Bamboo Health

Succeeding In a Rapidly Evolving SNF Landscape With Real-Time Notifications

Skilled Nursing News

SUCCEEDING IN A RAPIDLY EVOLVING SNF LANDSCAPE WITH REAL-TIME NOTIFICATIONS

As the skilled nursing facility (SNF) payment landscape continues to shift in favor of the best clinical outcomes, successful operators are acutely aware of the value real-time information — in particular admission, discharge, and transfer (ADT) notifications — brings amidst COVID-19 and beyond. This data supports SNFs in their ongoing care coordination and quality improvement initiatives, and helps reduce hospital readmissions.

The Centers for Medicare and Medicaid Services (CMS) updated its Conditions of Participation (CMS-9115-F), requiring hospitals to send inpatient and emergency ADT notifications to applicable post-acute providers and suppliers for the purpose of improving care coordination and quality of care. The requirements create significant opportunities for SNFs as more real-time information can help prevent readmissions, support referral mechanisms, and coordinate care.

Everything SNFs were doing in the early portion of 2020 to succeed under new payment and quality programs continues to have urgency as the effects of the COVID-19 pandemic continue. COVID-19 changed almost every aspect of how skilled nursing providers operate, and drastically accelerated the need for real-time information as coordination with hospitals and other providers became even more critical.

Even though CMS granted several waivers and program changes in light of COVID-19, it's more important than ever for SNFs to focus on safe care transitions, cross-continuum coordination, and quality to maintain their operations and ensure future success.

There are several key areas where operators can focus their efforts to provide care that best fits each patient's needs while ensuring their financial and operational success. This white paper proposes strategies skilled nursing providers can use to navigate the changing payment landscape, boost workflow efficiencies, and improve care collaboration by leveraging real-time notifications.

Changing Payment and Reimbursement Landscape

The ongoing transformation from a fee-for-service system to value-based payments coupled with the emergence of COVID-19 places a premium on real-time patient data that SNFs can use to instantly track referrals, monitor patients post-discharge, and assess performance on quality metrics, such as readmission rates. Access to real-time notifications can also help SNFs drive internal process improvement activities, and enhance collaboration and communication with provider partners.

Without such data, SNFs must rely on manual workflows that can introduce errors or delays. They also face a much higher likelihood of missed referral opportunities and fragmented care for patients without access to real-time information.

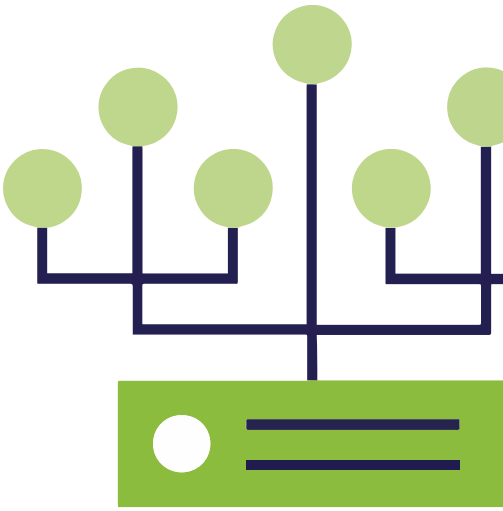
"Having information at our fingertips through PatientPing (Bamboo Health) has helped us maintain certain benchmarks, perform better, stay ahead of our competition, and provide better care to our patients," Erik Iverson, Vice President of Business Development for Chicago-area Legacy Healthcare, wrote in a 2020 blog post.

Operators are faced with two realities: narrow margins that are pushed to new limits with COVID-19, and changes in reimbursement models and CMS regulations that favor high-quality providers. One such example is the Discharge Planning Conditions of Participation that took effect in late 2019. As part of this requirement, hospitals must provide SNF quality ratings to patients as they make decisions about post-acute care placements and referrals. Patients will most often favor those providers with higher scores, making it essential for SNFs to attain or maintain high ratings on quality metrics, such as injury rates, emergency department (ED) visits, readmissions, vaccinations, and successful patient returns to their homes.

While the early, overall increase in reimbursements under the Patient-Driven Payment Model (PDPM) was good news for skilled providers, the urgency to adopt more value-based care approaches and technology solution to drive efficiency and quality continues to increase.

