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Educational Webinar Series

Transforming transitions for high-risk patients

March 14, 2023

Today’s speakers

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Senior Director of Case & Utilization Management
CAIPA

Tommy Gotreaux, MBA, BSN, RN
Senior Clinical Solutions Architect
CarePort, powered by WellSky

Who is CAIPA?
Coalition of Asian-American IPA

- Greater New York Area
- 70 Specialties
- 1,200+ Physician Members & Affiliates
- 1,800+ Medical Offices
- 500,000+ Patient Population in the Asian Community
- Managed Care Organization Focused on Quality & Efficiency

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My role & team at CAIPA

- Responsible for clinical and administrative oversight including program metrics, performance metrics, patient outcomes and delegations and compliance

- Ensure adherence for NCQA aligned case management and utilization management programs

- Provide Leadership for the Care Team which has an IDT of Registered Nurse Case Managers, Licensed Social Workers and Non-Clinical Coordinators who:
    - Focus on care outcomes along the care continuum
    - Facilitate linkages to community resources
    - Ensure patient and provider engagement
    - Enhance provider communication and collaboration
    - Facilitate patient education

Care Transitions program

Developed to assist high-risk, high-cost AAACO patients to address their care needs and reduce preventable utilization while lowering administrative burden for providers and creating additional savings

Key objectives

- Reinforce and facilitate patients' ability to adhere to treatment plan created by the provider
- Enable patients to achieve an optimal level of physical and psychosocial wellness by addressing both medical and social determinants of health
- Reduce preventable utilization

Care Transitions program continued…

Focuses on three components:

1. Complex case management
   - Focus on high-cost, high-utilizing patients
   - Focus on patients with modifiable risk factors

2. Diabetes Disease Management/DSMES
   - Focus on patients with diabetes
   - Target interventions based on condition severity and risk of complications

3. Care transition
   - Focus on patients transitioning from hospital to home
   - Ensure discharge plan and follow-up care is understood and implemented

Care Transitions program continued…

CAIPA's Care Transitions program focuses on transitions from hospital to home and involves contacting patients after hospital discharge to:

- Identify any needs requiring urgent/emergent intervention
- Ensure understanding of discharge instructions
- Review medications
- Assist in coordinating follow-up care if necessary
- Assist with any issues regarding post hospital services, from home care, to medical equipment

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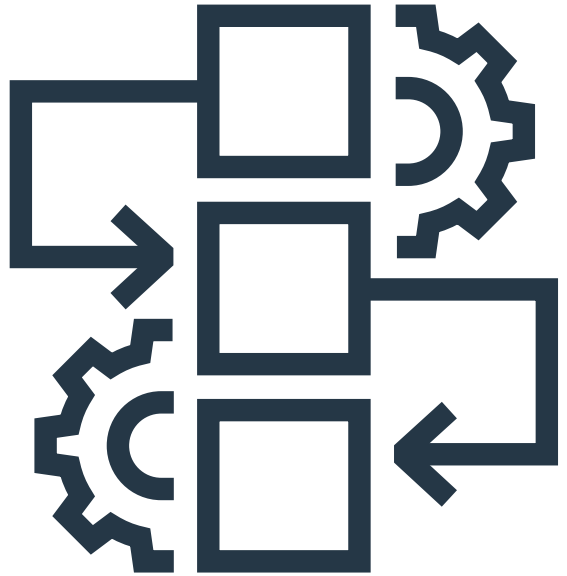
Past workflows

- AAACO Care Transitions process did not involve telephonic patient assessment post discharge
- Transactional discharge process
  - Staff reliance on discharge notifications from facilities which were not always timely
  - Delayed admission notifications
- Staff communicated discharges to providers after receiving the discharge notifications delaying notification of patient transitions
- Receipt of discharge summaries not consistent or timely



Recognizing the need for technology & partnership

- CarePort's penetration with the acute hospitals in our regions and PAC providers allow us ability to manage transitions of care between acute, PAC and home
- Allow ACOs to manage length of stay in PAC
- Potential access to CCDA data without need for individual consent by members, a requirement with the New York State HIE
- Support data normalization and scrubbing to ensure the more reliable patient identification and information transfer
- Robust notification process and workflow - via email notification to end users

