CareForum 2022

The WellSky® Conference

CarePort Connect & Insight:

Client success snapshot with Cleveland Clinic

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Today's speakers

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Agenda

- Overview of Cleveland Clinic & CarePort
- Cleveland Clinic's ACO
- SNF Connected Network
- Shift to home-based care
- 2022 and Beyond

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

Cleveland Clinic's use of CarePort

2004: Care Management - ECIN

2014: CarePort Guide

- Post-acute search tool
- Need to be more strategic and guide patients to high-quality locations while still offering appropriate "choice"
- Growth through the years:
  - Aligned SNF, Cleveland Clinic Providers, ACO Waiver Facilities and Floor to SNF networks

2018: CarePort Connect and Insight

- Break away from accountability on SNF to provide hand-keyed performance metrics
  - Source of truth directly from CC and SNF EMR-true metrics across the board
- Resource for care coordination across care continuum

How Cleveland Clinic harnesses the power of CarePort for visibility across the continuum

Discharge Planning

Inpatient Case Managers use CarePort Care Management to create referrals, manage communication, identify select patient populations using rules engine, advanced tasking rules drive chart to right person at the right time and tag patients for reporting

Inpatient Case Managers use CarePort Guide for discharge planning/patient choice. High performing PACs are sorted to the top of search and tagged so patients can make informed decisions about care

Transitions of Care

OP Navigators and ACO Navigators use Connect to track patients post DC, allowing for outreach, identifying unplanned admissions, and keeps Collaborative PAC networks accountable

OP Intake staff receive referrals from CCF Hospital in RM

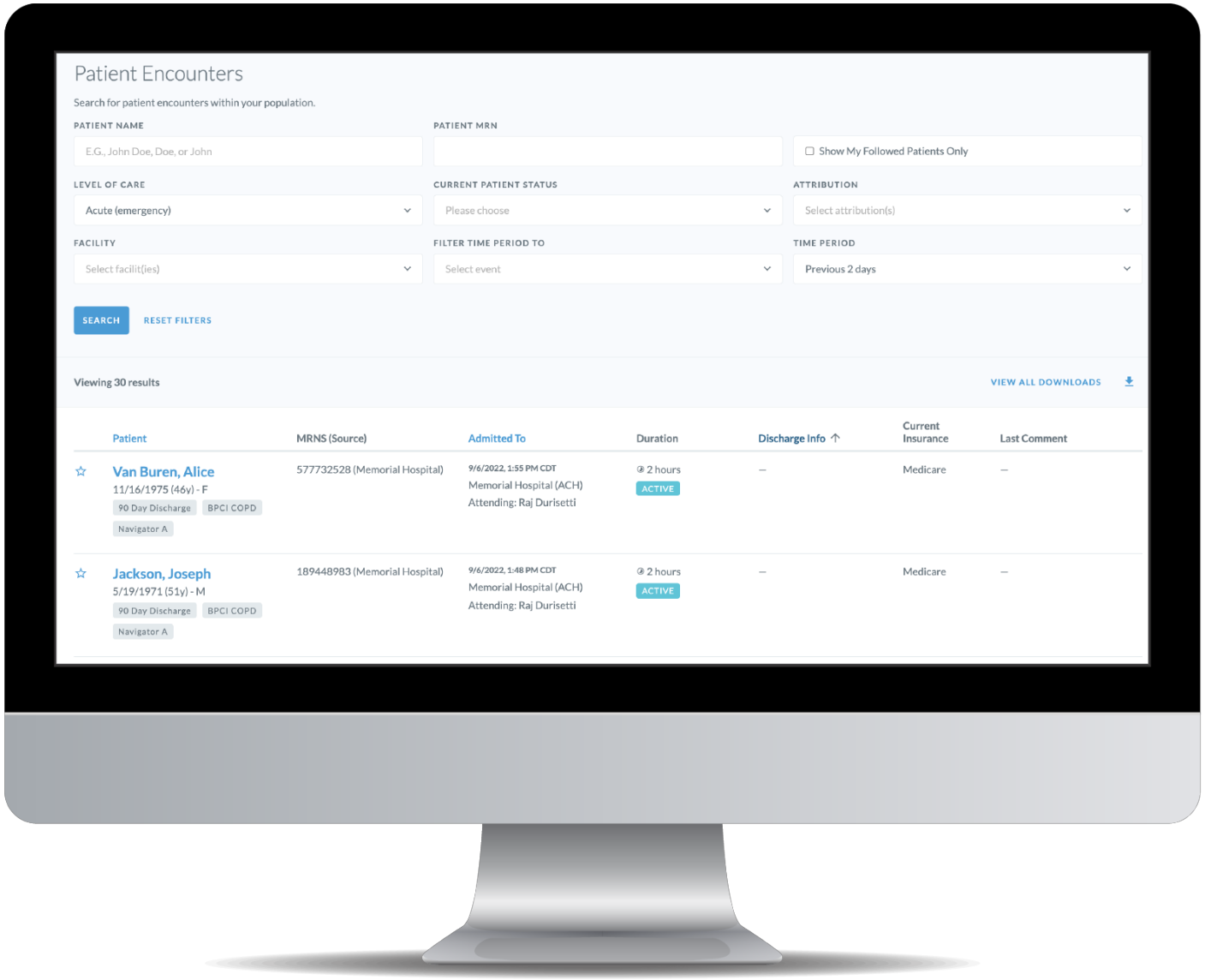
Post-Acute Performance

Program managers and Data Analysts use Insight data to scorecard PAC performance by combining data with other data streams to create holistic picture of performance month by month

