Post-Acute Care Networks: How to Succeed and Why Many Fail to Deliver

HEALTH FORUM AND AHA LEADERSHIP SUMMIT
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Post-Acute Care Continuing Care Network Essential for Risk Bearing Hospitals

• A PAC-CCN is a select group of providers that is organized to deliver high quality care, leverage clinical expertise and provide oversight in order to improve efficiency, patient outcomes and patient experiences.

• Without a CCN, Health systems have no control over clinical quality for discharges to unaffiliated post-acute setting.

• Even if you own one or more post-acute venues, you will need to partner to assure access and quality across the continuum.
CMS Policies Spur Preferred Network Development

CMS waivers of 3 day stay creates “de facto” preferred networks

CJR regulations permit preferred providers

Proposed discharge planning regulations require hospitals to share quality data
Medicare Patients Use Multiple Post-Acute Settings of Care

Medicare FFS Hospital Discharges

41.4 % to PAC

1st Discharge Setting

SNF 19.5%

Home Health 16.8%

Acute Rehab 3.2%

LTACH 1.1%

2nd Discharge Setting

42.9%

4.2%

64.3%

60.2%

Choice of First Discharge Setting Determines Total 90 day Episode Costs (CJR Bundle with and without Fracture)

**Average Medicare Spending**

<table>
<thead>
<tr>
<th></th>
<th>Home</th>
<th>%</th>
<th>HHA</th>
<th>%</th>
<th>SNF</th>
<th>%</th>
<th>IRF</th>
<th>%</th>
<th>LTCH</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>LEJR w/o Fracture</td>
<td>$17,424</td>
<td>20.9%</td>
<td>$19,656</td>
<td>39.1%</td>
<td>$28,495</td>
<td>32.5%</td>
<td>$34,714</td>
<td>6.4%</td>
<td>$61,780</td>
<td>0%</td>
</tr>
<tr>
<td>LEJR w/Fracture</td>
<td>$24,300</td>
<td>7.1%</td>
<td>$23,137</td>
<td>5.5%</td>
<td>$41,370</td>
<td>65.9%</td>
<td>$44,489</td>
<td>20.3%</td>
<td>$69,054</td>
<td>0.5%</td>
</tr>
</tbody>
</table>

*Source: Dobson | DaVanzo analysis of Medicare fee-for-service claims data for FFY 2013 and 2014.*
CJR Bundles (No FX): Variation in SNF Costs for Medicare Discharges

Variation in SNF costs almost 3 fold

Source: Dobson | DaVanzo analysis of Medicare fee-for-service claims data for FFY 2013 and 2014.
CJR Bundles (With FX): Variation in SNF Costs for Medicare Discharges

US: 28.0%

Variation in SNF costs 1.5 fold

Source: Dobson | DaVanzo analysis of Medicare fee-for-service claims data for FFY 2013 and 2014.
Care Redesign is a **Business Imperative**

- Risk stratify patients
- Create diagnosis specific pathways
- Manage care across the episode
- Right size post acute care use

**Gainsharing and Risksharing permissible with PAC to align incentives**
ACOs that Achieved Shared Savings Reduced PAC Expenditures

Source: CMS Medicare Shared Savings Program Webinar, September 1, 2015
OhioHealth Approach to SNF Continuing Care Network

• Significant readmissions coming from SNFs in Columbus market
• Physician and patient concern about quality
• Changes in healthcare environment
  – ACOs
  – Bundled payments
  – Value-Based Purchasing
• Overutilization of SNFs in Columbus market
OhioHealth Approach - Guiding Principles

• Focus on quality:
  – Oversight provided by Quality of Care Committee - OhioHealth’s Board of Directors

• Create a narrow network for effective management without impacting access

• Honor patient choice

• Not based on payment to OhioHealth

• Create an organizational structure to support SNF CCN
OhioHealth Approach - Critical Selection Criteria

- Meets or exceeds median federal quality standards
- State and federal regulation compliance
- 30-day hospital readmission rate ≤ national and state averages
- Nursing Ratios (1 nurse:15 patients)
- **Experience and engagement** with OhioHealth Central Ohio Hospitals
## OhioHealth Approach – Network Success Factors

