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Educational Webinar Series

Harnessing Data in Value-Based Care:

How Atlantic Health Drives Success in Shared Savings Programs

CarePort, powered by WellSky and Atlantic Health team up to share best practices for using real-time post-acute performance analytics build and maintain a high-performing post-acute network.

Oct. 5 | 1:00 PM ET

Dr. Mark Calderon
Medical Director, Integrated Care
Atlantic Health

Thomas Martin
Director of Post-Acute Analytics
CarePort, powered by WellSky

Agenda

CarePort® powered by WellSky®

01 Atlantic Health overview

02 Building a high-performing post-acute network

03 Key findings

04 Measuring for success

05 Questions

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

Post-acute care is critical to value-based care….

But there's still an extreme unexplained variance in quality among SNFs

NBER | NATIONAL BUREAU of ECONOMIC RESEARCH

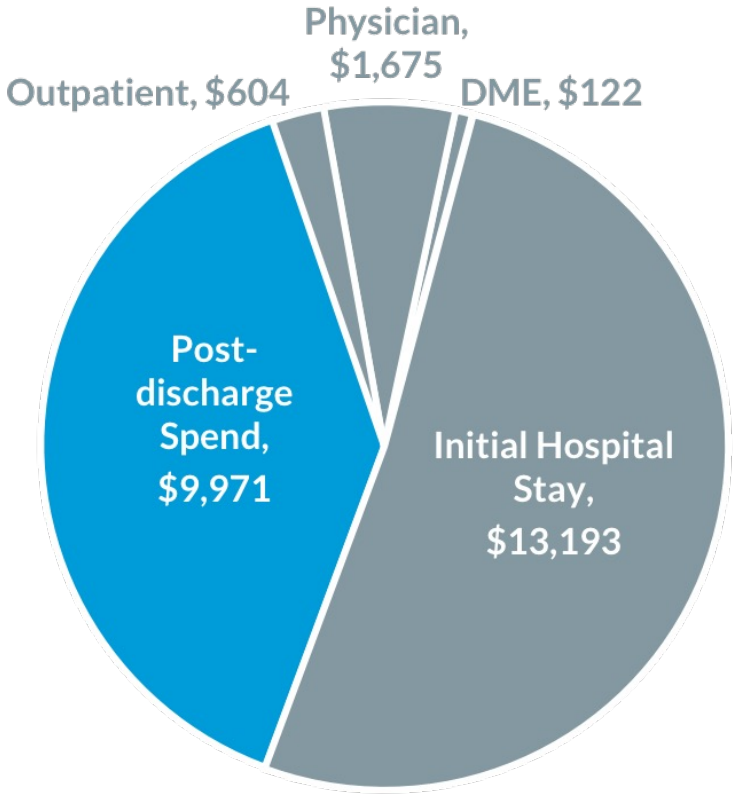
Paper published by NBER in August 2022 "Producing Health: Measuring Value Added of Nursing Homes" finds:

1. "compared to a 10th percentile SNF, a 90th percentile SNF is able to discharge a patient at the same health level about a week sooner"
2. "results point to the potential for substantial gains through policies that encourage reallocation of patients to higher-quality SNFs within their market."

Variance can lead to **poor quality** and **unnecessary cost**

Markets have **unique characteristics**

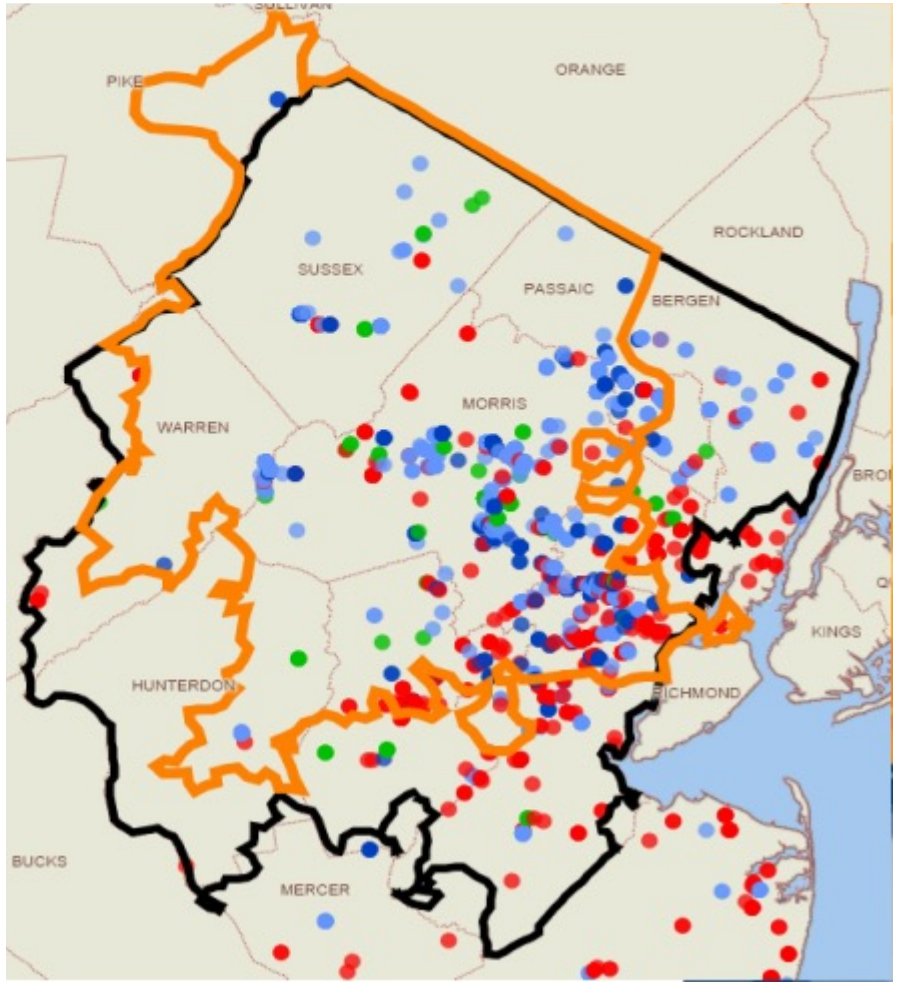
Technology is needed to facilitate **transparency**



