Advisory Board | Post-Acute Care Collaborative

Reducing Avoidable Delays in Care

5 key delays hindering
hospital to post-acute discharges

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The best practices are the ones that work for **you.**SM

Individual days add up to a big problem

1.2
Average number of avoidable days per patient

25%
of hospital days are avoidable

10.8
million avoidable days 2017-2018

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Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.

Contextualizing avoidable days

What 10.8 million means in practice

Thousands of beds maintained to house avoidable patient days

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Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.

Hospital bottom lines damaged by inefficiency

Health systems hurt by avoidable days, regardless of occupancy

Hospitals with high occupancy

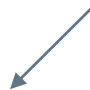
Limited bed availability

Avoidable days reduce the number of new patients hospitals are able to admit

Hospitals with low occupancy

Unnecessary resource use

Avoidable days limit hospitals' flexibility to scale down staffing and resource use as appropriate



Negative financial implications

Missed revenue from potential patients

Increased labor and facility costs

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Source: Post-Acute Care Collaborative interviews and analysis.

For post-acute, a mixed picture

Avoidable hospital days offer both challenges and opportunities

Excess hospital days exacerbate financial troubles, but can also create incentives

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Source: Post-Acute Care Collaborative interviews and analysis.

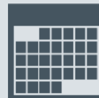
Taking a closer look

Calculations for our analysis of avoidable acute care days

Methodology in brief

Analysis uses data from CMS' Standard Analytical Files (SAF) which include 100% Medicare FFS[1] claims data

Utilizes GMLOS[2], which is determined by multiplying all of the length of stay values and then taking the Nth root, where N is the number of values



Includes Medicare FFS claims data from Q2 2017 to Q1 2018

Representative avoidable days calculation

(4.2 - 4.0) x 100 = 20

4.2 — **Average length of stay** for a specific hospital or patient group

4.0 — **National GMLOS** for that patient group

100 — **Patient volume** for that specific hospital or group

20 — **Avoidable days**

1) Fee-for-Service.
2) Geometric Mean Length of Stay.

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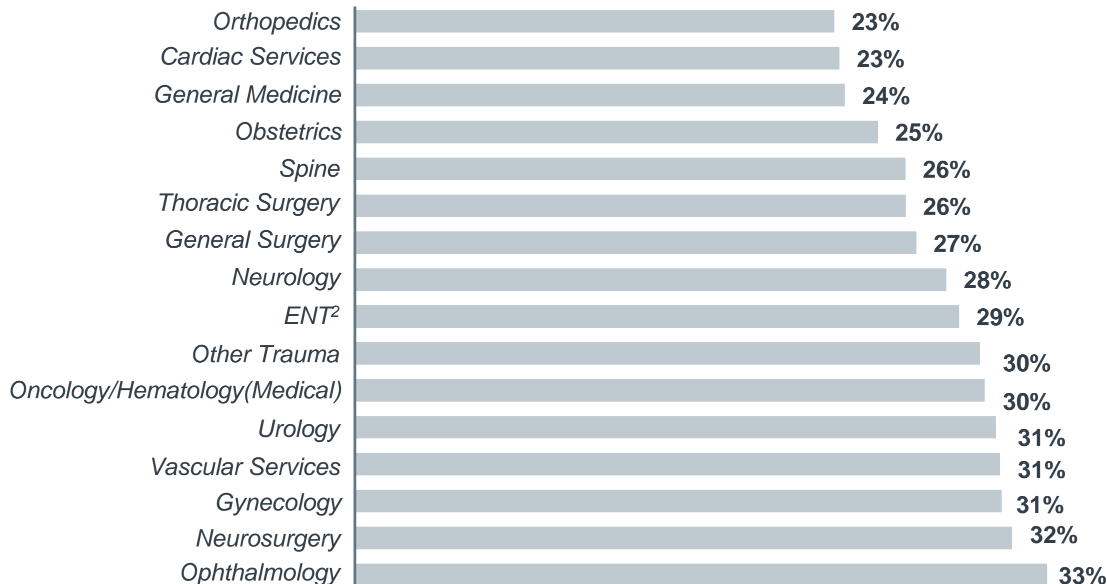
Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.

Avoidable days are ubiquitous across service lines…

Share of avoidable days by service line

Medicare FFS[1], Q2 2017-Q1 2018



1) Fee for Service.
2) Ear, Nose, Throat.

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Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.

