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Managing Your Post-Acute Spend: The Cost of Doing Nothing

Presented by Real Time Medical Systems

Margie Latrella, APN-C, VP Clinical and Network Quality

Phyllis Wojtusik, RN, EVP, Health System Solutions

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Housekeeping

- Speakers will present for approximately 45 minutes
- Q&A will take the remainder of time
- You can submit written questions using the Questions tab on your dashboard to the right of your screen at any time during the webinar
- Webinar is being recorded
- Slides and recording will be available on the NAACOS website within 24 hours. You will receive an email when they are available

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Today's Speaker

Margaret (Margie) Latrella, APN-C

VP, Clinical and Network Quality
Real Time Medical Systems

Margie brings 30+ years working as an acute care RN and cardiac APN in both hospital and physician practices to Real Time. Previously, she applied her clinical experience to her administrative role at St. Joseph's Health, focusing on clinical programming, quality improvement interventions, and reporting for value-based programs. Margie demonstrated success in total cost of care savings in two-sided risk agreements, including MSSP ACO and CMS BPCI-A programs, by developing collaborative workflows and comprehensive care coordination necessary for success.

Phyllis Wojtusik, RN

Executive Vice President, Health System Solutions
Real Time Medical Systems

With over 35 years of health care experience in acute care, ambulatory care, and post-acute care, Phyllis has led the development of a preferred provider SNF network for PENN Medicine Lancaster General Health. In this network she developed and implemented strategies that reduced total cost of care and readmissions while improving quality measures and patient outcomes.

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Learning Objectives

- Understand the financial and clinical impact "*doing nothing*" has as it pertains to post-acute spend
- Improve transitions of care by ensuring patients go to the right care setting at the right time
- Implement data-driven strategies to meet quality scores and increase earned shared savings while improving quality of care

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The Cost of "Doing Nothing" with Post-Acute Partners

- Average cost of readmission: **$17,100**[1]
- Average Medicare spend per beneficiary: **$22,491.85**[2]
- Average 30-day readmission rate (SNF to Hospital): **23%**[3]
- Average cost of Skilled Nursing Facility (SNF) day: **$600/day**[3] **($400-$800)**
- Average SNF length-of-stay (LOS): **30 days**[3]

Example:

- ACO with 10,000 attributed lives, approximately 5% with a SNF stay
  - Medicare A cost: 500 patients x $600/day x 30-days = **$9M**
  - 23% (115 patients) readmitted back to hospital at average cost of $17,100/stay **= $1,966,500**
  - Medicare Part B costs in SNF and hospital

- **Cost for 500 patients approaches $11 – $12.5M**

1. Excel Medical: Hospital Readmissions Costs Medicare Millions Each Year
2. Hospital Compare October 2022
3. Real Time Medical Systems: https://realtimemed.com/how-health-plans-and-acos-can-pass-the-snf-test/

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Post-Acute Data Transparency

The Opportunity to Increase Quality and Decrease Total Cost of Care

- About $60 billion or 15% of annual Medicare spending is for post-acute care (PAC)[1]
- Medicare spend for skilled nursing facilities (SNFs) was $27.6 billion or 48% of PAC spend in 2019[1]
- Poorly coordinated care transitions from hospital to other care settings cost $12-$44 billion per year[2]
- Medicare beneficiaries will exceed 80M by 2040[3]
  - 80% will have 1 chronic condition, while 75% will have 2 chronic conditions[4]
  - 75% will require long-term care, while 40% will require SNF stays[4]
  - Access to PAC data improves care coordination to reduce readmissions, ensure appropriate LOS, leading to better patient outcomes and reduced cost

1. MedPac, 2021
2. Center for Health & Research Transformation
3. Administration on Aging. 2021 Profile of Older Americans. November 2022. Found on the internet at https://acl.gov/sites/default/files/Profile%20of%20OA/2021%20Profile%20of%20OA/2021ProfileOlderAmericans_508.pdf
4. Fact Sheet: Healthy Aging. National Council on Aging. (2016). Accessed at https://www.ncoa.org/article/get-the-facts-on-healthy-aging

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How to “Do Something” to Impact Post-Acute Spend

Patient Focus

- Prevent poor transitions of care
- Risk stratify SNF patients
- Prevent readmissions with live data
- Monitor LOS
- Monitor outcomes: readmissions/LOS/quality
- Improve patient satisfaction

Post-Acute Data Transparency is Essential

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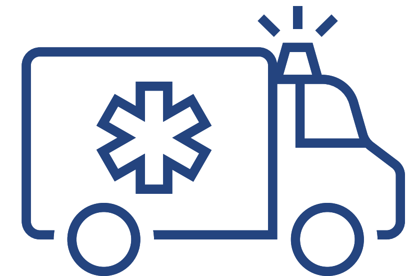
Transitions of Care, Why so Costly?