Tracking Cleveland Clinic Patients Across the Continuum

CarePort Connect

- CCF populates Connect with ADT feeds from facilities + Rosters for ACO and other programs
- Extensive Attribution efforts tags patients allowing users to quickly track the right cohort of patients at the correct facilities without excessive noise
- Surveys
  - Readmission
  - 6-Clicks surveys
- Expected Length of Stay



CarePort Insight

Use Case: Hold SNF partners accountable for quality outcomes in transparent way and ensure CCU network maintains high quality

- Monthly report generated monthly includes measures such as
  - 30-day post SNF Discharge readmission rate captures the ability of the SNFs discharge planning team to safely transition patients back to community.
  - Readmission from community is captured using acute data from Careport customers
- Estimated % of captured readmission
- Preferred Provider Indicator
- Distance From Nearest Sponsor Hospital

Cleveland Clinic Accountable Care Organization

Population Health Program Framework

$$\textbf{Value} = \frac{\text{Health outcomes/quality}}{\text{Costs of delivering care}}$$

Objective:

To achieve better health outcomes for patients at lower costs

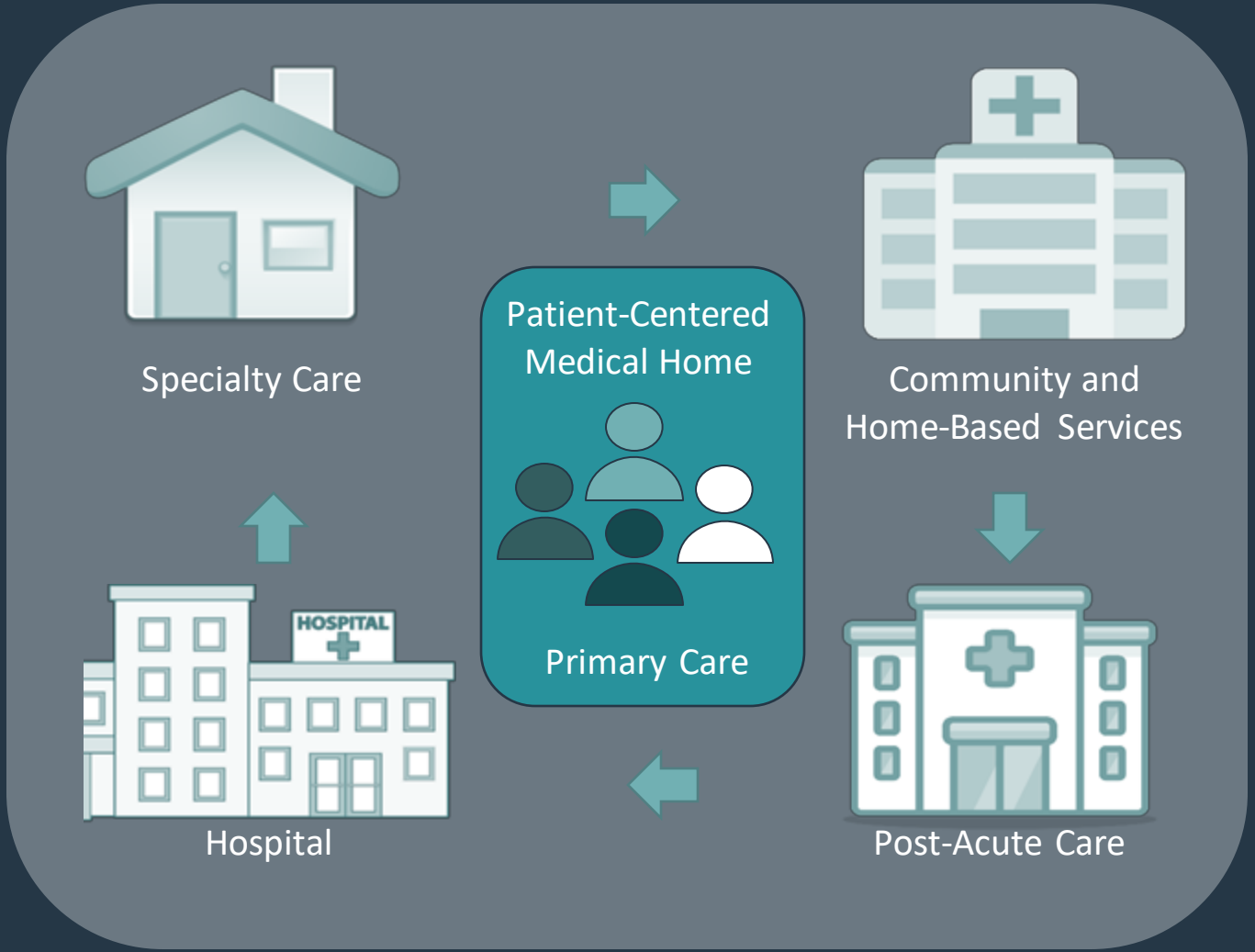
1. Understand the patient population
2. Engage patients in multidisciplinary care
3. Support patients across the care continuum
4. Tailor interventions to meet population needs
5. Build IT tools to support population management
6. Create a performance management structure
7. Evaluate, disseminate, and scale