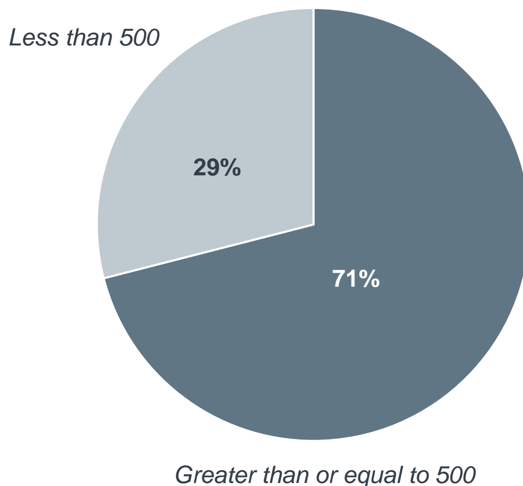
…and also common among the majority of hospitals

On average, patients stay half a day longer than necessary

Share of avoidable days by hospital per 1000 cases

Medicare FFS, Q2 2017- Q1 2018

n = 3,357 hospitals



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Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.

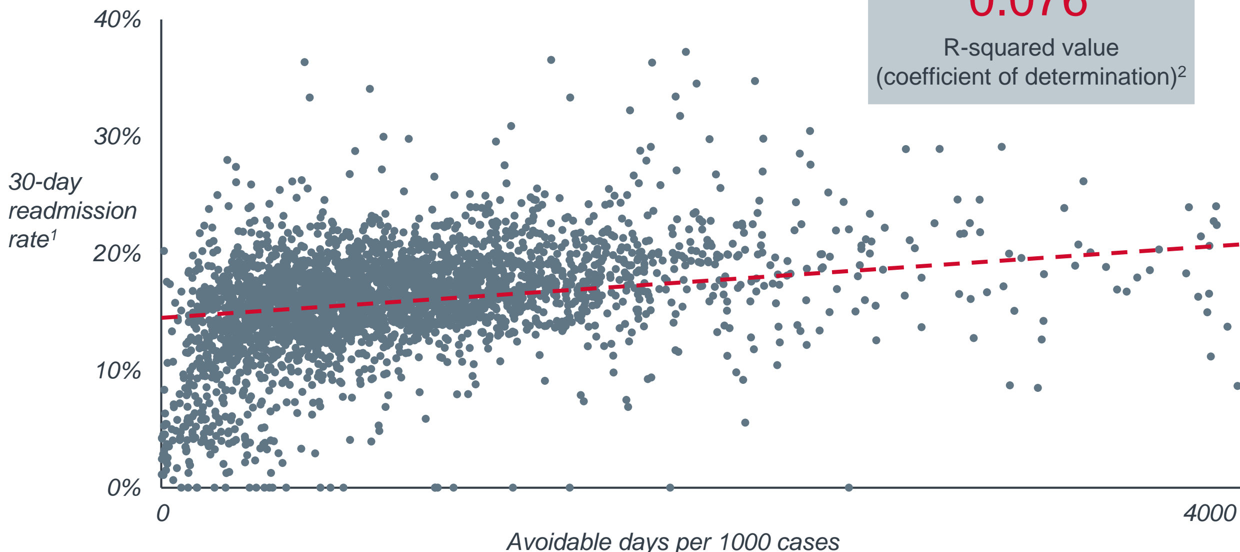
Excess hospital days not deterring readmissions

Longer hospital stays don't correlate with lower readmission rates

30 day readmission rates vs. avoidable days per 1000 cases

Medicare FFS, Q2 2017-Q1 2018

n = 3,357 hospitals



1) Values greater than 40% not displayed due to outliers.
2) The coefficient of determination explains how much of the variability in the Y-variable can be explained by the X-variable. Values close to 1 indicate perfect correlation whereas values near 0 indicate no correlation.