<table>
<thead>
<tr>
<th></th>
<th>Target</th>
<th>BASELINE MAR14- JUN14</th>
<th>FY15 YTD</th>
<th>Mar 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Overall Volume</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Inpatient Discharges to any SNF</td>
<td></td>
<td>16.1%</td>
<td>15.8%</td>
<td>15.8%</td>
</tr>
<tr>
<td><strong>Medicare Volume</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Medicare Inpatient Discharges to any SNF</td>
<td>20.0%</td>
<td>25.1%</td>
<td>26.1%</td>
<td>25.3%</td>
</tr>
<tr>
<td><strong>RETENTION</strong></td>
<td>Target</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients Living in Franklin County Discharged to SNF CCN (% of SNF Discharges)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% Inpatient Discharges to SNF CCN of all discharges to Skilled Care</td>
<td>63.0%</td>
<td>57.6%</td>
<td>58.8%</td>
<td>60.0%</td>
</tr>
<tr>
<td><strong>SNF CCN LENGTH OF STAY (BASED ON SNF D/C DATE)</strong></td>
<td>Target</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF CCN ALOS - All patients</td>
<td></td>
<td>21.2</td>
<td>24.0</td>
<td>14.3</td>
</tr>
<tr>
<td><strong>Readmission Rate</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>30-Day Readmission Rate for Franklin County Inpatients Discharged to any SNF</td>
<td>15.9%</td>
<td>15.4%</td>
<td>18.1%</td>
<td></td>
</tr>
<tr>
<td>30-Day Readmission Rate for Franklin County Inpatients Discharged to any SNF - Medicare patients</td>
<td>15.2%</td>
<td>15.4%</td>
<td>16.1%</td>
<td></td>
</tr>
</tbody>
</table>
## OhioHealth Approach - Facility Scorecard

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target *</th>
<th>January-15</th>
<th>February-15</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Count</td>
<td>%</td>
</tr>
<tr>
<td><strong>Data Integrity</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chart Audit Discrepancies (# out of 40)</td>
<td>0</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>SNF CCN Discharges</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total OH patients discharged from SNF</td>
<td>N/A</td>
<td>13</td>
<td>-</td>
</tr>
<tr>
<td>Total OH Medicare FFS patients discharged from SNF</td>
<td>N/A</td>
<td>6</td>
<td>-</td>
</tr>
<tr>
<td><strong>Length of Stay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Medicare FFS patients w/ LOS &lt; 21 days</td>
<td>&gt; 90%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Length of Stay - Medicare FFS joint replacement patients (MS-DRG - 469 &amp; 470)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Medicare FFS joint replacement patients (MS-DRGs - 469 &amp; 470) w/ LOS ≤ 14 days</td>
<td>&gt; 90%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>**Readmissions of patients discharged from OH acute setting *****</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All payer 30-day, all cause readmissions to OH hospital only</td>
<td>≤ 19%</td>
<td>1</td>
<td>17%</td>
</tr>
<tr>
<td>Medicare 30-day, all cause readmissions to OH hospital only</td>
<td>≤ 19%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Patients seen by physician or APN w/in 48 hours of admission</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>&gt; 80%</td>
<td>8</td>
<td>62%</td>
</tr>
<tr>
<td><strong>Patients scheduled to be seen by physician relevant to SNF stay within 7 days of SNF Discharge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>&gt; 80%</td>
<td>2</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Hospice care of less than 3 days for patients who expired</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># pts hospice svc &lt; 3 days</td>
<td>≤ 20%</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Medication reconciliation completed for all patients at admission</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>&gt; 80%</td>
<td>13</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Medication reconciliation completed for all patients at discharge</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>&gt; 80%</td>
<td>5</td>
<td>83%</td>
</tr>
<tr>
<td><strong># of patients referred to ED within 72 hours of admission</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td># Patients referred to ED ≤ 72 hours</td>
<td>≤ 10%</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>
CCN vs Non-CCN Readmission Rates
March 2015 – March 2016 Residents of all counties

Readmission Rates

SNF CCN
NON CCN
Advocate Health Care

12 Hospitals
• 10 acute care hospitals
• 1 children’s hospital (two campuses)
• 1 critical access hospital
• 5 Level I trauma centers
• 4 major teaching hospitals
• 1 medical group with 1,500 physicians
• 350 sites of care
• 11,000 daily census in our Home Health/Post-Acute network

35,000 Associates

Advocate Physician Partners
• 11 PHOs
• 5,000 participating physicians
• One of the largest ACOs in the US – over 800,000 covered lives
• Nationally recognized CI Program
• Leader in Population Health management
Advocate Continuum of Care

<table>
<thead>
<tr>
<th>Provider</th>
<th>ADC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate Hospitals</td>
<td>2,126</td>
</tr>
<tr>
<td>Advocate at Home</td>
<td>9,925</td>
</tr>
<tr>
<td>Advocate Post Acute Network</td>
<td>1,245</td>
</tr>
<tr>
<td>Advocate Rehab Network</td>
<td>93</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>13,389</strong></td>
</tr>
</tbody>
</table>

Advocate Post Acute represents an ADC of 11,254 or 84.1% of Total ADC

YE 2015
## Medicare Spending per Beneficiary

### National

<table>
<thead>
<tr>
<th>Period</th>
<th>Highest (NJ)</th>
<th>Average (US)</th>
<th>Lowest (OR)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1–3 Days Before Admission</td>
<td>$239</td>
<td>$252</td>
<td>$224</td>
</tr>
<tr>
<td>During Index Hospitalization</td>
<td>$10,017</td>
<td>$10,122</td>
<td>$10,945</td>
</tr>
<tr>
<td>1–30 Days After Discharge</td>
<td>$9,508</td>
<td>$7,984</td>
<td>$5,844</td>
</tr>
<tr>
<td>Complete Episode</td>
<td>$19,764</td>
<td>$18,358</td>
<td>$17,013</td>
</tr>
<tr>
<td>Percent Post Acute Spend</td>
<td>48.1%</td>
<td>43.5%</td>
<td>34.4%</td>
</tr>
</tbody>
</table>

