Close the Gap on Post-Acute Care Performance and Payment with Live Data

Presented By:

Steven M Stein MD, *Chief Medical Officer* – **Real Time Medical Systems**

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We are a network of health care professionals addressing the challenges posed by the emerging landscape of value-based care and government health care reform.

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Our mission is to provide a community for like-minded professionals to come together for networking, education, and industry collaboration to stay ahead and advance their careers.

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THREE COMMUNITIES

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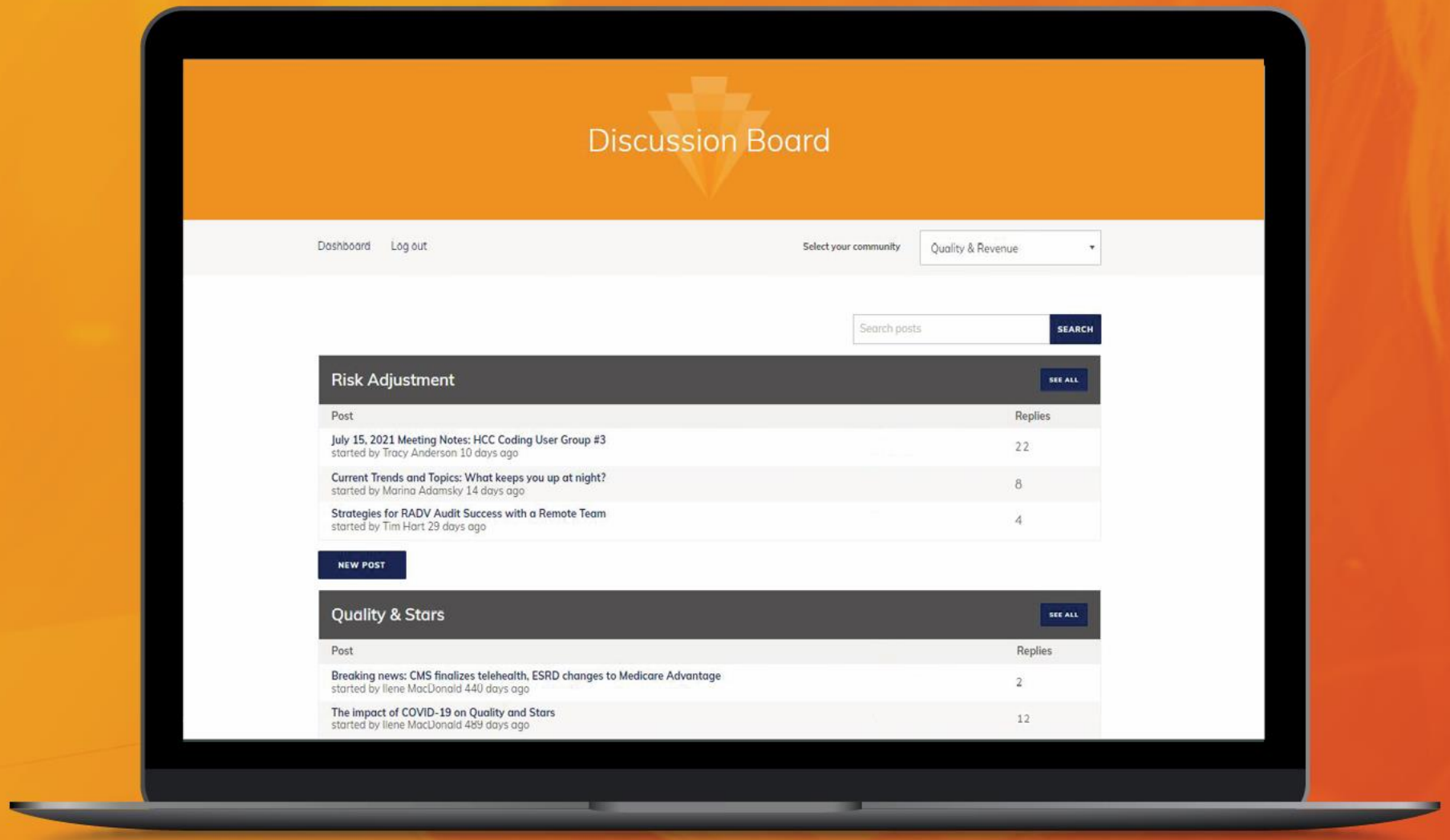

ASK YOUR QUESTIONS IN OUR DISCUSSION BOARD

Introduction

Dr. Steven Stein

Chief Medical Officer
Real Time Medical Systems

Dr. Steven Stein's vast knowledge of the post-acute market guides the clinical advancements of Real Time's Interventional Analytics platform. Previously, Dr. Stein held Chief Medical Officer positions at both Trinity Health Continuing Care and UnitedHealthcare, leveraging his expertise in population health, managed care, and high-risk patient program development to improve care outcomes. Board-certified in internal medicine and geriatrics, Dr. Stein also proudly served on the White House Council on Aging for both the Clinton and Obama administrations.