Program Highlights

- 100K Medicare patients
- High-risk population
- $1bn/yr health expenditures
- 98% quality score achieved during PY2020
- Generated $20M in savings for Medicare in PY2020

SNF Network – 3 types of facilities: Waiver, Connected Care Units (CCU), Quality Partners. SS N=59-71 PACs

High-Performing Clinically Integrated Network



Highly coordinated care for patients at the right time and right place

The continuum of post-acute care

From SNF to Home Care: Cleveland Clinic's experience building and maintaining high-performing networks

Building a high-performing SNF network

Without Connect & Insight

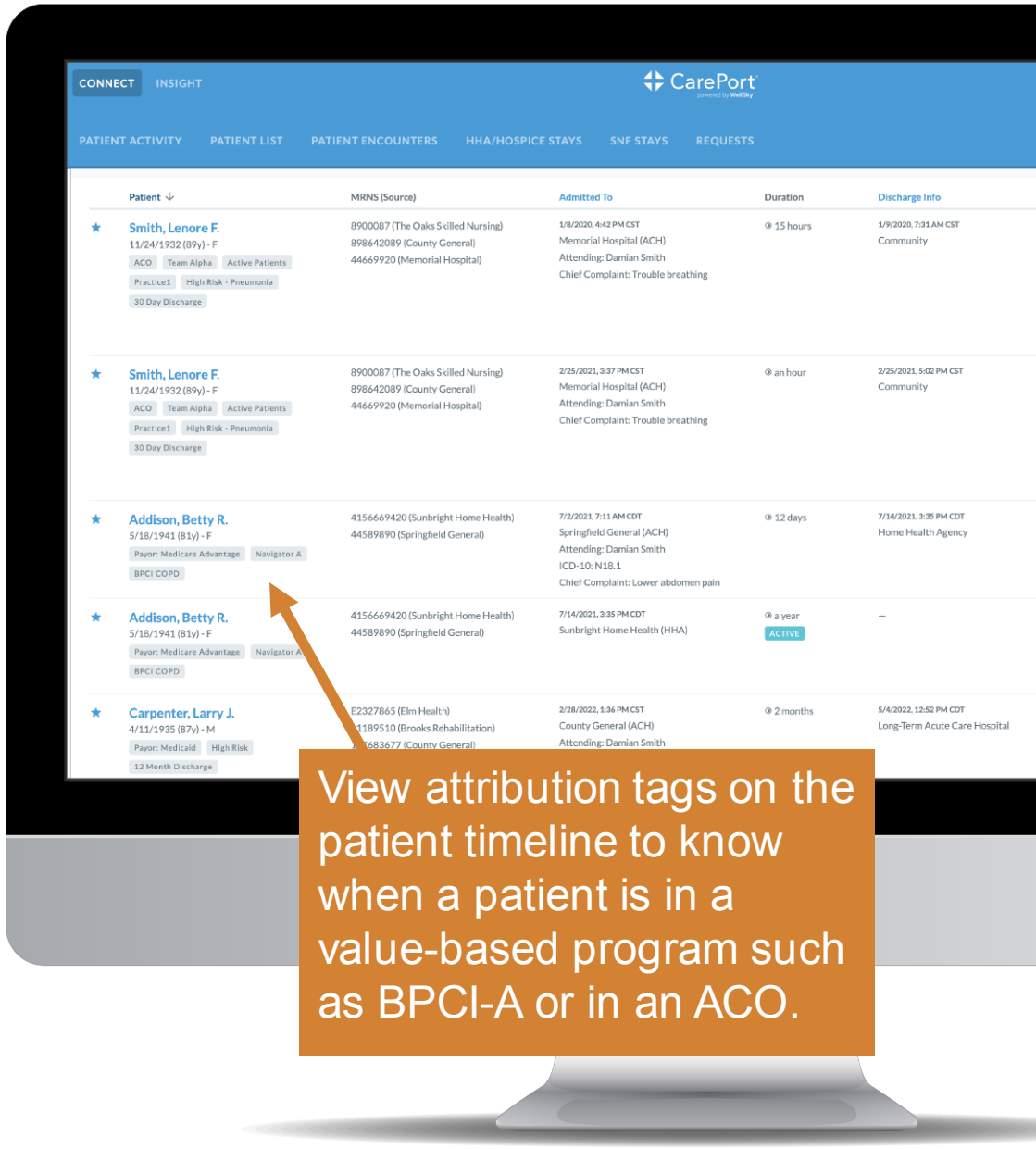
- Inadequate SNF scorecards
  - SNFs would track LOS, readmissions, and more in a spreadsheet that was submitted monthly
- Manual entry would mean typos, timeline delays, and no validation of metrics.

With Connect & Insight

- Patient-specific visibility across the continuum
- Improved communications with network partners
- Grew from 12 connected care buildings to 37.
- Ability to scorecard SNF facilities to compare to their SNF counterparts.

