Guidehouse

Post-Acute, Readmissions, Enabling Care at Home

Guidehouse helps healthcare organizations with a range of post-acute, readmissions, and care at home strategies, including:

- Reducing acute care length of stay by removing discharge barriers.
- Improving margin of owned post-acute assets.
- Preventing readmissions.
- Filling gaps in the continuum.
- Forming partnership to improve quality and lower the cost of care.
- Addressing challenges emerging from COVID-19.
- Creating hospital at home and remote patient monitoring strategies.

Organizations are facing increasing margin pressures and operational challenges: an aging population with increasingly complex needs; an increase in Medicare and Medicaid spending driven largely by post-acute and long-term care services; a growing use of technology to manage and deliver care to patients; and an additional need for care coordination and population management across the continuum. Value-based payment transformation has refocused attention on the continuum of care and the opportunity for health systems to align with post-acute providers to improve quality, enhance the patient experience, and lower the cost of care. Optimizing post-acute, readmissions, and care at home strategies and operations are essential to achieving financial and clinical goals.

Guidehouse solutions span multiple venues of care, including inpatient rehabilitation facilities, skilled nursing facilities, long-term acute care hospitals, home health, hospice, palliative care, hospital at home, and outpatient rehabilitation. The lack of standardized pathways guiding post-acute utilization has significant quality and spending implications that impact payers and providers. Cost across the continuum highlights the need to pick the most appropriate level of care, particularly among high-cost and high-complexity patients enrolled in Medicare and Medicaid.

Guidehouse helps payers, providers, and government entities improve patient experiences and clinical outcomes along the continuum of care.

Solutions

- Development of Preferred Post-Acute Partnership Networks
- Evaluation of Strategic Partnership Models
- Enabling Care at Home
- Clinical and Operational Effectiveness
- Positioning for Payment Transformation
- Post-Acute Bed Demand Analysis
- Reduction of Avoidable Readmissions
- Continuum Care Management Models
- Development of a SNFist Program

Key Trends Driving the Focus on Post-Acute Care, Readmissions, and Enabling Care at Home

1 Triple AIM
Post-acute care has received heightened focus as a critical component to achieving the Triple Aim

2 Payment Transformation
Payment transformation continues to evolve, shifting risk to providers resulting in new approaches to post-acute and long term care

3 Spend Comparisons
Value-based reimbursement is emphasizing post-acute payment differentials and shifting post-acute utilization patterns

4 Network Formation
Post-acute networks are being developed to align with providers for improved performance / development of preferred post-acute networks and are influencing patient informed choice

5 Volume Shift
Post-acute volumes are shifting

6 Managed Care
As populations are transitioned to managed plans, authorization processes become more stringent

7 New Models
New post-acute models continue to evolve as alternative to more costly levels of care

8 New Regulations
Ongoing changes in post-acute regulations will continue to significantly impact historical work processes and paradigms

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