Today's Objectives

- Learn to build and strengthen preferred Post-Acute Care (PAC) partnerships to incentivize value-based performance and increase member satisfaction
- Understand how data transparency enhances clinical line of sight and drives performance at the member and network level
- Enhance critical transitions of care and patient-centered discharge planning by incorporating live post-acute data into your daily workflow

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Incentivize Value-Based Performance and Increase Member Satisfaction

Build and strengthen preferred post-acute care partnerships

Audience Poll Question

Have you established any financial incentives/penalties for SNFs in your preferred network related to their readmission rate?

- ❑ Yes
- ❑ No
- ❑ Planning to in the next 6 months
- ❑ Considering for the future

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Value-Based Payment Already Impacting SNFs

- Patient Driven Payment Model (PDPM) for SNFs (icd-10 based)
- Readmission Penalties for SNFs (2% reduction in revenue for subsequent year)
- Institutional Special Needs Plan
  - Provider-owned vs. Health Plan-owned
- Increasing Medicare Advantage penetration
- Medicare FFS and Commercial Payer Accountable Care Organizations
- Direct Contracting Entities (DCE)
- Bundle Payment Care Improvement Advanced (BPCI-A)
- Medicaid Managed Care
- Dual-Eligible Demonstrations
- FFS Medicaid Payments Impacted by State-Defined Quality Measures

Incentives for In-Network SNFs

- Keep it simple: one or two measures max
- Consider *unintended consequences* of measure
  - ALOS incentive should always be married to 30-day readmit rate
  - Include ER visits and 30 day readmits cost in average cost of SNF stay
  - Risk-adjusted incentives vs. “observed”
- Clearly define metrics at the beginning of each contract year
  - Revise yearly to focus SNFs on greatest opportunity for improvement
  - Create incentives focused on
    - Incremental improvement
    - Reaching best in class outcomes

Choose the SNF with the Shorter ALOS?

- Patient #1 readmitted to hospital from SNF A on Day 15 of SNF stay:
  - Average SNF cost per day was $500 for a SNF A cost per stay of $7500
  - IP cost of readmission was $13,700
  - Actual cost of SNF A stay was $21,200 or $1,413 per SNF day
- Patient #2 had a SNF B stay of 30 days before going home, no readmission:
  - Avg SNF B cost per day was $550 per day
  - Actual B cost per stay was $16,500

Choose the SNF with the Shorter ALOS?

- Patient #3 was admitted to SNF C and stayed for 15 days without a readmission during the SNF stay:
  - On day 2 *after arriving home* from SNF C, patient #3 was readmitted
  - Cost of SNF C stay at $7500 ($500 per day) and cost of IP stay at $13,700
  - Actual Cost of SNF stay for Patient #3 was $21,200

- Patient #4 was admitted to SNF D and stayed for 20 days without a readmission during the SNF stay:
  - Patient #4 remained safely at home without a readmission
  - Cost of SNF C stay was $10,000 ($500 per day)
  - Actual cost of SNF D stay for Patient #4 was $10,000

Audience Poll Question

How do you monitor adherence of clinical pathways for common diagnoses with SNFs?

- ❑ By phone or email
- ❑ In scheduled meetings
- ❑ Post-acute EHR access
- ❑ We don’t monitor clinical pathways with SNFs

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Successful Post-Acute Network Relationships

Remotely direct and manage care in post-acute settings

1. Establish preferred physician group in each SNF
2. Establish evidence-based clinical pathways that are woven into the workflow of SNF clinical staff and physician group
3. Monitor adherence to agreed upon pathways
4. Invest in education of frontline staff at high volume SNFs

Set Clearly Defined Expectations

- Establish criteria for next level of care
- Communicate expected length of stay to patients/family ***and*** post-acute providers
  - Consider written patient education document at discharge from IP or admission to SNF that includes expectations on the SNF experience and the length of stay

Enhance Clinical Line Of Sight to Drive Performance at the Member & Network Levels

With data transparency

Audience Poll Question

What type of data do you use to measure the success of the SNFs in your network?

