HDM KLAS room

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Real Time MEDICAL SYSTEMS

Topic: A scalable model of execution across care transitions. A model example from an **Academic Medical Center**.

TRAVERSING THE CARE CONTINUUM | HealthData Management | KLAS

Transitions of Care

$26 Billion Spent on poor transitions of acute care Medicare patients per year*

Patients are at ***highest risk*** of readmission around care transitions

- Little to no handoff
- Overwhelming amount of unorganized information sent to receiving facility
- Patients may arrive in less than an ideal physiological state – pain, unstable vital signs
- Receiving facility may not have – equipment, medications or other necessary items to care for patient properly
- Medication reconciliation a major issue – high risk meds - A/C's, antibiotics, insulin, and antidiabetic agents

*Transitions of Care | The Roadmap to Effective Transitions

How to Go from Troubled, to Award Winning?

The Challenges

- Limited day to day insight as to what was happening with patients
- Manually capturing readmissions data on lists and spreadsheets
- Not possible to determine if trends were developing
- Unable to see changing clinical conditions or when patient diagnoses were being made
- Inability to accurately determine which patients were at highest risk
- Not possible to intervene prior to a readmission

The Outcomes

- Viewing post-acute patient clinical data and nursing notes as it occurs – *no matter where they were discharged from*
- Risk stratification of all patients to identify and manage high-risk populations
- Ability to contact facilities to intervene in treatment by monitoring vital signs, diagnosis, and orders
- Utilizing discharge reports to connect with patient in the community and to connect back to PCP
- Receive Up to the minute network performance comparisons
  - Readmit rates, Length of stay (LOS), Readmission case types
- Monthly unblinded data reporting in a network meeting
- Identification of best practices and sharing across post acute providers
- Understanding acute care impact on post-acute setting

How Do You Get Here?

St. Joseph's Health System First Year Results

ACHIEVED POST-ACUTE COST SAVINGS
$1.6M Total Cost Savings with a **19x ROI**

REDUCED READMISSIONS
Readmission rate down from **24.0% to 17.8% (↓25.8%)**

INCREASED POST-ACUTE NETWORK REFERRALS
High Performing Network discharges **up from 57% to 82% (+43.9%)**

IMPROVED CARE TRANSTIONS
Minimizing length of stay to return patients back to the community

STRENGTHENED NETWORK PARTNERSHIPS
Live, shared data improved communications and care standards with PAC partners

AWARD WINNING PROGRAM
Recipient of the **2022 NAACOS Leaders In Quality Excellence Award**

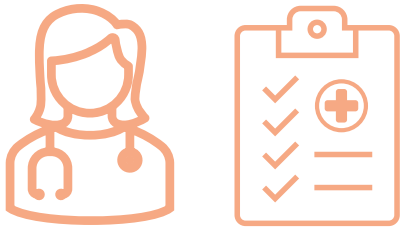
Principles Driving Successful PAC Transitions & Cost Savings

Obtain Live Post-Acute Data Transparency

Accesses live patient data from the PAC EHR, improving collaboration with post-acute partners.

Create High Performing PAC Network

Utilize live data to measure PAC performance and lead quarterly network management meetings.



Establish PAC Nurse Navigation Role

Focus on patients discharged to PAC setting to improve Clinical Outcomes, Transitions of Care, Readmissions, and LOS.

