

The evolution of care: An annual care delivery report

from CarePort®, powered by WellSky®

2023 edition



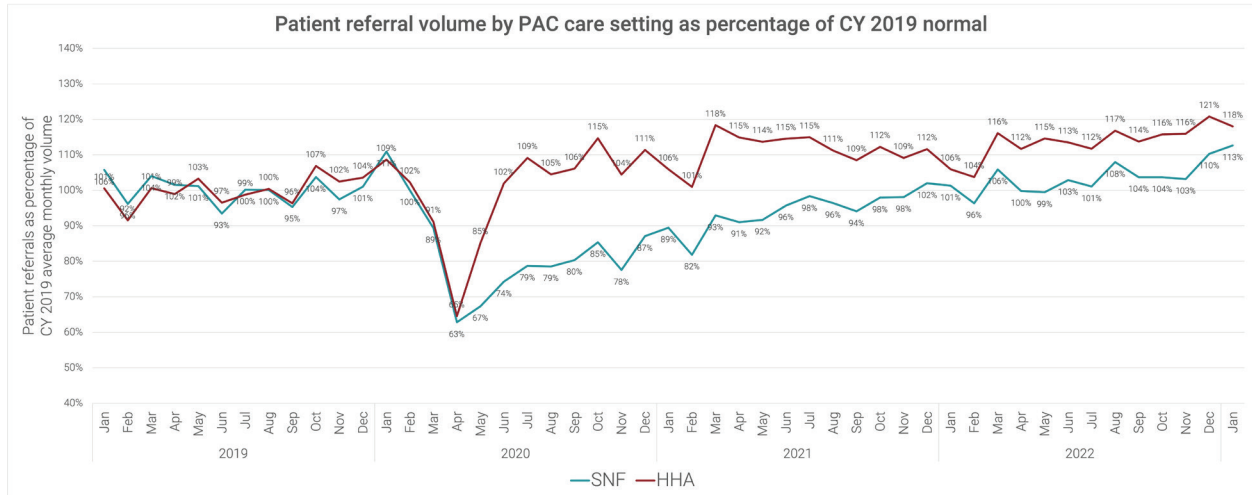
Key findings

- With the end of the public health emergency (PHE), providers need to prepare for the changes in policy, practice, and waived requirements.
- Hospitals are finding it harder to place patients in the face of rising demand for post-acute care:
 - The number of referrals has increased as patient acuity rises
 - Referral rejection rates are also increasing
- The time patients spend in the hospital prior to discharge has lessened from its peak during the pandemic, but it's still higher than pre-pandemic levels.
- Staffing shortages continue to be a challenge, with widespread burnout and increased turnover leading to the use of costly contract labor to fill gaps.

The COVID-19 pandemic has had a profound impact on healthcare delivery in the United States, highlighting the need for increased flexibility, innovation, and resilience in the face of a public health crisis. The Biden administration ended the COVID-19 Public Health Emergency (PHE) on May 11, 2023. The end of the PHE will mark a transition from emergency response mode to more regular modes of care delivery. Providers and facilities that were temporarily repurposed or reorganized to accommodate the demands of the emergency may need to be returned to their original use, and changes in regulations, funding, and policies could have significant implications for providers and systems. These changes will likely bring both challenges and opportunities for the healthcare industry as we adjust to the post-PHE world.

WellSky, a leading health and community care technology company, leverages its CarePort suite of solutions to support more than 2,000 hospitals and 130,000 post-acute care providers nationwide in coordinating care for more than 13 million patients per year. In this report, based on proprietary data from CarePort, we explore the ways care delivery has evolved over the last year and shed light on the implications for patients and providers as we enter a new era of healthcare.

Referral volume grows as providers face challenges finding post-acute care



In the face of rising demand for post-acute care, hospitals are finding it harder than ever to place patients in the appropriate post-discharge care setting. As of early 2023, referral volume to skilled nursing facilities (SNFs) has recovered – and grown – since 2022, while referral volume to home health agencies (HHAs) continues to be higher than pre-pandemic levels.

