OPTIMIZING POST-ACUTE CARE PATHWAYS: THE NEW ORDER FOR VALUE-DRIVEN CARE
Value-driven post-acute care manages the post-acute process from end-to-end. It moves beyond a one-size-fits-all approach and instead, manages the complex differences among individual patients.
Meet Jim Smith (age 84). Jim has a history of Parkinson’s and mild dementia. Due to his age and increasing seriousness of his dementia, Jim’s self-care has deteriorated over the past several years. He developed a fever and became very confused. His wife immediately called 911 for an ambulance. Jim was treated at the Emergency Department where it was discovered he had left a Urinary Tract Infection untreated. Jim was admitted to the hospital and IV antibiotics were administered.

After being hospitalized for a few days, Jim was eager to be discharged. Karen, the hospital discharge planner, arranged for Jim’s post-acute care (PAC) at a nearby Skilled Nursing Facility (SNF). Karen sends patients there because it’s easy, habitual, and the SNF is local.

After spending 24 days in SNF, it was time for Jim to go home. His care plan included physical therapy and follow-up visits with his physician. Unfortunately, Jim’s caregiver, his wife, was overwhelmed and unable to get him to follow-up visits. Jim became dehydrated, lethargic, and confused. As a result, he was sent back to the hospital, a traumatic experience for Jim and a costly case for the health plan.

This scenario plays out in hospitals millions of times each year. At each point of transition, Jim, his wife and his team made decisions that impacted his care, its cost, and how effectively he may heal. Jim’s “path home” began to look more like a maze.

What can health plans, providers, and patients do differently to get on the right path home?

**Optimized post-acute care – The final frontier for value-based savings**

PAC accounts for an estimated 20 - 25 percent of total spend in Medicare Advantage plans. For certain conditions, such as chronic obstructive pulmonary disease (COPD) or congestive heart failure, PAC may account for up to 70 percent of total costs. As a result, PAC is a growing area of focus in the industry.

To optimize PAC, we must leverage a host of synergies across the care continuum— home-based care, care coordination, patient coaching, communication technology, medication management, and data analytics. The goal of PAC integration is to increase quality and control costs by addressing individual patient needs. It requires unprecedented insight.
and assimilation: medical condition, medical history, demographics, home resources, provider network, and more. Value-driven advances in information technology, evidence-based medicine, quality standards, and cost transparency are now bringing integration and optimization to PAC. Value-driven PAC manages the post-acute process from end-to-end. It moves beyond a one-size-fits-all approach and instead, manages the complex differences among individual patients.

**A hundred patient pathways to home**

Patients with multiple conditions and complex care needs frequently receive care in multiple settings. Every PAC journey is characterized by transitions – from hospital to a SNF, or to inpatient rehab (IRF), or to long-term acute care hospital (LTCH). Some patients might be able to go straight home, but can benefit from working with a care coordinator, and home health services. Others return home without home health services to a normal home life. At each decision point, the “path” splits, and potential risk increases for adverse patient outcomes, such as an avoidable hospital readmission.

A seminal study found that 30 percent of patients had more than one transfer (18 percent included two transfers, 8.5 percent involved three transfers, and 4.3 percent involved four or more transfers), which creates additional risk for the patient.

> “The fact that over 30 percent of patients in this investigation underwent more than one post-hospital transfer is significant since the potential for mismanagement or medical errors increases as patients undergo more care transitions.”

The conclusion: Patients at risk for complicated PAC should be identified at the time of discharge and managed in a manner appropriate to their needs. Our goal should be to minimize the transitions that are required on the patient’s path home.

Unfortunately, most patients receive little PAC coordination. A recent study published in the Journal of the American Geriatrics Society found that “most respondents reported receiving only a list of SNF names and addresses from discharge planners and that hospital staff was minimally involved...Proximity to home and prior experience with the facility most often influenced choice of SNF.”
Rethinking length of stay

Reducing length of stay (LOS) in hospitals has long been a key target for reducing costs. According to Harvard researchers, hospital LOS is no longer the most important metric for measuring the impact on patients admitted to the hospital. They propose use of “home-to-home time,” which measures total inpatient facility time – hospital, SNF, and rehabilitation facilities. This is a more accurate measure of the impact of acute illness on how long patients are away from home, and a better predictor of cost than hospital LOS.

