



FEATURE

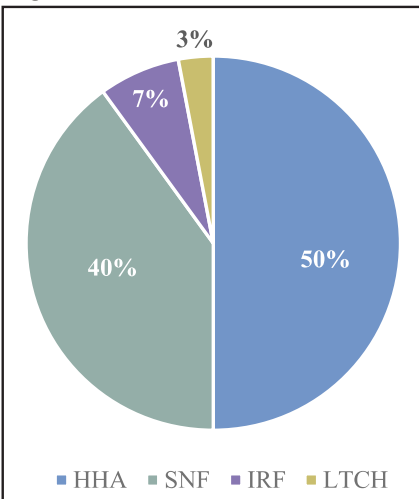
Complete Your Continuum

The Top Three Factors Behind Successful Partnerships in Post-Acute Care

In a health care industry that is transitioning from a fee-for-service model to a value-based reimbursement system, hospitals are selling outcomes, not procedures. This shift has had a substantial impact on health care delivery and treatment, especially in regard to hospitals' partnerships with post-acute care providers.

Although post-acute care providers include long-term care hospitals (LTCHs), inpatient rehabilitation facilities (IRFs), skilled nursing facilities (SNFs), and home health agencies (HHAs), the majority of services are rendered by SNFs and HHAs (Figure 1).

Figure 1: Post-Acute Care Providers



Developing partnerships with these service providers is of crucial importance to reducing re-admittances to the hospital and improving overall outcomes.

Nearly 42% of Medicare patients are discharged to a post-acute care setting and in order for improvements to be made, the process must first be measured and tracked.¹ This becomes

complicated as nearly 50% of hospitals refer patients to 18 or more post-acute care providers.² The more post-acute care providers in the network of the hospital, the more resources will be required to manage the care process to ensure quality care is given after discharge. Hospitals that identify and select the correct strategic partners should achieve better outcomes with their patients.

1. Identifying and Selecting Strategic Partners

1. <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb205-Hospital-Discharge-Postacute-Care.pdf>

2. "Why Post-Acute Care Partners Are Critical to Hospitals' Future," <http://www.hhnmag.com/articles/7421-why-post-acute-care-partners-are-critical-to-hospitals-future>

There is a plethora of information out there to assist hospital management in screening for potential strategic partners. Big data resources such as Medicare.gov is a good place to start. Here are some important measures of performance to focus on for SNFs and HHAs:

SNFs:

- Three out of five-star quality rating minimum. A three-star quality rating is needed to waive the three-day-stay rule to allow for the transference of patients to a post-acute care setting more quickly for comprehensive joint replacement (CJR) and certain managed care companies and ACO programs. Approximately 64% of SNFs have a rating of three or higher, leaving more than one-third of all SNFs below the requirement.
- Below average re-hospitalization rates
- Number of registered nurses
- Patient and family satisfaction survey information

HHAs:

- Star scores at or above the state average
- Recertification rates at the state average
- Patient survey results

Although the five-star system started out as just a tool to measure SNF performance, it has developed into a highly sophisticated payment tool which is closely monitored by post-acute care providers. The ratings in the five-star system are calculated on a state-by-state basis, with the top 10% of facilities receiving five stars, the middle 70% receiving a rating of two, three or four, and the bottom 20% receiving one star. These ratings are based upon health inspection scores, staffing, case mix and quality. Those metrics may vary from year to year, thus it is important to look at the historical ratings of the facilities. Reviewing re-hospitalization rates are also important and although the national average is currently 17.5%, special care should be given to analyze the acuity level of the facility (typically, the higher the acuity of the patient, the higher the chances of readmission are). Additionally, the appropriate number of registered nurses should be analyzed

based on the acuity and number of patients at the facility, with careful distinction between registered nurses and licensed practical nurses. Becoming a registered nurse requires additional training that allows for more accurate and timely assessments.

For HHAs, the five-star rating system is not as widely used as it is for SNFs. However, it still provides valuable information and will likely become more widely used as more patients utilize the Home Health Compare function on Medicare.gov. Recertification rates are also useful, as they provide the proportion of non-initial patient episodes to initial episodes, giving an indication as to the incidence of chronic, multi-episode patients. Finally, because home health occurs in the patient's home, patient surveys are a good source to review as well.

Consideration should be given to the proximity of the patients to the hospital if they are not returning home. Closer facilities present obvious benefits, such as less travel time for a patient should a complication occur and re-admittance prove necessary. Closer facilities also allow for more networking between the post-acute care provider and the hospital. This could prove beneficial in improving the lines of communication, resulting in reduced mistakes and aligning both organizations to improving outcomes of patients. On-site reviews of the post-acute care facility and interviews of senior management are also key in determining the culture fit and quality of care.

2. Investing in People and Technology

To truly achieve an integrated health care delivery model, post-acute care must act as an extension of the care a patient receives at a hospital. Hospitals need to be able to monitor patients in the post-acute care setting the same way they monitor patients in their own facility. This requires significant investment in technology that is able to communicate effectively with the hospital's own technology as many of these patients have co-occurring health conditions. Although many hospitals may have sophisticated electronic health records systems, the same cannot always be said of post-acute care providers. Special attention should be paid to the integration of health information technology systems to ensure health information is able to be shared in a secure and timely manner. The best health management systems are able to identify and issue alerts on a real-time data exchange to the hospital on patients discharged to post-acute care settings. Post-acute care providers that have implemented these systems may come at a higher price but a reduction in re-admission rates may justify the increased cost.

Similar to inter-departmental meetings at the hospital, best practices denote regular meetings with management of the post-acute care facility to review trends in patient care, discuss readmission causes and identify any weaknesses in the provision of care after discharge from the hospital. Assigning a hospital care coordinator with accountability in the patient outcomes and re-admission rates from a specific post-acute

care facility could lead to better results. Additionally, aligning the incentives of the hospital and post-acute care provider by sharing savings if certain quality metrics are met may improve outcomes as well.

3. Remaining Flexible

The implementation of the Affordable Care Act (ACA) has disrupted the traditional health care delivery model and, no matter what the ACA's future, it is likely that there will be continued change. Retaining flexibility is vital to hospital operators and post-acute care providers alike. To deal with some of these changes, hospitals and accountable care organizations (ACOs) have been forming post-acute continuing care networks comprised of select post-acute care providers. Although these care networks are still in the developmental phase, they are emerging as a means of ensuring there is a certain quality of care given to patients after discharge from the hospital.

Some hospitals are forming joint ventures with post-acute care providers, building new facilities located on or near the hospital's main campus. This allows for a streamlined process and uninterrupted care after discharge from the hospital. The joint venture aligns the organizations and leverages experience from both acute care and post-acute care to improve patient outcomes. Other hospitals are choosing to instead lease space to post-acute care providers on their campuses in an effort to bring the organizations closer together.

Although there is no one-size-fits-all solution to building successful partnerships with post-acute care providers, hospitals that allocate resources efficiently and remain open to new care delivery models will be best positioned to provide quality care to their patients.



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