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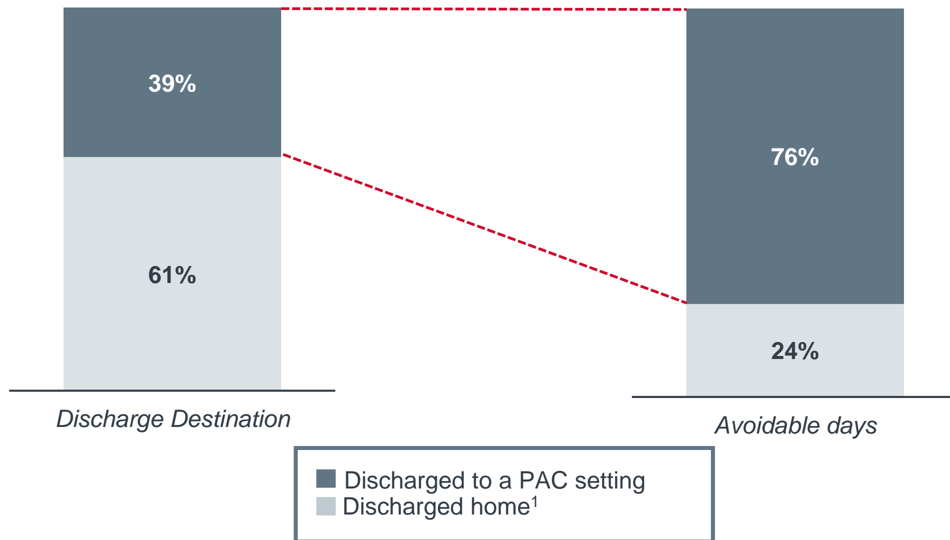
Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.

Post-acute discharges fraught with excess days

Discharges to PAC comprise a disproportionate share of avoidable days

Post-hospital discharge setting, all patients
Medicare FFS, Q2 2017 to Q1 2018

Share of days deemed avoidable, by discharge destination
Medicare FFS, Q2 2017 to Q1 2018



1) Without Post-Acute Services.

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Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.

All post-acute settings share the burden

Avoidable hospital days by discharge setting

Setting-specific GMLOS[1], Q2 2017-Q1 2018

Discharge setting	Total number of inpatient days	Total number of avoidable days	Share of days deemed avoidable
Hospice	2,085,917	611,651	29.2%
LTACH	1,195,290	277,734	23.2%
Home Health	4,837,081	1,093,972	22.6%
IRF	2,080,198	468,271	22.5%
SNF	12,171,650	2,392,904	19.7%

1) Geometric Mean Length of Stay.

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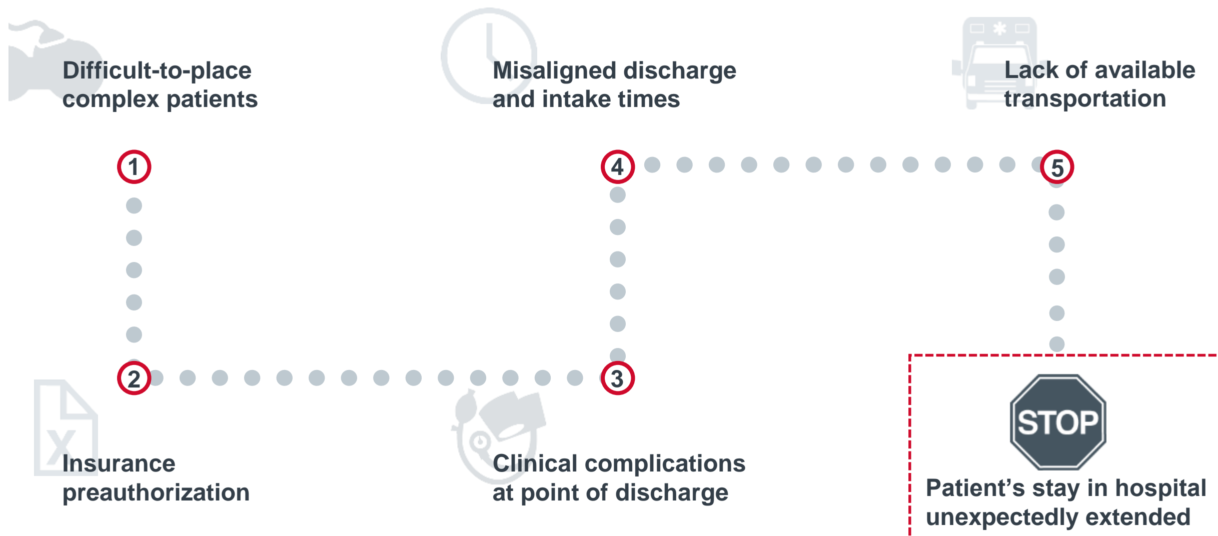
Source: CMS, Advisory Board Analysis; Post-Acute Care Collaborative interviews and analysis.