Attributions

- Attributions help staff quickly see relevant information about the patient and allow for effective cohering of patients so Navigators can search for their populations efficiently
  - **49 attribution types**
- 30-day discharges
- SNF Connected Care
- ACO
- ACO – Discharging Facility
- ACO – High-Risk Disease State
- CC High Risk
- BPCI (no longer in use)



Storytime

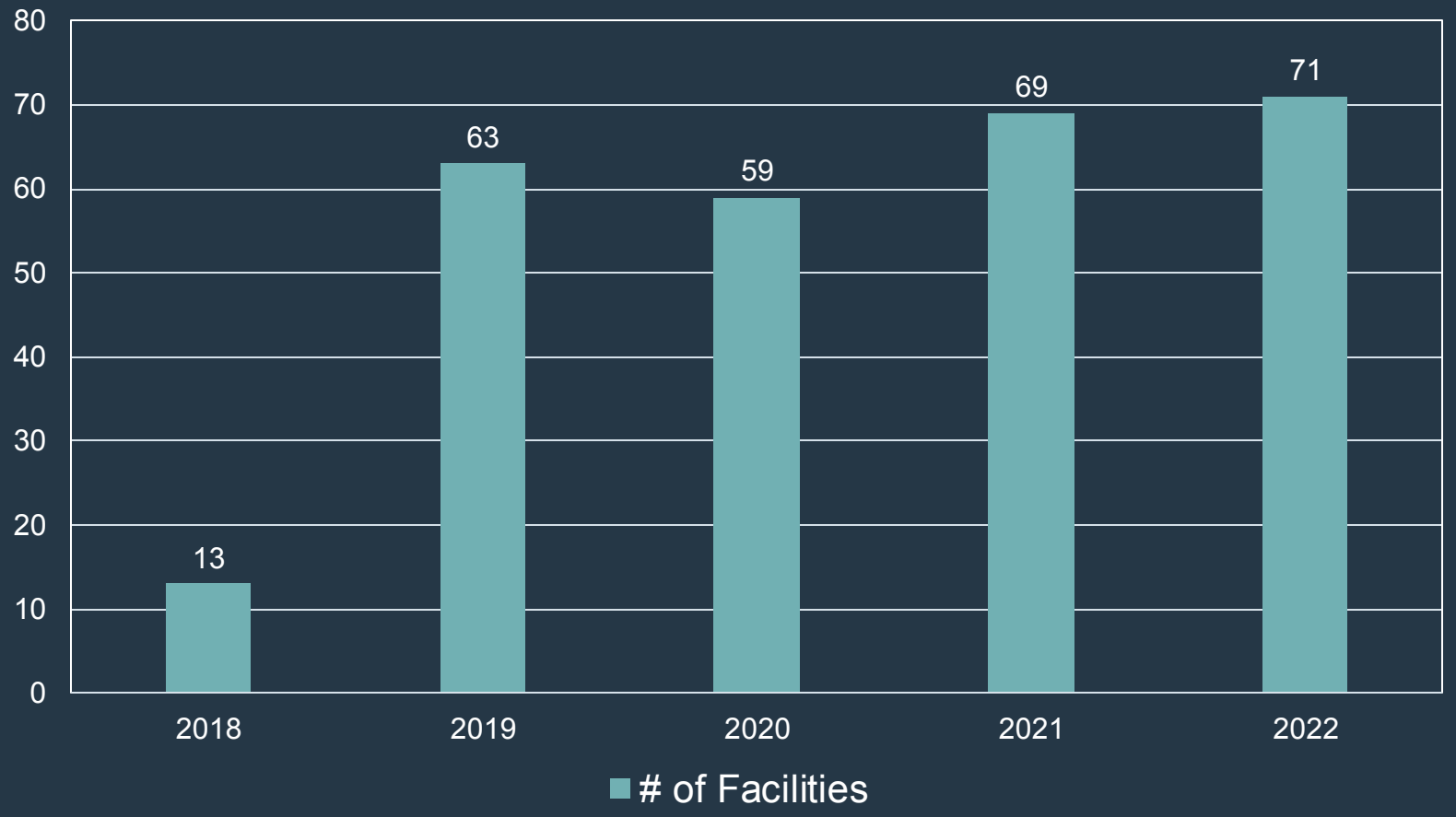
Post-acute care was known as the black hole… but no longer

How Cleveland Clinic gained visibility into their SNF ACO network

And how CarePort helped them get there

ACO SNFs by Contract Year

The network include 3 types of facilities: Waiver, Connected Care Units (CCU), and Quality Partners



Today, if a SNF wants to be part of the Cleveland Clinic's ACO Waiver Network or its SNF Connected Care Network, it is a requirement that they use CarePort Connect and CarePort Insight.

SNF Connected Care

Program Scope and Goal 2022

- Within network, CCU patients have lower percentage return to hospital than Non CCU patient. Capture rate in CCU (of total SNF placements) is averaging over 36%
- Goal: Continue to drive readmission rate to 20% advantage to general market.

