CASE STUDY

Hospital System Reduces Readmissions, Lowers Cost of Care and Skilled Nursing Utilization

Hospital Description:
Three hospitals in south central Pennsylvania- acute care, maternity and women and rehab totaling 663 beds. Discharges per year total more than 35,000. These hospitals are part of a major health system in Pennsylvania.

Challenges:
- Cost control and utilization of care in the post-acute care arena
- ACO accountability for post-acute quality and cost containment
- Managing post-acute care network of more than thirty skilled nursing facilities
- Average 3,000 to 4,000 discharges per year to skilled nursing facilities
- Impact of readmission rates and lengths of stays on total cost of care
- Lack of visibility into post-acute care clinical and financial outcomes in skilled nursing facilities not owned by hospitals

Solution:
Real Time post-acute care software was deployed to the skilled nursing members of the hospital’s preferred provider network. The software enabled the hospital’s care transitions team the ability to collaborate with the clinical teams in the skilled nursing facilities based on clinical, functional and financial outcomes. Real Time gives the care transitions team the ability to easily see readmissions by facility, diagnosis and by time periods. Clinical alerts gave the team information on what was happening with patients in real time, which helped to improve relationships and bridge the communication gap between the hospitals, skilled nursing facilities and providers. Since Real Time allows alerts to be customized, the hospital was able to set alerts based on their clinical plans and pathways. Real Time’s key word search scours the entire patient record identifying and highlighting subtle signs that may be missed by staff.
Background:

In 2015, a hospital and ACO in south central Pennsylvania were looking for a way to impact cost and quality of post-acute care of its patients. Skilled nursing costs in this area were dramatically higher than the national average. A case management program was in place with a strategy around having a preferred provider network. Electronic data sharing between the skilled nursing facility network and hospitals was limited by lack of systems. When tracking patients after hospital discharge, the hospital’s care management team found telephone communication to be slow and unreliable. Calls to update case information were often returned too late to be able to impact the care and prevent a hospital readmission.

Real Time was identified by the hospital/ACO as a solution that would provide insight into the care continuum post-hospital discharge and enable them to work collaboratively with the skilled nursing team to effect better outcomes, control costs of care, and prevent unnecessary hospital readmissions.

Results:

• Readmission rates in the preferred network dropped from an average of 18% prior to Real Time Medical Systems implementation to 8.55% in the first performance year*.

• Skilled nursing lengths of stays decreased by 43%* in the first performance year for the ACO.

• The decrease in utilization led to a cost savings of $4 million* for the total cost of care for that performance year.

*Claims data.

Standardized care plans and clinical alerts were used to monitored patients more closely. Length of stay were managed by monitoring the patient’s functional status to determine appropriate guidelines and timing of discharge. Outpatient follow-up care was embedded in the clinical standards to maintain the patient’s connection with the health system.