Post-discharge spending drives **39% of spending per episode**

Poll Question

In 2017, Atlantic Alliance, a Clinically Integrated Network, was created simplify care collaboration in northern and central New Jersey and strengthen relationships between organizations affiliated with Atlantic Health System.



Providers	Primary Care	Specialists	Grand Total
Atlantic ACO	548	2038	2586
Optimus ACO	367	449	816
Total Providers	915	2487	3402

Programs	Commercial Attribution	MSSP Attribution	Grand Total
Atlantic ACO • MSSP BASIC E Downside Risk • Commercial Contracts	196,239	36,277	232516
Optimus ACO • MSSP Basic E Downside Risk • Commercial Contracts	176,527	28,414	204,941
Total Attribution	372,766	64,691	437,457

Q3 Attribution for Commercial Q1 2022 for MSSP

Influencing Change

Atlantic is taking a broad approach to population health

Atlantic Health's goals

1. Establish a high performing network and measure performance
2. Drive performance improvement when meeting with post-acute facilities using real-time data
3. Improve clinical integration between AHS and SNFs
4. Engage SNF attendings on their performance
5. Improve hospital throughput for SNFs

Data and reporting for insight into:

- Admission/discharge dates
- Patient demographics
- Patient matching
- Discharge disposition
- Historical patient information (timeline)
- Current documentation associated with a patient (CCDs and etc)

Requirements to join Atlantic Health's high-performing network

Mandatory Requirements

Submission of Intent to Collaborate – Commitment to cooperation biannually (SurveyMonkey)

Electronic integration with CarePort Insight & Epic Carelink

Collaboration Score: Citizenship, PAC liaisons, AHS CM

- Facility Leadership engagement / attendance at regular meetings (1:1, plus any quarterly meetings
- Responsiveness to requests (from PAC Liaisons, hospital CM teams, etc.)
- Allowing engagement/participation in UR and onsite visits
- Timely return of discharge paperwork to PAC liaison

Quality Score: CMS Short Stay Quality of Resident Care

- Reflects quality of care of temporary residents
- Objective data directly from Medicare Compare

Value Score: CarePort Insight Reporting Metrics

- Rehospitalization Rate
- Average Short Stay LOS

Three scores equally weighted are averaged to determine Total HPN Score

Network reassessed biannually | Limited exceptions on HPN facility selection will be made based on AHS network need

From out-of-network to in-network: One SNF's journey

Atlantic Health System

Proud to be a preferred provider in the Atlantic Health System High Performing Network of Skilled Nursing Facilities.

What to consider when measuring performance

Poll Question

Risk-adjustments

Which PAC do you want to send your referrals to?

SNF A

Observed Hospitalization Rate: 29.9%
For every 100 patients admitted to the SNF, about 30 return to the hospital within 30 days

Expected Hospitalization Rate: 35.4%
Based on the high acuity of the patients at the SNF, our model predicted that about 35 out of every 100 patients would return to the hospital within 30 days

Adjusted Hospitalization Rate: 16.5%
Holding patient acuity constant, the SNF is performing **better** than the observed rate suggests.

SNF B

Observed Hospitalization Rate: 13.8%
For every 100 patients admitted to the SNF, about 14 return to the hospital within 30 days

Expected Hospitalization Rate: 8.4%
Based on the relatively low acuity of the patients at the SNF, our model predicted that about 8 out of every 100 patients would return to the hospital within 30 days

Adjusted Hospitalization Rate: 32.2%
Holding patient acuity constant, the SNF is performing **worse** than the observed rate suggests.