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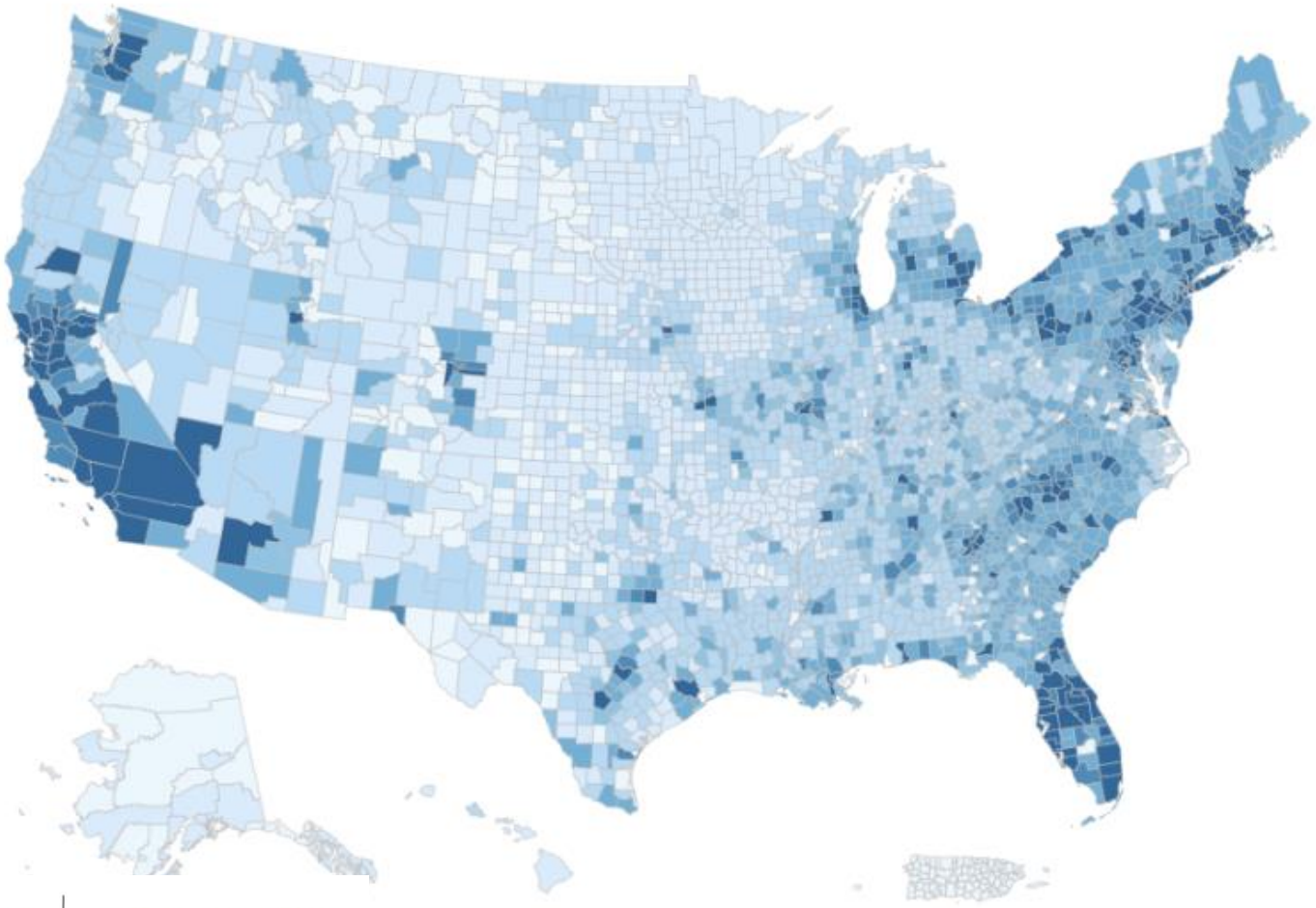
CarePort® powered by WellSky®

The most complete care coordination network available today



2,500
Hospitals & Physician Practices

130,000
Post-acute Providers

~52M
Referrals/Year

20M
Lives

12M
Event notifications per day

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**Patient referrals to certified PAC providers*

Over 500 practices have patients managed in CarePort

Impacting over 14 million patients at a variety of organization types

agilon health

Organizations that help practices take on risk

GENESIS MEDICAL ASSOCIATES, INC.
A TRADITION OF QUALITY HEALTHCARE

Independent Primary Care Practices

Allegheny Health Network

Integrated healthcare delivery systems

CAIPA

Independent IPAs

Careport empowers ambulatory providers with:

Visibility

Real-time care transition **notifications** from both acute & post-acute facilities

