50 Shades of Data: Strategically Leveraging Your Post-Acute Care Data Webinar Q&A

Susie Mix
CEO/President

What are some of the key differences between the administration of standard Medicare patients and Medicare or private managed care patients?
With standard medicare patients, the post-acute care provider is in charge of the stay and the one who dictates RUG rate, how much therapy to give, when a patient is discharged, and so on. There is familiarity with the process as it has been in place for years.

With managed care patient stays, everything is kind of outside of post-acute care provider's hands. The provider is given an authorized level dictated by the healthplan/med group and is told when the patient will leave the facility, as well as which vendors they will need to use for home health support for the patient. That's a huge difference that can be hard to get used to.

What types of data do the SNFs who are dealing more with managed care patients need to start collecting and tracking?
The most important thing is to make sure the data in their contracts is not only accessible, but being used by everyone in the facility who manages the patient. Take note of exclusions, levels, and acuity in these contracts because it's going to be critical in managing the patient according to the contract.

Without due diligence on the front end, a patient can coast through our facility, get clinical care and then go home. The problem is that no one has compared the care being provided against the patient contract – and this is what costs the facility. Assigning one person to manage this process from the get-go is extremely important to getting clinical care in sync with the contract.

When a SNF works directly with an HMO case manager on a patient – what data does the HMO have and what data should the SNF case manager be prepared to provide?
The case manager really just needs a review of what is "skilling" the patient. It should be along the same guidelines as Medicare. The data shared should reflect the patients skilled needs and the progress the patient is making with each need

Developing a standard progress report form helps case managers in facilities gather the appropriate information that managed care case managers want to know. It shows the skill required by the patient (IV administration, therapy, wound care, stage 3, stage 4, etc.) and the progress made with that ailment – the skill is very important.

It's also important to stay timely – update forms every 3 days. If the managed care case worker wants it once a week, have that information handy and ready for them. And, don't be late.

Drew Filchak
Chief Administrative Officer

What are you generally providing in your care outcome reporting? Who do you provide it to? And, what sort of impact do you see from this data?
We provide care outcome reporting on two different levels.

One is at the 'big picture' C-suite level, to help establish preferred partnerships. Both hospitals and managed care organizations require this data. They're happy with the fact that we're able to present what they need, alongside the benefits of contracting with us.

Vivage is getting referrals and preferred partnerships as a result. It's slow, it's a tough process, but we've made new inroads this way. We lay out data in a way they want to see it and in the way that most benefits them

We also provide this reporting at a community level, to drive operations. It's starting to really make a difference in departmental operations and in facility leadership. Being able to take this data from a corporate office and provide them with a snapshot of what we're seeing is key.

Using the primeVIEW dashboard, we're able to get much of this with a click of a button. Clinical outcomes are definitely impacted by real-time access by our ability to benchmark ourselves against others.

Lastly, having ready access to all of this data also helped us develop focused care studies. We review data for resident placed in our facility by a referral partner all the way through the care transition back to home – and share this with our referral care partners.

How does having care cost per DRG affect key decisions at Vivage? For example, does it affect your admission decisions?
Absolutely, and our business partner decisions. If we don't know our cost per DRG or cost per RUG, then we can't take a bundled arrangement. If we do, it's not going to make our bundled partner very happy.

We use a worksheet very similar to what Susie showed to calculating the cost of a patient. At a community-level, we translate cost per DRG to cost per RUG because that's what we're familiar with. We establish cost to a RUG reimbursement and then depending on what the managed care contract cheat sheet says, we look at the direct cost, the equipment cost, the therapy, extraordinary pharmacy, the specialty supplies, etc. We can then estimate how much this patient is going to cost us at "this" level of care – and even fine tune cost.

We follow the same process for ortho, cardiac or neurological patients.

What is Vivage doing proactively to reduce readmission rate data to go after reductions?

Quite a bit. If we want to partner with hospitals, we must reduce our readmission rates. And in some instances, in the not so distant future, we expect to face value-based penalties if we don't.

We work with PointRight to compile a readmissions big picture. We also have a monthly operations review with each community that includes readmissions.

Our goal is 8% for readmits. Our current average across post-acute homes is between 5-8%, which means that some are at 11, 12 and 13% percent.

For focus purposes, we have a daily call with our sub-acute home to review the data from hospitals and ERs. We're logging it and analyzing it – by diagnosis and attending physician patterns – which is really key. We're also looking at time of day. With all of these different data points in mind, we're able to really zero in on how we can reduce that readmission rate.

And because close to a quarter of our resident mix is with Optum, we include Optum nurse practitioners and physician extenders in our care determinations – their goals are similar to ours.

Are you having any difficulty getting DRG info for the patients being discharged to your facilities? If not, how are you getting that info in a timely manner?
We are getting DRG info; it can be a little bit of a battle though. Our clinical liaisons for the different referral sources are responsible for getting DRG data. These liaisons have some long-standing professional relationships with the referral partners, which benefits us. It gives us a full picture of what's involved before we decide to take a resident.