Real-time data

Which PAC do you want to send your referrals to?

SNF A

Nursing Home Compare

Risk-adjusted Readmission Rate: 29.6%

89th percentile nationwide

SNF A (12 months later)

Nursing Home Compare

Risk-adjusted Readmission Rate : 22.1%

50th percentile nationwide

Visibility into specific patient cohorts

Which PAC do you want to send your referrals to?

SNF A

All SNF Admissions Population

Risk-adjusted hospitalization Rate: 8.9%

For every 100 patients admitted to the SNF, about 15 return to the hospital within 30 days

SNF A (New Population)

ACO Population

Risk-adjusted hospitalization Rate: 17.3%

For every 100 patients admitted to the SNF, about 15 return to the hospital within 30 days

Key Findings

What Atlantic Health discovered using Insight

Physician performance is just as important as provider performance

How CarePort Insight helped identify unknown ACO attendings

What's the goal?

Value-based care driven by physicians

AHS tracks:

- SNF Attending
- Admits
- Readmits
- ALOS

Dr. SNF Attending SNFist Scorecard DOS Q4 2021

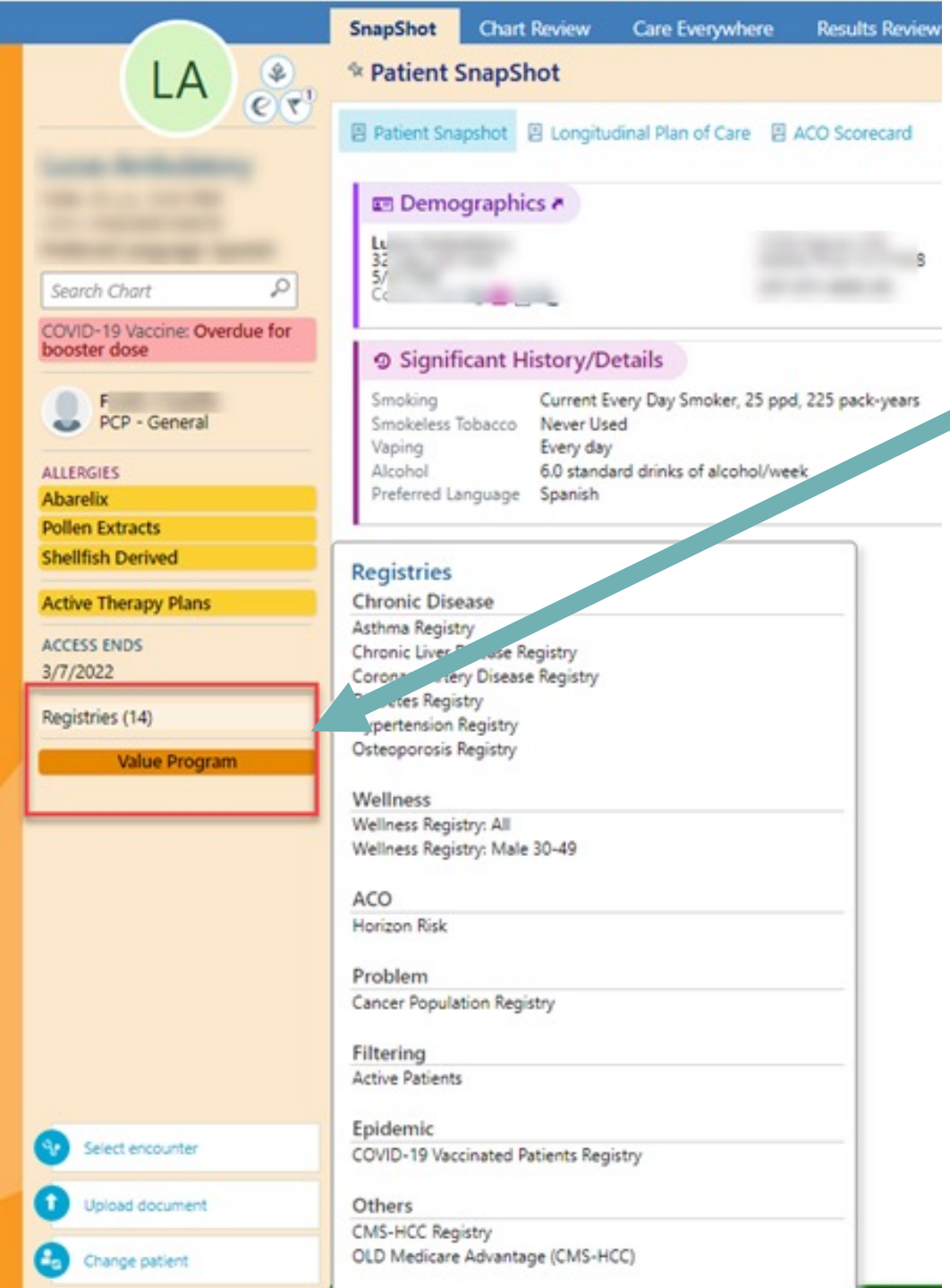
			Rehospitalizations			Length of Stay			
Facility	Total SNFist Admits	Total SNFist Discharges	Facility 30 Day Rehosp Rate %	SNFist 30 Day Reshosp.	SNFist 30 Day Rehosp. Rate %	Facility Total LOS	Facility Short Stay LOS	SNFist Total LOS	SNFist Total LOS
SNF 1	56	46	15.1	13		19.79	21.51		
SNF 2	53	41	9.96	7		26.06	23.5		
Total Dr. SNF Attending	**109**	**85**		**20**	**18.3**			**24.2**	**20.5**
Total High Performing Network (HPN) Q4 2021					**15.2**			**20.1**	**20.8**

