



VBCExhibitHall
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Educational Webinar Series

Post-acute care: The Nexus of VBC success



Rhonda Sanders-Allamon
Chief Mission Access Officer
Empath Health



Tom Martin
Senior Director of Data Insights
WellSky

Agenda

The background of the slide features a complex network of blue lines connecting various nodes, some of which are represented by human silhouettes. The overall color scheme is a gradient of blues, from dark to light, creating a sense of depth and connectivity.

- Empath Health overview
- Challenges Empath Health faced
- How Empath Health plays a vital role in VBC success
- How it works
- Q&A

What type of organization do you work for?

Empath Health at-a-glance



20
Counties



3800
Employees



48
Years of
providing high
quality care



Serving
Florida

Services provided

- Hospice care
- Home health care
- Personal care
- Palliative care
- Pharmacy and DME
- Grief services
- And much more...

*Empath Health currently utilizes the following WellSky solutions:
CarePort Intake for managing patient referrals and CarePort Connect for tracking patients.*

Challenges Empath Health faced

Manual Processes

- Limited access to actionable data and data sharing to become a collaborative partner with hospitals and ACOs
- Manually pulling data and making phone calls to follow up with partners around patient outcomes and changes in care
- No centralized place to manage patients across the continuum



Lack of patient visibility

- Not knowing when a patient is readmitted to the ED, or has a change in condition
- No real-time clinical event notifications or diagnosis codes to manage cost of care across multiple providers
- Understanding patient comorbidities and when to have care plan conversations with patients
- Lack of understanding around most appropriate point of contact to share pertinent clinical information with



Disconnected from hospitals and other partners

- Lack of connectivity between systems for home health, hospice, and other PAC providers
- Difficulty caring for high-risk geriatric patients and VBC managed patients
- Inability for PACs to establish measurable metrics with hospitals and ACOs



Under utilization of hospice care

High costs of End-of-Life (EOL) care

- Over 25% of Medicare spending occurs in the last year of life
- Intensive medical interventions dominate EOL care

Limited time on hospice benefit

- Median hospice stay is less than 18 days
- Over 50% of patients have stays under a week

Contributing factors

- Late referrals due to prognostic uncertainty and cultural/systemic barriers
- Lack of awareness among patients and families about the hospice benefit

Implications

- Patients miss out on quality-focused care, while families bear emotional and physical tolls
- Healthcare system experiences increased costs due to unnecessary hospitalizations



Empath Health outcomes

EHR

Manual
updates by
clinician

Subject to
human error
and delays
in updates



How Empath Health plays a vital role
in VBC success

Improving care and cost savings across the continuum



Know patient changes in condition in real-time

- Provide timely information and clinical insights back to partners to support MIPS and enhance patient outcomes and partnerships
- Collaborate with the Care Team in real-time to support patient transitions to ensure the most appropriate patient care plan
- Improve customer experience with patients' and families
- Identify patient diagnosis and change in condition in real-time for more appropriate clinical care and oversight

Enhanced patient experience measured

- **Improved patient engagement**
 - Enhanced health literacy and understanding
 - Improved patient engagement in care plan
- **Quality of care improvement**
 - Improved adherence to treatment and care plans
 - Lower infection rates
- **Cost reduction**
 - Decreased total cost of care
 - Decreased utilization of hospital and ED
- **Improved care coordination**
 - Reduced medication errors
 - Improved patient outcomes
- **Improved patient satisfaction**
 - Improved HCAHPS
 - Improved NPS
- **Patient outcome improvement**
 - Improved readmission rates
 - Increased LOS hospice
 - Improvement in functional status

Bridging the gap between ACOs and hospitals



Understand when a patient needs EOL care

- Enable ACOs, primary care, and at-risk providers to identify patients in-need of hospice care through shared real-time information
- Provide visibility into patient history and utilization to determine hospice suitability
- Intervene early for optimized cost savings and enhanced quality

Geriatric at-risk groups and ACO program measures shared through CarePort Connect

- Patient centered goals and priorities
- Early intervention requests
- Multi-disciplinary care updates
- Continued monitoring and change in condition status updates
- Polypharmacy and medication reconciliation
- Changes in care setting and condition

Coordinating and collaborating with care teams



Receive ED alerts for repatriation

- Coordinate patient care with at-risk partners to intervene and avoid unnecessary hospital stays
- Identify patients before admitted to the ED or in the ER to deploy dedicated staff for patient consultations
- Trend avoidable readmissions and provide real-time root cause analysis and process improvement.

