Best Practices for Developing Post-Acute Care Networks

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Speakers

- **Blair Childs**, Senior Vice President, Public Affairs, Premier Inc.

- **Andy Edeburn**, Principal, Premier Population Health Advisory Services

- **Donna Sabol**, RN, MSN, CPHQ, Vice President and Chief Quality Officer, St. Luke’s University Health Network - Bethlehem, PA

- **Nancy Guinn**, MD, Medical Director of Healthcare at Home, *Presbyterian Healthcare Services* - Albuquerque, NM
Healthcare leaders are increasingly looking to oversee care beyond the hospital walls as patients enter into post-acute care.

85% of C-suite leaders plan to expand their partnerships with local post-acute care providers over next three years.

95% of C-suite leaders report hospitals and health systems may experience challenges in creating successful, high-value post-acute partnerships.

Source: Premier Fall 2016 Economic Outlook Survey
Why Is This Issue Important Now?

Accountability

Variation
Accountability

Alternative payment models are the new reality.

- Bundled payments
- ACOs
- Patient-Centered Medical Homes
- MACRA – PTAC
## Skilled Nursing Facility Quality Variation

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Mean</th>
<th>25th percentile</th>
<th>75th percentile</th>
<th>Ratio of 75th to 25th percentile</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharged to the community</td>
<td>37.6%</td>
<td>29.4%</td>
<td>46.5%</td>
<td>1.6</td>
</tr>
<tr>
<td>Potentially avoidable readmissions during SNF stay</td>
<td>10.9%</td>
<td>7.8%</td>
<td>13.6%</td>
<td>1.7</td>
</tr>
<tr>
<td>Potentially avoidable readmissions within 30 days after discharge from SNF</td>
<td>5.6%</td>
<td>3.6%</td>
<td>7.3%</td>
<td>2.0</td>
</tr>
<tr>
<td>Average mobility improvement across the three mobility ADLs</td>
<td>43.5%</td>
<td>35.5%</td>
<td>52.1%</td>
<td>1.5</td>
</tr>
<tr>
<td>No decline in motility during SNF stay</td>
<td>87.1%</td>
<td>82.7%</td>
<td>92.7%</td>
<td>1.1</td>
</tr>
</tbody>
</table>

Note: SNF (skilled nursing facility), ADL (activity of daily living). Higher rates of discharge to community indicate better quality. Higher readmission rates indicate worse quality. “Mobility Improvement” is the average of the rates of improvement in bed mobility, transfer, and ambulation, weighted by the number of stays included in each measure. “No decline in mobility” is the share of stays with no decline in any of the three ADLs. Rates are the average of facility rates and calculated for all facilities with 25 or more stays, except the rates of potentially avoidable readmissions during the 30 days after discharge, which are reported for all facilities with 20 or more stays.

Variation in Cost

Readmission rates

- Low Performer: 23% +
- High Performer: < 15%

Length-of-stay

- Low Performer: 34 days
- High Performer: 24 days

$4,000 differential

Source: New England Journal of Medicine
Variation in Cost

Top Opportunity to Reduce Costs for Hip Replacements, Colectomies: Post-Acute Care

Difference between top and bottom quintile incost per episode

- **Lowest cost**
  - Hip replacement: $17,784
  - Colectomy: $24,693

- **Highest cost**
  - Hip replacement: $25,392
  - Colectomy: $27,992

Percent of difference between highest and lowest cost case by service type

- **Index Admission**
  - Hip replacement: 84%
  - Colectomy: 7%

- **Readmission**
  - Hip replacement: 9%
  - Colectomy: 36%

- **PAC**
  - Hip replacement: 44%
  - Colectomy: 11%

Source: Health Affairs - http://content.healthaffairs.org/content/30/11/2107.full
Placement decisions often reflect local practice patterns and the availability of different types of providers.
No More Siloes

Solution: Create effective partnerships with top-performing post-acute care providers.

The key is how do leaders create effective partnerships?
Andy Edeburn
Principal, Premier Population Health Advisory Services
Post-Acute Care Overview

**Skilled Nursing Facilities**
(2014)
- 15,000 SNFs
- 2.4 million Medicare-covered stays
- 1.7 million Medicare beneficiaries served
- $28.6 billion spent

**Home Health Care**
(2014)
- More than 12,400 agencies
- 3.4 million beneficiaries served
- $17.7 billion spent

**Long-term acute care hospital**
(2014)
- 134,000 Medicare-covered stays
- 118,000 Medicare beneficiaries served
- $5.4 billion dollars spent

**Inpatient rehabilitation facility**
(2014)
- 1,180 facilities
- 376,000 Medicare-covered stays
- 39,000 Medicare beneficiaries served
- $7 billion spent
We’ve gleaned shared learnings, strategies and best practices from our members and participants within Premier’s Bundled Payment Collaborative, which helps providers develop, implement and succeed in using bundled payment arrangements in both public and private markets.
Best Practices

1. Determining Roles and Accountability
2. Begin to Understand Consumption, Costs and Outcomes through Data
3. Start Dialogue with Post-Acute Care Providers
4. Establish Narrow Network with Preferred Institutions
5. Improve Care Together for Patients
Determining Roles and Accountability

First step is to define who oversees leadership and management of the network, and who has ownership and accountability for implementing, monitoring and improving network operations.

Why is this important?

Who should oversee this work?
When looking at potential partners, there is a distinct need to understand the gaps between the current landscape and desired state in order to create the infrastructure necessary to sustain a high-performing post-acute care network.