Within 10% of HPN avg. | **>10% <20% HPN avg.** | **>20% HPN avg.**

Metric Definitions

Total SNFist Admits = total number of your patients admitted to skilled nursing facilities during the time frame specified in the Admit Date Range filter. This patient group defines the population associated with all subsequent columns.
Total SNFist Discharges = total number of the SNF Admits that have been discharged from the facility as of the current date.
Total 30 Day Rehospitalizations = total number of SNF Admits that were rehospitalized within 30 days of their SNF admission (rehospitalization is determined by patients discharged from the SNF with a Discharge Disposition of Acute Care Hospital
30 Day Rehospitalization Rate % = the 30-day rehospitalization rate, calculated by Total 30 Day Rehosp / Total SNF Admits
Avg Short SNF Stay LOS = the average length-of-stay for SNF Discharges.
Avg Total SNF LOS (Excl. Long Term) = the average length of stay for SNF Discharges for short stay patients only.

Notes: Bolded facilities are part of AHS High Performing Network. SNF attending performance is compared to the Total High Performing Network Target.



Storyboard in CareLink & AHS Value Program

- We have added Registries and Value Program to the Storyboard in Carelink.
- You will be able to see if a patient is on a registry and if a patient is a part of the AHS Value program.

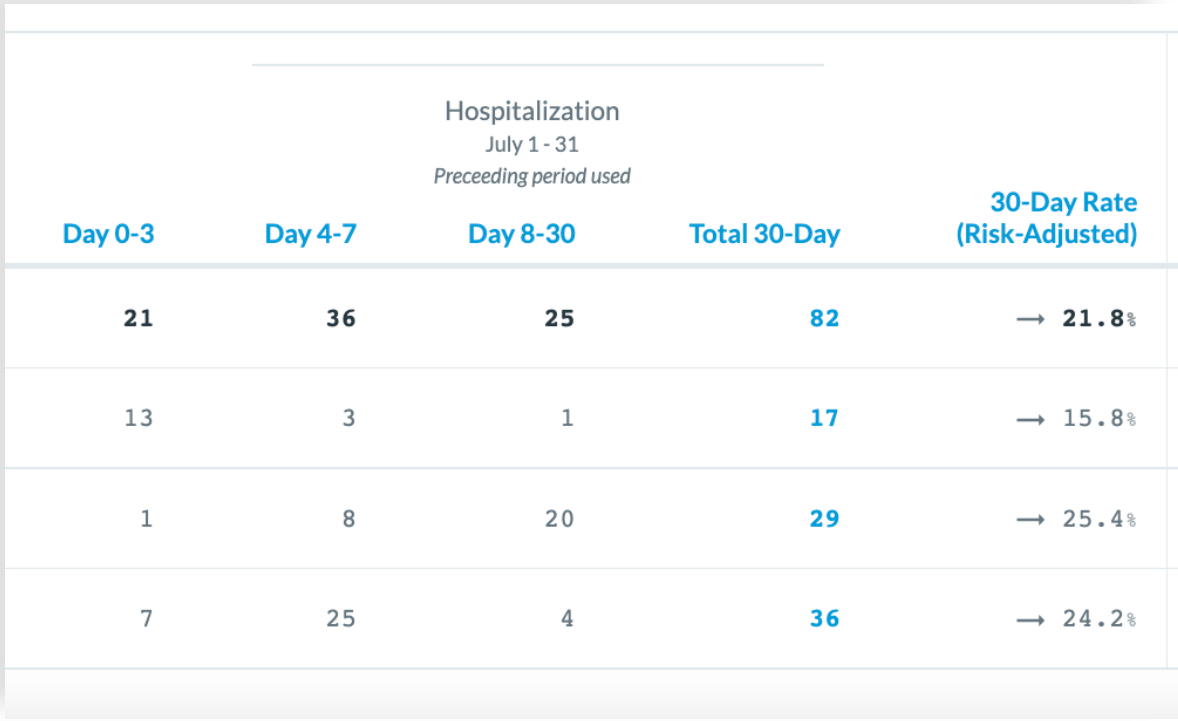
SNF Attending	Group	Total Admits
Stevie Wonder	Atlantic Alliance	8
Merle Haggard	Atlantic Alliance	13
Elvis Presley	Atlantic Alliance	2
Johnny Cash	Other	6
Bob Seger	Other	1
Waylon Jennings	Other	1
	Total	**31**

Hospital discharge teams need to be accountable

Digging into the cause of Day 0-3 readmissions

Managing hospital throughput

- Are you ensuring clear communication to SNF to prevent readmissions?
- Time of SNF discharge, is it disruptive?
- Is there a pattern in diagnoses that is driving readmissions?



