Collective Medical helps skilled nursing provider cut hospital readmissions by 60%

Marquis/Consonus Companies

Marquis/Consonus Companies owns and maintains senior healthcare and assisted living facilities in Oregon, California, and Nevada. Operating through a network of home health care, assisted living, post-acute rehabilitation, Alzheimer's care, pharmacy and rehabilitation, intermediate care, and residential care facilities, Marquis focuses on person-centered care—putting individual's choices and experiences at the forefront of their care.

"Before utilizing the Collective Platform, our providers could only see what happened within their four walls. Now, with real-time visibility, they're able to support patients with the best possible care and keep them out of the hospital.**"**

- Anthony Laflen,
Director of Data
Analytics, Marquis
Companies

Challenge

In recent years, readmissions have become a major concern for many skilled nursing providers (SNFs) across the country. New payment models that incentivize providers for keeping recently discharged SNF patients out of the hospital and the mounting pressure from Value-Based Purchasing (VBP) models leave SNFs in a difficult situation. Under VBP, providers automatically receive a two percent cut in Medicare fee-for-service rates if they fail to comply with readmission improvement benchmarks.

If they lower their readmission rates, providers can earn the two percent cut back—but that's not easily achievable. The Centers for Medicare & Medicaid Services (CMS) report almost three-quarters of the providers in the country will receive a cut under VBP, but only 27 percent earn the "bonus" CMS provides to facilities with the best readmission scores.

After a patient is discharged from a SNF, the 30-day readmission window begins. In many cases, the SNF doesn't have control or visibility over the care the patient receives elsewhere. Additionally, if a patient seeks care at a hospital, the SNF will likely never know about the visit—and that patient could be discharged into a different SNF facility.

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Solution

Anthony Laflen, the Director of Data Analytics at Marquis, realized the intrinsic flaws of segmented healthcare. Not being able to track patients across care settings places a financial burden on providers and leads to poor patient outcomes.

In early 2018, Marquis joined the Collective Network and implemented the Collective Platform at its facilities to gain real-time visibility into patients across care settings. Collective currently supports more than 700 hospitals, every national health plan, and tens of thousands of providers and enables real-time visibility into when a patient is observed, admitted, transferred, or discharged.

If a former resident receives care at a hospital, Marquis care providers get an instant notification seamlessly delivered within their preexisting workflows. This workflow benefits both Marquis and nearby hospitals—SNFs can reach out to the hospital to potentially readmit the resident to the SNF, avoiding a potentially unnecessary and costly hospital readmission, and hospitals are likewise notified of the patient's history and care team contact information, allowing for seamless coordination. Marquis utilizes this invaluable information by collaborating with the hospital on any further care needs to avoid medically unnecessary readmissions.

Outcomes

In May 2018, Marquis implemented the Collective Platform across three of its Oregon-based facilities. Prior to implementation of the Collective Platform, these facilities had seen a combined average readmission rate as high as 19 percent.
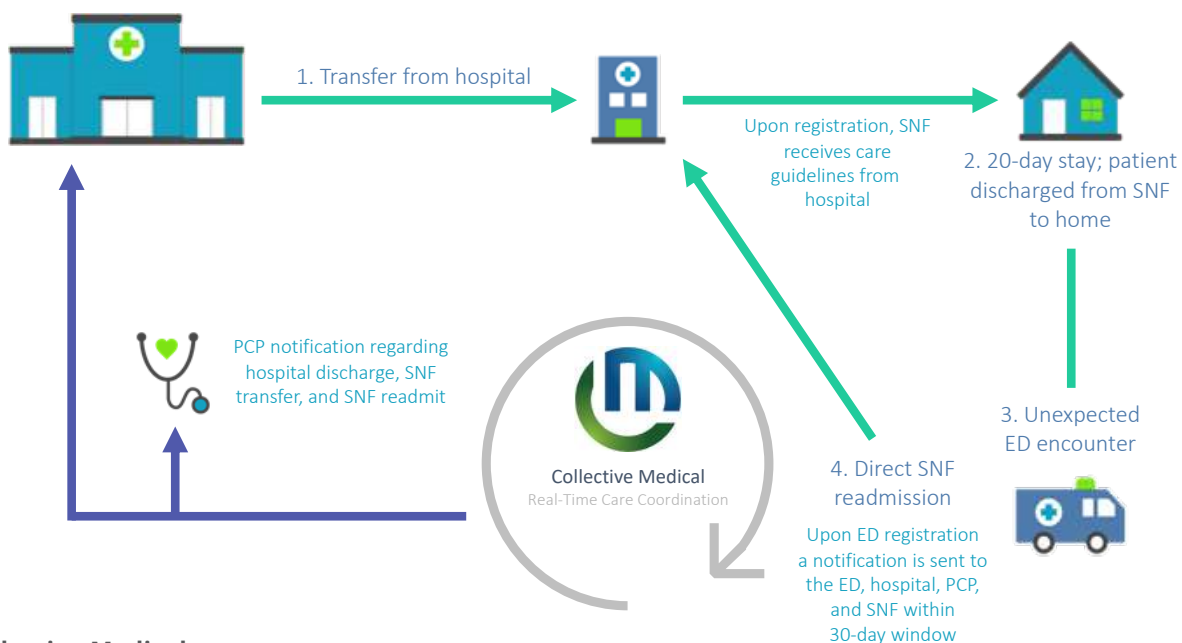
By June 2018, the rate dropped to 15.9%

By October 2018, the rate dropped to 6.3%

This represents an overall drop of 60% in less than 6 months

*The drop in Marquis's rate places it below CMS requirements. Avoiding this penalty qualifies Marquis to earn nearly $115,000 in reimbursements.

Patient Scenario:
SNF 30-Day Readmission Alert

1. Transfer from hospital

Upon registration, SNF receives care guidelines from hospital

2. 20-day stay; patient discharged from SNF to home

3. Unexpected ED encounter

4. Direct SNF readmission

Upon ED registration a notification is sent to the ED, hospital, PCP, and SNF within 30-day window

PCP notification regarding hospital discharge, SNF transfer, and SNF readmit

Collective Medical
Real-Time Care Coordination

About Collective Medical

Collective empowers care teams to improve patient outcomes by closing the communication gaps that undermine care.

www.collectivemedical.com

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