- ❑ Claims
- ❑ MDS
- ❑ Unencumbered EHR access
- ❑ Self-reported

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Post-Acute Measurement

Develop regular interactions with senior management of PAC partners

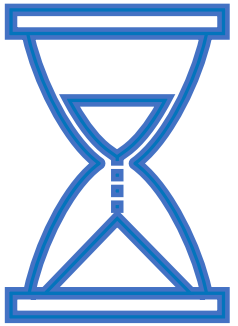
- Schedule routine meetings with clear agenda and specific action items
- Build “metrics-driven” discussions
- Identify member-specific opportunities for improvement
- Foster collaboration among PAC partners (and even among payers) to hardwire care

Why is Access to Live, Meaningful SNF Data Essential?

- SNF staffing issues
- Unsophisticated SNF EMR:
  - Rising risk members not identified despite changes in condition
  - Subtle changes in condition unattended to in a timely way
  - Difficult to impact LOS if left to traditional weekly UM reviews
- Monthly or quarterly meetings with SNFs on readmissions and LOS limited in efficacy if looking at old info:
  - earlier opportunities to prevent readmits
  - transition patients to home or to non-skilled area of SNF

Claims and MDS Too Old and Too Generic to Nimbly Move SNFs In and Out of Preferred Network

- Minimum Data Set (MDS) = months-old, payment-driven data
  - Assessment tool completed by an administrative nurse
  - Information is limited
  - Performance is reimbursement-driven
  - Old data
    - The initial MDS is not available for review until 15 or more days into the SNF stay
    - Lag time for MDS outcomes is most often 3 months after the date of service



Why is Data Recency Important?

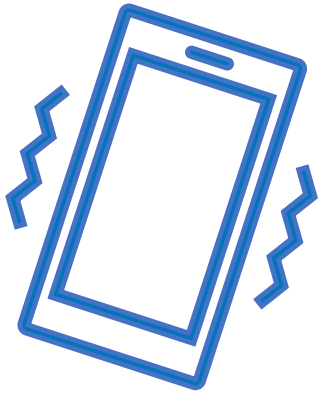
- Claims data and MDS information limited to pre-determined fields
- Ability to identify highest risk members
- Ability to conduct root cause analysis of readmissions
- Supports prioritization of advance care planning discussions
- Admission denials: high acuity of member vs. no beds
- Infection surveillance

Timely & Actionable Insights

- **Case Managers** should be alerted to subtle changes in condition as they occur, to prevent hospitalization;
  Examples include
  - CHF patient with 5-pound weight gain
  - Stroke patient with new cough and a low-grade fever
  - Frequent loose bowel movements a couple of weeks after treated with antibiotics
- **Utilization Management** (UM) nurses should be alerted when medical condition and functional status appears to make home a safe setting

Importance of Live Alerts for SNF Attending Physicians, NPs & PAs

- Rounding by attendings in SNFs with much variation
- Highlight high-risk members for Physicians/NPs/PAs
- Stay connected when the attending is offsite
- Ensure attending physicians have instant access to alerts



How Your Evidence-Based Protocols Can Be Part of SNF's Workflow and Not Just Gain Dust on a Shelf

- Customize content of alerts
- Mandate alert interventions be tailored to evidence-based protocols

Enhance Critical Transitions of Care and Patient-Centered Discharge Planning

Incorporate live post-acute data into your daily workflow

Audience Poll Question

Do you work closely with your SNFs on discharge planning for each transition?