Hospitalization July 1 - 31 *Preceeding period used*				
Day 0-3	Day 4-7	Day 8-30	Total 30-Day	30-Day Rate (Risk-Adjusted)
21	**36**	**25**	**82**	→ **21.8%**
13	3	1	**17**	→ 15.8%
1	8	20	**29**	→ 25.4%
7	25	4	**36**	→ 24.2%

Measuring for **success**

Improving TOC Outcomes			
Report	**CarePort Resource**	**Metrics**	**Goal**
Development of High Performing Network	SNF Analytics	Admits, Readmits, ALOS. % of admits from Atlantic Health Sys.	SNF Engagement
Development of SNF Utilization Performance Scorecard	SNF Analytics	Admits, Readmits, ALOS	SNF Engagement
Development of SNF Quality Performance Scorecard	SNF Market Analytics	Careport and CMS rating, payroll-based staffing, short stay MDS and claims based QMS	SNF Engagement
Development of SNF Attending Performance Scorecard	SNF Analytics	SNF Attending, Admits, Readmits, ALOS	SNF Attending Engagement
Improving Clinical Integration-Atlantic Visiting Nurse			SNF Engagement
Improving Clinical Integration-Atlantic Alliance Physicians	SNF Analytics	SNF, SNF Attending	SNF and SNF Attending Engagement
Improving Hospital TOC Communication, Processes and Workflow	SNF Analytics	Readmits 0-3, SNF admission date & time	Hospital Engagement
Clinical Care Paths	SNF Analytics	Primary & Secondary Admit Diagnoses	SNF/Hospital Engagement

SNF Analytics to build & maintain high-performing network

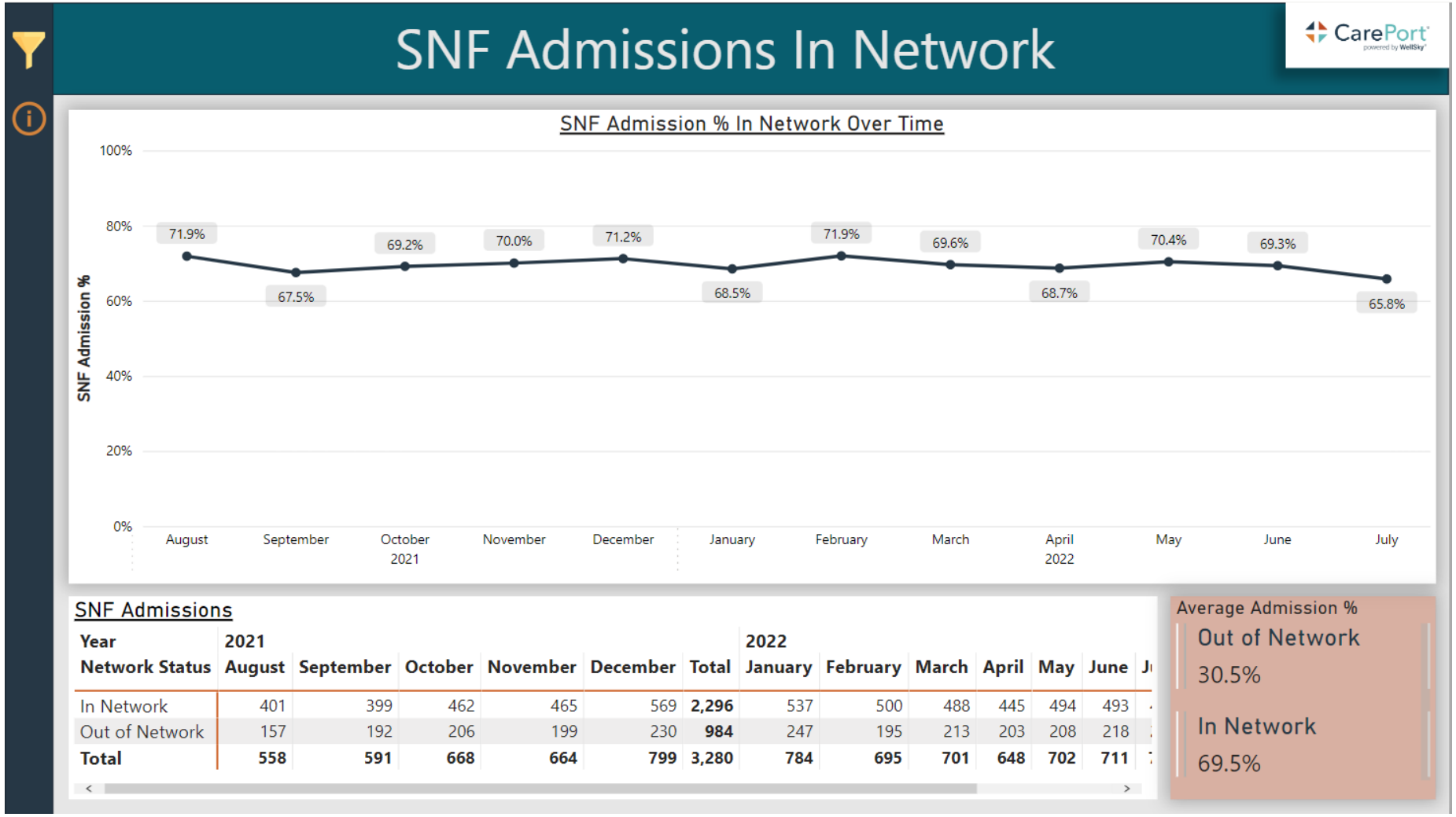
What's the goal?

