PointClickCare®

Care Coordination Benchmark Study

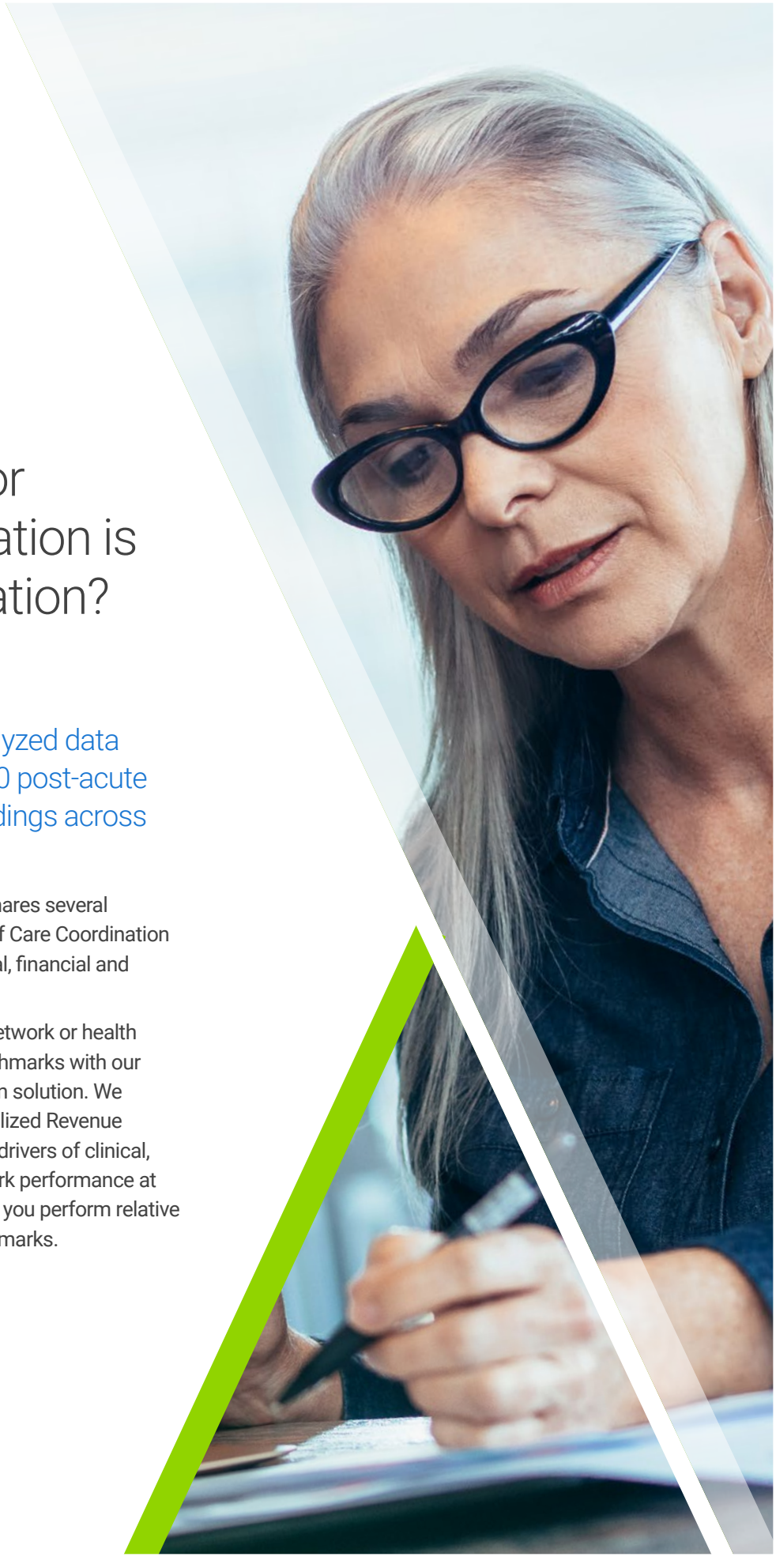
Six key insights for health systems to enhance their care coordination performance.

Executive Summary

The launch of this Care Coordination Benchmark Study couldn't be better timed. With hospital networks and health systems strained in the face of a global pandemic, combined with fee-for-service being pushed aside, replaced by outcomes-based, patient-centred care, the challenges facing acute care organizations have never been more complex. The need to capture, interpret and act on timely data about patients and post-acute facility performance is heightened. The opportunity to improve care transitions, patient management and network performance represents real and meaningful impacts on clinical, financial and operational outcomes.