Care Coordination

As a result of COVID-19, creating effective care coordination among multiple care settings is more challenging for skilled nursing facility owners and operators than ever before, both due to the rapid changes to patient wellbeing and the sheer number of patients requiring care.



SNFs possessing a technology solution to manage the influx of patients and real-time communication needs will be better positioned for success. The new normal created by COVID-19 will require SNFs to expand collaboration efforts and build new partnerships — supported by real-time data. Adding to these dynamics is CMS's new electronic event notification Conditions of Participation (CoP), which requires hospitals to send real-time notifications to providers across the care continuum.

3 KEY WAYS TO IMPROVE CARE COORDINATION AMIDST COVID-19

Bamboo Health's (formerly PatientPing) real-time COVID-19 solution offers SNFs three key ways to improve their care coordination strategies:

- **IDENTIFY** the COVID-19 patients admitted, discharged, or transferred to or from their facilities to adhere to quarantine protocols and keep patients and staff safe
- **KNOW** in advance about any incoming COVID-19 patients to properly prepare for and allocate resources (oxygen tanks, ventilators, etc.) for their admission
- **WORK** with other providers and case management teams to transition low-risk patients to the community to open up scarce SNF beds for high-risk, COVID-19 patients

CARE COORDINATION (CONTINUED)

Through these CoP provisions, SNFs will receive real-time notifications when their patients have an ED or hospital encounter. This gives skilled providers the ability to engage with the hospital team and help fulfill care coordination needs. Having the ability to receive and act on these notifications will allow SNFs to be effective and high-quality community partners to hospitals, and can position them as successful operators.

"Some of the care coordination challenges that we face center around data integrity," said Tim Carey, Director of Data and Performance Analytics at BaneCare Management, which operates 12 SNFs throughout Massachusetts. "When we meet with our partner organizations, there are times when our data on patients' care events don't match up. ... This fragmented data for the hospital and (accountable care organization) creates many challenges, especially for the clinical staff members who are responsible for following patients during their care journeys."

BaneCare uses Bamboo Health's Pings solution to receive real-time notifications whenever their patients have a care encounter after leaving their facility. By using data that builds a patient profile, and sharing that data with other providers, the SNF and their value-based care organization partners always know how, and when, to contact patients and providers.

"This feature has helped us strengthen relationships with other organizations in the community because providers can collaborate more closely to reduce readmissions and help get patients to the right care settings at the right time," Carey said.

With the quality outcomes demanded by PDMP becoming intensely more important during and after COVID-19, therapy moving to telehealth, and more patients transferred home with chronic conditions, successful SNF operators need technology solutions to manage patient transitions and provide the best coordinated care.

Workflow Efficiency

SNFs invest staff time and resources to follow up with patients and their caregivers after discharge, to ensure patients are continuing to improve. Many SNFs depend on phone check-ins at set intervals — such as 24 hours, 48 hours, 7 days, and so on. During those phone calls, discharge coordinators try to learn more about each patient's progress to detect any decline in health status.

Unfortunately, that manual process is expensive, often ineffective, and can be unnecessarily time consuming — draining much needed personnel resources. These workflows are well-intentioned and designed to be proactive to preempt a care event, but SNFs often become reactive because the workflows lack real-time notifications.

"A significant problem with this approach is that a SNF could call a patient two days after discharge and the patient could be doing well, but if on Day 5 they start feeling acutely sick, they are likely going to seek care at an emergency department," says Vanessa Kuhn, Ph.D., Director of Health Policy at PatientPing (now Bamboo Health). "That's a patient who in many cases

will be rehospitalized. This is not only a poor outcome for patients but also for the SNF, which will likely be responsible for a readmission. By using real-time notifications to support coordination and outreach efforts, SNFs have an increased opportunity to prevent such adverse outcomes."

SNF operators are increasingly embracing technology tools with real-time notifications to track patients as they move into and out of facilities. The systems help post-acutes and their partners monitor patients' post-discharge progress and can help facilitate other needed care to reduce avoidable readmissions and other adverse outcomes.