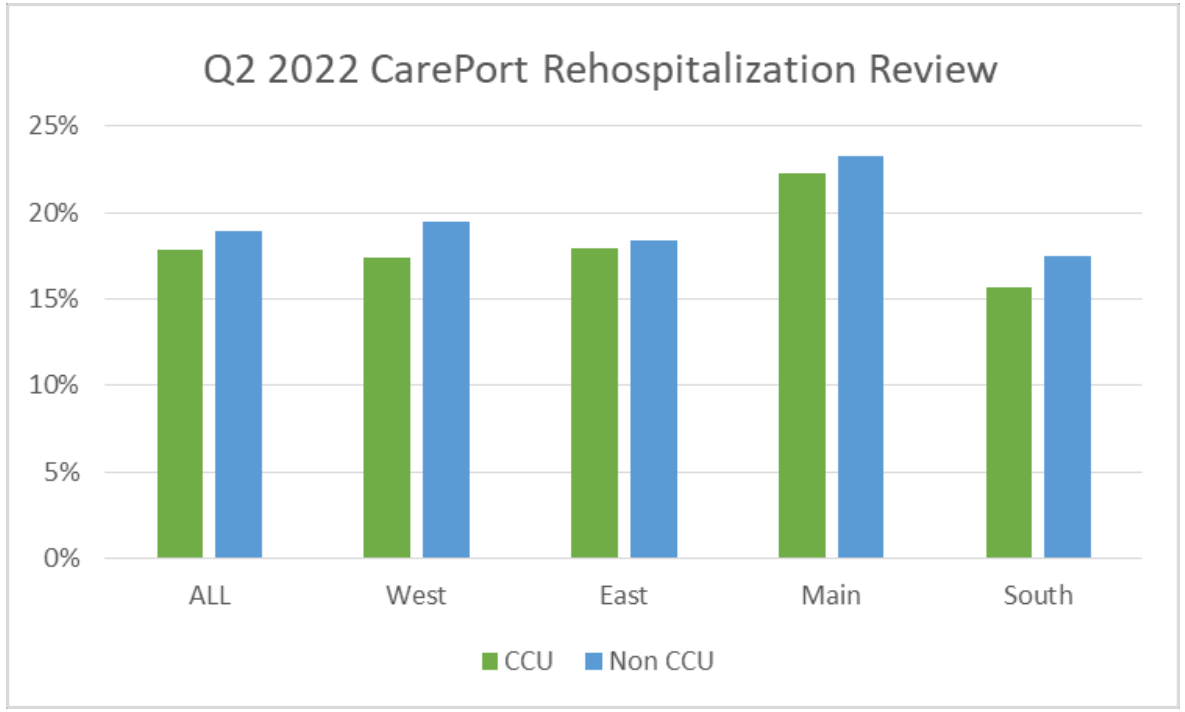
Challenges & Opportunities

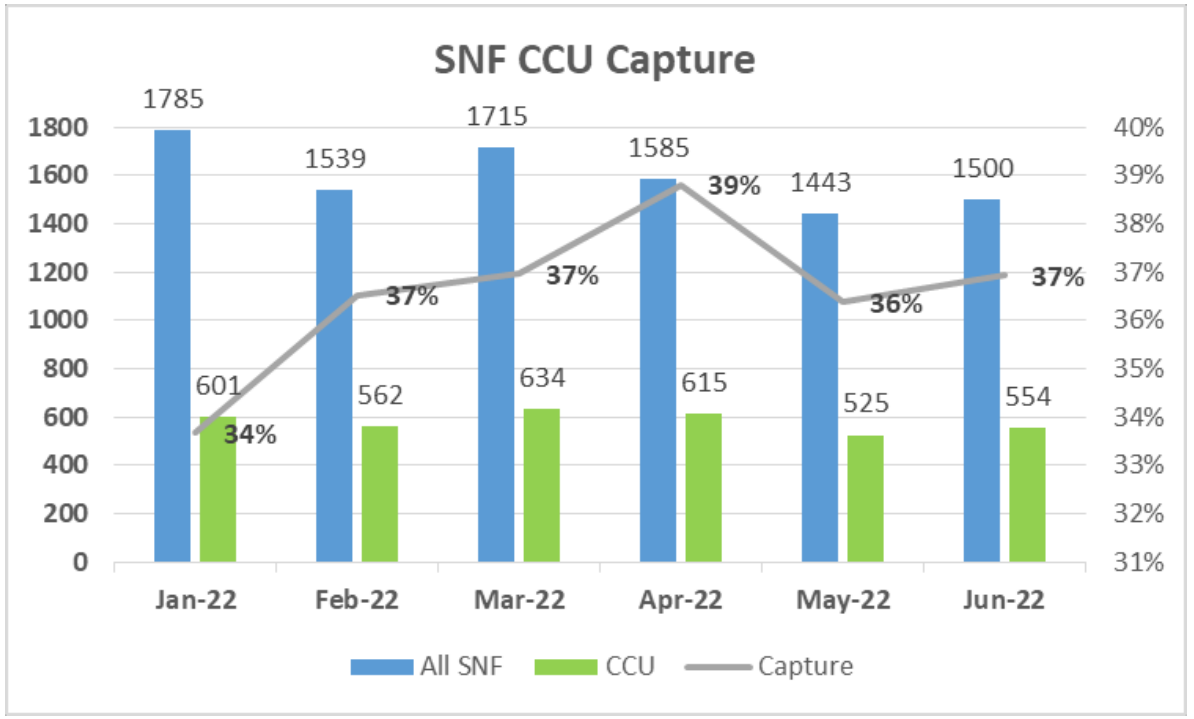
*Continue to grow capture (*incremental resources (10) needed for add'l capture-no hiring constraints)
*Continue to identify SNFs for network inclusion