- ❑ Yes
- ❑ No
- ❑ Sometimes

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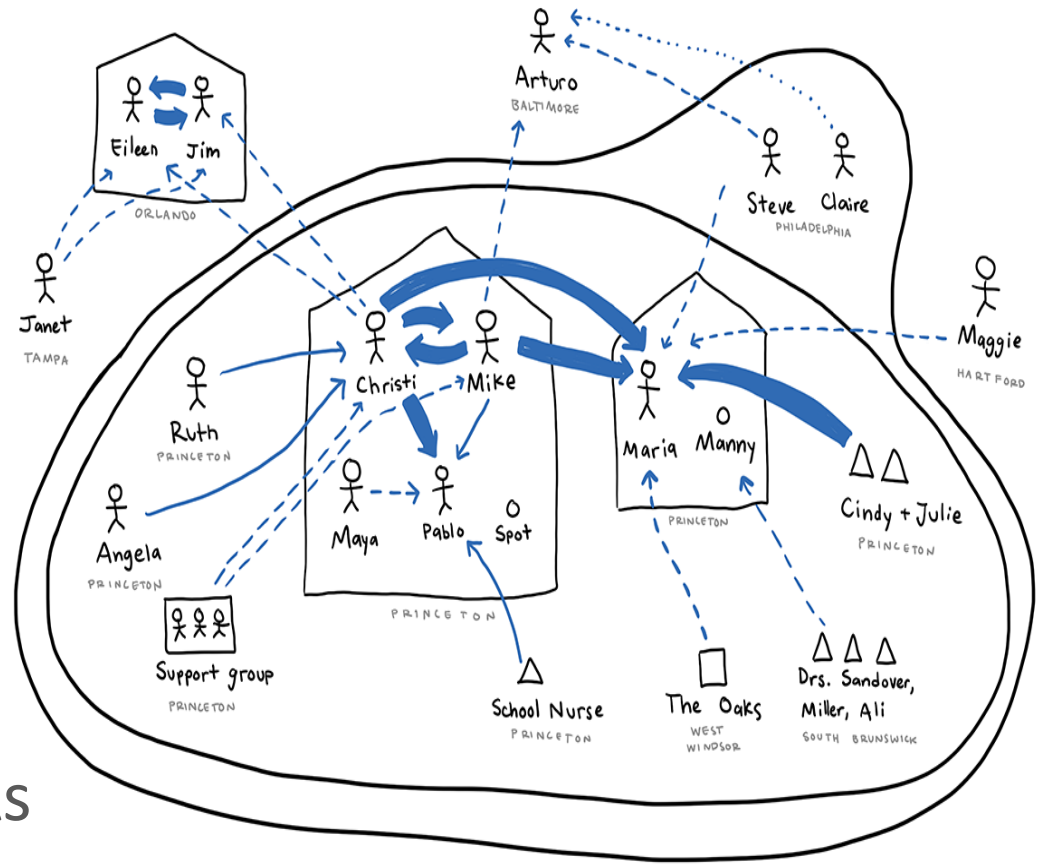
Specific Live Data Supports Proactive Discharge Planning

- Medical acuity
- Align member discharge goals with advanced care planning discussions
- Functional status
- Caregiver support
- Social Determinants of Health (SDoH)
- Use of high performing *in network* HHAs
- Align DC meds with patient's Part D coverage
- Geographically close *in network* community providers

Set Expectations for Each SNF Provider in Discharge Planning

- Care Mapping:
  - Identify caregiver support risk
  - Minimize non-value added post-SNF costs



- Choose high performing, in-network HHAs
- Leverage no cost resources from local community agencies

Set Expectations for Each Provider in Discharge Planning (cont'd)

- SNF ensures meds are covered under Part D plan
- SNF clarifies with member/caregiver how member will get meds
- SNF sets community-based appointments within days of DC
- PCP prioritizes timing of first appointment
- SNF supports required transitional care code documentation
- Distribute immediate discharge summary
- SNF forwards POLST (or advance directive) to plan, PCP, key community-based specialists, referring hospital, and HHA

Define Expectations in Proactive Discharge Plan *Implementation*

- HHA 1st visit is same or next day of SNF DC
- Confirm essential medical equipment arrived, meds obtained, PCP appointment made
- Get patient to 1st PCP and specialist appointment
- Work with member/caregiver on medication reconciliation
- Support HHA in filling of HEDIS measure gaps
- Monitor HHA number of episodes and episodes/LUPA ratio

Use Case

of a Managed Care Organization

Use Case: The Effect of Live Post-Acute Data

The Background

World-class health system in the New York/ New Jersey tri-state area

MSSP ACO participating in 4 BPCI-A Service Lines

5,000 ACO attributed lives

Use Case: The Effect of Live Post-Acute Data

Post-Acute Network Challenges

- No insight as to what was happening with patients transferred into post-acute care
- Readmissions data was captured on lists and spreadsheets
- Unable to identify development of potential trends
- Unable to see changing clinical conditions or when patient diagnoses were being made
- Inability to accurately determine which patients were at highest risk
- Not possible to intervene prior to a readmission

"We had no ability to start the conversation with our post-acute partners without access to data on what was happening to our patients right now."