Uncovering barriers to timely transitions

Five major sources of delayed transitions



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Source: Post-Acute Care Collaborative interviews and analysis.

Discharge often delayed for the “usual suspects”

Common patient needs complicating care transitions

	Psychosocial	**Clinical**	**Financial**
Patient characteristic	Behavioral issues and substance abuse concerns make patients difficult to manage in post-acute settings	Complex clinical needs may go beyond the expertise or technical abilities of PAC providers	An inadequate, missing, or pending payer source makes patient acceptance a gamble for downstream providers
Post-acute challenge	Safety concerns associated with difficult behaviors increase risks to PAC staff and other patients	Post-acute settings lack knowledge, infrastructure, and staffing to take a higher percentage of complex diagnoses	Traditional reimbursement methods do not offset the high cost of care
Sample patients	• Patients experiencing suicidal thoughts • Patients addicted to opioids • Registered sex offenders	• Patients with multiple comorbidities • Patients on ventilators or with tracheostomies • Bariatric patients	• Uninsured patients • Patients waiting on Medicaid eligibility • Patients on high-cost medications

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Source: Post-Acute Care Collaborative interviews and analysis.

A creative way to ensure placement

Sometimes, paying for PAC placement is the most efficient option

Luna Health's[1] PAC funding mechanism

Payment agreements established
Luna Health entered into a payment contract with five of their PAC partners

Patients identified
Patients–underfunded or without post-acute benefits–are flagged by case manager as unable to transition

Predetermined payment completed
Luna Health pays the contracted SNF a predetermined rate, based on patient severity, for patients flagged as unable to transition

Luna invests in post-acute care for ready-to-transition patients

"If a patient no longer requires inpatient services, **you think about right care, right place**…if you were to clear that bed and pay for the SNF bed, it provides access to others in need of tertiary and quaternary care."

AVP Care Transitions
Academic Health Center

1) Pseudonym.

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Source: Post-Acute Care Collaborative interviews and analysis.

CASE EXAMPLE

Luna Health[1]

- Based in southeastern United States
- Multi-hospital system offering a variety of services including a comprehensive cancer center and partnerships with LTACHs

- Luna Health maintains a contracted payment system with 5 post-acute providers within their network where they pay to transition patients based on severity.
- Luna Health piloted the program in 2015 with 5 post-acute providers already in their network. After conducting internal data analysis, Luna Health determined that paying to transition patients lacking payer source was more financially advantageous than holding them in the hospital and created hospital access for patients waiting on a bed.
- Luna Health supports 20 to 30 patients per month under this model.

1) Pseudonym.

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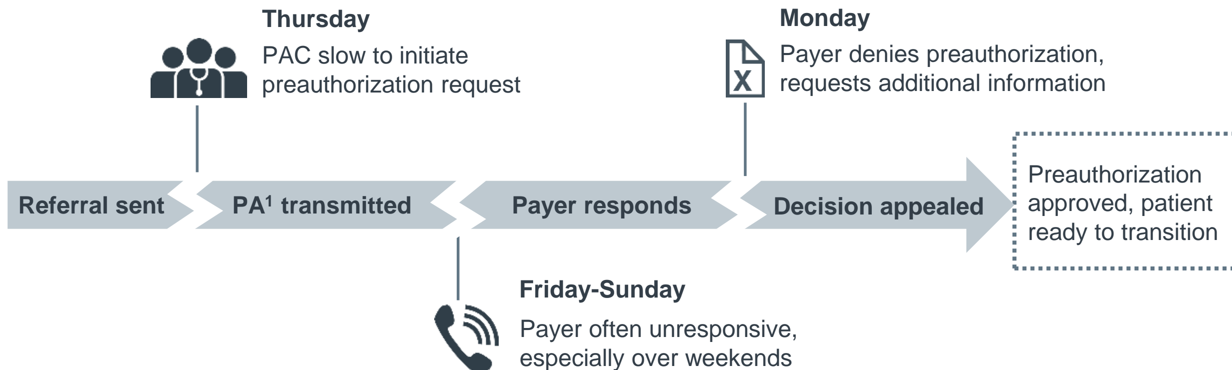
Source: Post-Acute Care Collaborative interviews and analysis.

Delayed payer response hinders preauthorization

Preauthorization process creates multiple opportunities for delays



1) Preauthorization.

