Preferred Skilled Nursing Facility Network Partnerships
Virginia Health Care Association & Virginia Center for Assisted Living
2016 Convention and Trade Show
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Health Dimensions Group
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Agenda
• Introductions
• Current trends impacting health system and influencing expansion of provider networks
• Intricacies of best-in-class post-acute network, including:
  – How to choose best partners
  – Outcome expectations
  – Maximization of network results through continuous quality improvement and collaborative tactic
• Survival outside of a network
• Case study review
• Questions and discussion

Introduction to Health Dimensions Group
Lori Aronson, MBA, NHA  
Manager of Consulting Services

- More than 15 years of experience in the health care industry, with a focus on post-acute care and the senior population
- Expertise in post-acute network development; physician practice development and operations; and Program of All-inclusive Care for the Elderly (PACE), skilled nursing, and telehealth operations
- Provides assistance to post-acute health care organizations with operational assessments, strategic planning, program development, due diligence activities, and continuing care development
- As director of senior services at TriHealth, worked collaboratively with nursing and post-acute facilities in the Greater Cincinnati area to improve outcomes for patients throughout the care continuum
- Serves on Public Policy Committee of National PACE Association and presents nationally at industry events

Health Dimensions Group: 
What We Do

Strategic Consulting
- Strategic planning and positioning
- Health care continuum alignments
- Market growth strategies
- PACE development
- Bundling implementation
- Senior service line development
- Post-acute medicine development

Operational and Performance Improvement
- Clinical
- Financial and billing
- Regulatory compliance
- Reimbursement advisory
- Transaction advisory
- Business office support
- Operations re-engineering

Management Solutions
- Strategic planning and positioning
- Turnaround management
- Transitional leadership
- Full-service management
- Acquisitions & divestiture
- Interim management

The Case for Building a Skilled Nursing Facility (SNF) Network

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The Case for Building a SNF Network:

**Background**

Affordable Care Act:
- Created shifting landscape toward value-based care
- Mandated managing patient populations across entire care continuum
- Prompted hospitals to work more closely with post-acute providers
  - Hospitals face Medicare penalties for high readmission rates and Medicare spend per beneficiary

**Results**

- Establishing narrow networks of post-acute partners can encourage providers to improve quality of care
- Tactics for improving care between acute and post-acute partners include “warm handoffs”
  - Actual conversations, not just exchange of paperwork, between clinicians on both sides
- New staffing models gaining ground
  - SNFists
  - Nurse care navigators

Costs Vary by Initial Post-Acute Setting

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<tbody>
<tr>
<td>HHA</td>
<td>$13,470</td>
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<tr>
<td>SNF</td>
<td>$20,318</td>
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<tr>
<td>IRF</td>
<td>$33,295</td>
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<tr>
<td>LTCH</td>
<td>$45,293</td>
</tr>
<tr>
<td>STACH</td>
<td>$23,679</td>
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<tr>
<td>Community</td>
<td>$12,388</td>
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Overall Average = $14,928
Post-Acute Care Plays Key Role in Bending the Cost Curve

Health systems often have limited control of costs and outcomes sent to nonaffiliated post-acute settings.

Medicare FFS Acute Hospital Discharges

- Skilled Nursing Facility (SNF): 20%
- Home Health: 17%
- Acute Rehab: 4%
- LTACH: 1%

42% Sent to Post-Acute

Sometime an essential setting for controlling total costs and managing outcomes.

Value- and Outcome-Based Payment Growth

Health and Human Services set goals for Medicare fee-for-service (FFS) payments linked to quality and alternative payment models in 2016 and 2018 targets.

- All Medicare FFS: 2016
- FFS linked to quality: 2016
- Alternative payment models: 2016

Health Care Transformation Task Force

Several of nation’s largest health care systems and payers, joined by purchasers and patient stakeholders, have committed 75% of their business into value-based arrangements by 2020.