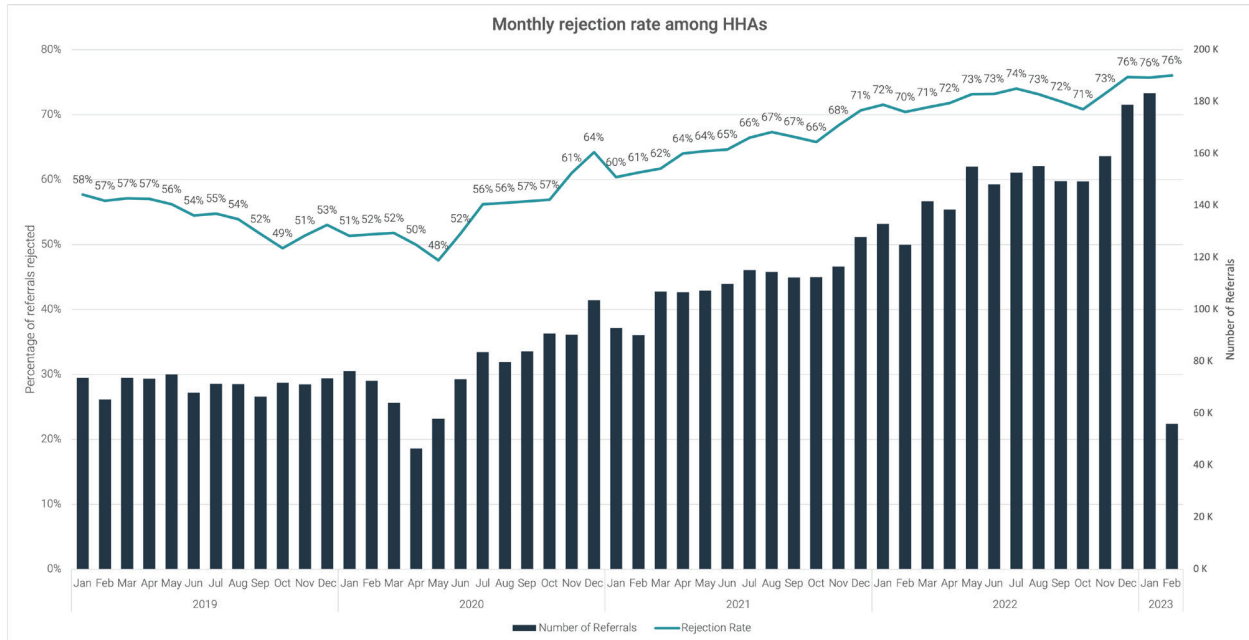


Since our [2022 report](#), SNF referral volume has increased 10%, likely due to the increase in demand for care and continued staffing shortages, while HHA referral volume has increased by 11%, according to data from CarePort.

2x Average increase in number of referrals per patient sent to skilled nursing facilities (SNFs) and home health agencies (HHAs)

40% Increase in HHA rejection rates

Additionally, while HHAs are receiving a higher volume of referrals overall, the number of referrals sent per patient also continues to increase as acute providers struggle to secure post-acute care for their patients in a timely manner. Furthermore, rejection rates to HHAs hit an all-time high at an average of 76% in December 2022, up from 54% in 2019.



The WellSky suite of CarePort care transition solutions helps providers optimize transitions of care and post-acute selection. These solutions provide intelligent care management capabilities through predictive analytics to enhance clinical decision-making, help hospitals find the right post-acute settings based on quality and outcomes, manage networks of high-performing post-acute providers, and streamline all transitions of care activities.

Using CarePort solutions, providers can facilitate “warm” handoffs to the appropriate next level of care to optimize outcomes, increase utilization management efficiency, streamline the post-acute prior authorization process, and understand their organizations’ transitions of care trends and patterns through advanced reporting capabilities.

CarePort also provides insight into factors like patient-readmission risk and eligibility for value-based care programs. It enables providers to be proactive and engage with patients earlier in their care to make more intelligent, informed care decisions, control spend, and improve outcomes.