Prevent avoidable readmissions

- ER divergence program
- Call us first program
- Multidisciplinary disease management programs
- Patient education
- Enhanced care coordination and clinical liaison hospital model
- Transitional care

How it works

Track and manage patients with CarePort Connect

Know where your patients are across the continuum including outside your network

Real-time visibility and alerts when active patients present at the ED, admit inpatient to the hospital, or discharge from the hospital

View clinical documentation and key events to drive actionable care coordination

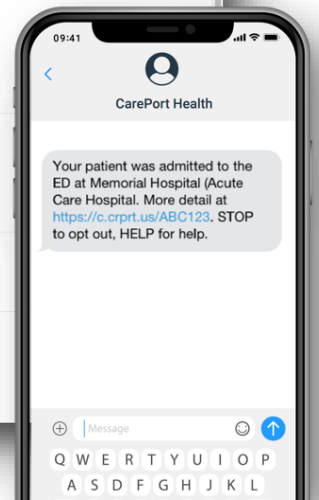
Collaborate with hospitals, health plans, risk-bearing organizations, physicians, and other post-acute care providers

The screenshot displays the CarePort Connect interface for patient Nancy T. Martin (91yF, 11/24/1932). The patient is marked as 'FOLLOWING'. Key information includes:

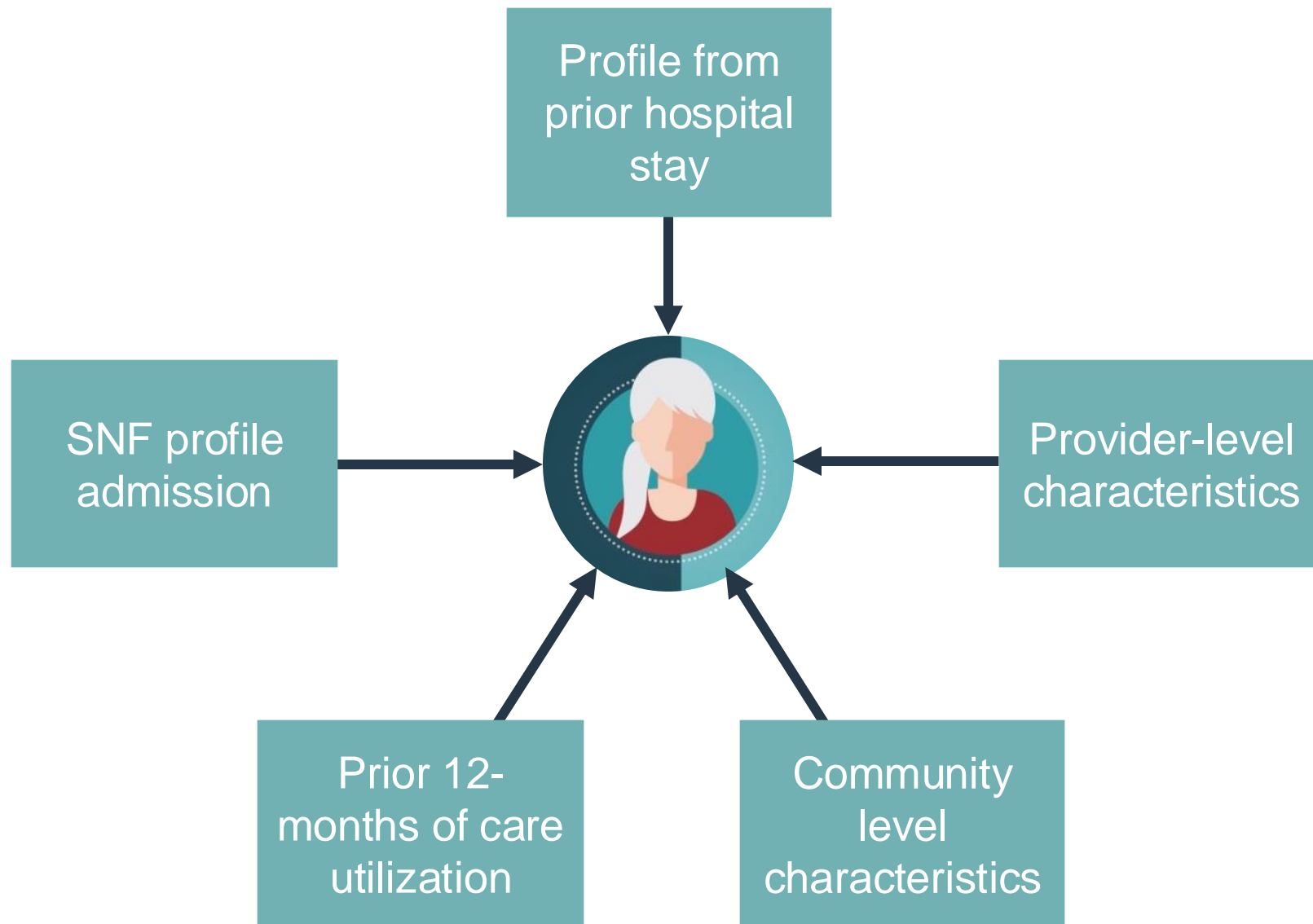
- PATIENT CONTACT INFO:** 98 Monks St., Boston, MA 02127, (617) 909-1744
- MRNS:** 100002010 (Memorial Hospital), 8900086 (Elm Health), 55669900 (County General)
- PRIMARY CARE PROVIDER:** Dr. Regina Parnell (regina.parnell@org.com, 617-221-0308)
- CARE COORDINATOR:** Cindy Blackwell RN (cindy.blackwell@theorg.com, 415-252-2343)
- PATIENT RISK PROFILE:** High ED Utilizer, Hospice Suitability: Possibly Suitable