2022 Goal: Minimum 50% of Total Medicare PAC Provider Payments Bundled

Reduce Spend by 2.85%
The Traditional Continuum of Care

Hospital → Rehab → Skilled Nursing Facility

Long-term Acute Care Hospital → Home Health Agency

The Problems:
- Medicare dollars are spent at every phase of continuum
- Hospitals financially responsible for:
  - 100% of post-acute spending
  - 40.3% of all Medicare spending

Controlling Readmissions Is Key to Success

Cost of 30-Day Fixed Length Episode With and Without Readmission

MS-DRG 247: Percutaneous coronary intervention with drug-eluting stent w/MCC
MS-DRG 470: Major joint replacement or arthroplasty of lower extremity w/o MCC
MS-DRG 481: Hip and femur procedures except major joint w/CC
MS-DRG 192: Chronic obstructive pulmonary disease w/o CC/MCC
MS-DRG 194: Simple pneumonia and pleurisy w/CC
MS-DRG 291: Heart failure and shock w/MCC

Post-Acute Cost and Quality Control Attributed to ACO Savings

- Banner Health Network (BHN), a remaining Pioneer ACO, accounted for $29 million in total savings; the Montefiore ACO saved $18 million
- Officials at both organizations said performance was boosted by attention to PAC costs and quality
- BHN ACO developed preferred network of SNFs & recommends those facilities to patients, vetting local SNFs with questions on quality and culture
- BHN CMO indicated improvement in PAC was significant contributor to ACO’s results
- Montefiore ACO worked with SNFs to avoid hospitalization, where possible, by finding alternatives for services that could be delivered elsewhere, such as blood transfusions
Which Post-Acute Vendors Will Win?

- Large, market- and geographic-dominant providers
- Hospital-based providers valued by their system
- Providers with aligned interest of payors and referring partners
  - Lowest-cost provider
  - Focused on same quality metrics as partners
- Proven partner with verifiable data

Fundamentals of SNF Network Design

- Attendance at ongoing meetings in conjunction with reactive communication is a necessity
- PAC facilities must regularly report quality metrics to ensure continued eligibility in affiliation networks
- Standardization of referral protocols ensures rapid placement of patients in appropriate PAC settings
- Acceptance tracking generates data for future conversations between hospitals and PAC facilities
- Standardized referral protocols
- Clinical Quality Reporting
- Patient Acceptance Tracking
- Require Ongoing Communication
- Four Essentials of PACN Relationships
  - Acceptance tracking generates data for future conversations between hospitals and PAC facilities
  - Standardization of referral protocols ensures rapid placement of patients in appropriate PAC settings
  - Clinical Quality Reporting
  - Patient Acceptance Tracking
  - Require Ongoing Communication
  - PAC facilities must regularly report quality metrics to ensure continued eligibility in affiliation networks
### How Hospitals and Payors are Selecting Post-Acute Partners

**Demonstrated access and quality outcomes**
- Data proving low 30-day hospital readmission rate across your post-acute episode (SNF-HHA, LTACH-SNF, IRF-HHA)
- Immediate admissions; competencies for high-acuity, medically complex patients; solutions for difficult-to-place patients
- Appropriate use of hospice

**Integration with primary care physicians (PCPs)**
- Embedding PCPs into post-acute and senior services
- Communication, reporting solutions for patients with non-medical needs

**Care management**
- Care transitions (between all settings); care navigation beyond episode

### Networks: Metrics for Getting In

#### Common Criteria for Selection

- High-Volume Discharges
- Patient Experience
- Case Managers'/Physicians' Experience
- ACO Network Physician/NP in SNF
- Hospital Readmissions
- SNF Length of Stay, Cost

### Additional Measures

Other measures and metrics may also impact payment, depending on MCO, ACO, or potential partner:
- State survey scores
- CMS Five-Star Quality Rating
- Clinical indicators:
  - Acquired pressure ulcers
  - Falls
  - Restraint usage involving CMS quality indicators (e.g., NQF’s 21 measures)
- Employee satisfaction and turnover
- Facility leadership/senior staff tenure

We should additionally expect that reporting time frames will grow closer to real-time!
Networks: Metrics for Staying In

<table>
<thead>
<tr>
<th>Metrics for SNFs</th>
<th>Expectation</th>
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<tbody>
<tr>
<td>Patients who “probably” or “definitely” would recommend SNF to others</td>
<td>≥ 90%</td>
</tr>
<tr>
<td>Patients readmitted for all causes, all diagnoses, from SNF to acute care setting or less from discharge from acute care setting</td>
<td>&lt; 10%</td>
</tr>
<tr>
<td>Within 72 hours of SNF admission, number of patients referred to emergency department (ED)</td>
<td>&lt; 10%</td>
</tr>
<tr>
<td>Patients discharged from SNF to home</td>
<td>≥ 80%</td>
</tr>
<tr>
<td>Patients discharged from SNF to home with evaluation for home health agency (HHA) services</td>
<td>≥ 80%</td>
</tr>
<tr>
<td>SNF ALOS ≤ 15 days</td>
<td>≥ 80%</td>
</tr>
<tr>
<td>Patients who had palliative or hospice care referral prior to death</td>
<td>≥ 80%</td>
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A “Health Care Neighborhood”
For Those with Advanced and Chronic Illness

Overview of the Process
HDG’s Approach to Building a SNF Network
Continuing care/SNF networks focus on a select group of providers to deliver high-quality care; leverage clinical expertise and oversight; and improve efficiency, patient outcomes, and patient experiences.