$12 – $44B spent on poor transitions of acute care Medicare patients per year*

- Patients are at ***highest risk*** of readmission around care transitions
  - Little to no handoff
  - Overwhelming amount of unorganized information sent to receiving facility
  - Patients may arrive in less than an ideal physiological state – pain, unstable vital signs
  - Receiving facility may not have equipment, medications or other necessary items to care for patient properly
  - Medication reconciliation a major issue – high risk meds – A/C's, antibiotics, insulin, and antidiabetic agents



* Center for Health & Research Transformation

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Improve Transitions with Post-Acute Data Transparency

Acute to Sub-Acute

- Monitor transition process – standardize and reassess as needed
- Ensure accurate transfer of orders from acute to post-acute (meds and other orders)
- Monitor for readmission trends:
  - Occurring within 72-hours of transfer
  - Among patients with same diagnosis
  - Coming from the same location/unit

Sub-Acute to Home

- Attend UR calls and use data to ensure appropriate LOS (monitor functional status)
- Work with SNF Social Worker (SW) to prepare for patient’s transition back to community – arrange for needs at home (VNS/PT)

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Risk Stratify Patients – Increase Efficiency Amid Labor Force Issues

- Risk stratification – prioritizes cases/care
- Include history (comorbid conditions), changes in condition, transition of care timing/errors, and readmission history in risk score
- Focus on highest risk patients with clinical changes first – highest risk for readmission
- Rounding providers target right patients to see; ability to see additional patients
- Live data facilitates mandatory SNF reporting without burden
- Manual reporting processes no longer necessary
- Staff with increased time to care for patients

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How to "Do Something" to Impact Post-Acute Spend

Network Focus

- Create a High Performing Post-Acute Network (PAN)
- Implement clinical pathways
- Monitor SNF performance to re-evaluate and adjust High Performing PAN
- Dedicate staff specifically for your ACO/value-based populations
  - PAC Navigator to monitor data and intervene in care when needed
  - Social Worker to drive patients to your High Performing Network
  - Case Manager for smooth transition of care for patients going home or for home needs following SNF discharge

Post-Acute Data Transparency is Essential

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Post-Acute Networks (PAN)

- Developed by Acute Care Entities (hospitals), ACOs, and value-based programs to manage quality and performance of the post-acute continuum
- Can include SNFs, IRFs, LTACHs, and Home Health
- Range from loose agreement to work together to strict readmission, LOS, and quality metrics
- Strategies include:
  - Case Management – clinical management, care coordination
  - Strategize with your PAN to identify conditions/issues for treat in place
  - Clinical Pathways – standardized care processes
  - Transition of care management
  - Annual/bi-annual performance review
  - Shared goals!

48% of all Post-Acute Care Costs are from SNFs*

*MedPac, 2021

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Strategies Surrounding High Performing SNF PAN Development

- Understanding SNF incentives:
  - Margins are razor thin
  - Value-based care is not the norm
  - Volume is essential to survival
  - Longer LOS = continued reimbursement
  - Patient Driven Payment Model (PDPM)
- Truly partner with your PAN
  - Understand their challenges and barriers
  - Work together to overcome those barriers for the patients' benefit
  - Be willing to evaluate your processes and improve them for the benefit of the patient
  - Intentional measurement of ***process*** and ***outcomes***
  - Share those results routinely and work together to improve them

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Dedicated ACO/Value-based Staff

Success in care transitions and improved quality of care

- **PAC Navigator**
  - Warm hand-off from acute care, med/order rec, accurate transition
  - Establish ELOS, monitor progress and anticipate possible changes to date – manage LOS
  - Monitor clinical data/alerts, high-risk first, intervene to prevent ED visits/ readmissions
  - Ensure smooth transition home
- **Social Worker**
  - Meet with pt./family as soon as D/C plan is SNF
  - Present SNF list to patient, highlight High Performing Network, encourage transfer to one (however-patient always has the choice of PAC facility)
  - Arrange for transfer as soon as patient is ready, anticipate D/C date, s/w physician to coordinate
- **Care Manager**
  - Discharge planning for patients going home, VNS/PT/HHA community referrals
  - Assist as needed with transfers from SNF to home, community referrals that were missed

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Create a High Performing SNF Network

- **Analyze your discharges to SNFs**
  - Case-types
  - Volume by facility and case-type
  - Performance metrics
- **Identify high performers**
  - Readmission rates
  - ALOS
  - Patient satisfaction
  - 5-Star Rating
- **Invite high performers to participate in network activities**
  - Identify network goals
  - Case reviews on readmissions
  - Clinical standards deployment
  - Educational activities

SNF Patient Data Transparency = *Interventional* Analytics

- Early ID of clinical changes and keywords lead to rapid clinical interventions
  - Prevents further clinical decompensation
  - Improves quality of care and patient outcomes
  - Reduces readmission
- Patient monitoring to ensure appropriate LOS and discharge needs to transition back to the community
  - Functional Status
  - Skilled Nursing Needs
  - Follow-up Care – MD appointment

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SNF Buy-In Benefits of Achieving Appropriate LOS Goals

