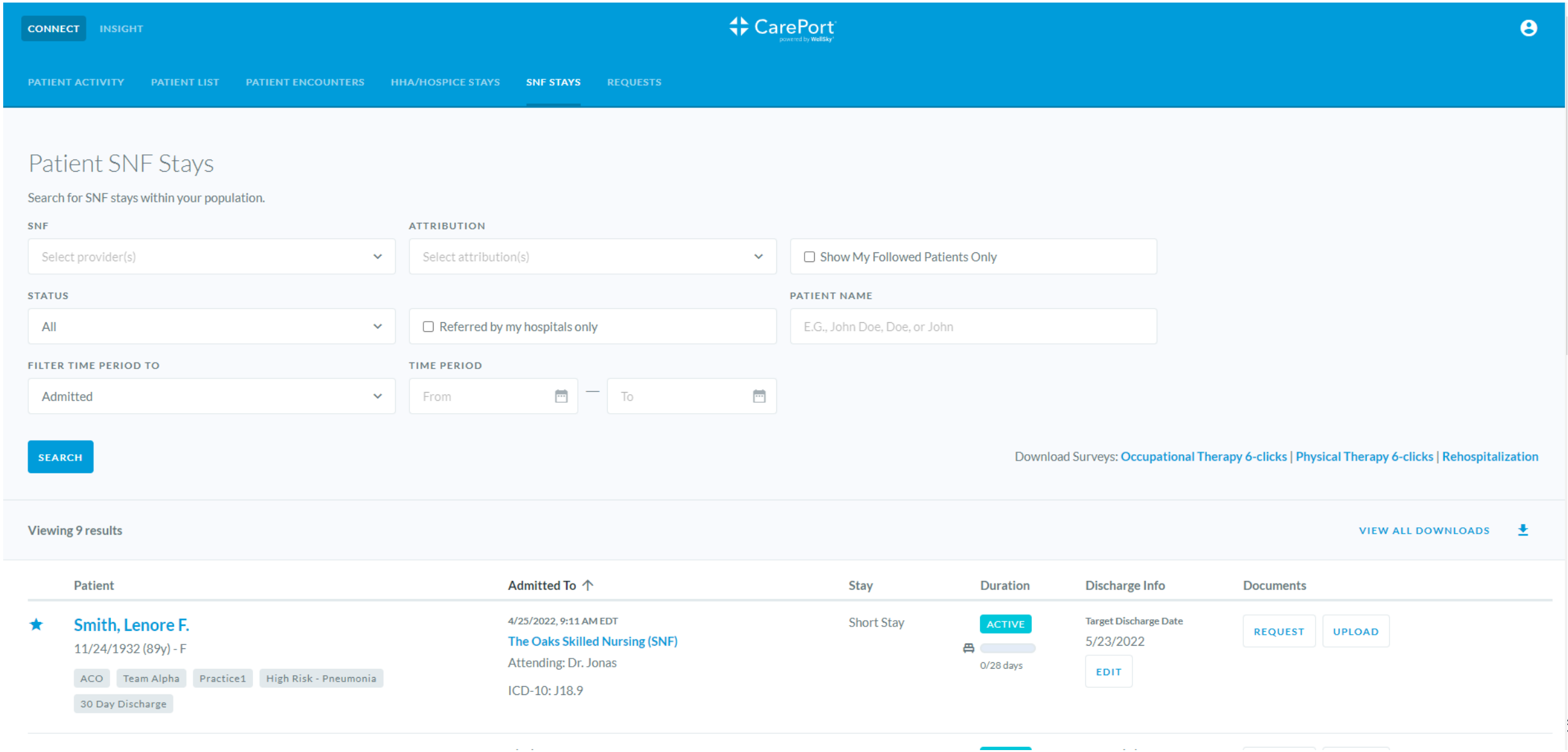
Optimize SNF length of stay (LOS)

There is significant variation in SNF average length of stay (ALOS) among Medicare beneficiaries following an acute inpatient hospital stay. According to 2019 data, relatively efficient SNFs achieved an ALOS of 27 days, while other SNFs reported a 31-day ALOS. SNFs represent a significant proportion of Medicare fee-for-service (FFS) and are paid on a per diem basis, and so reducing medically unnecessary days from a patient's SNF stay can have a significant impact on Medicare spend.

Leveraging the CarePort platform, hospitals can identify the expected number of days a short-stay SNF patient will require prior to discharging back to the community (home with or without home health services).

According to 2019 data, relatively efficient SNFs achieved an **ALOS of 27 days**, while other SNFs reported a **31-day ALOS**.

Managing your patients in the post-acute setting



Leveraging predictive analytics to identify and manage ACO patients in real-time

Predictive analytics use patient demographics and ICD-10 diagnosis codes that are delivered in SNF admission, discharge, and transfer (ADT) data.

