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ISSUES BRIEF

A WIN-WIN APPROACH TO MANAGING LENGTH OF STAY IN YOUR POST-ACUTE CARE NETWORK

These days, the push and pull between hospitals and post-acute networks can feel a lot like wading in the ocean on a rough day. Standing tall in this push-pull environment means managing length of stay while also improving outcomes for patients. How can hospitals and SNFs work together under the umbrella of value-based care to achieve these goals—and make sure patients don't get caught up in the churning waters?

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INTRODUCTION

These days, the push and pull between hospitals and post-acute networks can feel a lot like wading in the ocean on a rough day. On the surface, requirements by the Centers for Medicare & Medicaid Services (CMS) are pushing hospitals to monitor patients post-discharge during a Skilled Nursing Facility (SNF) stay more closely, reducing their length of stay. But under those waves is an undertow: SNFs have different business goals. And some of those goals may compete with hospital objectives.

Standing tall in this push-pull environment means managing length of stay while also improving outcomes for patients. How can hospitals and SNFs work together under the umbrella of value-based care to achieve these goals—and make sure patients don't get caught up in the churning waters?

IT'S ABOUT TRANSPARENCY AND COMMON DATA

The answer lies with interventional analytics (IA). With IA, hospitals get clinical indexes from the SNF's electronic health record (EHR) in real-time. As patients progress through their SNF stay, these alerts provide insights about relevant clinical status and rehab progression. Then appropriate actions can be taken.

If a patient is at risk of a negative outcome, an alert lets the hospital know an intervention is needed. And if a patient has made progress in specific measures, a functional status indicator lets the hospital know that patient is ready to go home.

With the right data, it's easy to move patients to the right place at the right time. IA helps hospitals and SNFs improve quality of care through transparency and prevent avoidable readmissions.

IMPROVING PATIENT OUTCOMES, TOGETHER

With IA software, SNFs and hospitals can work together to move patients through levels of care through management and monitoring. IA helps patients go home when they are ready—and not return to the hospital. Collaboration improves patient outcomes by partner SNFs. When that happens, hospitals are more likely to give those SNFs referrals. So, while SNFs may see shorter stays initially, their volume is likely to grow. For the hospital, the SNF, and the patient, it's win-win-win.

Or, getting back to that choppy ocean, win-win-swim.

If you are interested in learning more about improving outcomes and managing length of stay, contact us at info@realtimemed.com.

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Connecting Care Through Interventional Analytics

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