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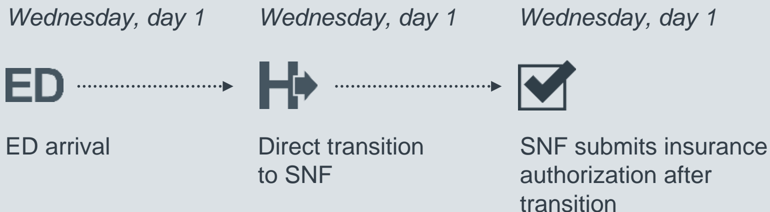
Source: Post-Acute Care Collaborative interviews and analysis.

Eliminating preauthorization for specific patient groups

Negotiating with MA payers to bypass acute care stay reduces delays

Standard post-acute transition timeline

Aultman's expedited post-authorization process



Notable benefits

- Avoids unnecessary hospital stay
- Improves ED and acute care throughput
- Mitigates opportunities for discharge delays

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Source: Aultman Health Foundation, Canton, OH; Post-Acute Care Collaborative interviews and analysis.

Post-authorization helps avoid an acute care stay

Aultman's post-authorization process explained

1 Patient identification

ED social services flag patients that don't need acute stay, and can't safely transition home

Plan allows direct PAC transition for certain conditions like cardiac or medical respiratory

2 SNF transition

Partnering SNF admits patients around the clock

SNF postpones preauthorization until after transition

3 Insurance authorization

Insurance approves entirety of the patient's SNF stay

Payer prevents unnecessary acute stay, hospital avoids potential readmission

70+ Acute care hospitalizations **avoided** in 2 years

100% Post-authorization requests **approved**

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Source: Aultman Health Foundation, Canton, OH; Post-Acute Care Collaborative interviews and analysis.

Aultman Health Foundation

- Based in Canton, Ohio
- Multi-hospital system offering a variety of acute and post-acute services including LTACHs, home health, hospice/palliative care, skilled nursing care, and inpatient rehab

- Aultman Health Foundation directly transitions medical respiratory and medical cardiac patients from the ED to a partnering SNF, bypassing an acute care stay. The SNFs complete the preauthorization process after the patient begins care in the SNF setting.
- Aultman has piloted this program with three Medicare Advantage payers.
- The program has been in place since 2017 and Aultman has transitioned 78 patients under this model, with two readmissions in 2017 and zero in 2018. No post-authorization request has been denied by payers to this date.

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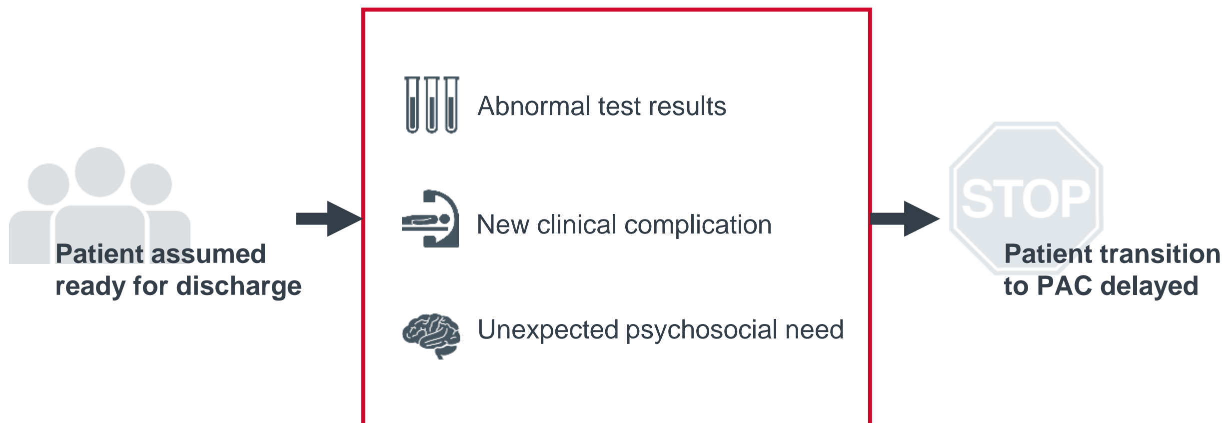
Source: Aultman Health Foundation, Canton, OH; Post-Acute Care Collaborative interviews and analysis.