Current Performance Measurement

*May **SNF CCU Readmission Rate 16%** vs. Ohio AVG 24%
*June **CCU Program Capture 37%**

Proposed Shared Goal/Strategy: 65% capture rate of all SNF discharges from participating hospitals





Meeting measures | Not meeting, improving | Not meeting, not improving

J F M A M J J A S O N D

Initiatives to Reduce Readmissions

Network expansion

- Total 37 in network currently

Improve Capture Rate in CCUs

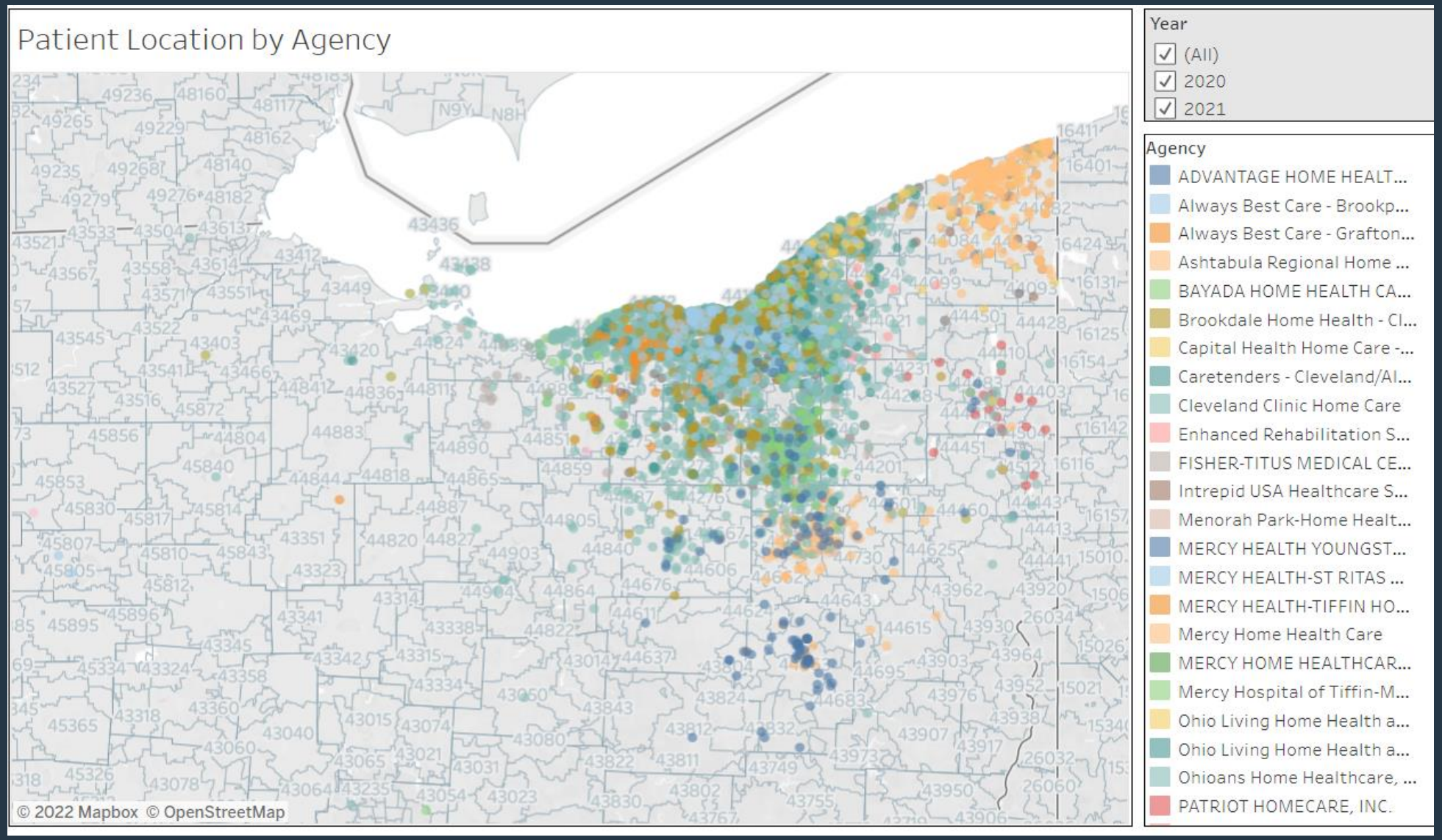
Countermeasures to Readmissions:

- Initial Visits within 48 hours of SNF placement
  - >90%
- Increased clinician oversight
  - Mean 3 visits/week
- Initiatives to Reduce Readmissions
  - Virtual Visit capability 24/7

Cleveland Clinic is

Meeting the moment: addressing the shift to home-based care

Geographic Reach of Network



Covers all or portions of the following counties:

- Ashland
- Ashtabula
- Columbiana
- Cuyahoga
- Erie
- Geauga
- Huron
- Lake
- Lorain
- Mahoning
- Medina
- Ottawa
- Portage
- Sandusky
- Stark
- Summit
- Trumbull
- Tuscarawas
- Wayne
- Beyond

Home Care Network Timeline

Q1 2022

- Create RFI
- Distribute RFI to potential agencies

April / May

- Review RFIs
- Engage analytics in understanding high performing, high volume HHAs
- Select HHAs to join network
- Invites out to HHAs