Why is this important?
Internal practice and trends also a key component of the post-acute puzzle.

Key questions to ask:
» Who is referring?
» Where are they being referred?
» What is rationale for being referred?
After taking a deep dive on preliminary data and after gaining a sense of how a post-acute network will be managed and developed, the next step is to begin the discussion with post-acute care providers within the community to determine the level of interest in collaboration.
Health system leaders should be equipped with the right information to identify potential partners that share or are willing to adopt accountable care measures, as well as a culture that values safety, quality and patient centeredness.
Establish Narrow Network with Preferred Institutions

Hospitals in Action: Banner Health (Phoenix, AZ)

Banner Health examined the operations, culture and quality of care at nearly 100 skilled nursing facilities in Phoenix.

Elements of success:
- Establish Network
- Create Partnership Agreement
- Track Results
What is the challenge?
» Creating an effective network which significantly improve care and reduces costs.
» The hard work lies in setting up the network for success.

Shared mission, vision and goals
Many patients receive care in multiple PAC settings during a given episode.

Figure 4: Analysis of Selected Discharge Patterns among Medicare PAC Users, 2006

Note: Percentages indicate share of beneficiaries who completed transition through that point. Includes only patterns representing more than 1.3% of all transitions.

Source: American Hospital Association
http://www.aha.org/research/reports/tw/10nov-tw-postacute.pdf
Successful partnerships will:

- **Be tailored** to a community’s unique needs – no one partnership is the same.
- **Improve** both acute discharge and referral process and post-acute care clinical practice.
- **Evolve** based on opportunities for process improvement.
Donna Sabol, RN, MSN, CPHQ, Vice President and Chief Quality Officer, St. Luke’s University Health Network, Bethlehem, PA
SLUHN Experience

- **About St. Luke’s Post-Acute Program**
  - Piloted in four hospitals
  - 84 bundles
  - $100M annual claims

- **Why take this on?**
  - Served as a learning opportunity
  - Anticipated CMS future payment model
  - Saw opportunity for system-wide change
Investments, strategies and assets used to help the SNF Preferred / Aligned Partners program succeed include:

- Staffing
- Technology
- Data Analysis → SNF Scorecard
- Care Coordination
- Gainsharing
**SLUHN - Initiatives**

- **Readmission Reduction**
  - Mitigate risk factors
  - Align care coordination
  - Improve transitions of care
  - Physician access

- **Bundle Specific Interventions**
  - Major Lower Joint
  - Sepsis
  - Geriatric Surgery Program

**Outcome Data**

<table>
<thead>
<tr>
<th>Initiative</th>
<th>% Improved</th>
</tr>
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<tbody>
<tr>
<td>Readmissions</td>
<td>51.97%</td>
</tr>
<tr>
<td>Sum of PSI 12 PE/DVT</td>
<td>39.41%</td>
</tr>
<tr>
<td>PSI 09 Hemorrhages</td>
<td>21.23%</td>
</tr>
<tr>
<td>Post-Op Dx PN</td>
<td>41.65%</td>
</tr>
<tr>
<td>Discharge Dx Delirium</td>
<td>42.08%</td>
</tr>
<tr>
<td>HAC, Falls, or Trauma</td>
<td>100%</td>
</tr>
</tbody>
</table>
Post Acute Alignment

- Started with 16 SNF Partners → Winnowed down to 9 SNF Partners (April 2016)
- Created Preferred Provider Collaborative (June 2016)
- Ambulatory Care Coordinators: Primary Care; Chronic Disease

Source:
H&HN
May 2015
Results

- **SNF Length of Stay (90 Day Episode)**
  36.8 days → 28.9 days

- **SNF Readmission (90 Day Episode)**
  34.4% → 26.6%
## Performance

### Medicare Spending Per Beneficiary

<table>
<thead>
<tr>
<th>Facility</th>
<th>Initial Spending</th>
<th>Final Spending</th>
</tr>
</thead>
<tbody>
<tr>
<td>St. Luke’s A/B</td>
<td>1.01</td>
<td>0.97</td>
</tr>
<tr>
<td>St. Luke’s RA</td>
<td>0.95</td>
<td>0.93</td>
</tr>
<tr>
<td>St. Luke’s W</td>
<td>1.00</td>
<td>0.93</td>
</tr>
</tbody>
</table>
Nancy Guinn, MD, Medical Director of Healthcare at Home, Presbyterian Healthcare Services - Albuquerque, NM
Presbyterian By the Numbers

11,000 employees
New Mexico’s largest private employer

$100 million annually
Amount of free and uncompensated medical care provided

Largest not-for-profit healthcare system in New Mexico
Serving One in Three New Mexicans
470,000 members of Presbyterian Health Plan
Complete Care

Focusses on 5% of Medicare Advantage members with most serious illnesses

These members are responsible for 50% of costs

Identified by case managers, health assessments, Home Health intake and Epic registries
Complete Care: details

- Accepts the most complex patients
- “One number to call,” 24-7
- RN in-home case management
- Integrated with Palliative Care and House Calls practice
- Track many outcomes, such as ED visits, hospitalizations, falls, urgent visits, hospice
Complete Care: results

Readmission and hospitalization rate 50% of predicted for this population

85% of patients who die do so at home by their choice

553 urgent home visits; 372 of them directly avoided ED visits and subsequent hospitalizations

Initial reports: savings of $700+ per member, per month