Care Coordination has emerged as a strategy to provide caregivers and decision-makers with actionable insights about patients and facilities. Clinically, this new strategy has shown to reduce 30-day readmissions and improve care coordination during a post-acute episode. Financially, hospital networks have been able to reduce revenue lost to network leakage as patients move out of network post-discharge. And operationally, the single source of truth around facility performance offered by Care Coordination has allowed hospital systems to better manage and optimize their post-acute networks.

How Ready for Care Coordination is Your Organization?



PointClickCare has analyzed data from more than 130,000 post-acute episodes in 20,000 buildings across 50 states.

The 2021 edition of this study shares several key themes around the impact of Care Coordination Readiness on clinical, operational, financial and network performance.

Understand how your hospital network or health system compares to these benchmarks with our award-winning Care Coordination solution. We will prepare and share a personalized Revenue Impact Report that unpacks the drivers of clinical, operational, financial, and network performance at your organization, including how you perform relative to your state and national benchmarks.

First Analysis of the Relationship Between Acute and Post-acute Care

3,100 counties

15,000+ Skilled Nursing Facilities (SNF)

4,039 hospital networks

300 hospital referral regions

Behind the Numbers*

740 MSDRG categories

48 episode categories

146,000 post-acute episodes

*Data gathered between 2017 and 2020

6 Key Takeaways

Data developed based on the following metrics:

1. Average Length of Stay
2. Readmission Penalties
3. Cost per Episode
4. Readmission Percentage
5. Network Revenue Leakage
6. BPCI Benefits

PointClickCare's database, the largest database of post-acute care outcomes in the world, comprises:

22,000
post-acute and senior living provider facilities from all 50 states

100%
of national health plans

1,300+
hospitals

1,000+
ambulatory practices and ACOs

2021 Highlights

6 Ways Care Coordination Boosts Bottom-Line Performance

01

Addressing the Readmissions Cost Imbalance

By examining readmission penalties across health systems, our study identifies disparities in average readmission penalties per patient life between larger and smaller health systems. Large health systems (10,000 or more annual discharges to post-acute care) saw an average readmission penalty of $412 per patient life. Hospitals discharging fewer than 10,000 patients averaged $297.

While this may seem counter intuitive to some (thinking larger systems would reap more efficiencies), larger systems have more SNFs to coordinate. More nodes contribute to more room for error. This 38% gap in penalty per patient life may also be caused by differences in acuity levels accepted by larger systems with more resources compared to systems responsible for fewer discharges.

Care Coordination has been shown to improve enterprise efficiency, critical to reducing readmission costs.

Penalties

(10,000+ annual discharges to post-acute care facilities)

Large Health Systems

$412

per patient life

02

Small Increases In Readmission Rates = Large Cost Driver

Readmission Rate

(10,000+ annual discharges to post-acute care facilities)