Goals of SNF Network

Communications
- Affiliation agreement
- Intranet site
- Monthly meetings
- Education to improve clinical skills
- Standardizing practice across settings
- Compliments and complaints
- Hard-to-place patients
- Public transparency for SNF and members’ performance

Monitoring
- Meaningful quality information
- Site visit findings
- Readmissions monitoring
- Complaint tracking
- Volume by facility
- Hospital-paid care assistance
- Patient-family surveys
  - How well were you prepared for discharge?
  - How satisfied were you with the SNF?

Our Experience: Some Keys to a Successful SNF

SNF Network as Part of Broader Overall Strategy

- Post-acute medicine providers/SNFists
- Home health network
- Post-acute care coordinators
- Care transformation
- Emergency department diversion
- Community-based services
Proven Steps to a Successful SNF Network

Develop post-acute assessment and strategy

Analyze SNF access & related organizational practices

Evaluate market area SNF provider organizations and gap analysis

Develop SNF and SNFist network

Redesign care to effect an acute/post-acute continuum

Establish means to measure return on investment (ROI)

Develop Post-Acute Assessment and Strategy

• Conduct internal organizational assessment relating to post-acute outcomes, historical SNF use, and potential future need:
  - SNF utilization
  - Provider visits/SNFist
  - MS-DRG LOS analysis
  - Discharge volume by post-acute provider
  - MSPB analysis

• Review any post-acute provider data already gathered

• Request additional information to support analysis and subsequent strategic recommendation development

• Evaluate market area SNF provider organizations and gap analysis

Analyze SNF Access and Related Organizational Practices

Determine number and types of post-acute skilled nursing beds and geographic coverage needed to support current & future hospital volume:

• Identify geographic and specialty program needs

• Identify hospital length-of-stay issues related to patients discharged to post-acute venues

• Characterize geographic area to be covered

• Assess internal capacity of post-acute assets and strategic relationships and their impact on need for SNF beds

• Identify most important needs of physicians and case managers relative to SNF discharges

• Understand historical practices regarding SNF use, challenges, anecdotal perceptions about market providers, and other dynamics not reflected in quantitative analyses
Evaluate current provider base to determine market capacity and clinical ability to address potential SNF needs:

- Review public and commercially available data regarding SNF provider performance to develop summary evaluation grid of potentially suitable providers
  - Medicare Five-Star Quality Rating summary quality data
  - Staffing and survey history
  - State quality data
  - Cost report indicators
- Survey sample group of SNF providers to gather expanded data on capacity and capabilities of SNF providers that receive highest volume of historical referrals and can potentially meet geographic needs of patients

Evaluate Market Area SNF Provider Organizations and Gap Analysis: Evaluate Current Provider Base

Moving forward with SNF preferred network development includes:

- Detailed findings of analyses and research
- Strategic recommendations to answer 3 implied questions:
  - Degree of SNF services needed
  - Securing access to such services
  - Potential goals for a network based on current outcomes
- Organization leadership involvement regarding potential infrastructure required to address these areas and next steps for organization to ensure successful post-acute SNF network

Selection criteria vary by network, depending on organization’s needs; some general measures emerge across all networks:

- Five-Star Quality Rating
- Facility size, physical organization, and capacity
- Private versus semi-private room distribution
- Average LOS for Medicare FFS and managed care
- Short-stay to LTC transfer rate
- Program specialties and capacity
- Primary care coverage and medical director relationship
- Leadership tenure and turnover
- DRG specific bundling or risk experience
- Staffing, especially RN coverage
- Therapy provision
- (5 versus 6 versus 7 days/week)
- INTERACT deployment and use
- EHR deployment, use, and integration
- FIM subscriber status
- Admission volume and “churn”
- Complex care delivery by volume
- 30- to 90-day readmission rates
- Survey history
- Community discharge rates
- Number of patients discharged to HHA