Follow specific patients or generate comprehensive **patient worklist**

View of previous **utilization history** across various settings

Intelligence

Prioritize higher risk patients

Predictive **risk flags** help identify patients that could benefit from intervention

Improved insight into **post-acute provider performance** and better manage collaborative networks

Action

Influence your patient's discharge and care plan

Guide patients to higher performing post-acute providers

Communicate electronically with post-acute providers

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Cross-continuum solutions to improve clinical and financial outcomes

Care Coordination

Real-time alerts and communication during transitions of care

ED Optimization

Reducing unnecessary admissions

Patient Engagement

Engaging patients when they need you & important resources the most

Referral Automation

Enabling two-way communication with community providers

Influencing the Discharge Plan

Seamlessly share preferred provider lists with care teams

Transitional Care Management

Establishing interactive contact with patients and readmission reduction

Network Management

Providing real-time, objective analytics of post-acute providers

Value-based Programs

Optimizing outcomes for risk-based programs throughout the continuum

Complex Care Management

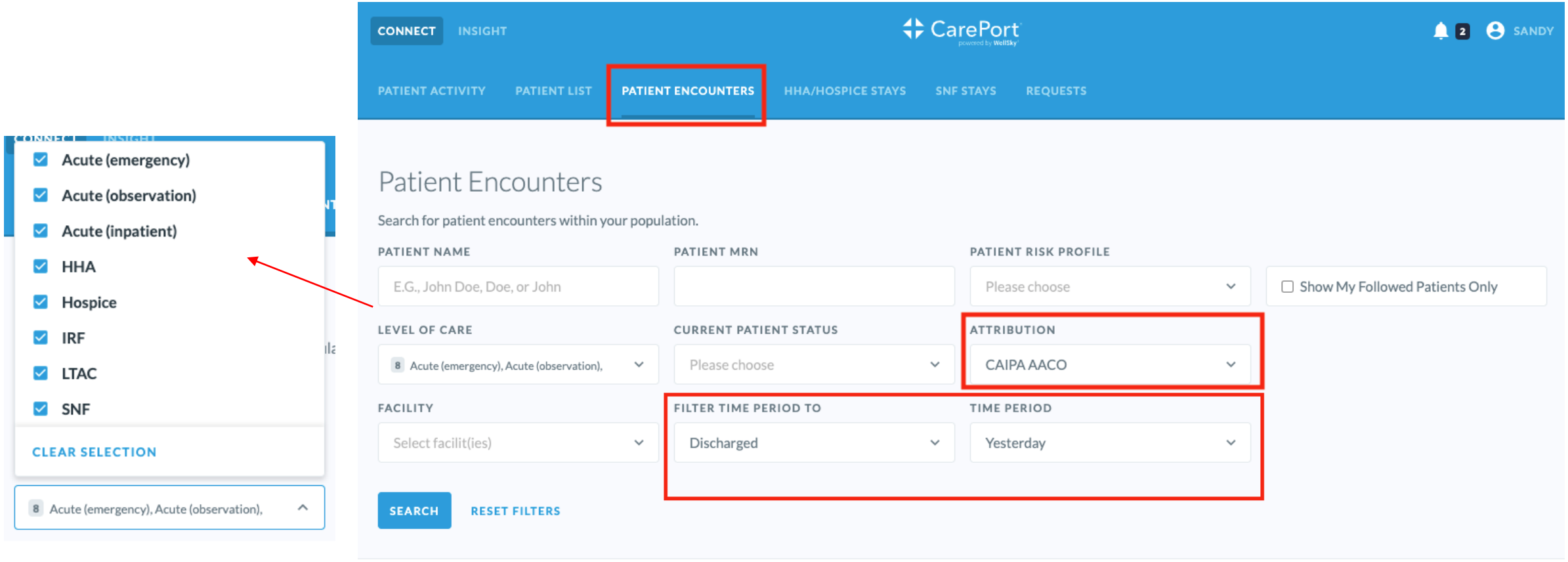
Helping focus on complex cohorts of patients

Provider Collaboration

Streamlining care team communication by electronically chatting as soon as the patient has a care event

CAIPA Connect workflow

- Identify patients that have had an admission or discharge the previous day to produce a worklist of patients to contact for TOC and TCM

