Post-Acute Care Networks: How to Succeed and Why Many Fail to Deliver
Please note that the views expressed are those of the conference speakers and do not necessarily reflect the views of the American Hospital Association and Health Forum.
Panel Presentation

Why Post Acute Networks Now
Jade Gong, MBA, RN
Jade Gong & Associates LLC

OhioHealth Critical Success Factors
Jim Newbrough
OhioHealth Home Reach

Advocate Critical Success Factors
William A. Adair, MD
Advocate

Successful PAC-CCN Creation
Kathleen Griffin, Ph.D.
Valley Consultants LLC
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>Setting</th>
<th>Home (Average)</th>
<th>Home (%)</th>
<th>HHA (Average)</th>
<th>HHA (%)</th>
<th>SNF (Average)</th>
<th>SNF (%)</th>
<th>IRF (Average)</th>
<th>IRF (%)</th>
<th>LTCH (Average)</th>
<th>LTCH (%)</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

US: 14.9%

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></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patients Living in Franklin County Discharged to SNF CCN (% of SNF Discharges)</td>
<td>63.0%</td>
<td>57.6%</td>
<td>58.8%</td>
<td>60.0%</td>
</tr>
<tr>
<td>% Inpatient Discharges to SNF CCN of all discharges to Skilled Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SNF CCN Length of Stay (based on SNF D/C Date)</td>
<td>Target</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SNF CCN ALOS - All patients</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Readmission Rate</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>Count</td>
<td>%</td>
<td>Count</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>0</td>
</tr>
<tr>
<td>Total OH Medicare FFS patients discharged from SNF</td>
<td>N/A</td>
<td>6</td>
<td>0</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>0</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

<table>
<thead>
<tr>
<th>Month</th>
<th>SNF CCN</th>
<th>NON CCN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-15</td>
<td>17.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Apr-15</td>
<td>18.0%</td>
<td>19.0%</td>
</tr>
<tr>
<td>May-15</td>
<td>19.0%</td>
<td>21.0%</td>
</tr>
<tr>
<td>Jun-15</td>
<td>17.0%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Jul-15</td>
<td>18.0%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Aug-15</td>
<td>22.0%</td>
<td>24.0%</td>
</tr>
<tr>
<td>Sep-15</td>
<td>21.0%</td>
<td>23.0%</td>
</tr>
<tr>
<td>Oct-15</td>
<td>20.0%</td>
<td>22.0%</td>
</tr>
<tr>
<td>Nov-15</td>
<td>19.0%</td>
<td>19.0%</td>
</tr>
<tr>
<td>Dec-15</td>
<td>18.0%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Jan-16</td>
<td>17.0%</td>
<td>18.0%</td>
</tr>
<tr>
<td>Feb-16</td>
<td>19.0%</td>
<td>19.0%</td>
</tr>
<tr>
<td>Mar-16</td>
<td>21.0%</td>
<td>23.0%</td>
</tr>
</tbody>
</table>

SNF CCN | NON CCN

Readmission Rates for CCN vs Non-CCN residents from March 2015 to March 2016 showing the rates for each month.
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><strong>Advocate at Home</strong> (Home Health, Hospice, RT/DME, Home Infusion)</td>
<td>9,925</td>
</tr>
<tr>
<td>Advocate Post Acute Network (SNF, LTACH, Physician at Home, Home base Palliative)</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

<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 with in a residential facility

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

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

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
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
Advocate SNF/PAN Care Model

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

1-2 Physician FTE + 1 APN FTE = Capability to manage SNF ADC

* 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

Jade Gong
Jade Gong Associates
jade@jadegong.com
703-243-7391

James Newbrough
OhioHealth Home Reach
jnewbro2@ohiohealth.com
614-566-0807

William A. Adair, MD
Advocate Health
william.adair@advocatehealth.com
708-684-5451

Kathleen M Griffin, PhD
Care Management Innovations
valleyconsultant@cox.net
480-922-9366