

Taking Ownership of Total Cost of Care: Empowering Coordinated Care through High-Performing PAC Networks

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Atlantic
Health System

Introductions



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Why have a High Performing Network of SNF Partners? (Electronic Integration)

AHS hospitals and ACO's are moving further into value-based risk arrangements therefore improving outcomes became essential for improving value

- Improving transitional care outcomes
- Improving the patient experience
- Reducing 30-day all cause readmissions
- Improving hospital throughput and LOS challenges
- Increasing hospital discharges to home

Effective care transitions requires timely utilization and quality metrics of our Nursing Home partners and SNF attendings

Value Based Risk	
• Advanced BPCI	• Medicare Advantage
• MRRP	• ACOs

Requirements to join our High-Performing Network



Mandatory Requirements

Electronic integration with:

- CarePort Insight
- Epic Carelink

Collaboration Score: Citizenship, PAC liaisons, AHS CM and HC

- Facility leadership engagement at collaboration meetings
- Responsiveness to requests for information
- Supporting engagement/participation in UR and onsite visits
- Timely provision of discharge paperwork

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 (double weighted)
- Average Short Stay LOS

Three scores
equally
weighted are
averaged to
determine
Total HPN
Score

Network reassessed biannually

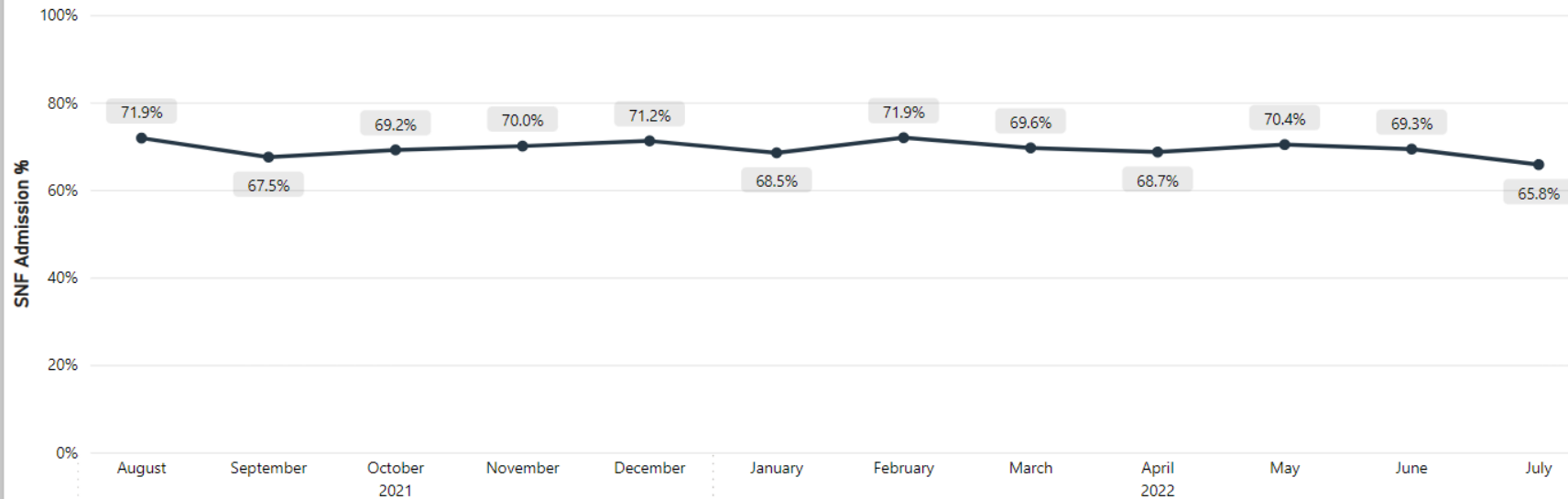
Limited exceptions on HPN facility selection will be made based on AHS network need

Improving High Performing In-Network Utilization (Clinical Integration)

SNF Admissions In Network



SNF Admission % In Network Over Time



SNF Admissions

Year	2021						Total	2022					
	August	September	October	November	December	January		February	March	April	May	June	July
In Network	401	399	462	465	569	2,296	537	500	488	445	494	493	...
Out of Network	157	192	206	199	230	984	247	195	213	203	208	218	...
Total	558	591	668	664	799	3,280	784	695	701	648	702	711	...