A SNF eLOS Model predicts the expected length of stay for a patient's successful discharge to community to determine, on average, how many days of SNF care are required to discharge that patient home safely.

Results

Improved performance from fourth to **first quartile** as compared to other ACOs across the U.S.

Reduced post-acute ALOS by **one third** *(from 27 days to 18 days, a decrease of **9 days**)*

70% increase in primary care provider (PCP) follow-up appointments post-SNF discharge

Saw **$1,500 in savings** per SNF patient

Roughly two million patients are readmitted to the hospital annually, costing Medicare $26 billion — and it is estimated that $17 billion of that is caused by potentially avoidable readmissions

5

Reduce hospital readmissions

Hospitals are under increasing pressure to reduce potentially avoidable hospital admissions and readmissions to contain costs and succeed under initiatives such as the Centers for Medicare & Medicaid Services' (CMS) Hospital Readmissions Reduction Program (HRRP), which penalizes hospitals with relatively higher rates of Medicare readmissions. Preventing hospital admissions and readmissions, and avoiding CMS readmission penalties, is critical.

Successful strategies for reducing hospital admissions

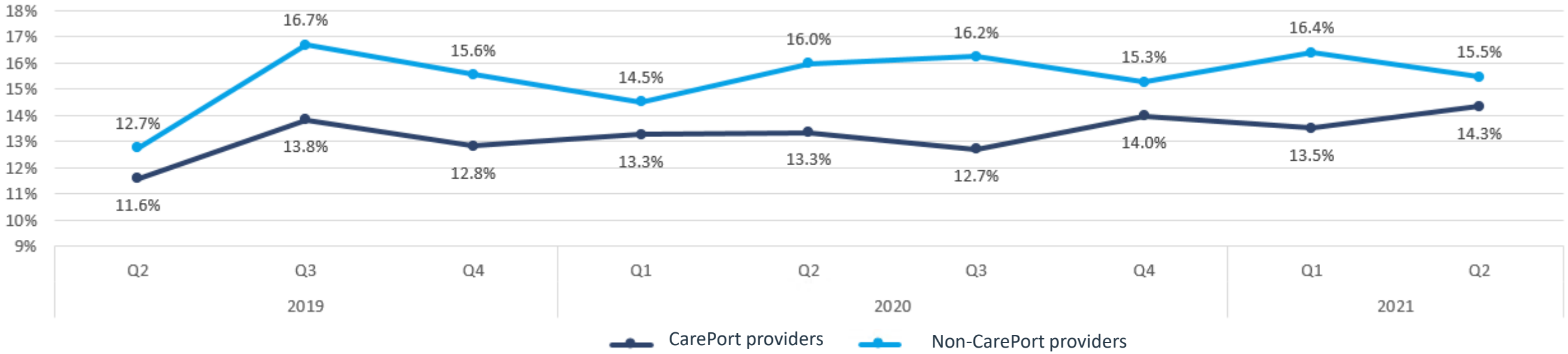
- Good transitional care management programs
- Ambulatory navigators who get patients connected to community resources

- Guide patient decision-making during discharge and increase referrals to high-quality providers
- Receive real-time updates on when and where patients receive care post-discharge, whether at a skilled nursing facility (SNF), via home health, or in the ED, and intervene if necessary
- Identify gaps in care and opportunities for improvement within the post-acute network
- Drill down and evaluate post-acute provider performance for specific patient populations, such as those tied to a bundled payment program or other value-based initiative

At a Glance: Success with Value-Based Care

Population: Patients that discharge to the Community and are eligible for TCM

Products: Guide, Connect, Insight



Acute Discharges	2019				2020				2021		Group Avg	Spark Line
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2		
All Attributions	19,778	63,060	65,858	66,217	69,650	57,684	87,144	94,308	94,835	102,490	72,102	
	2,787	9,969	10,320	10,291	10,578	8,895	11,490	11,935	11,735	11,923	9,992	
CarePort Providers	1,355	3,616	4,455	4,620	4,596	3,846	5,497	5,387	5,181	5,171	4,372	
Non-CarePort Providers	1,203	5,446	5,462	5,349	5,627	4,651	5,762	5,805	5,895	5,979	5,118	

Q&A

with CarePort's Mike Ipekdjian

Stop by our VBCExhibitHall.com Virtual Booth:

[Visit the CarePort exhibit booth]

CarePort® powered by WellSky®

Thank you.

Contact us

careport@careporthealth.com

"In evaluating potential partners to optimize our health system's transitions of care, CarePort's end-to-end solution differentiated itself from other offerings on the market. The platform's real-time data and alerts, as well as its integration with the EHR, will streamline our care management workflows and enhance our discharge planning process, giving us visibility to the activation of the post-acute service - particularly home health care."

Andy Crowder
SVP and Chief Information and Analytics Officer
Atrium Health