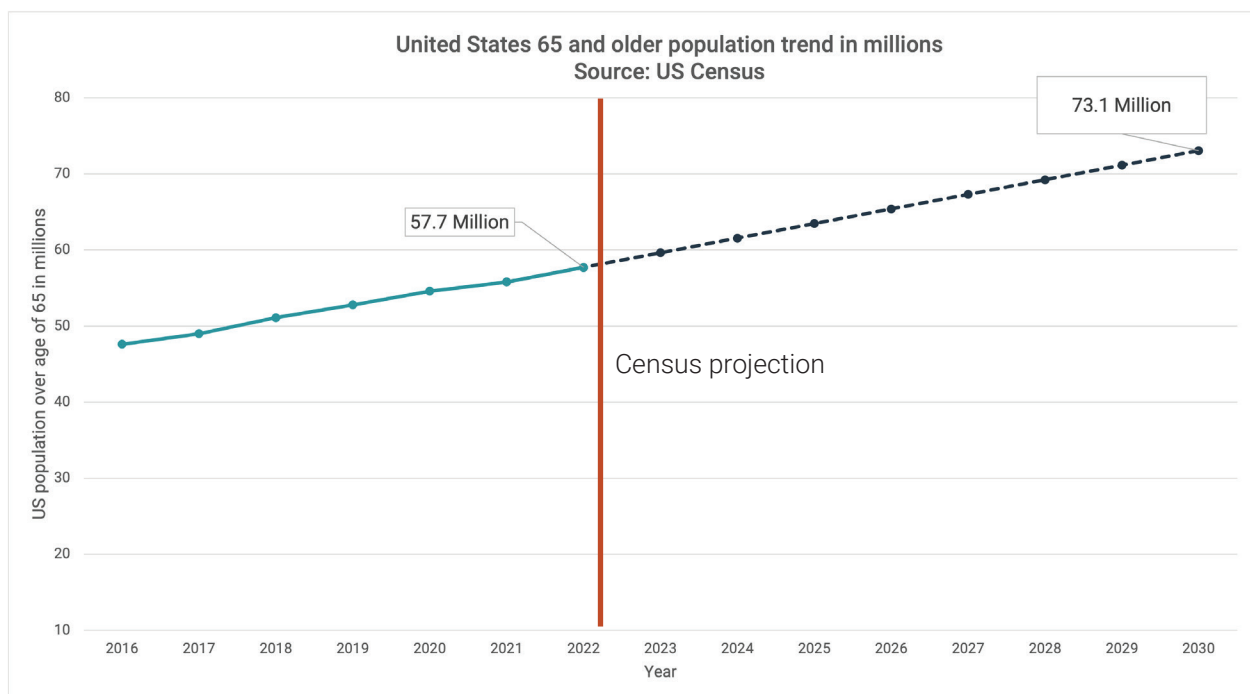
With CarePort, providers can see:

- ✓ Reduced length of stay (LOS)
- ✓ Lower readmission rates
- ✓ Increased staff efficiency and decreased manual processes
- ✓ Improved performance in value-based care programs

Higher acuity patients

As demand for care rises, data from CarePort shows that compared to 2019 averages, patients in the hospital are now 6% more acute (van Walraven Comorbidity Score) at discharge. Patients with higher acuity typically have more complex care needs and a higher risk of complications and readmissions after discharge. To address these more complex needs, providers need to arrange more services post-discharge, such as physical therapy, behavioral health, and medication management. These factors can make it more challenging to manage care and ensure a safe and successful transition from hospital to home or another post-acute care setting.

Another factor contributing to higher patient acuity is age. It is estimated that by 2030, 73 million baby boomers in the United States will be 65 or older. Chronic conditions such as hypertension, diabetes, and arthritis are more common in older adults and can contribute to higher acuity.




According to data from CarePort, from pre-pandemic 2019 to 2022, patients referred to post-acute care had relative increases in several conditions:

- Neurological disorders: **+17%**
- Pulmonary circulation diseases: **+8%**
- Alcohol-use disorders: **+16%**
- Psychoses: **+3%**
- Drug-use disorders: **+12%**

As patient acuity increases, so does hospital length of stay and the complexity and number of referrals required to secure care. This can put a further strain on an already challenged staffing and referral landscape.


Patients are spending more time in the hospital prior to PAC discharge

While improving since its peak in winter 2022, hospital average length of stay (ALOS) prior to post-acute discharge remains high and has increased by approximately one day since 2019. Increased hospital ALOS can increase costs, as patients require more resources and care for each additional day they spend in the hospital. It can also lead to longer wait times and decreased patient satisfaction and access to care. In addition, an increased hospital ALOS can reduce the overall capacity of the hospital, as patients occupy beds and resources for longer than necessary, which can limit the ability to treat new patients and may result in cancelled or delayed procedures.