Average Admission %

Out of Network
30.5%

In Network
69.5%

69.5%
of patients
find their way
into AHS' high-
performing
network

SNF Analytics to build SNF utilization scorecard



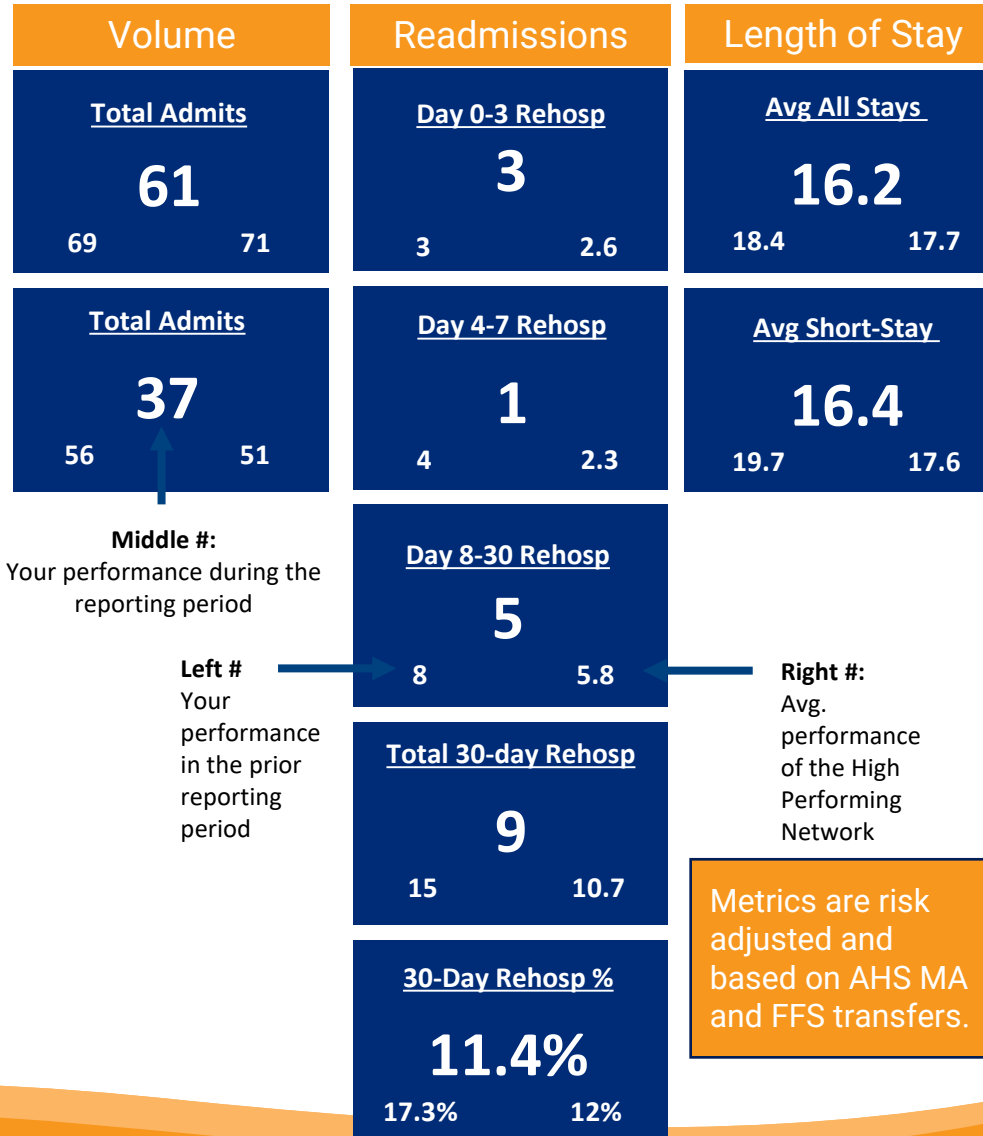
What's the goal?