Large Health Systems

22%

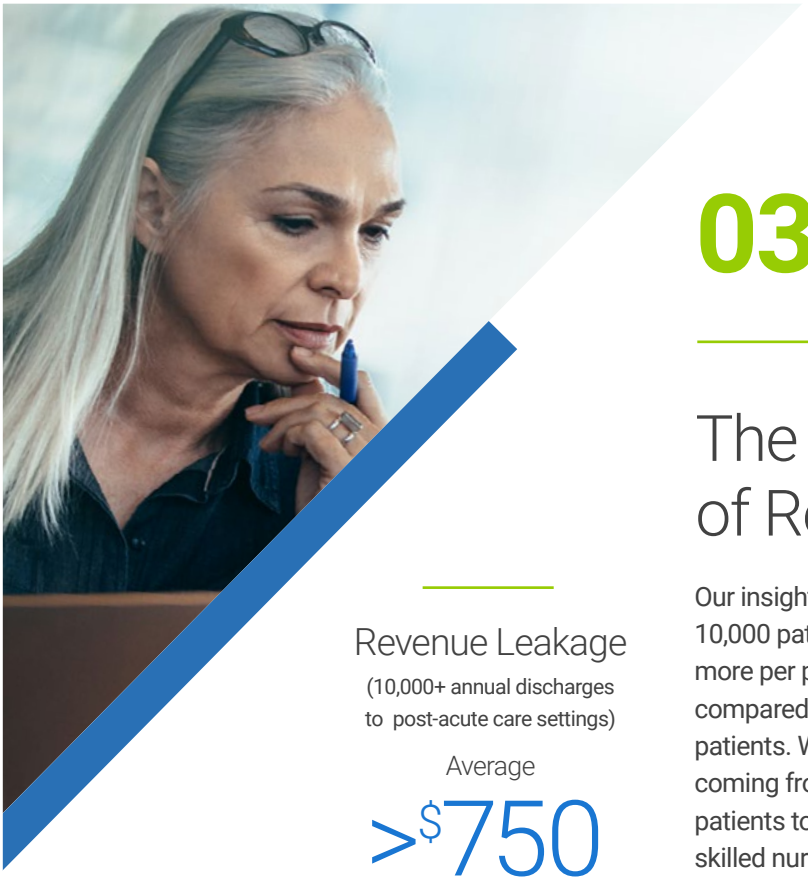
compared to

20.8%

Small Health Systems

Delving deeper into readmissions, our analysis has shown that larger health systems (10,000 or more discharges to post-acute care facilities) on average, have a higher network readmission rate of 22% compared to smaller health systems with an average of 20.8%. While these gaps between the two cohorts may not appear significant, don't be fooled.

This difference in readmission rates translates into a 5% increase in terms of real numbers of readmissions. With the average cost of rehospitalization to a health system sitting at $11,400 per patient, even a modest improvement in care transitions in the first 72 hours post-discharge, or care coordination during an episode can translate to a big impact on the bottom line.



Revenue Leakage
(10,000+ annual discharges
to post-acute care settings)

Average
>$750
per patient in
the following year revenue

03

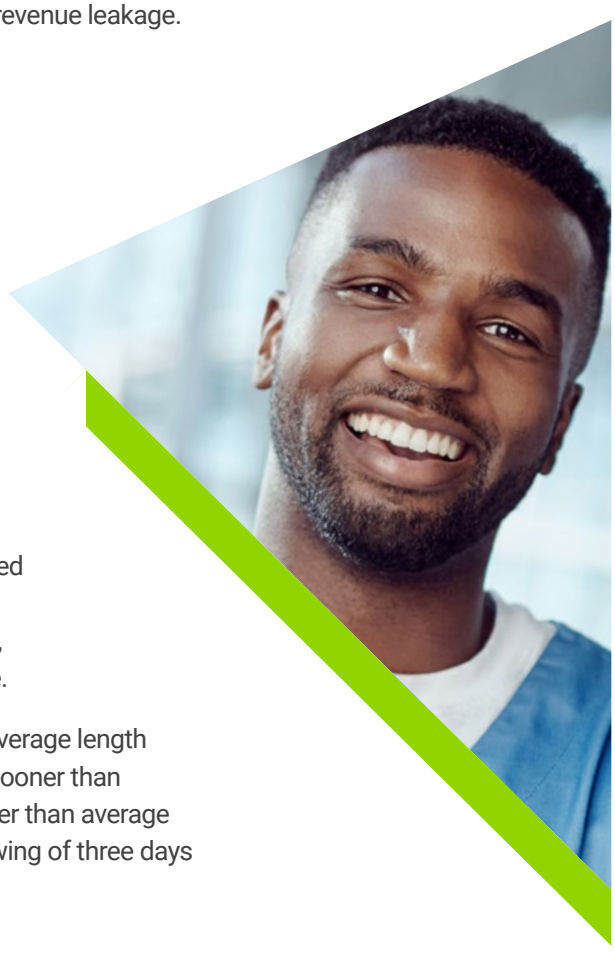
The Rising Risk of Revenue Leakage

Our insights show that hospitals that discharge more than 10,000 patients to post-acute care settings average $750 more per patient in revenue leakage in the following year -- compared to those hospitals discharging fewer than 1,000 patients. With 13% of overall revenue leakage typically coming from post-acute care, the overall impact of losing patients to other hospital systems after discharging to a skilled nursing facility has the potential to add up quickly!

Care Coordination has proven it has the ability to enable early medical intervention before an adverse or emergent event. This is critical for keeping patients in the network and preventing revenue leakage.