Clinical complications don't happen on a schedule

Frequent causes of unexpected delays after initial discharge readiness



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Source: Post-Acute Care Collaborative interviews and analysis.

Interdisciplinary rounds proactively surface issues

Standard discharge rounds

Delayed huddles

Discharge plans discussed late, often on the day of discharge

Informal agenda

Meetings don’t include detailed discussions of every patient’s discharge plans and potential red flags

Inconsistent tracking

No formalized process to identify patients with delayed discharges and offer additional discharge assistance

Maddox Health’s[1] proactive rounds

Early and regular discussions

Physicians meet daily to discuss discharge needs and send reports to discharge staff

Comprehensive agenda

Agenda includes a discussion of every patient’s discharge plan, dates, and areas of potential complications

Elevated assistance

Patients who fail to discharge by anticipated date are automatically flagged for additional assistance

15% **Decrease in time** from discharge order to actual patient discharge post implementation of rounds

1) Pseudonym.

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Source: Post-Acute Care Collaborative interviews and analysis.

CASE
EXAMPLE

Maddox Health[1]

- Based out of Mid-Atlantic US
- Three-hospital network offering a variety of services such as a comprehensive cancer center, urgent care services, home care and hospice

- Maddox Health implemented daily interdisciplinary care rounds, meetings between physician, pharmacy, social worker, and nurse representative, to discuss discharge plans for each patient.
- The physicians meet in the morning to discuss discharge plans, anticipated discharge times, and discharge delays. All daily discharges that are completed are then logged into their EMR. The team reconvenes in the afternoon in a "huddle" to discuss progress, identify any additional discharge barriers, and elevate pending discharges for additional assistance.
- Maddox Health reduced the average time from discharge order to discharge by 15% after implementation.

1) Pseudonym.

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Source: Post-Acute Care Collaborative interviews and analysis.

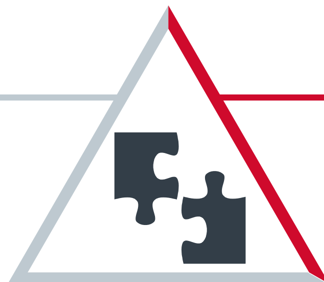
Discharge and intake times don't always fit

Patients can't be discharged if no one is available to take them

Hospital discharge times and post-acute intake hours are historically misaligned

Hospital Discharge

Discharges occur **later in the afternoon or evening** and towards the **end of the week**



Post-Acute Intake

Physician, nurse, and therapy staffing highest during **traditional business hours,** Monday through Friday

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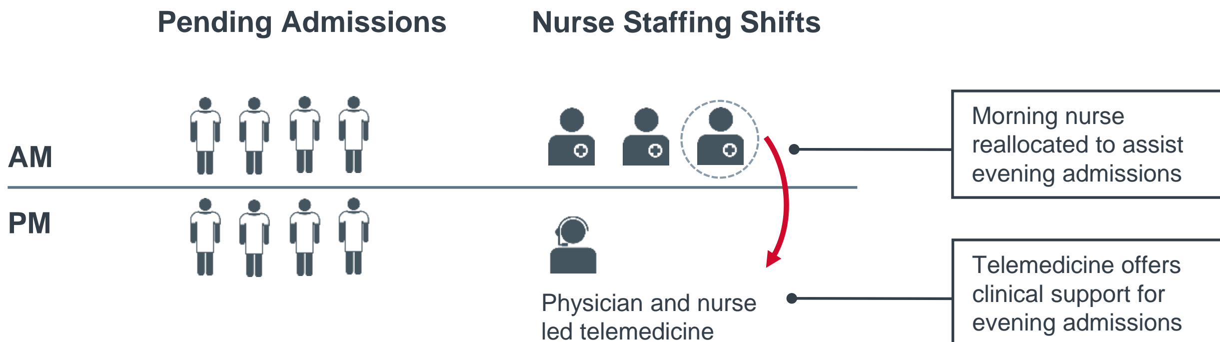
Source: Post-Acute Care Collaborative interviews and analysis.

Reallocating staff to better meet hospital needs

Redstone Presbyterian Seniorcare shifts nurse staffing to match intake volumes



> "We're competing for those patients. If it's hard for those patients to come to Redstone, they will go to the nursing home down the street."
>
> *Vicki Loucks, VP & COO*
> *Redstone Presbyterian Seniorcare*

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Source: Redstone Presbyterian Seniorcare, Greensburg, PA; Post-Acute Care Collaborative interviews and analysis.