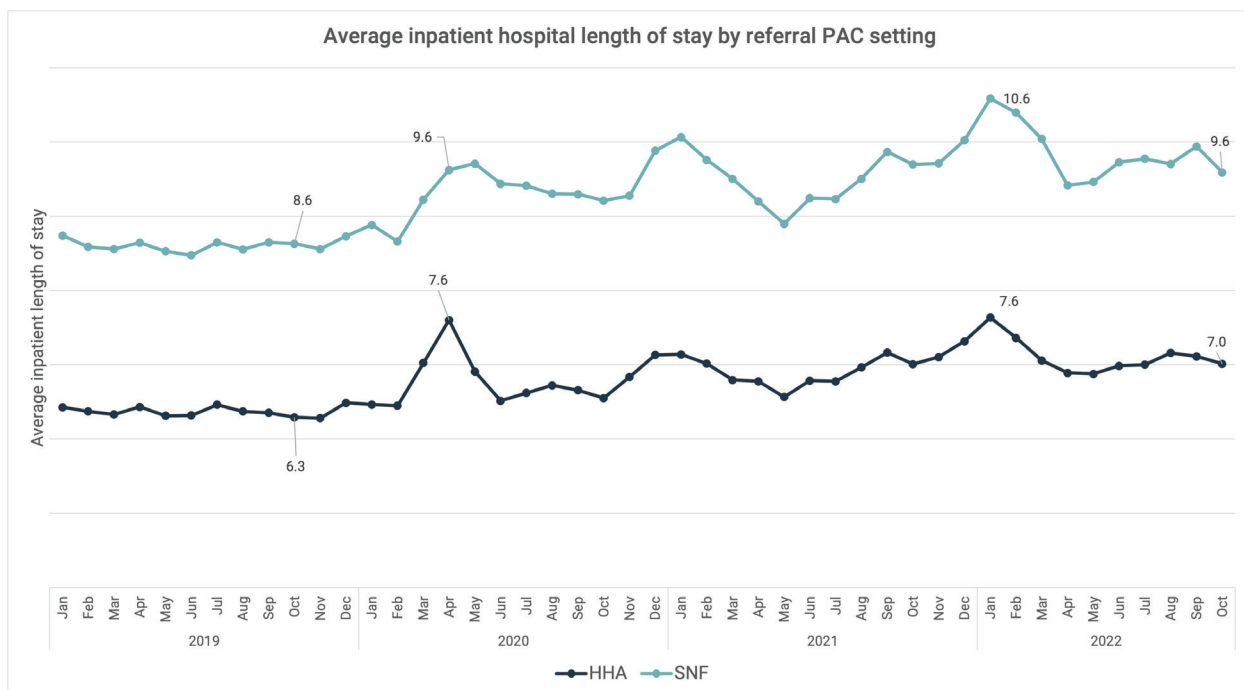
+12%

For patients discharged to SNFs, hospital ALOS has increased 12% (2022 vs. 2019)




+11%

For patients discharged to home health, hospital ALOS has increased 11% (2022 vs. 2019)







 Care managers, patients, and families use **CarePort Guide** in the WellSky suite of CarePort solutions to find post-acute care that meets patient needs based on provider quality and patient choice, helping to reduce discharge delays and increase patient satisfaction. CarePort Guide helps alleviate the difficulties often associated with identifying high quality post-acute care for a patient's specific needs through a maintained national database of post-acute providers, including HHAs, SNFs, and hospice providers.

Clients using CarePort Guide see:

- 7% average increase in the number of patients admitted to an in-network SNF provider
- \$914k estimated annual reduction in PAC spend
- Patients admitted to SNFs that are rated a half-star better than the average SNF

 With **CarePort Connect**, disparate providers that share patients across the continuum can gain the visibility to coordinate care through real-time, actionable insights that help improve patient outcomes and spend, and strengthen relationships with provider partners. CarePort Connect empowers providers with the intelligence to support clinical decision-making, risk prioritization, and streamlined workflows.