The researchers looked at 81.6 million hospitalizations over seven years and found that even though the policy goal of reducing hospital LOS has been achieved, patients were essentially being pushed into other facilities in response. The chart below shows how the reduction in hospital LOS has been offset by increased PAC LOS:

- **Hospital**: In a seven-year period, the average hospital LOS decreased – from 6.3 to 5.7 days.
- **Post-Acute**: During this same time, the average LOS in PAC facilities went up – from 4.8 to 6.0 days.
- **Home-to-Home**: Bottom line, the net LOS (acute + PAC inpatient time) went up during the period studied – from 11.1 to 11.7 days.

Even though a bed in a SNF may be less costly than a hospital, keeping a patient in a SNF beyond what is clinically appropriate results in significant waste and additional cost. By identifying patients that are ready to transition home, we not only reduce “home-to-home time” for the patient, we also can reduce health plan cost.

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Tapping into the next opportunity for savings

PAC represents an often overlooked yet big target for savings, and there are several approaches to management that can reduce unwarranted variability. Here are five key areas for PAC savings:

1. **Appropriate Setting** – Directing care to the most appropriate setting delivers dramatic savings. In one example, 40 percent of the patients who were discharged to a LTCH didn’t need LTCH level of care. Shifting patient care to more appropriate, less costly settings would yield $35 billion in savings to Medicare over ten years.\(^7\)

Compare costs for these typical settings (right):

The challenge for discharge planners is that they can’t unilaterally decide which patients are candidates for home health with the accuracy and scale needed, without a sophisticated clinical infrastructure that includes advanced analytics and predictive intelligence - something few have access to.

2. **Network Quality** – We expect higher quality networks to be more expensive, but in the PAC world, narrower networks tend to reduce costs. By directing care to facilities with higher quality or increased specialization, we can deliver better outcomes at lower cost. A recent study found hospitals that used narrow networks of SNFs had lower readmission rates compared to hospitals that did not create or use narrow networks.\(^8\)

3. **Length of Stay** – A recent report prepared for Centers for Medicare & Medicaid Services (CMS) discovered that SNF length of stay was directly tied to reimbursement rates and not necessarily clinical need.\(^9\) With so many discharged patients transitioning from hospital to the SNF, PAC length of stay is a key factor in PAC costs. Over the past 30 years, the proportion of Medicare patients discharged from the hospital to a SNF, instead of the home, increased from 5 percent to 20 percent.\(^10\)\(^11\) Advanced analytics can determine the ideal length of SNF stay for each patient and ensure timely discharge to the home.
4. **Readmissions** – In 2014, readmissions cost the healthcare system $41.3 billion. Much of this cost could have been avoided. Payors cover $17.5 billion in costs due to potentially preventable readmissions, while patients face unnecessary medical risks and costs. A MedPAC study estimated that 17 to 20 percent of Medicare patients discharged from the hospital were readmitted within 30 days. Seventy-six percent of these readmissions were considered potentially avoidable and accounted for $12 billion in Medicare expense.\(^{12}\) By using predictive intelligence to determine risk of readmission, stratify patients, and employ closely-coordinated hand-offs, the readmission rate for high-risk patients could be significantly reduced.

5. **Fraud, Waste, and Abuse** – CMS estimates that $60 billion in payments, or more than 10 percent of Medicare’s total budget, was lost last year to fraud, waste, abuse and improper payments. An integrated PAC management system also includes analytic tools to identify patterns, statistical outliers, and billing inconsistent with nationally recognized coding standards and payer policies. The recoveries can result in significant cost-savings.

**Implementing an integrated approach**

Ultimately, PAC is interconnected. Reducing costs in one area, without careful planning, can have an unanticipated impact in another area. For example, reducing over-utilization of SNFs must be augmented with closely-coordinated home care to prevent hospital readmissions.

CareCentrix has developed an integrated approach to PAC that is patient-focused with the goal of sending the patient home as soon as it is safe and clinically appropriate. This integrated approach fills the gaps between fragmented services by identifying the best path for the patient’s care, engaging the highest-performing providers, and intervening for patients most at-risk for readmissions. The CareCentrix integrated approach is possible through proprietary technology that keeps patients, providers, and caregivers connected throughout the healing journey.

With the CareCentrix integrated approach, health plans can:

- Apply Big Data, advanced analytics, and predictive intelligence to identify the optimal path of care for the patient being discharged,
- Leverage specialized PAC provider networks to identify the providers with the best quality outcomes for the patient’s specific condition, and
- Reduce hospital readmissions and improve quality of care while allowing patients to heal in the comfort of their home.
1. Patient information is illustrative only.