Measuring, and improving, SNF engagement

The SNF Utilization Scorecard measures:

- Admissions
- Readmissions
- Average length of stay

Rehab & Healthcare Center



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.

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



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

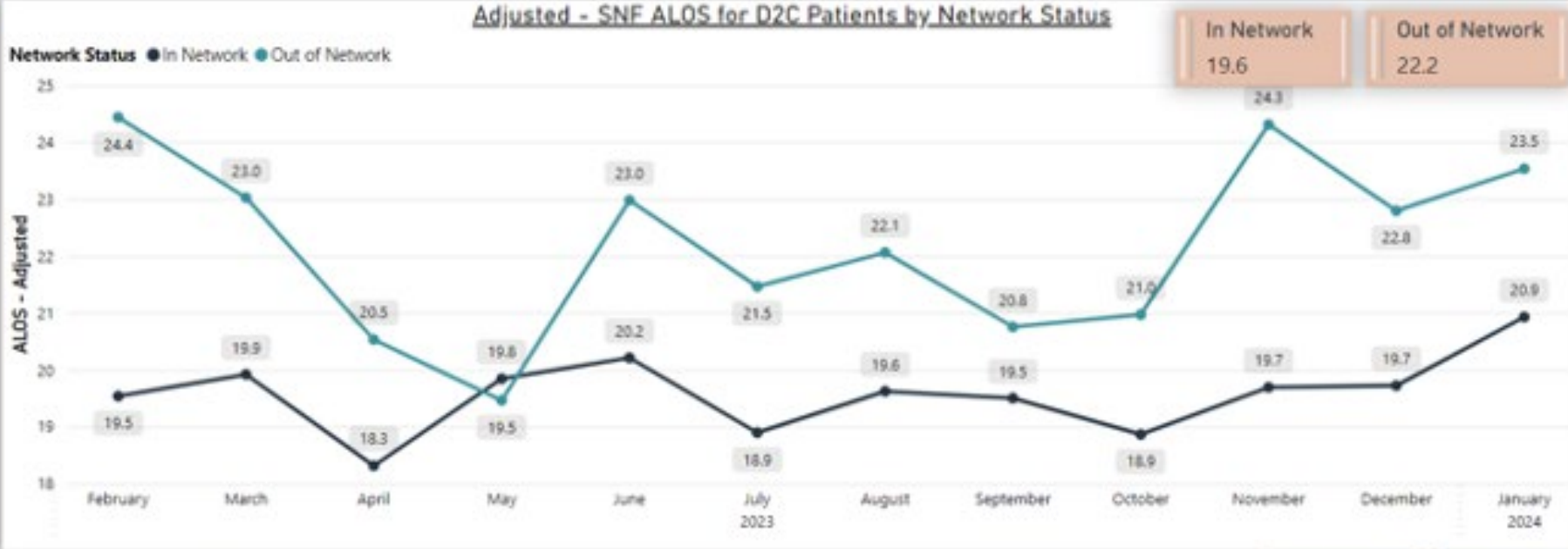
Staffing - This section contains the CMS publicly available measures for RN Hours per Resident Day and Total RN, LPN, CNA Hours per Resident Day.