- 21% increase in number of transitional care management (TCM) calls completed year-over-year
- 10% reduction in hospital wide 90-day readmission rates
- 4% decrease in acute length of stay for patients discharging to SNF

 **CarePort Insight** enables hospitals and providers to actively build and manage effective high-performing post-acute collaboratives. CarePort Insight offers visibility and intelligence to help monitor and optimize provider performance with real-time measures, as well as to track outcomes for patient cohorts across the care continuum using one unified platform.

- 4% higher than average discharge-to-community rate
- 11% lower than market average risk-adjusted rehospitalization rate
- 3.9 day reduction in risk-adjusted LOS
- \$4.5 million estimated average annual value of building and maintaining a high-performing SNF collaborative with CarePort

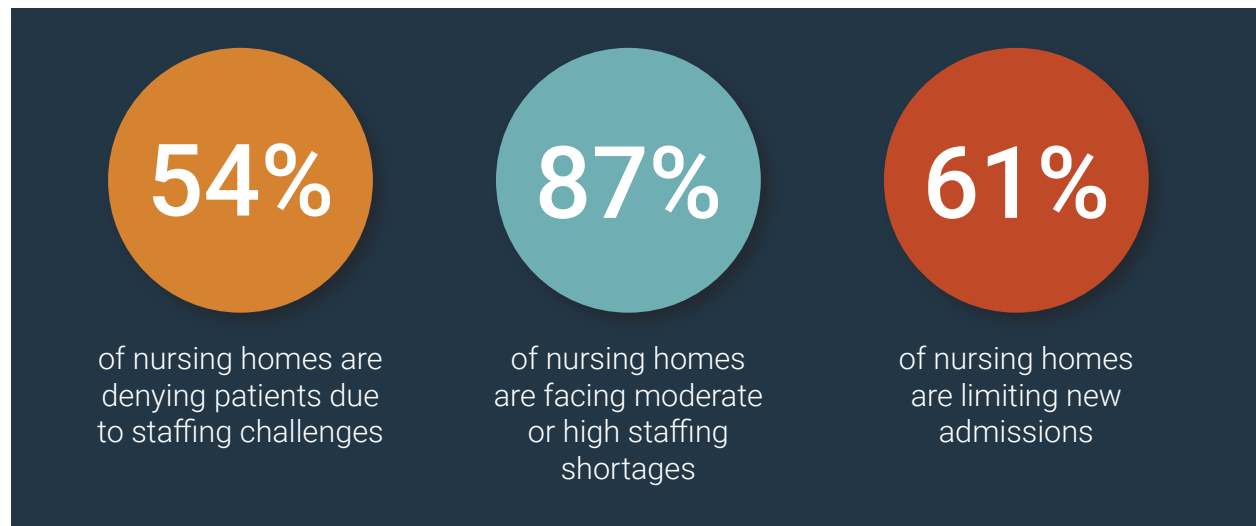
Staffing challenges persist

Despite the increasing demand for care, staffing shortages across the industry have continued to be a challenge in the wake of the COVID-19 pandemic. Issues with staffing have a significant impact on the healthcare industry as it can affect patient care, staff workload and burnout, and contribute to facility capacity issues.

Adequate staffing levels are critical to providing high-quality patient care. When facilities are understaffed, it can lead to longer wait times, delayed treatments, and decreased patient satisfaction. Furthermore, overworked staff are more likely to experience burnout, which can lead to decreased productivity, increased absenteeism, turnover, and have a negative impact on quality of care.

The skilled nursing industry remains 220,200 jobs below pre-pandemic levels, according to data from the Bureau of Labor Statistics, and shortages are highest among skilled nursing workers, such as nursing staff and aides, according to a report from the National Investment Center for Seniors Housing and Care. One of the strongest signs of staffing challenges is the use of staffing agencies. Since the pandemic, utilization of contract staff has increased threefold and continues to climb.

Staffing is particularly challenging in the SNF industry right now, and it is important to ensure a provider is adequately staffed to care for new patients. Low staffing can have a dangerous trickle-down effect, leading to heavier workloads, more stress, and burnout for remaining staff, as well as a negative impact on patient care. More staff is highly correlated with lower readmission rates.



The CarePort Referral Management and CarePort Intake solutions allow post-acute providers to receive, respond, and review all patient referral activity electronically – providing a simplified and automated process that enables a short-staffed workforce to better focus on patient care.