Evaluate Market Area SNF Provider Organizations and Gap Analysis: Develop SNF Network

Evaluate Market Area SNF Provider Organizations and Gap Analysis: Selection Criteria
Visit post-acute venues, develop criteria grid, and select facilities in concert with post-acute facility bed need:
• Develop criteria grid for post-acute settings, taking into account bed needs; needs for geographic coverage by home health and hospice; and findings from surveys, interviews, and site visits
• Conduct introductory meeting of post-acute venues to discuss most important needs of organization for post-acute settings in network; includes credentialing criteria and data that will be collected and reported monthly
• Assist leadership in defensible selection process for post-acute venues for network in each area
• Prepare and facilitate launch meetings of established standing committees for network implementation and monitoring

• Review needs and opportunities with physician for physician group, other relevant physicians, and organization leadership to discuss and design SNFist program and medical care management specific to SNF network
• SNFist practice can manage patients in network; desired outcomes:
  – Structure
  – Expectations of SNFists clearly outlined
  – Leadership
  – Compensation
  – Staffing
  – Provider types
  – 24/7 coverage
  – Reporting process developed

![SNF Patient Encounters and Unplanned Discharges](source: IPC Analysis 2012)
Redesign Care to Effect an Acute/Post-Acute Continuum: Collaborate with Network Members

Collaborate with network members to redesign care to effect integrated acute/post-acute continuum and ensure SNF care delivery model, leading to return on investment

- Through hospital data and staff input, identify specific throughput challenges
- Establish strategies to identify and target patients with most complex and costly care needs
- Furnish guidance for hospital on assessing needs for and providing outreach education to PAC venues in network; and measuring the results of education

Redesign Care to Effect an Acute/Post-Acute Continuum: Determine Care Redesign Elements

- Physician involvement and availability
  - One study pointed out average number of combined visits per month was only 0.83 in FFS setting
- Diagnostic testing availability
- Nursing assessment skills
- Clinical competencies of staff
- Nurse/physician communication and understanding
- Advance directives, surrogate decision making, end-of-life planning
- Family expectations
- Transition issues—accurate transfer data and medical info, continuity of care

Redesign Care to Effect an Acute/Post-Acute Continuum: Develop Care Management Strategies

Develop care management strategies across continuum, beginning in acute care setting:

- Identify risk for rehospitalization
- Establish and identify appropriate registry for complex patients
- Initiate provider notification communication channels across continuum regardless of point of entry
- Engage in early identification and planning for SNF discharge
- Incorporate advance care planning/palliative care/hospice referral systems
- Establish intentional patient/family interface with SNF network and supported decision-making
- Establish warm handoffs between all internal and external settings (e.g., acute to SNF; SNF to IRF or HHA; and SNF to home with primary care physician coverage)
- Integrate with other care management programs offered, and other key components of care processes
Redesign Care to Effect an Acute/Post-Acute Continuum: Identify Strategies to Achieve Triple Aim

Identify across continuum strategies to meet 7 essential intervention categories for reaching Triple Aim:

1. Medication management
2. Transition planning
3. Patient and family engagement & education
4. Health care providers' engagement
5. Follow-up care
6. Information transfer
7. Shared accountability across providers and organizations

Establish Means to Measure Return on Investment (ROI)

- Establish internal metrics to measure effectiveness and ROI of PAC network
- Suspend PAC venues that fail to comply with credentialing criteria and/or achievement levels for metrics; ROI monitoring activity could include:
  - Analysis of readmission rates of SNF discharges
  - Root cause analysis for continuous outcome improvement on key indicators:
    - Readmission, infection, pressure ulcers
  - Length of acute stay of current SNF discharges
  - Length of stay in SNF post-discharge
  - Outcomes analysis of network member submitted data
  - Customer service ratings along with comparison to data post-implementation

Surviving Outside of the Preferred Network

Become a valued customer
- Medical directors
- Rounding physicians, nurse practitioners, and physician assistants
- Laboratory and phlebotomy services
- Oxygen and durable medical equipment
- Home health and hospice

Find your specialty and set yourself apart
- E.g., wound care, psychiatric support, chronic illness management

Stay focused and engaged
- Improve outcomes
- Quantify your value
- Share your value proposition with stakeholders
Case Study Network Outcome Examples

Length of Stay Reductions
Network Goals, Decision-making Framework, and Operational Components
Network Goals, Commitment to Network Membership, and Membership Criteria