CASE EXAMPLE

Redstone Presbyterian Seniorcare

- Based out of Greensburg, PA
- Offers rehab, hospice and palliative care, home health, and a variety of ancillary senior care services

- Redstone Presbyterian Seniorcare receives a significant number of intake requests in the evenings.
- Redstone restructured their Nurse Navigation department, reallocated morning staff to the evening shift, and implemented a physician and nurse supported telemedicine model to meet increased need for evening intakes.
- This has increased Redstone's ability to intake patients later in the day and has helped improve relationships with upstream providers.

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Source: Redstone Presbyterian Seniorcare, Greensburg, PA; Post-Acute Care Collaborative interviews and analysis.

Limited transportation options stranding patients

Flaws in common patient transportation options

Ambulance Transport

Overtaxed by high patient volumes

Difficult to hold accountable to expected discharge times

Ambulance companies reluctant to negotiate with hospitals

Family/Caregiver Transport

Family/caregiver unable to pick up patient as anticipated

Patient not stable enough to transport without clinical support

Patient requires additional transportation assistance not readily available via caregiver's personal car

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Source: Post-Acute Care Collaborative interviews and analysis.

Transportation investment key to timely transitions

Owned van fleet speeds up patient movement

Key components of a successful transportation program

Vehicles

Operates five ambulances and four ambulettes

Payer source

Billed to Medicare/Medicaid or private pay

Patient base

Available to patients going to both Shiloh Care[1] settings and other post-acute facilities

Potential roadblocks

High cost of initial investment

Competition from community ambulances

Shiloh Care[1] solutions

Ambulances are rented to other PACs, creating an additional revenue source

Patients aren't delayed, resulting in fewer bed vacancies

Non-competitive intentions are communicated to ambulance providers to establish goodwill

1) Pseudonym.

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Source: Post-Acute Care Collaborative interviews and analysis.

CASE EXAMPLE

Shiloh Care[1]

- Based out of Midwestern United States
- Multi-service post-acute provider offering skilled nursing care, post-acute rehabilitation, hospice, and home health services among other services

- Shiloh Care owns five ambulances and four ambulettes that transport patients out of the hospital and into their care.
- Shiloh Care invested in their own ambulances to mitigate transportation delays for patients relying on hospital or community ambulances.
- The ambulances also serve as an additional source of revenue as Shiloh Care offers transportation services to other skilled nursing facilities in their area.

1) Pseudonym

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Source: Post-Acute Care Collaborative interviews and analysis.

Or choose a different transportation adventure

Alternative transportation options are also available, for a price

	Key Differentiator	*Payment Source*
Uber Health *Renown Health* Case managers order rides on UberHealth's dashboard	• Options range from cars to wheelchair accessible vans • Rides can be ordered instantly or scheduled up to a month in advance	 Health system

	Key Differentiator	*Payment Source*	
Door-to-door transport *FirstLight Home Care* Transport included in Readmission Rescue program	• Non-medical home care support (medicine pick up, DME supplies) also available • Improves timely care access and adherence to care plan	 Health system	 Insurance

Source: Renown Health, Reno, NV; FirstLight Home Care, Cincinnati, OH; Post-Acute Care Collaborative interviews and analysis.

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CASE
EXAMPLE

Renown Health

- Based out of Reno, Nevada
- Three-hospital network offering a variety of services including an urgent care center, lab services, x-ray and imaging services, primary care, and home health and hospice services

- ► Renown partners with UberHealth to provide patients with transportation out of the acute care setting into post-acute and home settings.
- ► UberHealth is a rideshare transportation service providing both scheduled and on demand medical transportation.
- ► As a part of this program, case managers can arrange Uber transportation, up to a month in advance, if a patient requires transportation services. The Uber Health drivers also provide door-to-door support.
- ► Renown has provided 2,024 rides over a 14 month period.

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Source: Renown Health, Reno, NV; Post-Acute Care Collaborative interviews and analysis.

CASE EXAMPLE

FirstLight Home Care

- Based out of Cincinnati, Ohio
- Offers a variety of non-medical home care services including companion, personal, and dementia care to seniors in over 240 US markets

- FirstLight Home Care offers Readmission Rescue services to hospitals. Part of this program includes services such as medication pick up, sitter services, and transportation support.
- FirstLight Home Care staff offer door-to-door transportation support and additional services like medication pick up and telehealth solutions for patients discharged from the hospital with FirstLight services.
- FirstLight is working with several payers and hospitals that will pay for the service due as a means of reducing readmission rates and improving discharge efficiency.