CarePort analysis highlights the importance of quick and efficient referral response times: Nearly half of placed patients go to the post-acute provider that responds within 15 minutes of an acute referral. With CarePort Referral Management, post-acute providers are alerted in real time of incoming referrals on their computer or mobile device and can expedite the referral process by reducing their typical response time by eight minutes on average. Additionally, post-acute

providers can automatically receive and respond to referrals from hospitals, as well as post-acute providers and community partners, in a matter of minutes – helping to transform workflows and patient outcomes.

Using the CarePort Referral Management and CarePort Intake solutions to facilitate faster referral responses, post-acute providers could see increases in their referral volume. According to a study of new CarePort Referral Management subscribers since 2019, PAC providers increased their total number of referrals by an average of 66% in the six months after becoming a CarePort Referral Management subscriber. In addition, PAC providers increased their total number of Medicare referrals by an average of 57% in the first six months. For SNF providers, this represents an average of \$1 million in potential Medicare fee-for-service reimbursement annually.



The impact of the end of the COVID-19 PHE

The Biden administration ended the COVID-19 national emergency and PHE declarations on May 11, 2023.

In the wake of this announcement, many providers are wondering how the end of these emergencies will affect their operations, as many of the federal programs and waivers developed in response to the PHE will have been in effect for over three years. While things like access to COVID-19 vaccinations, Medicare and Medicaid telehealth flexibilities, and the FDA's Emergency Use Authorizations for COVID-19 products will not be affected, there are many changes on the horizon.

Patient choice:

During the PHE, some of the existing regulatory flexibilities that were put in place to support patient and family decision-making were waived. Hospitals were not required to inform Medicare beneficiaries that they have a right to choose a PAC provider or to provide a full list of participating providers in the area where a patient lives or requests to go. Additionally, hospitals and HHAs did not have to share provider performance on quality metrics to assist patients and families in selecting an appropriate PAC provider.

Overall, the end of these flexibilities could have a positive impact on patient choice by increasing transparency and access to information. This could help patients and their families make more informed decisions about their post-acute care, leading to better outcomes and higher quality of care.

Qualifying hospital stay (Three-day stay):

During the PHE, the required three-day inpatient hospital stay to qualify for Medicare A coverage of SNF services was waived to allow beneficiaries to admit patients directly to the nursing home for skilled care regardless of and/or in the absence of time spent in the hospital, if the individual met all other qualifying SNF criteria. With the conclusion of the PHE, patients transferred from a hospital to a SNF in fewer than three days will once again incur out-of-pocket costs. However, those organizations participating in value-based payment models will still qualify for waivers.

Hospital at home:

During the pandemic, hospital-at-home programs became increasingly popular as a way to reduce the risk of COVID-19 exposure and conserve hospital resources. The Centers for Medicare & Medicaid Services (CMS) expanded reimbursement for hospital-at-home services during the PHE, which helped facilitate rapid adoption of these programs.

At the end of 2022, CMS extended the Acute Hospital Care at Home waiver until December 31, 2024. This will allow hospitals to provide hospital-at-home services and bill CMS for the equivalent of an inpatient hospital stay. The extension of this waiver is a strong indication that hospital at home will exist as a permanent part of the American healthcare landscape.

Overall, the end of the PHE is likely to bring both challenges and opportunities for the healthcare industry. Providers will need to adapt to changing reimbursement rates, staffing needs, and supply chain challenges, while also continuing to prioritize public health initiatives in the post-pandemic world.

Conclusion

Data from CarePort highlights the importance of collaboration between providers across the continuum of care. Patients discharged from the hospital have higher acuity and require more complex care coordination to ensure both access to and timely delivery of these services. Furthermore, as the PHE ends, providers will need to adapt to meet the changing needs of their patients and the healthcare landscape.

The aftermath of the pandemic, combined with the financial climate and an increasing need for technology and data, has dramatically changed the health care landscape in the last year. Data from CarePort shows that as demand for post-acute care continues to increase, intelligent care coordination technology — that provides visibility and powers clinical decision-making to ensure patients receive the right care at the right time — is more important than ever.



Learn more! Contact CarePort[®] to learn how your organization can leverage intelligent care coordination technology.

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