Length of Stay Reductions

Atrius Health
Banner Health Network
Providence-Swedish Health Alliance

Atrius Health, Massachusetts

- Encompasses physician practices including Dedham Medical Associates, Granite Medical Group, and Harvard Vanguard Medical Associates
- Participates in Commercial ACO and Pioneer ACO models
- Evaluated 100 SNFs to be considered for preferred network; chose 36 SNFs as preferred providers
- SNF average length of stay metrics include:
  - SNF providers with Atrius-employed physicians 13.9 days
  - SNF preferred providers 15.8 days
  - All other SNFs 22.3 days

Source: https://www.advisory.com/daily-briefing/2015/05/12/hospitals-create-preferred-networks-for-post-acute-care
Banner Health Network (BHN), Arizona

- Encompasses Banner Health affiliated physicians, 13 acute care Banner hospitals, and other Banner services in Arizona
- Participates in Pioneer ACO model and number of Commercial ACOs
- In 2014, evaluated nearly 100 SNFs; selected just 34 to participate in BHN preferred network
- SNF average length of stay for 2014 metrics include:
  - SNF providers within BHN 12.5 days
  - Banner-affiliated SNFs (but not in network) 16.7 days
  - All other SNFs 23.7 days
Providence-Swedish Health Alliance, Washington State

- Collaboration between Providence Health & Services and Swedish Health System that addresses Triple Aim
- Participates in Commercial ACO also sponsored by Cigna and has experience as Medicare ACO
- Through Commercial ACO, SNF average length of stay was reduced from 29 to 20 days
  - 30-day all-cause readmission rate was also reduced significantly for patients in SNFs, from 13.3% to 7.5%

Network Goals, Decision-making Framework, and Operational Components

VCU Health, Virginia

Through partnership and collaboration, VCU Health seeks to improve the care continuum for patients discharged from the VCU Health Medical Center to skilled nursing and long-term care providers.

The improvement will be achieved through a seamless and integrated patient experience and will meet the objectives of providing safe, timely, efficient, effective, equitable, and patient- and family-centered care.

This new structure will enhance the strong work being performed both at VCU Health and at nursing homes across the community, and will better enable the Network to meet the objectives of enhancing population health and driving down the cost of care.
VCU Health: Member Selection: Decision-Making Framework

- Historical referral and transactional relationships
- Provider capacity
- Geographic distribution
- Performance and resources via data-oriented questionnaires and in-person analyses
  - Clinical outcomes could include star rating, length of stay, readmission rates, utilization of emergency department, etc.
- Willingness to accept all payor sources
- Willingness to collaboratively work toward outcome improvements
- Patient satisfaction
- Clinically advanced diagnosis acceptance

VCU Health: SNF Network Operational Structure Components

To promote best practice design and optimal ROI of the network, HDG and VCU Health collaboratively established:

- Provider agreement, including uniform indigent contracting component
- Ongoing provider oversight structure
- Network member requirements
- VCU Health obligations and commitment to members
- Joint operating committee structure
- Data collection

Network Goals, Commitment to Network Membership, and Membership Criteria

RWJBarnabas, New Jersey
Primary Network Goals
- Reduced readmission rate
- Increased use of POLST/Advanced Directives (initiation and completion)
- Reduced acute LOS

Secondary Network Goals
- Reduced SNF LOS
- Increased rate of discharge to community
- Increased updated information on next of kin
- Increased patient and family satisfaction
- Increased use of post-acute provider network

RWJBarnabas: Commitments to Provider Network
- Earlier referrals; minimize late discharges
- Education to patients regarding the network
- Assessment of readmitted patients
- Quarterly meetings
- Semi-annual (minimally) education to SNF staff
- Annual re-evaluations
- Assessment of leakage outside of the network

RWJBarnabas Network Membership Criteria
- Admission 24/7; Therapy 7 days per week; RN 24 hours per day
- Sharing patient-level outcomes/information
- Root cause analysis on readmission and ED utilization (every patient)
- Timeliness of data submission
- Use of Curaspan (care transition solution)
- Specific patient-level data to be collected on monthly basis based on network goals:
  - Readmission and ED utilization rate (30 day and 90 day)
  - Percentage of patients initiated and completed POLST or Advanced Directives
  - Rate of discharge to community
  - Patient and family satisfaction results
  - Any root cause analysis (all readmissions and any ED utilization)
The Acute Care Bridge to Improving the Health and Outcomes of Individuals Transitioned to Post-Acute Providers

Discussion and Questions

For More Information

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