June

- Kickoff meeting with HHAs
- CarePort BAA completion with HHAs
- Finalize CarePort and data feed
- Finalize performance management structure for HHAs

July / August

- Receive completed agreements
- Begin formal network relationship
- Complete CarePort integration
- Education to hospitals, practices, SNF network

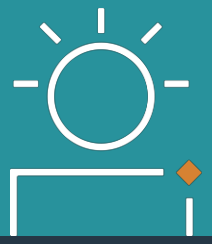
Network Goals and Expectations

ACO Home Care Network Participant Benefits

- Priority listing in CarePort Guide within our hospitals
- Opportunity to grow volume through increased referrals

- Enhanced bi-directional communication among inpatient, ambulatory, and post-acute care teams
- Opportunities to share best practices and lessons learned within network
- Educational opportunities

- Access to data around overall ACO performance and the impact you are having
- Data-sharing and more granular and real-time insights into performance



Improved transitions for patients across the continuum of care

Goals & Requirements of ACO Home Care Network

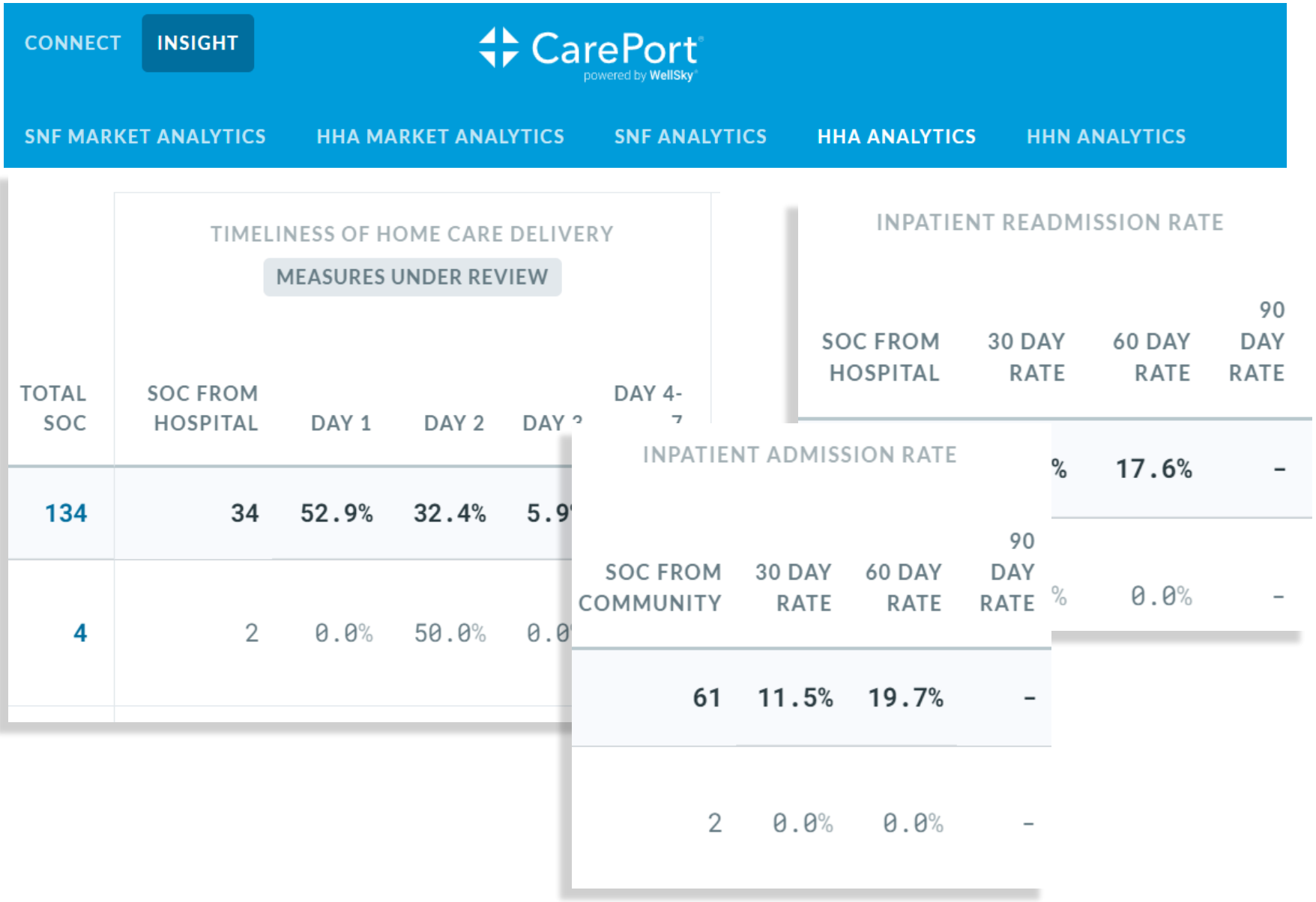
Network Goals

- Improve continuity of care for patients
- Reduce readmission rates
- Encourage appropriate length of stay (LOS) / recertification of patients
- Ensure timely Start of Care
- Accept complex and difficult to place patients
- Diffuse innovative care models (HC+) and standardize care paths

