



Open More Beds During COVID

How hospitals and risk-bearing ACOs can manage patients safely and more cost-effectively

Patient safety has always been a concern of providers—and even moreso during the pandemic.

In 1999, the number of deaths were estimated to be as high as 98,000 by the Institute of Medicine’s “To Err is Human” report. After the release of that report, the healthcare industry underwent a significant shift in how it prioritized patient safety. As the past 20 years have shown, patient safety is of paramount importance to the healthcare field.

These days, however, that call to patient safety is being tested as **healthcare providers grapple with two concurrent and unprecedented threats to safety**—a steep rise in in-patient volume during each surge of the pandemic coupled with the (related) severe labor shortage as healthcare workers leave the workforce in unprecedented numbers. In the face of these challenges, **hospitals and risk-bearing ACOs also face a third threat**—they are being increasingly paid for “value over volume.”

How can hospitals and risk-bearing ACOs face this triple threat? By opening more beds—now.

By acting now to **more precisely align medical necessity with the intensity of services provided, institutions can move patients to more appropriate care settings**, thus opening more hospital beds—which is paramount to ensuring patient safety during COVID surges (and beyond) and providing financially viable healthcare.

The key to aligning patient needs with the right services and setting: The right clinical data with the RIViR AI-powered technology platform.

Tackling the complexities of managing patient populations is difficult without having a direct line of sight into exactly who that population is, the conditions that require treatment, and an analysis of the right healthcare setting—from an observation room to an outpatient clinic—to treat each patient safely and cost-effectively. Providers need to also re-evaluate where elective surgeries take place to ensure both safety during the pandemic and the changing payment landscape.

Qlarant’s RIViR solution, a technology platform powered by 100+ AI models that focus on clinical outcomes of utilization across all areas of spending, evaluates risk-adjusted frequency of hospitalizations as well as use of emergency departments, observation beds and in-patient utilization across clinical entities in a hospital. **RIViR then compares that data to other peer institutions to identify abnormal variations that—rather than being driven by value spending—are instead wasteful processes or behaviors.** The result? In as little as a few weeks, providers using RIViR are able to open more beds, reduce the risk of transmission to others, and alleviate their staff shortages.

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In the graphic below, RIViR compares three hospitals in Ohio in how they treated patients presenting with heart failure. RIViR highlights the large amount of variation in site of care (after adjusting for demographics, disease severity and comorbid illness).

	Cases Across Three Settings	Predicted Inpatient Cases	Predicted Observation Cases	Predicted Outpatient Cases	Observed Inpatient Cases	Observed Observation Cases	Observed Outpatient Cases	PCT INPT	PCT OBS	PCT EDHOME	O/E INPT (Lower is Better)	O/E OBS (Higher is Better)	O/E EDHOME (Higher is Better)
Hospital A	593	494	23	76	362	58	173	61.05%	9.78%	29.17%	0.73	2.57	2.26
Hospital B	1039	774	50	215	747	45	247	71.90%	4.33%	23.77%	0.96	0.90	1.15
Hospital C	744	672	20	52	726	7	11	97.58%	0.94%	1.48%	1.08	0.36	0.21

Using RIViR, these hospitals can immediately see where they need to streamline the process of matching medical necessity with intensity of services, thus safely opening more beds for patients and reducing staffing needs.

Hospital A

RIViR shows how **Hospital A is maximizing capacity by aggressively managing patients at first presentation to the hospital and sending them home after evaluation and management.** For Hospital A, this results in a 27% lower rate of inpatient utilization (after adjustment for patient severity of illness).

Hospital C

In stark contrast, RIViR shows **Hospital C is admitting many heart failure patients to the inpatient setting.** This is reducing capacity for other patients, creating a less safe patient environment during the COVID surge, and putting stressors on existing staff. If Hospital C was operating at the same efficiency as Hospital A, with the same acuity patients, the institution would have 182 fewer patients annually, amounting to 728 fewer inpatient days.*

*Calculation: 182 less patients are derived from: 672 which is the predicted inpatient cases - (726 inpatient cases * 0.73 which is Hospital A's efficiency / 1.08 which is Hospital C's efficiency) = 181.3 (approx. 182). 728 fewer inpatient days = 182 less patients * 4 days of inpatient stays on an average

Open more beds during COVID surges:

By showing you where to redirect your clinical staffing capacity and how to use existing utilization protocols to transfer patients to safe and more cost-effective settings, RIViR can help you quickly transition to the lower in-patient numbers shown by Hospital A for 30 clinical entities.