04

Reducing Length of Stay



When analyzing factors contributing to the average length of stay at a post-acute care facility, our analysis showed that the consistency of EHR vendors used across a post-acute network had a material impact. Hospitals who had a single, common EHR deployed in greater than 50% of their post-acute network facilities had a 1.4% lower average length of stay compared to the state average. By comparison, when there was no majority EHR deployed across skilled nursing facilities in a referral network, the average length of stay was 4.3% higher than the state average.

To translate these figures into real terms, a 1.4% decrease in the average length of stay represents discharging a patient a little less than one day sooner than the state average. Meanwhile, an average length of stay 4.3% higher than average would result in about two days longer in the facility. That overall swing of three days represents a big impact on the bottom line and patient outcomes.

05

Reducing Average Cost Per Episode

We also looked at the impact having a common EHR has on average cost per skilled nursing facility episode. When greater than 50% of the skilled nursing facilities in a hospital discharge network share the same EHR vendor, the average cost per SNF episode to the anchor hospital is 8% lower than the state average. Even more surprising is that when there is no majority among the EHR being used across SNFs in a discharge network, the cost per SNF episode to the anchor hospital is 20% higher than the state average. That equates to a spread of almost 30% between majority EHR use and no majority use.

Actions taken at skilled nursing facilities through EHR have a large financial impact on health systems. Adopting one vendor multiplies efficiencies throughout the care chain.

Average cost of SNF episode to anchor hospital

↓8%

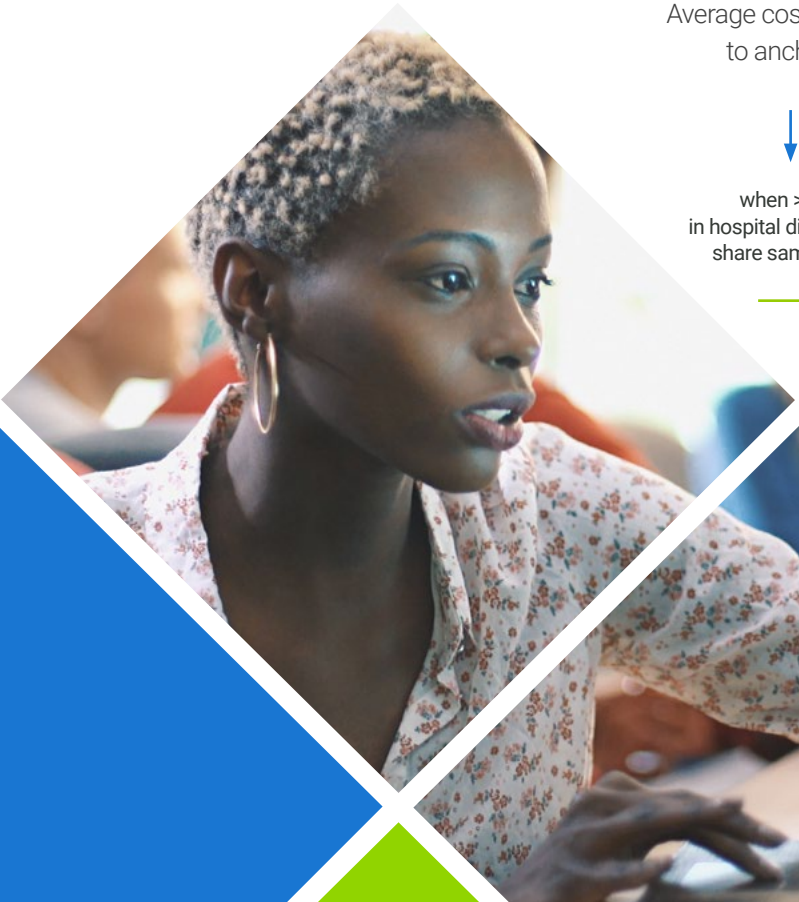
when > 50% SNFs in hospital discharge network share same EHR vendor