Network Requirements

- Compliance with MSSP rules and regulations
- Appropriate and timely responses to referrals
- Participation in quarterly Home Care Network meetings
- Maintenance of ≥ 3 star CMS rating
- Maintain updated and accurate CarePort Guide profile
- Provide and maintain capability to integrate with CarePort Connect and Insight

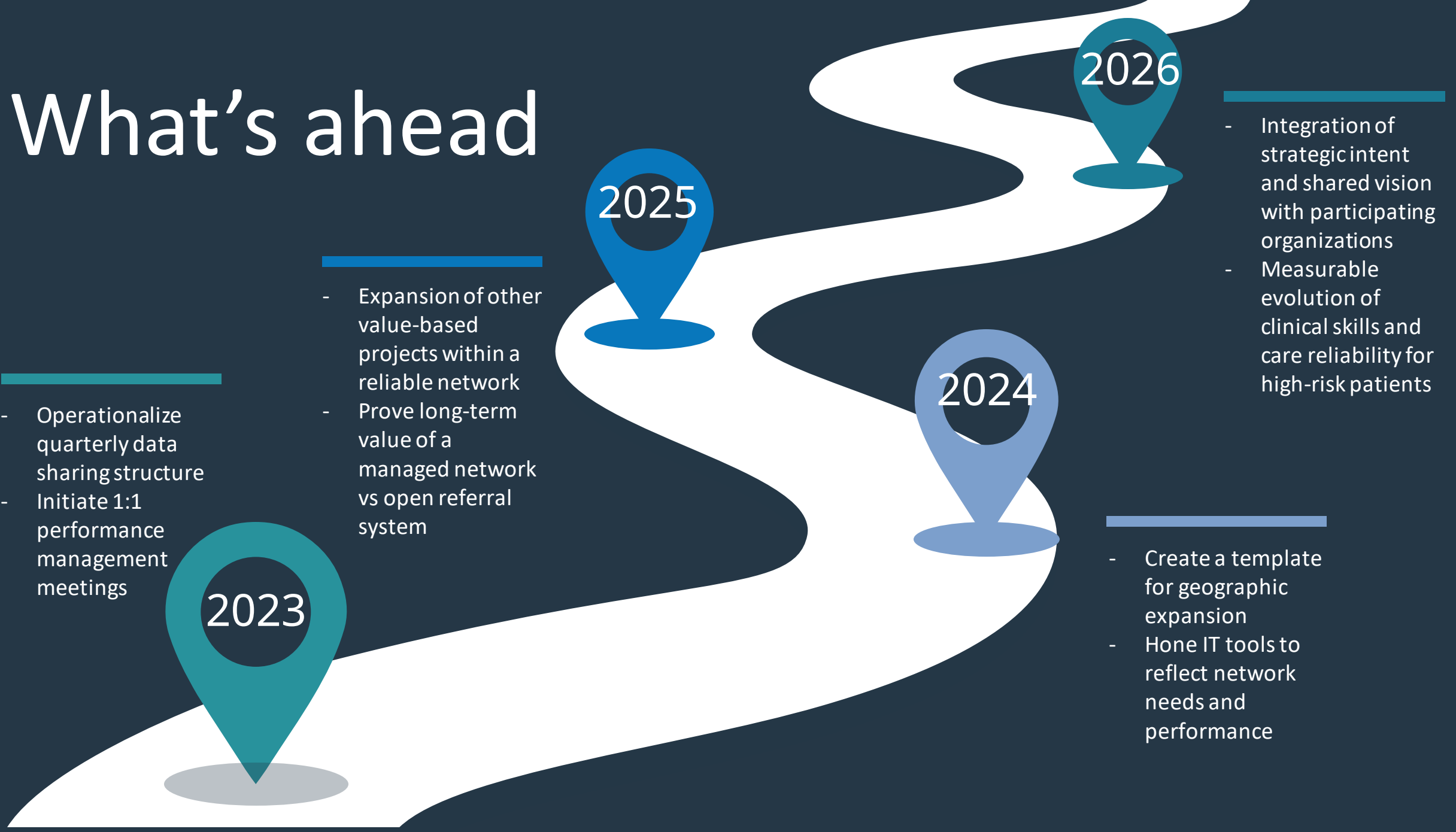
Data Sharing: A source of truth



- Timeliness to Care/ Start of Care
- Inpatient Admission Rate
  - 30, 60 and 90d
- Length of Stay (LOS)
- Payer Mix
- Total Costs of Care
- Inpatient Readmission Rate

Data Points We Care About

What’s ahead



- Integration of strategic intent and shared vision with participating organizations
- Measurable evolution of clinical skills and care reliability for high-risk patients

- Expansion of other value-based projects within a reliable network
- Prove long-term value of a managed network vs open referral system

- Create a template for geographic expansion
- Hone IT tools to reflect network needs and performance

- Operationalize quarterly data sharing structure
- Initiate 1:1 performance management meetings

Continued collaboration

What's important as we look ahead…

Closer connections across the continuum of care

- Partnership around hospital and SNF transitions
- Connections to ambulatory and home-based services

Chronic disease management

- Care paths and best practice

Improving end-of-life care

- Identification of hospice appropriate patients
- Linkage to palliative care, geriatrics

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Thank you.

Learn more about CarePort Connect & Insight

Request a consultation today!

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