HOW TO GET STARTED

For skilled providers looking to launch new real-time technology capabilities, here are three steps to follow:

- **Develop your infrastructure:** Evaluate what technology solution is best suited to complement your existing systems, including integration capabilities with your EHR, and determine your user interface and reporting needs.
- **Build your culture:** Include staff in designing workflow changes to support strong adoption and use of real-time notifications. Consider implementing a train-the-trainer model and develop internal champions who help reinforce adoption goals.
- **Refocus your partnerships:** Build an impactful business development strategy that is focused on partnerships supporting effective care coordination activities. Use real-time notifications to deliver best in class care transitions and high quality care to ensure success in value-based care efforts.

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> -Vanessa Kuhn, Ph.D., Director of Health Policy, PatientPing (now Bamboo Health)

Transitions Of Care

Managing patient care transitions is an increased focus for SNFs today, helping them attain high quality ratings, avoid readmission penalties within the Value-Based Purchasing Program, and position themselves as excellent referral partners.

Many SNFs are also partnering with other health care providers in value-based care arrangements, such as accountable care organizations (ACOs), that focus on effective care transitions to manage total cost of care and improve patient outcomes. Since 2017, the continued increase in ACOs participating in the Medicare Shared Savings Program (MSSP) has led to a corresponding four-fold increase in the number of SNFs partnering with ACOs as SNF affiliates.

SNF affiliates can admit Medicare ACO patients without having to meet the 3-Day Rule requirements. However, to be a successful partner in this program, SNFs need real-time information when patients present to the hospital. Timely response and coordination with the designated hospital teams are essential to successfully transfer patients to the SNF quickly and reduce hospital costs, thereby reducing total cost of care, while also continuing to ensure high quality care.

Real-time coordinated care transitions and the need for monitoring patients post-discharge has proven even more critical during the COVID-19 crisis as adverse events and hospitalizations pose increasingly dire consequences for patients and their families. In addition, CMS changed SNF discharge policies and timelines due to the influx of COVID-19 patients via the declaration of a public health emergency. For example, in a guidance released in the end of March 2020, CMS announced it would allow is allowing long-term care operators to transfer patients "solely for the purposes of cohorting and separating residents with and without COVID-19." Having real-time information is critical to identify and monitor these patient's locations.

TRANSITIONS OF CARE (CONTINUED)

As the effects of the COVID-19 pandemic continues, SNFs will face more atypical care transitions and referrals for patients that have different length of stay experiences and needs. In early April 2020, a Skilled Nursing News survey of nearly 100 SNF owners and operators revealed that 29% of SNFs felt pressure to admit a resident who had tested positive for the virus, while about 24% indicated that they had brought that patient into their facilities. Having more real-time information available to prepare for increasing numbers of COVID-19 patient admissions can help SNFs secure needed protective equipment and room accommodations to keep both staff and patients safe.

At the same time, the poll showed that 28% of SNFs saw family members requesting patients be discharged for fear that their loved one would contract COVID-19. This has led to shorter lengths of stays for some patients, changed discharge procedures, and post-discharge care protocols. Real-time notifications increase the predictability of these changes by continuing to allow SNFs to get notified when their recently discharged patients have new care events. SNFs are then able to act on those notifications very quickly and coordinate with the other care setting to ensure the most appropriate care is delivered for the patient.

Lastly, COVID-19 patients face a challenging recovery process, especially those at higher risk of complications — including the elderly and those with significant underlying comorbidities. That means SNFs need to be even more vigilant about each patient's wellbeing post-discharge in order to prevent adverse health events, including readmissions. Real-time notifications allow SNFs to be alerted when patients seek care at EDs and provide opportunities for collaboration and possible referral back to the SNF as clinically indicated.

To ensure high quality-of-care standards and the best health outcomes for patients, SNF operators must focus on the discharge process, care transitions, and communication across settings. With real-time notifications, SNFs obtain greater visibility into patient status while fostering better care transitions across settings and minimizing costly readmissions.

Success under value-based payment models means evaluating current tools, workflows, and partnerships. To learn more about value-based care changes and how real-time notifications positively impact workflows, care coordination, and transitions of care, contact Bamboo Health at connect@bamboohealth.com.

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