Measuring, *and improving,* SNF engagement

Atlantic Health reports on:

- Admissions
- Readmissions
- Average length of stay
- % of admissions from Atlantic Health System

Discharging patients in-network



69.5%

of patients typically find their way into the network

Using SNF Analytics to build SNF utilization scorecard

What's the goal?

Measuring, *and improving,* SNF engagement

The SNF Utilization Scorecard measures:

- Admissions
- Readmissions
- Average length of stay

Rehab & Healthcare Center Period Q2 2022 YTD

Volume	Readmissions	Length of Stay
Total Admits 61 (69 / 71)	**Day 0-3 Rehosp** 0 (3 / 2.6)	**Avg All Stays** 16.2 (18.4 / 17.7)
Total Admits 37 (56 / 51)	**Day 4-7 Rehosp** 1 (4 / 2.3)	**Avg Short-Stay** 16.4 (19.7 / 17.6)
	Day 8-30 Rehosp 8 (8 / 5.8)	
	Total 30-day Rehosp 9 (15 / 10.7)	
	30-Day Rehosp % 11.4% (17.3% / 12%)	

Middle #: Your performance during the reporting period

Left # Your performance in the prior reporting period

Right #: Avg. performance of the High Performing Network

Metrics are risk adjusted and based on AHS MA and FFS transfers.

Metric Definitions

Total Admits = total number of your patients admitted to skilled nursing facilities during the time frame specified in the Admit Date Range filter. This patient group defines the population associated with all subsequent columns.

Total SNF Discharges = total number of the SNF Admits that have been discharged from the facility as of the current date.

Day #-# Rehosp = total number of SNF Admits that were rehospitalized with a SNF LOS of # to # days (ranges include: 0-1, 2-3, 4-7, and 8-30).