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

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

In-network providers do a better job managing utilization

SNF ALOS for Patients Discharged to Community



AHS' high-performing providers report a reduction of

2.6 days

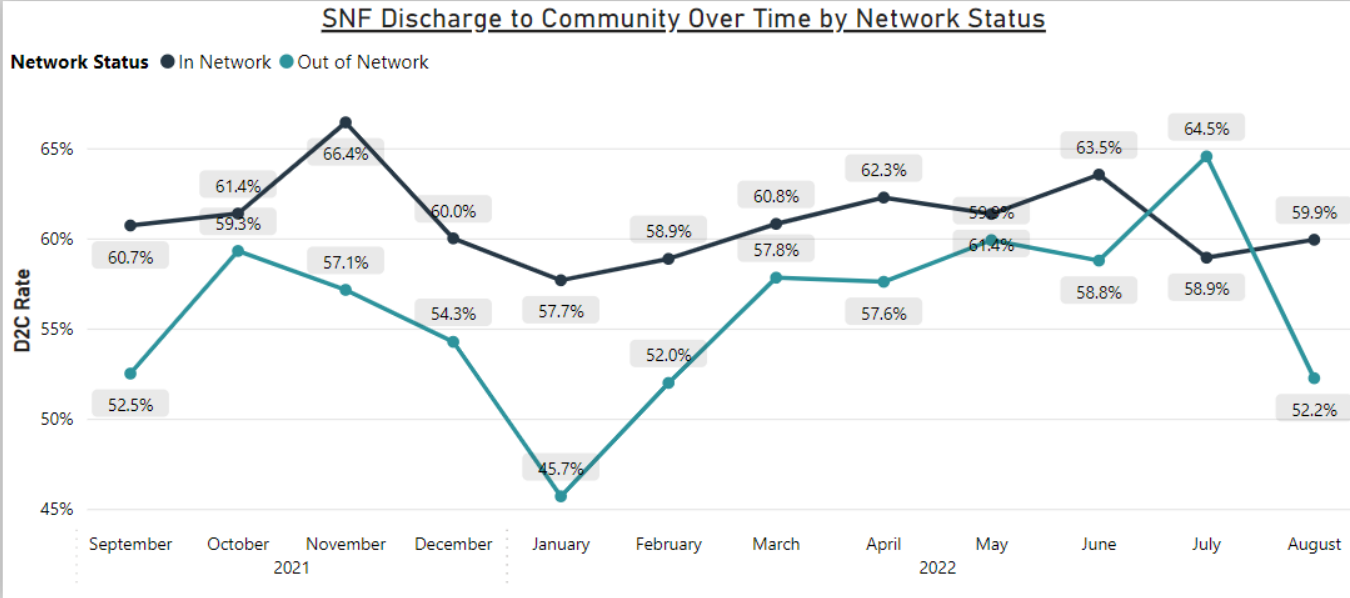
in SNF adjusted length of stay

Count of SNF Community Discharges

Year	2023												2024		Total
	February	March	April	May	June	July	August	September	October	November	December	Total	January	Total	
In Network	371	427	344	380	404	412	461	415	405	367	404	4,390	382	382	4,772
Out of Network	139	140	115	153	171	214	216	219	232	230	250	2,079	227	227	2,306
Total	510	567	459	533	575	626	677	634	637	597	654	6,469	609	609	7,078

In-network providers discharge more patient's home

SNF Discharge To Community (D2C)



Average Discharge to Community Rate

- In Network: 60.9%
- Out of Network: 55.9%

AHS' in-network patients are safely discharged to the community

5%

More than out-of-network providers

SNF DISCHARGE TO COMMUNITY RATE (%)

Year	2021					2022
	September	October	November	December	Total	
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
	September	October	November	December	Total	
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.

CarePort Insight was a great start,
But we still had more to do...

Bringing CarePort Connect to Atlantic Health

Three areas of focus:

1

Patient Visibility

Needing more than what the HIE and EHR provides

2

Operational Efficiency

Streamlining workflows and difficulty managing transitional care management

3

Building on PAC Relationships

Acting on trends to help drive better collaboration

Patient Visibility

- Track patient movement over time, across settings of care
- Accurate discharge facility information
- ACH and SNF stay summaries
- Ability to see patient's PCP