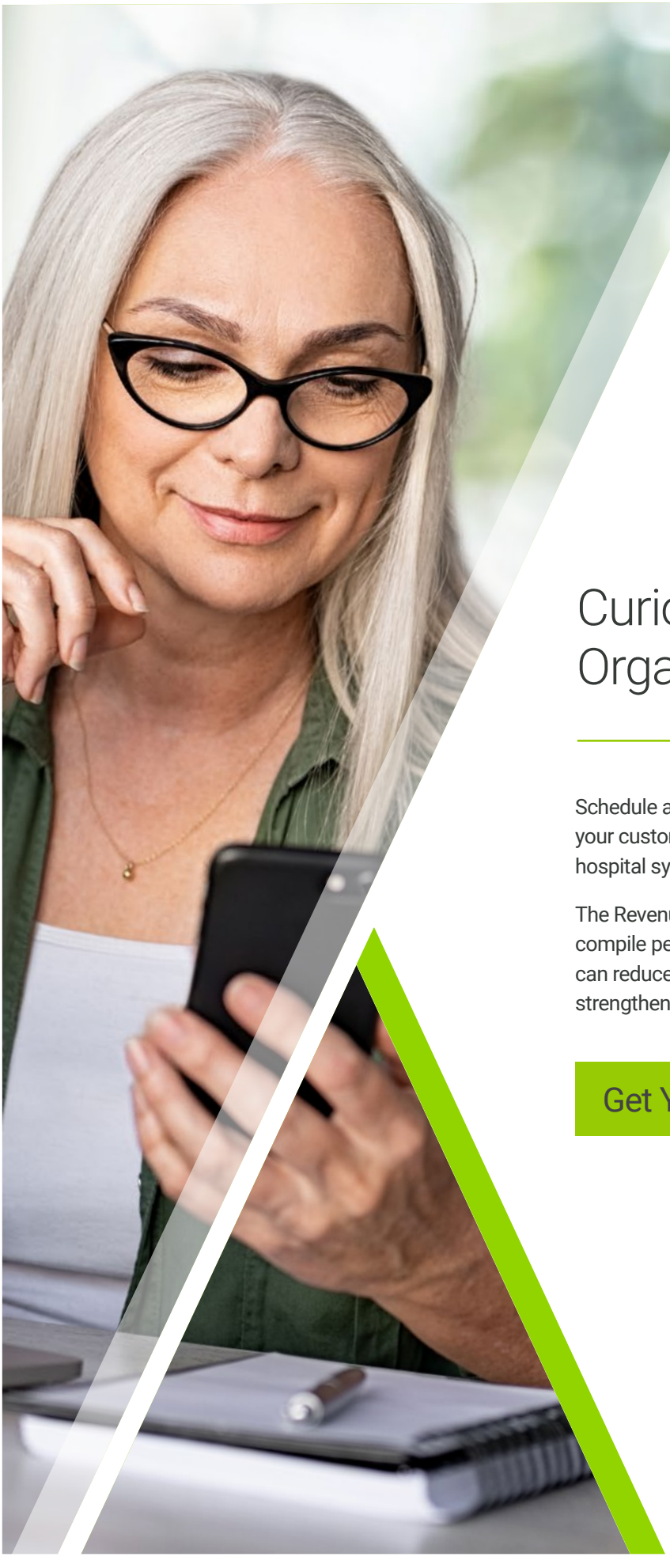
06

BPCI Programs Reduce Cost Per Episode

Finally, our analysis looked at the relationship between Bundled for Payments for Care Improvement (BPCI) programs and SNF cost per episode. What we found was that hospitals that opted into BPCI programs reduced their cost per episode by 15.8% on average (in their top five episodes) compared with hospitals who do not opt into BPCI programs.

Our insights show that BPCI programs do work! Hospital systems that partner with SNFs through BPCI programs can improve care coordination and reduce costs.





Curious How Your Organization Compares?

Schedule a 20-minute meeting with our team to review your custom Revenue Impact Report and see how your hospital system compares to state and local benchmarks.

The Revenue Impact Report analyses live network data to compile personalized insights on how your organization can reduce readmissions, prevent revenue leakage, and strengthen care coordination with your network.

Get Your Revenue Impact Report

PointClickCare®

Our award-winning Care Coordination solution, improves post-acute network management and patient outcomes with actionable insights about patients and facilities.

PointClickCare gives providers access to the right patient data in their existing workflow without disrupting care teams when discharging or receiving a patient. It helps monitor high-risk patients during their long-term post-acute stay by receiving live updates as patients' health changes. And it prevents readmissions and enhances care outcomes with a single place to monitor post-acute patients across facilities.

Request a Demo