Getting a Seat at the Table

OPTIMIZING THE RELATIONSHIP WITH YOUR ACUTE CARE PARTNERS

HTS is laser-focused on helping to position our clients to be the best partners in care. We have listed the most commonly requested and tracked metrics and conversations derived from countless hours of predictions talking with hospital CFOs, case management, care navigators, physicians, quality directors and nursing across four states. There is no silver bullet, as each hospital's objectives are unique. It is important to ask for a meeting with your hospitals independently. If they have not reached out to you…reach out to them first. **Show your hospitals that you bring value as a post-acute network provider!**

REPORTS TO PULL & ANALYZE

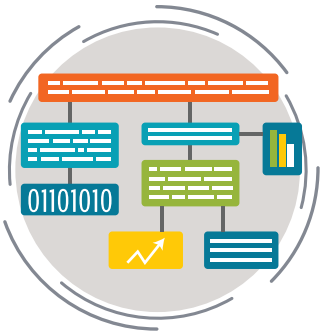
- **Quality Measures**
- **CASPER Report**

ITEMS TO PULL FROM YOUR CURRENT ELECTRONIC HEALTH RECORD

- **Average Length of Stay by Diagnosis**
- **Average Length of Stay by Payer (Medicare A, Managed Care)**
  - You may want to consider having a average LOS and median LOS to give a more clear glimpse into your program.
- **Are you a part of any insurance networks? List all payer options. Make note if you are already working with insurance case managers.**
- **What is your case mix percent in different types of diagnosis?—Cardiac, CABG, AMI, CHF, COPD, Pneumonia, Fractures, Joint Replacements, Sepsis, UTI, CVA/Stroke, etc.**
  - Does it track the number of cases or patients with these diagnoses?
- **Hospital Readmission Percent in the Last 30 Days: How many were within 72 hours?**
  - Do you use Abaqis or other type of software to calculate a risk-adjusted readmission rate versus a raw readmission rate?

SYSTEMS TO PREVENT HOSPITAL READMISSIONS

- **What systems or tools are you using to prevent re-hospitalizations?**
  - INTERACT, SBAR, and/or QAPI?
- **Do you have more than one medical director? Are your doctors working closely with you to prevent readmissions? If so, how?**



EDUCATION & CLINICAL PATHWAYS/PROTOCOLS

- **What type of clinical education do you provide to your nurses and aides to care for certain diagnosis?**
- **List any clinical areas of excellence or specialties.**
  - Reference Tool: INTERACT Nursing Home Capabilities worksheet
- **Do you offer special diets for cardiac, diabetic and renal patients?**

DISCHARGE PLANNING/CARE TRANSITION

- **What is your discharge planning/care transition process?**
- **Do you perform Med Reconciliations at the start and end of care?**
- **Are you scheduling doctor appts, labs, DME needs and home health, etc. prior to the patient returning home?**
- **Are you making follow-up phone calls at 24 hour, 3 day, 7-15-21-30?**
- **Are you collaborating with outside services (e.g. Meals On Wheels) to keep our discharged guests successful and sustainable at home?**
- **Does your pharmacy provide 30 days of medication at discharge or any medication follow-up?**
- **How are you tracking successful discharge? What percentage is readmitted back to your facility?**

EPISODIC SPENDING

- **Are you tracking your episodic spending? If so, is it similar to the way the hospital is tracking your cost of care? If it is not the same, you may consider tracking both ways.**
- **Can you report your cost per patient by diagnosis?**

Hopefully you are doing the majority of these things in order to get and KEEP a seat at the table of your acute care partners. This is not the be-all and end-all of lists—but a brief checklist of common requests. As they say..."In God we trust, all others bring data." **Continue to show your value and stay at it!**

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