CONNECT INSIGHT SURVEYS								
CarePort <small>powered by MEDSY</small>								
PATIENT ACTIVITY PATIENT LIST PATIENT ENCOUNTERS HHA/HOSPICE STAYS SNF STAYS REQUESTS								
Patient	Admitted To ↓	Duration	Discharge Info	External Attribution	Current Insurance	Patient Risk Profile	Discussion	Documents / Surveys
☆ Abbot, Ronald 97yF • 12/12/1926	1/20/2024, 3:58 pm EST County General (Emergency, Observation, Inpatient) MRN: 113423902 Encounter ID: brady1 Attending: Nancy Norris From: Brady Homecare DRG: 565 (E)	⌚ 2 months ACTIVE	Expected Discharge: 3/24/2024	County General: Navigator A	Medicare	Hospice Suitability: Possibly Suitable	START DISCUSSION	—
☆ Abrams, Scott 91yM • 5/11/1932	3/19/2024, 4:30 pm EDT Brady Homecare (HHA) MRN: 113423988 Attending: Sam Jones From: The Oaks Skilled Nursing	⌚ a day ACTIVE	—	Brady Homecare: Navigator A	Medicare	SNF Hospitalization Risk: 7 Hospice Suitability: Possibly Suitable	START DISCUSSION	—
☆ Abrams, Vera 93yF • 1/17/1931	3/18/2024, 4:15 pm EDT Brady Homecare (HHA) MRN: 113423977 Attending: Sam Jones From: The Oaks Skilled Nursing	⌚ 2 days ACTIVE	—	Brady Homecare: Navigator A	Medicare	Hospice Suitability: Possibly Suitable	START DISCUSSION	—
☆ Adkinson, Thomas 89yM • 3/25/1935	3/16/2024, 4:15 pm EDT County General (Emergency, Observation, Inpatient) MRN: 55669987 Encounter ID: h9...1	⌚ 4 days ACTIVE	Expected Discharge: 3/22/2024	County General: BPCI COPD County General: Navigator A	Medicare	Hospice Suitability: Probably Suitable	START DISCUSSION	Discharge Summary

Operational Efficiency

- Transitions of Care Coordinators:
 - Validate start of HHA services
 - Notification of discharge
 - Document requests
- Post Acute Care Coordinators:
 - Run daily discharge reports
 - Notification of discharge
 - Track and trend LOS and readmissions



Building on PAC Relationships:

AHS/SNF Shared Collaborations Supporting Better Outcomes

Discharge Planning

CareOne & Morristown PA Heart Success Program

Specialized facility dedicated to cardiac care, rehab, and observation

Ocean Healthcare Care Coordination

Specialty in the management of challenging discharge dispositions

Logistics Coordination

Support on transportation

Commercial SNF Prior Auth Delegation

Complete Care, CareOne, Genesis, etc. supporting SNF referral management

Atlantic Visiting Nurse & Hospice Integration

All SNF partners are measured

Care Continuity

Dialysis and Blood Transfusion Services

Birchwood Rehab and Complete Care

Atlantic Alliance Physician Engagement

SNF Medical Directors at 7 SNF locations

Morristown MC Emergency Department Follow Up

*Morristown Post-Acute
Complete Care*

Atlantic Hospice Collaboration

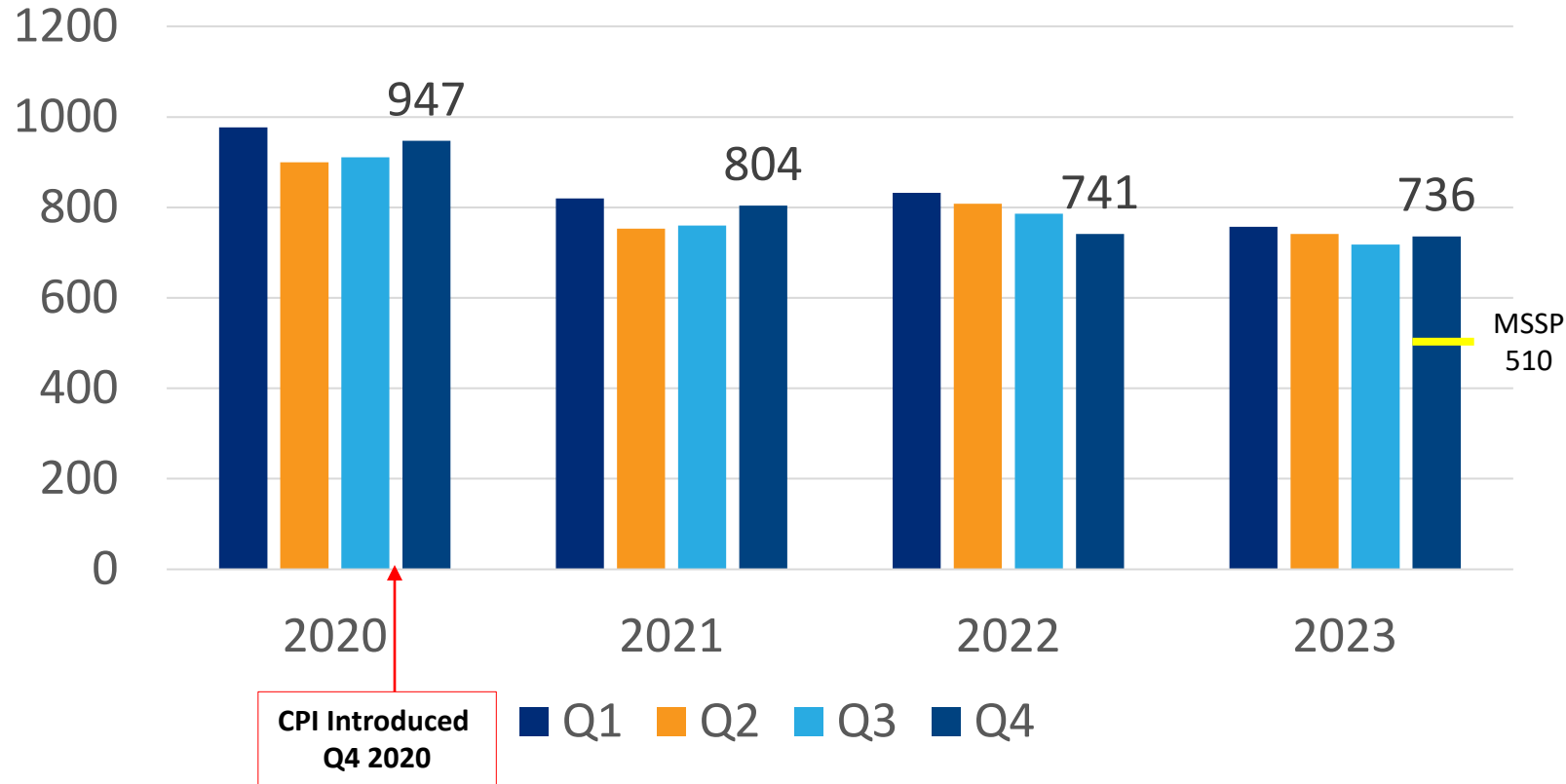
CareOne Morris County Facilities

Nurse Practitioner House Calls to Homebound

CareOne Morris County Facilities

Q4 2023 Atlantic ACO SNF Cost

AACO SNF Unit Cost



- AACO SNF unit cost trend favorable year over year
- CarePort Insight introduced Q4 2020

Source: Quarterly Preliminary Prospective Aggregate Expenditure/Utilization Reports Medicare Shared Savings Program

Applying People, Process, and Technology for Better Outcomes

People



1:1 Meetings



Home Care



**Atlantic
PAC
Liaisons**



**AMG SNF
Attendings
& Medical Directors**

Process



**Nurse to Nurse
Hand off
Communication**



**Timely & Accurate
Discharge Summaries**



**Education &
Training
Opportunities**

Technology



**Access to
EMR**



**Identification and
Communication Regarding
Risk for Readmission**



**WellSky
Analytics**

Questions?