Advocate hospital post acute spend proportion ranges from **39% to 51%** (2014 data) vs. national mean of 43%.
Post-Acute Strategy

**Skilled Nursing Facility**
- Cares for medically complex and rehabilitation patients
- Short term care facility or a unit within a residential facility

**Inpatient Rehab Facility**
- Provides comprehensive rehabilitation services
- 60% rule has shifted patient population from orthopedic to neurological patients

**Home Health Agency**
- Provides short term clinical support and education to rehab and chronically ill patients
- Goal is to teach patients to be independent and manage their own care

**Long-Term Acute Care Hospital**
- Serves patients needing ongoing acute care level services, LOS typically exceeds 25 days
- Ventilator, wound care are primary services but patient population is diverse
Post-Acute Network Results

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of SNFs</th>
<th>Patient Volume</th>
<th>30 Day Readmission Rate</th>
<th>SNF ALOS</th>
<th>Home Care Capture Rate at DC</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>---</td>
<td>---</td>
<td>20%</td>
<td>30+</td>
<td>---</td>
</tr>
<tr>
<td>2012</td>
<td>12</td>
<td>1,918</td>
<td>13.7%</td>
<td>19.6</td>
<td>65.4%</td>
</tr>
<tr>
<td>2013</td>
<td>29</td>
<td>6,180</td>
<td>14.8%</td>
<td>18.3</td>
<td>75.4%</td>
</tr>
<tr>
<td>2014</td>
<td>37</td>
<td>9,290</td>
<td>14.6%</td>
<td>17.1</td>
<td>80.5%</td>
</tr>
<tr>
<td>2015</td>
<td>39</td>
<td>8,669*</td>
<td>13.5%</td>
<td>15.7</td>
<td>82.4%</td>
</tr>
</tbody>
</table>

*Annualized

**From 2011 to 2015 ...**

- PAN facilities increased **from 12 to 39** (now 41 in 2016)
- Readmission rate from **20% to 13.5%**
- SNF ALOS decreased from **30 days to 16 days**

**Resulting in ...**

- **$45M in savings**

---

*From 2011 to 2015 ...*
Advocate SNF/PAN Care Model

This model is currently in place as a nationally recognized model of APN/Physician SNF Rounding Team.

* Physician visits 1x per week, APN 5x’s per week
Proven Steps to a Successful Post-Acute Continuing Care Network

- ACO/Health System Infrastructure and Data
- Select & Partner with Post-Acute Provider Members
- Metrics and Reporting
- Acute/Post-Acute Care Redesign
Your Clinical-Administrative Leadership and Communications

- PAC-CCN Coordinator (SW, Case Manager)
- Administrative Champion (Whole Hospital Buy-in)
- Physician Champion (Attendings, Specialists, SNFist Program)
- APN (Care Redesign)

Create A Real Partnership
Affiliation Agreements
Clinical Coordinating Council
- Health System
Operating Committee
- PACs + Health System, transparent reporting, solutions
Ad Hoc Care Redesign Task Forces
- Acute/Post-Acute Continuum

PAC Partners Want Shared Risk-Shared Savings
## Partner Selection: Credentialing Criteria

- Geographic access for all patients
- History of good working relationship with hospital/physicians
- SNFs - 24/7 admissions, 3+ stars, lower than average deficiencies, ACO/Health System physicians as SNFists
- HHAs – No cherry picking, start within 24 hours of hospital discharge, HHCAHPS scores
- Interoperability for EHR and metrics collection/reporting
Metrics Reporting: Staying in the Network

30-day hospital readmission rates

Patient/family satisfaction ratings

No emergency room visits within 3 days of PAC admission

Scheduling of primary care visit within 7 days after PAC discharge

Monthly Rolling Achievement Metrics

Efficiency Metrics: SNF = LOS, HHA = Recerts
Redesign Care for Acute/Post-Acute Continuum

• **Process redesign examples**
  – Early identification of, and SNF CCN information to, post-acute discharges
  – Standardized advance care planning; palliative care consults in SNFs
  – Warm hand-offs – all settings (doctor to doctor, nurse to nurse, PCP integration in process)
  – Integration with risk stratified, medically complex care management program

• **Ad-hoc subcommittees for cross continuum clinical practice; improved evidence-based practices across the continuum**

• **IT subgroup for interconnectivity among between hospitals, PCP offices, SNFs and your home health and hospice**
Hospitals can be successful in managing post-acute care.
Questions & Dialogue

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Resources

By Jade Gong and Kathleen Griffin

http://www.aha.org/research/reports/tw/15dec-tw-postacute.pdf
Resources (cont’d)

By Jade Gong and Kathleen Griffin