Collaborating for Post-Hospital Care: Developing Continuing Care Networks

AHA Rural Health Care Leadership Conference
Phoenix, AZ – 10 February 2014
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Road Map for Continuing Care Networks

- Critical success factors for health systems taking payment risk
- Description of post-acute continuing care network (CCN)
- Rationale for developing post-acute CCN
- Six steps to a proven CCN model
- Lessons learned in establishing CCNs for ACOs and health organizations

Please note that the views expressed by the conference speakers do not necessarily reflect the views of the American Hospital Association and Health Forum.
Critical Success Factors for Hospitals and Health Systems into the Future

1. **Physician Alignment and Access** that assures immediate access to office-based primary care or house calls as well as primary care management in acute and post-acute venues

2. **Robust IT Platform and Just-in-Time Business Intelligence** that provides cross continuum information in real time for pre-acute, acute, post-acute, and home-based encounters

3. **Risk-Adjusted Enterprise Care Management** that includes stratifying population and tailoring care management as well as longitudinal management of beneficiaries

4. **Developing Network of Post-Acute Providers** for standardized, evidence-based care across the acute/post-acute continuum and seamless, optimal patient experience

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Post-Acute Hasn’t Become a Burning Issue for Many...

- Hospital care: 31%
- Physician clinical services: 21%
- Other professional services: 6%
- Other retail products: 3%
- Rx drugs: 10%
- Home health: 3%
- Nursing home care: 6%
- Dental: 4%
- Investment: 7%
- Gov't. public health activities: 3%
- Program Administration: 7%

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But PAC Is Getting Recognized

- Hospitals, emerging ACOs and other payors recognize that post-acute care will play an important in pivotal role in reducing costs and managing population health.

  "Policymakers and health care providers increasingly recognize that coordination between acute care hospitals and post-acute providers is essential to improving the overall quality of care and reducing health spending."

- Rich Umbdenstock, President & CEO, AHA

Recognizing and integrating, however, are two very different things.

Post-Acute Continuing Care Networks

- Continuing care networks play an important role for health care systems, especially for those with shared risk payment arrangements
  - About 43% of Medicare fee-for-service beneficiaries are discharged to one of the four Medicare-defined post-acute settings:
    - Long-term acute care hospitals (LTACHs)
    - Inpatient rehabilitation facilities – hospitals or units (IRFs)
    - Skilled nursing facilities (SNFs)
    - Home health agencies (HHAs)
  - Many of these patients use more than one post-acute setting
  - Health systems have no control over payments, clinical quality for discharges to unaffiliated post-acute setting

*Continuing Care Networks (CCNs) 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*
Care coordination must be a continuous process that begins before illness warrants hospitalization, continues when hospitalization is necessary, and seamlessly moves back into the community.

For many patients, particularly for those with chronic illness, the episode of care has no definite end.

Innovations in care coordination need to further develop lifelong models of longitudinal care.


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Lack of CCN Poses Significant Risk for Health Systems in New Delivery Model

“Medicare Spend” on Post-Acute Care by Condition

- Stroke
- Hip and Femur Proc.
- Cardiac Bypass
- Heart Failure

0% 20% 40% 60% 80% 100%

Source: MedPAC September 2012; MedPAC Analysis of 2004-2006 5% Medicare claims files

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2020 Goal: Minimum 50% of Total PAC Provider Payments Bundled

Reduce Spend by 2.85%

2013 2015 2017 2018 2020

BPCI pilot begins October 1

BPCI begins for all PAC providers

Challenge for CCNs: Post-Acute Silos, “Continuum” Is not a Given

LTACHs

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SNFs

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HHAs

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Source: MedPAC Report to Congress, March 2013

PTY = proprietary; NP = not-for-profit; HB = hospital-based; Gov = government; FS = freestanding

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Proven Steps to a Successful Post-Acute Continuing Care Network

1. Project Mobilization: Data Gathering and “Right System Team on the Bus”
   - Understand and build on health system’s post-acute continuum work to date (not recreating the wheel)
   - Identify system’s project team (administrator, physician, APN) and preliminary CCN coordinator, clinical specialist and leadership champion
   - Define charter, develop work plan and set launch target for project
   - Identify needed data to guide subsequent steps of the process

2. Analysis for Access, System Clinical Integration, Continuum Care Management

3. Establish CCN Infrastructure

4. Select and Confirm CCN Post-Acute Provider Members

5. Establish Metrics and Reporting System

6. Redesign Care to Effect Clinically Integrated Acute/Post-Acute Continuum
2. Analysis for Access, System Clinical Integration, Continuum Care Management