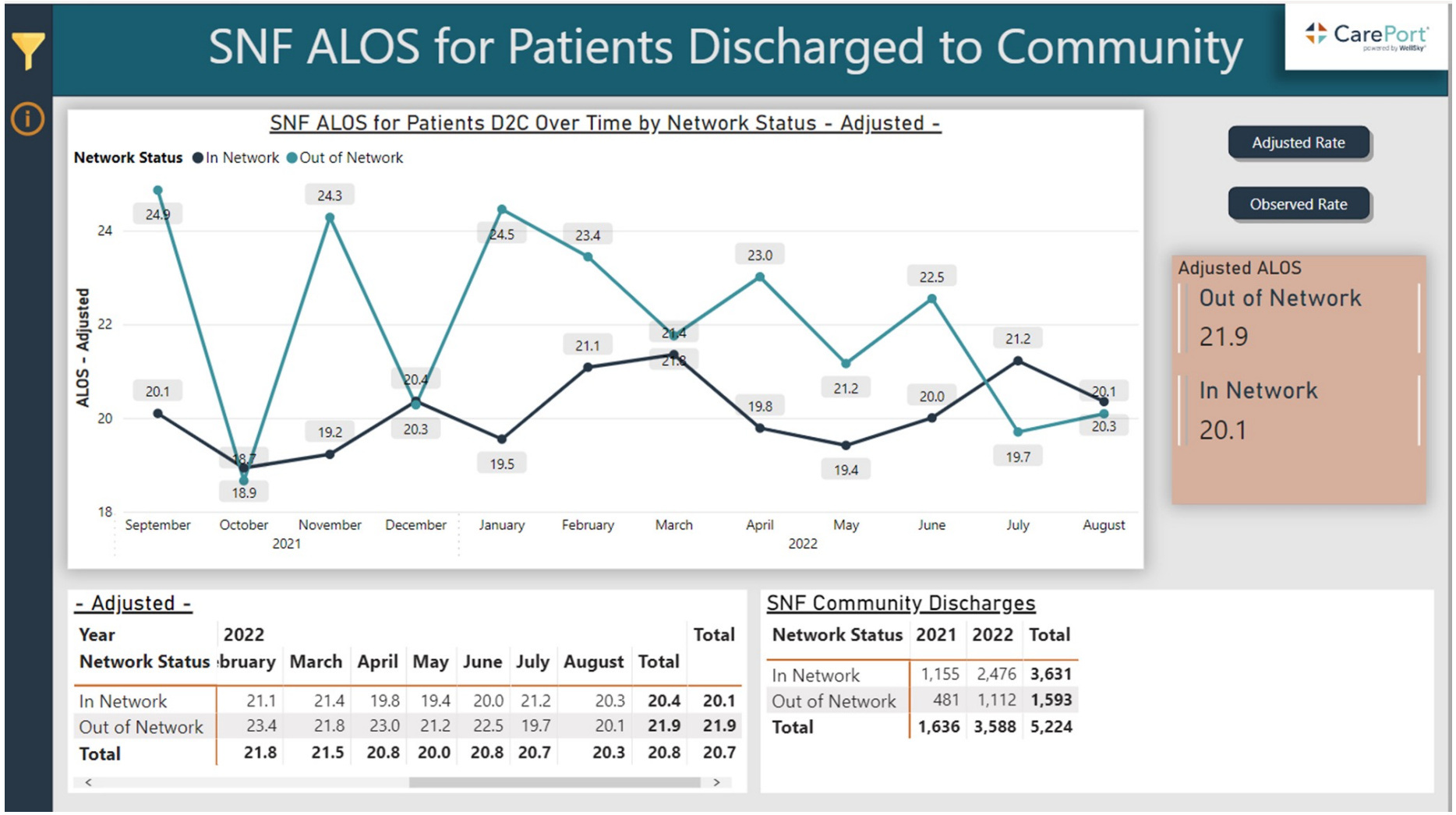
Total 30 Day Rehosp = total number of SNF Admits that were rehospitalized within 30 days of their SNF admission (rehospitalization is determined by patients discharged from the SNF with a Discharge Disposition of Acute Care Hospital).

30 Day Rehosp % = the 30-day rehospitalization rate, calculated by Total 30 Day Rehosp / Total SNF Admits.

Avg SNF LOS = the average length-of-stay for SNF Discharges.

Avg SNF LOS (Excl. Long Term) = the average length of stay for SNF Discharges for short stay patients only.

In-Network providers do a better job managing utilization



Year	2022							Total
Network Status	bruary	March	April	May	June	July	August	Total	
In Network	21.1	21.4	19.8	19.4	20.0	21.2	20.3	**20.4**	**20.1**
Out of Network	23.4	21.8	23.0	21.2	22.5	19.7	20.1	**21.9**	**21.9**
Total	**21.8**	**21.5**	**20.8**	**20.0**	**20.8**	**20.7**	**20.3**	**20.8**	**20.7**

Network Status	2021	2022	Total
In Network	1,155	2,476	**3,631**
Out of Network	481	1,112	**1,593**
Total	**1,636**	**3,588**	**5,224**

Marginal Benefit to Patient Discharged into Network:

1.8 days

Fewer days

Using Market Analytics to develop SNF Quality Performance Scorecard

What's the goal?

Measuring, *and improving,* SNF engagement

The SNF Quality Scorecard measures:

- Careport and CMS rating
- payroll-based staffing
- short stay MDS and claims based QMS

Rehab & Healthcare Center

Period Q2 2022 YTD

COMPOSITE SCORES	SHORT STAY QMS	STAFFING
Overall	**Medicare spending per beneficiary**	**RN HRPD**
3 (3 / 3.9)	0.9% (0.9% / 1%)	0.5h (0.6h / 1h)
Survey	**% Successfully Discharged to Community**	**Total HRPD**
3 (3 / 3)	65% (65% / 63%)	3.4h (3.6h / 3.9h)
Staffing	**% Visited ED**	
3 (3 / 3.6)	8 (8 / 5.8)	
Quality		
5 (5 / 4.9)		

Metric Values

Center # - Your performance during the reporting period

Left # - Your performance in the prior reporting period

Right # - Avg. performance of the High Performing Network

CMS ANALYTICS

Quality Report Generated Monthly

Metric Definitions

Overall- The overall rating is based on a nursing home's performance on 3 sources: survey, staffing, and quality of resident care measures.