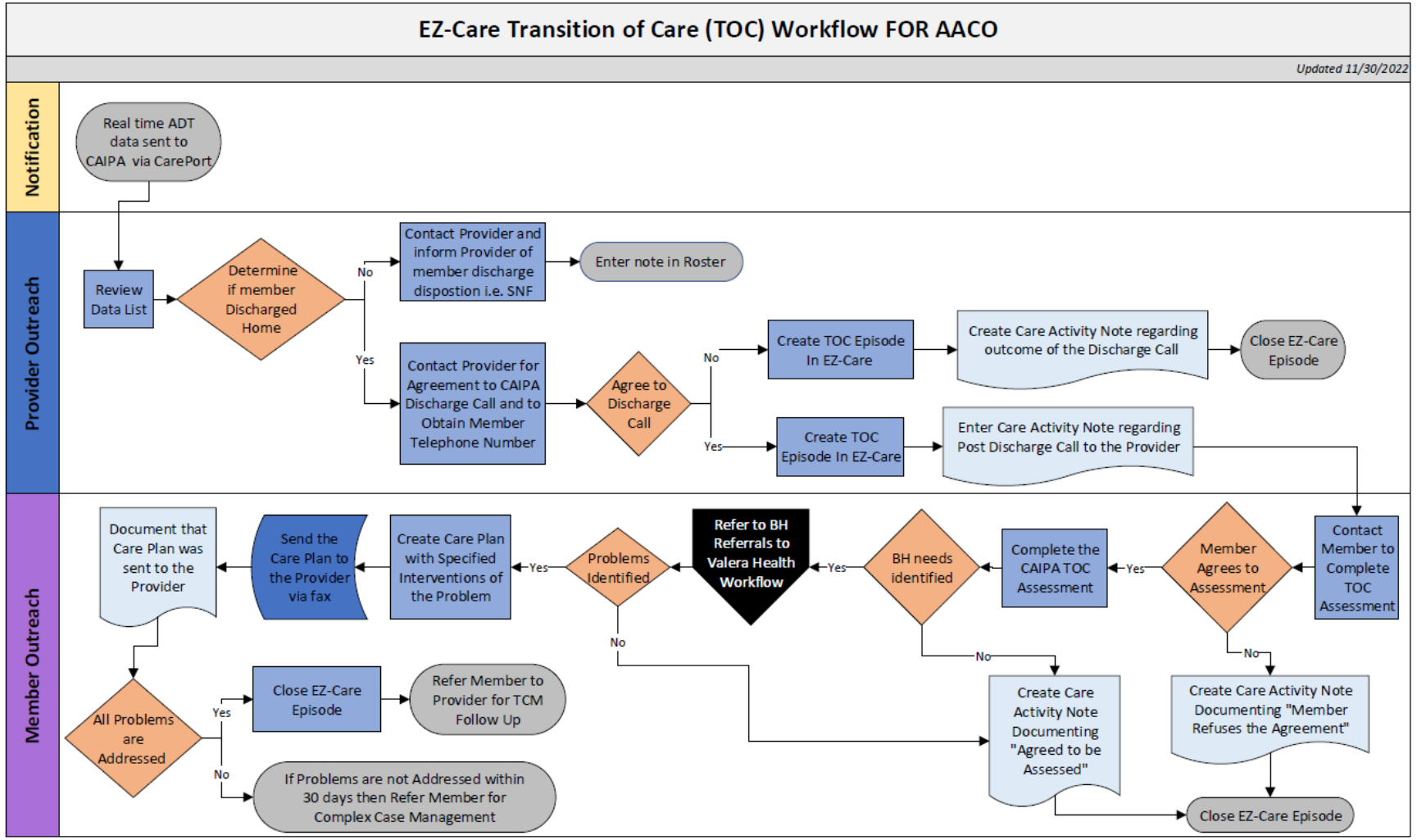


CAIPA workflow w/CarePort search results

Displaying all 6 results Download CSV View all downloads

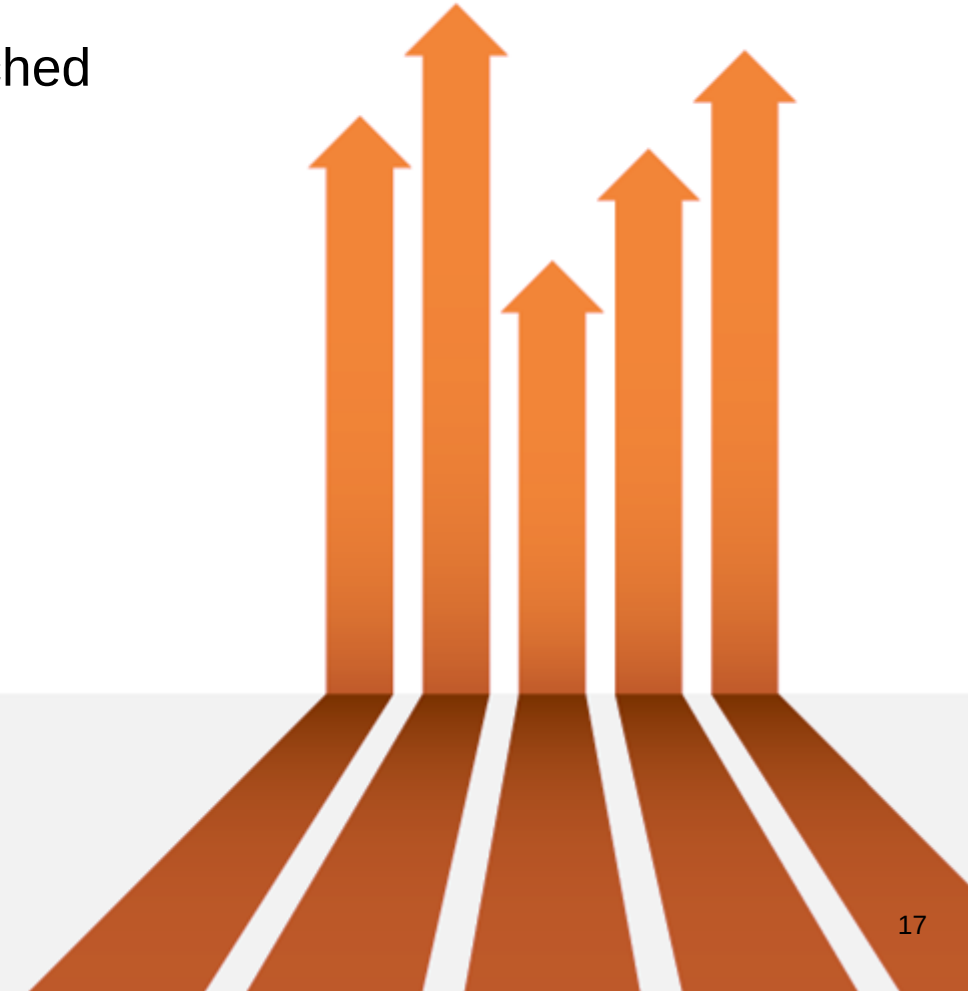
PATIENT	MRNS (SOURCE)	ADMITTED TO	DISCHARGE INFO	CURRENT INSURANCE	LAST COMMENT	DOCUMENTS	
Jones, Michael 85yM • 4/5/1937 CAIPA AACO*	XXXXXX (CAIPA ACO) XXXXXX(Center for Rehabilitation and Nursing Care) XXXX (County General Hospital) XXXXX (Payer ID) XXXX (Visiting Nurse Services)	2/21/2023 11:12 AM EST County General Hospital (Emergency) Encounter ID: ABABAB Chief Complaint(s)	2/21/2023 3:58 PM EST Happy Manor Nursing Home Skilled Nursing Facility	Medicare Part B Outpatient			☆
Smith, Suzy 87yF • 8/4/1935 CAIPA AACO*	XXXX (County General Hospital) XXXX (Family Hospital) XXXX (Orthopedic Hospital) XXXXX (CAIPA ACO) XXXXX (Convener FFS) XXXXX(Harry Potter Hospital) XXXXX (Island Medical Center)	2/20/2023 6:11 PM EST Family Hospital (Emergency) Encounter ID: ABABABAB R11.2	2/21/2023 12:10 AM EST HOME Home (Self-Care Only)	MEDICARE		Emergency Summary	☆

CAIPA workflow w/CarePort search results



Results

- Facilitated 93% outreach calls to patients/providers within 24-72 hours of notification of discharge.
- 79% (735/930) of eligible discharged patients were outreached (acute facilities)
- 56% reached and assessed
- Facilitates early intervention for gaps in care for patients discharged home from acute care facilities
- 2.3% drop in readmission rate



The Future: Where we are going with CarePort

- Adding new populations
- Expanding roster system to 150,000 lives
- Considering CarePort Insight for enhanced analytics and quality metrics
- Influencing the discharge plan
  - Communicating with the discharge planner while patients are with them
- Focus on PAC performance, behavioral health, and HEDIS measures

Q&A

Thank you

Contact us

careport@careporthealth.com

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[Visit the CarePort exhibit booth]