- Attractive to Health System – get invited to high performing networks – receive increased referrals = **VOLUME!**
- Improve patient outcomes
- Improve quality of life for patient – less time away from home
- Improve patient satisfaction – increased patient referrals
- Improve Star Ratings
- Reduced manual reporting
- PDPM Reimbursement at higher rate for a new complex patient – keep acuity high
- Potential shared savings opportunity for SNF
- Lower PAC spend – increases $ towards shared savings

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Identify Quality and Performance Metrics

- Readmission and LOS targets – always!
- PCP appointments post discharge
- Readmissions 30-day post SNF discharge
- Adherence to clinical pathways or standards
- Utilization of High Performing Network
- Health care acquired infections
- Successful discharges to community
- ED utilization rates

Manage this by monitoring monthly data and sharing performance at network meetings

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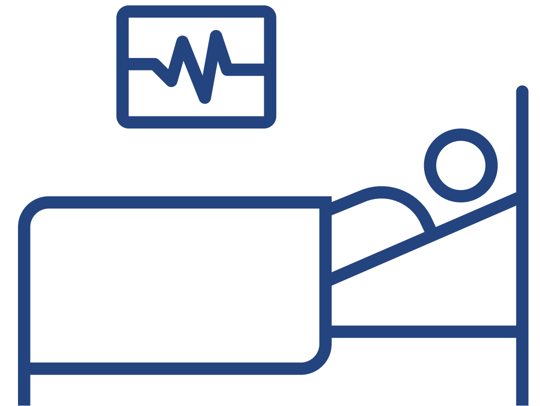
Implement Clinical Pathways

- Standard of care for your population based on disease management principles
- Meet with SNF Medical Directors to get buy-in, drive clinical adoption, and identify outstanding issues
- Measurement of outcomes
- Ensure smooth transitions of care
- Return patient to primary care for ongoing management
- Reinforce patient education



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Identifying Case Types for Clinical Pathways

- High Volume
- High Risk with Moderate Volume
- Can’t have a Clinical Pathway for every condition
  - Clinical protocols on routine management – Diabetes
- Top 5 Case Types
  - CHF
  - Sepsis
  - Pulmonary – Pneumonia/COPD exacerbation
  - Fractures – hip
  - CVA

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Create Collaborative SNF Relationships

- Monthly/Quarterly Network meetings to share unblinded data
- Improved communication – essential to better serve patient
- Supportive, collaborative relationships between SNFs
- Shared best practices for identified issues
- Safe networking venue for the SNFs
- Shared responsibility for patient between Health System and SNF

Keep communications open – discuss ELOS, barriers to discharge, ways hospital/ACO can assist SNF

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Live PAC Data to Optimize Your Network

- Up to the moment network performance
  - Intervene with poor network performers early
  - Continual assessment of performance
- Ability to quickly deploy network clinical strategies based on patient outcomes
- Network partners view the same data at the same time
  - No fighting over which data is right or better
- Utilize high performers to share best practices to improve group performance

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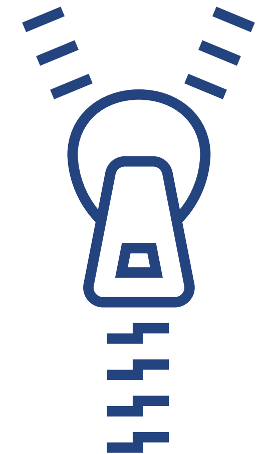
Close Quality Gaps

- Advanced Care Planning – patient identification
- Pull data based-upon demographics, SDOH for ACO REACH reporting
- Transition back to PCP
- Vaccination data
- HEDIS data
- Identify specific case-type quality measures and monitor



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The Value of "Doing Something"

A Health System Success Story

St. Joseph's Health System Value-Based Programs

- Small MSSP ACO – 5,000 attributed lives
- BPCI-A – 4 service lines

Year 1 Results

- $1.6 million savings in post-acute network
- Reduced readmissions – 24% to 17.8%
- Increased referrals to High Performing Network from 57% to 82%
- Improved care transitions
- Strengthened network relationships

Awarded the NAACOS Leaders in Quality Excellence Award, Spring 2022

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Wrap Up

Post-Acute Data Transparency – The Key to Successful Population Management both Clinically and Financially

- Improved quality of care and quality gap closures
- Reduced readmissions
- Appropriate SNF LOS
- Shared accountability for patient success during healthcare journey
- Increased provider/staff efficiency during labor shortages
- Increased SNF reimbursement accuracy
- Increased shared savings on VBC contracts

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Questions? Let's Discuss!

Margaret Latrella, APN-C
VP, Clinical and Network Quality
Real Time Medical Systems
mlatrella@realtimemed.com | 201.321.1855

Phyllis Wojtusik, RN
EVP, Health System Solutions
Real Time Medical Systems
pwojtusik@realtimemed.com | 443.859.7120

Real Time Medical Systems is the KLAS Rated, HITRUST-Certified Interventional Analytics solution that turns post-acute EHR data into actionable insights.

Serving healthcare organizations nationwide, Real Time improves value-based outcomes by reducing hospital admissions, accurately managing reimbursements, detecting early signs of infectious disease, and advancing care coordination through post-acute data transparency.

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