Survey: Composite measure based off approximately the last 3 years of the SNFs state survey regulatory citations

Staffing: Composite measure based off RN and total nurse staffing hours per resident day

Quality: Composite measure based off various quality measures for both the skilled and custodial population

Short Stay QMS - This section contains the CMS publicly available measures for Medicare Spending per Beneficiary, Percentage Successfully Discharged to Community, Percent Visited ED.

Medicare Spending Per Beneficiary: Ratio that shows how much the SNF bills Medicare stays compared to other SNFS. Lower ratio means lower spend.

% Successfully Discharged to Community: Rate of successful return to home and community from a SNF.

% Visited ED: % of Short Stay patients who have had an outpatient ED visit

Staffing - This section contains the CMS publicly available measures for RN Hours per Resident Day and Total RN, LPN, CNA Hours per Resident Day.

RN HPRD: RN hours per resident day. This measure is adjusted for the provider's patient case mix.

Total HPRD: Total RN, LPN and CNA hours per resident day. This measure is adjusted for the provider's patient case mix.

In-Network providers discharge more patients home

SNF Discharge To Community (D2C)

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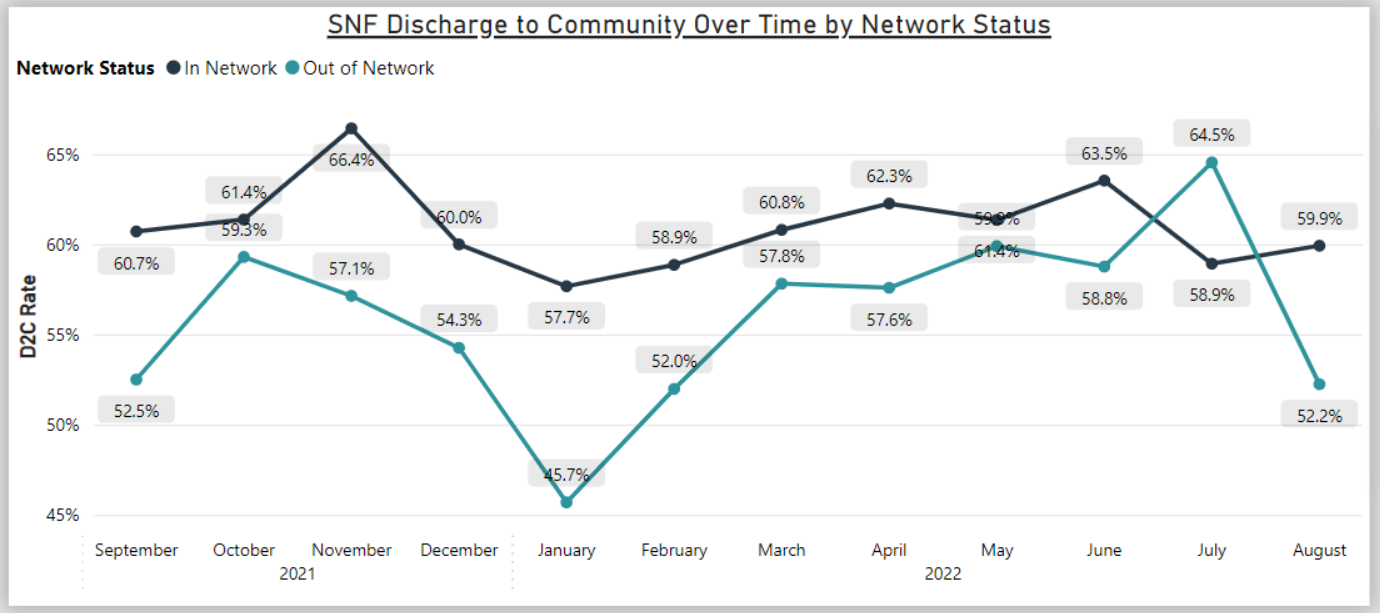

Average Discharge to Community Rate

In Network
60.9%

Out of Network
55.9%

SNF DISCHARGE TO COMMUNITY RATE (%)

Year	2021					2022
Network Status	September	October	November	December	Total	January
In Network	60.7%	61.4%	66.4%	60.0%	**62.1%**	57.7%
Out of Network	52.5%	59.3%	57.1%	54.3%	**55.8%**	45.7%
Total	**58.1%**	**60.8%**	**63.6%**	**58.3%**	**60.2%**	**53.8%**

SNF DISCHARGES (COUNT)

Year	2021					2022
Network Status	September	October	November	December	Total	January
In Network	336	422	429	510	**1,697**	48
Out of Network	160	172	189	223	**744**	23
Total	**496**	**594**	**618**	**733**	**2,441**	**71**

Marginal Benefit to Patient Discharged in Network:

5%

more discharged to community

What’s ahead

for Atlantic’s high-performing network?

KEY TAKEAWAYS

Invest in technology – implement electronic workflows

Define performance measures & goals

Ensure data transparency/clinical integration of technology

Evaluate & re-evaluate preferred providers

Q&A

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Thank you

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