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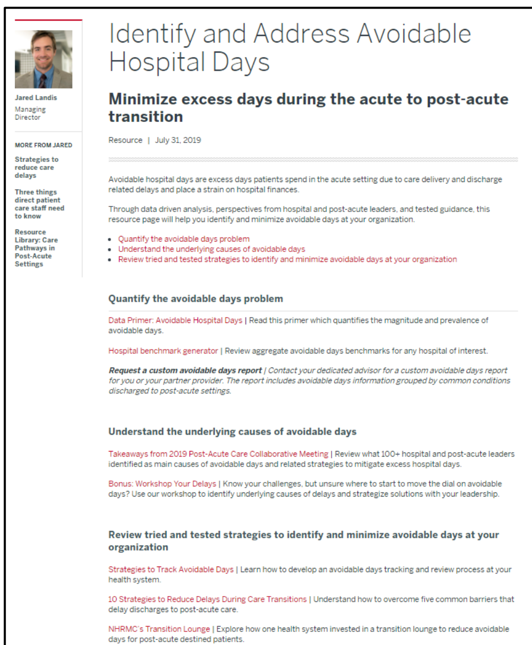
Source: FirstLight Home Care, Cincinnati, OH; Post-Acute Care Collaborative interviews and analysis.

Introducing the avoidable days resource suite

Post-Acute Care Collaborative resources to manage avoidable days at your organization



Jared Landis
Managing Director

MORE FROM JARED

Strategies to reduce care delays

Three things direct patient care staff need to know

Resource Library: Care Pathways in Post-Acute Settings

Identify and Address Avoidable Hospital Days

Minimize excess days during the acute to post-acute transition

Resource | July 31, 2019

Avoidable hospital days are excess days patients spend in the acute setting due to care delivery and discharge related delays and place a strain on hospital finances.

Through data driven analysis, perspectives from hospital and post-acute leaders, and tested guidance, this resource page will help you identify and minimize avoidable days at your organization.

- Quantify the avoidable days problem
- Understand the underlying causes of avoidable days
- Review tried and tested strategies to identify and minimize avoidable days at your organization

Quantify the avoidable days problem

Data Primer: Avoidable Hospital Days | Read this primer which quantifies the magnitude and prevalence of avoidable days.

Hospital benchmark generator | Review aggregate avoidable days benchmarks for any hospital of interest.

Request a custom avoidable days report *| Contact your dedicated advisor for a custom avoidable days report for you or your partner provider. The report includes avoidable days information grouped by common conditions discharged to post-acute settings.*

Understand the underlying causes of avoidable days

Takeaways from 2019 Post-Acute Care Collaborative Meeting | Review what 100+ hospital and post-acute leaders identified as main causes of avoidable days and related strategies to mitigate excess hospital days.

Bonus: Workshop Your Delays | Know your challenges, but unsure where to start to move the dial on avoidable days? Use our workshop to identify underlying causes of delays and strategize solutions with your leadership.

Review tried and tested strategies to identify and minimize avoidable days at your organization

Strategies to Track Avoidable Days | Learn how to develop an avoidable days tracking and review process at your health system.

10 Strategies to Reduce Delays During Care Transitions | Understand how to overcome five common barriers that delay discharges to post-acute care.

NHRMC's Transition Lounge | Explore how one health system invested in a transition lounge to reduce avoidable days for post-acute destined patients.

Data and analytics support

National avoidable days metrics and **custom avoidable days reports for STACH**[1] to understand industry pressures and individual challenges.

Member-sourced insights

Executive-supported strategies and **an interactive workshop** to address common avoidable days causes.

Proven implementation resources

Sample avoidable days tracking strategies along with **example delay-reduction interventions** to mitigate excess hospital days.

1) Short-Term Acute Care Hospital.

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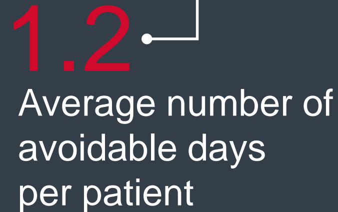
Source: Post-Acute Care Collaborative interviews and analysis.

Seize the avoidable day opportunity



1.2

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