- Volume of SNF beds, admissions to home health agencies, and geographic locations needed by hospital/system to assure access to post-acute venues and hospice
- Access to venues, post-acute utilization, and hospital length-of-stay issues to be addressed by CCN
- Assessment of owned and most used unaffiliated post-acute venues (LTACHs, IRFs, SNFs, HHAs, hospice); level of clinical integration
- Assessment and analysis of care redesign needs for post-acute CCN management and integration with health system’s ongoing or previous efforts at coordination, care management model

3. Establish CCN Infrastructure

- System refinement of “typical” requirements for CCN member credentialing and assessment of health system’s resources for CCN and members
- Establish health system’s internal organizational structure for CCN, including job descriptions, internal resources required, external needs
- Finalize credentialing criteria and narrow list of potential CCN members based on quality indicators, barriers to access, and other factors
- Prepare model for primary care coverage and care/cost management in CCN SNFs
- Complete documents for implementing internal CCN processes and selection of/reporting by CCN members
- Establish CCN Coordinating Committee and work plan for CCN creation
Examples of Documents and Tools Needed to Implement & Monitor

- The CCN structure and committee compositions
- SNFist model, responsibilities
- Provider conditions of participation – each venue
- Outcome measures and metrics – applicable to all and to specific venues
- Provider agreements – each venue
- Communications plan
  - Internal and External
- Educational outreach program
  - High-intensity nursing education program
- Patient flow processes
- Ad hoc subcommittees for standardizing evidence-based practice in specific clinical areas across the continuum, transfers, coordination and so on.
4. Select and Confirm Post-Acute CCN Provider Members

- Perform the data review (geographic, specialty programs, capacity, capabilities needs), summarize public data on post-acute venues, ultimately followed by survey or RFP from target participants
- Define expectations with unaffiliated post-acute providers and verify interest in CCN membership
- On-site review of post-acute venues as needed to validate self-reported data and update or refine
- Develop rating system to select narrow network of post-acute providers
- Decide whether to conditionally credential certain providers, initial number of each venue providers in CCN, and how to add members

5. Establishing Metrics and Reporting Systems for the CCN

- Metrics tailored to health care system or ACO post-acute challenges as well as performance issues in post-acute settings
  - Always include admissions, readmissions, and ED visits in first 72 hours for all settings
- Input from post-acute venues and CCN coordinating committee
  - Idea is to stretch providers and clarify educational resources from health system needed to assure success of CCN
- Set up reporting methods from CCN members; internal analysis and transparent comparative reporting; determine internal resources to support and managed the process
- Use metrics to retain, eliminate, and add members; establish agreed upon processes for these areas
Selecting CCN Members is the easy part. 
Making the CCN work for your patients, physicians, and the health system requires skill, discipline, experience, and time.

6. Redesign Care to Effect Acute/Post-Acute Continuum

• Process redesign includes a variety of acute/post-acute and transition areas, such as:
  – Early identification of, and CCN information to, post-acute discharges
  – Standardized advance care planning; palliative care consults in post-acute care
  – Warm hand-offs – all settings (doctor to doctor, nurse to nurse, PCP integration in process)
  – Integration with risk stratified, medically complex, care management program
• Venue-specific committees; roles, charters, membership, expectations
• Ad hoc subcommittees for cross continuum clinical practice; improved evidence-based practices across the continuum
• IT subgroup for interconnectivity among settings
Success will be defined by delivering quality outcomes and value
CCN ROI to Health System

Fundamental to Assessing Success

• Reported metrics by CCN members reflect hospital quality measures including:
  – Patient/family satisfaction
  – Patient engagement
  – Incidence of events that show less than optimal quality
• Financial indicators:
  – Readmission rates
  – Admission rates from long-term care
  – Post-acute readmissions
  – ED visits; during and after post-acute episode
  – Medicare payment across the post-acute episode (number of settings used, SNF days, HHA re-certifications, LTACH use)

Results Are Promising

• Impressive reductions in post-acute LOS, particularly for SNFs – in one market dropping from 42 days on average to less than 28.
  – The 14-day reduction represents, on average, a $5,300 Medicare savings per patient discharged to a CCN participating facility
• Corollary reductions in readmission also lead to cost savings and reduced risk for the hospital, system or ACO:
  – For one CCN, the SNF-to-acute readmission rate fell from 18% to less than 2% in 12 months.
• Family and patient satisfaction with discharge management is also improved, given hospital/PAC effort to better coordinate care along the continuum.
Our Experience: Some of the Keys to a Successful CCN

**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 re: CCN 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?

In the middle of difficulty lies opportunity.

*Albert Einstein*
Questions?

Thank You!

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