The main section is a 'TIMELINE' with tabs for ASSIGNED USERS, DISCUSSIONS, ATTRIBUTION, and DOCUMENTS. The timeline lists several events:

Presented To	Discharge Info	SNF Suitability	Referrals	Attribution	External Attribution	Coding	Discussion	Documents / Surveys	Assigned Users During Encounter
4/27/2024, 1:29 pm EDT Memorial Hospital Encounter ID: h1-e2 C/C: Trouble breathing MRN: 100002010	Projected Discharge: 5/9/2024	SNF Suitability: Likely	Sent to Skilled Nursing Facility Auth: Not Started	Active Patients	County General: BPCI COPD	DRG: 464 (W) ICD-10: J43.2 M81.8 W19.XXXXA	5/8/2024, 11:44 am EDT David Hsu (Care Coordinator) Sounds great Regina! We have noted this and will be looking forward to an update later this week. OPEN DISCUSSION	Continuity of Care Document (CCD)	M. Mathes until 5/26/2024 S. Swoods until 6/1/2024
2/8/2024, 1:29 pm EST Elm Health MRN: 8900086	3/9/2024, 8:21 am EST Community	-	-	-	County General: BPCI COPD County General: High Risk - Pneumonia	-	START DISCUSSION	-	S. Swoods
2/8/2024, 8:48 am EST County General Encounter ID: h1-e4 C/C: Joint pain MRN: 55669900	2/8/2024, 1:21 pm EST Skilled Nursing Facility	-	Booked to Skilled Nursing Facility	-	County General: BPCI COPD County General: High Risk - Pneumonia	ICD-10: M81.8 W19.XXXXA	START DISCUSSION CONTACT HOSPITAL DP (\$1)	-	-
9/10/2021, 8:05 pm EDT Grace Hospital Encounter ID: h1-e5 C/C: Joint pain MRN: 55669902	9/10/2021, 9:39 pm EDT Community	-	-	-	-	ICD-10: M81.8 W19.XXXXA	START DISCUSSION CONTACT HOSPITAL DP (\$1)	-	-
8/9/2021, 9:30 am EDT Brady Homecare MRN: 300030	9/8/2021, 12:00 pm EDT Community	-	-	30 Day Discharge	-	ICD-10: M81.8 W19.XXXXA	START DISCUSSION	-	-
8/2/2021, 11:15 am EDT Memorial Hospital Encounter ID: h1-e7 C/C: Joint pain MRN: 55669900	8/6/2021, 12:07 pm EDT Home Health Agency	SNF Suitability: Not Likely	Booked to Home Health Agency	Active Patients 30 Day Discharge	-	ICD-10: M81.8 W19.XXXXA	START DISCUSSION 8/5/2021, 10:25 am EDT David Hsu (Discharge Planner) Confirmed with ordering MD and have updated referrals. Thank you.	-	-



CarePort Connect predictions



Hospice suitability score

WellSky | Connect | Dashboard | Patient Activity | Patient List | Patient Encounters | HHA/Hospice Stays | **SNF Stays** | Requests | 🔔 👤 Sandy

Patient SNF Stays

SNF: Attribution: Assigned Users: Followed Patients: Show My Followed Patients Only Referred By My Hospitals Only

Status: Patient Name: Patient Identifier: Patient DOB: Patient Risk Profile: Filter Time Period To:

Time Period:

SEARCH [RESET FILTERS](#) [SURVEY REPORTING](#) [COMPLETED SURVEYS](#)

Viewing 1 Patient Encounter [VIEW ALL DOWNLOADS](#) [📄](#) [⚙️](#)

<input type="checkbox"/>	Patient	Admitted To	Duration	Discharge Info	Stay Type	Current Insurance	Patient Risk Profile	Discussion	Documents / Surveys	Users Assigned During Encounter
<input type="checkbox"/>	★ Bloom, Agatha S. 77yF • 7/17/1947 <small>Payor: Medicare Advantage 30 Day Discharge High Risk - ESRD</small>	11/26/2024, 10:05 am EST The Oaks Skilled Nursing (SNF) MRN: 113423902 Attending: Nancy Norris From: Memorial Hospital ICD-10: I50.21	🕒 11 days	12/7/2024, 12:20 pm EST Acute Care Hospital	Short Stay	Medicare	SNF Hospitalization Risk: 8 Hospice Suitability: Possibly Suitable Discharged from hospital in past 30 days	START DISCUSSION	REQUEST UPLOAD	M. Mathers until 1/4/2025

Where is your organization in adopting technology to track patients and collaborate across the continuum?

KEY TAKEAWAYS



Identify patients early who need hospice or palliative care



Reduce readmissions with ED repatriation



Improve communication between ACOs, hospitals, and post-acute care providers

Q&A



Stop by our VBCExhibitHall.com Virtual Booth:



[Visit the WellSky exhibit booth](#)

Contact us

cn-general@wellsky.com