- Helen Ali, Manager of Clinical Transformation, St. Joseph's Health,

Use Case: The Effect of Live Post-Acute Data

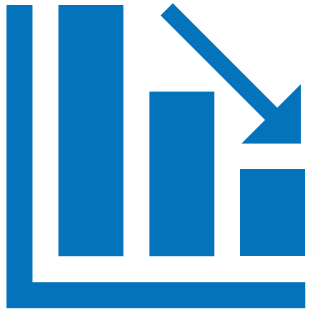
The Solution

- Access live data from the post-acute EHR 365/24/7
- Monitor patient care post-discharge
- Immediately identify at-risk patients
- Collaboratively work with post-acute clinical team to intervene in care
- Deploy clinical standards in both acute and post-acute settings
- Analyze performance of post-acute providers to focus network on high-quality, low cost SNFs

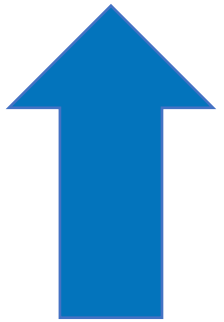
Use Case: The Effect of Live Post-Acute Data

Results *(after first year)*

Achieved Post-Acute Cost Savings of $1.6M



Reduced Readmissions from 24% to 17.8%



Increased Network Referral Compliance by 43%

QUESTIONS?

THANK YOU

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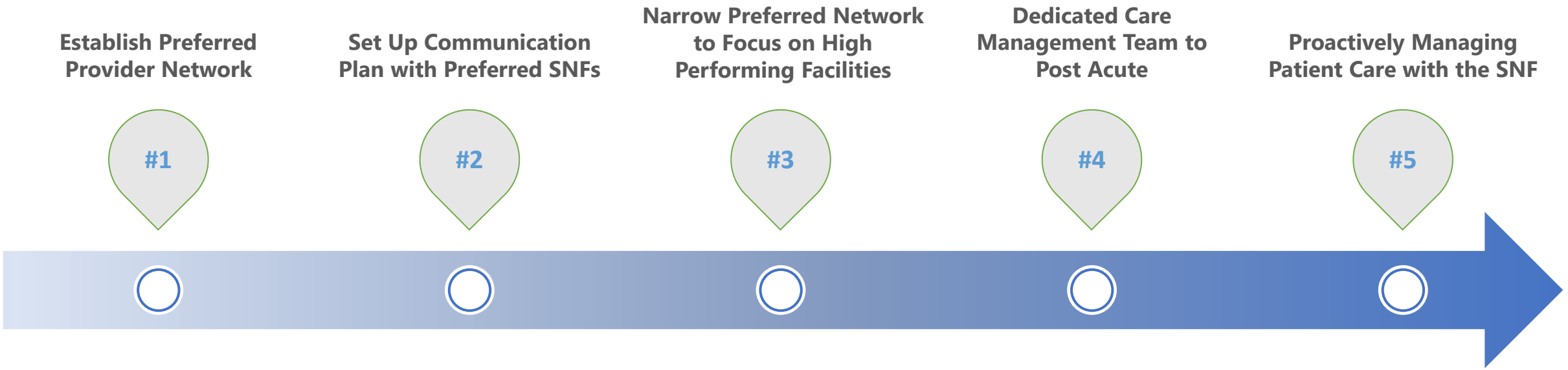
Real Time Medical Systems *is the industry-leading Interventional Analytics platform that provides Health Plans and Payers with post-acute interoperability. The cloud-based solution improves member outcomes by offering live post-acute data transparency that reduces rehospitalizations 52%, decreases length-of-stay 43%, establishes centralized infection surveillance, and risk stratifies members in the PAC-setting.* ***www.realtimemed.com***

In Summary…

Establishing & Maintaining a Preferred SNF Network



- Use Claims Data to understand where patients are going today and leverage large network of data share agreements to determine high performing facilities

- Strengthen your communication efforts with your preferred network by using consistent and timely data

- Leverage live analytics to better understand which facilities are your high performing
- Use data to run root cause analysis on readmissions to improve performance at Hospital / SNF

- Drive efficiencies for your care management team (staffed or outsourced) by giving them a live stream of data from the SNFs network

- With live data and a team dedicated to managing the care of SNF patients
- VBC entities have the strongest ability to impact care across the continuum and reduce total cost of care

Utilizing Data Transparency to Manage Patients